

RECEIPT FOR DAY CARE EXPENSES

Payment received from: _____

In the following amount: _____

For services rendered: _____

Name of eligible dependents:

Provider Information:

Name: _____

Address: _____

City: _____

State, Zip: _____

SSN or Tax ID _____

I certify that I have accepted payment for the above-referenced dependent care services.

Provider Signature & Date: _____