OREGON DEPARTMENT OF REVENUE

Instructions for Form OR-PS, Care Provider Statement

Introduction

Form OR-PS is used to meet record- keeping requirements for 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.

Form OR-PS is commonly requested by the department 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 proof of your dependent care payments. 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 Form OR-PS for each provider. If you have more than six dependents who received care by one provider, print or make an additional copy of the form to give to them. Please make copies of forms prior to writing on them. Our scanners may not be able to read photo copies taken after being written on.

Give Form OR-PS 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.

Form OR-PS 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.

Note: The level of evidence we require increases when payments are made in cash or when the provider is a relative or someone with whom you have a personal relationship with, such as a friend.

If you can't obtain a statement from your provider or if your provider is a relative or personal friend, submit legible proof of your qualifying individual's care expenses (including proof of payment and of receipts) and care provider information.

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.
- Electronic history report or statement showing money was sent by you and to whom it was sent.

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 business name or, if you don't have a business name, your own name. Enter your 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 only taxpayer's name 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.