

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/Date of Birth: _____

Name: _____ Age/Date of Birth: _____

Name: _____ Age/Date of Birth: _____

This documentation will serve as a receipt for Dependent Care expenditures.

(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:



Southern Administrators and Benefit Consultants, Inc.

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