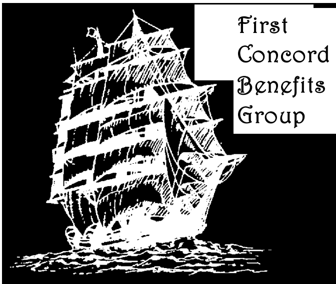

P.O. Box 67220
Lincoln, NE 68506

Phone: 402-423-4454
Fax: 402-423-4549

Employer: ___________________________________

Employee Name: ___________________________________

Social Security Number: _____________________________

Dependent Care Services

Dates of Services Month/Day/Year	Dependent(s) for whom care was provided	Dollar Amount
		$
		$
		$
		$
		$
	TOTAL AMOUNT PAID	$

I verify these charges and state that the full amount of the cost for daycare is or will be paid by the above mentioned individual.

____ _______________________

Signature of Daycare Provider/Social Security Number Date

____

Name of Daycare Center/Provider