



LOW INCOME CAREGIVER CREDIT

For Home Care of a Low Income Person Age 60 or Older

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|---|---------------------------------|-------------------------------------|
| Your Last Name | Your First Name and Initial | Your Social Security No. — — |
| Spouse's Last Name (if a joint return) | Spouse's First Name and Initial | Spouse's Social Security No. — — |
| Your Present Home Address (include city, state, and ZIP code) | | |

GENERAL INSTRUCTIONS

The person you care for must be certified by the Department of Human Services. To do this, fill in Part I of this form. Send it to: Seniors and People with Disabilities, Department of Human Services, 500 Summer St NE, E02, Salem OR 97301-1073. The form will be returned to you showing whether the person you care for is certified. If the person you care for is already certified, fill in Part II on the back of this form. **NOTE: To qualify for the credit, your household income must be less than \$17,500 and the person you care for must have household income of \$7,500 or less.**

PART I

The questions below are about the person you care for.

1. Name _____ Birth date _____ Social Security No. _____
2. Did the person stay in a nursing home, rehabilitation facility, or other long-term care facility during the year?
 YES NO If yes, list the dates _____
3. Did the person receive home care services from Oregon Project Independence during the year?
 YES NO If yes, list the dates _____
4. Did the person receive any medical assistance from Seniors and People with Disabilities during the year?
 YES NO If yes, list the dates _____
5. Check any of the seven conditions that existed, for the person you care for, during the year:
 - A. Problems with **communication**. These include severely limited vision, hearing, speaking, or ability to identify oneself to others.
 - B. Problems with **mobility**. These include having great difficulty in traveling inside or outside the home even with a cane, walker, or wheelchair.
 - C. Problems with **managing a household or nutrition**. These include having great difficulty in doing housekeeping, shopping, or following a special diet.
 - D. Problems with **maintaining personal independence or relationships**. These include great difficulty in handling changes, personal problems, and emotional situations. It also includes great difficulties with friends and living arrangements.
 - E. Problems with **managing money**. These include being unable to write checks, pay bills, or keep expenses within income.
 - F. Problems with **health**. These include several medical problems requiring regular visits from a doctor or nurse. It also includes being unable to take prescribed medicine.
 - G. Problems with **personal care tasks**. These include bathing, toileting, dressing, and feeding.
6. Based on the condition(s) you checked above, would the person you care for normally be placed in a nursing home?
 YES NO If yes, during which months did the condition(s) exist? _____

I certify that the above questions were answered truthfully to the best of my knowledge. _____
 Taxpayer's Signature

For Official Department Use Only

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|---|--|
| CERTIFIED: <input type="checkbox"/> Total tax year 20 _____ <input type="checkbox"/> Partial tax year 20 _____ | Reason: <input type="checkbox"/> Not Certified Authorized Signature <input checked="" type="checkbox"/> |
| Dates: _____ | |

PART II

HOUSEHOLD INCOME

List your household income and the household income of the person you care for in the space below. Household income is the taxable and nontaxable income of both spouses (living in the same household). See the Elderly Rental Assistance (ERA) Form 90R instructions for more information on household income.

NOTE: The support you provide for the person you care for is considered a gift. The amount you pay over \$500 must be included in their household income. Enter it on line 8.

| TYPE OF INCOME | YOUR HOUSEHOLD INCOME | HOUSEHOLD INCOME OF PERSON YOU CARE FOR |
|--|-----------------------|---|
| 1. Wages, salaries, and other pay for work | 1. _____ | 1. _____ |
| 2. Interest, dividends (total taxable and nontaxable) | 2. _____ | 2. _____ |
| 3. Business net income (loss limited to \$1,000) | 3. _____ | 3. _____ |
| 4. Total gain on property sales (loss limited to \$1,000) | 4. _____ | 4. _____ |
| 5. Social Security, SSI, and Railroad Retirement | 5. _____ | 5. _____ |
| 6. Pensions, annuity (taxable and nontaxable) | 6. _____ | 6. _____ |
| 7. Adult and Family Services (welfare) | 7. _____ | 7. _____ |
| 8. Gifts and grants over \$500 | 8. _____ | 8. _____ |
| 9. Other (specify) _____ | 9. _____ | 9. _____ |
| 10. TOTAL HOUSEHOLD INCOME | 10. _____ | 10. _____ |

If your household income is \$17,500 or more, **or** if the person you care for has household income of more than \$7,500, you are not eligible for the credit.

11. You may claim food, clothing, medical, and transportation expenses you pay or incur for the person you care for. The expenses must be paid or incurred during the period certified by the Seniors and People with Disabilities Division. Amounts you pay for lodging don't qualify. Subtract any reimbursement received from insurance or from the person you care for when you figure the costs you paid.

- A. Food (includes purchase and preparation) \$ _____
- B. Clothing (includes purchase, cleaning, and repairing) \$ _____
- C. Medical care (includes doctor fees, medicine, special equipment, etc.) \$ _____
- D. Transportation (includes transportation for medical and personal needs) \$ _____

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| 12. Total expenses paid (add the amounts on lines A, B, C, and D) | 12. _____ |
| 13. Multiply the amount on line 12 x .08 (8 percent) | 13. _____ |
| 14. Maximum credit..... | 14. \$250 |
| 15. Allowable credit (lesser of line 13 or line 14) | 15. _____ |