



State of Florida

APPLICATION FOR ADOPTION BENEFIT

Parts I, II and III must be completed. If applying for a 'special-needs' benefit, the Part III section about the type must be completed by the adoption agency. Submit original application to:

Department of Children and Families
Office of Family Safety
1317 Winewood Boulevard
Building 1, Room 306-F
Tallahassee, Florida 32399

Please Note: A certified copy of the Final Order of Adoption naming the employee as the adoptive parent must accompany this application for the adoption benefit. A separate application must be submitted for each adopted child. For multiple adoptions, if the Final Order of Adoption lists all children, only one certified copy of the order needs to be submitted.

Part I – Employee Application: *To be completed by employee. (Please print)*

Employee Name: _____ Employee Social Security No.: _____

Employee Mailing Address: _____

Employee Phone Number: (Work) _____ (Home) _____

Employee Agency: _____

Class Title: _____ Class Code: _____

Position No.: _____ Full-Time Part-Time FTE: _____

Amount of Benefit applied for: \$5,000 \$10,000

Adoption Agency:
 Department of Children & Family Services **or** Licensed Child-Placing Adoption Agency:
 Phone No.: (____)_____ Name: _____
 Phone No.: (____)_____

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 is an employee of this agency at the time of application for this benefit.

Name: _____ Phone Number: (____)_____

Title: _____

Agency Head Signature: _____ Date: _____

Part III – Certification of Department of Children & Family Services or Florida-Licensed Child-Placing Agency: *To be signed and completed by the Licensed Child Placing Agency for the adoption. (Please print)*

Adoptive Child Name: _____

Date of Birth: _____

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 Family Services or to a Florida-licensed child-placing agency (**if this box is not checked, child is ineligible**)

AND

2. a child that 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. Eight years of age or older;
3. A person with a developmental disability;
4. A person with a physical or emotional handicap;
5. Of a black or racially mixed parentage; or
6. A member of a sibling group of any age, provided two or more members of a sibling group remain together for the purposes of adoption.

AND

- A child for whom a reasonable but unsuccessful effort has been made to place the child without providing a maintenance subsidy. (ALL children who do not receive a subsidy meet this criteria.)

Licensed Child-Placing Adoption Agency:

Department of Children & Family Services **or** Florida-Licensed Child-Placing Adoption Agency:
Name: _____

Signature Name (Please print): _____

Fed ID No.: _____

Title: _____

Phone No.: () _____

Certifying Signature: _____

Date: _____

Part IV – For Office of Family Safety Use Only

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

Name: _____

Title: _____

Signature: _____

Date: _____

Comments: