Clear Form

For tax year

Oregon Form WFC-DP

Verification of Disabled Parent or Guardian for Oregon Working Family Child Care Credit

Last name of disabled taxpayer	First name of disabled taxpayer	Social Security no. (SSN) of disabled taxpayer
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Important: The law was changed in 2007 to allow an exception if a **spouse or registered domestic partner** is disabled as described in ORS 315.262. This exception is not available for tax year 2006 or earlier. This form is for tax years 2007 or later.

Instructions: Enter the name and Social Security number of the disabled taxpayer above. If the disability is **not permanent**, enter the tax year. If the disability is **permanent** and the physician identifies that the taxpayer will permanently meet the criteria listed below, enter "Permanent" instead of the tax year. Your physician will need to complete Section B and keep a copy of this form signed by you, so that we may verify the information provided.

Section A—To be completed by patient

I give permission for the physician and the physician's employees to verify the existence and severity of my disability and other information on this form with the Oregon Department of Revenue. This authorization for **this tax year** expires four years from the date received by the Oregon Department of Revenue.

Signature of disabled taxpayer	Date
X	

Important:

- If your disability is **not permanent,** you will need to obtain a **new** verification form for **each** tax year you have a qualifying disability for the working family child care credit.
- If your disability is **permanent,** you are not required to fill out a new Form WFC-DP each year that you claim this credit. When your physician has completed this form verifying that you have a permanent qualifying disability, keep the original form and attach a copy of it to your return each year that you claim the working family child care credit. Write "Permanent" in the tax year box at the top of this form.
- **Attach this form to your tax return.** If you file your return electronically, fax this completed form to: 503-945-8786, Attn: Suspense; or mail it to: COR-TROL, Attn: Suspense, PO Box 14999, Salem OR 97309-0990.
- To revoke this authorization to disclose, write "revoked" across this form and send a copy to both the physician and the Oregon Department of Revenue.
- Keep this form with your records for at least four years after you file your tax return. We may ask you for a copy of this form during that time.

Section B—To be completed by physician

I verify that the above person was unable to care for him or herself and had a disability that required assistance with one or more activities of daily living during the tax year indicated at the top of this form. This disability kept the person from doing **all** of the following:

- Providing child care;
- Being gainfully employed; and
- Attending school.

Check the activities of daily living that your patient required assistance with:

☐ Dressing ☐ Feeding ☐ Toileting ☐ Other activity of daily living: _____ .

Did your patient meet the criteria listed above for the entire tax year indicated at the top of this form? ..... ☐ Yes ☐ No

If not, enter the dates during the year that your patient met the above criteria: _____ to _____

Do you expect your patient to continue to meet the criteria listed above for the foreseeable future because the disability is permanent? ..... ☐ Yes ☐ No

Physician's signature	Date
X	

Please print or type:

Physician's last name	Physician's first name

Physician's office address	Physician's office phone
	( )

Note to physician: The Department of Revenue may contact you to verify this information.

—YOU MUST ATTACH THIS FORM TO YOUR OREGON INCOME TAX RETURN—