## DEPENDENT CARE RECEIPT

*Please Print*

Received from (Parent's Name) ______________________________

payment for dependent care services for the period _________________ to ________________

in the amount of $ _______________________ .

______________________________
Name of Facility or Person Providing Care

______________________________ ______________________________
Signature of Provider Date

**** All Receipts must be attached to a Dependent Care Reimbursement Request Form ****

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