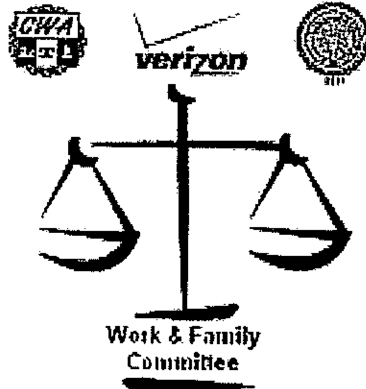


# Dependent Care Reimbursement Fund Application

If you are eligible, you may receive reimbursement tax-free to help you pay for the care of a dependent. This packet contains information and enrollment information that you should read prior to applying for this Fund.

**While the Regional Work & Family Committee intends to continue the Dependent Care Reimbursement Fund, the Regional Work & Family Committee reserves the right to terminate or amend the plan at any time funds are anticipated to be depleted.**

# EMPLOYEE CERTIFICATION

*please check all that apply*

**I certify that I am**

☐ Married
☐ Single
☐ Divorced
☐ Legally Separated

☐ I certify that the Child listed as my dependent on this application is less than 13 years old and will be listed as a dependent on my current Federal Income Tax return. If I am divorced or legally separated I certify the child listed as the dependent on this application is less than 13 years old and is in my custody for the greater part of the year. Any other dependent listed on this form is physically or mentally incapable of self-care and qualifies as my dependent for Federal Income Tax purposes. The dependent spends at least 8 hours a day in my home.

☐ If married my spouse is employed or is actively seeking employment, or is a full-time student, or is physically or mentally disabled and unable to provide self-care.

☐ I certify that my provider is not a relative listed as a dependent on my Federal income tax return and not my own child under the age of 19. To the best of my knowledge my provider is in compliance with all the laws and regulations governing the operation of the business.

☐ I assume all responsibility for determining the quality and capability of a childcare dependent care provider, and I assume all responsibility for choosing a provider. I understand that VERIZON, CWA and IBEW 2213 do not hire, train or supervise child or dependent care providers, nor do they screen, endorse, or recommend any provider of care, nor represent or guarantee the provider I have chosen will provide quality care. I understand VERIZON, CWA, and IBEW 2213 are not responsible or liable for any injuries or damages of any nature suffered as result of the acts or omission of a provider of care in the operation of its business.

☐ I understand VERIZON, CWA and IBEW 2213, retain the right to change the eligibility requirement or amount of reimbursement as well as any other provision of the Dependent Care Reimbursement Fund.

☐ I understand that it is my responsibility to notify the Work & Family Committee at 120 Hicksville Road, Room 200-A, Massapequa N.Y. 11758 of any lifestyle change, IE: Marriage, Birth, or adoption of a child.
beverly.steele@verizon.com (516) 797-3872

☐ I understand that my eligibility for reimbursement terminates upon my termination of employment with Verizon.

☐ I certify to the best of my knowledge, the information I have provided on this form is correct.

| EMPLOYEE SIGNATURE | Date |
| --- | --- |
| ______________________________ | ____________ |

While the Regional Work & Family Committee intends to continue the Dependent Care Reimbursment Fund, the NY/NE Regional Work & Family Committee reserves the right to terminate or amend the plan at any time funds are anticipated to be depleted.

# CWA VERIZON IBEW 2213
# Dependent Care Reimbursement Fund- Enrollment Application

☐ Re- enrollment ☐ New-enrollment

## Employee Information

| EMPLOYEE LAST NAME | FIRST NAME | EMPLOYEE ID # : | NCS DATE : |
|---|---|---|---|
| | | VZ ID # : | Job Title |

☐ CWA LOCAL ________ Local # ☐ IBEW 2213 ☐ MANAGEMENT

| HOME ADDRESS : | APT. # : | CITY | STATE | ZIP |
|---|---|---|---|---|

HOME TELEPHONE : ( ) area code — PERSONAL CELL NUMBER : ( ) area code —

STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ LEGALLY SEPARATED

PREFERRED E-MAIL ADDRESS ( this will be the e-mail address we will use to communicate with you)

## Work Information

| WORK ADDRESS | CITY | STATE | ZIP | WORK REACH # : |
|---|---|---|---|---|

## Dependent Information

| DEPENDENT FULL NAME | DEPENDENTS DATE OF BIRTH / / | CURRENT AGE |
|---|---|---|

IS YOUR DEPENDENT SHOWN ON YOUR 2008 IRS 1040 FORM? ☐ YES ☐ NO

If you checked "No" attach explanation of legal custodial arrangements. If you checked no you must submit one or both of the following: Birth certificate, legal custodial arrangements. In order to be eligible to participate in the fund, your dependent must reside with you and must be claimed on your income tax.

