Submit completed forms to:
860-676-1303 (Fax)
cahcgroup@uchc.edu (Email)

Request For Connecticut Paid Family And Medical Leave Employee to Complete

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	

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

1. Employee's legal name (first name, middle initial, last name)	2. Other last names, if any, under which employee has worked

3. Employee's mailing address Street	City	State	Zip Code	Country (if not USA)

4. Employee's Social Security Number or TIN	5. Employee's date of birth (MM/DD/YYYY)	6. Employee's primary telephone number
		( )

7. Employee's preferred email address while on CT PFML (if available)	8. Employee's gender
	☐ Male ■ Female ☐ Not designated/Other

9. Reason for CT PFML request:
☐ Bond with child ☐ Adoption/Foster child ■ Care for family member ☐ Employee Impacted by Family Violence
☐ Military qualifying event ☐ Military Caregiver: Care of a family member injured in the line of duty
☐ Own serious health condition due to Covered Employee serving as a Bone Marrow Donor
☐ Own serious health condition due to Covered Employee serving as an Organ Donor
☐ Own serious health condition due to pregnancy ☐ Own serious health condition (other)

10. The family member is employee's: ☐ Child ☐ Spouse or registered domestic partner ☐ Family Member Equivalent
☐ Sibling ☐ Parents and legal guardians (or spouse's parent) ☐ Grandparent ☐ Grandchild

11. Will CT PFML be for a continuous period of time and/or periodic?
■ Continuous _____ / _____ / _____ _____ / _____ / _____ ■ Dates are estimated
CT PFML start date (MM/DD/YYYY) CT PFML end date (MM/DD/YYYY)

Identify dates periodic CT PFML will be taken:
☐ Periodic _____ ☐ Dates are estimated

12. Date employer was notified. If providing less than 30 day's advance notice to the employer, please explain:

Employment Information (to be completed by the employee)

13. Business name	14. Employee's date of hire (MM/DD/YYYY)	14a. Employee's last day of work (MM/DD/YYYY)
Capital Area Health Consortium		

15. Has your employment ended? If so, what was your termination date?
N/A

16. Employee's work location Street address
270 Farmington Avenue, Suite 352

City	State	Zip code	Country (if not U.S.A.)
Farmington	CT	06032	

17. Employer's telephone number for contact regarding this request.	18. Is employee currently receiving Workers' Compensation Benefits?
(860) 676-1110	☐ Yes ■ No

19. List income you will be receiving while on CT PFML, source of pay and amount.
None

20. Have you taken any leave in the last 12 months?	21. If yes list dates and type of leave.
☐ Yes ☐ No	

Disclosure statement: Information regarding CT PFML benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Declaration and signature

Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Employee's signature	Date signed (MM/DD/YYYY)

■ FICA tax and FLI tax is not required on paid leave benefits and will not be withheld.

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Request For
Connecticut Paid Family And Medical Leave
Employee to Complete

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	

PART B - EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address
Capital Area Health Consortium, Inc.

Mailing address
270 Farmington Avenue, Suite 352

City	State	Zip code	Country (if not U.S.A.)
Farmington	CT	06032	

2. Employer's FEIN
51-0173264

3. Employer's EIN	4. Employer's contact name for questions related to CT PFML
51-0173264	Michelle Nielson

5. Employer's contact telephone number	6. Employer's contact email address
(860) 676-1110	nielson@uchc.edu

7. Employee's date of hire (MM/DD/YYY)	7a. Employee's last day of work (MM/DD/YYY)

8. Employee's Weekly Wages
$

9. Employee's Typical Work Week Hours
40 hours - varies per week

10a. Check Days Normally Worked ■ Monday ■ Tuesday ■ Wednesday ■ Thursday ■ Friday ☐ Saturday ☐ Sunday

10b. Is employee hourly or salaried? ☐ Hourly ■ Salaried

11. List the last date the employee will receive pay, for example the last date through which sick leave benefits, if any, will be paid.

12. Will any full days of accrued paid time* be used at the same time as PFML? ☐ Yes ☐ No
If so, please provide dates where full days of accrued paid time is being used. _____
**Accrued paid time could be sick leave, annual leave, vacation leave, personal leave, compensatory leave or paid time off.*
Use of full days of accrued paid time, in place of PFML benefits, will decrement the employee's PFML bank.

