WES MOORE
Governor

ARUNA MILLER
Lieutenant Governor

Maryland
DEPARTMENT OF BUDGET AND MANAGEMENT

YAAKOV "JAKE" WEISSMANN
Secretary

MARC L. NICOLE
Deputy Secretary

DEPENDENT CARE FSA (DCFSA)

CHANGE IN STATUS

Name: _____

W#: _____

Description of Change:

- Date of Change in Cost: ___/___/_____
- Original Annual Election: $_____
- New Estimated Annual Costs: $_____
- New Annual Election Amount: $_____

Reason for Change (check one):

- (●) Change in provider rate (decrease)
- ( ) Change in provider
- ( ) Dependent no longer requires full-time care
- ( ) Other: _____

Employee Certification

I certify that the information above is accurate and that I have experienced a change in status consistent with IRS regulations. I am reducing my election because my qualified dependent care expenses have decreased. I understand that I am responsible for any tax liabilities if this reduction is deemed ineligible.

Signature: _____ Date: