HOW TO REQUEST REIMBURSEMENT FROM YOUR DEPENDENT CARE ACCOUNT

Use this form to request reimbursement for your dependent care expenses only. To view a detailed list of eligible dependent care expenses, access the **Flexible Spending Eligible Expense Guide** at **http://judiciary.shps.com** under **Get Documents**. In general, the following rules apply to dependent care expenses:

Dependent care expenses qualify if they are for the care of children under age 13 or other dependents that are physically or mentally incapable of caring for himself or herself. These expenses must be incurred so that you and your spouse, if married, can work, or your spouse can attend school full-time. However, if either you or your spouse had no earned income for the year, you are not eligible for the Dependent Care Reimbursement Account.

The annual amount of reimbursed dependent care claims cannot exceed:

- Your annual deposit amount up to $5,000 ($2,500 if you and your spouse are filing separate returns), or
- Your annual salary or your spouse's annual salary, if less than $5,000, or
- Your annual election plus any childcare subsidies cannot total more than $6,000, depending on your tax situation.

- Children must be under age 13 or physically or mentally incapable of caring for themselves if over age 13.
- Services provided by a childcare or elder care center must comply with all state and local laws to be an eligible reimbursement expense.
- The Judiciary Benefits Center cannot pay for services that have not been rendered.

Step 1: Fill out the form

Please type or print in capital letters, with your letters centered in the boxes provided, and fill in all ovals as shown:

A	B	C	D		1	2	3	4

● YES ○ NO

For Section 1: Complete all areas of "Employee Information." You will receive an email confirming receipt of your claim.

For Sections 2 & 5: Complete a separate line for each individual expense. Do not lump expenses together.

- Complete all sections of the form. Sign and date the form where indicated.
- Please use page 3 for additional expenses if you exceed the number of lines provided on page 2.

Step 2: Attach supporting documentation

In addition to completing the form, you must submit the documentation described under A and B below:

A. For allowable Dependent Care expenses, attach a copy of the bill or signed receipt. If the receipt is not available, the provider must sign the affidavit for each expense.
B. Requests **will not be processed** without the Tax ID Number or Social Security Number for all providers.

Step 3: Read the Certification and then sign and date the form where indicated

Step 4: Submit your form

- **By Fax:** Fax the form and supporting documentation to 1-800-778-0045 (toll-free).
- **By Mail:** Place the form and the supporting documentation into an envelope, apply the correct postage, and mail to SHPS Processing Center, PO Box 35680, Louisville, KY 40232.
- Keep a copy of your completed form and receipts for your records.

Reimbursement will be made via Electronic Funds Transfer (EFT) to the same account as your Pay. Payment will be sent within five (5) business days, on average.

Type of Supporting Documentation:

You must include supporting documentation for your dependent care expenses with your claim. Attach a copy of the bill or signed receipt, or have the provider sign the Affidavit on Section 2 or 5 of the claim form. Claims without the Tax ID number or SSN for all providers will be denied. If your provider is tax exempt, enter all 9s for the Provider's Tax ID.

Helpful Hints:

- Have your provider sign the affidavit section of the form each time you submit to avoid including receipts
- Submit expenses for the full month **after** the month has ended, OR
- Submit previous week expenses
- The Total Requested box will automatically calculate the sum of expenses you list on page 2, or pages 2 and 3.

Please Do NOT :

- Use red ink
- Use a photocopy of this form
- Highlight receipts or any part of the form
- Staple your copied receipts to the form
- Write outside the boxes provided
- Fax the same form more than once
- Mail the same form that you have faxed
- Include this instruction sheet with your fax
- Submit claims **before** services are rendered
- Submit expenses for multiple plan years on the same form

Questions? Go to http://judiciary.shps.com or contact a Judiciary Benefits Center Counselor at 1-888-442-FLEX (3539).

MAIL: SHPS Processing Center
PO Box 35680
Louisville, KY 40232

PHONE: 1-888-442-FLEX (3539)

DEPENDENT CARE CLAIM FORM

Use only CAPITAL LETTERS

FAX TO: 1-800-778-0045 TOLL-FREE

For additional expenses, please use next page.

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SECTION 1: EMPLOYEE INFORMATION

EMPLOYEE SSN OR ID (NO DASHES)

PROGRAM NAME: THE FEDERAL JUDICIARY

FOR SHPS USE

EMPLOYEE LAST NAME

EMPLOYEE FIRST NAME

EMPLOYEE EMAIL

DAYTIME PHONE # (AREA CODE FIRST, NO DASHES)

SECTION 2: YOUR DEPENDENT CARE EXPENSES

EXPENSE 1

START DATE OF SERVICE (MMDDYY)

PROVIDER TAX ID OR SSN (ENTER ALL 9'S IF TAX-EXEMPT)

AMOUNT REQUESTED (DOLLARS . CENTS)

$.

