

DEPENDENT CARE CERTIFICATON FORM

DATE: _____

NAME: _____

EMPLOYER: _____

This form is to verify that \$_____ was paid for dependent care expenses for dates beginning _____ and ending _____ for the following person(s):

Name: _____ Age/Date of Birth: _____

Name: _____ Age/Date of Birth: _____

Name: _____ Age/Date of Birth: _____

Signature of the Child Care Provider

Provider Tax ID or SS#

Note: If you fax this form to our office, please do not mail the original.

This form acts as a receipt from your day care provider. Please submit this form along with the Reimbursement Request Form in order to be reimbursed for day care expenses.

Please feel free to contact our office at (601) 982-0331 or 1-800-326-4885, if you have any questions.