PERSONNEL **4149.a**

REQUEST FOR ADOPTION ASSISTANCE PLAN BENEFITS

NAME: _____ DATE OF REQUEST
SCHOOL:

In accordance with Diocesan policy, I am requesting reimbursement for eligible adoption-related expenses not to exceed $1,000.00 for my adoptive child/children: Name/s:_____ who has/have been placed with me on _____. Attached are copies of the actual bills/payments made related to this adoption. By my signature, I certify that this information is correct and permit the Employer to obtain verification of this information, if necessary. I understand that the final authority of accepting/rejecting this request rests with the Employer.

Itemization of Eligible Bills/Payments

	Amount
A. Adoption Agency Fees Name of Adoption Agency.	$
B. Lawyer's Fees/Court Costs	$
C. Medical Expenses:	
- Hospital expenses for newborn	$
- Maternity expenses for natural mother	$
- Physical examinations for adoptive parents	$
D. Temporary Foster Care Charges $_____ per day for _____ days	$
SUBTOTAL ELIGIBLE EXPENSES Multiplied by 80%	$
TOTAL EXPENSES ELIGIBLE FOR CLAIMED REIMBURSEMENT:	$

Employee's Signature: _____ Date:

Principal's Recommendation	
Signature:	Date:
Approval	Disapproval
Employer's Review	
Signature	Date
Approval	Disapproval
Amount Payable $	

(up to a maximum of $1,000.00)