COUNTY OF SANTA CRUZ
DEPENDENT CARE REIMBURSEMENT ACCOUNT
CLAIM FORM

_____ _____
EMPLOYEE # DATE

_____ _____
EMPLOYEE NAME WORK TELEPHONE NUMBER

_____ _____
HOME ADDRESS CITY, STATE & ZIP

INSTRUCTIONS:
1. Complete the entire form
2. A copy of an itemized statement should be attached if a claim for reimbursement of dependent care expenses is being made. If a statement is not available, the Provider Statement below must be completed.

PROVIDER STATEMENT (Must be completed by the Provider if an itemized statement is not attached).

I, _____, hereby certify that the amount of $_____ was paid by the

employee or his/her spouse to me this plan year for the care of _____
(Name of the dependent)
for the period of _____ to _____.

Provider Signature_____ Date_____
Social Security No. or Employer Identification No. _____

3. Submit this completed form and attachments to Auditor-Controller's Office, Payroll Section.
Claim forms received by Wednesday Noon will be processed for payment on Friday.

READ CAREFULLY BEFORE SIGNING – Signature required for all transactions. I hereby certify that the information above is correct and that I have a qualified dependent. The expenses submitted were incurred this plan year, are not reimbursable by any other plan, and have not been previously reimbursed by this plan. To the best of my knowledge, the reimbursement requested is for tax-deductible expenses for this plan year. I understand that upon receipt of this payment from my reimbursement account, I may not claim these expenses on my income tax return as an itemized deduction or tax credit for this plan year and that this dollar amount must be reduced from the dollar limit on expenses that are eligible for the child care tax credit. I further certify that I am not paying a dependent relative (personal exemption deduction) for child care services.

I hereby release the County of Santa Cruz and its offices or representatives from any obligations or tax consequences that may arise if I fail to meet the requirements or become ineligible to claim part or all of these expenses. I agree to notify the County of any changes in my circumstances that could affect my qualifications to claim these expenses.

_____ _____
EMPLOYEE NAME DATE