END DATE OF SERVICE (MMDDYY)

DEPENDENT DATE OF BIRTH (MMDDYYYY)

EXPENSE 1 COVERS:
DEPENDENT NAME _____

AFFIDAVIT:
Your daycare provider only needs to sign this if you do not have supporting documentation, such as an itemized receipt.
I hereby certify that I provided adult or child daycare services to the above individuals in accordance with the amounts and dates that are requested.

PROVIDER'S SIGNATURE _____ DATE _____

SECTION 3: CERTIFICATION Please read carefully before signing.

TOTAL REQUESTED (SUM OF EXPENSES FROM ALL PAGES SUBMITTED)

$

I affirm that:

- I HAVE NOT ALREADY BEEN PAID FOR THESE EXPENSES FROM MY FSA PLAN and I HAVE NOT REQUESTED AND WILL NOT RECEIVE REIMBURSEMENT FOR THESE EXPENSES FROM ANY OTHER PLAN; AND
- I have submitted the above information in good faith and it is correct to the best of my knowledge.
- The total of any reimbursed dependent care expenses does not exceed my or my spouse's earned income (W-2 Pay) for the year, if either of our annual incomes are less than $5,000.

I understand that:

- Reimbursement is not a guarantee that this payment is tax-free.
- The service(s) for which I am requesting reimbursement must be incurred during my period of coverage.
- I have until April 30 following the end of the Plan Year to submit my claim for reimbursement of eligible expenses incurred during my period of coverage. If I do not submit claims for reimbursement by that date, I will forfeit any funds remaining in my account in accordance with IRS rules.
- I cannot use dependent care expenses reimbursed through my Dependent Care Reimbursement Account (DCRA) as a dependent care credit on my personal income tax return. Therefore, reimbursement of dependent care expenses reduces, and may eliminate completely, my ability to claim a dependent care credit on my personal income tax return.
- I am submitting dependent care claims for my dependent child(ren) under age 13 and/or for my age 13 or over dependents who are physically or mentally incapable of caring for themselves and includes anyone I claim on my Federal Income Tax return as a qualified IRS dependent.
- Dependent care expenses (including overnight day care expenses) must be incurred so that my spouse and I, if married, can work, look for work or my spouse can attend school full-time.
- My household limit for dependent care reimbursement cannot exceed $5,000 per year, including my annual election, any child care subsidies that I receive, and/or amounts that my spouse has elected through another account.
- The balance in my DCRA must be at least equal to the expenses submitted with this claim. If the balance in my DCRA is less, these expenses will be held until the balance in my account is sufficient to pay these expenses.
- I can only be reimbursed for my DCRA expenses after the date of service has passed.

Employee Signature* _____ **Date** (MMDDYY)

* Your signature and date are required in order to process your claim for reimbursement.

USE AN ORIGINAL FORM (NOT A PHOTOCOPY)

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USE THIS PAGE FOR ADDITIONAL DEPENDENT CARE EXPENSES.

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SECTION 4: EMPLOYEE INFORMATION (ABBREVIATED)

EMPLOYEE SSN OR ID (NO DASHES)

EMPLOYEE LAST NAME

EMPLOYEE FIRST NAME

SECTION 5: YOUR ADDITIONAL DEPENDENT CARE EXPENSES

EXPENSE 2

START DATE OF SERVICE (MMDDYY)

PROVIDER TAX ID OR SSN (ENTER ALL 9'S IF TAX-EXEMPT)

AMOUNT REQUESTED (DOLLARS . CENTS)

$.

END DATE OF SERVICE (MMDDYY)

DEPENDENT DATE OF BIRTH (MMDDYYYY)

EXPENSE 2 COVERS:
DEPENDENT NAME _____

EXPENSE 3

START DATE OF SERVICE (MMDDYY)

PROVIDER TAX ID OR SSN (ENTER ALL 9'S IF TAX-EXEMPT)

AMOUNT REQUESTED (DOLLARS . CENTS)

$.

END DATE OF SERVICE (MMDDYY)

DEPENDENT DATE OF BIRTH (MMDDYYYY)

EXPENSE 3 COVERS:
DEPENDENT NAME _____

AFFIDAVIT:
Your daycare provider only needs to sign this if you do not have supporting documentation, such as an itemized receipt.
I hereby certify that I provided adult or child daycare services to the above individuals in accordance with the amounts and dates that are requested.

PROVIDER'S SIGNATURE _____ DATE _____