Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

DEPENDENT CARE ASSISTANCE PLAN (DCAP) REIMBURSEMENT REQUEST FORM

Must print in Black or Blue ink ONLY

Employee ID	Rcd No.	Last Name, First Name

Mailing Address, City, State, Zip Code	Telephone	Email Address:

INSTRUCTIONS: To request reimbursement from your DCAP account, complete this form, itemizing eligible expenses. **You must attach copies of your receipts for the expenses.** All receipts must show the dependent's name, the dependent care provider's name, the amount of the expenses, and the date for which the expenses were incurred. If your receipt does not include all of the information above, please have your provider sign this form where indicated.

Only expenses incurred during the Calendar Year will be eligible for reimbursement. In the event that your reimbursement request exceeds your account balance, you will be paid the funds that are available. As additional deposits are made to your account, subsequent check(s) will be issued automatically.

Dependent Name	Federal Tax Dependent	Relationship	Birth Date
	☐ Yes ☐ No		
Dependent Name	**Federal Tax Dependent**	**Relationship**	**Birth Date**
	☐ Yes ☐ No		
Dependent Name	**Federal Tax Dependent**	**Relationship**	**Birth Date**
	☐ Yes ☐ No		
Dependent Name	**Federal Tax Dependent**	**Relationship**	**Birth Date**
	☐ Yes ☐ No		

DEPENDENT CARE INFORMATION

	Dependent Care Provider (Name and Address)	Taxpayer ID or Social Security Number	Date of Service From	To	Amount Paid to Provider
1.					
2.					
3.					

Employee Certification - Your signature on this form certifies that you:

1. Have incurred these expenses and have not previously requested payment for them for this Plan or any other source
2. Have met all the reimbursement requirements for eligible dependent care expenses listed on the next section of this form and all expenses qualify as eligible according to the Internal Revenue Code Section 125
3. Understand that expenses reimbursed under the DCAP cannot be claimed as a credit on your personal income tax return and directly offset your personal income tax credit
4. Agree to notify your employer if you have reason to believe that any expense for which you obtained reimbursement is not a qualifying expense
5. Agree to indemnify and reimburse your employer on demand, for any liability it may incur for failure to withhold federal, state or local income tax, or Social Security tax from any reimbursement you receive for a non-qualifying expense, up to the amount of additional tax you actually owed

Employee Signature	Date

Provider Certification: Your signature on this form certifies that you provided care for the dependent(s) listed above for the date(s) of service and the amount(s) specified in the Dependent Care Information section.

Provider Signature	Date

DISTRIBUTION: Original - EBSD-HR (0440)
157 W. 5th Street, First Floor
San Bernardino, CA 92415-0440
(909) 387-5648 - Claim Inquiries

REIMBURSEMENT REQUIREMENTS

Under the Plan, you will be reimbursed only for the dependent care expenses meeting all of the following conditions:

1. The expenses are incurred for services rendered after the date of this DCAP enrollment and during the Calendar Year to which it applies
2. The expenses are for qualified dependent(s) meeting the following criteria:

A Qualifying Dependent

a) Your child who was under age 13 when care was provided and lived with you for more than half of the calendar year.
   i. The child must be your son, daughter, stepchild, sibling, step sibling, or a descendant of any such individual, eligible foster child, legally adopted child, or a child lawfully placed with you for adoption.
   ii. The child must not have provided over one half of their support during the calendar year.

b) Your spouse, relative or child over the age of 13, who is physically or mentally incapable of self-care, lived with you for more than half of the calendar year, and regularly spends at least eight (8) hours each day in your household.

c) Dependents defined by Internal Revenue Code Section 152 as a qualifying relative must meet the following criteria to be eligible:
   i. They received more than half of his or her support from you for the calendar year.
   ii. They cannot meet the eligibility requirements of a qualifying child of yours or anyone elses.

3. The expenses are incurred for the care of a dependent defined above, or for related household services, and are incurred to enable you or your spouse to be gainfully employed.
4. The dependent care expenses submitted must be eligible for reimbursement. Eligible expenses are:
   a) Payments for the care of an eligible dependent in your home or at a dependent care facility that complies with all licensing requirements or is exempt from such requirements. This includes care provided by a baby sitter, nurse, or housekeeper in your home, as long as part of their service benefits the dependent.
   b) Preschool care, before and after school care, and day camp during school vacation.
5. The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred.
6. The expenses are not paid or payable to an individual for whom you or your spouse are entitled to personal tax exemption as a dependent.