	APPLICAT		•	sistance Program URSEMENT - C	HII D CARE SE	RVICES	3
1. NAME(S)	OF PARENT(S)	IOITTOR CO	OT KEIIVID	2. ADOPTIVE PARENT'S SS#			3. DATE
4. ADDRESS			CITY	STATE	Z	P	5. COUNTY
6. CHILD'S N	IAME (For whom reimbursement is requested)		7. CHILD'S BIRTHDA	TE	8. CHILD'S RACE	6	9. CHILD'S SOCIAL SECURITY
IO. REASON	CHILD CARE WAS NEEDED (Be specific and a	attach dacumentation)					
	CHILD CARE USED					12. IS P	ROVIDER LICENSED/APPROVED
	mily Day Care Group Day ARE PROVIDER NAME AND ADDRESS	Care Other (Ex	plain)	СПУ	STATE		ZIP .
	ON ASSISTANCE WORKER NAME SEPT. OF SOCIAL SERVICES RESPONSIBLE FO		DE DI IDCHASE	OF CHILD CARE EXPEN	JOITI IRES		
MONTH	Vegr	EXPEND		MONTH - Year	ADITORES		EXPENDITURE
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	May			November			- H
	June		-	Dece	mber		
priority o	licant attests to the accuracy of f need. The Applicant agrees ax or other purposes.	f the information prov to provide and retain	rided to determ copies of rece	nine the need for child co ipts and other documen	are and the station for	Annual Total	
PARENT SIGN	NATURE		DATE	PARENT SIGNATURE			DATE
SUBJ:	COST REIMBURSEMENT - CI	HILD CARE	LDSS	DATE RECD BY LD	oss	DATE SENT	TO SSA
TO:	Social Services Administration	n, Office of Executive	Management	and Support		7	•
FROM:	LDSS WORKER COMPLETING FORM LDSS TELEPHONE #						
ADOPTIVE FA	AMILY NAME			CASE # CLIENT IC	D #	PRIORITY RE	ASON #
NAME OF IVE CHILD						CUENT ID #	
	irms that the above applicant retation, and qualifies for priority		or cost reimburs	sement for the year	, provid	ded the ne	cessary
LDSS DIRECT	OR OR DESIGNEE SIGNATURE	DATE					
☐ Fund	OMPLETED BY SSA/OEMS AN s Available- Payment Approved ficient Funds - No Payment Ap	d. Amount:		COMMENTS:			
SIGNATURE		DATE					

Adoption Assistance Program APPLICATION FOR COST REIMBURSEMENT - CHILD CARE SERVICES									
1. NAME(S) C	OF PARENT(S)				E PARENT'S SS#			3. DATE	
4. ADDRESS	СПУ				STATE		ZIP	5. COUNTY	
6. CHILD'S NA	AME (For whom reimbursement is requested)		7. CHILD'S BIRTHDA	TE	E 8.		CE	9. CHILD'S SOCIAL SECURITY	
10. REASON CHILD CARE WAS NEEDED (Be specific and attach documentation)									
	cHILD CARE USED anily Day Care Group Da	y Care Other (Exp	olain)				12. IS	PROVIDER LICENSED/APPROVED	
13. CHILD CAI	RE PROVIDER NAME AND ADDRESS			СПУ		STATE		ZIP	
14. ADOPTION	N ASSISTANCE WORKER NAME								
15. LOCAL DE	PT. OF SOCIAL SERVICES RESPONSIBLE F	OR ADOPTION ASSISTANCE		-andrey 7					
		RECORD O	F PURCHASE (OF CHILD	CARE EXPENDITURES				
MONTH -	Year	EXPENDIT	URE	MON	VTH - Year	-	EXPENDITURE		
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priority of	cant attests to the accuracy of need. The Applicant agrees or other purposes.	of the information provide to provide and retain o	ded to determine opies of receipt	ne the ne ots and o	ed for child care and the her documentation for	,	Annual Total		
PARENT SIGNA	NTURE		DATE	PARENT S	IGNATURE			DATE	
			LDSS	JSE ON	Y				
SUBJ:	COST REIMBURSEMENT - C	HILD CARE			DATE RECD BY LDSS		DATE SENT	TO SSA	
	Social Services Administratio	on, Office of Executive	Management o	ind Supp	ort				
FROM:	A: LDSS WORKER COMPLETING FORM LDSS TELEPHONE #								
ADOPTIVE FAM	TIVE FAMILY NAME CASE # CLIENT ID # PRIORITY REASON #						EASON #		
NAME OF IV-E CHILD					CHILD'S CASE #		CLIENT ID #	CLIENT ID #	
This confirms that the above applicant meets requirements for cost reimbursement for the year, provided the necessary documentation, and qualifies for priority reason indicated.									
LDSS DIRECTOR OR DESIGNEE SIGNATURE DATE									
SSA USE ONLY									
	MPLETED BY SSA/OEMS AN			COMMENTS					
	Available Payment Approved ient Funds - No Payment Ap								
SIGNATURE									

Adoption Assistance Program APPLICATION FOR COST REIMBURSEMENT - CHILD CARE SERVICES										
1. NAME(S) OF PARENTICS) 2. ADOPTIVE PARENT'S SS# 3. DATE										
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4. ADDRESS		1	СПУ		STATE		ZIP	5. COUNTY		
6. CHILD'S N	AME (For whom reimbursement is requested)			8. CHILD'S RAC	I	9. CHILD'S SOCIAL SECURITY				
10. REASON CHILD CARE WAS NEEDED (Be specific and attach documentation)										
For	nily Day Care Group Da	y Care Other (Exp	olain)					S PROVIDER LICENSED/APPROVED		
13. CHILD CA	RE PROVIDER NAME AND ADDRESS			СПУ		STATE		ZIP		
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SUBJ:	COST REIMBURSEMENT - CI	HILD CARE			DATE RECO DI 1255		DATE SEIVI	10 334		
TO:	Social Services Administratio	n, Office of Executive	Management a	ind Supp	ort					
FROM:	DM: LDSS WORKER COMPLETING FORM LDSS TELEPHONE #									
ADOPTIVE FAM	VE FAMILY NAME CASE # CLIENT ID # PRIORITY REASON #						EASON #			
NAME OF IV-E	CHILD		CHILD'S CASE #		CLIENT ID #					
	This confirms that the above applicant meets requirements for cost reimbursement for the year, provided the necessary documentation, and qualifies for priority reason indicated.									
LDSS DIRECTOR OR DESIGNEE SIGNATURE DATE										
SSA USE ONLY										
TO BE COMPLETED BY SSA/OEMS AND RETURNED TO LDSS: COMMENTS:										
Funds Available- Payment Approved. Amount:										
Insuffic	ient Funds - No Payment Ap	oproved.								
SIGNATURE		DATE								

DHR/SSA 769 (1/99) Supersedes Previous Editions

Adoption Assistance Program APPLICATION FOR COST REIMBURSEMENT - CHILD CARE SERVICES										
1. NAME(S) O		HON FOR CO	2. ADOPTIVE PARENT'S SS#			3. DATE				
				2.7.00				J. Date		
4. ADDRESS			СПУ		STATE		ZIP	5. COUNTY		
6. CHILD'S NA	ME (For whom reimbursement is requested)		7. CHILD'S BIRTHDAT	TE	8. CHILD'S		E	9. CHILD'S SOCIAL SECURITY		
10. REASON CHILD CARE WAS NEEDED (8e specific and attach documentation)										
11. TYPE OF CHILD CARE USED Family Day Care Group Day Care Other (Explain) 12. IS PROVIDER LICENSED/APPROVED										
13. CHILD CAR	RE PROVIDER NAME AND ADDRESS			СПА		STATE		ZIP		
14. ADOPTION	N ASSISTANCE WORKER NAME									
15. LOCAL DEF	PT. OF SOCIAL SERVICES RESPONSIBLE FO	OR ADOPTION ASSISTANCE								
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MONTH -	Year						EXPENDITURE			
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SUBJ:	COST REIMBURSEMENT - CI	HILD CARE			DATE RECD BY LDSS		DATE SENT	TO SSA		
TO:	Social Services Administratio	n, Office of Executive	Management o	and Supp	ort					
FROM:	LDSS WORKER COMPLETING FORM				LDSS		Т	ELEPHONE #		
ADOPTIVE FAM	ILY NAME			CASE # CLIENT ID #		PRIORITY REASON #				
NAME OF IV-E	ME OF ME CHILD				CHILD'S CASE #		CLIENT ID #			
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