ADOPTION BENEFITS FOR STATE EMPLOYEES AND OTHER ELIGIBLE APPLICANTS

Parts I, II and III must be completed. The Part III section must be completed by the Community Based Care Agency that facilitated or subcontracted the facilitation of the adoption. Please submit the completed application to:

StateEmployee.Adoption@myflfamilies.com

Please Note: A separate application must be submitted for each adopted child.

Part I – Employee Application: *To be completed by employee. (Please print)*

The Social Security Number is requested to record adoption benefit payments and report payments to the IRS as required by law.

Employee Name: Employee Social Security No.:

Employee Mailing Address:

Employee Phone Number: (Work) (Home)

Employee Agency:

Class Title: Class Code:

Position No.: ☐ Part-Time ☐ Full-Time FTE:

Amount of Benefit applied for: ☐ $5,000 ☐ $10,000

Community Based Care Agency:

Name: _____ Phone No.: (___) ___-____

Address: _____

Adoptive Child Name: _____ **Date of Birth:** _____

Date of Final Order of Adoption: _____

Employee Signature:

_____ Date:_____

Part II – Employing Agency Certification: *To be completed by the agency head or designee. (Please print)*

I hereby verify that the employment status and FTE of the applicant listed in Part I of this form are accurate and the applicant was an employee of this agency at the time the **adoption finalized.**

Name: _____ Phone Number: _____ _____

Title: _____

Agency Head Signature:

_____ Date:_____

Part III – Certification by Department of Children and Families: *To be signed and completed by the Community Based Care Agency that facilitated or subcontracted the facilitation of the adoption. (Please print)*

Adoptive Child Name: _____ **Date of Birth:** _____

Pre-Adoptive Child Name: _____ FSFN Pre-Adoption Case Number: _____ Post Adoption Case Number: _____

I hereby certify that the above named child is:

1. ☐ a child whose permanent custody (termination of parental rights order) was awarded to the Department of Children and Families **(if this box is not checked, child is ineligible).**

AND

2. ☐ a child who does not meet the criteria of "special needs".

OR

3. ☐ a child with one or more special needs:
   (Please check as many of the boxes below as are applicable.)
   - ☐ 1. Has established significant emotional ties with his or her foster parents.
   - ☐ 2. Is eight years of age or older.
   - ☐ 3. Has a developmental disability.
   - ☐ 4. Has a physical or emotional handicap.
   - ☐ 5. Is of a black or racially mixed parentage.
   - ☐ 6. Is a member of a sibling group of any age, provided two or more members of the sibling group remain together for the purposes of adoption.

AND

☐ Except when a child is being adopted by the child's foster parent or relative caregivers, a child for whom a reasonable but unsuccessful effort has been made to place the child without providing a maintenance subsidy. (ALL children receiving subsidy already meet this criteria.)

Date of Final Order of Adoption: _____

CBC Agency: _____

Name of Signatory (please print): _____

Title: _____ Phone Number: _____ _____

Certifying Signature:_____ Date:_____

Part IV – For Office of Child Welfare Staff Only

Is applicant eligible? ☐ Yes ☐ No Amount of Total Benefit: $_____ Date Request for Payment Submitted: _____

Name: _____ Title: _____

Signature:_____ Date:_____

Comments: