



Adoption Assistance Reimbursement Claim Form

Date: _____		
Employee Information:		
Stanford University Employee's Name: Last	First	Middle Initial
SU ID Number	Email:	

Contact Information:			
Home Address: Street	City:	State:	Zip:
Work Address:			Mail Code:
Department:	Daytime Phone:	Alternative Phone:	Fax:
Spouse/Partner's Name:		Spouse/Partner's Employer:	

Child Information:	
Child's Name:	Is the child in your home? <input type="checkbox"/> Yes (please indicate Placement Date below) <input type="checkbox"/> No (Explanation: _____)
Date of Expected or Completed Adoption:	Date of Placement:

Expenses:			
Date:	Paid to:	Services Rendered:	\$ Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
(Attach separate sheet of paper for additional expenses)			<div style="border: 1px solid black; padding: 2px; display: inline-block;">Total</div>
			<div style="border: 1px solid black; padding: 2px; display: inline-block;">\$ _____</div>

By signing below, I certify that I have attached all applicable documentation for reimbursement under Stanford University's Adoption Assistance Program. I understand I must notify the WorkLife Office of any change regarding the adoption. I certify under penalty of perjury that all statements and documentation relating to this claim are complete and true. I understand that incomplete or inaccurate information may adversely affect my eligibility under this program up to and including repayment to Stanford University of any funds awarded, and/or may result in adverse employment consequences for myself.

Employee Signature: _____ Date: _____