Dependent Care Assistance Program is a division of the Office of Labor Relations' Pre-Tax Benefits Program

DEPENDENT CARE ASSISTANCE PROGRAM (DeCAP) CLAIMS FORM

40 Rector Street, 3rd Floor, New York, NY 10006
Tel: (212) 306-7760 TTY: (212) 306-7629 nyc.gov/olr

DeCAP

1) IMPORTANT INSTRUCTIONS AND INFORMATION

1. A "Plan Year" is the calendar year, or for a newly eligible employee, any remaining portion thereof.
2. Reimbursements can only be made for expenses resulting from services provided in the applicable Plan Year. However, if services provided begin in one Plan Year and end in the next Plan Year, a claims form for each Plan Year is required. No reimbursement can be made prior to services being performed.
3. You may submit claims once a month, however, only claims received by the close of the month will be processed for that month. Once your claims are approved, you will receive reimbursement at the end of the following month.
4. The deadline to submit claims is the last day of the Plan Year (December 31st). You should submit your claims in a timely fashion, however, there is a Claims Run-Out Period until February 28th following the close of the Plan Year to submit claims for services performed during the previous Plan Year. Claims received after February 28th will **not** be processed.
5. **Any unclaimed year-end balance in your account may not be carried to the next Plan Year and will be forfeited.**
6. Dependent care reimbursement requests must be signed by your service provider with his/her name, address, and Federal Tax ID or Social Security number. Requests will not be processed without this information.
7. **Definitions**:
   a) **Eligible Employment-Related Dependent Care Expenses**: Services which are performed to enable you and your spouse, if married, to remain employed or attend school full-time and which are related to the care of one or more dependent care recipients (including household services related to such care). Services may be performed within or outside your home. If your spouse is not employed, he/she must be incapacitated or a full-time student. Benefits for eligible employment-related dependent care expenses may not be more than your or your spouse's earned income.
   b) **Dependent Care Recipient**: Any dependent claimed on your tax return who regularly spends at least eight (8) hours a day in your home and is either: (i) a child (son, daughter, stepson, or step-daughter) under age thirteen (13); (ii) a dependent or spouse who is physically or mentally incapable of caring for himself/herself; or (iii) any other dependent whose gross income for the Plan Year is less than the IRS maximum annual salary.
   c) **Qualifying Caregiver**: A person performing eligible employment-related dependent care services who is (i) not your dependent; (ii) not your spouse; or (iii) not your child or your spouse's child unless he/she has attained the age of nineteen (19) at the close of the Plan Year in which the services were provided.
   d) **Qualifying Day Care Center**: Care at licensed nursery schools, pre-schools, day camps (not overnight camps), and child or adult care centers which provide day care. The day care center must: (i) comply with all applicable laws and regulations of the state, city, town, or village in which it is located; (ii) provide care for more than six (6) individuals (other than individuals who reside at the day care center); and (iii) receive a fee, payment, or grant from any individual to whom it provides services (regardless of whether facility is operated for a profit).
8. Be sure to sign and date this form. Return your completed form to the address shown above. You may obtain additional claims forms on the FSA Web site at nyc.gov/olr.

DEPENDENT CARE ASSISTANCE PROGRAM (DeCAP)

2) EMPLOYEE (PARTICIPANT) INFORMATION (Please type or print clearly.)

Last Name:	First Name:	M.I.:	Social Security Number:

☐ **Check here if this is a new address**

Home Address - Number and Street:	Apt. No.:	City:	State:	Zip Code:

Agency Name (Not Division):	Home Phone Number (Area Code):	Work Phone Number (Area Code):
	( )	( )

3) REIMBURSEMENT REQUESTS

Please read Important Instructions and Information on the reverse side before completing this form and refer to your enrollment information for DeCAP rules and regulations. If the service was provided for more than one day, show the beginning date and the ending date.

1.

Name of Dependent:	Type of Service:	Date(s) of Service: / / to / /	Reimbursement Requested: $
Provider's Name and Address:			Provider's Federal Tax ID# or SS#:

I have supplied the care listed above and have received payment in the amount listed above.

Provider's Signature: Dated:

2.

Name of Dependent:	Type of Service:	Date(s) of Service: / / to / /	Reimbursement Requested: $
Provider's Name and Address:			Provider's Federal Tax ID# or SS#:

I have supplied the care listed above and have received payment in the amount listed above.

Provider's Signature: Dated:

3.

Name of Dependent:	Type of Service:	Date(s) of Service: / / to / /	Reimbursement Requested: $
Provider's Name and Address:			Provider's Federal Tax ID# or SS#:

I have supplied the care listed above and have received payment in the amount listed above.

Provider's Signature: Dated:

4.

Name of Dependent:	Type of Service:	Date(s) of Service: / / to / /	Reimbursement Requested: $
Provider's Name and Address:			Provider's Federal Tax ID# or SS#:

I have supplied the care listed above and have received payment in the amount listed above.

Provider's Signature: Dated:

Total Reimbursement Amount Requested (1 + 2 + 3 + 4): $_____

4) EMPLOYEE (PARTICIPANT) SIGNATURE

The above is a true and accurate statement of unreimbursed dependent care expenses incurred by me for my eligible dependent(s) on the date(s) indicated. I understand that expenses reimbursed herein cannot be claimed on my or anyone else's Federal Income Tax return. All claims submitted by me comply with the rules and definitions as set forth on the reverse side of this form. I understand that the Internal Revenue Code and DeCAP Plan Document are the final authority in determining eligible expenses.

Signature: _____ **Date:** _____