



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

DIRECTIONS for completing and submitting this claim form to the SOURCE program:	
<p>1. Check your eligibility. To use SOURCE, you must:</p> <ul style="list-style-type: none"> • Be eligible for full Harvard University benefits; AND • Earn under \$75,000 per year, annualized full-time equivalent salary based on 35-hour week. <p>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.</p> <p>3. Complete the employee section of this form and sign.</p> <p>4. Have your dependent-care provider complete their section. If you have more than one provider, you may use more than one claim form.</p>	<p>5. Submit form(s) to the Office of Work/Life.</p> <ul style="list-style-type: none"> • By SCAN/PHOTO: worklife@harvard.edu NOTE: Image file size 1MB or greater • By FAX: 617-495-4124 <p>You will receive a confirmation email once received</p> <p>6. Receive the reimbursement via your paycheck. Your reimbursement will reflect required additional <u>federal tax withholdings at approximately 40%.</u></p>
<p>Claims are processed around the 15th of each month. Final Deadline: July 8, 2022</p>	

HARVARD EMPLOYEE – Complete this section:

Harvard Employee Name: _____ Harvard ID: _____

First names of your DEPENDENTS in care of this provider: _____

Dependent Type: Child(ren) Dependent Adult(s) Self

Reason(s) for Back Up Care: Regular Provider unavailable (e.g., vacation, snow day, scheduled closing)
 Mildly sick or ill dependent
 Evening/weekend/off-schedule university event/work/duties
 Rehabilitation care (e.g, post-hospital, transportation to appointment)

Dates and Times of Back Up Care: _____

Total paid to this provider for period shown above: \$ _____

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](#) 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.
(http://policies.fad.harvard.edu/files/fad_policies/files/fraud_policy_download.pdf)

Employee Signature & Date: _____

CHILD CARE PROVIDER – Complete this section:

Childcare Provider Name: _____

Street Address: _____

Phone Number: _____

Center License # or Tax ID # _____

OR In-home provider: “I affirm that I am legally able to work in the US”: Yes

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

Back Up Care Provider Signature & Date: _____