MMI FLEX
Bridging Benefits & Service

Verification of Dependent Care Expenses

NAME OF EMPLOYER: **LEON COUNTY SCHOOLS**

NAME OF EMPLOYEE:_____

SOCIAL SECURITY #:_____

This is to certify that my dependent receives childcare/dependent care services from

_____, Tax I.D.#_____.
(Dependent Care Provider)

My cost incurred for the plan year is $_____ for the following dependent(s):

Dependent(s) Name	Age*
_____	_____
_____	_____

_____ _____
Provider Signature Employee Signature

_____ _____
Date Date

*Qualifying child must be your dependent and under the age of 13.

Send completed form to: 125info@murfeemeadows.com, or fax to 205.871.9519