

# CITY OF FLAGSTAFF HOUSING AUTHORITY

## Qualified Domestic Partner Enrollment Forms and Instructions

The documents contained herein are to assist employees and retirees enrolling a Qualified Domestic Partner.

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**IF YOU WISH TO ENROLL A DOMESTIC PARTNER'S DEPENDENT CHILD (REN), YOU MUST COMPLETE A DEPENDENT CHILD ENROLLMENT FORM.**

# CITY OF FLAGSTAFF HOUSING AUTHORITY

## Qualified Domestic Partner Certification Instructions

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### Adding a Qualified Domestic Partner

Complete and return the form(s) in this packet

#### Step One (Coverage Eligibility):

- a. Complete the *Qualified Domestic Partner Affidavit* form and the *Qualified Domestic Partner Dependent Child* form, if applicable.
- b. Review and complete Section I; be sure you and your qualified domestic partner meet the criteria.
- c. Read and complete Section II.

#### Step Two (Tax Treatment):

- a. Review the *Declaration of Tax Status for a Qualified Domestic Partner* to determine whether your qualified domestic partner fulfills the requirements to be a tax dependent.
- b. **Your qualified domestic partner does not need to qualify as a tax dependent to qualify for insurance coverage, however if your qualified domestic partner does not qualify as a tax dependent, you may be taxed on the fair market value (FMV) of the benefit.**
- c. If you are unsure whether your domestic partner meets the support requirement for dependent status, you may confirm eligibility by using the optional *Worksheet for Determining Support*.
- d. If completing the optional *Worksheet for Determining Support*, you will need to know your qualified domestic partner's
  1. Gross monthly income; **AND**
  2. Mortgage/rental payment; **AND**
  3. Monthly expenses for items such as food, utilities, repairs, clothing, education, medical, travel, etc.
- e. Sign and date the *Declaration of Tax Status for a Qualified Domestic Partner* form.
- f. Keep the worksheet for your personal records. You do not need to return the worksheet with the other forms.

#### Step Three:

- a. Return the forms (excluding the Worksheet) to the Human Resources Division

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## Qualified Domestic Partner Affidavit

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### SECTION I:

I, \_\_\_\_\_ certify that \_\_\_\_\_ and I are  
(Employee/Retiree Name – Print) (Qualified Domestic Partner Name – Print)

qualified domestic partners and have been qualified domestic partners since \_\_\_\_\_  
date of partnership (mo/day/yr)

and each of us:

- a. Is not a benefit eligible employee with another NAPEBT employer; **AND**
- b. Has signed with the subscriber, (an active employee) a notarized affidavit of such domestic partner relationship; **AND**
- c. Shares the same permanent residence; **AND**
- d. Has resided with each other continuously and is expected to continue to reside with the each other indefinitely; **AND**
- e. Has not signed a declaration or affidavit of Qualified Domestic Partnership with any other person within the last twelve (12) months; **AND**
- f. Is no less than 18 years of age and is not a blood relative: **AND**
- g. Is not legally married to or legally separated from another person; **AND**
- h. Both persons are capable of consenting to the domestic partnership; **AND**
- i. Is financially interdependent in at least two (2) of the following ways (supporting documents are required to be submitted):
  - 1. Holding one or more credit or bank accounts jointly;
  - 2. Owning or leasing your permanent residence as joint tenants;
  - 3. Naming your partner as a beneficiary of your life insurance or your will and being named by your partner as a beneficiary of their life insurance or will;
  - 4. Each agreeing in writing to assume financial responsibility for the welfare of the other (i.e., durable power of attorney).

### SECTION II:

I understand that this affidavit shall be terminated upon the death of my domestic partner or dissolution of the domestic partnership. I agree to notify the Human Resources Division if there is any change of circumstances attested to in the affidavit within thirty-one (31) days of the change by filing a *Qualified Domestic Partnership Termination* form. After such termination, I understand that another *Affidavit of Qualified Domestic Partnership* cannot be filed until twelve (12) months after a previous *Qualified Domestic Partner Affidavit* has been filed with the Human Resources Division.

\_\_\_\_\_  
Employee/Retiree Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Qualified Domestic Partner Signature

\_\_\_\_\_  
Date

State of \_\_\_\_\_ County of \_\_\_\_\_

Subscribed and sworn before me on this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Commission Expiration mo/day/yr

\_\_\_\_\_  
Notary Public

**CITY OF FLAGSTAFF HOUSING AUTHORITY**

**Qualified Domestic Partner Declaration of Tax Status**

I, \_\_\_\_\_, have completed a *Qualified Domestic Partner*  
(Employee/Retiree Name – Print)

Affidavit swearing that \_\_\_\_\_ is my qualified domestic partner.  
(Qualified Domestic Partner's Name – Print)

I understand that my employer has a legitimate need to know the federal income tax status of my relationship.  
I understand that a qualifying domestic partner is considered a tax dependent for purposes of City provided group benefits **only if** each of the following requirements are met:

- a. My qualified domestic partner is **NOT** the qualifying child (dependent) of another taxpayer. Generally, to be a qualified child under IRC 152(c) and also meet plan coverage eligibility, the child must:
  - 1) Be under age 19 at the end of the year, **OR**  
Be under age 24 at the end of the year and a full-time student, **OR**  
Be any age and permanently and totally disabled; **AND**
  - 2) Have lived with you for more than half of the year.

**AND**

- b. My qualified domestic partner and I will live together (share our principal residence) for the full taxable year except for temporary absences for reasons such as vacation, military service, or education. In other words, my qualified domestic partner and I must live together from January 1st through December 31st.

