OREGON DEPARTMENT OF REVENUE

LOW-INCOME CAREGIVER CREDIT

For Home Care of a Low-income Person Age 60 or Older

Clear Form

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 Home Address Where the Care was Provided (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 Year _____ 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 each 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 with 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. X _____
Taxpayer's Signature

For Official Department Use Only

CERTIFIED: ☐ Total tax year 20 _____
☐ Partial tax year 20 _____
Dates: _____

Reason:
☐ Not Certified
Authorized Signature
X

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.

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

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 of care 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 ..... $ _____

    B. Clothing (includes cost of purchase, cleaning, and repairing) ..... $ _____

    C. Medical care (includes doctor fees, medicine, special equipment, etc.) ..... $ _____

    D. Transportation (includes transportation for medical and personal needs) ..... $ _____

12. Total expenses you paid (add the amounts on lines A, B, C, and D) ..... 12. _____
    Note: The expenses you paid for the person you care for are considered a gift. The amount you paid over $500 must be included in their household income. If the amount on line 12 is more than $500, include the excess on line 8b.

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). Enter result here and on "Other credits" line of your tax return. Identify using code 718 and enter your credit amount ..... 15. _____

DO NOT ATTACH THIS FORM TO YOUR OREGON RETURN. KEEP IT WITH YOUR TAX RECORDS.