County of Santa Cruz

Dependent Care (D-Care) Reimbursement Program

REIMBURSEMENT FORM

Employee Payroll #: _____ Date:_____

Employee Name (print): _____ Phone: _____

Mailing Address: _____
Street Address City State Zip code

INSTRUCTIONS:

1. Complete the entire form.
2. A copy of an itemized statement should be attached if a claim for reimbursement of dependent care expenses is being made. If a statement is not available, the Provider Statement below must be completed.

PROVIDER STATEMENT (Must be completed by the Provider if an itemized statement is not attached.)

I, _____, hereby certify that the amount of

$_____ was paid to me by the employee (or their spouse) during the current plan year for the care of: _____
Name of Dependent Receiving Care

during the period of _____ through _____.
MM/DD/YYYY MM/DD/YYYY

Provider Signature _____ Date_____

Provider SSN or EIN: _____

---

3. Submit the completed form and any attachments to AUDPayroll@santacruzcountyca.gov or Auditor-Controller, 701 Ocean Street, Room 100, Santa Cruz, CA 95060. 831-454-2500

Claim forms received by Wednesday noon will be processed for payment on Friday.

READ CAREFULLY BEFORE SIGNING – Signature required for all transactions. I hereby certify that the information above is correct and that I have a qualified dependent. The expenses submitted were incurred this plan year, are not reimbursable by any other plan, and have not been previously reimbursed by this plan. To the best of my knowledge, the reimbursement requested is for tax-deductible expenses for this plan year. I understand that upon receipt of this payment from my reimbursement account, I may not claim these expenses on my income tax return as an itemized deduction or tax credit for this plan year and that this dollar amount must be reduced from the dollar limit on expenses that are eligible for the childcare tax credit. I further certify that I am not paying a dependent relative (personal exemption deduction) for childcare services.

I hereby release the County of Santa Cruz and its offices or representatives from any obligations or tax consequences that may arise if I fail to meet the requirements or become ineligible to claim part or all of these expenses. I agree to notify the County of any changes in my circumstances that could affect my qualifications to claim these expenses.

Employee Signature: _____Date: _____