

**Reimbursement Request  
Dependent Care Spending Account**

AUDITOR'S USE ONLY
Date Received: _____

Employee name: \_\_\_\_\_

Personnel No: \_\_\_\_\_

Current Mailing Address: (  Check this box **ONLY** if this address differs from the address on file in the Auditor/Controller's Office)

Street	City/State	Zip
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*Note:* See the back of this form for instructions on how to complete the information below and a description of the bills or other information which must be submitted with your request.

Summary of Expenses					
Name of child or dependant receiving care	Relationship to employee	Provider of care	Date of care		Amount to be reimbursed
			From	To	
		Name: Social Security or TIN #			
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I certify to the best of my knowledge, the above information is accurate and that payment is being requested only for expenses of eligible parties ( a child under 13 years old whom I claim as a dependent for tax purposes or my spouse or another dependent who is unable to provide his or her own care). I understand that I am solely responsible for the accuracy and veracity of all information relating to this claim. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year.

Employee signature: \_\_\_\_\_

Date: \_\_\_\_\_

## How to Use Your Dependent Care Spending Account

### Filling out the form

Complete all sections of the form. You must print the form and then sign and date it.

- 1) Submit only expenses that are reimbursable under the Dependent Care Spending Account. Expenses may be reimbursed only for services that make it possible for you to work. If you are married, your spouse must be a wage earner, a full-time student for at least five months during the year, or disabled.
- 2) **Name of child or dependent receiving care** – Enter the first and last name of the person who received the care for which expenses are being submitted.
- 3) **Relationship to employee** – Indicate spouse, son, daughter, or other dependent, such as mother, father, sister, brother.
- 4) **Provider of care** – Enter the name of child or adult dependent care center or the name of the individual providing care, as well as the provider’s Social Security or Tax Identification Number (TIN).
- 5) **Date of care** – Enter the beginning and ending dates during which care was provided. These dates must occur during your

participation in the Plan.

- 6) **Amount to be reimbursed** – Enter the amount to be reimbursed from your account. This amount should include only that portion of the expense that was not eligible for payment by any insurance plan.
- 7) **Total** – Enter the total amount of reimbursement you are requesting.

### Attaching your bills and records

When you submit your request for reimbursement you must also provide copies of itemized bills or receipts that clearly state each of the services and supplies provided including:

- name of person or organization providing the care
- name of the person receiving the care
- dates that care was provided
- total charge for the care

### Submitting your request

Send the original copy of your completed form and copies of your bills to the Auditor/Controller’s Office, Room 220-D, County Government Center, San Luis Obispo, CA 93408.

If you have any questions about how to complete this form, or what bills to submit, contact 781-5034 or 781-5007.

### EXAMPLE

Robin Taylor has her son, Jason, in a day care center. She is billed \$600 a month by the Wonderland Child Care Center. She attaches the bill and completes the reimbursement form as follows:

#### Summary of Expenses

Name of child or dependent receiving care	Relationship to employee	Provider of care	Date of care		Amount to be reimbursed
			From	To	
Jason Taylor	Son	Name: Wonderland Child Care Center SSN or TIN: 88-123456789	2/1/2001	2/28/2001	\$600