## Provider Information

* THIS FORM MUST BE COMPLETED FOR EACH CARE PROVIDER WHEN MULTIPLE PROVIDERS ARE PAID

PROVIDER'S FULL NAME or NAME OF CHILD CARE BUSINESS (PLEASE PRINT) PROVIDER'S TELEPHONE NUMBER (INCLUDING AREA CODE) ( ) -

| PROVIDER BUSINESS ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|

AMOUNT PAID TO PROVIDER $ ________ per ☐ day ☐ week ☐ month ☐ other ________ explain

AUTHORIZED PROVIDERS SIGNATURE : ________ DATE : ________

IS CARE PROVIDED MONDAY –FRIDAY ☐ YES ☐ NO

If care is provided less than 5 days per week check all days care is provided.

| MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| Provider's License Number | Provider's registration number | Provider's Tax ID | Provider's Social Security No: |
|---|---|---|---|

check all that apply

**FOR CHILDCARE**

- ☐ A relative ( non spouse)
- ☐ Family care provider outside home
- ☐ Care provided at employees home
- ☐ Childcare center
- ☐ Before school
- ☐ After school

check all that apply

**FOR ADULT CARE**

- ☐ Adult care program
- ☐ In home services
- ☐ In home medical services
- ☐ Other ________

*See reverse for certification to complete this form*

# CHECKLIST FOR FUND ENROLLMENT

- ☐ Complete this enrollment application and Certification form.
- ☐ You must Attach a COPY of "Page One" ONLY of your most recent IRS 1040 FORM and W-2 FORM (married employees who file separately from their spouse must also attach a copy of their spouse's most recent IRS 1040 & W-2).
- ☐ If you or your spouse is self-employed and filed income tax for your business, you must attach a copy of the IRS Schedule C.
- ☐ If your dependent is not shown on your most recent IRS 1040 form you must attach an explanation of legal custodial arrangements and or a copy of child's birth certificate.
- ☐ If you filed a joint return but are no longer married attach legal documentation.

Forward via US Mail only, the completed application, certification form, required tax information and copies of any applicable custody/support documents to: NY/NE Regional Work and Family, Beverly Steele, Fund Administrator, 120 Hicksville Road, Room 200-A, Massapequa N.Y. 11758 beverly.steele@verizon.com (516) 797-3872

In order to receive monthly reimbursement you must first complete an enrollment application and be approved. You will be notified via e-mail regarding your acceptance into the fund. Be sure to provide a valid e-mail address. If no e-mail address is available we will forward your correspondence to the home address you have provided on your application.

# Verizon Local Work & Family Committee Members

NY/NE Regional Work and Family, Beverly Steele, *Fund Administrator*
120 Hicksville Road, Room 200-A
Massapequa N.Y. 11758

