A guide for family care

June 28, 2022

NYS Workers' Compensation Board

Agenda

1. Why New York Needs Paid Family Leave
2. Eligibility, Benefits and Contributions
3. Taking Paid Family Leave for Family Care
4. Top Questions About Paid Family Leave for Family Care
5. Paid Family Leave and COVID-19
6. Resources
7. Questions

Why do we need Paid Family Leave?

Why do we need Paid Family Leave?

1. Employees struggle to choose between maintaining a job and caring for loved ones.
2. Employees face the stress of weeks of lost wages.
3. Employees fear losing their jobs.

New York leads the nation

In April 2016, New York State enacted the nation's strongest and most comprehensive Paid Family Leave policy into law.

- Paid Family Leave is employee-funded insurance that helps workers be there for their family when they're most needed.
- Workers no longer have to choose between caring for their loved ones and their jobs.

Paid Family Leave basics

Provides **paid time off** and **job protection** so you can:

Bond with a new child

Care for a family member with a serious health condition

Assist loved ones when a spouse, domestic partner, child, or parent is deployed abroad

Paid Family Leave & COVID-19

Care for yourself or your minor dependent child when under an order of quarantine or isolation due to COVID-19.

Your rights and protections

Paid time off and:

- **Job protection**.
- **Continued health insurance** while on leave, on the same terms as if you had continued to work.
- **Protection from discrimination and retaliation** for requesting or taking Paid Family Leave.

Paid Family Leave for family care

Caring for a family member with a serious health condition

Proven benefits:

- Increased quality of care for a family member.
- Improved pediatric, medical and surgical experience.
- Improved management of chronic diseases.
- Increased meaning and purpose for the caregiver.
- Limits length of hospital stays, readmissions, emergency room use.
- Decreased stress regarding financial stability.

Caring for a family member with a serious health condition

Qualifying family members include:

- Spouse
- Domestic partner
- Child
- Stepchild
- Parent
- Parent-in-law
- Stepparent
- Grandparent
- Grandchild

NEW! Effective January 1, 2023, siblings will be included in family members eligible to receive family care under Paid Family Leave.

These family members **can live outside** of New York State and even outside the U.S.

Caring for a family member with a serious health condition

A serious health condition is defined as an illness, injury, impairment, or physical or mental health condition requiring either:

- **Inpatient care;** or
- **Continuing treatment or supervision** by a health care provider.

A COVID-19 diagnosis may be considered a serious health condition.

Caring for a family member with a serious health condition

Examples of conditions that may qualify as serious health conditions:

- your mother is receiving chemotherapy and needs emotional support,
- your spouse/domestic partner is recuperating from surgery,
- your child is undergoing treatment for addiction.

Caring for a family member with a serious health condition

Examples of health conditions not considered serious under Paid Family Leave:

- common cold/flu
- routine dental, orthodontia
- cosmetic treatment

Benefits & contributions

Time off and wage benefits

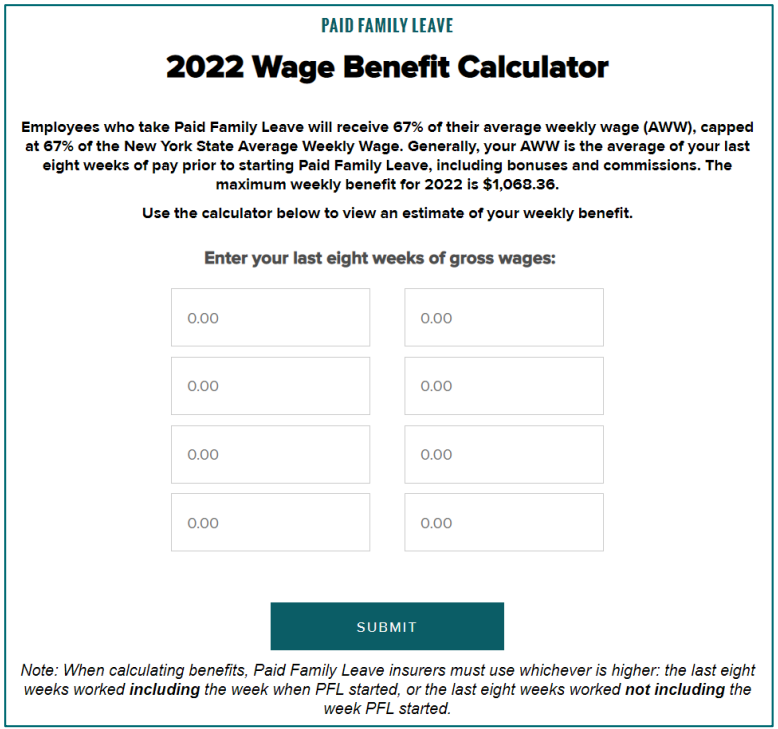
Eligible employees may take up to **12** weeks of PFL.

BENEFITS FOR 2022		
Year	**Weeks of Leave**	**Benefits**
2022	12 Weeks	67% of employee's AWW, Up to 67% of SAWW

Wage benefit calculator

A wage benefit calculator is available:

PaidFamilyLeave.ny.gov/PFLbenefitscalculator2022



PAID FAMILY LEAVE

2022 Wage Benefit Calculator

Employees who take Paid Family Leave will receive 67% of their average weekly wage (AWW), capped at 67% of the New York State Average Weekly Wage. Generally, your AWW is the average of your last eight weeks of pay prior to starting Paid Family Leave, including bonuses and commissions. The maximum weekly benefit for 2022 is $1,068.36.

Use the calculator below to view an estimate of your weekly benefit.

