DEPENDENT CARE

RECEIPT FORM

TO: (YOUR NAME): _____

(YOUR EMPLOYER): _____

By the signature below, I certify that the total of $ _____ for the month(s) or week(s) of _____ has been received for Dependent Care Expenses for the following person(s):

Name:_____ Age _____

Name:_____ Age _____

Name:_____ Age _____

Children that have reached their 13 birthday do no qualify, unless that meet certain qualifications. Five year old kindergarten does not qualify as dependent care.

(Please have your Dependent Care Provider Sign this receipt).

FROM: _____
Signature of Dependent Care Provider

_____
Dependent Care Provider Tax Id or SS #

_____
Date

FORM PROVIDED BY:

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