

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)	
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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 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not designated/Other		
9. Reason for CT PFML request: <input type="checkbox"/> Bond with child <input type="checkbox"/> Adoption/Foster child <input type="checkbox"/> Care for family member <input type="checkbox"/> Employee Impacted by Family Violence <input type="checkbox"/> Military qualifying event <input type="checkbox"/> Military Caregiver: Care of a family member injured in the line of duty <input type="checkbox"/> Own serious health condition due to Covered Employee serving as a Bone Marrow Donor <input type="checkbox"/> Own serious health condition due to Covered Employee serving as an Organ Donor <input type="checkbox"/> Own serious health condition due to pregnancy <input type="checkbox"/> Own serious health condition (other)					
10. The family member is employee's: <input type="checkbox"/> Child <input type="checkbox"/> Spouse or registered domestic partner <input type="checkbox"/> Family Member Equivalent <input type="checkbox"/> Sibling <input type="checkbox"/> Parents and legal guardians (or spouse's parent) <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild					
11. Will CT PFML be for a continuous period of time and/or periodic? <input type="checkbox"/> Continuous ____ / ____ / ____ <input type="checkbox"/> 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: <input type="checkbox"/> Periodic _____ <input type="checkbox"/> 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)	
15. Has your employment ended? If so, what was your termination date?				
16. Employee's work location Street address				
City		State	Zip code	Country (if not U.S.A.)
17. Employer's telephone number for contact regarding this request. ()		18. Is employee currently receiving Workers' Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No		
19. List income you will be receiving while on CT PFML, source of pay and amount.				
20. Have you taken any leave in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		21. If yes list dates and type of leave.		

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

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

1. Business's full legal name and mailing address			
Mailing address			
City	State	Zip code	Country (if not U.S.A.)
2. Employer's FEIN			
3. Employer's EIN		4. Employer's contact name for questions related to CT PFML	
5. Employer's contact telephone number ()	6. Employer's contact email address		
7. Employee's date of hire (MM/DD/YYYY)	7a. Employee's last day of work (MM/DD/YYYY)		
8. Employee's Weekly Wages			
9. Employee's Typical Work Week Hours			
10a. Check Days Normally Worked <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday			
10b. Is employee hourly or salaried? <input type="checkbox"/> Hourly <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please provide dates where full days of accrued paid time is being used. _____ <i>*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.</i>			
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.			
13b. Is the leave request a result of employee's injury on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, has the employee applied for Worker's Compensation payments/benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, has the employee received Worker's Compensation payments/benefits? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No			
14. What dates will the employer be seeking reimbursement for?			
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 <input type="checkbox"/> 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 Michael Tran	Date signed (MM/DD/YYYY)		
Title			

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

Employee's Name	Date of Birth
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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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Health Care Provider Instructions Cont.**

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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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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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