New York State Department of Taxation and Finance

## Claim for Child and Dependent Care Credit

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				Read instruction This is a scan									
		e	Please	file this original wi	15	Þ							
		or Type	Last name	First name and middle	▼ Your social security number								
	Print or Type		Mailing address (number	and street or rural route)		Apartment number	▼ Spouse's social security number						
	_		City, village or post office	9	State	ZIP code	New York State county of	residence					
1		-	d your 1996 New York S this claim with a return.		?		Yes	No					
2	Persons or org	anizati	ons who provided the ca	re.									

• •	Care provider's las first name and mi	•	(B) Address		(C) Identifying number (SSN or EIN)									(D) Amount paid (see instruction						
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4				•			+	-				•			ļ					
List below		ersons you are claim			Р	erson	1									-				
	Last	name, first name and	d middle initial			with \star ability		Social security					number				Year of			
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2					•		•			Ţ	T.	_	<u>.</u> T	Ì	1	1.	1	9	Г	
* Soo in	nstructions.																-			
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This is a scannable form; please file this original with the Tax Department

IT-216 1996

**IT-216** 

														Do	ollars	5	(	Cen	Its
11	Amount from page 1, line 10											[	11	,			].[		
12	Enter below your New York Adjusted Gross In	come (Form	IT-200 filer	rs fror	m wo	rksheet	in IT-:	21	6 insti	ucti	ons;								
	IT-201 filers, line 31; IT-203 filers, line 31) New York adjusted gros	ss income						].											
	If your New York adjusted gross income ab	ove is:	c	ý Dver		, But n	ot		Inter										
			\$0		_	<b>Over</b> 10.000		I	ine 12 .300	2									
			10	·	-	10,400 10,800			.295 .285									-	
			11	,200	-	11,200 11,600			.275 .265										
			12	,000	-	12,000 12,400 12,800			.255 .245 .235								-		
			12 13	,800 ,200	_	13,200 13,600			.225 .215										
			13	,999	-	13,999 No limi			.205 .200			[	12			[			
13	Multiply line 11 by the decimal amount on line care credit (see instructions)											🗹	13				].[		
Par	rt-year Residents must comple	oto linos	14-21	Δ١Ι	ot	hore	sta	n	hor	10									
								•				Г	14				ר ר		
14	Enter the amount from Form IT-203, line 38 . If line 14 is equal to or more than line	13, stop! Yo	ou do not									· · · · L	14				┛╸└		
	If line 14 is less than line 13, continu	e on line 15	Delow.									F				Т	רר		
15	Subtract line 14 from line 13. This is your exe	cess child a	nd depend	dento	care	credit						· · · · L	15				ן.ך רר		
16	Enter the amount from Form IT-203-ATT, line 3 If Form IT-216, line 16 is equal to or n												16				J.L		
	with this worksheet. Enter the line If line 16 is less than line 15, enter the	15 amount of	on Form IT	-203-	ATT,	line 35.													
	line 35 and continue on line 17 belo				200	,													
17	Subtract line 16 from line 15. This is your rer	naining exce	ess child a	and d	lepei	ndent c	are ci	red	lit			[	17				].[		
18	Enter amount from Part-Year Resident Income	9																	
	Allocation Worksheet, Column B, line 18, fro page 14 of your Form IT-203 instructions bo	<u>_</u> .	8																
10				<b>,</b> .		_ <b>,</b>		_,-	<u> </u>										
19	Enter amount from <i>Part-Year Resident Income</i> Allocation Worksheet, Column A, line 18, fro	om						7											
	page 14 of your Form IT-203 instructions bo	oklet 1	9	Ļ		Ļ						F							
20	Divide line 18 by line 19 (carry the result to fo	ur decimal pl	<i>aces)</i> This	amo	ount c	annot e	xceec	1 1	00% (	1.00			20		_].[				
21	Multiply line 17 by line 20. Enter the result her section). This is the refundable portion of					•	ondor	nt i	are (	rod	lit	_	21				ר		
	section). This is the retundable portion of	your part-yo			iliu a	nu uep	enuei				<b>nt</b>	••••					┚・∟		
	Paid Preparer's signature	Date	Mark "X" if employed r	self-			Your	sigr	ature										
	parer's Firm's name (or yours, if self-employed)	Preparer's socia		mber		ign	Spou	se's	signat	ure	(if joint claim)								
Addr		Employer identit	ication numb	ber	Н	ere	Date			D	aytime phone	e numb	er (optio	onal)					