

DEPENDENT CARE ACKNOWLEDGEMENT



FAX TO FEBCO @ 502-695-9692

Employee Name: _____

Employer Name: _____

Social Security Number: _____ Employee Phone Number: _____

(Dependent Care provider)

It is hereby acknowledged by _____ that I have received or will receive \$ _____ [] weekly [] bi-weekly [] monthly from the below named participant for dependent care services.

The services will be rendered from _____ 200_ to _____ 200_ for the following participant dependent

Dependent _____ Dependent _____

Dependent _____ Dependent _____

[] PRIVATE SITTER _____

(Dependent Care provider)

X _____

*Signature of Dependent Care Provider or
Dependent Care Representative*

[] [] []
*SOCIAL SECURITY Number of Dependent Care
Provider or Dependent Care Representative*

[] DEPENDENT CARE CENTER _____

DEPENDENT CARE CENTER TAX I.D. NUMBER _____

X _____

Signature of Dependent Care Provider or Dependent Care Representative

** If you are a Dependent Care Center you must be licensed under and in compliance with any and all state and local regulations governing dependent care centers, and that for a fee it provides care for more than six individuals (other than individuals who reside at the facility).

Incomplete forms can not be processed.

DEPENDENT CARE EMPLOYEE PARTICIPANT _____

DATE FORM COMPLETED: _____ E-mail address _____ @ _____