Syracuse University
Human Resources

Adoption Assistance Reimbursement Form

Return this form to:
HR Shared Services
hrservice@syr.edu
Phone 315.443.4042 Fax 315.443.1063
621 Skytop Road, Suite 1001, Syracuse, NY 13244

Employee Name _____

SUID _____ Telephone _____

Home Address _____

City _____ State _____ Zip Code _____

Work Telephone Number _____ Email Address _____

I am requesting reimbursement of adoption-related expenses for (please check one):

☐ up to $5,000 for my adopted child ☐ up to $8,000 for my adopted children

Child's name _____ **Date of Birth** _____

Country of Birth _____ U.S. Adoption Finalization Date _____

Date of Adoption in Child's Country of Birth (if applicable) _____

Child's name _____ **Date of Birth** _____

Country of Birth _____ U.S. Adoption Finalization Date _____

Date of Adoption in Child's Country of Birth (if applicable) _____

Please list expenses for which you are seeking reimbursement and attach receipts in U.S. dollars.
A copy of the adoption decree is also required.

Expense	Paid To	Date	Amount
Agency Fees			
Legal Fees			
Medical Bills (birth mother)			
Medical Bills (child)			
Temporary Foster Care			
Transportation/Lodging			
Other (attach description)			

Total* _____

*Reimbursements made to eligible employees under the 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 expenses incurred on or after July 1, 1998.

I certify that the foregoing expenses are qualified adoption expenses, as defined in the Plan, and that I have not received reimbursement for these expenses from any other source, nor have I claimed a tax credit for such expenses. I agree to be responsible for any taxes owed on the reimbursement claimed herein.

Employee Signature _____ Date _____

Human Resources use only:
Approval _____ Date _____