Dependent Care Expense Receipt

Dear Dependent Provider,

The individual identified below is a Participant in an employer sponsored Dependent Care Flexible Spending Account (FSA). The Participant is requesting expense reimbursement from this pre-tax account for qualified dependent care expenses paid to you as the dependent care provider.

Employer Name:

FSA Participant (Employee) Name:

Employee Street Address:

City:

State:

Zip Code:

Employee Contact Phone:

Employee SS# (last 4 digits only):

New name/address change:

Yes ☐ No ☐

The IRS requires that a proof of services (e.g. receipt) be provided by the dependent care provider as validation of qualified Dependent Care services delivered. Please provide the requested information below with your signature.

Provider Name (required):

Provider Tax ID/Social Security # (all digits):

Type of Care Delivered:

Type of Care Delivered:

Name(s) of Individual Under Care:

Start Date of Care:

End Date of Care:

I verify that all information contained on this form regarding the delivery of Dependent Care services is accurate, and that all associated expenses have been paid by the Employee Participant identified above.

Dependent Care Provider Signature:

Date: