Dependent Day Care Receipt
For use when appropriate receipts/documentation are not provided

Care Provider Name:	Payer Name:	
Address:	Address:	
Tax ID/SSN:	Dependent Name(s):	
Care Provider Signature:		
Date(s) of Care Provided: (months, weeks, days of the week)	Services Rendered:	Amount(s) Paid:
Total Dependent Day Care Cost:		$

Care Provider Name:	Payer Name:	
Address:	Address:	
Tax ID/SSN:	Dependent Name(s):	
Care Provider Signature:		
Date(s) of Care Provided: (months, weeks, days of the week)	Services Rendered:	Amount(s) Paid:
Total Dependent Day Care Cost:		$