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2020 Schedule OR-WFHDC-PR

18892001010000

Office use only

 Oregon Department of Revenue
(Rev. 08-24-20 ver. 01)

Working Family Household and Dependent Care Credit for Prior Year Expenses

Submit original form—do not submit photocopy

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

Instructions: Only use this worksheet if you paid providers in early 2020 for services received toward the end of the year in 2019. You will need information from your 2019 Oregon return and Schedule OR-WFHDC to complete this worksheet. If you did not claim this credit for tax year 2019, you will need to complete federal Form 2441, *Child and Dependent Care Expenses,* for 2019 even if you did not claim the federal credit.

1. Enter your 2019 qualified expenses paid in 2019 ..... 1. .00
2. Enter your 2019 qualified expenses paid in 2020 ..... 2. .00
3. Add lines 1 and 2 ..... 3. .00
4. Enter the amount from line 23 of your 2019 Schedule OR-WFHDC ..... 4. .00
5. Enter the smaller of your and your spouse's 2019 earned income. If you claimed the WFHDC credit in 2019, this is the smaller of lines 25 and 26 on your 2019 Schedule OR-WFHDC. If you didn't claim the credit in 2019, fill out federal Form 2441 for 2019. 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 smallest amount from lines 3, 4, or 5 above ..... 6. .00
7. If you claimed the credit in 2019, enter the amount you claimed on line 27 of your 2019 Schedule OR-WFHDC. If you did not claim the credit in 2019, 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 2020 credit based on prior year's expenses. If more than zero, continue to line 9 ..... 8. .00
9. Enter your 2019 **federal** adjusted gross income (2019 Form OR-40, line 7; Form OR-40-N or Form OR-40-P, line 29F) ..... 9. .00
10. Enter your 2019 **Oregon** adjusted gross income (2019 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 line 28 of your 2019 Schedule OR-WFHDC. If you did not claim this credit in 2019, use the online calculator for tax year 2019 and enter the decimal value ..... 12. .
13. Multiply line 8 by line 12. If you filed a 2019 full-year resident return, enter this amount on your 2020 Schedule OR-WFHDC, line 31. If you filed a 2019 part-year or nonresident return, continue to line 14 ..... 13. .00
14. Enter the decimal value from line 35 of your 2019 Form OR-40-N or Form OR-40-P ..... 14. .
15. Multiply line 13 by line 14 and enter this amount on your 2020 Schedule OR-WFHDC, line 31 ..... 15. .00

—Keep this worksheet with your tax records.—

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Providers. Complete all information for each provider you paid in 2020 for expenses incurred in 2019. Only list the amounts you paid in 2020 that apply to services provided in 2019. If you have more than three providers, submit an additional page 2.

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 all of the providers. Enter the result here. ..... 19. .00

Qualifying persons. Complete all information for each qualifying individual who received care in 2019 that you paid for in 2020. Only list the amounts paid in 2020 that apply to services provided in 2019. If you have more than three qualifying individuals, submit an additional page 2.

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

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

23. Total the amounts in columns (a)–(c) for all qualifying individuals. Enter results here..... 23. .00 .00 .00

—Keep this worksheet with your tax records.—