ADOPTION BENEFITS FOR STATE EMPLOYEES AND OTHER ELIGIBLE APPLICANTS

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

Parts I, II and III must be completed. Part III of the application must be completed by the Community Based Care Agency that facilitated or subcontracted the facilitation of the adoption. Applicants must 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)

Law Enforcement Officer: ☐ Yes (Please attach Global Profile Sheet)

Amount of Benefit applied for: ☐ $5,000 ☐ $10,000 ☐ $25,000 (Law Enforcement Officers only)

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.

Agency Head/Designee Name: _____ Phone Number: _____ _____

Agency Head/Designee Title:_

Employee Class Title: Employee Class Code:

Position No.: Employee Status: ☐ Part-Time ☐ Full-Time

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

Employee Classification: ☐ FTE ☐ OPS (OPS employee must be employed with a Florida state agency for at least one 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 "difficult to place".

OR

3. ☐ a child with one or more difficult to place criteria:
   (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. A member of a racial group that is disproportionately represented among children in the child welfare system.
   - ☐ 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 & Family Well-Being Staff Only

Is applicant eligible? ☐ Yes ☐ No Amount of Total Benefit: $_____ Date Request for Payment Submitted: _____

Name: _____ Title: _____

Signature: _____ Date: _____

Comments: