



# CLAIM FORM – DEPENDENT CARE ASSISTANCE PLAN (DCAP)

ANSWER ALL QUESTIONS FULLY, ATTACH BILLING, OR RECEIPT AND FAX TO BAC AT (614) 863-0184, OR MAIL TO PO BOX 107, REYNOLDSBURG, OH 43068-0107

## A. STATEMENT OF PARTICIPANT: PLEASE ANSWER ALL QUESTIONS FULLY

EMPLOYER NAME:			
EMPLOYEE NAME (LAST, FIRST, M.):		SOCIAL SECURITY NUMBER:	
HOME ADDRESS:	CITY:	STATE:	ZIP CODE:
PHONE NUMBER:	DATE OF BIRTH (MM/DD/YYYY):	EMAIL ADDRESS:	IS THIS A NEW ADDRESS?: <input type="radio"/> YES <input type="radio"/> NO

## B. DEPENDENT CARE EXPENSE INFORMATION:

1.	DEPENDENT'S NAME:	DATE OF BIRTH (MM/DD/YYYY):	RELATIONSHIP:
	DATE(S) OF SERVICE (MM/DD/YYYY): FROM: / / THROUGH: / /		TOTAL AMOUNT SUBMITTED: \$:
2.	DEPENDENT'S NAME:	DATE OF BIRTH (MM/DD/YYYY):	RELATIONSHIP:
	DATE(S) OF SERVICE (MM/DD/YYYY): FROM: / / THROUGH: / /		TOTAL AMOUNT SUBMITTED: \$:
3.	DEPENDENT'S NAME:	DATE OF BIRTH (MM/DD/YYYY):	RELATIONSHIP:
	DATE(S) OF SERVICE (MM/DD/YYYY): FROM: / / THROUGH: / /		TOTAL AMOUNT SUBMITTED: \$:

## C. EXPENSE FOR BEFORE AND AFTER SCHOOL INCLUDING KINDERGARTEN:

4.	DEPENDENT'S NAME:	DATE OF BIRTH (MM/DD/YYYY):	RELATIONSHIP:
	DATE(S) OF SERVICE (MM/DD/YYYY): FROM: / / THROUGH: / /		TOTAL AMOUNT SUBMITTED: \$:

## D. CAREGIVER EXPENSE INFORMATION: (IF THE CAREGIVER SIGNS BELOW, NO RECEIPT IS REQUIRED)

5.	CAREGIVER'S NAME:	IS CAREGIVER A RELATIVE: <input type="radio"/> YES <input type="radio"/> NO	CAREGIVER'S TELEPHONE NO.:
	DATE(S) OF SERVICE (MM/DD/YYYY): FROM: / / THROUGH: / /	CAREGIVER'S SSN OR TAX ID NO.:	TOTAL AMOUNT SUBMITTED: \$:
	CAREGIVER'S ADDRESS:	CAREGIVER'S SIGNATURE: <b>X</b>	DATE SIGNED (MM/DD/YYYY):

## E. EMPLOYEE AUTHORIZATION:

I certify that all the expenses listed above for which I am seeking reimbursement from the Dependent care account have been incurred. I further certify that these expenses have not been reimbursed, nor shall I seek reimbursement from another dependent care assistance program. I also certify that I have not and will not claim a tax deduction or credit for these expenses on my federal income tax return, nor will I claim a tax deduction or credit for these expenses on my state or local returns in violation or state of local law. I further certify that the above dependent care expenses are for the care of a Qualifying Dependent, are employment related, and do not include separate charges for food, clothing, education, entertainment, activities, late fees, or overnight care. I agree to submit and retain sufficient documentation for any expense for which I seek reimbursement.

**X** \_\_\_\_\_  
EMPLOYEE'S SIGNATURE (NOT VALID UNLESS SIGNED IN INK): DATE SIGNED (MM/DD/YYYY):

**Any person who knowingly and with intent to defraud files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime!**

## G. REIMBURSEMENTS:

BAC WILL REIMBURSE FOR CLAIMS SUBMITTED VIA CHECK OR DIRECT DEPOSIT ACCORDING TO THE PARTICIPANT'S CHOICE ON THE CAFETERIA PLAN ELECTION FORM. TO CHANGE THE METHOD OF REIMBURSEMENT, PLEASE SUBMIT A DIRECT DEPOSIT AUTHORIZATION/CHANGE FORM FOUND ON BAC'S WEBSITE.

