

**College of Coastal Georgia**  
**Dependent Care Flexible Spending Account**  
**Request for Reimbursement**

Employee: Complete this claim and attach a receipt or invoice from the care provider which includes: (1) care provider's name and taxpayer ID or SSN; (2) dependent's name, (3) amount charged for the care, and (4) dates of service period. **\*If an invoice or receipt with all this information is not available, you must have the Care Provider read and sign the "Care Provider's Certification" in the gray box below.** Submit claim to the CCG Human Resources Office.

\_\_\_\_\_  
**Employee's Name (Please Print)** \$ \_\_\_\_\_  
**Amount to be Reimbursed**

**Service Period Covered** (also include the year): \_\_\_\_\_

(Ex. If claim is for one week's care, state beginning and ending date of the week claimed, such as January 7-11, 2008. If claim is for four consecutive weeks, state first date and the last date of the four-week coverage period, such as January 7 – February 1, 2008.)

\_\_\_\_\_  
**Care Provider's Name** **Provider Address** **Provider Tax ID or SSN**

Name(s) of Dependent(s) Covered by this Reimbursement Request	Dependent's Birthdate

**\*CARE PROVIDER'S CERTIFICATION:**  
 (Care Provider must complete this section if invoice or receipt with all the required information is not provided.)  
 I hereby certify that: (1) I provided care for the person(s) named above during the dates stated above; (2) the amount I charged for these services is not less than the amount claimed above; and (3) my taxpayer ID is correctly stated above.

**CARE PROVIDER'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

*Definitions – The following terms and basic definitions apply to the Employee's Certification statement below.*  
**Qualifying Dependent:** (1) A dependent child under age 13 for whom you claim an exemption on your tax return (if divorced or legally separated, the child does not have to be claimed as a dependent on your tax return if you have custody of the child for a period longer than the other parent); (2) other persons who may be claimed as a dependent on your Federal income tax return, and who reside in your home, and who are incapable of self-care because of a physical or mental disability. **Eligible Expenses:** Expenses you pay for the care and well-being of a qualifying dependent for the purpose of allowing you and your spouse, if married, to be gainfully employed. The care-provider is usually a licensed child-care or adult-care center, a licensed provider of child care, or an independent baby sitter who is not a dependent of the employee or his/her spouse.

**EMPLOYEE'S CERTIFICATION**  
 I hereby certify by my signature below that the expenses being claimed for reimbursement are "eligible expenses" for a "qualifying dependent" in accordance with the CCG Dependent Care FSA Plan. I further certify that: (1) I incurred the above listed expense during a period in which I am or was an active participant in the CCG Dependent Care FSA Plan; (2) I have paid or will pay the above listed expense to the service provider indicated; (3) the above listed expense has not been or will not be submitted for reimbursement from any other Dependent Care FSA; (4) I will be responsible for any tax reporting requirements with respect to the reimbursable expenses, including filing IRS Form 2441; (5) I will not use this expense for a child care credit on my tax return; (6) all the information recorded on this request is true and correct; and (7) I understand the College's Plan Administrator may suspend or deny this claim for insufficient documentation or if the expense does not appear to be eligible for reimbursement in accordance with the respective IRS rules and regulations.

\_\_\_\_\_  
**Employee's Signature** \_\_\_\_\_  
**Date**

*Copy Distribution – Send original to Human Resources after making copy for your records*