ADOPTION BENEFITS FOR STATE EMPLOYEES AND OTHER ELIGIBLE APPLICANTS

Please review the Adoption Benefits for State Employees or Other Eligible Appliants Reference Guide to ensure that eligiblity for this benefit is met and all documentation is properly captured.

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 Email

Employee Agency:

Veteran or Servicemember: ☐ Yes (Please attach DD214 or copy of Common Access Card (CAC) and copy of Driver's License)

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.** Please note that contracted providers such as Adjunct professors, Graduate Assistants and Substitute teachers are not eligible. OPS staff must be employed with a Florida state agency for at least one year prior to adoption finalization to be eligible.

Name: ______ Phone Number: ______ ______

Title: ______

Employee Class Title: Employee Class Code:

Position No.:

Employee Status: ☐ Part-Time ☐ Full-Time

FTE: (part-time employees' FTE must be converted to the equivalent of a full-time FTE)

Employee Classification ☐ FTE ☐ OPS (OPS employees must be employed with a Florida state agency for at least 1 year prior to adoption finalization)

Number of years employed in OPS position:

Agency's Vendor ID/EIN:

Agency Head Signature: Email:

______________________ Date:_____________

Comments:

Part III – Certification of Department of Children and Families: *To be signed and completed by the Community Base 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 criterion.)

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: