Clear form

Form OR-PS

Page 1 of 2, 150-101-190 (Rev. 01-19) Oregon Department of Revenue
Version 2

18310002010000

Office use only

Care Provider Statement

Submit original form—do not submit photocopy

Taxpayer's first name	Taxpayer's last name	Letter ID	Tax year

Spouse's first name	Spouse's last name

Provider's full name

Provider's Social Security number (SSN), or federal employer identification number (FEIN)

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Part 1: Dependents. Complete this section for care you provided to the dependents of the taxpayer(s) during the tax year above. Third party payments are payments made from other sources than the taxpayer(s), including payments from Department of Human Services or individuals not listed above.

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

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Taxpayer's first name	Taxpayer's last name	Letter ID

Provider's full name

Part 2: Additional Information. Complete this section for care you provided to the taxpayer's dependent(s) during the tax year.

1. How often did the taxpayer(s) pay you? ☐ Monthly ☐ Weekly ☐ Biweekly ☐ Other (explain below)

2. How did the taxpayer(s) pay you? ☐ Cash ☐ Check ☐ Electronically ☐ Money Order

   ☐ Other (explain)

3. If a third party paid you on the taxpayer's behalf, who paid you?

4. Did you provide the taxpayer with a receipt every time you were paid? ☐ Yes ☐ No If no, why not?

5. Are you related to the dependent(s)? ☐ Yes ☐ No If yes, what is your relationship?

6. Did you provide care for dependents of other clients? ☐ Yes ☐ No

Part 3: Documentation and declaration. Attach **all** of the following required information:

- ✔ A detailed year-end summary for each of the dependents listed in Part 1, showing:
  - ✔ The amounts you were paid by the taxpayer(s) or others, indicating who made each payment;
  - ✔ The dates the payments were made;
  - ✔ The individual amounts you charged for care, other services, other costs, or late fees; and
  - ✔ The amounts of any refunds or discounts given.
- ✔ The total hours per month and the typical days and times the dependents were in your care.
- ✔ A copy of the front and back of your driver license or government-issued ID, if you are an individual operating outside of a facility.

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 of provider	Facility name

Signature	Date
X	/ /

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 the completed form and additional information, indicated in Part 3, provide a copy to the taxpayer and mail the original form(s) to us at:

Oregon Department of Revenue
Attn: Appeals, Discovery and Processing Unit
PO Box 14999
Salem OR 97309-0090

OREGON DEPARTMENT OF REVENUE

Instructions for *Form OR-PS, Care Provider Statement*

Introduction

Form OR-PS, Care Provider Statement is used to meet record-keeping requirements for the working family household and dependent care (WFHDC) credit and the previous working family child care (WFC) credit for tax years 2015 and earlier. All references to WFHDC credit also apply to the WFC 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 us when the 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 on our website.

Instructions for taxpayers

Complete the first lines of the form by entering your name (and your spouse's, 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 the last four digits of your (and your spouse's) SSN instead.

Enter the tax year that you claimed the credit.

Your provider will complete the rest of the form. If you have more than one provider, copy or print a separate *Care Provider Statement* for each provider.

Give the *Care Provider Statement* to each 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 we have requested proof for this credit, you have 30 days from the date of our letter to provide the requested information. Include the required supporting documentation from Part 3.

The *Care Provider Statement* alone is not sufficient proof. Without the supporting documentation, your WFHDC credit may take longer to process and may be adjusted or denied.

If your provider completed the statement and returned it to you, submit it to us with any other supporting documentation we requested. Keep a copy for your records.

If you can't obtain a statement from your provider, you may submit legible proof of payments and receipts for those payments as described in our letter.

Note: The level of evidence we require increases when payments are made in cash or when the provider is a relative.

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, make sure the information is listed separately for each one.

Care provider information

Provide the following information about your care provider:

- Name.
- Tax identification number (SSN, ITIN, or FEIN).
- Phone number.
- Address.

Instructions for care providers

Enter your name and SSN or FEIN. If you don't have an SSN or FEIN, enter your individual tax identification number (ITIN) in the SSN box. Complete Parts 1 and 2, then gather and attach the information for Part 3.

For each dependent in **Part 1**, list:

- Their name and age.
- Total payments you received for them.
- Total payments you received from sources other than the taxpayer(s).
- Total payments you received from the taxpayer(s).

Example: Jane is the taxpayer listed at the top of Form OR-PS. You received $6,000 to care for Jane's son. Jane paid $2,000. The remaining $4,000 came from the Department of Human

Services and the child's father. You will enter $6,000 in the total box, $4,000 in the box for third party payments, and $2,000 in the box for payments from the taxpayer.

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 from Part 3** to the taxpayer as soon as possible. They have 30 days to submit the information to us once it has been requested.

You may also send the statement and supporting documentation to us directly. If you'd like to submit the completed form(s) and additional information, provide a copy to the taxpayer and mail the original form(s) to us at:

Oregon Department of Revenue
Attn: Appeals, Discovery and Processing Unit
PO Box 14999
Salem OR 97309-0090

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.