Child and Dependent Care Expenses Credit Additional Schedule

CALIFORNIA FORM

3506

SSN or ITIN

Attach to your California Form 540, 540A, or Long Form 540NR.

Name(s) as shown on return

CHCR C AND S S				4	490-54-9	999
Part II Persons or Organizations Who Pro	vided the (Care in California	- Schedule Attatchment			
		Pro	ovider		Pi	ovider
a. Care provider's name	•			•		
b. Care provider's address						
(number, street, apt. no., city, state, and						
ZIP Code)	•			•		
c. Care provider's telephone number	•			•		
d. Is the provider a person or organization?		Person	Organization		Person	Organization
e. Identification number (SSN, ITIN, or FEIN)	•			•		
f. Address where care was provided						
(number, street, apt. no., city, state, and						
ZIP Code) PO Box not acceptable.						
g. Amount paid for care provided	•			•		

			Provider			P	rovider
a.	Care provider's name	•			•		
b.	Care provider's address						
	(number, street, apt. no., city, state, and						
	ZIP Code)	•			•		
c.	Care provider's telephone number	•			•		
d.	Is the provider a person or organization?		Person	Organization		Person	Organization
e.	Identification number (SSN, ITIN, or FEIN)	•			•		
f.	Address where care was provided						
	(number, street, apt. no., city, state, and						
	ZIP Code) PO Box not acceptable.						
g.	Amount paid for care provided	•			•		

			P	Provider				Provider	
a.	Care provider's name	•				•			
b.	Care provider's address								
	(number, street, apt. no., city, state, and								
	ZIP Code)	•				•			
c.	Care provider's telephone number	•				•			
d.	Is the provider a person or organization?		Person		Organization		Person		Organization
e.	Identification number (SSN, ITIN, or FEIN)	•				•			
f.	Address where care was provided								
	(number, street, apt. no., city, state, and								
	ZIP Code) PO Box not acceptable.								
g.	Amount paid for care provided	•				•			

			Provide	er		Provid	der	
a.	Care provider's name	•			•			
b.	Care provider's address							
	(number, street, apt. no., city, state, and							
	ZIP Code)	•			•			
c.	Care provider's telephone number	•			•			
d.	Is the provider a person or organization?		Person	Organization		Person	Organization	
e.	Identification number (SSN, ITIN, or FEIN)	•			•			
f.	Address where care was provided							
	(number, street, apt. no., city, state, and							
	ZIP Code) PO Box not acceptable.							
g.	Amount paid for care provided	•			•			

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Part II Persons or Organizations Who Pro	vided the (Care in California	- Schedule Attatchment			
		Pro	ovider		Pi	ovider
a. Care provider's name	•			•		
b. Care provider's address						
(number, street, apt. no., city, state, and						
ZIP Code)	•			•		
c. Care provider's telephone number	•			•		
d. Is the provider a person or organization?		Person	Organization		Person	Organization
e. Identification number (SSN, ITIN, or FEIN)	•			•		
f. Address where care was provided						
(number, street, apt. no., city, state, and						
ZIP Code) PO Box not acceptable.						
g. Amount paid for care provided	•			•		

			Provider			P	rovider
a.	Care provider's name	•			•		
b.	Care provider's address						
	(number, street, apt. no., city, state, and						
	ZIP Code)	•			•		
c.	Care provider's telephone number	•			•		
d.	Is the provider a person or organization?		Person	Organization		Person	Organization
e.	Identification number (SSN, ITIN, or FEIN)	•			•		
f.	Address where care was provided						
	(number, street, apt. no., city, state, and						
	ZIP Code) PO Box not acceptable.						
g.	Amount paid for care provided	•			•		

			P	Provider				Provider	
a.	Care provider's name	•				•			
b.	Care provider's address								
	(number, street, apt. no., city, state, and								
	ZIP Code)	•				•			
c.	Care provider's telephone number	•				•			
d.	Is the provider a person or organization?		Person		Organization		Person		Organization
e.	Identification number (SSN, ITIN, or FEIN)	•				•			
f.	Address where care was provided								
	(number, street, apt. no., city, state, and								
	ZIP Code) PO Box not acceptable.								
g.	Amount paid for care provided	•				•			

			Provide	er		Provid	der	
a.	Care provider's name	•			•			
b.	Care provider's address							
	(number, street, apt. no., city, state, and							
	ZIP Code)	•			•			
c.	Care provider's telephone number	•			•			
d.	Is the provider a person or organization?		Person	Organization		Person	Organization	
e.	Identification number (SSN, ITIN, or FEIN)	•			•			
f.	Address where care was provided							
	(number, street, apt. no., city, state, and							
	ZIP Code) PO Box not acceptable.							
g.	Amount paid for care provided	•			•			

•

•

•

Part III Credit	for Child and Dependent (Care Expenses - Schedule Attatch	hment		
2 Information abo	out your qualifying person	(s).			
Q	(a) ualifying person's name Last	(b) Qualifying person's social security number (SSN) (See instructions)	(c) Qualifying person's date of birth (DOB - mm/dd/yyyy) or if disabled	(d) Percentage of physical custody (See instructions)	(e) Qualified expenses you incurred and paid in 2019 for the qualifying person's care in California
			• DOB:		
•	•	•	Disabled Yes	•	•
			• DOB:		
•	•	•	Disabled Yes	•	•
			• DOB:		
•	•	•	Disabled Yes	•	•
			• DOB:		
•	•	•	Disabled Yes	•	•
			• DOB:		
•	•	•	Disabled Yes	•	•
			• DOB:		
•	•	•	Disabled Yes	•	•
			DOB:		
•	•	•	Disabled Yes	•	•
			• DOB:		
•	•	•	Disabled Yes	•	•
			• DOB:		
•	•	•	Disabled Yes	•	•
			• DOB:		
•	•	•	Disabled Yes	•	•
			• DOB:		
•	•	•	Disabled Yes	•	•
			• DOB:		
	1			1	1

Disabled Yes

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