Syracuse University
Human Resources

Application For 2019 Dependent Care Subsidy

An annual tax-free subsidy for eligible dependent care expenses is available to eligible faculty and staff with gross household incomes of less than $150,000. The age of the eligible dependent as of 7/1/2019 determines the subsidy amount, which will not exceed $3,000 per household. Subsidy: $1,500 per child younger than 6, $750 per child ages 6 through 12, and/or $750 for elder or disabled dependents age 13 and over. Please complete this application and submit it along with your documentation by **December 7, 2018** to the Office of Human Resources.

EMPLOYEE / CO-APPLICANT INFORMATION

Name: _____ SUID#: _____

Co-Applicant's Name: _____ SUID# (if applicable): _____

EMPLOYEE ELIGIBILITY

Please check the box that explains your current marital status:

☐ I am unmarried, not in a domestic partnership, and not living with the parent of a child on this application.

☐ I am married, in a domestic partnership, or living with the parent of a child on this application. This individual must be listed above as the co-applicant. I attest that my co-applicant meets one of the following criteria:

- ☐ Employed at least part-time
- ☐ A full-time student
- ☐ Considered legally disabled
- ☐ Unemployed but actively seeking employment (must have legal work authorization to work in the United States).
- ☐ Stay at home parent
- ☐ Self-employed

HOUSEHOLD INCOME

Your total household income must be less than $150,000 in order to meet the program's eligibility guidelines.

Please complete the information required below:

Adjusted Gross Income on YOUR Federal Income Tax Return: _____
(Line 37 on Form 1040, line 21 on Form 1040A; line 4 on Form 1040EZ)

If filing separately, Adjusted Gross Income on YOUR CO-APPLICANT'S Federal Income Tax Return: _____
(Line 37 on Form 1040, line 21 on Form 1040A; line 4 on Form 1040EZ)

Combined Adjusted Gross Income: _____

Please submit a copy of your most recent tax returns and those of your co-applicants, if filing separately.

Please complete the information required below. Please reference the Federal Taxable Gross Amount listed on the paycheck in order to compute your average pay amount.

Your Paycheck Information:

Average pay amount over your most recent two paychecks: _____

Number of pay periods per calendar year: _____

Your Co-Applicant's Paycheck Information:

Average pay amount over his or her most recent two paychecks: _____

Number of pay periods per calendar year: _____

Other Income Anticipated During the Year:

Includes child support, alimony, etc.: _____

Please submit copies for both you and your co-applicant (if applicable) of your two most recent paycheck stubs (including those for other employment).

Please provide information on your eligible dependents or child(ren) expected to be added to your family this year. For the box labeled *Type of Dependent Care*, please utilize the choices included in the detailed information found at http://hr.syr.edu/dependentcaresubsidy.

Dependent 1:

Name: _____ Relationship to You: _____

Social Security Number: _____ Date of Birth: _____

Type of Dependent Care: _____ Anticipated Care Provider: _____

Dependent 2:

Name: _____ Relationship to You: _____

Social Security Number: _____ Date of Birth: _____

Type of Dependent Care: _____ Anticipated Care Provider: _____

Dependent 3:

Name: _____ Relationship to You: _____

Social Security Number: _____ Date of Birth: _____

Type of Dependent Care: _____ Anticipated Care Provider: _____

Dependent 4:

Name: _____ Relationship to You: _____

Social Security Number: _____ Date of Birth: _____

Type of Dependent Care: _____ Anticipated Care Provider: _____

☐ I am pregnant, or my spouse/partner is pregnant

Anticipated Date of Birth: _____

Type of Dependent Care: _____

☐ I am currently planning to adopt a child

Anticipated Date of Adoption or Placement: _____

Name of Anticipated Child Care Provider: _____

2019 FSA INSTRUCTIONS	**Please select one option:** ☐ I have already elected a Dependent Care Flexible Spending Account for 2019. If approved for this benefit, please keep my salary deductions the same and increase my total election by the subsidy. I understand that my household maximum contribution cannot be more than $5,000 annually and if the total election exceeds this, my salary deductions will be reduced. ☐ I have already elected a Dependent Care Flexible Spending Account for 2019. If approved for this benefit, please decrease my salary deductions by the subsidy leaving my total elections the same. ☐ I have not enrolled in a Dependent Care Flexible Spending Account for 2019. Please set up an account.
EMPLOYEE VERIFICATION	**Please attest to the following:** ☐ I attest that I will be claiming the dependents listed on this form as my tax dependents for the year in which I receive the subsidy. In addition, if approved for the benefit, I will request reimbursement from the flexible spending account administrator only for eligible expenses for the dependents approved for this subsidy. By virtue of my signature, I am verifying that all information provided on this form is true and complete. **Note: Print, sign and scan this form to email, or print and sign to deliver to HR as directed below.** Signature: _____ Date: _____ **This application and all required signed Federal Income Tax Returns and supporting documentation must be submitted to the Office of Human Resources via email at hrservice@syr.edu or in person at the HR Office in the Skytop Office Building by December 7, 2018.** If your application for the child care subsidy is approved, you will be notified via email to your syr.edu account.
INTERNAL USE ONLY	☐ APPROVED SUBSIDY: _____ ☐ DENIED REVIEWER: _____ DATE: _____

APPLICATION CHECKLIST

For your convenience and timely processing, a checklist is provided below to ensure all requested documents are provided at the time of submission. The application and your supporting documents must be submitted to the Office of Human Resources via email (**hrservice@syr.edu**) or in person (Skytop Office Building, Room 101) by December 7, 2018.

- ☐ 2017 1040 for employee (first two pages with the second page signed)
- ☐ 2017 1040 for co-applicant, if filed separately (first two pages with the second page signed)
- ☐ Two most recent paycheck stubs for employee
- ☐ Two most recent paycheck stubs for co-applicant, if employed at least part-time
- ☐ Proof of dependent's eligibility (i.e. birth certificate, adoption paperwork, or legal custody paperwork) if not already on file with the Office of Human Resources. You may call the HR Service Center at 315.443.4042 with inquiries.
- ☐ Documentation supporting self-employment (i.e. Certificate of Organization, 2017 form 2095, or other documents filed with the IRS indicating income)
- ☐ Signature and date on third page of application