

FORMS ARE DUE BY **5:00pm** ON THE **5th** OF EACH MONTH.  
 IF THE 5th IS A HOLIDAY OR WEEKEND, FORMS ARE DUE THE NEXT BUSINESS DAY BY 5:00pm.

**OARDC Child Care Program**

**Monthly Expense Reimbursement Form** *(Revised: March 2014)*

Employee/Student Name \_\_\_\_\_

Child Care Provider's Name \_\_\_\_\_

Provider's Address \_\_\_\_\_

Provider's Phone Number \_\_\_\_\_

Reimbursement Requested for Month/Year \_\_\_\_\_

Child's Name (one form per child) \_\_\_\_\_

Date	Daily \$ Amount Paid to Provider	\$ Amount Eligible \$25/day Maximum	Date	Daily \$ Amount Paid to Provider	\$ Amount Eligible \$25/day Maximum
1			16		
2			17		
3			18		
4			19		
5			20		
6			21		
7			22		
8			23		
9			24		
10			25		
11			26		
12			27		
13			28		
14			29		
15			30		
			31		

	(\$ Amt. Paid to Provider)	(\$ Amt. Eligible to Employee)
Total \$ Amounts For Month		

*Only hours during which both parents (or single custodial parent) were working or attending registered classes are eligible for reimbursement.  
 Child care hours during times of Sickness, FMLA Leave, Vacation, or OSU Holidays are **not** eligible for reimbursement*

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

*I hereby certify that the charges listed above are accurate and payment has been made of these amounts.*

❖ See page 2 for the Sample Form and Instructions for submitting child care expenses.

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***Fiscal Office and Child Care Program Use Only***

Total Amount to be Reimbursed \$ \_\_\_\_\_

Authorized by OARDC Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**OARDC Child Care Program *SAMPLE* Monthly Expense Reimbursement Form**

Employee/Student Name                     **BRUTUS BUCKEYE**                    

Child Care Provider's Name                     **XYZ CHILD CARE**                    

Provider's Address                     **123 Child Care Lane**                    

Provider's Phone Number                     **330-555-5555**                    

Reimbursement Requested for Month/Year                     **March 2014**                    

Child's Name (one form per child)                     **BEATRIX BUCKEYE**                    

Date	Daily \$ Amount Paid to Provider	\$ Amount Eligible \$25/day Maximum	Date	Daily \$ Amount Paid to Provider	\$ Amount Eligible \$25/day Maximum
1			16		
2			17	\$33	\$25
3	\$33	\$25	18	\$33	\$25
4	\$33	\$25	19	\$33	\$25
5	\$33	\$25	20	\$33	\$0 ( <i>home sick</i> )
6	\$33	\$25	21	\$33	\$0 ( <i>home sick</i> )
7	\$33	\$25	22		
8			23		
9			24	\$33	\$25
10	\$33	\$25	25	\$33	\$25
11	\$33	\$25	26	\$33	\$25
12	\$33	\$25	27	\$33	\$25
13	\$33	\$25	28	\$33	\$25
14	\$33	\$25	29		
15			30		
			31	\$33	\$25

	(\$ Amt. Paid to Provider)	(\$ Amt. Eligible to Employee)
Total \$ Amounts For Month	<b>\$693.00</b>	<b>\$475.00</b>

Employee Signature                     *Brutus Buckeye*                    

*I hereby certify that the charges listed above are accurate and payment has been made of these amounts.*

- ❖ **Hours eligible for reimbursement are only those during which both parents (or single custodial parent) were working or attending registered classes. Hours are not eligible if using child care provider during times of Sickness, FMLA Leave, Vacations, or OSU Holidays. A thirty minute grace period is allowed to provide time to drop off and pick up the child at the center. The maximum amount eligible is \$25/day.**
- ❖ **Return this form and original receipt(s) to the Child Care Program, OARDC Fiscal Office, Research Services Building, Wooster, OH 44691 on or before 5th day of the month by 5:00pm following services rendered. Reimbursements will not be paid until services are rendered. Please complete all columns on the form indicating the daily amount paid to the Provider and the amount eligible for reimbursement.**
- ❖ **Funds claimed and reimbursed through the OARDC Child Care Program cannot be claimed and reimbursed through The Ohio State University Dependent Care Flexible Spending Program, to do so is a violation of university policy and can result in disciplinary action up to and including termination.**