Employment Development Department
State of California

Claim for Paid Family Leave (PFL) Benefits

2501F10161

DO NOT DETACH PAGES - NO SEPARE LAS PAGINAS

PART A – STATEMENT OF CLAIMANT (CARE OR BONDING PROVIDER)

A1. YOUR SOCIAL SECURITY NO.

A2. YOUR DATE OF BIRTH
M M D D Y Y Y Y

A3. LANGUAGE YOU PREFER TO USE
ENGLISH ESPAÑOL OTHER (PRINT BELOW)

A4. YOUR LEGAL NAME
FIRST NAME MI LAST NAME

A5. YOUR GENDER
MALE FEMALE

A6. YOUR TELEPHONE NUMBER

A7. OTHER LAST NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED

A8. YOUR MAILING ADDRESS (TO RECEIVE MAIL AT A PRIVATE MAIL BOX—NOT A US POSTAL SERVICE BOX—YOU MUST SHOW THE NUMBER IN THE "PMB#" SPACE.) PMB# (IF APPLICABLE)
CITY STATE/PROV. ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)

A9. NAME OF YOUR EMPLOYER MAILING ADDRESS
CITY STATE/PROV. ZIP OR POSTAL CODE EMPLOYER'S TELEPHONE NUMBER

A10. DATE YOU LAST WORKED
M M D D Y Y Y Y

A11. DATE YOU WANT YOUR PFL CLAIM TO BEGIN
M M D D Y Y Y Y

A12. DATE YOU RETURNED OR WILL RETURN TO WORK
M M D D Y Y Y Y

A13. DID YOU WORK OR WILL YOU CONTINUE TO WORK DURING YOUR FAMILY LEAVE PERIOD?
NO YES

A14. WHY DID YOU OR WILL YOU REDUCE YOUR WORK HOURS OR STOP WORKING?
CARE FOR FAMILY MEMBER BOND WITH CHILD OTHER (EXPLAIN)

A15. WHAT IS YOUR OCCUPATION?

A16. LEGAL NAME OF PERSON FOR WHOM YOU ARE CARING (FIRST MIDDLE INITIAL LAST) OR WITH WHOM YOU ARE BONDING (CARE OR BONDING RECIPIENT)

A17. THE ABOVE-NAMED CARE OR BONDING RECIPIENT IS YOUR:
CHILD SPOUSE REGISTERED DOMESTIC PARTNER PARENT PARENT IN-LAW GRAND PARENT GRAND CHILD SIBLING OTHER (EXPLAIN)

A18. IS ANY OTHER FAMILY MEMBER READY, WILLING, AND ABLE AND AVAILABLE TO PROVIDE CARE FOR THE SAME PERIOD YOU ARE CLAIMING PFL BENEFITS?
NO YES

A19. HAVE YOU CLAIMED OR DO YOU PLAN TO CLAIM WORKERS' COMPENSATION BENEFITS FOR ANY PORTION OF THE PERIOD COVERED BY THIS CLAIM?
NO YES

A20. DO YOU HAVE MORE THAN ONE EMPLOYER?
NO YES

A21. IF YOUR EMPLOYER(S) CONTINUED OR WILL CONTINUE TO PAY YOU DURING YOUR FAMILY LEAVE, INDICATE TYPE OF PAY:
SICK VACATION OTHER (EXPLAIN)

A22. MAY WE DISCLOSE BENEFIT PAYMENT INFORMATION TO YOUR EMPLOYER(S)?
NO YES

A23. AT ANY TIME DURING YOUR PFL LEAVE, WERE YOU IN THE CUSTODY OF LAW ENFORCEMENT AUTHORITIES BECAUSE YOU WERE CONVICTED OF VIOLATING A LAW OR ORDINANCE? ..... NO YES

A24. **Declaration and Signature.** By my signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was providing care for or bonding with the care recipient named above; (2) authorize EDD to release my personal information as shown on this claim to the care recipient and to the care recipient's treating physician as they are respectively listed in Part C and Part D of this claim; (3) authorize my employer(s) to disclose to EDD all facts concerning my employment that are within their knowledge; and (4) authorize release and use of information as stated in the "Information Collection and Access" portion of this form. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.

