FFCRA Worker Claim Request form

Families First Coronavirus Response Act

Complete this form if asking for benefits under the FFCRA, effective 4/1/20 to 12/31/20. (**CDCS and CSG only)**

Worker Name**:**	
Participant Name:	Representative Name:

Length of Leave Requested

Expected Date of Leave: _____/_____/_____ Expected Date of Return: _____/_____/_____

The weekly amount of leave being requested: _____ hours

Please complete the schedule below for payment *(reminder to only use the hours that you would normally work)*:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Type of leave requested

I am requesting this emergency paid sick leave and/or extended Family Medical Leave Act due to my inability to work because *(check the appropriate reason below)*:

- ☐ 1) I am subject to a Federal/State/Local Quarantine Order related to COVID-19.
- ☐ 2) I have been advised by a health care provider to Self-Quarantine related to COVID-19.
- ☐ 3) I am experiencing COVID-19 symptoms and seeking a medical diagnosis.
- ☐ 4) I am caring for an individual who is subject to an order described in #1 or self-quarantine as described in #2.
- ☐ 5) I am caring for my own child (under the age of 18) whose school or place of care is closed, or childcare provider is unavailable due to COVID-19 related reasons.
- ☐ 6) I am experiencing another substantially similar condition specified by the US Department of Health and Human Services.

Paid Leave Entitlements

- Reasons #1, #2, & #3 - *Full Pay (max $511/day) Up to 2 weeks*
- Reason #4 & #6 - *2/3rd Pay (max $200/day) up to 2 weeks*
- Reason #5 - *2/3rd Pay (max $200/day) up to 12 weeks (2 weeks paid sick time + 10 weeks expanded FMLA)*

Worker Leave Supporting Statement Form

☐ I have completed the required *Worker Leave Supporting Statement* form (see next page) and attached appropriate documentation supporting my need for leave.

Worker Agreement:

I understand that providing false or misleading information regarding the need for FFCRA leave benefits will be grounds for corrective action, up to and including termination of employment.

_____ _____

Worker Signature **Date**

_____ _____

Representative Signature **Date**

Worker Leave Supporting Statement – *Required*

I, _____ (Worker's Name), provide the following information in support of my request for emergency paid sick and/or expanded family medical leave act (complete all that apply):

Leave Related to Government-Issued Quarantine or Isolation Order

Name of Issuing Government Agency: _____

Effective Date of Order: _____/_____/_____ Expected Date of Return: _____/_____/_____

Leave Related to Health Care Provider's Advice to Self-Quarantine

Name of Health care Provider: _____

Written documentation is available and attached: ☐ Yes ☐ No

Name of Individual I am caring for: _____ **Relation to Individual:**_____

Leave Related to School or Place of Child Care Closed Due to COVID-19

Name of School or Place of Care: _____

Name(s) and age(s) pf child(ren) needed to care for: _____

No other suitable person is available to care for my child for the requested leave period: ☐ True ☐ False

List any special circumstances requiring my need for leave to care for a child ages 15-17:

_____

Time off work is expected to be for (select the most appropriate box):

☐ Continuous block of time
☐ Reduced work schedule
(Ex: fewer hours per day or per week)

If a reduced work schedule is needed, indicate the days and hours you are available for work:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Leave Related to Substantially Similar Condition Specified by Secretary of Health & Human Services

Provide details regarding the need for this leave:

_____

I attest that the above information is accurate and complete. I understand falsification of any information given may lead to disciplinary action.

_____ _____

Worker Signature **Date**