Dependent Care (DCAP) Recurring Claim Certification Form

Employee Information					
Employer Name:					
Employee Name:		SSN:			
Employee Address:					
City:		ST:		ZIP:	

Dependent Information			
Dependent Name:		SSN:	
Dependent Name:		SSN:	

Provider Information	
Provider Name:	
Fed EIN (Business) or SSN (Individual):	

Claim Information		Service From:	Service To:
Total Reimbursement Amount			

I hereby certify:

- Each dependent listed above will qualify as a dependent on my federal income tax return for the current year;
- The expenses are not for kindergarten or post-kindergarten tuition expenses;
- These expenses are necessary to allow me to work, and if married, to allow my spouse to work or to be a full-time student;
- My provider is not a dependent, is at least 19 years of age as of end of year, and reports their personal or business income;
- The expenses claimed above are eligible for reimbursement under the Dependent Care Assistance Plan and neither I, nor my spouse, have receive reimbursement for these claimed expenses from another source;
- I understand that any claim for which I am reimbursed cannot also be used for federal child and dependent care tax credit purposes;
- I understand that a new Certification must be completed and submitted each plan year; and
- All of the information I have submitted on this form is true and complete.

Employee Signature: ____ Date: _________________

Upon completion, please return the completed and signed form to:

flex@mcgregoreba.com
997 Governors Lane
Suite 175
Lexington, KY 40513