Are You Ready for New York Paid Family Leave?

A Last-Minute Guide to Implementation and Integration

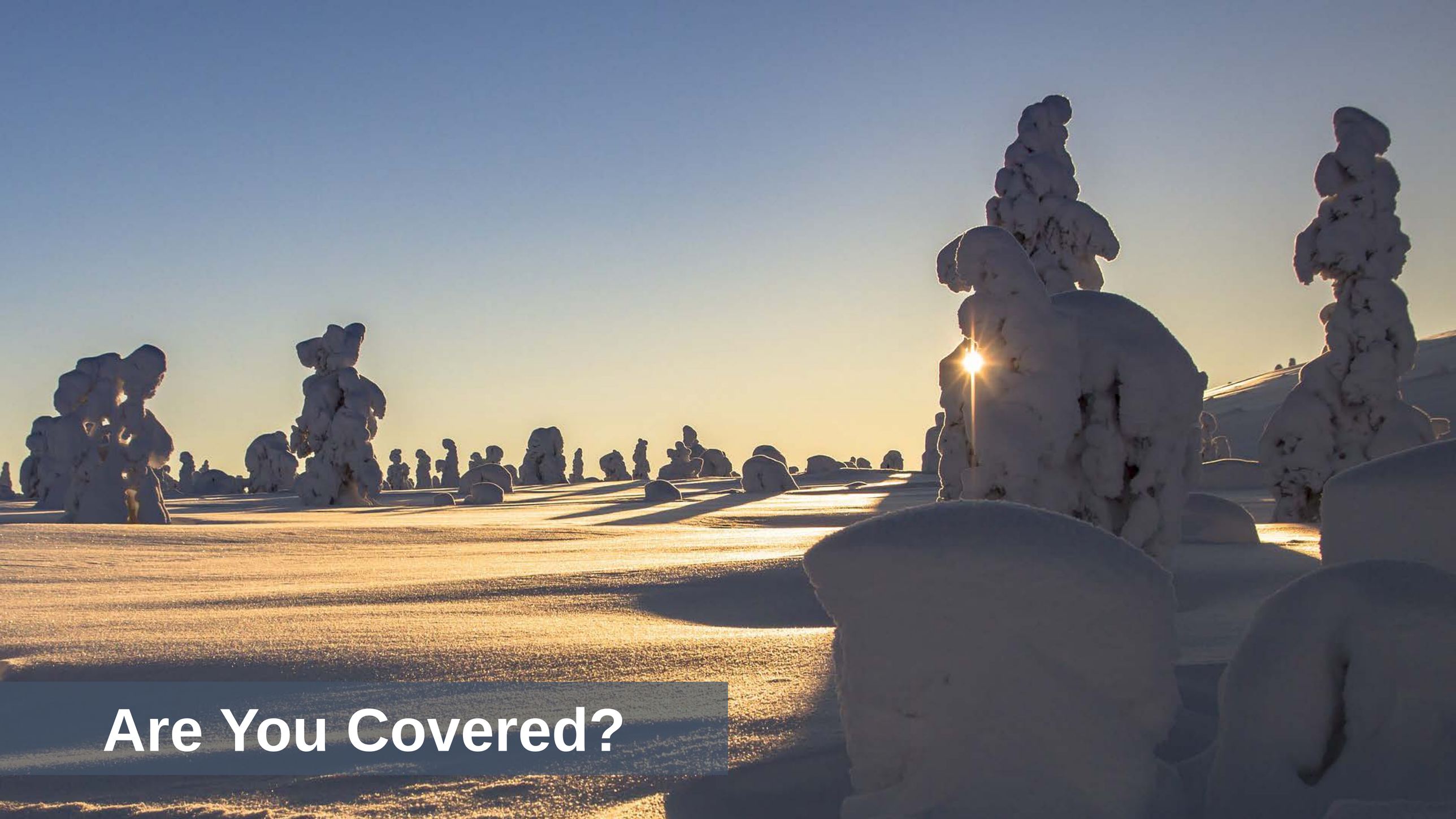
Scott P. Horton

Horton Law PLLC

HORTON
Management Law

Overview

1. Basics
2. Employee Waivers
3. Request Forms
4. PFL Policies
5. Interaction with FMLA



Are You Covered?

Regularly scheduled . . . .

20+ Hrs./week

- Eligible after 26 consecutive work weeks of employment

<20 Hrs./week

- Eligible after 175 days worked

Unlike FMLA:

- Don’t have to be employed for a year
- No hours worked requirement
- Doesn’t matter how many employees in proximity

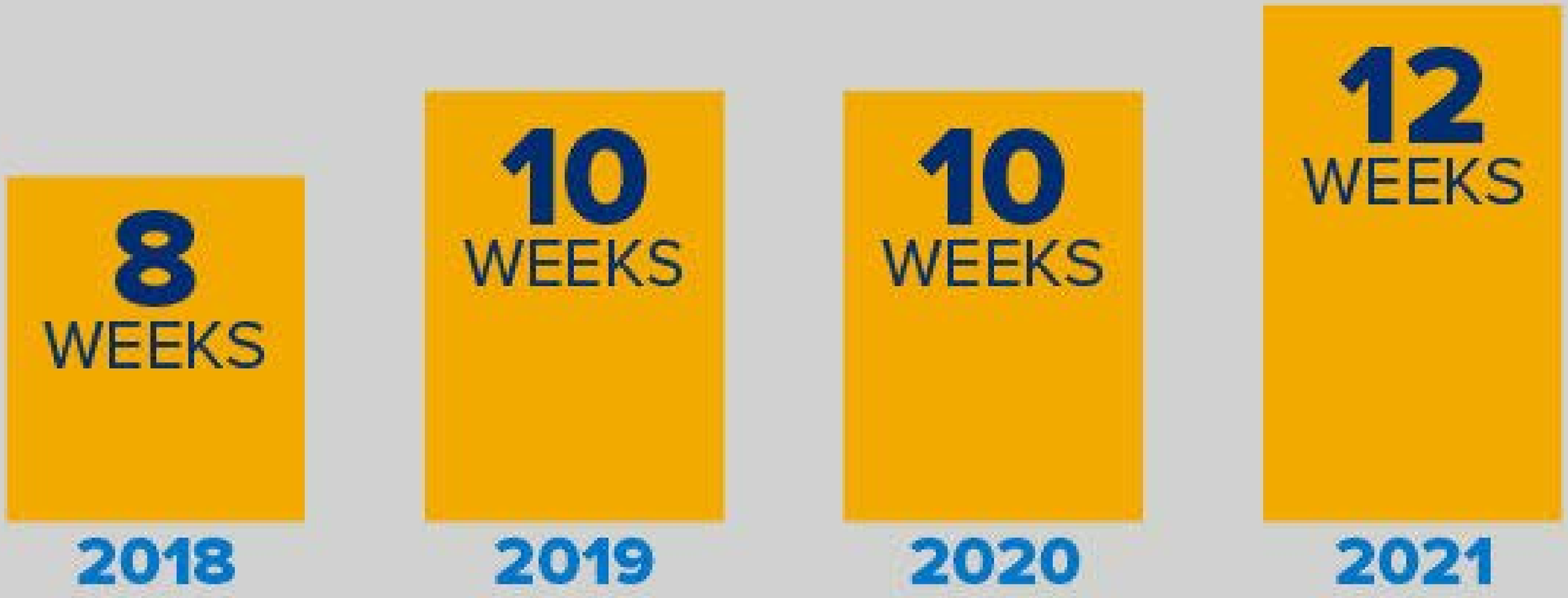
Employee Payroll Deductions

~~Up to~~ 0.126% of an employee's weekly wage with a maximum deduction of $1.65 per week.

Qualifying Purposes

- Bonding w/New Child
- Family Member
  Serious Health Condition
- Family Member
  Military Deployment

Maximum Leave Allowed



How much?

Percentage of Average Weekly Wage (AWW)

Percentage of Wages, with Cap

Year	Max Weeks	% AWW	% NYS AWW
2018	8	50	50
2019	10	55	55
2020	10	60	60
2021	12	67	67

The 2017 New York State Average Weekly Wage is $1,305.92. So, the initial maximum paid family leave benefit will be $652.96.

NEW YORK STATE | Paid Family Leave

STATEMENT OF RIGHTS FOR PAID FAMILY LEAVE

IF YOU NEED TO TAKE TIME OFF FROM WORK TO CARE FOR A FAMILY MEMBER, YOU MAY BE ENTITLED TO PAID FAMILY LEAVE BENEFITS

Paid Family Leave is employee funded insurance that provides job-protected, paid time off to:

- Bond with a newly born, adopted or fostered child;
- Care for a family member with a serious health condition; or
- Assist loved ones when a family member is called to active military service abroad.

Eligibility:

- Employees with a regular work schedule of **20 or more hours per week** are eligible after **26 consecutive weeks** of employment.
- Employees with a regular work schedule of **less than 20 hours per week** are eligible after **175 days worked**.

You are eligible regardless of your citizenship or immigration status.

Benefits: In 2018, you can take up to eight weeks of Paid Family Leave and receive 50% of your average weekly wage, capped at 50% of the New York State average weekly wage. Generally, your average weekly wage is the average of your last eight weeks of pay prior to starting Paid Family Leave.

Rights and Protections

- **Job Protection**: Return to the same or comparable job after you take leave.
- You keep your **health insurance** while on leave (you may have to continue paying your portion of the premium costs, if any).
- Your **employer is prohibited from discriminating or retaliating** against you for requesting or taking Paid Family Leave.
- You **do not have to exhaust sick leave or vacation** accruals before using Paid Family Leave.

Paid Family Leave Request Process

1. Notify your employer at least 30 days in advance, if foreseeable, or as soon as possible.
2. Complete and submit the Request for Paid Family Leave (Form PFL-1) to your employer.
3. Complete and attach the additional forms as required and submit to the insurance carrier listed below.
4. The insurance carrier must pay or deny your request within 18 days of receiving your completed request.

You may obtain all forms from your employer, their insurance carrier listed below or online at www.ny.gov/PaidFamilyLeave.

Disputes

If your Paid Family Leave claim is denied, you may request to have the denial reviewed by a neutral arbitrator. The insurance carrier listed below will provide you with information about requesting arbitration.

Discrimination Complaints

If your employer terminates your employment, reduces your pay and/or benefits, or disciplines you in any way as a result of you taking or asking about Paid Family Leave, you may request to be reinstated by taking these steps:

1. Complete the Formal Request for Reinstatement Regarding Paid Family Leave form (PFL-DC-119)
2. Send your completed form to your employer and a copy of the completed form to: Paid Family Leave, P.O. Box 9030, Endicott, NY 13761-9030
3. If your employer does not reinstate you within 30 days, you may file a discrimination complaint with the Worker's Compensation Board using form PFL-DC-120, available at http://www.ny.gov/PaidFamilyLeave. The Worker's Compensation Board will assemble your case and schedule a hearing.

For more information, forms, and instructions, visit www.ny.gov/PaidFamilyLeave or call (844)-337-6303.

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law. Your employer's paid family leave benefits insurance carrier is:

Insert Name, Address and Telephone Number of PFL Carrier

PRESCRIBED BY THE CHAIR, WORKERS' COMPENSATION BOARD

PFL-271S (11-17)

NYS Paid Family Leave • PO Box 9030, Endicott NY 13761
PFL Helpline: (844) 337-6303 • www.ny.gov/PaidFamilyLeave

Employer Obligations

- Notice Posting
- Written Guidance
- Waivers
- Statement of Rights

Waiver of Coverage/Contribution

Employee may choose to waive if:

- Schedule is 20+ hrs./week, but will not work for 26 consecutive weeks, or
- Schedule is less than 20 hrs. per week, and they won’t work 175 days in 52 consecutive weeks.

NEW YORK STATE | Paid Family Leave

EMPLOYEE OPT-OUT OF PAID FAMILY LEAVE BENEFITS

Information on the option to opt-out of paid family leave and directions for completing this form can be found on page 2.

Employer Information

1. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	
2. ADDRESS	4. EMPLOYER FEIN
3. CITY, STATE and ZIP CODE	5. TELEPHONE NUMBER

Employee Information

6. EMPLOYEE NAME	
7. HOME ADDRESS	
8. CITY, STATE and ZIP CODE	9. TELEPHONE NUMBER

Employment Information

10. AVERAGE NUMBER OF HOURS WORKED PER WEEK (BASED ON LAST 8 WEEKS)	12. IS THIS JOB TEMPORARY? ☐ YES ☐ NO
11. AVERAGE NUMBER OF DAYS WORKED PER WEEK (BASED ON LAST 8 WEEKS)	IF YES, HOW LONG IS THE JOB EXPECTED TO LAST?

Employee Affirmation

1. I would like to waive paid family leave coverage at this time because (select one):
   - ☐ I regularly work 20 hours or more per week, but will not work 26 consecutive weeks (6 months) for this employer.
   - ☐ I regularly work less than 20 hours per week, but will not work 175 days in 52 consecutive weeks (a year) for this employer.
2. I understand that this waiver is revoked if my work schedule changes and it is anticipated I will work more than 20 hours per week for 6 months, or will work less than 20 hours per week but at least 175 days in a 52 consecutive week period (1 year).
3. I understand that this waiver is **OPTIONAL AND REVOCABLE**.
   (a) My employer may not force me to opt out of paid family leave benefits.
   (b) I may decide later to revoke this waiver even if my schedule does not change.
4. I also understand if this waiver is revoked (either by me or by a change in my work schedule), my employer may take retroactive deductions for the period of time I was covered by this waiver, and this period of time counts towards my eligibility for paid family leave.

Certification

I certify to the best of my knowledge the foregoing statements are complete and true.

Employer's Signature: _____ Date Signed: _____

Employee's Signature: _____ Date Signed: _____

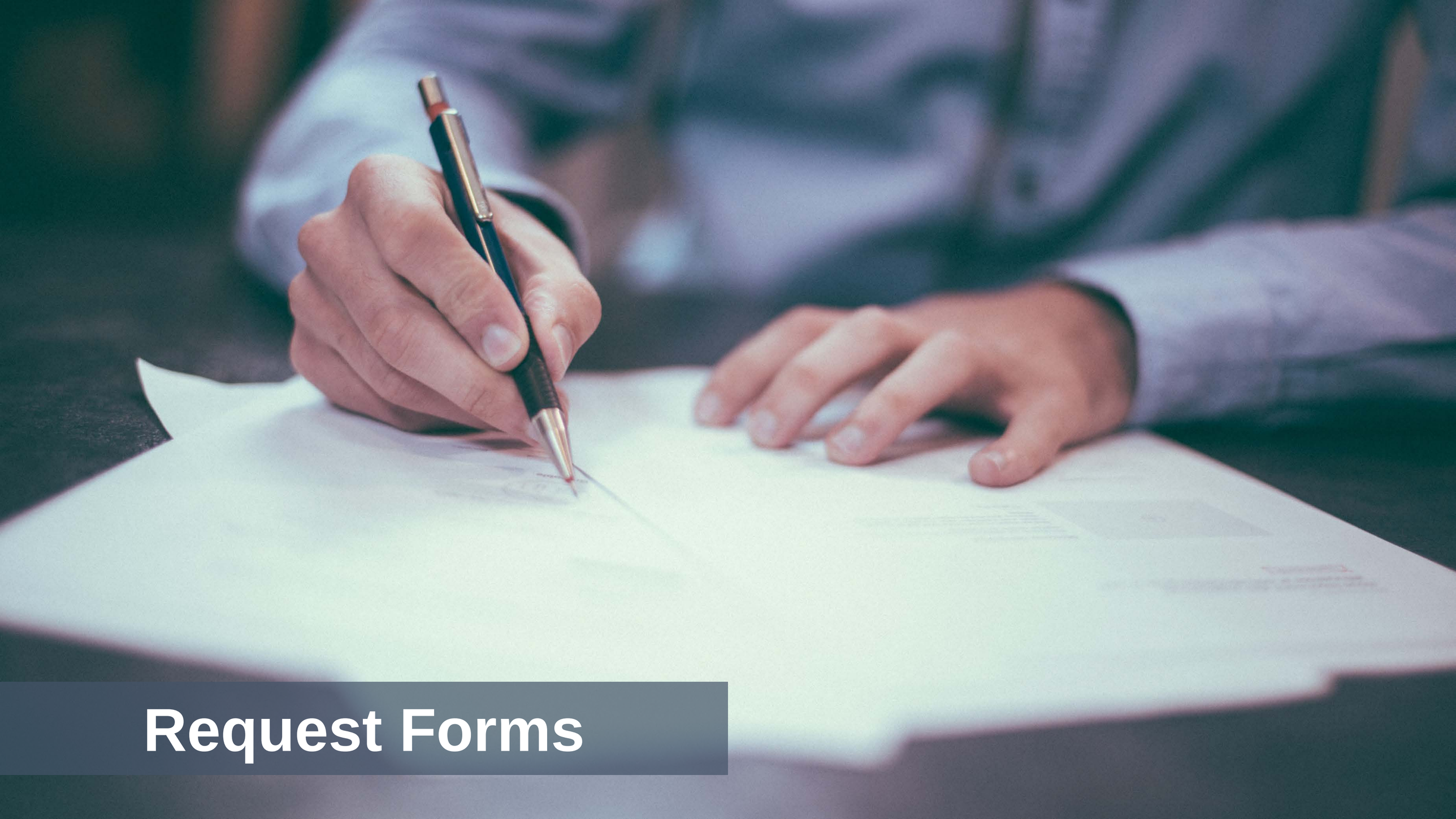
Please note: Employer must keep a copy of the fully executed waiver on file for as long as the employee remains in employment with the covered employer.

If you need assistance, contact the Paid Family Leave Helpline at (844)-337-6303

www.ny.gov/PaidFamilyLeave

Waiver Form

- Optional (for Employees)
- Revocation
- Retroactive Deductions
- Impact on Eligibility?



Request Forms

Request Procedure

1. *Employee completes claim form, gives to employer*
2. *Employer enters information, returns to employee*
3. *Employee attaches certification and submits to carrier*
4. *Carrier must pay/deny within 18 days*

Request for PFL

NEW YORK STATE | Paid Family Leave

Request For Paid Family Leave
(Form PFL-1)

INSTRUCTIONS INCLUDED WITH FORM

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 address
   - City, State
   - Zip code
   - Country (if not U.S.A.)

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 PFL** (if available)

8. **Employee's gender**
   ☐ Male ☐ Female ☐ Not designated/Other

9. **Employee's preferred language**
   ☐ English ☐ Español ☐ Русский ☐ Polski
   ☐ 中文 ☐ Italiano ☐ Kreyòl ayisyen ☐ 한국어
   ☐ Other

Optional (for research purposes)

10. **Employee's ethnicity/race**
    For purposes of health demographic only. (U.S. Centers for Disease Control and Prevention (CDC) code set, version 1.0.)

Is employee of Hispanic, Latino/a, or Spanish origin?
(One or more categories may be selected.)
- ☐ Mexican
- ☐ Mexican American
- ☐ Chicano/a
- ☐ Puerto Rican
- ☐ Dominican
- ☐ Cuban
- ☐ Another Hispanic, Latino/a, or Spanish origin
- ☐ Not of Hispanic, Latino/a, or Spanish origin
- ☐ Unknown

What is employee's race?
(One or more categories may be selected.)
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ White
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Other race

Paid Family Leave (PFL) Request (to be completed by the employee)

11. **Reason for PFL request:** ☐ Bond with child ☐ Care for family member ☐ Military qualifying event

12. **The family member is employee's:**
    ☐ Child ☐ Spouse ☐ Domestic partner ☐ Parent ☐ Parent-in-law ☐ Grandparent ☐ Grandchild

Form PFL-1 continued on next page

TO BE COMPLETED BY THE EMPLOYEE

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

Employee's date of birth (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

PART A - EMPLOYEE INFORMATION (to be completed by the employee) - continued from prior page

Form PFL-1 continued from prior page

13. **Will PFL be for a continuous period of time and/or periodic?**

☐ Continuous — PFL start date (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐ — PFL end date (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐ — ☐ Dates are estimated

☐ Periodic — Identify dates periodic PFL will be taken: — ☐ Dates are estimated

14. **If providing less than 30 day's advance notice to the employer, please explain:**

Employment Information (to be completed by the employee)

15. **Business name**

16. **Employee's date of hire** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

17. **Employee's work location**
    - Street address
    - City, State
    - Zip code
    - Country (if not U.S.A.)

