Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

CHILD CARE REIMBURSEMENT REQUEST FORM

HEALTHCARE PROVIDERS & EMERGENCY RESPONDERS ONLY

Must print in Black or Blue ink ONLY.

To be eligible for this benefit, employees must be in an eligible classification that the County has identified as a healthcare provider or emergency responder with eligible childcare expenses up to $600 from the period of April 1, 2020 through June 30, 2020.

1. Personal Information

Employee ID	Last Name, First Name	Phone No.	Email Address

Mailing Address	City	State	Zip

Company	Department	Job Classification

2. I am requesting reimbursement for the listed dependent/s

Attach appropriate documentation (e.g receipts)

Dependent Name	Relationship	Date of Birth

3. Dependent Care Provider Information

Dependent Care Provider	Tax ID or Social Security Number	Date of Service From	Date of Service To	$ Amount Being Claimed
1.				
2.				
3.				

Employee (Print & Sign)	Date

Office Use Only

☐ Healthcare Provider/Emergency Responder

Eligibility Verified by	Date

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