Reimbursement Form (Dependent Care)

53536

Participant TASC ID

Client Name STATE OF CONNECTICUT

Submit Requests for Reimbursement:

a. By Fax: **608-661-9601**

b. Or by Mail: **TASC**
PO Box 7308
Madison, WI 53707-7308

Date of Service:	**through:**	**Request amount**	**Dependent Name:**
/ /	/ /	.	
/ /	/ /	.	
/ /	/ /	.	

I certify the total cost of qualified adult/child care services below have been provided during the period indicated for the dependents on this form.

☐ **Receipts Attached (Select this option if receipts are attached)**

☐ **Provider signature in lieu of Receipts (Enter Provider name and signature)**

Provider Name

Provider Signature

Date / /

To the best of my knowledge and belief, all statements and information provided with this Request for Reimbursement are complete and true. I have read and understand the Terms of Use for my account and certify that I am requesting reimbursement for eligible expenses incurred by eligible persons as allowed under the Terms of Use for my account. For tax-free reimbursements, I certify that these expenses have not been previously reimbursed by any other source, and they will not be submitted as deductible expenses when I file my personal tax returns. I understand I am responsible for retaining copies of all receipts and will provide a copy when required and as allowed by law. I authorize my Accounts to be reduced by the amounts in this Reimbursement Request.

EmployeeSignature(required)

Date / /

DEPC