

## **Dependent Care Assistance Program (DeCAP)** *Your Welcome Kit Includes*

- ~ Important Website Information
- ~ Claims and Reimbursement Procedures
- ~ How to Read Your DeCAP Statement
- ~ DeCAP Claims Form

Procedures Guide

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**Plan Year 2018**

***Please visit the  
Flexible Spending Accounts (FSA) Program  
Website at [nyc.gov/fsa](http://nyc.gov/fsa)  
for detailed information on:***

- The Dependent Care Assistance Program (DeCAP)
- The Health Care Flexible Spending Account (HCFSA) Program
- The MSC Health Benefits Buy-Out Waiver Program
- The MSC Premium Conversion Program

***You can select Forms & Downloads for:***

- Plan Year 2018 Brochures and Enrollment/Change Forms
- FSA Program Claims Forms
- FSA Direct Deposit Enrollment/Change/Cancellation Form

## *Dependent Care Assistance Program (DeCAP) Claims and Reimbursement Procedures*

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Please follow these procedures for the expedient processing of your claims:

- Submit your Claims Forms once a month, on or before the last day of the month.
- Claims Forms must be signed and dated by your service provider with his/her name, address, and Federal Tax I.D. Number or Social Security Number. Claims will not be processed without this information.
- Indicate the service date(s) and dollar amount(s) of your claim(s).
- Claims for each dependent must be filed separately.
- If you have more than one claim in a given month, you must indicate the total reimbursement amount of all claims.
- Claims Forms must be signed and dated by the participant.

Reimbursement for approved claims received by the last day of each month will be directly deposited into the account you indicated on your Enrollment/Change Form or Direct Deposit Form by the close of the following month.

If no account information is indicated in Section D on the Enrollment/Change Form, a reimbursement check will be sent to your address on file.

If there is no deposit credit recorded on your monthly claims payment statement, please check the next monthly claims payment statement for the deposit credit.

If you have any further questions regarding your DeCAP claims, please call the DeCAP Administrative Office at (212) 306-7760.

**Note:** This instruction sheet was formulated to assist you in the submission of your claims. Please refer to this sheet throughout the Plan Year.

## Dependent Care Assistance Program (DeCAP)

### How to Read Your DeCAP Statement

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A DeCAP claims payment statement will be sent to you every month indicating your opening balance, payroll deduction deposits, a deduction for the up to \$4.00 monthly administrative fee,\* and your closing balance.

Your itemized claims are divided into three categories: (1) “Claims to be Paid this Month” (i.e., the month that the statement is issued); (2) “Claims Pending;” and (3) “Insufficient Fund Claims.” A claim may not be paid if the claim amount exceeds your available balance. Your available balance is equal to the amount you have contributed to the program, less the monthly administrative fee\* and the total amount of claims paid from your account.

The last section of the statement includes the “Total Claims Reimbursed,” “Closing Account Balance,” and “Year-to-Date Payments.”

The following is an explanation of terms used:

Opening Balance:	funds in your account on the first day of the month
Administrative Fee*:	up to \$4.00 monthly, up to \$48.00 annually
Deposits:	your monthly contribution to the program. (Note: Activity during the last pay period of each month may not appear until your next statement)
Claims to be Paid this Month:	funds available for reimbursement in a given month
Claims Pending:	claims already submitted that have yet to be paid
Insufficient Fund Claims:	the dollar amount of claims submitted which exceeds your available account balance
Total Claims Reimbursed:	claims submitted that will be paid
Closing Account Balance:	the amount equal to your opening balance plus deposits, minus claims paid and up to \$4.00 for the monthly administrative fee
Year-to-Date Payments:	total amount of claims paid

\* The annual administrative fee may be adjusted by the FSA Program Administrator, but will not be greater than \$48 per program.

**Note:** This instruction sheet was formulated to assist you in the reading of your statements. Please refer to this sheet throughout the Plan Year.