Enter your last eight weeks of gross wages:

0.00	0.00
0.00	0.00
0.00	0.00
0.00	0.00

SUBMIT

*Note: When calculating benefits, Paid Family Leave insurers must use whichever is higher: the last eight weeks worked **including** the week when PFL started, or the last eight weeks worked **not including** the week PFL started.*

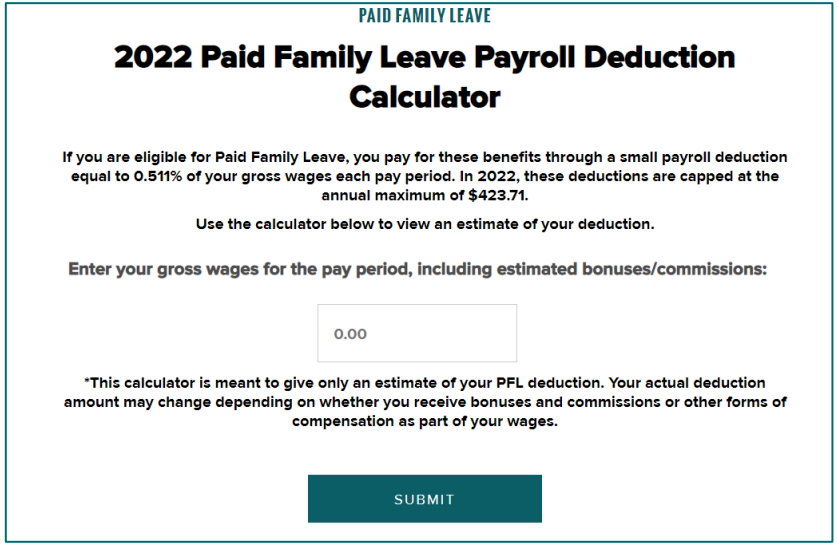
How much do you pay?

- In 2022, the payroll contribution is **0.511%** of your gross wages each pay period, capped at an annual maximum of **$423.71**
- If you earn less than the New York State Average Weekly Wage, your annual contribution will be less than the cap

Weekly deduction calculator

A weekly deduction calculator is available:

PaidFamilyLeave.ny.gov/paid-family-leave-calculator2022



PAID FAMILY LEAVE

2022 Paid Family Leave Payroll Deduction Calculator

If you are eligible for Paid Family Leave, you pay for these benefits through a small payroll deduction equal to 0.511% of your gross wages each pay period. In 2022, these deductions are capped at the annual maximum of $423.71.

Use the calculator below to view an estimate of your deduction.

Enter your gross wages for the pay period, including estimated bonuses/commissions:

0.00

*This calculator is meant to give only an estimate of your PFL deduction. Your actual deduction amount may change depending on whether you receive bonuses and commissions or other forms of compensation as part of your wages.

SUBMIT

Summarizing the updates for 2022

- **Maximum weekly benefit increase**: Benefit increased from $971.61 to **$1,068.38**
- **Employee contribution rate**: As of January 1, 2022, employers may deduct at the rate of **0.511%** of an employee's gross wages each pay period, capped at an annual maximum of **$423.71**

Full details at: **PaidFamilyLeave.ny.gov/2022**

Employee eligibility

Who is covered?

- Most employees who work for private employers.
- If you work for a public employer, your employer may opt in.
- If you're a public employee represented by a union, you may be covered if Paid Family Leave is collectively bargained.

Who is eligible?

Employees who work for covered employers are eligible if you:

- **Regularly work 20 or more hours per week.**
  - After 26 consecutive weeks of employment with the same employer.
- **Regularly work fewer than 20 hours per week.**
  - For 175 days with the same employer.

Citizenship and/or immigration status is not a factor in eligibility.

Who is eligible?

- **NEW! Domestic workers**
  - Effective January 1, 2022
  - Covered for disability benefits and Paid Family Leave if employee is working 20 or more hours per week for the private homeowner
  - Eligible once in employment for 26 consecutive weeks

Can you waive coverage?

You can only waive coverage if you:

- **Regularly work 20 or more hours per week** but won't be in employment with your employer for 26 consecutive weeks; or
- **Regularly work fewer than 20 hours per week** and won't work 175 days in a 52-week period.

Employers must provide a waiver form to all employees who qualify.

Employees who properly file a waiver will be **ineligible** for benefits and **exempt** from making contributions.

Taking Paid Family Leave for family care

How to request leave

Step 1

Notify your employer

Step 2

Complete the request forms

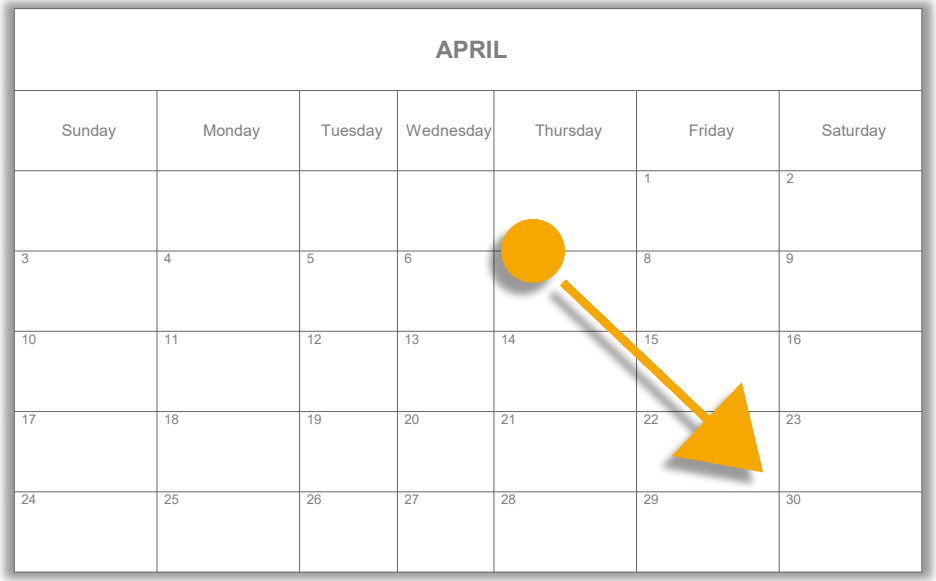
Step 3

Send forms to the **insurance carrier**

Notify your employer **at least 30 days before the start of your leave** if foreseeable, or as soon as possible. Insurers must pay or deny the request within **18 days of receiving a completed request,** or the first day of leave, whichever is later.

Step 1: Inform your employer

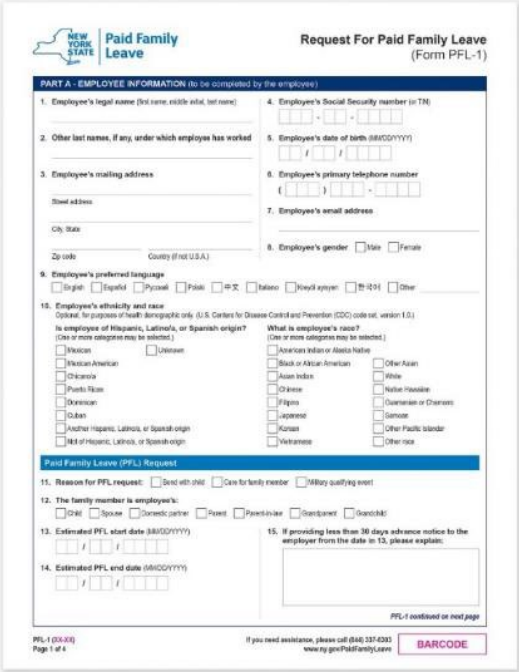
Let your employer know at least 30 days before your leave will start, if it's foreseeable.



Step 2: Complete the required PFL request forms

Family Care leave package includes three forms:

- *Request for Paid Family Leave (Form PFL-1)*
- *Release of Personal Health Information (Form PFL-3)*
- *Health Care Provider Certificate (Form PFL-4)*



NEW YORK STATE Paid Family Leave

Request For Paid Family Leave
(Form PFL-1)

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

1. Employee's legal name (first name, middle initial, last name)
2. Other last names, if any, under which employee has worked
3. Employee's mailing address
Street address
City, State
Zip code
Country (if not U.S.A.)
4. Employee's Social Security number (or ITN)
5. Employee's date of birth (MM/DD/YYYY)
6. Employee's primary telephone number
7. Employee's email address
8. Employee's gender Male Female
9. Employee's preferred language
English Español Русский Polski 中文 Italiano Kreyòl ayisyen 한국어 Other
10. Employee's ethnicity and race
Optional, for purposes of health demographic only. (U.S. Centers for Disease Control and Prevention (CDC) code set, version 1.0.)
Is employee of Hispanic, Latino/a, or Spanish origin? (One or more categories may be selected.)
Mexican Unknown
Mexican American
Chicano/a
Puerto Rican
Dominican
Cuban
Another Hispanic, Latino/a, or Spanish origin
Not of Hispanic, Latino/a, or Spanish origin
What is employee's race? (One or more categories may be selected.)
American Indian or Alaska Native
Black or African American
Asian Indian
Chinese
Filipino
Japanese
Korean
Vietnamese
Other Asian
White
Native Hawaiian
Guamanian or Chamorro
Samoan
Other Pacific Islander
Other race

Paid Family Leave (PFL) Request

11. Reason for PFL request: Bond with child Care for family member Military qualifying event
12. The family member is employee's:
Child Spouse Domestic partner Parent Parent-in-law Grandparent Grandchild
13. Estimated PFL start date (MM/DD/YYYY)
14. Estimated PFL end date (MM/DD/YYYY)
15. If providing less than 30 days advance notice to the employer from the date in 13, please explain:

PFL-1 continued on next page

PFL-1 (XX-XX)
Page 1 of 4

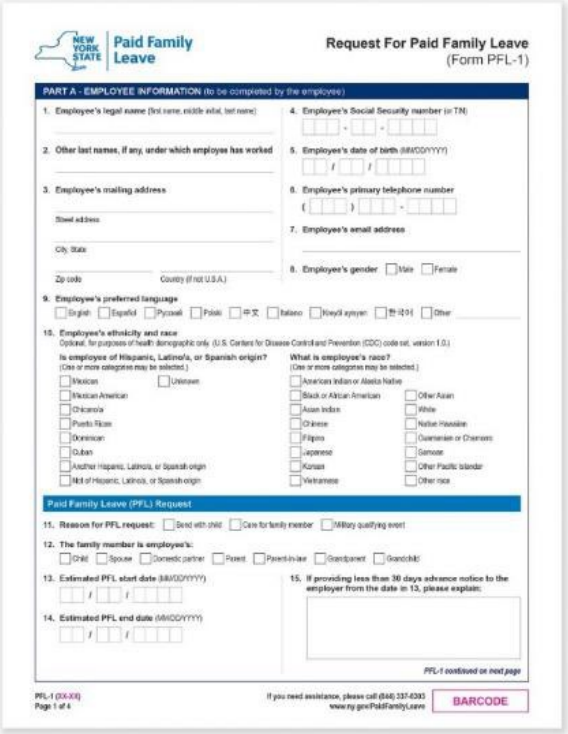
If you need assistance, please call (844) 337-8383
www.ny.gov/PaidFamilyLeave

BARCODE

Getting request forms

You can get Paid Family Leave request forms from:

- Your employer,
- Your employer's insurance carrier, or
- **PaidFamilyLeave.ny.gov/forms**



NEW YORK STATE | Paid Family Leave

Request For Paid Family Leave
(Form PFL-1)

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

1. Employee's legal name (first name, middle initial, last name)
2. Other last names, if any, under which employee has worked
3. Employee's mailing address
   Street address
   City, State
   Zip code
   Country (if not U.S.A.)
4. Employee's Social Security number (or TIN)
5. Employee's date of birth (MM/DD/YYYY)
6. Employee's primary telephone number
7. Employee's email address
8. Employee's gender ☐ Male ☐ Female
9. Employee's preferred language
   ☐ English ☐ Español ☐ Русский ☐ Polski ☐ 中文 ☐ Italiano ☐ Kreyòl ayisyen ☐ 한국어 ☐ Other
10. Employee's ethnicity and race
    Optional, for purposes of health demographic only. (U.S. Centers for Disease Control and Prevention (CDC) code set, version 1.0.)

