ADOPTION ASSISTANCE VENDOR
PAYMENT INSTRUCTIONS FOR PROVIDERS

County DSS address here

County
SIS Number
County Case Number

Child's Adoptive Name	Adoptive Parent Name

Adoption Assistance Vendor payment may be available for services or treatment related to a pre-existing psychological, emotional, or physical handicapping condition. **PLEASE ATTACH** documentation that identifies the child's diagnosis, special needs related to the diagnosis, how is the service related to the special needs, what are the goals the service is to accomplish and how achievement of goals will be measured.

In compliance with G.S. § 108A-50, the claim must represent only the amount due after all health insurance claims have been processed.

Please attach two (2) copies of your bill.

SECTION I - PROVIDER'S INFORMATION

Name		
Mailing Address		
City	State	Zip Code
Telephone Number	E-mail Address	
Signature of Provider	Date	

SECTION II – DEPARTMENT OF SOCIAL SERVICES INFORMATION

Signature of Director or Agency Representative	Position
Telephone Number	Fax Number

Use of Form: This form is used to request payment for services or treatment by provider. It is to be provided to the adoptive parents to give to each provider of services.

Instructions to Providers: Attach requested items and complete SECTION I - PROVIDER'S INFORMATION and mail to the Department of Social Services for reimbursement.