Clear form

2017 Worksheet OR-WFHDC

18891701010000

Office use only

Oregon Working Family Household and Dependent Care Credit Worksheet

For 2016 expenses paid in 2017

Submit original form—do not submit photocopy

First name and initial	Last name	Social Security number (SSN)
		– –
Spouse's first name and initial	Spouse's last name	Spouse's SSN if joint return
		– –

Instructions. Only use this worksheet if you paid providers in early 2017 for services received during the latter part of 2016. You will need information from your 2016 Oregon return and Schedule OR-WFHDC or Schedule OR-WFHDC-NP to complete this worksheet. If you did not claim this credit for tax year 2016, you will need to complete federal Form 2441, *Child and Dependent Care Expenses,* for 2016 even if you did not claim the federal credit.

1. Enter your 2016 qualified expenses paid in 2016 ..... 1. .00
2. Enter your 2016 qualified expenses paid in 2017 ..... 2. .00
3. Add lines 1 and 2 ..... 3. .00
4. If you had one qualifying individual in 2016, enter $12,000. If you had two or more, enter $24,000 ..... 4. .00
5. Enter the smaller of your and your spouse's 2016 earned income. If you claimed the WFHDC in 2016, this is the smaller of lines 22 and 23 on your 2016 Schedule OR-WFHDC or Schedule OR-WFHDC-NP. If you didn't claim the credit in 2016, fill out federal Form 2441 for 2016. Use the amounts listed on lines 4 and 5 (or lines 18 and 19 if lines 4 or 5 are blank). Do not enter less than zero ..... 5. .00
6. Enter the smaller of lines 3, 4, and 5 ..... 6. .00
7. If you claimed the credit in 2016, enter the amount you claimed on line 24 of your 2016 Schedule OR-WFHDC or Schedule OR-WFHDC-NP. If you did not claim the credit in 2016, enter zero ..... 7. .00
8. Subtract line 7 from line 6 and enter the result. If zero or less, stop here. You cannot increase your 2017 credit based on prior year's expenses. If more than zero, continue to line 9 ..... 8. .00
9. Enter your 2016 federal adjusted gross income (2016 Form OR-40, line 7; Form OR-40-N or Form OR-40-P, line 29F) ..... 9. .00
10. Enter your 2016 Oregon adjusted gross income (2016 Form OR-40, line 7; Form OR-40-N or Form OR-40-P, line 29S) ..... 10. .00
11. Enter the greater of line 9 or line 10 ..... 11. .00
12. Enter your decimal value from the online calculator for tax year 2016. (If you claimed this credit in 2016, use line 25 of your 2016 Schedule OR-WFHDC or Schedule OR-WFHDC-NP.) ..... 12. .
13. Multiply line 8 by line 12. If you filed a 2016 full-year resident return, enter this amount on Schedule OR-WFHDC, line 27; or Schedule OR-WFHDC-NP, line 28. If you filed a 2016 part-year or nonresident return, continue to line 14 ..... 13. .00
14. Enter the decimal value from line 35 of your 2016 Form OR-40-N or Form OR-40-P ..... 14. .
15. Multiply line 13 by line 14 and enter this amount on Schedule OR-WFHDC, line 27; or Schedule OR-WFHDC-NP, line 28 ..... 15. .00

—Keep this worksheet with your tax records.—

2017 Worksheet OR-WFHDC

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Providers. Complete all information for each provider you paid in 2017 for expenses incurred in 2016. Only list the amounts paid in 2017 that apply to services provided in 2016.

16.

Provider's full name			Provider's SSN	Provider's federal employer identification number (FEIN)
			– –	–
Address			Provider's phone	Qualifying person to provider relationship code
			( ) –	
City	State	ZIP code		
			Amount **you** paid to provider	.00

17.

Provider's full name			Provider's SSN	Provider's FEIN
			– –	–
Address			Provider's phone	Qualifying person to provider relationship code
			( ) –	
City	State	ZIP code		
			Amount **you** paid to provider	.00

18.

Provider's full name			Provider's SSN	Provider's FEIN
			– –	–
Address			Provider's phone	Qualifying person to provider relationship code
			( ) –	
City	State	ZIP code		
			Amount **you** paid to provider	.00

19. Total the amounts you paid to the providers on lines 16–18 and enter the result here..... 19. .00

Qualifying persons. Complete all information for each qualifying individual who received care in 2016 that was paid for in 2017. Only list the amounts paid in 2017 that apply to services provided in 2016.

				(a) Total expenses paid for care	**(b)** Portion of expenses someone else paid on your behalf	**(c)** Portion of qualified expenses **you** paid for care
20.	First name		Disabled			
	Last name		☐	.00	.00	.00
	SSN – –	Code*	Date of birth / /			
21.	First name		Disabled			
	Last name		☐	.00	.00	.00
	SSN – –	Code*	Date of birth / /			
22.	First name		Disabled			
	Last name		☐	.00	.00	.00
	SSN – –	Code*	Date of birth / /			

*Qualifying individual to taxpayer relationship code—see instructions to determine the appropriate code.

23. Total the amounts in columns (a)–(c) for lines 20–22 and enter the results here .....23. .00 .00 .00

—Keep this worksheet with your tax records.—