DEPENDENT CARE ACCOUNT

REIMBURSEMENT CLAIM FORM INSTRUCTIONS

Because you are responsible for understanding and complying with the IRS regulations and maintaining documentation for the information submitted on this reimbursement form, you should carefully read the requirements concerning eligible dependents and expenses outlined in the Employee Information Brochure. If you are audited by the IRS, you may have to provide substantiation to them regarding your expenses and/or eligibility.

Please provide the information requested on side 1 and attach a receipt or statement for the expenses incurred. The receipt or statement must provide the required details. The IRS has determined that canceled checks, statements showing only a balance due or credit card receipts are not acceptable as documentation of dependent care expenses. Be certain to keep copies for your records. The originals will not be returned to you.

You will be reimbursed up to the available balance in your account as of the pay date the reimbursement is processed. If your account balance is not sufficient to cover the amount requested, the remainder will be reimbursed as subsequent deductions are added to your account until that claim is fully reimbursed. Reimbursement cannot have been made or requested from any other source.

IRS regulations require that any money remaining in your account after all qualified reimbursements for the calendar year have been paid cannot be returned to you or carried forward to the next year but **must be forfeited**. You have until March 1 to submit a claim for eligible expenses for the prior year.

If you have any questions regarding the Dependent Care Account Program, please feel free to call the AOPC Payroll Department at 717-231-3325.

Administrative Office of Pennsylvania Courts

DEPENDENT CARE ACCOUNT

REIMBURSEMENT CLAIM FORM

Please print or type. See instructions on reverse side and attach required receipts.

Employee Name

_____ Social Security Number XXX - XX - _____
Last name, first name & middle initial — Last 4 digits only

Provider Information

Name: _____ Tax ID #_____

☐ Licensed Care Provider
☐ Provider is exempt from federal taxes
☐ Other than Licensed Care Provider

Address: _____

_____ Relationship to Employee, if any

_____ _____

Name(s) of Eligible Dependent(s) (Last, First, Middle Initial)	Dates of Service						Amount of Eligible Expense
	Beginning			Ending			
	Mo	Day	Year	Mo	Day	Year	
							$
							$
							$
							$
							$
							$
							$

Total Eligible Expenses $ _____

Reimbursement Requested if Different from Above $ _____

_____ _____
Employee Signature — Date

Please return completed form to:

Payroll Department
The Administrative Office of Pennsylvania Courts
601 Commonwealth Ave., Suite 1500
P.O. Box 61260
Harrisburg, Pennsylvania 17106-1260
FAX 717-231-3299