Care.com Personal Network Payment Receipt for Backup Care

All claims MUST be submitted within 30 days of the care taking place.

Only Backup Care days are eligible for reimbursement. **Today's Date**

Provider Information	**Provider/Business Name** **Street Address** **City, State, Zip** **Phone Number**
Service Detail	**Name of Benefit Holder** **Care Recipient(s) full name (s)/Ages(s)** **Service Description**

Service Rate ◯ Per Hour ◯ Per Day

Day of Week	Date of Care	Hours of Care		Service Rate	Total Rate		Work Hours	
		Start Time	End Time				Start Time	End Time
Monday				$	$			
Tuesday				$	$			
Wednesday				$	$			
Thursday				$	$			
Friday				$	$			
Saturday				$	$			
Sunday				$	$			
				Total	$			

I certify that this care meets the work-related requirement of the Backup Care program and does not include my family's regular care expenses.

Employee Signature **Date**

I certify that the information above, including dates of care and payment received by the above benefit holder, is true. I understand that I may be contacted by a representative to verify care.

Provider Signature **Date**