Summer Childcare Reimbursement Program

Claim Form

Return this completed form to the SLOCEA office via:

Fax: 805-543-4039

Email: bdickey@slocea.org

OR

In-person to 1035 Walnut St. SLO

YOUR NAME: _____ CHILD'S NAME: _____

Your reimbursement check will be <u>mailed to your home</u>. Please provide your current home address:

_____ _____ _____

STREET ADDRESS *(including space/apartment # if applicable)* CITY ZIP

Note: Instructions on how to complete this information below are on the back of this form

SUMMARY OF CHILDCARE EXPENSES					
Provider's Name	Provider's SS# or Tax ID#	Date Care Began	Date Care Ended	Amount Paid **Per Week**	**Total** Amount Paid
				$	$
				$	$
				$	$
				$	$
				$	$

I certify that, to the best of my knowledge the above information is accurate and that reimbursement is being requested only for eligible children (ages 14 and under) whom I claim as a dependent for tax purposes. I also understand that any expenses reimbursed from this claim cannot be used for a tax credit on my federal income tax return, nor can they be reimbursed under the County of San Luis Obispo's ITS Program.

_____ _____ _____

Employee's Signature Employee's County ID # Date