Revised 10/2007

COMMONWEALTH OF KENTUCKY
STATE EMPLOYEE ADOPTION ASSISTANCE APPLICATION

Date: _____

State Employee: _____
(Last Name) (First Name) (Middle Initial)

SSN: _____

Spouse: _____
(Last Name) (First Name) (Middle Initial)

SSN: _____

Address: _____
(Street) (City, State, Zip)

Phone: _____

Cabinet Name: _____ Division: _____

Work Telephone: _____ Fax: _____

Name of Child: _____ Date of Birth: _____

Date of Legalized Adoption: _____ (*Attach Adoption Decree*)

Special Needs Eligibility: (*Attach verification from the Health & Family Services Cabinet if applying for more than $3000*)

Applicant _____ Spouse _____