Connecticut Department of Children and Families

AGREEMENT FOR REIMBURSEMENT OF NON-RECURRING ADOPTION EXPENSES

DCF-739
1/19 (Rev.)

I. Adoptive Parent(s)

Parent 1		Parent 2			
Last Name:	First Name:	Last Name:		First Name:	
E-mail:	Phone:	E-mail:		Phone:	
Address: (No. and Street):		City:	State:		Zip:

II. Adoptive Child

Child's LAST Name:	Child's FIRST Name:	Child's DOB:	Child's Place of Birth:

What agency was named statutory parent for the purpose of placing this child into adoption? CT Department of Children and Families

What date did you or do you expect to adopt this child?:

Are you receiving or applying for adoption assistance for this child from any other state?: ☐ Yes ☐ No. If yes, please explain:

Have you applied for or received reimbursement for adoption related expenses from any other source?: ☐ Yes ☐ No. If yes, please explain:

III. Child's Status

(NOTE: *If DCF adoption, attached DCF-416 and required documentation. If a private agency adoption, please check below.)*

☐ The child cannot be placed without assistance due to:

- ☐ Age
- ☐ Membership in an ethnic or racial minority: Which Minority group?:
- ☐ Placed in your home with biological siblings
- ☐ Medical condition or physical handicap ★
- ☐ Mental or emotional handicap ★

★ Documentation is attached substantiating the child's medical or handicapping condition from a physician or psychiatrist.

☐ The child cannot or should not return home to biological parents because parental rights have been terminated. A copy of the order terminating parental rights is attached as verification.

☐ Documentation is attached that attempts were made to place him/her without adoption assistance, unless contrary to the child's best interest.

(NOTE: without proper documentation on the condition(s) outlined above, eligibility for this program cannot be granted.)

IV. Request for Reimbursement

I/We request reimbursement for the following non-recurring adoption expenses. I/We certify that these expenses are expenses that I/We are required to pay. *(Please attach copies of bill.)*

List Expense(s):	Cost:
TOTAL REIMBURSEMENT REQUESTED	$ 0.00

V. Release of Information

I/We give permission to the Department of Children and Families to obtain information from the following persons or agencies in order to verify information needed to determine eligibility for this reimbursement for non-recurring expenses related to the adoption. Please list any person or agency that can verify information provided in Section III.

1. Name / Agency:		Phone:	
Address: (No. and Street):	City:	State:	Zip:
2. Name / Agency:		Phone:	
Address: (No. and Street):	City:	State:	Zip:
3. Name / Agency:		Phone:	
Address: (No. and Street):	City:	State:	Zip:

VI. Certification

I/We certify that the information provided above is true to the best of my/our knowledge.

Adoptive Parent #1 Signature:	Parent #1 Social Security Number:	Date:
Adoptive Parent #2 Signature:	Parent #2 Social Security Number:	Date:

Please return this application, with the required documentation to:	LAST Name of SW:	FIRST Name of SW:

DCF Office:

Please Select DCF Office