ADOPTION AND SURROGACY ASSISTANCE PLAN REIMBURSEMENT FORM

Employees and Retired persons of SFHSS participating employers (the City and County of San Francisco, the San Francisco Unified School District, the Superior Court of San Francisco, and the City College of San Francisco) may be eligible for financial assistance to help cover certain expenses associated with the adoption of a child or a surrogacy. Eligibility for employees and retirees, qualified expenses, reimbursement limits, and reimbursement procedures are defined in the City and County of San Francisco Adoption and Surrogacy Assistance Plan, available at **sfhss.org** under “Other Benefits” (the “Plan”).

To apply for reimbursement for potential Qualified Expenses for an Eligible Adoption or Eligible Surrogacy under the Plan, please submit this form and return to the San Francisco Health Service System, along with documentation establishing payment of all fees and costs for each requested expense listed below, including, but not limited to, itemized bills, paid invoices, receipts and cancelled checks.

If approved by SFHSS, the reimbursed amounts for qualified adoption expenses for Eligible Employees will not have taxes withheld for federal income tax as permitted by the Internal Revenue Code. Reimbursed amounts will also not be subject to California personal income tax withholding up to the maximum amount allowed by law, at the time of reimbursement. Social Security and Medicare taxes, as well as applicable California employment taxes, will be withheld on all reimbursements. For more information, please visit ***irs.gov*** for Instructions for Form 8839. Reimbursed amounts for qualified surrogacy expenses will have taxes withheld for federal and state income tax as well as Social Security, Medicare, and applicable California employment taxes.

Any reimbursement request submitted more than twelve (12) months after finalization or termination of an eligible adoption, or more than twelve (12) months after a birth resulting from an eligible surrogacy, will be deemed untimely and denied on that basis.

Please refer to the Plan for complete details including, but not limited to, the definition of Eligible Employee, Eligible Retiree, Eligible Adoption, Eligible Child, Eligible Surrogacy, Eligible Surrogate, Qualified Expenses, as well as a list of expenses that are ineligible for reimbursement under the plan (Ineligible Expenses), and other limitations on expenses and reimbursements.

***BE SURE TO SUBMIT COMPLETE SET OF SUPPORTING DOCUMENTATION.**
DO NOT SEND ANY ORIGINAL DOCUMENTS. COPIES ARE ACCEPTABLE.

Your Personal Information:

Last Name		First Name		Initial
Street Address		**City**	**State**	**Zip Code**
Employee (DSW) #:	**Social Security #** *(if no Employee ID):*		**Home/Cell Telephone Number:**	
email Address:			**Work/Other Telephone Number:**	

Spouse/Domestic Partner Information *(if applicable)*:

Last Name		First Name		Initial
Street Address		**City**	**State**	**Zip Code**
Employee (DSW) # (if applicable):	**Social Security #** *(if no Employee ID):*		**Home/Cell Telephone Number:**	
email Address:			**Relationship:** Spouse ☐ Domestic Partner ☐	

Type of Reimbursement Request (check one):

☐ **Adoption** *Date of finalization/termination of adoption* (MM/DD/YYYY):__________________

For adoption expenses, include a copy of paperwork that demonstrates citizenship of the child and a final decree of adoption and/or documentation of the termination of the adoption proceedings, as applicable under the Plan.

☐ **Surrogacy** *Date of birth of child* (MM/DD/YYYY):__________________

For surrogacy expenses, include a copy of paperwork that demonstrates citizenship of the surrogate.

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Expenses Requested for Reimbursement:

Date of Expense (MM/DD/YYYY)	Paid To (NAME OF PERSON/ORGANIZATION)	Services Rendered (LEGAL, MEDICAL, OTHER DESCRIPTION)	Amount
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
Total Requested Reimbursement			$

Please attach a separate sheet for additional expenses and submit all required documentation for each reimbursement item.

If you have any questions regarding this Form or the Adoption and Surrogacy Assistance Plan, please contact HSS Member Services at (628) 652-4700.

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<u>Signature Page</u>:

I certify that the documentation I am submitting covers Qualified Expenses under the City and County of San Francisco Adoption and Surrogacy Assistance Plan. I also certify that these Qualified Expense have not been and will not be reimbursed under another plan or from another source, other than the City and County of San Francisco Adoption and Surrogacy Assistance Plan.

I acknowledge that I have read and agree to the following:

> The submission of expenses for reimbursement under the City and County of San Francisco Adoption and Surrogacy Assistance Plan does not guarantee reimbursement under the Plan.
>
> There is a limit of one (1) adoption or one (1) surrogacy per Eligible Employee or Eligible Retiree, and an employee or retiree spouse or domestic partner of an employee or retiree that has previously received any reimbursement for an adoption or surrogacy under the Plan is ineligible for reimbursement under the Plan.
>
> HSS does not make any guarantee that any amounts paid to me will be excludable from your gross income for income tax purposes or receive favorable tax treatment.
>
> It is the responsibility of each participating Employee or Retiree to determine the availability of any tax credit(s) and whether such credit(s) may be more advantageous to you with respect to a qualified expense than reimbursement for such expense under the Plan.
>
> The income tax liability on any benefits paid under the Plan is the sole responsibility of each participating Employee or Retiree.
>
> Each participating Employee or Retiree should consult his/her own tax advisor regarding the tax consequences of any payment received under the Plan.
>
> For more information, please visit ***irs.gov*** and ***ftb.ca.gov***.
>
> Any tax or legal information contained herein is general in nature and based on authorities that are subject to change. SFHSS guarantees neither the accuracy nor completeness of any information and is not responsible for any errors or omissions, or for results obtained by others as a result of reliance upon such information. SFHSS assumes no obligation to inform applicants of any changes in tax laws or other factors that could affect information contained herein. This form and accompanying Adoption and Surrogacy Assistance Plan do not, and are not intended to, provide legal, tax or accounting advice, and applicants should consult their tax advisors concerning the application of state and/or federal tax laws to any reimbursement of adoption or surrogacy expenses under this Plan.

Signature:______________________________________ Date:___________________

SFHSS USE ONLY:

☐ Approved & Reimbursement Amount: $____

☐ Denied & Reason: ____

Name/Title:________________________________

Signature:_________________________________

Date:_____________________________________