

**East Georgia College  
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT  
REIMBURSEMENT REQUEST FORM**

*Please Print:*

<b>Employee Name:</b>	<b>Employee ID Number:</b>
<b>Mailing Address:</b>	
(Street/P.O. Box)	(City/State)
(Zip)	

*Instructions: Complete the information below for dependent care expenses incurred by you or your spouse, for which you request reimbursement (For information as to what dependent care expenses can be reimbursed, see the plan summary and IRS Publication 503.) You must provide bills or paid receipts from your dependent care provider or other evidence that the expenses were incurred (cancelled checks will not be accepted). Be sure to provide all information requested by this form. If the form is incomplete, it will be returned to you and reimbursement will be delayed. Print or type the information requested, then date and sign the form. Send this form along with your supporting documentation to the Office of Human Resources.*

	EXAMPLE	Expense # 1	Expense # 2	Expense # 3	Expense # 4
<b>Date(s) the Dependent Care Service was Actually Provided</b>	<u>10/1/06</u> to <u>10/31/06</u>	_____ to _____	_____ to _____	_____ to _____	_____ to _____
<b>Name &amp; Age of Dependent</b>	Fred Jones Age 4				
<b>Name, EIN/SSN, and Address of Service Provider</b>	Sue Smith 888-88-8888 311 Day St. Seattle, WA				
<b>Proof of Expense(s) Attached</b>	YES  NO	YES  NO	YES  NO	YES  NO	YES  NO
<b>Total Expense</b>	\$ 250	\$	\$	\$	\$
<b>Amount Paid by Other Plans</b>	\$ 0	\$	\$	\$	\$
<b>Reimbursement Requested</b>	\$ 250	\$	\$	\$	\$

<b>TOTAL REIMBURSEMENT REQUESTED: \$</b>
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To the best of my knowledge and belief, my statements in this Reimbursement Request Form are complete and true. I have read, understand and make the certifications contained in the Certificate of Qualifying Dependent Care Expenses on page 2 of this document. I understand that these dependent care expenses may not be used to claim any Federal income tax deduction or credit (including the dependent care tax credit). I agree to file IRS for 241 with my tax return and provide any taxpayer identification number required thereon. I authorize a reduction in my Dependent Care Assistance Account in the amount of the reimbursement.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

# CERTIFICATE OF QUALIFYING DEPENDENT CARE EXPENSES

## PAGE 2

By signing and submitting this Dependent Care Reimbursement Request Form, you are certifying that expenses for which you request reimbursement meet all of the following conditions:

- 1) The expenses are incurred for services rendered after the date of your election to receive dependent care assistance benefits and during the plan year to which the election applies.
- 2) The expenses are incurred so you (and your spouse, if you are married) can work or look for work. Exception: If your spouse is not working or looking for work when the expenses are incurred, you certify that he/she is a full-time student or is physically or mentally incapable of caring for himself or herself.
- 3) The amount of the reimbursement requested, when aggregated with all other reimbursements received by you under the Plan during the same calendar year, do not exceed the lesser of
  - (A) your earned income; or
  - (B) if you are married, your spouse's actual or deemed earned income (see below).

(Your spouse is deemed to have monthly earned income of \$200 {\$400 if you are incurring dependent care expenses for more than one dependent}, if your spouse is either a full-time student or is physically or mentally incapable of caring for himself or herself).

- 4) Each dependent for whom you incur the expense is
  - (A) a person under age 13 for whom you are entitled to claim a dependency exemption on your Federal income tax return, or
  - (B) your spouse or a person who is your dependent under Federal tax law (even if you may not claim the dependency exemption on your Federal income tax return), but only if he or she is physically or mentally incapable of caring for himself or herself.
- 5) You (or you and your spouse together) are providing at least 50% of the cost of maintaining your household, and the expenses are incurred when at least one member of your household is a person described in 4(A) or 4(B) above.
- 6) The expenses are incurred for the care of a dependent, or for related incidental household services.
- 7) If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in 4(A) above (or who is described in 4(B) above and regularly spends at least 8 hours per day in your household).
- 8) If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
- 9) The person who provided care was not your spouse or a person whom you can claim as a tax dependent. If your child provided the care, he/she must be age 19 or older at the end of the year in which the expenses are incurred.
- 10) The expenses are not paid for services outside your household at a camp where the dependent stays overnight.

\_\_\_\_\_ Employee's Initials