

# 2019 Worksheet OR-WFHDC

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Oregon Department of Revenue



Office use only

## 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 2019 for services received toward the end of the year in 2018. You will need information from your 2018 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 2018, you will need to complete federal Form 2441, *Child and Dependent Care Expenses*, for 2018 even if you did not claim the federal credit.

1. Enter your 2018 qualified expenses paid in 2018..... 1.
2. Enter your 2018 qualified expenses paid in 2019..... 2.
3. Add lines 1 and 2..... 3.
4. Enter the amount from line 23 of your 2018 Schedule OR-WFHDC or Schedule OR-WFHDC-NP..... 4.
5. Enter the smaller of your and your spouse's 2018 earned income. If you claimed the WFHDC credit in 2018, this is the smaller of lines 22 and 23 on your 2018 Schedule OR-WFHDC or Schedule OR-WFHDC-NP. If you didn't claim the credit in 2018, fill out federal Form 2441 for 2018. 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.
6. Enter the smallest amount from lines 3, 4, or 5 above..... 6.
7. If you claimed the credit in 2018, enter the amount you claimed on line 24 of your 2018 Schedule OR-WFHDC or Schedule OR-WFHDC-NP. If you did not claim the credit in 2018, enter zero.....7.
8. Subtract line 7 from line 6 and enter the result. If zero or less, stop here. You cannot increase your 2019 credit based on prior year's expenses. If more than zero, continue to line 9..... 8.
9. Enter your 2018 **federal** adjusted gross income (2018 Form OR-40, line 7; Form OR-40-N or Form OR-40-P, line 29F)..... 9.
10. Enter your 2018 **Oregon** adjusted gross income (2018 Form OR-40, line 7; Form OR-40-N or Form OR-40-P, line 29S)..... 10.
11. Enter the greater of line 9 or line 10..... 11.
12. Enter your decimal value from line 25 of your 2018 Schedule OR-WFHDC or Schedule OR-WFHDC-NP. If you did not claim this credit in 2018, use the online calculator for tax year 2018 and enter the decimal value..... 12.
13. Multiply line 8 by line 12. If you filed a 2018 full-year resident return, enter this amount on your 2019 Schedule OR-WFHDC, line 31. If you filed a 2018 part-year or nonresident return, continue to line 14..... 13.
14. Enter the decimal value from line 35 of your 2018 Form OR-40-N or Form OR-40-P ..... 14.
15. Multiply line 13 by line 14 and enter this amount on your 2019 Schedule OR-WFHDC, line 31..... 15.

— Keep this worksheet with your tax records. —

# 2019 Worksheet OR-WFHDC



**Providers.** Complete all information for each provider you paid in 2019 for expenses incurred in 2018. Only list the amounts you paid in 2019 that apply to services provided in 2018. 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 <b>you</b> paid to provider <input style="width: 100px;" type="text" value=".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 <b>you</b> paid to provider <input style="width: 100px;" type="text" value=".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 <b>you</b> paid to provider <input style="width: 100px;" type="text" value=".00"/>		

19. Total the amounts you paid to all of the providers. Enter the result here. .... 19.

**Qualifying persons.** Complete all information for each qualifying individual who received care in 2018 that you paid for in 2019. Only list the amounts paid in 2019 that apply to services provided in 2018. If you have more than three qualifying individuals, submit an additional page 2.

	(a) Total expenses paid for care	(b) Portion of expenses someone else paid on your behalf	(c) Portion of expenses <b>you</b> paid for care
20. First name Last name SSN - - Code* Date of birth / /	Disabled <input type="checkbox"/>	<input style="width: 100px;" type="text" value=".00"/>	<input style="width: 100px;" type="text" value=".00"/>
21. First name Last name SSN - - Code* Date of birth / /	Disabled <input type="checkbox"/>	<input style="width: 100px;" type="text" value=".00"/>	<input style="width: 100px;" type="text" value=".00"/>
22. First name Last name SSN - - Code* Date of birth / /	Disabled <input type="checkbox"/>	<input style="width: 100px;" type="text" value=".00"/>	<input style="width: 100px;" type="text" value=".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.