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)*

Employee Name: Employee Social Security No.:

Employee Mailing Address:

Employee Phone Number: (Work) (Home)

Employee Agency:

Class Title: Class Code:

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

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

Community Based Care Agency: Name:
Address: _____ Phone No.: (_____)

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 is an employee of this agency at the time of application for this benefit.

Name: _____ Phone Number: (_____)______

Title: _____

Agency Head Signature: Date:

______________________________ ______________________________

Part III – Certification of Department of Children & Family 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**:

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. Isa 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:

Name of Signatory (Please print): _____ CBC Agency: _____

Title: _____ Phone No.: ( )

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: