Employee Application for Family and Medical Leave (FMLA)

For COVID-19 in relation to Families First Coronavirus Response Act (2020)

Eligibility Period: April 1, 2020 and shall continue until discontinued by the ACCGov Manager

FOR SUBMISSION BY EMPLOYEE
DIRECTLY TO THE BENEFITS & WELLNESS DIVISION OF THE HR DEPARMENT

FMLA SELF-CERTIFICATION FORM FOR LEAVE

ACCGov Employee, in order to keep your medical information confidential, after completing pages 2 – 3, return them directly to the Benefits department. Pages 2 – 3 do NOT need to be given to your department or supervisor.

Is your request for leave directly related to an "on-the-job" exposure to COVID-19?

Yes or No

Leave type requested for COVID 19 concern: *(Please check applicable letter)*

Paid Leave Entitlements:

Up to two weeks (80 hours, or a part-time employee's two-week equivalent) of paid sick leave based on regular rate of pay; paid at:

- *100% for qualifying reasons under payroll code CViso, (up to $511 daily and $5,110 total)*
- *2/3 for qualifying reasons under payroll code CVdep, (up to $200 daily and $2,000 total)l; and*
  - *Up to 10 additional weeks of paid sick leave and expanded family and medical leave paid at 2/3 for qualifying reason (e) below, (up to $200 daily and $12,000 total)*

A part-time employee is eligible for leave for the number of hours that the employee is normally scheduled to work over that period.

Payroll code: CViso (under CViso you may be eligible for short term disability. Please contact HR for additional information if your need for medical leave is beyond two weeks.)

a) Employee is subject to a federal, state, or local quarantine or isolation order related to COVID-19;
b) Employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19;
c) Employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis;

Payroll code: CVdep (see 2/3 pay listed above)

d) Employee is caring for an individual who is subject to a federal, state, or local quarantine or isolation order related to COVID-19 or has been advised by a health care provider to self-quarantine due to concerns related to COVID-19;
e) Employee is caring for a son or daughter whose school or place of care has been closed, or the son or daughter's child care provider is unavailable, due to COVID-19 precautions.

Please note: If you do not meet any of the above scenarios, but would like to take "unpaid" leave due to concerns of the coronavirus, please contact HR to discuss your leave options.

To be completed by the employee needing only intermittent leave:

Provide an estimate of the period during which intermittent leave will be required, and include a schedule in which leave is to be taken intermittently or you will need to work a less than full schedule.

Employee Signature Date

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FMLA for COVID-19 Eligibility Checklist and Acknowledgements

ACCGov Employee, in order to keep your medical information confidential, after completing pages 2 – 3, return them directly to the Benefits department. Pages 2 – 3 do NOT need to be given to your department or supervisor.

I CERTIFY ONE OR MORE OF THE FOLLOWING:	Initials
1. I have worked for ACCGov for at least 30 calendar days.	
2. I am unable to work remotely or report to my worksite.	
3. I am caring for my child(ren) who is younger than 18 whose school or place of care has closed.	
4. I cannot place my child(ren) with their childcare provider due to a public health emergency.	
5. I do NOT meet any of the COVID-19 concerns on page 2, but am cannot perform the full essential functions of my position due to personal illness or injury. (contact HR for additional FMLA/STD information)	

ACKNOWLEDGEMENTS OF UNDERSTANDING
Emergency Paid Sick Leave offered by ACCGov is intended to meet the requirements established by the Families First Coronavirus Response Act. In the case of any conflict or ambiguity in this policy, the Families First Coronavirus Response Act shall prevail.
I understand and acknowledge that paid leave entitlements under the FFCRA is limited to 80 hours of emergency paid leave for full-time employees, and part-time employees are entitled to the greater of: a. The number of hours which they are regularly scheduled over a two-week period; or b. The number of hours which they would work in a two-week period based on an average amount of work scheduled per day over the prior six months.
I understand and acknowledge that employees caring for their child(ren) under the age of 18 whose school or place of care is closed due to OCVID-19 may be eligible for up to 12 weeks of paid sick leave and expanded family and medical leave paid at 2/3 equivalent (up to $200 daily and $12,000 total.)
Once emergency paid leave hours under FFCRA are depleted, I understand that I may be eligible for additional time off (unpaid leave) under FMLA depending on my need for leave. I further understand that an additional FMLA/STD application will be required, and it is my responsibility to contact ACCGov Human Resources for further review.
I understand after exhausting FMLA, ACCGov is not obligated to place me back in my previous position or to find a different position for me and I may be subject to termination.
I understand and agree to report my progress of recovery and my intent to return to work to my supervisor and to the ACCGov Human Resources Department to recertify my health status for both FMLA and STD (if applicable)
I understand that if the leave is for my serious health condition, I am required to provide ACCGov with written medical certification by my health care provider **prior to** returning to work.
I agree to make payments directly to ACCGov for my benefit premiums if I stop receiving a paycheck from ACCGov due to a “No Pay” status. If I go on unpaid leave, I will pay these expenses no later than the first day of each month during my absence. I further understand that if I do not return to work, I will reimburse ACCGov for premiums paid on my behalf during my leave of absence.
If applied for and approved for STD benefits, I understand I will be placed in an inactive status on the 30th work day of disability, and I will stop accruing sick and annual leave at that time.
I understand it is my responsibility to contact the Benefits and Wellness Division of Human Resources upon my return to work when on FMLA for care of family member, and prior to return to work when on FMLA/STD for my own medical necessity.
My signature and date below certifies that I understand all of my rights and obligations under FMLA, FFCRA and STD, and have received all the necessary forms.
______________________________/______________________/______________________ **Name (Please type or print)** **Dept.** **Date**
Signature (Required)