Declaration of Claimant (Care Provider) Acting as Authorized Representative for Incapacitated or Deceased Care Recipient

Instructions:

- **Care Recipient Deceased –** If the person receiving care (care recipient) is now deceased:
  - The claimant (care provider) shall complete Sections A, B, and E.
- **Care Recipient Mentally Incapacitated –** If the person receiving care (care recipient) is mentally incapacitated:
  - The claimant (care provider) shall complete Sections A and E.
  - The care recipient's physician/practitioner shall complete Section C.
- **Care Recipient Physically Incapacitated –** If the person receiving care (care recipient) is physically incapacitated:
  - The claimant (care provider) shall complete Sections A, D, and E.
  - The care recipient's physician/practitioner shall complete Section C.

Section A – Claimant's Information and Certification

Claimant's (Care Provider's) Social Security Number: ______________________

Claimant's (Care Provider's) Name: ______________________

Claim Effective Date: ______________________

Person Receiving Care (Care Recipient's) Name: ______________________

I, ______________________, authorize the Employment Development Department to disclose my
Name of Claimant (Care Provider)

personal information, which is contained on this form, to the care recipient and the physician/practitioner certifying hereon to the care recipient's mental or physical incapacity.

Signature of Claimant (Care Provider):______________________ Date signed: ____________

Section B – Care Recipient Deceased

☐ **Care Recipient Deceased**

I declare that the person receiving care (care recipient) died on ______________________ at
Month, Day, Year

______________________, ______________________, ____________.
City, County, State

Section C – Physician/Practitioner's Certification for Mentally or Physically Incapacitated Care Recipient

I ______________________________ hereby certify that the patient (care recipient) named in this
Physician Practitioner's Name

document is under my care and based on my examination, the care recipient is: (select one)
☐ mentally unable ☐ physically unable
to sign documents or authorize release of their medical records.

______________________________	______________________________
Physician/Practitioner's Name as Shown on License	Physician/Practitioner Signature
______________________________	______________________________
Address	State License Number
______________________________	______________________________
Phone Number	Date

Section D – Care Recipient's Authorized Representative/Agent Appointment

I ______________________________, residing at ______________________________
Person Receiving Care (Care Recipient's) Name — City

______________________________, ______________________________
County — State

hereby appoint ______________________________ as my true and lawful representative/agent.
Authorized Representative/Agent's Name

The above named authorized representative/agent is authorized to sign documents on my behalf and release my medical records to my care provider (claimant) and to the Employment Development Department for purposes of establishing my care provider's claim for Paid Family Leave or Nonindustrial Disability Insurance – Family Care Leave benefits.

The authorized representative/agent must sign below in the presence of two witnesses.

______________________________	______________________________
Care Recipient's Signature – Signed by the Authorized Representative/Agent	Date

By ______________________________
Authorized Representative Agent/Claimant's Signature

______________________________	______________________________
Witness' Signature	Witness' Signature
______________________________	______________________________
Witness' Address	Witness' Address

Section E – Authorized Representative/Agent's Declaration

I, ______________________________ residing at ______________________________
Authorized Representative/Agent's Name — Street Address

______________________________, declare that I am the ______________________________
City, State, ZIP Code — Relationship to Person Receiving Care (Care Recipient)

of ______________________________.
Person Receiving Care (Care Recipient's) Name

I declare that I am the care provider (claimant) and authorized representative/agent of the person receiving care (care recipient) named in this document. I am legally authorized to sign documents on behalf of the care recipient and release the medical records of the care recipient for purposes of establishing eligibility for Paid Family Leave or Nonindustrial Disability Insurance – Family Care Leave benefits. I understand that this Declaration is for the sole purpose of releasing the care recipient's medical records pertaining to the care provider's (claimant's) Paid Family Leave or Nonindustrial Disability Insurance – Family Care Leave benefits. I accept the responsibilities and obligations arising from acting on behalf of the care recipient in accordance with the California Unemployment Insurance Code and authorized regulations pertaining thereto.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed at ____________________, ____________________, ____________________
City — County — State

______________________________ ____________________
Authorized Representative/Agent's Signature — Date