University Hospitals

Adoption Assistance Program
Reimbursement Request Form

Employee Information

Employee Name _____ Employee ID Number_____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone Number _____Work Phone Number _____Work Location_____

Employee Request for Reimbursement
I would like to request reimbursement for the qualified adoption expenses listed above, confirming that_____ (child's name), whose birth date is _____, was placed in my home for the purpose of adoption on _____ (date). The date for adoption finalization is _____. Attached is a copy of the adoption placement decree.

Eligible Adoption Expenses

Date Paid	Amount	Description
_____	_____	_____
_____	_____	_____
_____	_____	_____

Total Reimbursement Requested: _____

Note: Please attach itemized charges and receipts in U.S. dollars for all expenses listed above, as well as a copy of the adoption placement decree. Applicable taxes will be withheld from your reimbursement.

I certify that this is a request for reimbursement of eligible expenses under the University Hospitals Qualified Adoption Assistance Program and that I have not received reimbursement or credit for these expenses from any other source. I understand that the adoption credit for tax purposes is not available for any expenses reimbursed under this Program.

_____ _____
Signature of Employee Date

Submit your completed request for reimbursement form and supporting documentation to the University Hospitals HR Service Center located at the Management Services Center, 3605 Warrensville Center Rd., Shaker Hts., OH 44122-5203, or fax your request to 216-767-8997. If you have questions about the process, please call the HR Service Center at 1-877-471-7522.

HR Use Only	
HR Approval	Date
Amount	Payroll Processing Date