

PIT-CG

NEW MEXICO CAREGIVER'S STATEMENT

The caregiver must complete this PIT-CG and give it to the taxpayer to attach to the PIT-1 Return and Schedule PIT-RC. Each caregiver who provides daycare services for which a credit amount is claimed completes a separate PIT-CG. Failure to attach the required PIT-CG to the PIT-1 will cause the amount claimed for the child daycare credit to be disallowed. Attach the *Child Day Care Credit Worksheet* to the PIT-CG.

The caregiver must furnish the information on the number of days care was provided each month and the compensation received for each child for whom the credit is claimed. The caregiver must answer the three qualification questions; enter their name, address, phone number, and New Mexico CRS identification number; and sign this PIT-CG. The name and social security number for each child receiving daycare services is required on this PIT-CG. The taxpayer must also sign.

Do not include any charges for childcare for periods of unemployment or for childcare provided either before or after work (plus any necessary travel time) or for periods the taxpayer is attending school.

Taxpayer's first name and initial (as it appears on Form PIT-1)	Taxpayer's last name	Taxpayer's social security number
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PART I. QUALIFICATIONS FOR INDIVIDUAL CAREGIVERS

Caregiver's name	Caregiver's address	Caregiver's New Mexico CRS ID or SSN
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1. Were you, as a caregiver, age 18 or over at the time the care was performed?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Did you, as a caregiver, provide daycare service for less than 24 hours daily?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3. Were you a dependent of the above taxpayer for whom you provided childcare services?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

PART II. STATEMENT OF COMPENSATION RECEIVED BY CAREGIVER

TAX YEAR 20 _____	CHILD 1 Name and SSN		CHILD 2 Name and SSN		CHILD 3 Name and SSN		CHILD 4 Name and SSN	
Month	No. of Days	Compensation Amount Received Per Month	No. of Days	Compensation Amount Received Per Month	No. of Days	Compensation Amount Received Per Month	No. of Days	Compensation Amount Received Per Month
JANUARY								
FEBRUARY								
MARCH								
APRIL								
MAY								
JUNE								
JULY								
AUGUST								
SEPTEMBER								
OCTOBER								
NOVEMBER								
DECEMBER								
TOTAL								

Caregiver's signature _____ Caregiver's phone number _____

PART III. TAXPAYER: IF YOU COULD NOT OBTAIN A STATEMENT FROM THE CAREGIVER, COMPLETE THIS PART OF THE FORM.

If you made all reasonable attempts to complete this PIT-CG schedule, and you are still unable to locate the caregiver or to obtain the required information, complete Parts I and II of this schedule based on previous billings or other records, provide the name and address of the caregiver, and explain below why the caregiver did not complete the statement.

 Taxpayer's signature _____