Loyola University Maryland  
2018-2019 Employee Child Care Voucher Program  
(July 1, 2018 through June 30, 2019)

Monthly Cost Verification Form  
(Please print or type)

The employee is responsible for the timely completion and submission of this form. Incomplete forms will be returned to the sender for completion. Late forms will not be processed for payment. All forms must be submitted in a single PDF File Format.

Loyola Parent/Guardian ____________________ Loyola ID# __________________
******************************************************************************************

Provider/Center A.) _____________________________________________________________
   Telephone A.) __________________________
   Provider’s Address A.) _________________________________________________________
   Provider’s Federal ID # A.) __________________________

Provider/Center B.) _____________________________________________________________
   Telephone B.) __________________________
   Provider’s Address B.) _________________________________________________________
   Provider’s Federal ID # B.) __________________________

Provider/Center C.) _____________________________________________________________
   Telephone C.) __________________________
   Provider’s Address C.) _________________________________________________________
   Provider’s Federal ID # C.) __________________________
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This reimbursement request is for the month of __________________ Year _______

<table>
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<tr>
<th>Corresponding Provider letter (ex. A)</th>
<th>Full name(s) of child(ren)</th>
<th>Age</th>
<th>Full or Part Day</th>
<th>Attendance Hours per Week</th>
<th>Full Amount Paid for this child for this month</th>
<th>For HR Use Only</th>
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* Eligible types of child care include only Full or Part Day: Infant Care; Toddler Care; Preschool/Pre-Kindergarten; Before School; After School; Before and After Combined; and summer day care expenses.

NOTE: You must attach a copy of the payment receipt from your day care provider in order to receive reimbursement. Incomplete forms cannot be processed.

Employee Signature ___________________________________________ Date __________________

Please Print Name _______________________________ Employee Telephone __________________

Please email your completed form to the Benefits & Wellness Unit at ccvp@loyola.edu or fax to 410-617-5072

------------------------------------------------------------------This Space for HR Entries Only-----------------------------------

Date Processed: __________________________

HR Approving Signature: ___________________ Reimbursement Total: ____________________