USA PAYROLL
USA PAYROLL AGENCY

FSA Administration
120 Linden Oaks
Rochester, New York 14625
Phone (585) 427-2010 Fax (585) 427-2293

Section 125 FSA - AFFIDAVIT OF DEPENDENT CARE COSTS

Employer Name: _____

EMPLOYEE INFORMATION

Social Security Number: _____
Employee Name: _____
Address: _____
City/State/Zip Code: _____
Department: _____

Hire Date: _____
Effective Date: _____
Sex: ☐ Male ☐ Female
Date of Birth: _____
Home Phone #: _____
Alternate Phone #: _____

List all dependents covered by this affidavit:
1.
2.
3.
4.
5.

Calendar Year for Dependent Care Costs: _____

Provide the Monthly and Annual Total of Dependent Care Costs for the above Calendar Year:

January	**$**	**July**	**$**
February	**$**	**August**	**$**
March	**$**	**September**	**$**
April	**$**	**October**	**$**
May	**$**	**November**	**$**
June	**$**	**December**	**$**
		Annual Total:	**$**

I, the undersigned Day Care Provider or Administrator, certify that the above costs are accurate for the dependent(s) of the above named employee. I also certify that the dependents are under the age of 13 and are eligible for reimbursement under a Flexible Spending Plan.

Provider's Name: _____ Tax ID #: _____

Provider's Signature: _____

I certify that the above expenses are accurate at this time. I also certify that if the expsenses change at any time during the plan year, it is my responsiblity to notify USA Payroll FSA Administration regarding the changes.

Employee Signature: _____ Date: _____