Adoption Assistance Reimbursement Claim Form

Instructions

Please provide all of the following information and sign this form. Provide copies of bills or records that substantiate who (name and address) provided the services or goods, reason for the charges and the dates and amounts of the charges. Submit this form and substantiation to HRDC, Mission Health Human Resources, 1 Hospital Drive, Asheville, NC 28801. Please keep copies of all documents for your records.

Eligible Child Information

Child's Name: _____

SSN, TIN, ATIN (if available): ____-___-____
Child's DOB: ____/___/____

Child's Country of Birth: _____
When will the adoption be finalized? _____

Qualifying Adoption Expenses

Type of Expense	Date Expense Incurred	Amount

Qualifying Adoption Expenses: Qualified adoption expenses include, but are not limited to, reasonable and necessary adoption fees, court costs, attorney fees, traveling expenses (including amounts spent for meals and lodging) while away from home, and other expenses directly related to, and whose principal purpose is for, the legal adoption of an eligible child. $3,500 cap.

Non-Qualifying Adoption Expenses: Non-qualifying expenses are those that violate state or federal law; expenses for carrying out any surrogate parenting arrangement; expenses for the adoption of a spouse's child, grandchild or other family member; expenses paid using funds received from any other source (such as another employer or from a federal, state, or local program); or expenses taken as a credit or deduction under any other federal income tax rule.

Caregiver Certification

I hereby certify that all items requested to be reimbursed comply with Mission Health System's Adoption Assistance Plan and such items have not and will not be covered or reimbursed by any employer, governmental program, or any other person or entity. I further certify that such items will not be deducted or taken as tax credits on my personal federal income tax returns for any year.

Caregiver Signature: _____ Date: _____

Print Name: _____ Employee Number: _____

Street Address: _____City/State/Zip: _____