



NEW
YORK
STATE

Paid Family
Leave



A guide for family care

December 13, 2022


NYS Workers' Compensation Board



Agenda

1. Why do we need Paid Family Leave?
2. Basic uses of Paid Family Leave
3. 2023 benefits and contributions
4. Employee eligibility
5. Requesting Paid Family Leave for family care
6. Top questions about family care
7. Paid Family Leave and COVID-19
8. Resources
9. Questions



A photograph of a family caring for an elderly man. The man is seated in the center, wearing glasses and a grey sweater. A young man with glasses stands behind him, smiling and placing his hand on the elderly man's shoulder. A young woman with long dark hair sits to the right, looking at the elderly man with a smile. The background is a simple indoor setting with a window and curtains. The entire image has a teal overlay, and a large teal circle is on the left side containing the text.

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.



PaidFamilyLeave.ny.gov
(844) 337-6303



**Paid Family
Leave**

Basic uses of Paid Family Leave





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
- Sibling*
- Parent/stepparent
- Parent-in-law
- Grandparent
- Grandchild

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

*** New in 2023 – check with your employer for details on when this goes into effect for your policy**



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 work, orthodontia
- Cosmetic treatment



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A photograph of a man and a young child sitting in a hospital bed. The man is on the right, looking towards the left. The child is on the left, resting their head on the man's shoulder. The image is overlaid with a semi-transparent teal circle on the left side, which contains the text.

2023 benefits and contributions



Higher maximum benefit

In 2023, eligible employees may take up to **12** weeks of PFL at 67% of their AWW, up to 67% of the NYSAWW.

BENEFITS FOR 2023		
12 weeks	67% of employee's AWW, up to 67% of NYSAWW	New maximum weekly benefit \$1,131.08



Weekly benefits calculator

A wage benefit calculator is available:

[PaidFamilyLeave.ny.gov/
PFLbenefitscalculator2023](https://PaidFamilyLeave.ny.gov/PFLbenefitscalculator2023)

PAID FAMILY LEAVE

2023 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 2023 is \$1,131.08.

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.*



Lower employee contribution

- The 2023 payroll contribution is **0.455%** of an employee's gross wages each pay period, capped at an annual maximum of **\$399.43**.
- If an employee earns less than the New York State Average Weekly Wage of \$1,688.19, their annual contribution will be less than the cap.



Weekly deduction calculator

A weekly deduction calculator is available:

[PaidFamilyLeave.ny.gov/
paid-family-leave-calculator2023](https://PaidFamilyLeave.ny.gov/paid-family-leave-calculator2023)

PAID FAMILY LEAVE

2023 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 0.455% of your gross wages each pay period. In 2023, these deductions are capped at the annual maximum of \$399.43.

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

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

*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



2023 benefit and contribution summary

As of January 1, 2023:

- **Maximum weekly benefit:** Increases from \$1,068.36 to **\$1,131.08**.
- **Employee contribution rate:** Employers may deduct at the rate of **0.455%** of an employee's gross wages each pay period, capped at an annual maximum of **\$399.43**.

Full details at: PaidFamilyLeave.ny.gov/2023

PaidFamilyLeave.ny.gov
(844) 337-6303



Paid Family
Leave

Employee eligibility





Who is covered?

- Most employees who work for private employers are covered.
- 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 has been negotiated as part of your contract through collective bargaining.





Who is eligible?

Employees who work for covered employers are eligible if they regularly work:

- **Full-time employees: 20 or more hours per week**
 - 26 consecutive weeks of employment with the same employer
- **Part-time employees: Less than 20 hours per week**
 - 175 days with the same employer

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



Who is eligible?

■ Domestic workers

- 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.

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(844) 337-6303



Paid Family
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Requesting Paid Family Leave for family care





How to request leave



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.

DECEMBER						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31



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 Certification (Form PFL-4)*

Request For Paid Family Leave (Form PFL-1)

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

- Employee's legal name (last name, initials, first name)
- Other last names, if any, under which employee has worked
- Employee's mailing address (street address, city, state, zip code, county (not U.S.A.))
- Employee's Social Security number (or TIN)
- Employee's date of birth (MM/DD/YYYY)
- Employee's primary telephone number
- Employee's email address
- Employee's gender (Male/Female)
- Employee's preferred language (English, Spanish, Chinese, etc.)
- Employee's ethnicity and race (with checkboxes for various categories)
- Reason for PFL request (Selected with child, Care for family member, Willing qualifying event)
- The family member to whom leave is requested (Child, Spouse, Domestic partner, Parent, Parent-in-law, Spouse/partner, Grandchild)
- Estimated PFL start date (MM/DD/YYYY)
- Estimated PFL end date (MM/DD/YYYY)
- If providing less than 30 days advance notice to the employer from the date on 13, please explain.

PFL-1 continued on next page

PFL-1 (03/20) Page 1 of 4

If you need assistance, please call (848) 327-6263 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](https://www.PaidFamilyLeave.ny.gov/forms)

Request For Paid Family Leave (Form PFL-1)

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

- Employee's legal name (last name, middle initial, first name)
- Other last names, if any, under which employee has worked
- Employee's mailing address (Street address, City, State, Zip code, Country (if not U.S.A.))
- Employee's Social Security number (SSN)
- Employee's date of birth (MM/DD/YYYY)
- Employee's primary telephone number
- Employee's email address
- Employee's gender (Male/Female)
- Employee's preferred language
- Employee's ethnicity and race (Includes checkboxes for various ethnicities and races)

Paid Family Leave (PFL) Request

- Reasons for PFL request (Sick with child, Care for family member, Military qualifying event)
- The family member is employee's (Child, Spouse, Domestic partner, Parent, Parent-in-law, Grandparent, Grandchild)
- Estimated PFL start date (MM/DD/YYYY)
- Estimated PFL end date (MM/DD/YYYY)
- 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 (03/20) Page 1 of 4 If you need assistance, please call (848) 237-0233 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.

