

RECEIPT FOR PAYMENT OF DEPENDENT CARE SERVICES

(Please submit with a completed Dependent Care Claim Form)

DEPENDENT CARE SERVICES PROVIDED BY:

Name: _____

Address: _____

Tax ID Number (or Social Security Number): _____

Dates Dependent Care Services Provided: _____ to _____

Parent's Name: _____

Dependent's Name: _____

Dependent's Name: _____

Dependent's Name: _____

I certify that I have provided the dependent care services described above. I have received \$_____ in payment for the services I have provided.

Signature

Date