Clear form

Form OR-PS
Care Provider Statement

Oregon Department of Revenue

 • Use UPPERCASE letters. • Use blue or black ink. • Print actual size (100%). • Don't submit photocopies or use staples.

Instructions for care providers. Complete this form if you provided care for the dependent(s) of the taxpayer(s) shown on this form.

Required documentation that must be attached to this completed form:

- A detailed year-end summary for each of the dependents listed in part 2, showing:
  - The amounts the taxpayer or others paid you, indicating who made each payment;
  - The dates you received the payments;
  - The individual amounts you charged for care, other services, other costs, or late fees; and
  - The amounts of any refunds or discounts given.
- The total hours per month and the typical days and times you provided care for the dependent(s).
- A copy of the front and back of your driver license or government-issued ID, if you are an individual operating outside of a facility.

Return the original form and documents to the taxpayer(s) or, if you choose, send the original form and documents to: Oregon Department of Revenue; Attn: Appeals, Discovery, and Processing Unit; PO Box 14999; Salem OR 97309-0090; and give a copy of the completed form to the taxpayer(s).

Part 1: Taxpayer and provider information.

Letter ID

Tax year (YYYY)

Taxpayer first name

Initial

Taxpayer last name

Spouse first name

Initial

Spouse last name

Provider facility name, if applicable

Provider first name

Initial

Provider last name

Federal employer identification number (FEIN)

Provider Social Security number (SSN)

Address where services were provided

City

State

ZIP code

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Part 2: Dependent(s). Complete this section for care you provided to the dependent(s) of the taxpayer during the tax year above. Third party payments are payments made from sources other than the taxpayer, including payments from Department of Human Services or individuals not listed above.

Dependent first name | Initial | Dependent last name

Dependent age | Total amount received for this dependent | Total amount received from a third party | Total amount received from the taxpayer

Dependent first name | Initial | Dependent last name

Dependent age | Total amount received for this dependent | Total amount received from a third party | Total amount received from the taxpayer

Dependent first name | Initial | Dependent last name

Dependent age | Total amount received for this dependent | Total amount received from a third party | Total amount received from the taxpayer

Totals | **Total of all amounts received for these dependents** | **Total of all amounts received from a third party** | **Total of all amounts received from the taxpayer**

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Part 3: Additional Information. Complete this section for care you provided to the taxpayer's dependent(s) during the tax year.

1. How often did the taxpayer pay you? ☐ Monthly ☐ Weekly ☐ Biweekly ☐ Other (explain below)

2. How did the taxpayer pay you? ☐ Cash ☐ Check ☐ Electronically ☐ Money order ☐ Other (explain below)

3. If a third party paid on behalf of the taxpayer, who paid you?

4. Did you provide a receipt to the taxpayer for every payment received? ☐ Yes ☐ No; if no, why not (explain below)?

5. Are you related to the dependent(s)? ☐ Yes; if yes, what is your relationship (explain below)? ☐ No

6. Did you provide care for dependents of other clients? ☐ Yes ☐ No

Part 4: Provider declaration.

Under penalties of false swearing, I declare the information I have provided is, to the best of my knowledge and belief, true, correct, and complete. I understand the above income is considered taxable income. If I filed a return and didn't include this income, my return may be adjusted. I also understand that if I didn't file a return, a Notice of Assessment may be issued for failing to file.

Provider first name | Initial | Provider last name

Facility name

Signature

X

Date (MM/DD/YYYY) / / Provider phone number – –