JOHNS HOPKINS
UNIVERSITY

ADOPTION ASSISTANCE PLAN
EXPENSES REIMBURSEMENT REQUEST FORM AND AFFIDAVIT

Name of Faculty or Staff (Please Print) **JHED ID**

_____ _____

Address

_____
Street State Zip Code

_____ was placed in my home on _____ and/or the legal final
(Child's Name) (Month/Day/Year)

adoption date was _____ .
(Month/Day/Year)

Eligible Expenses - Eligible and non-eligible expenses are listed on the JHU Benefits & Worklife website at https://hr.jhu.edu/benefits-worklife/family-programs/adoption-assistance/.

I wish to apply for reimbursement of the following adoption expenses.

Date	Amount	Explanation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please attach to this form proof of the child being placed in your care or the final adoption decree from the courts and acceptable documentation of the listed expenses.

By signing this form, I certify and attest that I have attached all applicable documentation for reimbursement under The Johns Hopkins University's Adoption Assistance Plan. The receipts or cancelled checks that I have submitted are qualified adoption expenses under the university's program. "Qualified adoption expenses" means reasonable and necessary adoption fees, court costs, attorney's fees, and other expenses directly related to, and whose principal purpose is for, the legal adoption of an eligible child under 12 years of age.

I certify that these expenses are not incurred in violation of state or federal law or in carrying out any surrogate parenting agreement, nor are these expenses incurred in connection of the child of my spouse or domestic partner. Furthermore, these expenses have not been nor will they be reimbursed under an employer plan other than this Adoption Assistance Plan, nor have they been previously reimbursed to The Johns Hopkins University Adoption Assistance Plan, nor any other source.

I understand that The Johns Hopkins University does not make any commitment or guarantee that amounts paid to me under this Adoption Assistance Plan will be excludable from my gross income for federal, state, or

local income tax purposes, or that any other federal tax treatment will apply to or be available to me. I understand that it is my obligation to determine whether any payments made under the Adoption Assistance Plan is excludable from my gross income for federal income tax purposes.

I understand that it is my responsibility to report to the Office of Benefits Services any changes regarding the adoption. I certify that the statements relating to this form are complete and correct to the best of my knowledge and I understand that any intentional misrepresentation in this form may result in cancellation and repayment of my adoption assistance reimbursement and/or may result in adverse employment consequences for myself.

Faculty or Staff Signature _____ Date _____

Submit this form and all required documentation to: Johns Hopkins University, Office of Benefits Services, Johns Hopkins at Eastern, 1101 East 33rd Street, Suite C020, Baltimore, Maryland 21218, or fax to 443-997-6812.

Amount Requested for Reimbursement $_____

For Internal Department Use Only:

Amount approved $_____ Approval _____ Date _____