Adoption Assistance Program

APPLICATION FOR COST REIMBURSEMENT - CHILD CARE SERVICES

1. NAME(S) OF PARENT(S)	2. ADOPTIVE PARENT'S SS#	3. DATE

4. ADDRESS	CITY	STATE	ZIP	5. COUNTY

6. CHILD'S NAME *(For whom reimbursement is requested)*	7. CHILD'S BIRTHDATE	8. CHILD'S RACE	9. CHILD'S SOCIAL SECURITY

10. REASON CHILD CARE WAS NEEDED *(Be specific and attach documentation)*

11. TYPE OF CHILD CARE USED	12. IS PROVIDER LICENSED/APPROVED
☐ Family Day Care ☐ Group Day Care ☐ Other *(Explain)*	

13. CHILD CARE PROVIDER NAME AND ADDRESS	CITY	STATE	ZIP

14. ADOPTION ASSISTANCE WORKER NAME

15. LOCAL DEPT. OF SOCIAL SERVICES RESPONSIBLE FOR ADOPTION ASSISTANCE

RECORD OF PURCHASE OF CHILD CARE EXPENDITURES

MONTH - Year _____	EXPENDITURE	MONTH - Year _____	EXPENDITURE
January		July	
February		August	
March		September	
April		October	
May		November	
June		December	

The Applicant attests to the accuracy of the information provided to determine the need for child care and the priority of need. The Applicant agrees to provide and retain copies of receipts and other documentation for income tax or other purposes.

Annual Total

PARENT SIGNATURE	DATE	PARENT SIGNATURE	DATE

LDSS USE ONLY

SUBJ:	COST REIMBURSEMENT - CHILD CARE	DATE RECD BY LDSS	DATE SENT TO SSA
TO:	Social Services Administration, Office of Executive Management and Support		
FROM:	LDSS WORKER COMPLETING FORM	LDSS	TELEPHONE #

ADOPTIVE FAMILY NAME	CASE # CLIENT ID #	PRIORITY REASON #

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:

☐ Funds Available- Payment Approved. Amount: _____

☐ Insufficient Funds - No Payment Approved.

SIGNATURE DATE

COMMENTS:

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

ADOPTIVE FAMILY COPY

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DHR ACCOUNTING OPERATIONS