Employment Development Department
State of California

Claim for Paid Family Leave (PFL) Care Benefits

Enter your receipt number here.
R1

PART C – INSTRUCTIONS FOR PFL CARE CLAIMS

The care recipient (the person for whom you are providing care) must do the following: Complete and sign "Part C – Statement of Care Recipient." Read and sign the "Care Recipient's Authorization for Disclosure of Personal-Health information" on page 2. If the care recipient is physically or mentally unable to sign, call PFL at (1-877-238-4373) for instructions.

Both pages may be mailed or sent electronically in SDI Online as attachments. If submitting by mail, send to the following address: Paid Family Leave, P.O. Box 997017, Sacramento, CA 95799-7017. If submitting electronically, in SDI Online under Main Menu on your Home page click on: "File a New Claim," then click "Submit Electronic Paid Family Leave Care Attachments."

If the care recipient's physician/practitioner has completed "Part D – Physician/Practitioner's Certification" ONLINE (electronically), Stop Here! Do not go to the next step.

Have the care recipient's physician/practitioner complete and sign "Part D – Physician/Practitioner's Certification" and mail it to the following address: Paid Family Leave, P.O. Box 997017, Sacramento, CA 95799-7017. If the care recipient is under the care of an accredited religious practitioner, call Paid Family Leave at 1-877-238-4373 for the proper form DE 2502F.

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. CARE PROVIDER SSN	C2. RECIPIENT'S DATE OF BIRTH (M M D D Y Y Y Y)	C3. RECIPIENT'S TELEPHONE NUMBER	C4. RECIPIENT'S GENDER
			MALE ☐ FEMALE ☐

C5. **LEGAL NAME OF CARE RECIPIENT** (FIRST, MIDDLE INITIAL, LAST)

C6. **CARE RECIPIENT'S RESIDENCE ADDRESS**

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

C7. 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)

C8. **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)

Enter your receipt number here.
R1

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 1 in Item C7 of Part C shall be as valid as the original.

I understand that unless I inform EDD in writing at P.O. Box 997017, Sacramento, CA 95799-7017, 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 1 IN ITEM C7 OF PART C.

Care recipient's name (Print your name)

Date signed

Care recipient's signature (Sign your name)

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

Enter your receipt number here.

R1

PART D – PHYSICIAN/PRACTITIONER'S CERTIFICATION

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 CARE PROVIDER?
YES ☐ NO (SKIP TO D15) ☐

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 ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CARE PROVIDER
M M D D Y Y Y Y
PERMANENT CARE REQUIRED ☐

D12. DATE YOU EXPECT RECOVERY
M M D D Y Y Y Y
NEVER ☐

D13. APPROXIMATELY HOW MANY TOTAL HOURS PER DAY WILL PATIENT REQUIRE CARE BY A CARE PROVIDER?
HOURS COMMENTS

D14. WOULD DISCLOSURE OF THE MEDICAL INFORMATION ON THIS CERTIFICATE BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL TO YOUR PATIENT?
YES ☐ NO ☐

D15. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER

D16. STATE OR COUNTRY (IF NOT U.S.A.) IN WHICH PHYSICIAN/PRACTITIONER IS LICENSED TO PRACTICE

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:
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 physician/practitioner –
RUBBER STAMP IS NOT ACCEPTABLE

PHYSICIAN/PRACTITIONER'S TELEPHONE 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.

FEDERAL PRIVACY ACT**.** EDD requires disclosure of Social Security account numbers on a mandatory basis to comply with California Unemployment Insurance Code, sections 1253 and 2627; with California Code of Regulations, title 22, sections 1085, 1088, and 1326; with Code of Federal Regulations, title 20, part 604; and with U.S. Code, title 8, sections 1621, 1641, and 1642.

HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT. Federal law requires that we obtain a separate authorization and signature that permits the care recipient's physician/practitioner to provide medical information regarding your claim. EDD collects medical and health information in accordance with Code of Federal Regulations, title 45, part 164.

INFORMATION COLLECTION AND ACCESS**.** State law requires the following information to be provided when collecting information from individuals:

Agency Name:	**Title of Official Responsible for Information Maintenance**:
Employment Development Department (EDD)	Manager, EDD Paid Family Leave Office

Local Contact Person:	**Address and Telephone Number:**
Manager, EDD Paid Family Leave Office	The address and phone number of Paid Family Leave will appear on the "Notice of Computation," DE 429D, issued at the time your benefit determination is made.

Maintenance of the Information is authorized by:

California Unemployment Insurance Code, sections 2601 through 3306.
California Code of Regulations, title 22, sections 2706-1, 2706-3, 2708-1, 2710-1.

Consequences of not providing all or any part of the requested information:

- Failure to supply any or all information may cause delay in issuing benefit payments or may cause you to be denied benefits to which you are entitled.
- If you willfully make a false statement or representation or knowingly withhold a material fact to obtain or increase any benefit or payment, EDD will disqualify you from receiving benefits and/or services and may initiate criminal prosecution against you.

Principal purpose(s) for which the information is to be used:

- To determine eligibility for Paid Family Leave benefits.
- To be summarized and published in statistical form for the use and information of government agencies and the public. (Neither your name and identification nor the name and identification of the care or bonding recipient will appear in publications.)
- To be used to locate persons who are being sought for failure to provide child or spousal support.
- To be used by other governmental agencies to determine eligibility for public social services under the provisions of California Welfare and Institutions Code, division 9.
- To be used by EDD to carry out its responsibilities under the California Unemployment Insurance Code.
- To be exchanged pursuant to California Unemployment Insurance Code, section 322, and California Civil Code, section 1798.24, with other governmental departments and agencies, both federal and state, which are concerned with any of the following:
  - (1) administration of an unemployment insurance program;
  - (2) collection of taxes which may be used to finance unemployment insurance or disability insurance;
  - (3) relief of unemployed or destitute individuals;
  - (4) investigation of labor law violations or allegations of unlawful employment discrimination;
  - (5) the hearing of workers' compensation appeals;
  - (6) whenever necessary to permit a state agency to carry out its mandated responsibilities where the use to which the information will be put is compatible with the purpose for which it was gathered; or
  - (7) when mandated by state or federal law. Disclosures under California Unemployment Insurance Code, section 322, will be made only in those instances in which it furthers the administration of the programs mandated by that Code.
- Pursuant to California Unemployment Insurance Code, sections 1095 and 2714, information may be revealed to the extent necessary for the administration of public social services or to the Director of Social Services or his/her representatives.
- Information shall be disclosed to authorized agencies in accordance with California Unemployment Insurance Code, sections 1095 and 2714.