

Please enter all amounts paid in 2021 for the care of one or more dependents which enables you to work or attend school. Enter the amount of dependent care expenses paid for each qualifying dependent on Organizer Form ID:1040

	Taxpayer	Spouse
2020 employer-provided dependent care benefits used during 2021 grace period	+ _____ [3]	+ _____ [4]
Employer-provided dependent care benefits that were forfeited in 2021	+ _____ [5]	+ _____ [6]
Total qualified expenses incurred in 2021		_____ [9]
Were you or your spouse a full time student or disabled? (Yes or No)	_____ [10]	_____ [11]
Did you provide care expenses for any person(s) who is not listed as a dependent? (Y, N)		_____ [12]

Business name of provider \_\_\_\_\_  
 First and last name of provider \_\_\_\_\_  
 Street address of provider \_\_\_\_\_  
 City, State and Zip code \_\_\_\_\_  
 Social security number OR Employer identification number \_\_\_\_\_  
 Tax Exempt / LAFCP / Due Diligence (1 = Tax Exempt, 2 = Living Abroad Foreign Care Provider, 3 = Provider moved and unable to get TIN, 4 = Provider refuses to give TIN) \_\_\_\_  
 Amount paid to care provider in 2021 + \_\_\_\_\_ [7]  
 Foreign province or state of provider \_\_\_\_\_  
 Foreign country and Foreign postal code of provider \_\_\_\_\_

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