Administrative Office of Pennsylvania Courts

DEPENDENT CARE ACCOUNT

INITIAL EMPLOYMENT ENROLLMENT FORM

Before completing this form, please carefully read the information on page 2. Unless you become eligible for mid-year enrollment because of a qualified change of status, this form must be received by the AOPC Payroll Department **within 60 days of your employment start date** to enable you to participate in the Dependent Care Account Program during 2020. You should carefully estimate your qualified dependent care expense for the calendar year (see statements 1 – 5 on page 2). Please print or type your information.

Employee Name

____ XXX - XX - ________

Last name, first name & middle initial | Last 4 digits of social security #

Amount to be deducted per pay period
$ ___________. ____

Total amount to be deducted for 2020
$ ___________. ____

Not less than $25 per biweekly pay period or $50 per monthly pay period.

Name(s) of Eligible Dependent(s)	DATE OF BIRTH			DISABLED		RELATIONSHIP		
(Last, First, Middle Initial)	Mo	Day	Year	Yes	No	Child	Spouse	Parent

__________________________________ ______________________

Employee Signature | Date

Please return completed form to:
Payroll Unit
The Administrative Office of Pennsylvania Courts
P.O. Box 61260
Harrisburg, Pennsylvania 17106-1260
Fax: 717-231-3299
Email: Payroll@pacourts.us

Dependent Care Account Enrollment Form

I have received and read the Employee Information Booklet regarding the Dependent Care Account Program and understand the regulations governing contributions to and reimbursements from my Dependent Care Account. I understand that:

1. I may enroll, terminate participation or change my deduction during the remainder of 2020 **only** if I have a Qualified Change of Status listed below.
2. Any change to my Dependent Care Account deduction must be made within 60 calendar days of the Qualified Change of Status.
3. My gross salary will be reduced by the deduction amount I specify per pay period until the amount deducted equals the total annual amount I specify.
4. The deduction from my gross salary will begin with the first regular payroll of the calendar year following the receipt of my enrollment form by the Payroll Department.
5. The total annual amount to be deducted which I specify must not be greater than the amount allowable by IRS for my tax filing status and other criteria. If my annual deduction is greater than the amount allowable, I may have to pay the applicable taxes on the excess.
6. IRS regulations require that any money remaining in my account after all qualified reimbursements for the calendar year have been paid cannot be returned to me or carried forward to the next year but **must be forfeited**. I have until March 1 to submit a claim for eligible expenses for the prior year.
7. I am responsible for maintaining the required documentation to substantiate my eligibility for the program and my dependent care expenses.
8. By participating in the Dependent Care Account Program, my social security wages and tax will be reduced and consequently my future social security benefits may be lower.

Qualified Change of Status Events

01 Birth or adoption of a child
02 Placement for adoption
03 Gain custody of dependent
04 Lose custody of dependent
05 Child becomes 13 years old
06 Death of dependent
07 Marriage
08 Annulment
09 Legal separation
10 Divorce
11 Death of a spouse
12 Change in residence of self, spouse or dependent that affects eligibility for coverage
13 Change in employment status of self, spouse or dependent including the start or end of employment and the beginning or end of leave without pay
14 Change in provider
15 Significant increase or decrease in cost of dependent care if the provider is not a relative
16 Increase or decrease in hours of dependent care
17 Dependent receiving care is no longer eligible

If you have any questions regarding the Dependent Care Account Program, please feel free to call the AOPC Payroll Unit at 717-231-3325.