REV. 11/2007

PIT-CG

NEW MEXICO CAREGIVER'S STATEMENT

This schedule must be completed by the caregiver and given to the taxpayer to be attached to the Form PIT-1 and Schedule PIT-1-RC. A separate PIT-CG should be completed by each caregiver who provided day care services for which a credit amount is being claimed. Failure to attach the required PIT-CG to the Form PIT-1 will cause the amount claimed for the child day care credit to be disallowed.

The caregiver must furnish the information on the number of days of care provided each month and the compensation received for each child for whom the credit is being claimed. The three qualification questions must be completed and the name, address, phone number and New Mexico CRS identification number of the caregiver provided. For each child receiving day care services, provide the name and social security number. The statement must be signed by the caregiver.

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

Taxpayer's first name & initial (as it appears on Form PIT-1)	Last name	Taxpayer's Social Security Number

PART I - QUALIFICATIONS FOR INDIVIDUAL CAREGIVERS

Caregiver's name	Address	New Mexico CRS ID or Social Security Number

1. Were you, as a caregiver, age eighteen (18) or over at the time the care was performed? YES ☐ NO ☐
2. Did you, as a caregiver, provide day care service for less than 24 hours daily? YES ☐ NO ☐
3. Were you a dependent of the above taxpayer for whom you provided child care services? YES ☐ NO ☐

PART II - STATEMENT OF COMPENSATION RECEIVED BY CAREGIVER

YEAR	CHILD 1, Name and SSN		CHILD 2, Name and SSN		CHILD 3, Name and SSN		CHILD 4 , Name and SSN	
20____	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 CAREGIVER, COMPLETE THIS PORTION OF THE FORM.

If all reasonable attempts to complete this schedule have been made, and the taxpayer is still unable to locate the caregiver or to obtain the required information, the taxpayer should complete Part 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.

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_____

Taxpayer's signature _____