DEPENDENT CARE

RECEIPT FORM

TO: (NAME)**:** _____

(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.

_____
Signature of Dependent Care Provider

_____
Dependent Care Provider Tax Id or SS #

_____
Date

FORM PROVIDED BY:

Southern Administrators and Benefit Consultants, Inc.
P.O. Box 2449
Madison, MS 39130-2449
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