



Dependent Care Expense To be completed by parent or guardian

Section I – Dependent Care Costs

Effective _____, I, _____
Date Parent or guardian's name

pay for dependent care of the following individuals:

Name	Amount provider charges	- Child care subsidy	= Amount parent pays	Time period for which provider charges
				<input type="checkbox"/> Daily <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Other <input type="checkbox"/> Bi-weekly
				<input type="checkbox"/> Daily <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Other <input type="checkbox"/> Bi-weekly
				<input type="checkbox"/> Daily <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Other <input type="checkbox"/> Bi-weekly
				<input type="checkbox"/> Daily <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Other <input type="checkbox"/> Bi-weekly

Dependent care provider's name _____
Address _____ Phone _____

Section II – Dependent Care Transportation Costs

My transportation costs for dependent care are: None
 Drive to and from provider
_____ miles per day
_____ days per week
 Other – List type; for example:
Public transportation, taxi, etc.

\$ _____ per _____

Parent or guardian's signature

Date