Office of HUMAN RESOURCES | THE OHIO STATE UNIVERSITY

FSA—DEPENDENT CARE
Request for Reimbursement

Read detailed instructions on Page 2 prior to completing this form in order to prevent delays in processing.
Important Guidelines:

1. Total of the “Amount to be Reimbursed” **must** be $25 or greater.
2. Faxed copies of the completed form are not acceptable.
3. List no more than 10 expenses per form. Do not combine expenses or services dates, list one expense per line.
4. Staple appropriate bill(s) or receipt(s) to this form or in lieu of these, original provider signature may be used.
5. Include only eligible expenses in the “Amount to be Reimbursed” column. Claims are reimbursable on or after the end of the service dates. Future dated services are not eligible.
6. Contact your department human resource professional to verify or change your home mailing address.
7. Keep copies of reimbursement forms and receipts.

Section I: Faculty/Staff participant Information (please print)

Full Name ____________________ OSU Employee ID Number (Required) ____________________

Office/Daytime Phone Number ____________________ E-mail Address ____________________

Section II: Dependent Care Expenses

Service Dates: From MM/DD/YY	Service Dates: To MM/DD/YY	Total Amount Paid	Amount to be Reimbursed	Full Name of Dependent	Age	Service Provider’s Name	Provider Tax ID or SSN
		Total must be at least $25:					

____
Provider signature in lieu of bill or receipt, MUST be original

Section III: Participant Certification

I have received, read and understand the material explaining the terms and conditions of The Ohio State University Flexible Benefits Plan. I understand that any person who, knowingly and with intent to defraud, files a claim containing any materially false information is guilty of fraud, which is subject to disciplinary action, up to and including termination of employment. I certify, to the best of my knowledge, that the expenses included in this request are eligible dependent care expenses under the Internal Revenue Code, have been incurred during the Plan Year, and have not been reimbursed by any other source. I understand expenses reimbursed from this account cannot also be claimed as a tax deduction on my Federal Tax return. I understand it is my responsibility to verify, with the IRS or my tax consultant, that this is an eligible expense, and that I assume all tax liability for this reimbursement. I certify that all information provided on this form is true and correct to the best of my knowledge.

Participant Signature (must be original in ink) ____________________ Date ____________________

Return completed form to: The Ohio State University, Office of Human Resources, Benefits Processing/FSA, 1590 N. High St., Suite 300, Columbus, OH 43201-2190.
FSA checks produced Friday, typically for claims received the prior week.

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Instructions for Dependent Care FSA Reimbursement

Complete the front of this form in its entirety, with original signature(s) only. Incomplete forms, missing bills or incomplete receipts will delay the processing of your reimbursement request.

Required Proof of Incurred Eligible Expenses

Dependent care provider may do one of two things:

1. Sign Request form (original signature only) and provide taxpayer ID number, or
2. Supply itemized bill or receipt with the following:
   - Name of dependent(s) receiving service
   - Beginning and ending service dates, including month, day and year
   - Total charge
   - Provider's name
   - Provider's taxpayer ID number, if provider is an individual, his/her social security number must be supplied

Note: Copies of cancelled checks or credit card receipts cannot substitute for an itemized bill.
Statements with a "Balance Forward" or "Previous Balance" cannot be processed.
We do not need evidence that you have paid a dependent care expense in order for it to be reimbursed. You only need to have *incurred* the expense. You may pay the provider after we reimburse you, if such arrangements are acceptable to your provider.

Eligible Expenses

The requirements for eligibility of expenses are detailed in IRS Publication 503, Child and Dependent Care Expenses. In addition:

1. The participant is responsible for complying with IRS regulations.
2. The expenses must be incurred during the Plan Year in which you are enrolled.
3. Dependent Care expenses submitted for FSA reimbursement must not be claimed as a Dependent Care Tax Credit.

For additional information, request IRS Publication 503, Child and Dependent Care Expenses, by calling 1-800-TAX-FORM (1-800-928-3676), or visit **www.irs.ustreas.gov**.

Participant Records

The participant should retain copies of all paperwork submitted. Such information may be necessary for filing your federal tax return and/or undergoing an IRS audit of your personal tax return.

Availability of Participant Funds

Reimbursement requests must have expenses totaling $25 or more. If an eligible request is made for an amount that exceeds your account balance, a check will be issued for your account balance. The difference will be paid when your next payroll contribution is deposited. You may view your current account status at anytime by using FSA Online at **hr.osu.edu/benefits/flexible spending** or contact the Office of Human Resources Customer Service Center.

Reimbursement Checks

NEW this account year—checks are normally processed each Friday, typically for claims received the prior week. Checks mailed to home address.

Account Status

You may view your current account status at anytime by using FSA Online at **hr.osu.edu/benefits/flexible spending**. On the site you will be able to view year-to-date contributions to your account, amount available for reimbursement, claims paid and history of payments.

For More Information

Direct additional questions regarding reimbursement procedures to the Office of Human Resources Customer Service Center at service@hr.osu.edu, **hr.osu.edu**, (614) 292-1050, 1-800-678-6010.