



Internal Services Agency

Department of Personnel Services

Employee Benefits Office

AnnMarie Meyer, Manager

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## County of Sacramento

### DEPENDENT CARE CONTRACT

Employee Name \_\_\_\_\_ SSN \_\_\_\_\_

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Scheduled Payments \$ \_\_\_\_\_ EACH: DAY/WEEK/MONTH

Beginning \_\_\_\_\_ Date \_\_\_\_\_ Ending \_\_\_\_\_ Date \_\_\_\_\_

**I would like to be reimbursed (select one):**

Each Reimbursement Date  
(Twice a month on payday Friday)

2<sup>nd</sup> Reimbursement Date  
(Once a month on 2<sup>nd</sup> payday Friday)

Last Reimbursement Date  
(Once at end of the year)

**Please have your Child Care Provider sign verifying the above is true and correct:**

Provider Name \_\_\_\_\_ Tax I.D. or SSN \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

**IMPORTANT:**

- Services must be provided and funds must be in your account **before** they can be reimbursed.
- You may only claim work related expenses (do not include vacation or other non-work related expenses).
- It is your responsibility to submit a new contract immediately if there is a change in your dependent care provider, utilization, and/or rates.

I understand that by endorsing any reimbursement check and/or accepting a deposit of a reimbursement into my bank account that I am confirming that the dependent care expenses for which the amount is issued have been properly incurred according to the IRS regulations and the rules of the plan.

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**

Office Use Only

Reviewed By

Date