18. **Employee's average gross <u>weekly</u> wage** (This data will be requested of both employee and employer)

19. **Employer's telephone number for contact regarding this request** (☐☐☐) ☐☐☐ - ☐☐☐☐

20a. **Does employee have more than one employer?** ☐ Yes ☐ No

20b. **If yes, is employee taking PFL from the other employer?** ☐ Yes ☐ No

21. **Is employee currently receiving Workers' Compensation Lost Wage Benefits?** ☐ Yes ☐ No

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

Declaration and signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I am hereby making a request for paid family leave benefits under the NYS Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee's signature

Date signed (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

☐ I am submitting this form in advance (see instructions about pre-submitting). I understand the insurance carrier will contact me to advise how to submit the required missing information.

FORM PFL-1 - CONTINUED FROM PRIOR PAGE

TO BE COMPLETED BY THE EMPLOYEE

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

Employee's date of birth (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

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

1. **Business's full legal name and mailing address**

Business name

Mailing address

City, State | Zip code | Country (if not U.S.A.)

2. **Employer's FEIN** ☐☐ - ☐☐☐☐☐☐☐

3. **Employer's Standard Industrial Classification (SIC) Code** ☐☐☐☐

4. **Employer's contact name for questions related to PFL**

5. **Employer's contact telephone number** (☐☐☐) ☐☐☐ - ☐☐☐☐

6. **Employer's contact email address**

7. **Employee's date of hire** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

8. **Employee's occupation** Codes are available at: www.bls.gov/soc/2010/soc_alph.htm ☐☐ - ☐☐☐☐

9. **Enter the last 8 weeks of gross wages for the employee and calculate the average gross weekly wage**

Week no.	Week ending date (MM/DD/YYYY)	Number of days worked	Gross amount paid
1			
2			
3			
4			
5			
6			
7			
8			
Calculated average gross **weekly** wage:			

10. **If employee received or will receive full wages while on PFL, will employer be requesting reimbursement?** ☐ Yes ☐ No

Form PFL-1 continued on next page

FORM PFL-1 - CONTINUED FROM PRIOR PAGE

TO BE COMPLETED BY THE EMPLOYEE

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

Employee's date of birth (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

PART B - EMPLOYER INFORMATION (to be completed by the employer) - continued from prior page

Form PFL-1 continued from prior page

11a. **In the preceding 52 weeks has the employee taken leave for:** ☐ NYS Disability ☐ PFL ☐ Both Disability and PFL ☐ None

11b. **Enter the total number of weeks and days taken for both Disability and PFL in the last 52 weeks:**

Disability: Weeks | Days — Please provide specific dates for Disability:

PFL: Weeks | Days — Please provide specific dates for PFL:

12. **Is the employee taking Family Medical Leave Act (FMLA) concurrently with PFL?** ☐ Yes ☐ No

13. **PFL insurance carrier's name and mailing address**

PFL insurance carrier's name

Mailing address

City, State | Zip code | Country (if not U.S.A.)

14. **PFL insurance carrier's telephone number** (☐☐☐) ☐☐☐ - ☐☐☐☐

15. **PFL policy number** _____

Declaration and signature

☐ **I affirm the employee regularly works 20 or more hours per week and has been in employment for at least 26 consecutive weeks OR the employee regularly works less than 20 hours per week and has worked at least 175 days.**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I am the person authorized to sign as the employer of the employee requesting PFL. My signature affirms that to the best of my knowledge and belief, the information I have provided is true and accurate.

