

## Child and Dependent Care Expenses

ORG35

**CHILD AND DEPENDENT CARE EXPENSES**

Enter below the persons or organizations who provided the child and dependent care.

First Name (if person) Last Name (if person) OR Provider Business Name Additional Business Name	Provider Address	ID Number SSN on first line OR EIN on second line	Amount Paid
Provider Phone			
1	..... ..... Care at above address?..... <input type="checkbox"/>	..... ..... Tax-Exempt.. ▶ <input type="checkbox"/>	..... ..... Foreign ..... ▶ <input type="checkbox"/>
2	..... ..... Care at above address?..... <input type="checkbox"/>	..... ..... Tax-Exempt.. ▶ <input type="checkbox"/>	..... ..... Foreign ..... ▶ <input type="checkbox"/>
3	..... ..... Care at above address?..... <input type="checkbox"/>	..... ..... Tax-Exempt.. ▶ <input type="checkbox"/>	..... ..... Foreign ..... ▶ <input type="checkbox"/>
4	..... ..... Care at above address?..... <input type="checkbox"/>	..... ..... Tax-Exempt.. ▶ <input type="checkbox"/>	..... ..... Foreign ..... ▶ <input type="checkbox"/>

EXPENSES	2017	2016
1 Total employment taxes paid on wages for child care expenses .....		
2 Total expenses paid in 2017 but not incurred in 2017 .....		
3 Total expenses incurred in 2017 but not paid in 2017 .....		
4 Medical expenses paid for qualifying persons unable to care for themselves .....		

STUDENT/DISABLED PERSON INFORMATION FOR 2017	Taxpayer	Spouse
5 If taxpayer or spouse was a full-time student or disabled in 2017, answer the following questions:  a Number of months that taxpayer/spouse was a full-time student or disabled .....  b Did taxpayer or spouse work and earn less than \$250/\$500 during the months entered on line 5a? If No, leave line 5b blank. If Yes, multiply the number of months working and earning less by either \$250/\$500 and enter that amount here .....		