DEPENDENT CARE COST AFFIDAVIT

I,________________________________, residing at______________________________________
(PRINT NAME) (ADDRESS)

pay____for dependent care.
(NAME OF AGENCY, INSTITUTION, INDIVIDUAL PROVIDER)

I am currently receiving assistance from_________________________________to help me pay for my dependent care costs.
(DEPENDENT CARE SUBSIDY PROGRAM)

My household's total billed dependent care cost is $________per month.

I pay $________out-of-pocket for dependent care per month.

I declare under penalty of perjury under the laws of the State of California that the information provided in this affidavit is true, correct, and complete to the best of my knowledge.

SIGNATURE	DATE

(Fill out completely before signing.)