13a. What type of paid benefits will the employee receive while on CT PFML? Include the last date through which any compensation will be paid.
None

13b. Is the leave request a result of employee's injury on the job? ☐ Yes ■ No
If yes, has the employee applied for Worker's Compensation payments/benefits? ☐ Yes ☐ No
If yes, has the employee received Worker's Compensation payments/benefits? ☐ Yes ☐ No
Amount of Weekly Payment/Benefit: $_____ Effective date of benefits: _____

13c. If, while on CT PFML, the employee will receive wages in the form of sick leave, PTO, vacation or an extended illness leave bank that is at least equal to the benefit under the Group Policy, will the employer be requesting reimbursement ☐ Yes ■ No

14. What dates will the employer be seeking reimbursement for? N/A

CT PFML private plan contact info:

Return paperwork to Capital Area Health Consortium, Inc.

email to: cahcgroup@uchc.edu or fax to: 860-676-1303

Declaration and signature

■ I affirm the employee meets the eligibility for Connecticut Paid Family And Medical Leave.
Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate, and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Employer's authorized contact	Date signed (MM/DD/YYYY)
Michael Tran	

Title
Director of Payroll and Benefits

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cahcgroup@uchc.edu (Email)

Connecticut Paid Family And Medical Leave Certification for Own Serious Health Condition Health Care Provider Instructions

Employee's Name	Date of Birth

INSTRUCTIONS for HEALTH CARE PROVIDERS

This form is used to certify a serious health condition in order to qualify for Connecticut Paid Family and Medical Leave (CT PFML). Qualifying serious health conditions and authorized healthcare providers are described below. Answer each question to the best of your medical knowledge, based on your examination of the patient.

SERIOUS HEALTH CONDITION

A "**serious health condition**" is defined as a condition that involves inpatient care or continuing treatment by a health care provider.

- "**Treatment**" includes examinations to determine if a serious health condition exists and evaluations of the condition.
- A "**regime of continuing treatment**" includes, for example, a course of prescription medication (e.g. an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition.
- It does not include taking of over-the-counter medications such as aspirin, antihistamines, or salves, or bed rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.
- A person has a "serious health condition" if he/she has one or more of the following conditions summarized below:

Inpatient Care:

- An overnight stay in a hospital, hospice, or residential medical care facility.
- Includes any period of incapacity or any subsequent treatment in connection with the overnight stay.

(*Note: If surgery is elective, and an overnight stay in the hospital is required, leave is covered.*)

Continuing Treatment by a Health Care Provider (*any one or more of the following*)

Incapacity and Treatment: A period of incapacity of more than three consecutive full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:

- Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity, unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or
- At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider.

Examples: the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

Pregnancy: Any period of incapacity due to pregnancy.

Chronic Conditions Requiring Treatments: Any period of incapacity due to or treatment for a chronic serious health condition which:

- Requires periodic visits for treatment by a health care provider at least twice a year; and
- Recurs over an extended period of time; and
- May cause episodic rather than a continuing period of incapacity.

Examples: asthma, migraine headaches, diabetes, epilepsy

Permanent/Long-Term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider.

"Serious health condition resulting in incapacitation that occurs during a pregnancy" means:

- Prenatal medical appointments
- Pregnancy-related complications
- Recovery from pregnancies that do not end in a live birth
- Childbirth and delivery, and
- The period of time after the delivery during which the biological mother is certified by her doctor to be unable to perform the requirements for her job.

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HEALTHCARE PROVIDERS

"Health Care Provider" means:

- A doctor of medicine or osteopathy authorized to practice medicine or surgery by the state in which the doctor practices,
- A podiatrist, dentist, clinical psychologist, or optometrist authorized to practice in the state and performing within the scope of his or her practice;
- A chiropractor authorized to practice in the state and performing within the scope of his or her practice;
- A nurse practitioner, nurse-midwife, clinical social worker, or physician assistant authorized to practice in the state and performing within the scope of his or her practice;
- A Christian Science practitioner listed with the First Church of Christ, Scientist, in Boston, Massachusetts; or
- Any health care provider from whom the employer or the employer's group health plan's benefits manager will accept a medical certification to substantiate a claim for benefits.

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cahcgroup@uchc.edu (Email)

Connecticut Paid Family And Medical Leave Certifi cation for Own Serious Health Condition Health Care Provider to Complete

Employee's Name	Date of Birth

PART A: MEDICAL FACTS

1. Diagnosis: _____ Primary ICD Code (optional): _____

   Approximate date condition commenced: _____ Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

   If so, dates of admission: _____

   _____

   Date(s) you treated the patient for condition: _____

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ Yes ☐ No

   If so, state the nature of such treatments and expected duration of treatment: _____

   _____

2. Is the medical condition pregnancy? ☐ Yes ☐ No If so, expected/actual delivery date: _____
3. Complications with pregnancy or delivery? ☐ Yes ☐ No If yes please explain: _____

   _____

   _____

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No

   If so, are the treatments or the reduced number of hours of work medically necessary? ☐ Yes ☐ No

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

   _____

   _____

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

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Connecticut Paid Family And Medical Leave Certifi cation for Own Serious Health Condition Health Care Provider to Complete

Employee's Name	Date of Birth

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No

   Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ Yes ☐ No

   If so, explain: _____

   _____

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours or ____ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Health Care Provider's Name			
Address	City	State	ZIP
Phone No.	Fax No.		
Specialty/Type of Practice		License No.	

Declaration and signature

Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate, and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Signature of Health Care Provider	Date