    Is employee of Hispanic, Latino/a, or Spanish origin?
    (One or more categories may be selected.)
    ☐ Mexican ☐ Unknown
    ☐ Mexican American
    ☐ Chicano/a
    ☐ Puerto Rican
    ☐ Dominican
    ☐ Cuban
    ☐ Another Hispanic, Latino/a, or Spanish origin
    ☐ Not of Hispanic, Latino/a, or Spanish origin

    What is employee's race?
    (One or more categories may be selected.)
    ☐ American Indian or Alaska Native
    ☐ Black or African American
    ☐ Asian Indian
    ☐ Chinese
    ☐ Filipino
    ☐ Japanese
    ☐ Korean
    ☐ Vietnamese
    ☐ Other Asian
    ☐ White
    ☐ Native Hawaiian
    ☐ Guamanian or Chamorro
    ☐ Samoan
    ☐ Other Pacific Islander
    ☐ Other race

Paid Family Leave (PFL) Request

11. Reason for PFL request: ☐ Bond with child ☐ Care for family member ☐ Military qualifying event
12. The family member is employee's: ☐ Child ☐ Spouse ☐ Domestic partner ☐ Parent ☐ Parent-in-law ☐ Grandparent ☐ Grandchild
13. Estimated PFL start date (MM/DD/YYYY)
14. Estimated PFL end date (MM/DD/YYYY)
15. If providing less than 30 days advance notice to the employer from the date in 13, please explain:

PFL-1 continued on next page

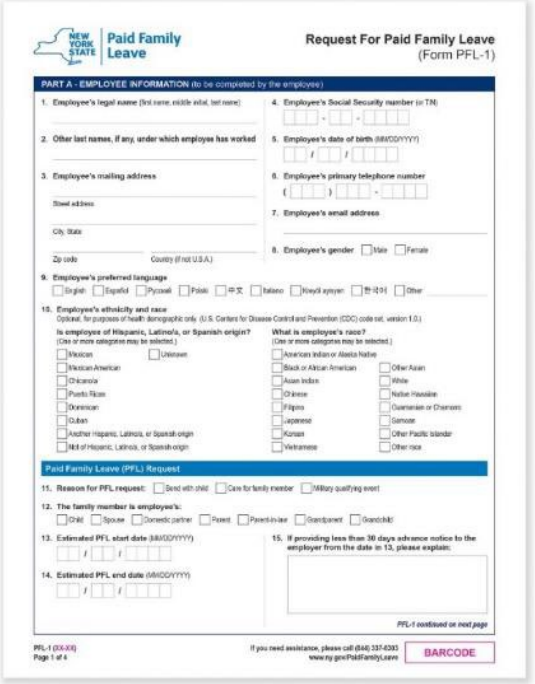
PFL-1 (xx/xx)
Page 1 of 4

If you need assistance, please call (844) 337-6393
www.ny.gov/PaidFamilyLeave

BARCODE

Completing the *Request for Paid Family Leave (Form PFL-1, Part A)*

- Employee fills out Part A.
- Employer fills out Part B.
- You must also state why you are requesting the leave and how the family member it pertains to is related to you.



NEW YORK STATE | Paid Family Leave

Request For Paid Family Leave
(Form PFL-1)

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

1. Employee's legal name (first name, middle initial, last name)
2. Other last names, if any, under which employee has worked
3. Employee's mailing address
   Street address
   City, State
   Zip code
   Country (if not U.S.A.)
4. Employee's Social Security number (or ITN)
5. Employee's date of birth (MM/DD/YYYY)
6. Employee's primary telephone number
7. Employee's email address
8. Employee's gender ☐ Male ☐ Female
9. Employee's preferred language
   ☐ English ☐ Español ☐ Русский ☐ Polski ☐ 中文 ☐ Italiano ☐ Kreyòl ayisyen ☐ 한국어 ☐ Other
10. Employee's ethnicity and race
    Optional, for purposes of health demographic only. (U.S. Centers for Disease Control and Prevention (CDC) code set, version 1.0.)
    Is employee of Hispanic, Latino/a, or Spanish origin? (One or more categories may be selected.)
    ☐ Mexican ☐ Unknown
    ☐ Mexican American
    ☐ Chicano/a
    ☐ Puerto Rican
    ☐ Dominican
    ☐ Cuban
    ☐ Another Hispanic, Latino/a, or Spanish origin
    ☐ Not of Hispanic, Latino/a, or Spanish origin
    What is employee's race? (One or more categories may be selected.)
    ☐ American Indian or Alaska Native
    ☐ Black or African American
    ☐ Asian Indian
    ☐ Chinese
    ☐ Filipino
    ☐ Japanese
    ☐ Korean
    ☐ Vietnamese
    ☐ Other Asian
    ☐ White
    ☐ Native Hawaiian
    ☐ Guamanian or Chamorro
    ☐ Samoan
    ☐ Other Pacific Islander
    ☐ Other race

