Dependent Care Claim
Certification Form

Flexible Spending Account

Cafeteria Plan Advisors, Inc.
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Braintree, MA 02184
www.cpa125.com

Email: info@cpa125.com
Phone: 781-848-9848
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Plan Year: _____

Name: _____ ***Employer:*** _____

Street: _____ ***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. Dependents eligible for FSA funding:

-Must be under age 13
-Reside with Participant
-Physically or mentally incapacitated
-Qualify as Dependent under IRS code section 151(c)
-Earn less than $3800 per year unless qualifying child

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

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 source, including, but not limited to, insurance, this plan, or other programs offered by my, or my spouses, employer. 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 at www.cpa125.com, 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 Cafeteria Plan Advisors, Inc. to reimburse me for the "Claim Amount" listed above, and, if applicable, reaffirm the authorization provided to Cafeteria Plan Advisors, Inc. to directly deposit the reimbursement into my bank.

PARTICIPANT'S SIGNATURE: _____ DATE: _____

Return page 1 via mail, fax, or email to info@cpa125.com

Please return only the first page of the claim form to Cafeteria Plan Advisors, Inc.

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		
Full-time student (5 months)	☐	☐
Disabled and unable to care for self/children	☐	☐

- ✓ 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 $5,000
- ✓ 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. $5000 ($2500 if you are married and do not file a joint tax return for the year).
    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 $5000 limit applies to both spouses together. For purposes of 7.c) above, your spouse will be deemed to have earned income of $200 ($400 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).

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