CHILD AND DEPENDENT CARE EXPENSES

Client Name:		AMOUNT PAID PER CHILD TO EACH PROVIDER	
Provider Name		Dependent's First Name	Amount Paid
Tax ID # or SS#			$
Address			$
City			$
State, Zip			$
Phone #	( ) -	Total for this provider	$
Provider Name		Dependent's First Name	Amount Paid
Tax ID # or SS#			$
Address			$
City			$
State, Zip			$
Phone #	( ) -	Total for this provider	$
Provider Name		Dependent's First Name	Amount Paid
Tax ID # or SS#			$
Address			$
City			$
State, Zip			$
Phone #	( ) -	Total for this provider	$
Provider Name		Dependent's First Name	Amount Paid
Tax ID # or SS#			$
Address			$
City			$
State, Zip			$
Phone #	( ) -	Total for this provider	$
Provider Name		Dependent's First Name	Amount Paid
Tax ID # or SS#			$
Address			$
City			$
State, Zip			$
Phone #	( ) -	Total for this provider	$