Claimant's Signature (DO NOT PRINT) | **If signature is made by mark (X), please place mark here.*** | **Date Signed** (MM | DD | YYYY)

***If your signature is made by mark (X), it must be attested by two witnesses with their addresses**

1st Witness Signature and Address | 2nd Witness Signature and Address

CARE RECIPIENT'S AUTHORIZATION FOR DISCLOSURE OF PERSONAL-HEALTH INFORMATION

I authorize my physician or practitioner, as identified on Part D of this claim, to disclose my current personal-health information to my care provider, as identified on Part A of this claim, and to the California Employment Development Department (EDD).

I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and an estimation of the amount of care that I require from my care provider as a result of my current condition. I further understand that disclosure of my personal-health information may include my AIDS/HIV status, drug or alcohol addiction, or any other physical or mental condition.

I understand that EDD may disclose this information as authorized by the California Unemployment Insurance Code and that such re-disclosed information may no longer be protected. I agree that photocopies of the authorization form in conjunction with my signature on Page 3 in Item 6 of Part C shall be as valid as the original.

I understand that unless I inform EDD in writing at P.O. Box 989315, West Sacramento, CA 95798-9315, that I wish to revoke this authorization, it will be valid for 10 years from the date EDD receives it or the effective date of this claim, whichever is later. I understand that I have the right to receive a copy of an authorization form from EDD if I request one in writing.

I make this authorization to support my care provider's claim for Paid Family Leave benefits. I understand that I may not revoke my authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

WE CANNOT PROCESS THIS CLAIM UNLESS YOU SIGN BOTH THIS PAGE AND PAGE 3 IN ITEM C6 OF PART C.

Care recipient's name (Print your name)

Date signed

Care recipient's signature (Sign your name)

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PART B – BONDING CERTIFICATION (TO BE COMPLETED BY PERSON CLAIMING PFL BENEFITS TO BOND WITH A CHILD)

B1. YOUR SOCIAL SECURITY NUMBER

B2. DATE OF FOSTER CARE OR ADOPTION PLACEMENT (M M D D Y Y Y Y)

B3. CHILD NAMED IN B8 IS MY: BIOLOGICAL CHILD | STEPCHILD | FOSTER CHILD | ADOPTED CHILD | OTHER

B4. YOUR LEGAL LAST NAME (NEEDED IN CASE PAGES OF THIS CLAIM BECOME SEPARATED)

B5. CHILD'S SOCIAL SECURITY NUMBER (IF AVAILABLE)

B6. CHILD'S DATE OF BIRTH (M M D D Y Y Y Y)

B7. CHILD'S GENDER: MALE | FEMALE

B8. LEGAL NAME OF CHILD (FIRST | MIDDLE INITIAL | LAST)

B9. CHILD'S RESIDENCE ADDRESS (IF DIFFERENT FROM CLAIMANT'S)

CITY | STATE/PROV. | ZIP OR POSTAL CODE | COUNTRY (IF NOT U.S.A.)

B10. AS EVIDENCE OF THE RELATIONSHIP IN B3, CHECK ONE OF THE FOLLOWING AND ATTACH A COPY OF THE DOCUMENT CHECKED. (DO NOT SEND ORIGINAL DOCUMENT. IT WILL NOT BE RETURNED.)

- ☐ CHILD'S BIRTH CERTIFICATE
- ☐ DECLARATION OF PATERNITY, CS-909
- ☐ FOSTER CARE PLACEMENT RECORD, SOC-815
- ☐ ADOPTIVE PLACEMENT AGREEMENT, AD-907
- ☐ INDEPENDENT ADOPTION PLACEMENT AGREEMENT, AD-924
- ☐ OTHER

B11. **Declaration and Signature.** By my signature on this bonding certification, I authorize the medical provider, adoption agency, adoption party(ies), or foster care placement agency to disclose to the Employment Development Department all facts concerning the birth, adoption, or foster care placement of the above-named child. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements or documents, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.

Original Signature of Bonding Claimant – RUBBER STAMP IS NOT ACCEPTABLE | Date Signed (M M | D D | Y Y Y Y)

PART C – STATEMENT OF CARE RECIPIENT

(MAY BE COMPLETED BY CLAIMANT IF CARE RECIPIENT IS MENTALLY OR PHYSICALLY UNABLE TO DO SO. MUST BE SIGNED BY CARE RECIPIENT OR CARE RECIPIENT'S AUTHORIZED REPRESENTATIVE.)

C1. RECIPIENT'S DATE OF BIRTH (M M D D Y Y Y Y)

C2. RECIPIENT'S TELEPHONE NUMBER

C3. RECIPIENT'S GENDER: MALE | FEMALE

C4. LEGAL NAME OF CARE RECIPIENT (FIRST | MIDDLE INITIAL | LAST)

C5. CARE RECIPIENT'S RESIDENCE ADDRESS

CITY | STATE/PROV. | ZIP OR POSTAL CODE | COUNTRY (IF NOT U.S.A.)