Phone: 516-797 3872
Email: Beverly.steele@verizon.com

| | | |
|---|---|---|
| Gladys Finnigan, Chairperson<br>*CWA Staff Rep/ Chair Person*<br>80 Pine Street, floor. 37<br>New York, New York 10005<br>212 344 7332<br><br>Email-gfinnigan@cwa-union.org | IBEW2213<br>Christine Gironda<br>Assistant Business Manager<br>One Telergy Parkway<br>6333 Route 298-Suite 1-C<br>East Syracuse, New York 13057<br><br>Phone:315 438 3322<br>Fax: 315 432 8255<br>christine@ibew2213.org | CWA Local 1103<br>Fran Gottron<br>345 Westchester Avenue<br>Port Chester, NY 105073<br>Phone: 914-939-8203<br>Fax: 914-939-5854<br><br>Email:fgottron@cwa1103.org |
| CWA Local 1104<br>Kim Young, E.V.P.<br>107 Murray ST.<br>Binghamton, NY 13905<br>Phone: 607-762-1104<br>Fax: 607- 773-5473<br><br>E-Mail kyoung@cwa1104.com | CWA Local 1104<br>Stella Pereyra,<br>One Florgate Road<br>Farmingdale, NY 11735<br>Phone: 516-420-1104<br>Fax: 516 420-8390<br><br>E-Mail: spereyra@cwa1104.com | CWA Local 1106<br>Anne Holland McCauley<br>Secretary.-Treasurer<br>221-10 Jamaica Avenue<br>Queens Village, NY 11428<br>Phone: 718 479-1106<br>Fax: 718-479-1128<br><br>Email: moneyholland @aol.com |
| CWA Local 1105<br>Beatrice Zapata, Secretary<br>3223 E. Tremont Ave<br>Bronx, NY 10461<br>Phone: 718 430 1500<br>Fax: 718 828 3204<br><br>Email:Beatrice@cwa1105.org | CWA Local 1108<br>Beth Boland, V. P<br>39 Baker Street<br>Patchogue, NY 11772<br>Phone: 631-654-1108<br>Fax: 631-654-1057<br><br>Email:Beth@cwa1108.org | CWA 1109<br>Nina Coban, E-Board Member<br>1845 Utica Ave<br>Brooklyn, NY 11234<br>Phone: 718-444-1109<br>Fax: 718-531-1141<br><br>Email:Ncoban@cwa1109.org |
| CWA Local 1118<br>Theresa Devine, B.A.<br>4 Wembley Court<br>Albany, New York 12205<br>Phone: 518-862-0095<br>Fax: 518-862-0651<br>Cell: 518-782-9977<br><br>Email: devine1@nycap.rr.com | CWA 1302<br>Peg Hathaway, V. P.<br>6 Sagamore Street<br>Revere, Mass 02151<br>Phone: 617 342-9926<br>Cell: 781-258-9025<br><br>Email:pegh1205@yahoo.com | CWA Local 1400<br>Karen Cusson<br>155 West Road<br>Portsmouth, NH 03801<br>Phone: 603-436-4388<br>Fax: 603-436-2962<br><br>E-mail kcusson1400@yahoo.com |

# What is the Dependent Care Reimbursement Fund?

The Dependent Care Reimbursement Fund was established in 1994 as part of the collective bargaining agreement and was created to help employees pay a portion of their child or elder care expenses.

Licensed care and legal custodial arrangements are major determinants for fund participation. The information provided on your enrollment application form will be verified by the NY/NE Regional Work and Family Staff.

The reimbursement is not taxed as long as the amount you receive plus any amount you have set-aside in the Dependent Care Spending Account (DCSA), combined with any similar accounts of your spouse, does not exceed $5,000 ($2,500 if you and your spouse file separate tax forms in the calendar year). Contact the Verizon Benefit Center at 1-877-489-2367 for more information on the Dependent Care Spending Account (DCSA).

## Who is Eligible?

- **You must be a NY/NE CWA, IBEW 2213, NY/NE Service Company employee or Verizon NY/NE management employee in order to be eligible to apply to this fund.** The Fund is part of the collective bargaining agreement between the NY/NE CWA, IBEW 2213 and Verizon. The NY/NE Regional Work and Family Committee oversee the Fund and the Committee membership is comprised of NY/NE CWA, IBEW 2213 and Verizon New York management representatives.
- The Fund rules and eligibility requirements are determined by the NY/NE Regional Work and Family Committee and are in compliance with the Internal Revenue Service.
- Employee application and reimbursement approvals are based on the guidelines established by the NY/NE Regional Work and Family Committee and the Internal Revenue Service.
- The maximum weekly reimbursement amount is $50.00 per week for one dependent per family.
- *You may request reimbursement for each day your child is at care. You do not have to deduct your expenses for each day during a short, temporary absence from work, such as for vacation or a minor illness, if you are required to pay for care anyway. An absence of 2 weeks or less is a short, temporary absence for the purposes of this fund.*
- School tuition to attend kindergarten or a higher grade is not reimbursable.

