



Adoption Assistance Reimbursement Form

Employee Information

Employee Name: _____ Employee ID#: _____
Home Address: _____ Department: _____
Contact Phone: _____ Position Title: _____

Adoption Information

Name of Child Adopted: _____ Birth Date: _____
Adoption Finalization Date: _____ Child's SSN: _____
☐ Adoption Decree is attached. (A copy of adoption decree is required)

Eligible Expenses

Please list expenses for which you are seeking reimbursement and attach all receipts in U.S. dollars.

DATE EXPENSE INCURRED	DATE EXPENSE PAID	AMOUNT OF ELIGIBLE EXPENSE	PAID TO	DESCRIPTION OF ELIGIBLE EXPENSE

Reimbursements made to eligible employees under Cedarville University's Adoption Assistance Program will be included in the taxable income of the employee. Applicable FICA taxes will be withheld from each reimbursement amount. Federal and state income taxes are not required to be withheld for qualified expenses.

I certify that the foregoing expenses are qualified adoption expenses, as defined by the Internal Revenue Service Section 137, and that I have not received reimbursement for these expenses from any other source. I agree to be responsible for any taxes owed on the reimbursement claimed herein.

Employee Signature _____ Date _____

UHR Approval _____ Date _____