

**HRPro**

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**Dependent Care Receipt Form**

Dear Dependent Care Provider:

The person named below is a participant in an employer sponsored Dependent Care Flexible Spending Account. The participant is requesting reimbursement from this pretax account for qualified dependent care expenses paid to you, the dependent care provider.

<b>Company Name</b>		<b>Plan Year</b>	
<b>Employee Name</b>		<b>Online Claim Reference Number or Employee Number</b>	

The IRS requires that a proof of services (e.g. receipt) be provided by you, the care provider. Please use this form as that receipt by verifying or completing the Provider Information section and signing below.

**Type of Care:**

<input type="checkbox"/> Adult Day Care	<input type="checkbox"/> Day Camp	<input type="checkbox"/> Nursery School Tuition**
<input type="checkbox"/> Child Day Care*	<input type="checkbox"/> Before/After School Care*	<input type="checkbox"/> Preschool Tuition
<b>* Please note: childcare is only eligible for children up to age 13</b>		
<b>** Please note: K-5 tuition is not eligible for reimbursement under Dependent Care FSA</b>		
<b>Some examples of ELIGIBLE expenses:</b>		<b>Some examples of INELIGIBLE expenses:</b>
Day Care Centers Elder Care Family Child Care Day Camps	Preschool After School Care Nanny / Au Pair	Transportation Fees Meals Overnight Camps Diapers
		Educational expenses, including Kindergarten Incidental fees: such as activity fees and field trips

**Provider Information:**

<b>Care Provider Name</b>		<b>Tax ID #/SSN</b>	
<b>Service Span Date</b>	From:      To:	<b>Total Amount Paid</b>	\$
<b>Dependent name(s) receiving care:</b>			

I verify that all information contained on this form regarding my dependent care services provided to the employee named above is accurate, and applicable amounts have been paid.

<b>Care Provider Signature</b>		<b>Date</b>	
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