

**ADOPTION ASSISTANCE PROGRAM
PAYMENT INSTRUCTIONS**

AFFIX
Department of Social Services
Address Label

| | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| County | | | | | | | | | | | | | | | | | | | | |
| SIS Number | | | | | | | | | | | | | | | | | | | | |
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| County Case Number | | | | | | | | | | | | | | | | | | | | |

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|-----------------------|----------------------|
| Child's Adoptive Name | Adoptive Parent Name |
|-----------------------|----------------------|

This child is eligible for Adoption Assistance Vendor payment for any combination of psychological, therapeutic, remedial and/or medical services. Adoption Assistance will provide payment, not to exceed \$2,400.00 per year, for services related to the treatment of the following condition(s): Describe child's special needs: _____

In compliance with NC General Statute 108A-50, the claim must represent only the amount due after all health insurance claims have been processed.

Please attach two (2) copies of your bill.

SECTION I - PROVIDER'S INFORMATION

| | | |
|-----------------------|----------------|----------|
| Name | | |
| Mailing Address | | |
| City | State | Zip Code |
| Telephone Number | E-mail Address | |
| Signature of Provider | Date | |

SECTION II - DEPARTMENT OF SOCIAL SERVICES INFORMATION

| | |
|--|------------|
| Signature of Director or Agency Representative | Position |
| Telephone Number | Fax Number |

Use of Form: This form is used to request payment for psychological, therapeutic, remedial and/or medical services by provider. The DSS 5115 is to be provided to the adoptive parents to give to each provider of psychological, therapeutic, remedial or medical services.

Instructions to Providers: Complete PROVIDER'S Section and mail to the Department of Social Services for reimbursement.