

**HAMDEN BOARD OF EDUCATION  
Dependent Care Assistance Plan  
Application for Reimbursement**

Employee Name: \_\_\_\_\_

Amount of Reimbursement: \_\_\_\_\_

Dependent Care Account funds cover care costs for your eligible dependents to enable you to work.

Please attach itemized statements from the Provider showing amount, date, and nature of expense, including person(s) expense is being incurred for, accompanied by receipts, cancelled checks, or other statements showing method and date of payments, if necessary.

I hereby certify that the above listed Dependent Care Expense has not been (and shall not be) reimbursed from any other source, and the Dependent Care Expense has not been (and shall not be) used by me (or my spouse, if applicable) in determining a credit toward my (or our) federal income tax liability.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date