



Dependent Care Reimbursement Program Application Form

Please Type or Print Information

Employee Information

Last Name, First Name, Middle Initial:	Employee ID#:
Department:	Department Cost Center:
Phone#:	Email:
Dependent type: Adult Child	Dependent(s) Name:

Dependent Care Provider Information

Provider Name:	
Provider Location:	Provider Type: <input type="checkbox"/> Adult <input type="checkbox"/> Child
Provider Phone #:	Provider License #:

Please submit application and all program documentation to be considered for reimbursement of expenditures.

It is the responsibility of the requester to submit all documentation required by the policy for consideration of the requester's application.

Required Documentation:

- Receipts/provider issued statements showing payments to your Dependent care provider.
 - Reimbursements are monthly, if you have multiple receipts please submit as one reimbursement.
 - Please submit for reimbursement by the 15th of the following month.
 - Please do not provide personal bank or credit card statements.
 - Please ensure that your submitted documents include provider information and dates of charged care for each dependent you are submitting for.
- Documentation of dependency, i.e. birth certificate, court order, dependent affidavit.

I have received and read the Dependent Care Reimbursement Policy and agree to the terms of the policy.

I hereby certify that all documents, records, and statements provided in this application are true, complete, and accurate to the best of my knowledge. I understand that any false statements, omissions, or misrepresentations may result in the immediate disqualification of my application or the termination of any subsequent reimbursements. I declare under penalty of perjury that the foregoing is true and correct.

Employee Signature

Date

All reimbursements are subject to approval by the Chief of Staff and Payroll Department. Email documents to BOCDependentCare@dekalbcountyga.gov.