



# DEPENDENT CARE CLAIM FORM

122 Parish Drive  
Wayne, NJ 07470

Employer Name: Upper Saddle River Board of Education

Employee Name: \_\_\_\_\_ SS#: X X X - X X -  
Last First Last 4 Digits Only

New Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Service	Service Provided	Dependent Name	Reimbursement Amount
Total Reimbursable Expense			

**Instructions:**

- Complete the top portion of the form.
- List the eligible expenses:
  - Date of Service: The date (or date range) the service was provided. Not the date it was billed.
  - Service Provided: Provide a brief description of the service received.
  - Dependent Name: Refer to you FSA Handbook for information who you can claim as a dependent.
  - Reimbursement Amount: Enter the amount requested for reimbursement.
- Sign and date your form.
- Attach the required documentation: send copies of records supporting each listed item of expense or have your Day Care Provider sign the statement below.
- Send completed form and attached documentation to gente.  
 For Prompt Service Fax to: 973-694-2913 or email: [claims@gente.solutions](mailto:claims@gente.solutions)

<b>Dependent Care Provider Statement:</b>	
I provided the Day Care services as stated above.	Tax ID# _____
_____ Day Care Provider Signature	_____ Date

I certify that the expenses listed above have been incurred by me and/or my dependent(s) and qualify for reimbursement, and that these expenses will not be claimed as a deduction on my personal income tax return.

\_\_\_\_\_  
Your Signature \_\_\_\_\_  
Date