Paid Family Leave (PFL) Request

11. Reason for PFL request: ☐ Bond with child ☐ Care for family member ☐ Military qualifying event
12. The family member is employee's:
    ☐ Child ☐ Spouse ☐ Domestic partner ☐ Parent ☐ Parent-in-law ☐ Grandparent ☐ Grandchild
13. Estimated PFL start date (MM/DD/YYYY)
14. Estimated PFL end date (MM/DD/YYYY)
15. If providing less than 30 days advance notice to the employer from the date in 13, please explain:

PFL-1 continued on next page

PFL-1 (XX-XX)
Page 1 of 4

If you need assistance, please call (844) 337-6303
www.ny.gov/PaidFamilyLeave

BARCODE

Completing the *Request for Paid Family Leave (Form PFL-1, Part A)*

PART A - EMPLOYEE INFORMATION (to be completed by the employee) - continued from prior page

Form PFL-1 continued from prior page

13. **Will PFL be for a continuous period of time and/or periodic?**

☐ Continuous — PFL start date (MM/DD/YYYY) __ __ / __ __ / __ __ __ __ — PFL end date (MM/DD/YYYY) __ __ / __ __ / __ __ __ __ — ☐ Dates are estimated

☐ Periodic — Identify dates periodic PFL will be taken: ☐ Dates are estimated

14. **If providing less than 30 day's advance notice to the employer, please explain:**

Completing the *Request for Paid Family Leave (Form PFL-1, Part A)*

Employment Information (to be completed by the employee)

15. **Business name**

16. **Employee's date of hire** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

17. **Employee's work location**

Street address		
City, State	Zip code	Country (if not U.S.A.)

18. **Employee's average gross <u>weekly</u> wage** (This data will be requested of both employee and employer)

19. **Employer's telephone number for contact regarding this request** (☐☐☐) ☐☐☐ - ☐☐☐☐

20a. **Does employee have more than one employer?** ☐ Yes ☐ No

20b. **If yes, is employee taking PFL from the other employer?** ☐ Yes ☐ No

21. **Is employee currently receiving Workers' Compensation Lost Wage Benefits?** ☐ Yes ☐ No

Disclosure statement: Information regarding PFL benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Completing the *Request for Paid Family Leave (Form PFL-1, Part A)*

Declaration and signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I am hereby making a request for paid family leave benefits under the NYS Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee's signature

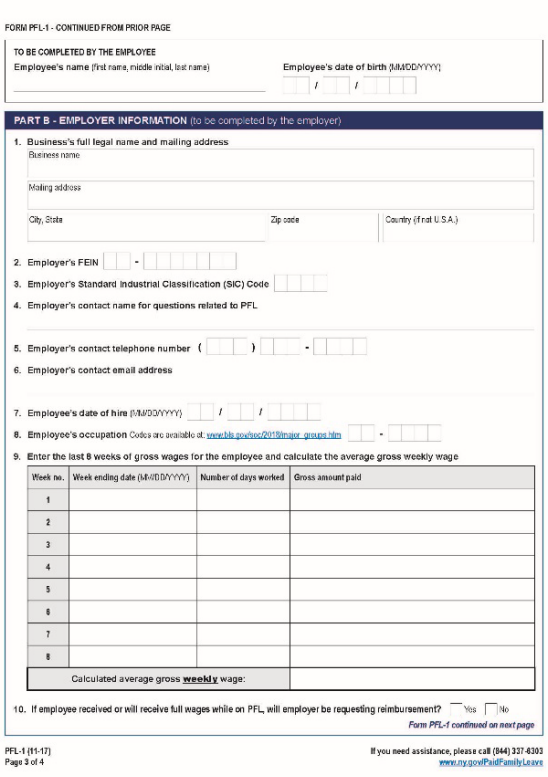
Date signed (MM/DD/YYYY)

☐ I am submitting this form in advance (see instructions about pre-submitting). I understand the insurance carrier will contact me to advise how to submit the required missing information.

PFL-1 (11-17)
Page 2 of 4

If you need assistance, please call (844) 337-6303
www.ny.gov/PaidFamilyLeave

Employer to complete *Request for Paid Family Leave (Form PFL-1, Part B)*



FORM PFL-1 - CONTINUED FROM PRIOR PAGE

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)

Employee's date of birth (MM/DD/YYYY)

PART B - EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address

Business name

Mailing address

City, State | Zip code | Country (if not U.S.A.)

2. Employer's FEIN

3. Employer's Standard Industrial Classification (SIC) Code

4. Employer's contact name for questions related to PFL

5. Employer's contact telephone number

6. Employer's contact email address

7. Employee's date of hire (MM/DD/YYYY)

8. Employee's occupation Codes are available at: www.bls.gov/soc/2018/major_groups.htm

9. Enter the last 8 weeks of gross wages for the employee and calculate the average gross weekly wage

Week no.	Week ending date (MM/DD/YYYY)	Number of days worked	Gross amount paid
1			
2			
3			
4			
5			
6			
7			
8			
Calculated average gross **weekly** wage:			

10. If employee received or will receive full wages while on PFL, will employer be requesting reimbursement? Yes No

Form PFL-1 continued on next page

PFL-1 (11-17)
Page 3 of 4

If you need assistance, please call (844) 337-8303
www.ny.gov/PaidFamilyLeave

Completing the *Release of Personal Health Information (Form PFL-3)*

NEW YORK STATE | Paid Family Leave

Request For Paid Family Leave
Release Of Personal Health Information
Under The Paid Family Leave Law (Form PFL-3)
INSTRUCTIONS INCLUDED WITH FORM