**AND**

- c. My qualified domestic partner receives more than half of his or her support from me. Enclosed is a *Worksheet for Determining Support*, similar to one the Internal Revenue Service (IRS) includes in its Publication 17, that you can use to determine whether you provide, or expect to provide, more than half of your qualified domestic partner's support.

**AND**

- d. My qualified domestic partner is a U.S. citizen, U.S. resident alien, U.S. national, or a resident of Canada or Mexico, for some part of the year.

Check one of the following boxes. Since the above is a summary of complex tax rules, we recommend you consult with your tax advisor regarding your specific circumstances.

Based on the criteria above, I declare that:

- Yes**, my qualified domestic partner is reasonably expected to be my tax dependent for the 20\_\_ calendar year. **ATTACH PREVIOUS YEAR FORM 1040**
- No**, my qualified domestic partner is not expected to be my tax dependent for the 20\_\_ calendar year. As a result, the employee is taxed on the fair market value (FMV) of group coverage extended to the employee's non-dependent domestic partner and his/her eligible dependent(s). The imputed income resulting from domestic partner coverage provided is deemed to be wages reported on the employee's W-2 and the City must withhold for required income taxes on the value of those benefits.

**By signing this form:**

I declare that the information I have provided is true, complete, and correct. If it is not, or if I do not update this information within thirty one (31) days, I may be liable for any claims paid by my health plan(s) or premiums paid on my behalf and my declared qualified domestic partner's behalf.

**I understand that:**

- a. This declaration of tax status may have legal implications under federal and/or state law.
- b. A civil action may be brought against me for any losses, including reasonable attorneys' fees, if I have made a false statement in this declaration.
- c. I must notify the Human Resources Division if there is a change in the qualified domestic partnership or tax status within thirty-one (31) days of the change. A change in my family status may directly impact the calculation of my taxable income.

\_\_\_\_\_  
Employee/Retiree Signature

\_\_\_\_\_  
Date

# CITY OF FLAGSTAFF HOUSING AUTHORITY

## Worksheet for Determining Support

This worksheet is modeled after the Internal Revenue Service Publication 17 worksheet and requests historical information. However, it is necessary that you determine whether your qualified domestic partner will qualify as a dependent for the calendar year in which the dependent is enrolling (the "enrollment year"). Complete this worksheet using the income and expenses you anticipate during the enrollment year to determine if you provide more than one-half of the support for your qualified domestic partner, or qualified domestic partner's dependent child. **A separate worksheet must be completed for each individual.**

### Individual's Income

1. Did the individual you supported receive any income, such as wages, interest dividends, pensions, rents, social security, or welfare?
  - Yes (Answer questions 2, 3, 4, and 5.)
  - No (Skip to question 6.)
2. Total annual income received \$ \_\_\_\_\_
3. Amount of income used for the individual's support \$ \_\_\_\_\_
4. Amount of income used for purposes other than support \$ \_\_\_\_\_
5. Amount of income either saved or not used for lines 3 or 4 \$ \_\_\_\_\_

**The total of lines 3, 4, and 5 should equal line 2.**

### Yearly household expenses for entire household where you and the individual live

6. Lodging (*Complete either a or b*):
  - a. Rent Paid \$ \_\_\_\_\_
  - b. If not rented, show fair rental value of your home. If your domestic partner owned the home, include this amount on line 21. \$ \_\_\_\_\_
7. Food \$ \_\_\_\_\_
8. Utilities (heat, light, water, etc. not included in line 6a or 6b) \$ \_\_\_\_\_
9. Repairs that were not included in line 6a or 6b \$ \_\_\_\_\_
10. Other (i.e., furniture). Do not include expenses of maintaining home (i.e., mortgage interest, real estate taxes, and insurance). \$ \_\_\_\_\_
11. Add lines 6a or 6b through 10 \$ \_\_\_\_\_
12. Total number of persons who lived in the household \$ \_\_\_\_\_

### Yearly Expenses for the Individual

13. Divide line 11 by line 12 to determine each person's part of household expenses  

$$\frac{\$ \text{line 11}}{\text{line 12}} \div \frac{\$ \text{line 12}}{\text{line 12}} =$$
\$ \_\_\_\_\_
14. Clothing \$ \_\_\_\_\_
15. Education \$ \_\_\_\_\_
16. Medical and dental \$ \_\_\_\_\_
17. Travel and recreation \$ \_\_\_\_\_
18. Other (please specify) \_\_\_\_\_ \$ \_\_\_\_\_
19. Total amount for the individual's yearly support (Add lines 13 through 18.) \$ \_\_\_\_\_
20. Multiply line 19 by 50% ( ½ of individual's support) \$ \_\_\_\_\_
21. Amount the individual provided for his or her own support:
  - Amount from line 3 \$ \_\_\_\_\_
  - Amount from line 6b (include if the individual owned the home) \$ \_\_\_\_\_
  - Add lines 3 and 6b, if each are applicable** \$ \_\_\_\_\_
22. Amount that others added to the individual's support. Include amounts provided by state, local, and other welfare societies or agencies. Do not include any amounts from line 2. \$ \_\_\_\_\_
23. Amount you provided for the individual's support:
  - $$\frac{\$ \text{line 19}}{\text{line 19}} - \frac{\$ \text{line 21}}{\text{line 21}} - \frac{\$ \text{line 22}}{\text{line 22}}$$
\$ \_\_\_\_\_
24. Is line 23 more than line 20? If so, the individual qualifies as a tax dependent. Check "Yes" on the appropriate *Declaration of Tax Status* form.