

Dependent Care Reimbursement Claim Form

Employee Name _____

Dependent Name(s): _____

Name of Day Care Provider: _____

Address of Provider: _____
(street) (city) (zip)

Tax ID or Social Security Number of provider: _____

Dates of Services _____ through _____

Total Charges for this claim: _____

I certify that I provided the services described above and received the payment described for those services.

(Signature of Day Care Provider)

EMPLOYEE CERTIFICATION

I hereby certify that all items requested to be reimbursed comply with the CSU, Chico Research Foundation FLEX Plan and such items have not and will not be covered by any other plan or program of any employer or other person. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns. In addition, I acknowledge the requirement to file IRS Form 2441 with my personal income tax return. The CSU, Chico Research Foundation does not accept responsibility for direct payment to any individuals other than the employee.

Employee Signature

Date