C6. CONFIRMATION OF MEDICAL DISCLOSURE AUTHORIZATION. I have read and signed the Care Recipient's Authorization for Disclosure of Personal-Health Information on page 2 of this claim. I understand that by signing it I have agreed to all its provisions and terms. I further understand that copies of my signature below are as valid as the original.

Care Recipient's Signature (DO NOT PRINT) | Date Signed (M M | D D | Y Y Y Y)

C7. **Authorized Representative** signing on behalf of care recipient must complete the following: I,_____, represent the care or bonding recipient in this matter as authorized by ☐ parental right ☐ power of attorney (attach copy) ☐ court order (attach copy) (For spouse or domestic partner, contact EDD.)

Authorized Representative's Signature (DO NOT PRINT) | Date Signed (M M | D D | Y Y Y Y)

Medical certifications must be completed by a licensed physician or practitioner authorized to certify to a patients disability/serious health condition pursuant to California Unemployment Insurance Code Section 2708.

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INSTRUCTIONS FOR COMPLETING THIS FORM:

Please complete the information in the spaces provided in UPPER CASE using black ink. Do not use special characters (- , . / '). If handwritten, print each letter or number in a separate box. Ignore the boxes provided if using a typewriter or printer.

PART D – PHYSICIAN/PRACTITIONER'S CERTIFICATION (DO NOT COMPLETE THIS PART IF YOU ARE BONDING WITH A CHILD.)

D1. PFL CLAIMANT'S (CARE PROVIDER'S) SOCIAL SECURITY NUMBER

D2. PFL CLAIMANT'S NAME (FIRST | MIDDLE INITIAL | LAST)

D3. **PATIENT'S** DATE OF BIRTH (M M D D Y Y Y Y)

D4. DOES YOUR PATIENT REQUIRE CARE BY THE CLAIMANT? NO (SKIP TO D15) YES

D5. PATIENT'S NAME (FIRST | MIDDLE INITIAL | LAST)

D6. DIAGNOSIS OR, IF NOT YET DETERMINED, A DETAILED STATEMENT OF SYMPTOMS

D7. PRIMARY ICD CODE

D8. SECONDARY ICD CODES

D9. DATE PATIENT'S CONDITION COMMENCED (M M D D Y Y Y Y)

D10. FIRST DATE CARE NEEDED (M M D D Y Y Y Y)

D11. DATE YOU EXPECT RECOVERY (M M D D Y Y Y Y) NEVER

D12. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CLAIMANT (M M D D Y Y Y Y) PERMANENT

D13. APPROXIMATELY HOW MANY TOTAL HOURS PER DAY WILL PATIENT REQUIRE CLAIMANT?
HOURS COMMENTS

D14. WOULD DISCLOSURE OF THIS CERTIFICATE TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL? ..... NO YES

D15. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER

D16. STATE OR COUNTRY PHYSICIAN/PRACTITIONER IS LICENSED.

D17. PHYSICIAN/PRACTITIONER'S NAME (FIRST | MIDDLE INITIAL | LAST)

D18. PHYSICIAN/PRACTITIONER'S ADDRESS (POST OFFICE BOX IS NOT ACCEPTABLE AS THE SOLE ADDRESS)
CITY STATE/PROV. ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)

D19. TYPE OF PHYSICIAN/PRACTITIONER

D20. SPECIALTY (IF ANY)

D21. PHYSICIAN/PRACTITIONER'S Certification and Signature: I certify under penalty of perjury that this patient has a serious health condition and requires a care provider. I have performed a physical examination and/or treated the patient. I am authorized to certify a patient disability or serious health condition pursuant to California Unemployment Insurance Code Section 2708.

Original Signature of Attending Physician/Practitioner – RUBBER STAMP IS NOT ACCEPTABLE | PHYSICIAN/PRACTITIONER'S PHONE NO. | Date Signed (MM | DD | YYYY)

Under sections 2116 and 2122 of the California Unemployment Insurance Code, it is a violation for any individual who, with intent to defraud, falsely certifies the medical condition of any person in order to obtain disability insurance benefits, whether for the maker or for any other person, and is punishable by imprisonment and/or a fine not exceeding $20,000. Sections 1143 and 3305 require additional administrative penalties.