## H. INSTRUCTIONS:

### DEPENDENT CARE EXPENSE INFORMATION:

#### List and separate expenses by individual Qualifying Dependents.

**THE FOLLOWING PRESENTS GENERAL IRS RULES.  
SEE YOUR CAFETERIA PLAN DOCUMENT FOR SPECIFICS.**

#### A QUALIFYING DEPENDENT IS:

1. Your qualifying child who is your dependent and who was under age 13 when the care was provided.
2. Your spouse who is physically or mentally unable to care for him/herself and lives with you for more than half the year.  
A person who is physically or mentally incapable of self-care cannot dress, clean or feed him/herself because of physical or mental problems.
3. A person who is physically or mentally unable to care for him/herself and lives with you for more than half the year, and either:

##### A. IS YOUR DEPENDENT, OR

##### B. WOULD BE YOUR DEPENDENT EXCEPT THAT:

1. He or She receives gross income in excess of the exemption amount, or
2. He/She files a joint return, or
3. You, your spouse if filing jointly, can be claimed as a dependent on someone else's return

For more information about who is a qualifying person, refer to Publication 503 at <http://www.irs.gov>

#### ELIGIBLE DEPENDENT CARE EXPENSES:

In home services for the care of a qualifying dependent, including baby sitters and nannies.

Services of a dependent care center for the care of a qualified person. A dependent care center is any facility that provides care for more than six individuals (\*other than residents), receives payments or grants for providing dependent care services and meets all requirements of state and local law.

Adult day care.

Summer day camp, including a camp that specializes in a particular activity – overnight camp not covered.

When provided by the care provider, transportation expenses to and from the care location are eligible for reimbursement.

Once the related day care services have started, day care deposits, registration fees and agency fees are eligible for reimbursement.

Tuition for kindergarten or higher level education is not an eligible expense. Services for before and after-school care qualify for reimbursement when listed separately.

#### REIMBURSEMENTS:

BAC will reimburse for claims submitted via check or direct deposit according to the participant's choice on the Cafeteria Plan election form. To change the method of reimbursement, please submit a Direct Deposit Authorization/Change Form found on BAC's website.

#### ADDITIONAL NOTES REGARDING REQUESTS FOR REIMBURSEMENTS:

Services are considered incurred when they have been rendered or received, regardless of when you paid for the services.

The qualifying dependent must regularly spend at least 8 hours per day in your home.

Unless your caregiver fee is paid on a weekly or longer basis and you are required to pay regardless of attendance, expenses for days that you do not work (ie part-time workers) are not looking for work or attending school are not eligible for reimbursement.

If you receive any reimbursement from your dependent care account the IRS requires that you complete form 2441 and attach it to your federal income tax return. Form 2441 requires the following dependent care provider information: Name, Address, Social Security Number/Tax ID Number; and amount paid. If you do not provide this information to the IRS you may lose the tax benefits of your dependent care account. You may refer to the IRS web site at <http://www.irs.gov> for forms, instructions, and publications and more information.

Payments made to your spouse, the parent of your qualifying dependent, your child under age 19 (even if not your dependent) or a person whom you claim as a dependent on your tax return are not reimbursable.

**NOTE:** A non-custodial parent cannot participate in a dependent care FSA, even if the non-custodial parent claims the dependency exemption for the qualified dependent.

Qualified expenses must have been incurred to enable you (or, if you are married, you and your spouse) to work or look for work. You may also qualify if your spouse is a full-time student or incapable of self-care.

**MAIL COMPLETED FORM TO:  
BAC, PO BOX 107 REYNOLDSBURG, OH 43068**

**OR FAX COMPLETED FORM TO:  
BAC AT: (614) 863-0184**