

South Carolina Department of Social Services
ADOPTION REIMBURSEMENT REQUEST

SECTION A: COMPLETED BY PROVIDER/ADOPTIVE PARENT

| | |
|------------------------------------|---|
| 1. Child's Name: (Last, First, MI) | 5. Payee's Name: |
| 2. Date of Birth: | 6. Payee's Address: |
| 3. Adoptive Family Name: | |
| 4. DSS Tracking No.: | 7. Payee's Federal ID or Social Security No.: |

| 8. Type of Service | Dates of Service | Total Cost | Less Insurance | Balance |
|--------------------|------------------|------------|----------------|---------|
| | | \$ | (\$) | \$ |
| | | \$ | (\$) | \$ |
| | | \$ | (\$) | \$ |
| | | \$ | (\$) | \$ |

Documentation: (Original bill, or copy if original not available, must be attached.) **Total Payment Amount:** \$ _____

SECTION B: CERTIFICATION BY ADOPTIVE FAMILY

I certify that the above services were provided on behalf of this child.

Adoptive Family's Signature: _____ Date: _____

SECTION C: CERTIFICATION BY PAYEE (Provider complete only if billing DSS directly.)

I do solemnly swear (or affirm) that I have examined the information contained in this request. That all such information has been prepared from the books and records of the provider named within. That the information is true and correct to the best of my knowledge and belief; and that no other request for reimbursement from other federal and/or state funds has been made nor has any other reimbursement been received. Any third party insurance has been applied for, or will be applied for the services herein described. That our agency has on file proper client authorizations for these services claimed and the necessary documentation to support these claims. That all claims reported are within the period of authorized eligibility.

Payee's Signature: _____ Title: _____

Date: _____

SECTION D: DSS ONLY

| | | |
|--------------------------------|------|--------------|
| Index: | PCA: | Object Code: |
| Adoption Official's Signature: | | Date: |

INSTRUCTIONS FOR DSS FORM 30129

Complete legibly and in two-part (yellow copy for payee) and mail to the South Carolina Department of Social Services, Division of Human Services, Adoption Services, 2638 Two Notch Road, Suite 200, Columbia, SC 29204.

Section A

1. Payee's Name: Enter the provider's name if payment is to be sent to the provider or adoptive parent if payment is to be sent to the adoptive family.
2. Payee's Address: Enter the complete address where payment is to be mailed; include city, state and zip code of provider or adoptive parent.
3. Payee's Federal ID or Social Security Number: Enter payee federal ID or Social Security number; this number must be on all forms in order to be paid. (If new provider, a completed Form W-9, Request for Taxpayer ID and Certification, must be completed and returned. This can be obtained from Adoption Services by calling 898-7682. If payee is family, please provide Social Security number.)
4. Child's Name: Enter the complete name for the child for which services were provided.
5. Date of Birth: Enter the child's date of birth.
6. Adoptive Family Name: Enter the complete adoptive family name.
7. DSS Tracking Number: To be completed by Adoption Services.
8. Service Cost: Enter the type of service (example: drugs, dental, psychological counseling, etc.) under type of service; date of service; total cost of services under total service cost; and any private insurance reimbursement under Insurance Payment; the Remaining Balance should be Total Service Costs Less Insurance Payments. Please combine charges for same types of services (such as drugs, office visits, counseling) and attach original bills and/or copy of "Explanation of Benefits" form from insurance company. Use additional form or attach listing if more space is needed.

Section B

Adoptive family must provide original signature certifying these services were provided on behalf of the child.

Section C

Provider of services must complete if billing DSS directly.

Section D

To be completed by DSS only.