

CAFETERIA PLAN DEPENDENT DAY CARE RECEIPT

PARENT'S NAME: _____
CHILD'S NAME: _____ AGE: _____
DATE OF SERVICE: FROM _____ TO _____
FEE FOR SERVICE: \$ _____
AMOUNT RECEIVED: \$ _____
CARE PROVIDED BY:
NAME: _____
ADDRESS: _____
TELEPHONE: _____
SOCIAL SEC# OR BUSINESS ID# _____
PROVIDER SIGNATURE: _____



* NOTICE TO CAFETERIA PLAN PARTICIPANT: No payment may be made under the plan if the service provider is your dependent for federal income tax purpose, or is your child or stepchild and is under age 19. The Dependent you are claiming must be under age 13 or have qualifying restrictions.



THIS FORM MUST BE SUBMITTED ALONG WITH A DEPENDENT CARE CLAIM FORM

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