

2025 Dependent Care Expenses Form

Taxpayer Name: _____

Please provide your 2025 Child and Dependent Care Expenses

Complete each care providers information in full

#1 Care Provider's Name (Persons or Organizations):

Address:

Identifying number (SSN or EIN) 9 Digits:

Total Amount paid:

Qualifying Person(s) - Name the dependent/child who received the care services?

#2 Care Provider's Name (Persons or Organizations):

Address:

Identifying number (SSN or EIN) 9 Digits:

Total Amount paid:

Qualifying Person(s) - Name the dependent/child who received the care services?

#3 Care Provider's Name (Persons or Organizations):

Address:

Identifying number (SSN or EIN) 9 Digits:

Total Amount paid:

Qualifying Person(s) - Name the dependent/child who received the care services?