

| Adoption Assistance Administrative House Wide Policy and Procedure | | |
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| Applicable Campus | Department Name | Approval Authority |
| Salem Health and West Valley Hospital | HR - Compensation & Benefits | Director, Human Resources Operations |
| Effective Date: February 2022 | | Next Review Date: January 2025 |
| List Stakeholders Position or Committee | Document Status | Date of Approval |
| Director, Human Resources Operations | Revised | 12/2021 |
| Manager, Benefits | Revised | 11/2021 |
| WVH Director, Clinical Operations | Reviewed | 12/2021 |
| Chief Human Resources Officer | Reviewed | 12/2021 |
| Director, Human Resources Operations | Reviewed | 12/2021 |
| Final Approval Date | Final Approval | 12/2021 |

Describe briefly the most recent revision made to this policy, procedure or protocol & why:

Simplification of language and clarification of timing of requesting reimbursement.

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| Policy Content |
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This policy was developed to assist eligible employees who are building families through adoption. Salem Health will provide financial reimbursement for certain adoption-related expenses. Leave time for adoption is provided through the Family and Medical Leave Act and other leave policies, where applicable.

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| Steps/Key Points Procedure |
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Eligibility

- A. *Eligible Employees*
 - 1. Effective January 1, 2007, all benefit-eligible full-time and part-time employees may apply for adoption benefits.
 - a. The employee must be actively employed in a benefits-eligible position at the time the expense is incurred and the financial reimbursement is made.
 - 2. If an employee and their spouse both work at Salem Health Hospitals and Clinics, only one employee can access the reimbursement benefit.
- B. *Eligible Child* – an eligible child would include any child under the age of eighteen (18) at the time the adoption becomes finalized.
- C. *Exclusion* – the plan does not cover adoption expenses for a spouse/partner adopting the child(ren) of an employee.

Qualified Expenses

- A. Qualified adoption-related expenses will be reimbursed up to a maximum of \$3,000 per adopted child, per household.
- B. Qualified adoption expenses are reasonable and customary adoption fees, court costs, attorneys' fees, and other expenses directly related to, and whose principal purpose is for, the legal adoption of an eligible child, such as:
 - 1. Home studies;
 - 2. Licensed agency and placement fees;
 - 3. Legal fees and court costs relative to the actual adoption;
 - 4. Up to 30 days pre-placement temporary foster care costs in an approved or licensed facility;
 - 5. Medical expenses of the birthmother;
 - 6. Medical expenses of the child not covered by insurance;
 - 7. Immigration, immunization and translation fees;

8. Domestic and international traveling expenses, including transportation and lodging for the employee and spouse/ domestic partner to bring an adoptive child home;
9. The child's passport and visa fees; and/or
10. Expenses related to home reconstruction necessary to accommodate a special needs child, (which is defined by federal and state law), or home health visits not covered by a medical plan.

Non-Qualified Expenses – expenses that are not eligible for reimbursement include, but are not limited to:

1. Fees for services not yet performed;
2. Fees for expenses incurred in violation of federal or state law;
3. Expenses covered under another adoption assistance or medical plan;
4. Voluntary donations or contributions;
5. Personal items for the child;
6. Expenses associated with a surrogate arrangement;
7. Living expenses of the biological parent(s); and
8. Costs of obtaining guardianship or custody of a child, which are not associated with the adoption of that child.

Taxation of Benefits

- A. Adoption reimbursements are reported as income and taxes will be withheld accordingly when paying the benefit to the employee.
- B. If an employee's income is within certain limits, as defined by the Internal Revenue Code Section 137, the employee may be eligible for a tax credit and/or exclusion for adoption-related expenses; income limits are subject to change each year.
- C. Employees utilizing the adoption reimbursement plan should refer to Internal Revenue Service instructions for IRS Form 8839 entitled *Qualified Adoption Expenses* or consult with a tax advisor regarding any benefit received from this program.

