HARVARD
Human Resources
WORK/LIFE

The SOURCE PROGRAM

SOURCE (Subsidy for Occasional, Unplanned, and Respite Care Expenses) Program is a reimbursement program that helps income-eligible employees get to work when regular child or adult care is unavailable or falls through. This service reimburses you for the cost of back-up care provided by a friend, neighbor, relative, other in-home provider, or licensed child/adult care center.

Harvard University will subsidize 100 percent of the cost of the back-up care you choose, **up to $350 per employee per year**.

These funds will be disbursed to you through your paycheck and taxes will be withheld at the supplemental tax rate.

Eligibility:

You can take advantage of this program if you:

- Are a benefits-eligible Harvard employee (includes administrative and professional staff, members of HUCTW, Service and Trade Unions staff non-bargaining unit support staff, faculty, and postdoctoral fellows) on the regular Harvard payroll and **earn less than $75,000** on an annualized basis.

Deadlines:

- Claim forms submitted by the 15th of any month will typically be added to the paycheck closest to the end of the month. Claim forms submitted after the 15th of the month will be processed the following month.
- The final deadline to submit any claim forms in a fiscal year (July-June) is July 15th – immediately past the fiscal year end. Forms submitted after this date for the prior fiscal year cannot be reimbursed.

Learn more on HARVie:
https://hr.harvard.edu/source-program
Download a claim form here
(over for claim form)

Contact us at 617-495-4100, or worklife@harvard.edu

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 FAX:** 617-495-4124
   - **By SCAN/PHOTO:** worklife@harvard.edu
     NOTE: Image file size 2MB or greater for photos

   You will receive a confirmation email once received
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 9, 2021

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: _____