Albert Einstein College of Medicine

Child Care Grant Application

Email application and receipt to: childcaregrant@einsteinmed.edu.

Today's Date: _____ Reimbursement Month: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Graduate Student: ☐ MD Student: ☐ Post Doc: ☐

Address: _____ Apt. # _____

City: _____ State: ____ ZIP Code: _____

Email Address: _____

Home Telephone: _____ Cell Phone: _____

Banner I.D.: _____ Last 4 Digits of Social Security #: _____

Child's Name: _____ Age: _____

Child Care Center: _____

Program License #: _____

Monthly Tuition: _____

Reimbursement Request:_____ ($300.00 per month/per child maximum, effective January 1, 2024)

☐ I attest the Child Care center named above has been vetted by myself as a state-licensed facility that operates without any standing or open violations.

☐ I understand that in accordance with federal and state tax rules, my childcare reimbursement should be taxable income to me. Where required, Albert Einstein College of Medicine will report the reimbursement to me on a Form W-2 or 1099. I understand that I should consult my tax advisor as to the impact of this reimbursement on my personal tax situation.

_____ _____

Signature Date