## Employee Eligibility:

- Employee must have at least 6 months net credited service.
- You must be in need of dependent care in order to work. Under Federal Law, you and your spouse must be working during the hours your dependents are in care in order to make this a tax-free benefit. The only exceptions are when your spouse is a full-time student, or is actively seeking work (i.e., unemployment), or is physically or mentally incapable of self-care.
- Fund reimbursement cannot be used to pay for child support.
- You pay a legally operating provider for the care of a dependent.
- If your dependent is not shown or your IRS 1040 from, due to birth, custodial care, foster care or adoption you must attach a copy of the child's birth certificate or appropriate legal documentation. (i.e., divorce decree)

## Tax Implications

Each employee is responsible for insuring they are in compliance with IRS guidelines. Employees should consult their tax advisor or the IRS (www.irs.gov) about their particular circumstances prior to applying to participate in the DCRF.

- Each household is limited to $5,000 of tax-free reimbursement per tax year (the limit is $2,500 if you and your spouse file separate tax returns).
- The $5,000 tax-free limit includes the monies from the Fund, and any amount an employee sets aside through the Verizon Dependent Care Spending Account or amounts a spouse sets-aside in any another dependent care account.
- Any reimbursement over the $5,000 limit will be taxed as income. Any reimbursement in excess of the IRS allowed tax-free level is subject to additional taxation. Since tax situations vary by employee, neither Verizon or the NY/NE Regional Work & Family Committee are not responsible for notifying employees or calculating for employees when the reimbursement exceeds the tax-free benefit allowed by the IRS, becoming taxable income.

## Dependent Eligibility

The Fund is a tax-free benefit and eligible dependents are defined by the Internal Revenue Service (IRS) rules and regulations. *See publication 503, Child and Dependent Care Expenses,* www.irs.gov

Your reimbursed dependent care expenses must be for one of the following:

- Your child under 13 years of age that is listed on your IRS 1040 Form as a dependent.
- Your spouse who is physically or mentally unable to care for himself or herself.
- Your dependent that is physically or mentally unable to care for himself or herself.

## Provider Qualifications

- Providers must be licensed or legally operating. If you don't know whether your care provider is legally operating you can call Anthem Employee Assistance Program 888 441-8674 or access website www.anthem.com/eap/verizon
- The Provider cannot be a dependent listed on your IRS 1040 Form.
- The Provider cannot be your child under the age of 18 years or be your dependent child under 19 years of age.
- Please be sure to notify your provider that Verizon will be calling. Your provider should be prepared to verify the amount he/she charges for providing care, hours/days the child is in her/his care and her/his license number, registration number, and/or social security number.
- You must report your provider's name, address, and social security or tax identification number on the Enrollment Application, (pg1) and Employee Monthly Reimbursement Form and IRS income tax forms.
- For the purpose of this fund your "provider" must file income tax each year at tax reporting time. Your provider must report all payments he/she receives as a result of this fund.
- You are not eligible to receive reimbursement for any time spent while you are attending college or taking any classes out of your normal working schedule.

## Reimbursement

Once approved for Fund participation you must submit a monthly request for reimbursement. You may do so by completing a "DCRF Reimbursement Form". A new request form must be forwarded monthly and your provider must sign the monthly form each month. However, if original receipts are provided you may attach your receipts to a completed monthly reimbursement forms mail it to the fund administrator. Reimbursement generally will appear in your paycheck on the last Thursday of each month for the previous month's expenses.

- In order to be reimbursed a new monthly reimbursement form must be submitted each month.
- The DCRF Monthly Reimbursement Form must be mailed and post marked no later than the Second Friday of each month for the previous month's services.
- Any request for reimbursement received after the post mark dead line date will be considered late and will not be paid.
- Employees are responsible for the submission of complete and valid information on all enrollment and monthly forms. Omission of any requested data can lead to non payment.
- Monthly forms should not be faxed unless specifically requested by the Fund Administrator. Xerox copies of application or monthly forms are not accepted unless specifically requested by the Fund Administrator.

