

DEPENDENT CARE

Provider 1:

Name _____
Address _____
SS# or EIN _____
Amount paid this year .. _____

Provider 2:

Name _____
Address _____
SS# or EIN _____
Amount paid this year .. _____

Provider 3:

Name _____
Address _____
SS# or EIN _____
Amount paid this year .. _____

Number of children under the age of thirteen
as of the end of the tax year _____

If one spouse has no earned income, answer the following:

Spouse is a full-time student five months out of the year YES NO
Spouse was physically or mentally incapable of self care YES NO

Did you incur dependent care expenses for dependents,
other than children who are physically or
mentally incapable of self care? YES NO