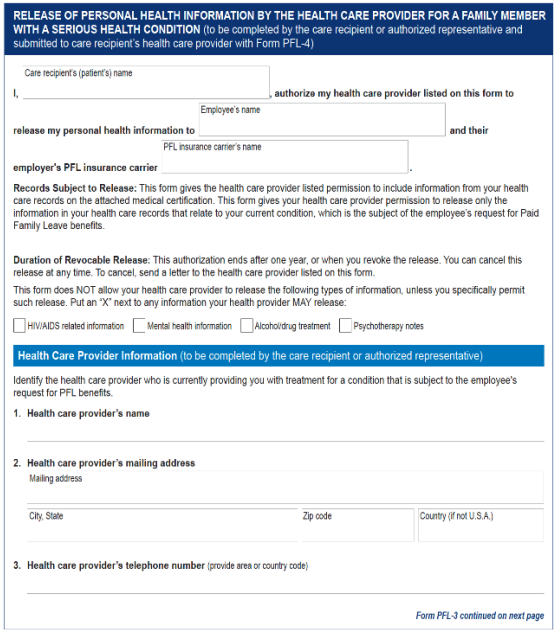
TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)

Care recipient's (patient's) name (first name, middle initial, last name)

Care recipient's (patient's) date of birth (MM/DD/YYYY)

Completing the *Release of Personal Health Information (Form PFL-3)*



RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form PFL-4)

Care recipient's (patient's) name

I, _____, **authorize my health care provider listed on this form to release my personal health information to** Employee's name **and their employer's PFL insurance carrier** PFL insurance carrier's name.

Records Subject to Release: This form gives the health care provider listed permission to include information from your health care records on the attached medical certification. This form gives your health care provider permission to release only the information in your health care records that relate to your current condition, which is the subject of the employee's request for Paid Family Leave benefits.

Duration of Revocable Release: This authorization ends after one year, or when you revoke the release. You can cancel this release at any time. To cancel, send a letter to the health care provider listed on this form.

This form does NOT allow your health care provider to release the following types of information, unless you specifically permit such release. Put an "X" next to any information your health provider MAY release:

☐ HIV/AIDS related information ☐ Mental health information ☐ Alcohol/drug treatment ☐ Psychotherapy notes

Health Care Provider Information (to be completed by the care recipient or authorized representative)

Identify the health care provider who is currently providing you with treatment for a condition that is subject to the employee's request for PFL benefits.

1. **Health care provider's name**

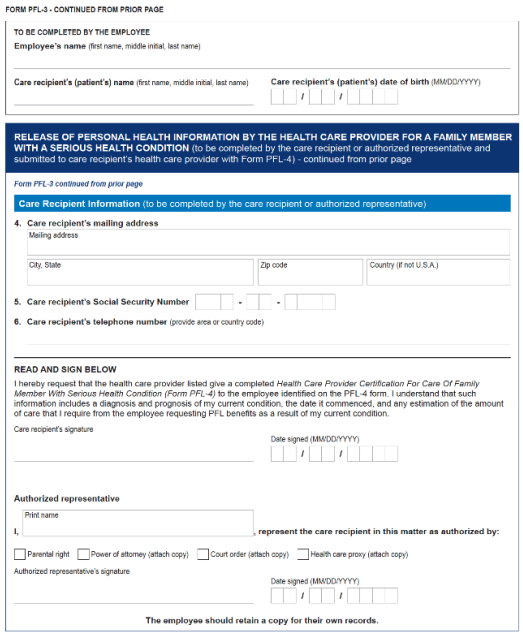
2. **Health care provider's mailing address**

Mailing address

City, State | Zip code | Country (if not U.S.A.)

3. **Health care provider's telephone number** (provide area or country code)

Form PFL-3 continued on next page



FORM PFL-3 - CONTINUED FROM PRIOR PAGE

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)

Care recipient's (patient's) name (first name, middle initial, last name) | **Care recipient's (patient's) date of birth** (MM/DD/YYYY)

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form PFL-4) - continued from prior page

Form PFL-3 continued from prior page

Care Recipient Information (to be completed by the care recipient or authorized representative)

4. **Care recipient's mailing address**

Mailing address

City, State | Zip code | Country (if not U.S.A.)

5. **Care recipient's Social Security Number** ___ - ___ - ____

6. **Care recipient's telephone number** (provide area or country code)

READ AND SIGN BELOW

I hereby request that the health care provider listed give a completed *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* to the employee identified on the PFL-4 form. I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and any estimation of the amount of care that I require from the employee requesting PFL benefits as a result of my current condition.

Care recipient's signature | Date signed (MM/DD/YYYY)

Authorized representative

I, Print name, **represent the care recipient in this matter as authorized by:**

☐ Parental right ☐ Power of attorney (attach copy) ☐ Court order (attach copy) ☐ Health care proxy (attach copy)

Authorized representative's signature | Date signed (MM/DD/YYYY)

The employee should retain a copy for their own records.

Completing the *Health Care Provider Certification (Form PFL-4)*

NEW YORK STATE | Paid Family Leave

Request For Paid Family Leave
Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)
INSTRUCTIONS INCLUDED WITH FORM

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)

Employee's date of birth (MM/DD/YYYY) / /

Other last names, if any, under which employee has worked

Employee's Social Security Number or TIN - -

Employee's mailing address

Mailing address

City, State | Zip code | Country (if not U.S.A.)

