

FCAP Status Change Packet

Family Care Account Program (FCAP) Status Change

This packet is 4 pages, including this page of instructions, and provides:

- Fax Cover Sheet to the HR Service Center
- Family Care Account Program Status Change Form

Instructions

1. Complete the form electronically. (Note: Your typed name in the "employee signature" field will serve as your electronic signature for online submission.)
2. Save a copy of the completed packet to your desktop.
3. If an Employee Self Service (ESS) user, you may submit the completed packet one of two ways:
 - a. Submit the packet online
 - i. Log into ESS (<https://www.myworkplace.pa.gov>)
 - ii. Click "Login"
 - iii. Click "Ask HR and View My Cases", located under the Ask HR widget
 - iv. In the "Subject" field, enter "FCAP Reimbursement"
 - v. In the "Issues" field, enter your preferred contact information (phone number or email address) along with the best time to contact you within the hours of 7:30 am and 5:00 pm Monday - Friday
 - vi. Under "Attachments", click "Add Attachment"; browse to your desktop and attach your saved packet
 - vii. Click "Submit" (a confirmation page will appear with your assigned case number)
 - b. Or save, print and fax the completed packet to 717.425.7190. Please remember to complete the Fax Cover Sheet.
4. Non ESS users may print and fax the completed packet to 717.425.7190. Please remember to complete the Fax Cover Sheet.
5. Retain a copy of the completed packet for your records.

FCAP Fax Cover Sheet

Status Change

To: HR Service Center **From:** _____

Fax: 717.425.7190 **Employee number:** _____

Date: _____ **Employee phone:** _____

of Pages: _____ (including this cover sheet)

Attached please find:

Fax Cover Sheet

Completed FCAP Status Change Form

Please retain a copy of this packet and the fax confirmation page for your records.

Questions? HR Service Center



Phone: 866.377.2672

PA Relay: 711

Fax: 717.425.7190

Email:

RA-HRSCfcap@pa.gov

7:30 a.m. – 5:00 p.m. Monday – Friday

Interpreters are available by request

Need More Information?

Visit the Employee Resource Center

www.employeeresourcecenter.oa.pa.gov

Not an Employee?

www.myHRonline.state.pa.us

Mail to HR Service Center

PO Box 824, Harrisburg PA 17108-0824

**PENNSYLVANIA STATE EMPLOYEE FAMILY CARE ACCOUNT PROGRAM
STATUS CHANGE**

DO NOT USE THIS FORM FOR ENROLLMENT. PLEASE PRINT OR TYPE.

KEEP A COPY FOR YOUR RECORDS

DATE OF EVENT OR CHANGE IN FAMILY STATUS MM/DD/YYYY		PAY DATE OF CHANGE MM/DD/YYYY		POSITION # (COMPLETE FOR DUAL EMPLOYMENT)		
NAME (LAST, FIRST, MI)						
WORK TELEPHONE NUMBER		HOME TELEPHONE NUMBER (xxx) xxx-xxxx (XXX) XXX-XXXX		CURRENT BIWEEKLY DEDUCTION		CURRENT ANNUAL CONTRIBUTION
<input type="checkbox"/> CHANGE (U)	<input type="checkbox"/> STOP (D)	NUMBER OF PAY PERIODS LEFT IN THE CALENDAR YEAR		PERSONNEL NUMBER		
SUBMISSION DATE MM/DD/YYYY	TYPE OF ACTION IT170 – FAMILY CARE ACC		NEW BIWEEKLY DEDUCTION		NEW ANNUAL CONTRIBUTION	
CHANGE IN STATUS CODE		DEPENDENT'S NAME			DATE STATUS CHANGE OCCURRED	
					MO	DAY
<input type="checkbox"/> 01 BIRTH OR ADOPTION OF CHILD						
<input type="checkbox"/> 02 PLACEMENT FOR ADOPTION						
<input type="checkbox"/> 03 GAIN CUSTODY OF DEPENDENT						
<input type="checkbox"/> 04 LOSE CUSTODY OF DEPENDENT						
<input type="checkbox"/> 05 CHILD BECOMES 13 YEARS OLD						
<input type="checkbox"/> 06 DEATH OF DEPENDENT						
<input type="checkbox"/> 07 MARRIAGE						
<input type="checkbox"/> 08 ANNULMENT						
<input type="checkbox"/> 09 LEGAL SEPARATION						
<input type="checkbox"/> 10 DIVORCE						
<input type="checkbox"/> 11 DEATH OF SPOUSE						
<input type="checkbox"/> 12 CHANGE IN RESIDENCE (OF SELF, SPOUSE, OR DEPENDENT THAT AFFECTS ELIGIBILITY FOR COVERAGE)						
<input type="checkbox"/> 13 CHANGE IN EMPLOYMENT STATUS (OF SELF, SPOUSE, OR DEPENDENT THAT INCLUDES START OR END OF EMPLOYMENT, STRIKE OR LOCKOUT, BEGINNING OR END OF A LEAVE WITHOUT PAY, AND CHANGE IN WORKSITE)						
<input type="checkbox"/> 14 CHANGE IN PROVIDER						
<input type="checkbox"/> 15 SIGNIFICANT INCREASE OR DECREASE IN COST OF FAMILY CARE (PROVIDER CANNOT BE A RELATIVE)						
<input type="checkbox"/> 16 INCREASE OR DECREASE IN HOURS OF FAMILY CARE						
<input type="checkbox"/> 17 DEPENDENT RECEIVING CARE IS NO LONGER ELIGIBLE						
<p>I authorize the Commonwealth of Pennsylvania to reduce my gross biweekly pay by the new biweekly deduction specified above.</p> <p>I understand that according to Federal Regulation, any money remaining in the account after all timely claims for the year have been submitted must be forfeited.</p> <p>I certify that the information provided on this form is true and complete. I understand that any misstatement or falsification of material facts will result in my removal from the Family Care Account Program and may further cause an IRS and/or State audit with possible additional tax, interest, and penalties.</p>						
EMPLOYEE SIGNATURE					DATE MM/DD/YYYY	

I have read the Family Care Account Program Booklet and I understand that:

- (1) I may disenroll, or change my deductions **only** during the annual open enrollment or within 60 days of a Change in Status as listed below.
- (2) A Change in Status **must** be reported within 60 days of the event to qualify for a mid-year change in deductions.
- (3) My gross biweekly pay will be reduced every pay period by the amount I specify on this Enrollment Form.
- (4) I have carefully read the booklet section on “How Much Money Can I Put Into My Account?”. My annual deduction must not be greater than the IRS approved maximum deduction for my tax filing status and family situation. If my deduction is greater than what the IRS allows, I may have to pay taxes on the excess amount.
- (5) My family care account must be used only for IRS approved dependent care expenses incurred during the calendar year.
- (6) **Under IRS regulation, any amount remaining in my family care account after all timely claims have been submitted must be forfeited.**
- (7) As a result of reducing my taxable wages for the calendar year, my future Social Security benefit may be lower.

CHANGE IN STATUS CODES

- 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 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 (includes start or end of employment, strike or lockout, beginning or end of a leave without pay, and change in worksite)**
- 14 Change in provider**
- 15 Significant increase or decrease in cost of family care (provider cannot be a relative)**
- 16 Increase or decrease in hours of family care**
- 17 Dependent receiving care is no longer eligible**