Timing / Procedure for Reimbursement

- A. The Adoption Assistance Claim Form (attachment A), a notarized copy of the record of placement or final court order, and itemized receipts for expenses are required for reimbursement.
- B. Because the adoption process can take a substantial period of time to complete, Salem Health Hospitals and Clinics will provide two stages of reimbursement to help minimize the up-front out-of-pocket expenses for employees applying the following reimbursement schedule:
 1. Up to \$1,000 reimbursement when the home study stage is completed and filed with an agency; and
 2. Up to \$2,000 reimbursement once the child is placed in the home.
- C. Requests for reimbursement must be made within 90 days of each event listed above. Salem Health requires proof of payment for home study, not a *copy* of the actual home study.

Procedures for Leave of Absence – (see Leave of Absence Policy & Procedure)

Coordination with Other Benefits

- A. Adoption is considered a Qualifying Life Event. Visit the Qualifying Life Event page on the Benefits SharePoint page for further detail.

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| Definitions – Insert N/A if not applicable |
| <ul style="list-style-type: none"> • Full-Time Employee - regularly scheduled to work an average of at least 35 hours per week on a continuous basis • Part-Time Benefit-Eligible Employee - regularly scheduled to work an average of at least 20 hours, but less than 35 hours per week, on a continuous basis |
| Equipment or Supplies - Insert N/A if not applicable |
| N/A |
| Form Name and Number or Attachment Name - Insert N/A if not applicable |
| Attachment A - Adoption Assistance Claim Form |
| Expert Consultants Position |
| Senior Benefits Analyst, Manager, Payroll & HR Compliance |
| References (Required for clinical Documents) : |
| N/A |
| Policy, Procedure or Protocol Cross Reference Information – Insert N/A if not applicable |
| Leave of Absence Policy & Procedure |
| Computer Search Words |
| adoption, reimbursement |
| Is there a Regulatory Requirement? No |
| N/A |

| Review and Revision History | | |
|---|--------------------|---------|
| History | Review or Revision | Date |
| Simplification of language and clarification of timing of requesting reimbursement. | Revision | 02/2022 |
| Minor revision, no changes to dates: Reviewed and revised to clarify what is needed for reimbursement for cost of home study. | Revision | 02/2020 |
| Reviewed and revised to clarify what is needed for reimbursement for cost of home study. | Revision | 03/2019 |
| Reviewed and removed Leave of Absence procedure steps | Reviewed | 01/2016 |
| | Revision | 01/2015 |
| | Revision | 11/2012 |
| | Review | 12/2009 |
| Approved / Effective | New | 01/2007 |

Attachment A

Adoption Assistance Claim Form

NOTE: Please read prior to completing this form –

- Submit a separate form for each applicable child;
- Faxed copies of the completed form are not acceptable;
- Staple all requested documentation to this form;
- Original receipts showing payment for the home study, and/or adoption placement certificate or final adoption decree is required; and
- All receipts must be in U.S. dollars.

I am requesting reimbursement for eligible expenses related to the following:

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|---|---|
| <input type="checkbox"/> Home Study is completed and was filed with an agency on: _____ | <input type="checkbox"/> Placement of my adopted child took place on: _____ |
|---|---|

Employee Information

| | |
|---------------------|--|
| Name | |
| Employee Number | |
| Home Street Address | |
| City, State, Zip | |
| Home Phone | |
| Work Phone | |

Child's Information

| | |
|-------------------------------|--|
| Name | |
| Date of Birth | |
| Date of placement in the home | |
| Date of Final Adoption Decree | |

Eligible Adoption Expenses

| Date Paid | Amount | Description (Attach copies of itemized receipts or documents): |
|--------------|--------|--|
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| | | |
| | | |
| TOTAL | | |

Employee Request for Reimbursement

By signing below I certify that this is a request for reimbursement of eligible adoption expenses under the Salem Health Adoption Assistance program, and that I have attached all applicable documentation required for reimbursement. I understand that it is my responsibility to verify with the IRS or my tax consultant the tax implications of receiving this money.

Employee Signature

Date

Human Resources Approval

Date:

\$ _____
Reimbursement Amount