Employer's authorized signature _____ Date signed (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

Title _____

Bonding Certification

NEW YORK STATE | Paid Family Leave

Request For Paid Family Leave
Bonding Certification (Form PFL-2)

INSTRUCTIONS INCLUDED WITH FORM

TO BE COMPLETED BY THE EMPLOYEE

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

Employee's date of birth (MM/DD/YYYY) / /

Other last names, if any, under which employee has worked

Employee's Social Security Number or TIN - -

Employee's mailing address

Mailing address

City, State | Zip code | Country (if not U.S.A.)

BONDING CERTIFICATION (to be completed by the employee)

1. **Child's date of birth** (MM/DD/YYYY) / /
2. **Child's gender** ☐ Male ☐ Female ☐ Not designated/Other
3. **Does child live with the employee requesting PFL?** ☐ Yes ☐ No
4. **Child is employee's:** ☐ Biological child ☐ Stepchild ☐ Foster child ☐ Adopted child ☐ Legal ward ☐ Spouse/Domestic partner's child
5. **Select one of the following and attach the document as required as evidence of the relationship.**

Parent of newborn child:

Birth mother:

- ☐ Health care provider certification of pregnancy (include expected due date AND mother's name); OR
- ☐ Health care provider certification of birth (include date of birth of child AND mother's name); OR
- ☐ Child's birth certificate

Other parent:

- ☐ Copy of birth certificate naming second parent; OR
- ☐ Voluntary acknowledgment of paternity; OR
- ☐ Court order of filiation; OR
- ☐ Birth mother documents (see above) PLUS one of the following:
  - ☐ Marriage certificate; OR
  - ☐ Certificate of civil union; OR
  - ☐ Evidence of domestic partnership
- ☐ OR; Other documentation of parental relationship

Foster parent:

- ☐ Letter of foster care placement or anticipated placement issued by county or city department of Social Services or authorized voluntary foster care agency

Adoptive parent:

- ☐ Court document finalizing adoption
- ☐ Documentation in furtherance of adoption

6. **Date of foster care or adoption placement, if applicable** (MM/DD/YYYY) / /

Form PFL-2 continued on next page

TO BE COMPLETED BY THE EMPLOYEE

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

Employee's date of birth (MM/DD/YYYY) / /

BONDING CERTIFICATION (to be completed by the employee) - continued from prior page

Form PFL-2 continued from prior page

Declaration and signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I am hereby making a request for paid family leave benefits under the NYS Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee's signature

Date signed (MM/DD/YYYY) / /

Medical Forms

NEW YORK STATE | Paid Family Leave

Request For Paid Family Leave
Release Of Personal Health Information
Under The Paid Family Leave Law (Form PFL-3)
INSTRUCTIONS INCLUDED WITH FORM

TO BE COMPLETED BY THE EMPLOYEE

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

Care recipient's (patient's) name (first name, middle initial, last name)

Care recipient's (patient's) date of birth (MM/DD/YYYY)
/ /

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form PFL-4)

I, Care recipient's (patient's) name, **authorize my health care provider listed on this form to release my personal health information to** Employee's name **and their employer's PFL insurance carrier** PFL insurance carrier's name.

Records Subject to Release: This form gives the health care provider listed permission to include information from your health care records on the attached medical certification. This form gives your health care provider permission to release only the information in your health care records that relate to your current condition, which is the subject of the employee's request for Paid Family Leave benefits.

Duration of Revocable Release: This authorization ends after one year, or when you revoke the release. You can cancel this release at any time. To cancel, send a letter to the health care provider listed on this form.

This form does NOT allow your health care provider to release the following types of information, unless you specifically permit such release. Put an "X" next to any information your health provider MAY release:

☐ HIV/AIDS related information ☐ Mental health information ☐ Alcohol/drug treatment ☐ Psychotherapy notes

Health Care Provider Information (to be completed by the care recipient or authorized representative)

Identify the health care provider who is currently providing you with treatment for a condition that is subject to the employee's request for PFL benefits.

1. **Health care provider's name**

2. **Health care provider's mailing address**

Mailing address

City, State | Zip code | Country (if not U.S.A.)