## Dependent Care Assistance Program (DeCAP)

### 2) EMPLOYEE (PARTICIPANT) INFORMATION (PLEASE TYPE OR PRINT CLEARLY)

LAST NAME		FIRST NAME	MI.	SOCIAL SECURITY NUMBER	
HOME ADDRESS - NUMBER AND STREET <input type="checkbox"/> CHECK HERE IF THIS IS A NEW ADDRESS					APT. NO.
CITY				STATE	ZIP CODE
HOME OR CELL (DAYTIME) PHONE NUMBER (     )     -     (     )     -     (     )     (     )	WORK PHONE NUMBER (     )     -     (     )     (     )	AGENCY NAME (NOT DIVISION)			

### 3) DeCAP REIMBURSEMENT REQUESTS

**Please read "Instructions and Important Information" on the reverse side before completing this form and refer to your enrollment information for DeCAP rules and regulations. If the service was provided for more than one day, show the beginning date and the ending date.**

<b>1</b> DEPENDENT LAST NAME		DEPENDENT FIRST NAME	MI.
ALL DATE(S) OF SERVICE MUST BE PRIOR TO THE DATE THIS FORM WAS SIGNED BY THE PARTICIPANT.			
DATE(S) OF SERVICE (MM/DD/YY) FROM ____/____/____ TO ____/____/____		TYPE OF SERVICE	REIMBURSEMENT AMOUNT REQUESTED \$ _____
PROVIDER'S NAME		PROVIDER'S FEDERAL TAX I.D. OR SS NUMBER	
PROVIDER'S ADDRESS - NUMBER AND STREET			APT. NO.
CITY			STATE    ZIP CODE
I HAVE PROVIDED CARE FOR THE DEPENDENT LISTED ABOVE AND HAVE RECEIVED PAYMENT IN THE AMOUNT LISTED ABOVE.			DATE ____/____/____
PROVIDER'S SIGNATURE _____			

<b>2</b> DEPENDENT LAST NAME		DEPENDENT FIRST NAME	MI.
ALL DATE(S) OF SERVICE MUST BE PRIOR TO THE DATE THIS FORM WAS SIGNED BY THE PARTICIPANT.			
DATE(S) OF SERVICE (MM/DD/YY) FROM ____/____/____ TO ____/____/____		TYPE OF SERVICE	REIMBURSEMENT AMOUNT REQUESTED \$ _____
PROVIDER'S NAME		PROVIDER'S FEDERAL TAX I.D. OR SS NUMBER	
PROVIDER'S ADDRESS - NUMBER AND STREET			APT. NO.
CITY			STATE    ZIP CODE
I HAVE PROVIDED CARE FOR THE DEPENDENT LISTED ABOVE AND HAVE RECEIVED PAYMENT IN THE AMOUNT LISTED ABOVE.			DATE ____/____/____
PROVIDER'S SIGNATURE _____			

<b>3</b> DEPENDENT LAST NAME		DEPENDENT FIRST NAME	MI.
ALL DATE(S) OF SERVICE MUST BE PRIOR TO THE DATE THIS FORM WAS SIGNED BY THE PARTICIPANT.			
DATE(S) OF SERVICE (MM/DD/YY) FROM ____/____/____ TO ____/____/____		TYPE OF SERVICE	REIMBURSEMENT AMOUNT REQUESTED \$ _____
PROVIDER'S NAME		PROVIDER'S FEDERAL TAX I.D. OR SS NUMBER	
PROVIDER'S ADDRESS - NUMBER AND STREET			APT. NO.
CITY			STATE    ZIP CODE
I HAVE PROVIDED CARE FOR THE DEPENDENT LISTED ABOVE AND HAVE RECEIVED PAYMENT IN THE AMOUNT LISTED ABOVE.			DATE ____/____/____
PROVIDER'S SIGNATURE _____			