Care recipient's (patient's) name (first name, middle initial, last name)

Care recipient's (patient's) date of birth (MM/DD/YYYY) / /

Completing the *Health Care Provider Certification (Form PFL-4)*

FORM PFL-4 - CONTINUED FROM PRIOR PAGE

TO BE COMPLETED BY THE EMPLOYEE

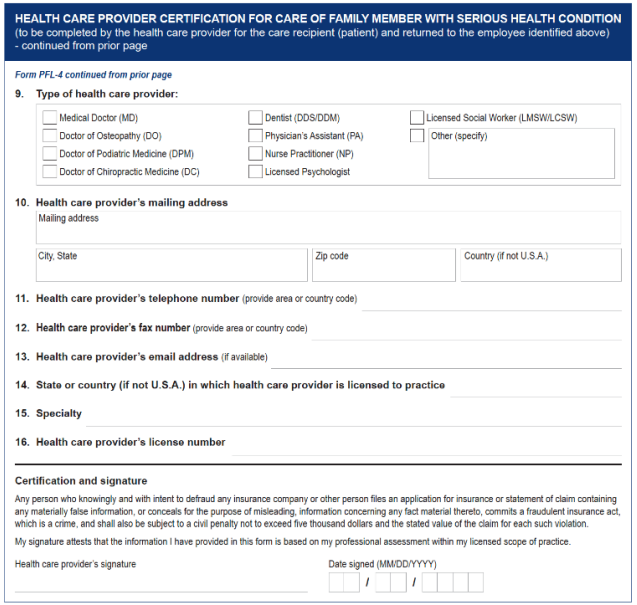
Employee's name (first name, middle initial, last name)

Employee's date of birth (MM/DD/YYYY)

Care recipient's (patient's) name (first name, middle initial, last name)

Care recipient's (patient's) date of birth (MM/DD/YYYY)

Completing the *Health Care Provider Certification (Form PFL-4)*



HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION
(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)
- continued from prior page

Form PFL-4 continued from prior page

9. Type of health care provider:

- ☐ Medical Doctor (MD)
- ☐ Doctor of Osteopathy (DO)
- ☐ Doctor of Podiatric Medicine (DPM)
- ☐ Doctor of Chiropractic Medicine (DC)
- ☐ Dentist (DDS/DDM)
- ☐ Physician's Assistant (PA)
- ☐ Nurse Practitioner (NP)
- ☐ Licensed Psychologist
- ☐ Licensed Social Worker (LMSW/LCSW)
- ☐ Other (specify)

10. Health care provider's mailing address

Mailing address

City, State | Zip code | Country (if not U.S.A.)

11. Health care provider's telephone number (provide area or country code)

12. Health care provider's fax number (provide area or country code)

13. Health care provider's email address (if available)

14. State or country (if not U.S.A.) in which health care provider is licensed to practice

15. Specialty

16. Health care provider's license number

Certification and signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

My signature attests that the information I have provided in this form is based on my professional assessment within my licensed scope of practice.

Health care provider's signature | Date signed (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

PFL-4 (11-17) HCP Certification
Page 2 of 2

If you need assistance, please call (844) 337-6303
www.ny.gov/PaidFamilyLeave

Step 3: Send forms to insurance carrier

- Send all forms and documentation to your employer's insurance carrier.
- The insurance carrier must pay or deny within 18 calendar days of receiving your completed request, or the first day of leave, whichever is later.

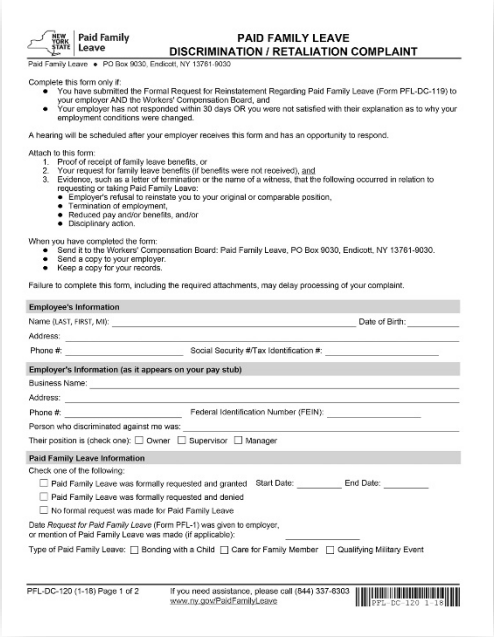
Handling disputes

- If your claim is denied, or you have another claim-related dispute, you may request arbitration.
- Arbitration for Paid Family Leave is handled by NAM (National Arbitration and Mediation) **nyspfla.namadr.com**.

Protection from discrimination

If your employer:

- does not reinstate you to the same or comparable position,
- terminates you,
- reduces your pay and/or benefits, or
- disciplines you in any way for requesting or taking Paid Family Leave, you can file a **discrimination claim** with the Workers' Compensation Board.



NEW YORK STATE | Paid Family Leave

PAID FAMILY LEAVE
DISCRIMINATION / RETALIATION COMPLAINT

Paid Family Leave • PO Box 9030, Endicott, NY 13761-9030

Complete this form only if:
- You have submitted the Formal Request for Reinstatement Regarding Paid Family Leave (Form PFL-DC-119) to your employer AND the Workers' Compensation Board, and
- Your employer has not responded within 30 days OR you were not satisfied with their explanation as to why your employment conditions were changed.

A hearing will be scheduled after your employer receives this form and has an opportunity to respond.

Attach to this form:
1. Proof of receipt of family leave benefits, or
2. Your request for family leave benefits (if benefits were not received), and
3. Evidence, such as a letter of termination or the name of a witness, that the following occurred in relation to requesting or taking Paid Family Leave:
   - Employer's refusal to reinstate you to your original or comparable position,
   - Termination of employment,
   - Reduced pay and/or benefits, and/or
   - Disciplinary action.

When you have completed the form:
- Send it to the Workers' Compensation Board: Paid Family Leave, PO Box 9030, Endicott, NY 13761-9030.
- Send a copy to your employer.
- Keep a copy for your records.

Failure to complete this form, including the required attachments, may delay processing of your complaint.

