# DEPENDENT CARE ASSISTANCE PROGRAM (DCAP) EXPENSE REIMBURSEMENT FORM

(FOR QUALIFIED DEPENDENT CARE EXPENSES **ONLY**)

EMPLOYEE NAME: _____

EMPLOYER NAME: _____

PROVIDER NAME: _____

DEPENDENT NAME: _____

SERVICE DATES: _____ TO _____

AMOUNT: $_____

In submitting this claim, I certify the following statements are true:

- The expense incurred enables my spouse (if applicable) and me to be gainfully employed (or, if my spouse is not employed, is in active search of employment, a full-time student, or incapable of self-care).
- The primary purpose of the care is custodial in nature (for the well-being and protection of the individual(s), not primarily for other purposes such as education, overnight camp, etc.
- These expenses have not been reimbursed and are not reimbursable under any other plan.
- Neither the dependent care tax credit nor any other credit have been or will be claimed for the same expenses I am submitting for reimbursement under this plan.

*Signature of Employee* _____ *Date* _____

## PROVIDER OF SERVICES:

I, _____, as provider (or administrator of the above named provider) certify that the above information is correct and have rendered services for the above listed dependent(s) for the dates listed and the amount stated.

| _____ | _____ | _____ |
|---|---|---|
| *Signature* | *Tax ID or SS #* | *Date* |

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