OMB Control No. 2900-XXXX
Estimated Burden: 10 Minutes
Expiration Date: XX/XX/20XX

Department of Veterans Affairs

VETERAN CHILD CARE REIMBURSEMENT CLAIM FORM

VA BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-XXXX, and it expires XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 10 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-XXXX in any correspondence. Do not send your completed VA Form 10-382 to this email address.
PRIVACY ACT STATEMENT: VA is asking you to provide the information on this form is solicited under 38 U.S.C. Section 17.324 to determine your eligibility for reimbursement for obtaining licensed community child care services during your eligible VA medical appointment. Information you supply may be verified through a computer-matching program. The information collected will become part of the Consolidated Health Record that complies with the Privacy Act of 1974. This form is part of a system of records identified as 24VA19 "Patient Medical Record–VA" as set forth in the Compilation of Privacy Act Issuances via online GPO access at https://www.gpo.gov/privacy. VA may disclose the information that you put on this form as permitted by law; including "routine use" disclosures. Information collected will not be used for any other purpose. Your provision of information is voluntary; however, failure to furnish the required information will result in an inability to provide services or process your claim, but will have no adverse effect on any other benefit to which you may be entitled.

1. VETERAN'S NAME *(Last, First, Middle Initial)*	2. VETERAN'S VA IDENTIFICATION NUMBER *(or Last 4 of SSN)*

3. VETERAN'S CELL PHONE NUMBER	4. VETERAN'S ADDRESS

5. DATE(S) NON-VA LICENSED CHILD CARE WAS USED FOR VA APPOINTMENTS *(MM/DD/YYYY)*	6. AMOUNT(S) PAID *(Per Individual Date)* FOR NON-VA LICENSED CHILD CARE

7. NAMES OF CHILDREN FOR WHICH CHILD CARE WAS OBTAINED

8. ATTACH COPY OF RECEIPT

Add Attachments

Penalty Statement: Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

I certify that I am an eligible Veteran under 38 CFR 17.324 and have incurred a cost related to child care services obtained from a licensed, community child care provider at the time of my eligible VA medical appointment. I have attached a copy of a receipt verifying expenses from the licensed child care provider. I am the only person claiming reimbursement for this episode of child care services and have not previously received payment for this particular child care service. I certify that the statements in this document are true and complete to the best of my knowledge.

9. VETERAN SIGNATURE	10. DATE SIGNED *(MM/DD/YYYY)*