Employee's Information

Name (LAST, FIRST, MI): _____ Date of Birth: _____

Address: _____

Phone #: _____ Social Security #/Tax Identification #: _____

Employer's Information (as it appears on your pay stub)

Business Name: _____

Address: _____

Phone #: _____ Federal Identification Number (FEIN): _____

Person who discriminated against me was: _____

Their position is (check one): ☐ Owner ☐ Supervisor ☐ Manager

Paid Family Leave Information

Check one of the following:

☐ Paid Family Leave was formally requested and granted Start Date: _____ End Date: _____

☐ Paid Family Leave was formally requested and denied

☐ No formal request was made for Paid Family Leave

Date *Request for Paid Family Leave* (Form PFL-1) was given to employer, or mention of Paid Family Leave was made (if applicable): _____

Type of Paid Family Leave: ☐ Bonding with a Child ☐ Care for Family Member ☐ Qualifying Military Event

PFL-DC-120 (1-18) Page 1 of 2 If you need assistance, please call (844) 337-6303 www.ny.gov/PaidFamilyLeave PFL DC 120 1 18

Top questions about Paid Family Leave for family care

How are Paid Family Leave and FMLA similar?

Both Paid Family Leave and the Family and Medical Leave Act provide:

- Leave for:
  - bonding with a child,
  - caring for a family member with a serious health condition, and
  - assisting when a family member is called to active military service abroad.
- Job protection.
- Continued health insurance during leave on the same terms as if you had continued to work.

How do Paid Family Leave and FMLA differ?

	PFL	FMLA
Benefits	**Paid**	**Unpaid**
Coverage	▪ Almost all private employers ▪ Public employers may opt in ▪ **One or more employees in employment** on each of at least 30 days in any calendar year	▪ Public and private employers ▪ **50 or more employees** in a 75-mile radius
Eligibility	▪ After **26** consecutive weeks of employment if regularly working **20** or more hours per week ▪ After **175** days worked if regularly working less than **20** hours per week	▪ **12** months of employment ▪ **1,250** hours of work in the **12**-month period preceding leave
Reason for Leave	▪ Employees **cannot** use for own serious health condition ▪ Can be used to care for a child of any age	▪ Employee **can** use for own serious health condition ▪ Can only be used to care for a child if the child is under 18 years old, or "incapable of self-care because of a mental or physical disability"
Length of Leave	▪ Only in full-day increments	▪ Hourly basis
Paid Time Off	▪ Employers cannot require employees use paid time off while on PFL	▪ Employer can compel an employee to use paid time off while on FMLA

If I have a sick family member in another country, what do I need to do?

- Location of your family member does not matter as long as the employee giving care is in close proximity during the majority of the leave period.
- Complete and submit all required documents.
  - Out-of-state/out-of-country health care provider responsible for completing medical certification.

What is needed to demonstrate a domestic partnership?

- Common ownership of property,
- Children in common,
- Sign of intent to marry,
- Shared budgeting, and
- Length of personal relationship.

What if I can't get my medical certification on time?

You have **30 days** from the beginning of your leave to submit your completed request without losing benefits.

- If you cannot get documentation to support a leave request within this timeframe, the insurance carrier can deny the request.
- You can apply for other leave dates once you have the supporting documentation.

Paid Family Leave and COVID-19

COVID-19 quarantine leave

Available when:

- You are subject to an order of mandatory or precautionary quarantine or isolation due to COVID-19.
- Your minor, dependent child is subject to an order of mandatory or precautionary quarantine or isolation due to COVID-19.

Employees who work for small employers

For most employees who work for an employer with **10** or fewer employees and a business net annual income of less than **$1 million:**

- You can use a combination of Paid Family Leave and disability benefits.
- After receiving your full Paid Family Leave benefit (up to **$840.70** weekly), you will receive disability benefits to match your full wages up to a maximum weekly disability benefit of **$2,043.92**, for a total of **$2,884.62** per week.
- There is no waiting period for either benefit.

You will have job protection for the duration of the quarantine.

Employees who work for medium employers

For most employees who work for an employer with **11 to 99** employees, and smaller employers (**1 to 10** employees) with a business net annual income greater than **$1 million:**

- Your employer is required to provide at least **five days** of COVID-19 paid sick leave.
- After that, you can use a combination of Paid Family Leave and disability benefits.
- After receiving your full Paid Family Leave benefit (up to **$840.70** weekly), you will receive disability benefits to match your full wages up to a maximum weekly disability benefit of **$2,043.92**, for a total of **$2,884.62** per week.
- There is no waiting period for either benefit.

You will have job protection for the duration of the quarantine.

Employees who work for large employers

For most employees who work for an employer with **100 or more** employees, as well as all public employees:

- Your employer is required to provide at least **14 days** of COVID-19 paid sick leave for a COVID-19-related quarantine, which should cover the period of a mandatory or precautionary order of quarantine or isolation.

You will have job protection for the duration of the quarantine.

Taking leave for your child's quarantine

You may also apply for NYS Paid Family Leave if your minor, dependent child is under an order of mandatory or precautionary quarantine or isolation.

- NYS Paid Family Leave provides 67 percent of pay, up to a maximum weekly benefit of $840.70.

Full details

PaidFamilyLeave.ny.gov/COVID19

PaidFamilyLeave.ny.gov
(844) 337-6303

NEW YORK STATE | Paid Family Leave

Paid Family Leave is here to help

Learn more

Visit **PaidFamilyLeave.ny.gov** to access:

- Detailed information on Paid Family Leave,
- Paid Family Leave request forms and fact sheets,
- Weekly benefit and payroll deduction calculators,
- Information about COVID-19 quarantine leave benefits.

Learn more

Helpline:
(844) 337-6303

Website:
PaidFamilyLeave.ny.gov

Get Email Updates:
Select “Get Updates” on the bottom of PFL website.

Questions?