

**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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