ACKNOWLEDGEMENT OF FIXED DEPENDENT CARE PAYMENTS*

I _____ HEREBY CERTIFY THAT _____
Dependent Care Provider Employee

IS PAYING $_____ PER YEAR FOR DEPENDENT CARE SERVICES FOR THE

PERIOD _____ THROUGH _____.

_____
Provider Representative

_____
Address

_____

_____
Tax ID or SS Number

_____
Date

TO BE COMPLETED BY PROVIDER OF SERVICES (receipt must be submitted quarterly)

RECEIPT OF DEPENDENT CARE PAYMENTS*

I _____ HEREBY ACKNOWLEDGE RECEIPT
Dependent Care Provider

OF $_____ FROM _____ FOR
Employee

DEPENDENT CARE SERVICES FOR THE PERIOD _____.

_____
Provider Representative

_____
Address

_____
Tax ID or SS Number

_____
Date