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, or attach receipts.** 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 SCAN/PHOTO: worklife@harvard.edu NOTE: Image file size 1MB or greater • By FAX: 617-495-4124 You will receive a confirmation email once received 6. **Receive the 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, 2024	

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/ADULT CARE PROVIDER – Complete this section:

Back-Up Care 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: _____