 Childcare Reimbursement Request

Employee Name:       Employee ID:

Department Name:       Department Number:

|  |  |  |  |
| --- | --- | --- | --- |
| **Provider** | **Date(s)** | **Amount Paid** | **Reimbursement Requested** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
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**Certification: (required)**

I,       (insert name here), certify that I have incurred these cost(s) for child care because my child’s school or child care provider closed or is unable to continue providing care due to the pandemic necessitating me to find alternative care for my child/children in order to allow me to continue to do my job. I certify that I have received a referral form from the COVID Childcare Team.

## Authorization

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

**Human Resources** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Input By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pay Period End Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Any child care expense paid by Ramsey County on your behalf is considered a benefit by current tax legislations. Due to the COVID-19 pandemic tax code changes may occur.  We recommend that you check with your tax preparer to determine how this benefit may affect your tax status.***