## Appeal Process (Enrollment / Monthly Reimbursement)

- Appeals must be submitted in writing to the NY/NE Regional Work and Family Committee with details of your situation. Enclose all necessary documentation. Your appeal must be received by the committee within 45 days of your written notification of denial of enrollment or within 45 days of non payment of your dependent care expense.
- Submit all appeal to Beverly Steele c/o NY/NE Regional Work and Family Committee, c/o Beverly Steele, 120 Hicksville Road, Room 200-A, Massapequa N.Y. 11758

# Frequently Asked Questions and Answers

Q: What if I don't have copies of my tax returns and W-2's?
A: Applications will not be considered without supporting tax information. A transcript is not acceptable. Copies of your tax return can be requested from the IRS. Copies of your W-2's can be requested from your employer's payroll department.

Q: What does it mean that I pay for dependent care in order to work?
A: Under federal law, you and your spouse (if applicable) need to be working during the hours your dependents are in care in order to make this benefit tax-free. The exception is when your spouse is a full-time student, is actively seeking work, or is physically or mentally incapable of self-care. In this case special rules apply and you may want to seek further guidance about your particular situation.

Q: I am enrolled and eligible but no longer wish to participate, what should I do?
A: Send written notice of withdrawal to: NY/NE Regional Work and Family, Beverly Steele, 120 Hicksville Road, Room 200-A, Massapequa N.Y. 11758

Q: My spouse is also a Verizon employee. If we meet the income eligibility requirements can we both participate in the Fund?
A: No, if both spouses work for Verizon, the family can only be reimbursed once for care. Remember, this also holds true for shared custody and separation. Be sure to send legal documentation to the NY/NE Regional Work and Family Staff.

Q: What is the difference between the Dependent Care Spending Account (DCSA) and the Dependent Care Reimbursement Fund (DCRF)?
A: Under the Dependent Care Spending Account you may reduce your take home pay by setting aside a portion of your income to pay for dependent care expenses. You do not pay taxes on the amount you set-aside from your take home pay. Any amount you set-aside but do not use for dependent care by the end of the year will not be refunded to you. The total amount that the IRS allows you to set aside and be tax-free is $5,000 ($2,500 if you and your spouse file separate tax forms in a calendar). Contact the Verizon Benefit Center at 1-877-275-8947 for more information. The NY/NE Regional Work and Family Committee or Staff does not handle the DCSA.

Q: Can I participate in both the Reimbursement Fund and the Spending Account?
A: Yes. Eligible employees can be reimbursed through the Fund AND set-aside a portion of their income in the Spending Account and not pay any taxes, up to a combined total of $5,000. For example, if you anticipate collecting $2400 for the next year from the Fund, then you and your spouse would not want to put more than $2600 in the Dependent Care Spending Account (or similar fund for your spouse) for that year, if you want to avoid having to pay taxes on amounts over $5,000. Any amount over the $5,000 maximum per family per year is subject to taxes. Remember any reimbursement in excess of the IRS allowed tax-free level is subject to additional taxation depending on how you file your taxes. Since tax situations vary by employee, Verizon is not responsible for notifying employees or calculating for employees when the reimbursement exceeds the tax-free benefit allowed by the IRS and becomes taxable income.

Q: When does reimbursement for the care of my 13-year-old end?
A: Reimbursement ends on the last day of the month prior to the month in which she/he turns 13 years old.

Q: If my spouse is disabled or does not work, can I participate in the Fund?
A: Yes, as long as your spouse is physically or mentally incapable of self-care, qualifies as your dependent for federal income tax purposes, and lives in your home. If your spouse is a full-time student, or is actively seeking work (i.e., unemployment) you may participate in the Fund. If your spouse is not working for other reasons, you are not eligible to participate in the Fund. Special rules may apply in these situations and you should speak to your tax advisor regarding your circumstances.

Q: I claim my grandfather as a dependent on my federal income tax return. He lives alone, and requires someone to come into his home to provide care. Can I be reimbursed for part of this expense?
A: No, the law provides that your dependent must live in your home in order to be eligible for reimbursement of your care expenses.

Q: My father is in a nursing home, and I help pay for this care. Can I be reimbursed for part of this expense?
A: No, the law provides that out-of-home care cannot be reimbursed unless your dependent lives in your home.

