Dependent Care Claim Certification Form

Flexible Spending Account

ebm *(formerly Cafeteria Plan Advisors)*
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Norwell, MA 02061
Website: *getebm.com* (*formerly cpa125.com*)

Email: *cpaclaims@getebm.com*
Phone: 781-848-9848
FAX: 781-848-8477

Plan Year: _____

Employee Name: _____ ***Employer:*** Town of Wellesley

Mailing Address: _____ ***SSN (Last four)*** ***XXX-XX-*** _____

City, State, Zip: _____ ***Participant Phone:*** _____

Check if New Address ☐ ***Email:*** _____

Eligible Dependents:

The dependent care expenses must be **employment-related** (incurred in order for the Participant and other caregiver, if applicable, to be able to go to work).
The dependent(s) you are claiming must be one of the following:

1. Your qualifying dependent who is **under age 13**, lived with you for more than half the year, and claimed on your tax return;
2. Your spouse who was not physically or mentally able to care for themselves and lived with you for more than half the year; or
3. A person who wasn't physically or mentally able to care for themself and who lived with you for more than half the year, and either: a) was your dependent; or b) would have been your dependent except that: i. they received gross income of $4,400 or more; ii. they filed a joint tax return; or iii. you—*or your spouse, if filing jointly*—could be claimed as a dependent on someone else's tax return for the taxable year.

Dependent Information:

Dependent Name	Relationship	Date of Birth		Dependent Name	Relationship	Date of Birth

Day Care Facility or Individual who provides care:

Name:	Name:
Address:	Address:
Corporate or Individual Tax ID (Required):	Corporate or Individual Tax ID(Required):

Claim Amount: $ _____ **Dates of Service:** _____ (Beg) - _____ (End)

Certification. This is to certify that I, the undersigned, have incurred expenses that qualify under IRC section 129 "Dependent Care Assistance Programs." I have not been, and **will not be, reimbursed for these expenses by any other source**, including but not limited to: insurance, this or another Dependent Care plan, other program(s) offered by my or another's employer, or any federal and/or state benefit program. I understand **these expenses may no longer be claimed as deductions for income tax purposes** since I am requesting reimbursement with funds deducted from my compensation on a pre-tax basis. The undersigned reaffirms that all eligibility criteria set forth by the IRS, found on the reverse side of this form and continue to be met at the time these dependent care expenses were incurred. I acknowledge that I am solely liable for any taxes or penalties on ineligible expenses processed through the dependent care plan. I, and only I, am responsible for the accuracy and validity of the submitted expenses. It is my responsibility to retain ALL receipts. I hereby authorize the spending account administrator to reimburse me for the "Claim Amount" listed above, and, if applicable, reaffirm the authorization provided to Cafeteria Plan Advisors to directly deposit the reimbursement into my bank.

PARTICIPANT'S SIGNATURE: _____ DATE: _____

Return page 1 via mail, fax, or email to *cpaclaims@getebm.com*, or upload to claims submitted electronically via your online portal at: *getebm.com* *(formerly cpa125.com)*

Please return only the first page of the claim form.

Section 125 Dependent Care Eligibility Worksheet

	Yes	No
Married (as defined by IRS)?	☐	☐
If married, is your spouse employed?	☐	☐
If married, do you file a joint tax return?	☐	☐
If married, does your spouse have a Dependent Care Plan?	☐	☐
If not employed, is spouse:		
A full-time student (5 months)	☐	☐
Disabled and unable to care for self/child(ren)	☐	☐

- ✓ If your spouse is not employed and is not actively seeking employment, you are not eligible for the Dependent Care plan unless he or she is a full-time student or is disabled.
- ✓ If your spouse has a dependent care plan, your combined election may not exceed $7,500 or your plans maximum if less.
- ✓ Funds not claimed for will be forfeited or otherwise handled in accordance with the plan document and the current IRS regulation.
- ✓ **IRS form 2441 should be filed with your tax form 1040 when dependent care has been deducted from your pay. The Dependent Care deduction should be shown in box 10 of the W2 form from your employer.**

Dependent Care Reimbursement Plan Guidelines

Employer provided dependent care assistance is tax-free only if the following conditions are met:

1. Each individual for whom you receive dependent care assistance is;
    a. A dependent under the age of 13 whom you are entitled to claim as a dependent on your tax return, or
    b. A spouse or other tax dependent who is physically or mentally incapable of caring for him or herself.
2. The dependent care assistance is provided for the care of a dependent described above or for the related household service and is incurred to enable you to be gainfully employed.
3. If the dependent care services are provided outside your household, they are incurred for the care of a dependent who is described in 1.a) above or who regularly spends at least 8 hours per day in your household.
4. If the dependent care is 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.
5. If the services are provided by a camp, the dependent does not stay overnight at the camp.
6. Payment for the services are not made to a child of yours who is under the age of 19 at the end of the year for which the expenses are incurred or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.
7. The reimbursement (or fair market value of the dependent care expenses) are provided for the applicable year and may not exceed the least of the following limits:
    a. $7,500 ($3,750 if you are married and do not file a joint tax return for the year) or 50% of the plans maximum if lower.
    b. Your taxable compensation (after any reductions under the 401(k) plan, dependent care assistance plan and medical/dental plans).
    c. If you are married, your spouse's actual deemed earned income.

    * For purposes of 7.a) above, if two employees are married to each other and file a joint tax return, a single $7,500 limit applies to both spouses together. For purposes of 7.c) above, your spouse will be deemed to have earned income of $250 ($500 if you have 2 or more dependents described in paragraph 1) above, for each month in which your spouse is: physically or mentally incapable of caring for him or herself or a full time student at an educational institution. For all purposes of paragraph 7) above, certain separated spouses are not treated as married.
8. You must report to the IRS on your tax return the name, address and social security number (or other tax payer identification number, if required) of any dependent care service provider who provides services to you during the relevant calendar year).
9. If your Dependent Care needs experience a qualifying change during the plan year, you may make election changes within 30 days of the qualifying change.
10. Participation in the Dependent Care Spending Account will limit your reporting on your IRS taxes.
11. If you elected and were reimbursed more than your dependent care costs, you may need to report the difference on your taxes. It is suggested you contact a Tax Advisor.
12. All claims must be submitted within 90 days after the plan year ends or your employment ends, whichever comes first.

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