Glynn Griffing & Associates
Professional Service. Personal Care.

P.O. Box 16509
Jackson, MS 39236

Dependent Care Certification Form

Employer Name: ____

Participant Name: ______________________________ Date: __________

This form is to verify that $ __________ was paid for dependent care expenses for the following dates:

Beginning: ____________________ and ending: ____________________

For the following person(s):

Name: ________________________ Age & Date of Birth: ______________

Name: ________________________ Age & Date of Birth: ______________

Name: ________________________ Age & Date of Birth: ______________

Signature of the Dependent Care Provider: ____________________________

Provider Tax ID or Social Security Number: ____________________________

Note: If you fax this form, please do not mail the original.

This form acts as a receipt from your day care provider.

Please submit this form along with a Reimbursement Request Form in order to be reimbursed for the day care expenses.

If you have any questions, please feel free to contact our office at (601) 982-0331.