Request For Paid Family Leave (Form PFL-1)

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

- Employee's legal name (first name, middle initial, last name)
- Other last names, if any, under which employee has worked
- Employee's mailing address
Street address
City, State
Zip code Country (if not U.S.A.)
- Employee's Social Security number (or TIN)
- Employee's date of birth (MM/DD/YYYY)
- Employee's primary telephone number
- Employee's email address
- Employee's gender Male Female
- Employee's preferred language
 English Spanish Physical Polish #P.R. Italian Hindi/Urdu #H-41 Other
- Employee's ethnicity and race
Optional for purposes of health demographic only. (U.S. Centers for Disease Control and Prevention (CDC) code not, version 1.0.)
Is employee of Hispanic, Latino/a, or Spanish origin?
(One or more categories may be selected.)
 Mexican American Dominican Puerto Rican Cuban Other 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 Other Asian Asian Indian White Native Hawaiian Other Pacific Islander Other race

Paid Family Leave (PFL) Request

- Reason for PFL request: Direct with child Care for family member Military qualifying event
- The family member is employee's:
 Child Spouse Domestic partner Parent Parent-in-law Grandparent Grandchild
- Estimated PFL start date (MM/DD/YYYY)
- Estimated PFL end date (MM/DD/YYYY)
- 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 (03/20) Page 1 of 4
If you need assistance, please call (846) 337-4333 or 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?

<input type="checkbox"/>	Continuous	PFL start date (MM/DD/YYYY) [][] / [][] / [][][][]	PFL end date (MM/DD/YYYY) [][] / [][] / [][][][]	<input type="checkbox"/> Dates are estimated
<input type="checkbox"/>	Periodic	Identify dates periodic PFL will be taken: []		<input type="checkbox"/> 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)

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.



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/oes/2018/major-groups.html _____ - _____

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

Week no.	Week ending date (M/DD/YYYY)	Number of days worked	Gross amount paid
1			
2			
3			
4			
5			
6			
7			
8			
Calculated average gross <u>weekly</u> 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



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



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
_____, Employee's name
release my personal health information to _____ and their
_____, PFL insurance carrier's name
employer's PFL insurance carrier _____.

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, _____, 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)



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:

<input type="checkbox"/> Medical Doctor (MD)	<input type="checkbox"/> Dentist (DDS/DDM)	<input type="checkbox"/> Licensed Social Worker (LMSW/LCSW)
<input type="checkbox"/> Doctor of Osteopathy (DO)	<input type="checkbox"/> Physician's Assistant (PA)	<input type="checkbox"/> Other (specify) <input type="text"/>
<input type="checkbox"/> Doctor of Podiatric Medicine (DPM)	<input type="checkbox"/> Nurse Practitioner (NP)	
<input type="checkbox"/> Doctor of Chiropractic Medicine (DC)	<input type="checkbox"/> Licensed Psychologist	

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) / /



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.

DECEMBER						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31



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

You can file a **discrimination claim** with the Workers' Compensation Board 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.

PAID FAMILY LEAVE DISCRIMINATION / RETALIATION COMPLAINT

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:

- Proof of receipt of family leave benefits, or
- Your request for family leave benefits (if benefits were not received), and
- 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 (F EIN): _____

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) 537-6303 www.ny.gov/PaidFamilyLeave

PaidFamilyLeave.ny.gov
(844) 337-6303



Paid Family
Leave

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
 - 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	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ Public and private employers ▪ 50 or more employees in a 75-mile radius
Eligibility	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ 12 months of employment ▪ 1,250 hours of work in the 12-month period preceding leave
Reason for Leave	<ul style="list-style-type: none"> ▪ Employees cannot use for own serious health condition ▪ Can be used to care for a child of any age 	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ Only in full-day increments 	<ul style="list-style-type: none"> ▪ Hourly basis
Paid Time Off	<ul style="list-style-type: none"> ▪ Employers cannot require employees use paid time off while on PFL 	<ul style="list-style-type: none"> ▪ 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?

- The 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 is 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
- 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 time frame, the insurance carrier can deny the request.
- You can apply for other leave dates once you have the supporting documentation.

PaidFamilyLeave.ny.gov
(844) 337-6303



Paid Family
Leave

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.





Taking leave for personal quarantine

- You may apply for a combination of Paid Family Leave and disability benefits to receive your full pay (up to a cap).
- Paid Family Leave benefits are **67%** of pay, up to a maximum of **\$840.70** weekly.
- Disability benefits make up the difference, up to a maximum of **\$2,043.92** weekly.
- The total combined weekly benefit is **\$2,884.62**.
- There is no waiting period for either benefit.

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% of pay, up to a maximum weekly benefit of \$840.70.





Full details

PaidFamilyLeave.ny.gov/COVID19



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Paid Family
Leave

Resources





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
- Paid Family Leave updates for 2023
- Information about COVID-19 quarantine leave benefits



Learn more

Helpline:

(844) 337-6303

Website:

[PaidFamilyLeave.ny.gov](https://www.PaidFamilyLeave.ny.gov)

Get Email Updates:

Select “Get Updates” on the bottom of the PFL website





Questions?