**TOTAL REIMBURSEMENT AMOUNT REQUESTED (1+2+3) \$ \_\_\_\_\_**

### 4) EMPLOYEE (PARTICIPANT) SIGNATURE

The above is a true and accurate statement of unreimbursed dependent care expenses incurred by me for my eligible dependent(s) on the date(s) indicated. I understand that expenses reimbursed herein cannot be claimed on my or anyone else's Federal Income Tax return. All claims submitted by me comply with the rules and definitions as set forth on the reverse side of this form. I understand that the Internal Revenue Code and DeCAP Plan Document are the final authority in determining eligible expenses.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_



## DEPENDENT CARE ASSISTANCE PROGRAM (DeCAP) CLAIMS FORM

Bowling Green Station, P.O. Box 707, New York, NY 10274  
Tel: (212) 306-7760 nyc.gov/fsa



### 1) INSTRUCTIONS AND IMPORTANT INFORMATION

1. A "Plan Year" is the calendar year, or for a newly eligible employee, any remaining portion thereof.
2. Reimbursements can only be made for expenses resulting from services provided in the applicable Plan Year. However, if services provided begin in one Plan Year and end in the next Plan Year, a claims form for each Plan Year is required. No reimbursement can be made prior to services being performed. Please note that claims cannot be submitted for any future dates, even if the payment is pre-paid or on-going throughout the year. A claim for each claim period must be submitted after the dependent care services have been incurred, completed and paid.
3. You may submit claims once a month, however, only claims received by the close of the month will be processed for that month. Once your claims are approved, you will receive reimbursement at the end of the following month.
4. The deadline to submit claims is the last day of the Plan Year (December 31<sup>st</sup>). You should submit your claims in a timely fashion. However, there is a Claims Run-Out Period until February 28<sup>th</sup> following the close of the Plan Year to submit claims for services provided during the previous Plan Year. Claims received after February 28<sup>th</sup> will not be processed.
5. **Any unclaimed year-end balance in your account will not be carried to the next Plan Year and will be forfeited.**
6. Dependent care reimbursement requests must be signed by your service provider with his/her name, address, and Federal Tax ID Number or Social Security Number. Requests will not be processed without this information.
7. **Definitions:**
  - a) **Eligible Employment-Related Dependent Care Expenses:** Services which are provided to enable you and your spouse, if married, to remain employed or attend school full-time and which are related to the care of one or more dependent care recipients (including household services related to such care). Services may be provided within or outside your home. If your spouse is not employed, dependent care expenses are eligible for reimbursement only if your spouse is incapacitated or a full-time student. Benefits for eligible employment-related dependent care expenses may not be more than your and your spouse's earned income. A spouse who is self-employed must provide a description of occupation on letterhead stationery; or without letterhead stationery, notarization is required.
  - b) **Dependent Care Recipient:** Any dependent claimed on your tax return who lives with you for more than half of the year in the Plan Year and is either: (i) a child (son, daughter, stepson, or stepdaughter) under age thirteen (13); (ii) a dependent (such as your handicapped child of any age) or spouse who is physically or mentally incapable of caring for himself/herself; or (iii) any other dependent whose gross income for the Plan Year is less than the IRS maximum annual salary.
  - c) **Qualifying Caregiver:** A person performing eligible employment-related dependent care services who is (i) not your dependent; (ii) not your spouse; or (iii) not your child or your spouse's child unless he/she has attained the age of nineteen (19) at the close of the Plan Year in which the services were provided.
  - d) **Qualifying Day Care Center:** Care at licensed nursery schools, pre-schools, day camps (not overnight camps), and child or adult care centers which provide day care. The day care center must: (i) comply with all applicable laws and regulations of the state, city, town, or village in which it is located; (ii) provide care for more than six (6) individuals (other than individuals who reside at the day care center); and (iii) receive a fee, payment, or grant from any individual to whom it provides services (regardless of whether facility is operated for a profit).
8. Be sure to sign and date this form. Return your completed form to the address shown above. You may obtain additional claims forms on the FSA website at [nyc.gov/fsa](http://nyc.gov/fsa)