



**EXPENSES INCURRED BY ADOPTIVE PARENT(S)**  
 (Reimbursement shall not exceed \$ 2,000.00. Attach verifying documents)

| <b>Expense</b>                        | <b>Amount</b> | <b>Expense</b>  | <b>Amount</b> |
|---------------------------------------|---------------|---|---------------|
| Attorney Fees                         | \$            | Adoption Agency Fees  | \$            |
| Psychological Examination             | \$            | Court Fees  | \$            |
| Lodging (subject to State guidelines) | \$            | Meals<br><i>(subject to State guidelines)</i>   | \$            |
| Birth Certificate                     | \$            | Mileage<br><i>(subject to State guidelines)</i>   | \$            |
| Medical Examination                   | \$            | Other Adoption related expenses <i>(specify. Use additional paper to list expenses, if necessary)</i> | \$            |

We (I) verify that the expenses listed above are reasonable and necessary adoption costs which were directly related to the legal adoption of the above named child with special needs. The reported expenses were incurred by the adoptive parent(s) and are not in violation of state or federal law. No reimbursement has been made from other sources or funds. We (I) claim reimbursement for the total amount of \$ \_\_\_\_\_ in completing this adoption.

Signature of Adoptive Mother \_\_\_\_\_ Social Security Number of Adoptive Mother \_\_\_\_\_ Date \_\_\_\_\_

Signature of Adoptive Father \_\_\_\_\_ Social Security Number of Adoptive Father \_\_\_\_\_ Date \_\_\_\_\_

Authorized Payee(s) \_\_\_\_\_

**COUNTY OFFICE USE ONLY**

I do affirm to the best of my knowledge that \_\_\_\_\_  has  has not met eligibility requirements and  
 \_\_\_\_\_ Name of Child  
 has  has not been determined as a child with "special needs".

Signature of Social Worker \_\_\_\_\_ Title \_\_\_\_\_

Adoption Agency \_\_\_\_\_ Date \_\_\_\_\_

**DISPOSITION OF REIMBURSEMENT CLAIM**

Approval of claim reimbursement  Denial of claim reimbursement

Reason for denial of claim reimbursement: \_\_\_\_\_

Signature of Agency Representative \_\_\_\_\_ Date \_\_\_\_\_

**FOR ADOPTIVE PARENT REIMBURSEMENT**

**MAIL COMPLETED FORM AND VERIFICATION DOCUMENTS TO:**

*(Affix DSS Address Mailing Label or Complete Information)*

\_\_\_\_\_ Department of Social Services

\_\_\_\_\_ Mailing Address

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code

Adoptive Parent(s) may qualify for the Adoption Tax Credit if eligible expenses were paid related to the adoption of youth in foster care. Adoptive Parent(s) may contact a tax preparer or the Internal Revenue Service (IRS) at 800-829-1040 or via website at <http://www.irs.gov/taxtopics/tc607.html>.