SOURCE: Subsidy for Occasional, Unplanned, and Respite Care Expenses

DIRECTIONS for completing and submitting this claim form to the SOURCE program

1. **Check your eligibility.** To use SOURCE, you must:
   - Be eligible for full Harvard University benefits; AND
   - Earn under $75,000 per year, annualized full-time equivalent salary based on 35-hour week.
2. **Pay for your dependent care**. This is a reimbursement program – we only reimburse you what you have paid up to $350 per fiscal year.
3. **Complete the employee section of this form and sign**.
4. **Have your dependent-care provider complete their section**. If you have more than one provider, you may use more than one claim form.
5. **Submit form(s)** to the Office of Work/Life.
   - **By MAIL:**
     Harvard Office of Work/Life
     114 Mt. Auburn Street, 4th floor
     Cambridge, MA 02138
   - **By FAX:** 617-495-4124
   - **By SCAN/PHOTO:** worklife@harvard.edu
6. **Receive reimbursement** via your paycheck. Your reimbursement will reflect required additional federal tax withholdings at approximately 40%.

Claims are processed around the 15th of each month. Final Deadline: July 10, 2020

HARVARD EMPLOYEE – Complete this section

Harvard Employee Name:		**Harvard ID Number:**
Dependent(s) in care of Provider	First Name (s):	☐ Child(ren) ☐ Dependent Adult(s) ☐ Self
Reason for care:	☐ Mildly sick or ill dependent ☐ Rehabilitation care (e.g, post-hospital, transportation to appointment) ☐ Regular Provider unavailable (e.g., vacation, snow day, scheduled closing) ☐ Evening/weekend/off-schedule university event/work/duties	

I affirm that this care enabled me to be at work. I certify that all statements and documentation relating to this claim are accurate and complete. I understand that the submission of inaccurate information may be reviewed under Harvard's Fraud Policy (http://policies.fad.harvard.edu/files/fad_policies/files/fraud_policy_download.pdf) and may lead to a requirement that I repay to Harvard University any funds received and/or may result in disciplinary action up to and including termination.

Signature: _____ Date: _____

CARE PROVIDER – Complete this section

Provider Name:		
Street Address:		**Phone Number:** (___) ___-____
City, State, Zip:		**Center License # or Tax ID #** _____ **OR** **in-home sitter: I have a SSN Yes No**
Dates and times of care:	**Start date:** _____ **End date:** _____	**Start time:** _____ **End time:** _____
Total Cost:		

I affirm that I provided care to the dependent(s) listed for the dates shown and was paid the above amount for this care.

Signature: _____ Date: _____