JOHNS HOPKINS ALL CHILDREN'S HOSPITAL
Adoption Assistance Program Application and Agreement

A separate application must be completed for each adopted child.

Employee Information

Employee Name: _____ Employee #: _____

Home Address: _____

Phone: _____ Work Extension: _____

Department Name: _____ Dept. #: _____

Child Information (attach legal adoption documentation)

Name: _____ SS#: _____

Date of Birth: _____ Date of Adoption: _____

Expenses (attach itemized receipts)

Description of Incurred Expenses	Incurred Expense Amount

I certify that I have read and understand the Adoption Assistance Program policy and work commitment related to the Adoption Assistance program and have provided accurate information. I further certify that I am benefit-eligible (scheduled to work a minimum of 25 hours per week).

Employee Signature: _____ Date: _____