

DCAP

Dependent Care Assistance Program Reimbursement Request



AUDITOR USE ONLY - DATE RECEIVED _____

Employee Name: _____ Employee ID Number: _____

Dept: _____ Phone: _____ Email: _____

Address change – **ONLY** print current mailing address if this is a new address not previously reported to this program.

Street (only required if reporting an address change) _____ City/State _____ Zip Code _____

Note: See the page 2 of form for instructions on how to complete the information below and a description of the bills or other information that **must** be submitted with your request. Submit expenses in date order **after** care has been received. **Submit the original to ACTTC Payroll, retain a copy for your records.**

Summary of Expenses					
Name of child or dependent receiving care	Relationship to employee	Provider of care	Dates of Care		Total charge
			From	To	
		Name: Social Security or TIN #:			
		Name: Social Security or TIN #:			
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Claim must total \$20 or more					Total

I certify that, to the best of my knowledge, the above information is accurate and that payment is being requested only for expenses eligible under the plan. I also understand that any expenses reimbursed from this account cannot be used for a tax credit on my federal income tax return. I certify that these expenses have not been, and will not be, reimbursed from any other source.

Employee Signature: _____ Date: _____

DCAP

Reimbursement Request Instructions Dependent Care Assistance Program

Filling out the form

Complete **all** sections of the form. Please print. Once you have completed the form, sign and date it. Submit the original; keep a copy for your records.

1. Submit expenses **after** care has been received. Submit only expenses that are reimbursable under the Child and Adult Dependent Care Assistance Plan. 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 **IRS Qualified dependent**.
4. **Provider of care** – Enter the care center's name or the name of the individual providing care, and the provider's social security or tax identification number (TIN).
5. **Dates of care** – Enter the beginning and ending dates the care was provided. Expenses are incurred on the date services are provided, and cannot be submitted prior to the services taking place.

Total charge – Enter the amount charged by the provider of care, for which you are requesting reimbursement.

Total – Enter the total amount of attached bills/receipts.

Attaching your bills and records

When you submit your request for reimbursement, you must provide copies of itemized bills or receipts that **clearly** state the care that was provided, including:

- Name of person providing the care and their SSN **or** organization providing the care and their TIN
- Name of the person receiving care
- Type of care provided
- Dates that care was provided
- Total charge for the care

Submitting your request

Send the original copy of your completed form and all back up to:

ACTTC PAYROLL OFFICE
COUNTY OF SONOMA
575 ADMINISTRATION DRIVE, ROOM 117A
SANTA ROSA CA 95403-2815

If you need more forms or have questions about how to complete this form or what documentation to submit, call (707) 565-6024 or 565-4690.

EXAMPLE

Robin Taylor's son, Jason, is in a day care center. She is billed \$600 a month by the Wonderland Child Care Center. She will attach the itemized bill or receipt and complete the reimbursement form as follows:

Name of child or dependent receiving care	Relationship to employee	Provider of care	Dates of Care		Total charge
			From	To	
Jason Taylor	Son	Name: Wonderland Child Care Center Social Security or TIN #: 88-123456789	2/01/xx	2/28/xx	\$600