THE UNIVERSITY OF IOWA

DEPENDENT CARE SPENDING ACCOUNT RECEIPT

Participant Name: _____ ID#: _____
(Employee ID or University ID)

Amount: $_____

Dates of Service: From _____/_____/_____ to _____/_____/_____
month day year month day year

Name(s) of Dependent(s): _____

Service Provider Information:

Name of Provider: _____

Tax ID or SS#: _____

Address: _____

City: _____

State: _____ Zip Code: _____

_____ _____
Child Care Provider's Signature Date

The receipt must be attached to a Reimbursement Form or an Online Claim.