# Frequently Asked Questions and Answers
## *continued*

Q: My mother currently cares for my children in my home while I work. Can I continue this arrangement and participate in the Fund?
A: Yes, as long as:
1. You pay for the care.
2. You do not claim your mother as a dependent on your tax return, and
3. Your mother is licensed as or legally operating as a child care provider "When should my provider be registered or licensed?" (page 5 – VZ-*LIFE* references)
4. If not licensed but meet requirements, the provider must report these monies to the IRS as income.

Q: The enrollment form asks for personal information. Who will see this information?
A: The information you provide in your enrollment materials will be kept confidential. The only people who will see the completed forms will be those directly involved in the administration of the Fund.

Q: If I have dependent care expenses, how do I start receiving money from the subsidy program?
A: A completed enrollment application must be submitted and your participation approved before you may begin to submit monthly claims for reimbursement.

Q: Do I have to re-enroll into the Program each year?
A: Not necessarily, fund participants are notified in advance if and when re-enrollment is necessary.

Q: Do I need to submit a receipt in order to receive reimbursement for dependent care expenses if I use a provider which meets legal requirements but is not licensed?
A: Only forms <u>completed in ink</u> bearing original signatures will be accepted. Retain copies of your submitted claims for your records.

Q: What if my provider will not give me her social security number or tax identification number?
A: You cannot participate in the Fund unless you provide the dependent care provider's name, address, and social security or tax identification number on the Enrollment Application and Employee Request for Reimbursement Monthly form. If you wish to change providers, Verizon VZ-*LIFE* program will assist you in finding alternative care arrangements. You can reach VZ-*LIFE* by calling 1-800-845-0632.

Q: How often do I need to complete and submit a Request for Reimbursement Form?
A: The Monthly Reimbursement Form must be postmarked no later than the second Friday of each new month for the prior months expense. Blank claim forms can be reproduced locally. You should keep copies of your dependent care claim receipts for your records.

Q: What if my child has 2 or more providers in the same claim period?
A: If a dependent has 2 or more providers in the same claim period, a separate Monthly Reimbursement Form must be completed for each provider and submitted to the Work and Family Staff.

Q: If I'm not at work because of vacation, scheduled days off, half days off or other absences, can I still get reimbursed?
A: You do not have to figure your deductions for each day during a short, temporary absence from work, such as vacations or a minor illness, if you have to pay for care anyway. Instead, you can figure your credit including the expenses you paid for the period of absence. An absence of two weeks or less is considered a short, temporary absence for the purposes of this fund only.

Q: How do I know how much I've been reimbursed?
A: For each paycheck that you receive Fund reimbursement, the prior month's amount of reimbursement plus the year to date total will be shown.

Q: Can I claim the child and dependent care tax credit on my personal income tax return if I participate in the Fund?
A: Expenses that are eligible to be used to calculate your tax credit must be reduced by amounts received from the fund and by non-taxable dependent care benefits you and your spouse receive from other sources. Consult your tax advisor for clarification.

# Verizon CWA IBEW 2213
# REQUEST FOR DCRF MONTHLY REIMBURSEMENT

For the Month of ______________

| Employee Name: ______________ (Last Name) ______________ (First Name) | | Emoloyee ID #: | |
|---|---|---|---|
| Home Address: | City : | State : | Zip : |
| Home Telephone # : | Personal Cell # : | | |
| Work Address: | City : | State : | Zip : |
| Work Telephone # : | Work e-mail Address : | | |

**Check one of the below boxes to indicate your affiliation with Verizon**

| ☐ CWA LOCAL # : ______ | ☐ IBEW 2213 | ☐ MANAGEMENT | ☐ OTHER ______ |
|---|---|---|---|
| Dependent Name : | | Dependent Date of Birth* : | Age* : |

## EMPLOYEE SECTION

*** You may request reimbursement for each day your child is at care. You do not have to figure your expenses for each day during a short, temporary absence from work, such as for vacation or a minor illness, if you have to pay for care anyway. An absence of 2 weeks or less is a short, temporary absence for the purpose of this form.**

| Employee must indicate Week Ending Friday Periods below | Employee must Indicate Dates Care was Provided | Employee must Indicate Dates Employee had off from work (see above)* | Employee must Indicate Amount Paid less days off |
|---|---|---|---|
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| **Enter total Monthly Paid Expense here >** | | | $ |

Check below indicating type of Dependent Care

- ☐ Day Care/Nursery/Pre-K
- ☐ Before & After School Care
- ☐ Pre-School
- ☐ Adult/Disability Care
- ☐ Elder Care
- ☐ Summer Care
- ☐ Day Camp
- ☐ Other (explain) ______________

I certify the accuracy of the above number of days off during my work week dates of provider service and that the above payments were made by me to the dependent care provider.

