DEPARTMENT OF TRANSFORMATION AND SHARED SERVICES - Office of Personnel Management

# Catastrophic Leave Bank Program
# Dependent Child Certification

**Part I - To Be Completed by Employee or Employee's Designee**

I hereby certify that: _____
Name of Child

SSN: _____ Date of Birth: _____

a. resides in my home at least 50% of the time ☐ Yes ☐ No

b. receives at least 50% of support from me ☐ Yes ☐ No

c. is a dependent child ☐ Yes ☐ No

d. is a dependent on my Arkansas Income Tax ☐ Yes ☐ No

e. if not claimed as a dependent - please explain below:

Arkansas Code §21-4-203 (4) states that ***"Catastrophic Illness" means a medical condition of an employee or of the spouse or parent of the employee or of a child of the employee which may be claimed as a dependent under the Arkansas Income Tax Act of 1929.***

I authorize the Arkansas Individual Income Tax Section to verify that the above listed child is claimed as a dependent on my Arkansas Individual Income Tax Return for the most recent tax year.

Employee's Agency _____ Agency Address and Fax # _____

Employee Signature _____ SSN _____ Date _____

For verification of dependent status, submit to:
**Arkansas Individual Income Tax,** 227 Ledbetter Building, Little Rock, AR 72201 or FAX 501-682-7691

**Part II - To be completed by Arkansas Individual Income Tax Section**

I hereby certify that the above listed child ☐ was ☐ was not listed as a dependent child of the employee for the most recent tax year.

Name and Title, DFA-Revenue-Individual Income Tax Section _____ Date _____

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