Clear form

Form OR-PS

Page 1 of 2, 150-101-190 (Rev. 12-17) Oregon Department of Revenue

18310001010000

Office use only

Care Provider Statement

Submit original form—do not submit photocopy

Taxpayer name(s)	Letter ID	Date from	Date to
		/ /	/ /

Provider's name

Provider's Social Security number (SSN)	Provider's individual tax identification number (ITIN)	Provider's federal employer identification number (FEIN)
– –	– –	–

Complete this form for care you provided for the taxpayer(s) during the dates above.

Dependent's name	Dependent's age	Total payment received for this dependent	Total payments received from a third party*	Total payments you received from the taxpayer(s)
		.	.	.
		.	.	.
		.	.	.
		.	.	.
		.	.	.
		.	.	.

* Department of Human Services, another individual, etc.

Totals	.	.	.

Form OR-PS

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Taxpayer name(s)	Letter ID	

Provider's name

1. Did you provide care for dependents not associated with the taxpayer(s)? ☐ Yes ☐ No
2. How often were you paid? ☐ Monthly ☐ Weekly ☐ Biweekly ☐ Other (please explain):

_____

3. How were you paid? ☐ Cash ☐ Check ☐ Money order ☐ Electronic payment
   ☐ Other (please explain): _____
4. Did you provide the taxpayer with a receipt every time you were paid? ☐ Yes ☐ No (if no, please explain):

_____

5. **Provide the following information on all of the dependents listed on the prior page:**
   - A detailed year-end summary;
   - The typical days and times in your care;
   - The total hours per month in your care;
   - The amounts you were paid, with the dates those payments were made; and
   - Your rate, late fees charged, and any refunds or discounts given to the taxpayer.
6. If you are an individual operating outside of a facility, provide a copy of the front and back of your driver license or other government-issued ID.

Provider declaration

Under penalties of false swearing, I declare that the information I have provided is, to the best of my knowledge and belief, true, correct, and complete. I understand that the above income is considered taxable income. If I filed a return and didn't include this income, my return may be adjusted. I also understand that if I didn't file a return, a Notice of Assessment may be issued for failing to file.

Printed name	Facility name	
Signature X		Date / /
Address where services are provided		Daytime phone ( ) –
City	State	ZIP code

— Return the completed form and supporting documentation to the taxpayer. —

If you'd like to submit this information directly to us, you can fax the completed information or mail it to us, with a copy to the taxpayer for their records.

Fax:
Attn: Suspense
(503) 345-2354

Mail:
Oregon Department of Revenue
Attn: Suspense
PO Box 14999
Salem OR 97309-0090

OREGON DEPARTMENT OF REVENUE

Instructions for *Care Provider Statement*

Introduction

The *Care Provider Statement* is used to meet record keeping requirements for the working family child care (WFC) credit and the working family household and dependent care (WFHDC) credit. The statement lists detailed information regarding the care that was provided for the taxpayer's dependents.

The *Care Provider Statement* is commonly requested by the department when the WFC or WFHDC credit is claimed. If requested, the statement will be mailed to the taxpayer to complete; however, if the statement is lost or not received, taxpayers may request their provider fill out the statement available on our website.

Instructions for taxpayers

Enter your and your spouse's name (if married filing jointly).

Enter the Letter ID from the letter you received from us requesting the *Care Provider Statement.* The Letter ID can be found on the top of the letter; it's an 11-digit code starting with "L." If you don't have a Letter ID, write your (and your spouse's) SSN on the line instead.

Enter the beginning and ending date of the tax year you claimed the credit and that your qualifying individual was in your provider's care. Generally, this will be January 1 and December 31 of the corresponding tax year.

If you have more than one provider, fill out a separate *Care Provider Statement* for each provider.

Give the *Care Provider Statement* to your provider to complete. Either your provider will return the original to you to submit to us, or they will submit the statement to us and give you a copy. If your provider sends us the completed *Care Provider Statement,* keep the copy for your records.

You have 30 days to return the statement to the department once it has been requested. Be sure the required supporting documentation is included. The *Care Provider Statement* alone is not sufficient proof.

If your provider filled out the statement and returned it to you, submit it to the department with any other supporting documentation we requested.

If you can't obtain a statement from your provider, you may submit legible proof of payments, receipts for those payments, and a letter explaining why you couldn't obtain the *Care Provider Statement.*

Proof of qualifying individual's care expenses

Acceptable **proof of payment** includes, but isn't limited to:

- Cancelled check (front and back).
- Money order stub, along with a corresponding bank statement showing the withdrawal.
- Cashier's check, along with a corresponding bank statement showing the withdrawal.
- Duplicate check, along with a corresponding bank statement showing the withdrawal.
- Bank statement showing the cash withdrawal.

Acceptable **receipts** must be received at the time of payment, must match the proof of payment, and must include the:

- Qualifying individual's full name.
- Dates of care.
- Date and amount paid.
- Name of the person or agency paying.
- Provider's name, address, and phone number.
- Provider's SSN, ITIN, or FEIN.
- Method of payment (check, money order, cash, etc.)

If you have more than one qualifying individual, be sure the information is listed separately for each.

Letter

- Provide the following information about your provider:
  - — Name.
  - — Tax identification number (SSN, ITIN, or FEIN).
  - — Phone number.
  - — Address.
- Explain why your provider was unable to complete the *Care Provider Statement.* We may contact your provider to verify the information.

Instructions for care providers

Enter your name and SSN, ITIN, or FEIN. Complete all subsequent lines on the statement.

If you provided care for more than six of the taxpayer's dependents, complete additional forms as needed.

Once you have completed the statement, return it **and the supporting documentation** to the taxpayer as soon as possible. They will submit the information to the department once it has been requested.

You may also send the statement to the department directly. To submit it to us, fax the completed information to (503) 345-2354, labeled "Attn: Suspense," or mail it to:

Oregon Department of Revenue
Attn: Suspense
PO Box 14999
Salem OR 97309-0090

If you send the information directly to us, provide the taxpayer with a copy for their records.

Do you have questions or need help?

www.oregon.gov/dor
(503) 378-4988 or (800) 356-4222
questions.dor@oregon.gov

Contact us for ADA accommodations or assistance in other languages.