**Employee Signature:** **Date:**

## CARE PROVIDER COMPLETE AND PLEASE SIGN BELOW

| Print Provider Name: | Provider's Phone # : | | |
|---|---|---|---|
| Provider's Address : | City : | State : | Zip : |
| Tax ID # : | Registration # : | | |

I certify that the above amounts of monies were received for services rendered, and I am responsible for reporting these monies to the IRS AS INCOME.

**Care Provider's Signature :** ______________ **Date :** ______________

*See reverse for instructions for completion of this form*

# How to Complete the DCRF Reimbursement Form

Employees upon confirmation of enrollment must complete a request for reimbusement form each month. **Each request for reimbursement must contain an original signature by the care provider and employee.** A request for reimbursement form must be used for each care provider when multiple care providers are used.

Attach original receipts or copy of cancelled check or money order when submitting this form.

Employees must notify the Fund Administrator if an enrolled dependent's status has changed as well as all changes regarding the care provider.

Employee requests for reimbursement must be submitted by mail to the fund administrator and postmarked no later than the second Friday of each month. Deadline dates for plan year 2016 are noted below.

| | January | February | March | April | May | June |
|---|---|---|---|---|---|---|
| Deadline Date | N/A | N/A | N/A | N/A | N/A | 8/12/16 |
| | July | August | September | October | November | December |
| Deadline Date | 8/12/16 | 9/9/16 | 10/14/16 | 11/11/16 | 12/9/16 | 1/13/17 |

**Fund Administrator:**
Beverly Steele
Telephone Number 516-797-3872

**Return this form via U.S. Mail to:**
NY/NE Regional Work & Family Committee
c/o Beverly Steele, Fund Administrator
Room 200-A
120 Hisksville Rd.
Massapequa, N.Y. 11758

## Appeals Process

**(Enrollment or Monthly Reimbursement)**

Appeals must be received within 45 days of your written notification of denial of enrollment or within 45 days of a denial of reimbursement for expenses.

**Appeals must be in writing and submitted to:**
NY/NE Regional Work & Family Committee
c/o Beverly Steele, Fund Administrator
Room 200-A
120 Hicksville Rd.
Massapequa, N.Y. 11758

You must enclose all necessary documentation when filing an appeal.

Include a valid reach number and current e-mail address for a response.

# How to complete this form

Employees must complete this form in its entirety. One form per provider. Only original signatures & reimbursement forms will be accepted. Photocopies or faxed copies will not be accepted unless requested by Fund Administrator.

Employee and Care Provider must sign and complete the Care Provider Section of this form. Attach original receipts or copy of cancelled check or money order when available.

Employee requests for reimbursement must be POSTMARKED no later than the SECOND FRIDAY OF EACH MONTH.

Return this Monthly Reimbursement Form via Regular U.S. MAIL to:

**VERIZON NY/NE Regional Work and Family Committee**
**c/o Beverly Steele, Fund Administrator**
**120 Hicksville Road, Room 200-A, Massapequa N.Y. 11758**
**beverly.steele@verizon.com (516) 797-3872**

*Reimbursement for dependent children ceases on the last day of the month prior to the month in which the child turns 13 years old.

# Appeal Process

(Enrollment / Monthly Reimbursement)

Appeals must be submitted in writing to the NY/NE Regional Work and Family Committee with details of your situation. Enclose all necessary documentation. Your appeal must be received by the committee within 45 days of your written notification of denial of enrollment or within 45 days of non payment of your dependent care expense.

Submit all appeal to:

**VERIZON NY/NE Regional Work and Family Committee**
**c/o Beverly Steele, Fund Administrator**
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