



VANTAGE FLEX, LLC.

RECEIPT FOR DEPENDENT CARE PAYMENTS

DATE	AMOUNT	PROVIDER
_____	_____	NAME _____
_____	_____	ADDRESS _____
_____	_____	CITY _____
_____	_____	STATE _____ ZIP _____
_____	_____	SS#/ID# _____
TOTAL AMOUNT	_____	
	-	

I RECEIVED THE ABOVE AMOUNT FROM _____ FOR DEPENDENT CARE SERVICES I PROVIDED.

SIGNED _____ DATE _____
(PROVIDER)