Claim for Dependent Care Reimbursement

Employer/Plan Sponsor Name_____Washington College_____

Employee Name_____ **SS#**_____

Please remember to sign the form and provide receipts for each reimbursement request. Thank you.

This claim form is to be used only to request reimbursement from your Flexible Spending Account for dependent care expenses. Please complete this claim form and attach the actual bill. Cancelled checks and credit card slips are not acceptable. If you use a private babysitter, you may not receive a bill, in which case *you will need to ensure that the Provider signs this form*. A day care center will normally provide you with a statement of payment which should be attached to the claim form. The tax identification number and address of your provider is required by the IRS.

Dependent(s) for Whom Care was Provided	Date(s) Care Provided	Amount Charged	Receipt Attached or Provider's Signature
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____
	Total:	**$_____**	

Signature of Day Care Provider:_____

Provider's Address: _____

Provider's Federal Identification or Social Security Number: _____

Dependent Care Flexible Spending Account Reimbursement Guidelines:

I certify that the dependent care expenses submitted for reimbursement meet the following requirements:

1. The expenses are either (a) for services (e.g., day care center, nursery school) or (b) for household services attributable to the care for a qualifying individual during the period I am a participant in the Dependent Care Flexible Spending Account. Educational expenses for a child in the first or higher grades are not eligible.
2. The expenses are for either (a) a child or children under the age 13 claimed as exemption(s) on my federal income tax return (if divorced or legally separated, the requirement that the child be an exemption does not apply if you have custody of the child for a period longer than the other parent); (b) my spouse or other dependent who is physically or mentally unable to care for himself or herself.
3. The expenses are for the purpose of allowing me and my spouse to be gainfully employed during the period I have responsibility for a qualifying individual. Payments to a child of mine under age 19 or to a person I or my spouse may claim as a dependent on my federal income tax return are not reimbursable expenses.
4. If married, the amount of reimbursable expenses will not exceed the lesser of my earnings or my spouse's earnings for the year. If my spouse is a full-time student or physically or mentally unable to care for himself or herself, my spouse is deemed to have earnings of $200 per month ($400 if I have at least two qualifying individuals).

I understand that I have the responsibility for any tax reporting or other legal requirements with respect to reimbursed expenses. I also understand that, to the extent dependent care expenses are reimbursed under the Dependent Care Flexible Spending Account, these expenses may not be claimed as expenses for purposes of the federal income tax credit for dependent care expenses.

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Employee Signature Date Daytime Phone Number

If you have any questions please contact Innovative Health Services at 410-763-8787, or 1-888-769-8787 ext. 101

Innovative Health Services
PO Box 778
Easton, MD 21601
Fax 410-763-8788