

**MSEA's Administrative, Supervisory, Professional & Technical, & Operations,
Maintenance & Support Services Bargaining Units**

2015 APPLICATION FOR ELDER CARE REIMBURSEMENT

SECTION A – (To be completed by Departmental Human Resource Officer)

NAME _____ SS# _____ **COMPANY NUMBER**

1. Full-Time Employees

Eligible full-time employees whose adjusted gross family income is less than \$28,000 who worked 12 months during the prior calendar year receive a benefit of up to \$1,300.00. Eligible full-time employees whose adjusted gross family income is more than \$28,000 but less than \$33,000 who worked 12 months during the prior calendar year receive a benefit of up to \$1,000.00. Eligible full-time employees whose adjusted gross family income is more than \$33,000 but less than \$38,000 who worked 12 months during the prior calendar year receive a benefit of up to \$700.00. Full-time employees who worked at least six months but less than 12 months are eligible for a pro-rated benefit. If an employee is in pay status a minimum of 10 days during the month, that month is credited.

2. Part-Time Seasonal Employees

Part-time and seasonal employees who have completed 1,040 hours of regularly scheduled work in the prior calendar year and who are otherwise eligible receive a pro-rated benefit calculated as follows:

- Pro-rate the number of regularly scheduled hours per week to full-time (# hours ÷ 40)
- Multiply this by either \$108.34 (for the \$1,300.00 benefit) or by \$83.34 (for the \$1,000.00 benefit) or by \$58.34 (for the \$700.00 benefit)
- Multiply this number by the credited months

3. Annual Benefit (Fill in **ONE** box below)

Full-Time Employee

Part-Time Employee

Seasonal Employee

I certify that the Form 1040/1040A/1040EZ and the Elder Care Expense Receipt submitted by this employee and a copy of this Form is on file and available in the Departmental Human Resource Office.

Human Resource Officer's Authorized Signature

Date

Send this Form to Accounts and Control

**MSEA's Administrative, Supervisory, Professional & Technical, & Operations,
Maintenance & Support Services Bargaining Units**

2015 APPLICATION FOR ELDER CARE REIMBURSEMENT

Section B – (To be completed by Employee)

COMPANY NUMBER

Name: _____ **Dept.:** _____

Address: _____ **Agency:** _____

SS#: _____ **Work Place Tel. #:** _____

Number of wage earners in family: _____

Number of elders receiving elder care: _____

Total employment-related elder care expenses: _____

Adjusted gross family income: _____

Period employed by State during past calendar year:

From: _____ **To:** _____

Full-Time: _____ **Part-Time:** _____ **Seasonal:** _____

Number of regularly scheduled hours per week: _____

I certify that the above information and the information on the attached Form 1040/1040A/1040EZ and on the attached Elder Care Expense Receipt is accurate.

Employee's Signature

Date