V12/10/13

Adoption Assistance Application

Name:	
Member entity:	Department:
Employee ID:	Daytime phone:
Home address:	

I acknowledge that proper documentation is attached and that this application, with complete documentation, must be submitted within ninety (90) days of the date of the adoption to be eligible to receive assistance of $10,000.00 per adoption, per family, per year, not to exceed expenses incurred. I also understand that no reimbursement will be made to me until the adoption is final and that I must be in actively working at THR.

Final Adoption Date:
Adoption Agency:
Agency address:
Agency phone number:

Employee signature:	Date:
Benefits approval:	Date:

Submit signed form, final adoption decree and copies of your related expenses to the following:

Email: THRBenefitsSupport@TexasHealth.org

Fax: 682-236-6997

Address: Texas Health Resources
Attn: Benefits Dept.
612 E. Lamar Blvd. Suite 400
Arlington, TX 76011