3. **Health care provider's telephone number** (provide area or country code)

Form PFL-3 continued on next page

TO BE COMPLETED BY THE EMPLOYEE

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

Care recipient's (patient's) name (first name, middle initial, last name)

Care recipient's (patient's) date of birth (MM/DD/YYYY)
/ /

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form PFL-4) - continued from prior page

Form PFL-3 continued from prior page

Care Recipient Information (to be completed by the care recipient or authorized representative)

4. **Care recipient's mailing address**

Mailing address

City, State | Zip code | Country (if not U.S.A.)

5. **Care recipient's Social Security Number** - -

6. **Care recipient's telephone number** (provide area or country code)

READ AND SIGN BELOW

I hereby request that the health care provider listed give a completed *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* to the employee identified on the PFL-4 form. I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and any estimation of the amount of care that I require from the employee requesting PFL benefits as a result of my current condition.

Care recipient's signature

Date signed (MM/DD/YYYY)
/ /

Authorized representative

I, Print name, **represent the care recipient in this matter as authorized by:**

☐ Parental right ☐ Power of attorney (attach copy) ☐ Court order (attach copy) ☐ Health care proxy (attach copy)

Authorized representative's signature

Date signed (MM/DD/YYYY)
/ /

The employee should retain a copy for their own records.

NEW YORK STATE | Paid Family Leave

Request For Paid Family Leave

Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)

INSTRUCTIONS INCLUDED WITH FORM

TO BE COMPLETED BY THE EMPLOYEE

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

Employee's date of birth (MM/DD/YYYY) / /

Other last names, if any, under which employee has worked

Employee's Social Security Number or TIN - -

Employee's mailing address

Mailing address

City, State | Zip code | Country (if not U.S.A.)

Care recipient's (patient's) name (first name, middle initial, last name)

Care recipient's (patient's) date of birth (MM/DD/YYYY) / /

HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION

(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

Patient Information / family member with serious health condition (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

1. **Does patient require care by the employee requesting Paid Family Leave (PFL)?**

   ☐ Yes ☐ No (If no, skip to "Health Care Provider Information".)

   Note: For the purposes of this section, "providing care" may include necessary physical care, emotional support, visitation, assistance in treatment, transportation, arranging for a change in care, assistance with essential daily living matters, and personal attendant services.

2. **Primary ICD-10 code (optional)**
3. **Diagnosis**
4. **Date patient's condition commenced** (MM/DD/YYYY) / /
5. **First date care for patient is needed** (MM/DD/YYYY) / /
6. **Expected date patient will no longer require care** (MM/DD/YYYY) / /
7. **Estimated number of days per week OR days per month patient requires care** Days/week **OR** Days/month

Health Care Provider Information (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

8. **Health care provider's name**

Form PFL-4 continued from prior page

TO BE COMPLETED BY THE EMPLOYEE

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

Employee's date of birth (MM/DD/YYYY) / /

Care recipient's (patient's) name (first name, middle initial, last name)

Care recipient's (patient's) date of birth (MM/DD/YYYY) / /

HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION

(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above) - continued from prior page

Form PFL-4 continued from prior page

9. **Type of health care provider:**

   ☐ Medical Doctor (MD) ☐ Dentist (DDS/DDM) ☐ Licensed Social Worker (LMSW/LCSW)
   ☐ Doctor of Osteopathy (DO) ☐ Physician's Assistant (PA) ☐ Other (specify)
   ☐ Doctor of Podiatric Medicine (DPM) ☐ Nurse Practitioner (NP)
   ☐ Doctor of Chiropractic Medicine (DC) ☐ Licensed Psychologist

10. **Health care provider's mailing address**

    Mailing address

    City, State | Zip code | Country (if not U.S.A.)

11. **Health care provider's telephone number** (provide area or country code)
12. **Health care provider's fax number** (provide area or country code)
13. **Health care provider's email address** (if available)
14. **State or country (if not U.S.A.) in which health care provider is licensed to practice**
15. **Specialty**
16. **Health care provider's license number**

Certification and signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

My signature attests that the information I have provided in this form is based on my professional assessment within my licensed scope of practice.

Health care provider's signature | Date signed (MM/DD/YYYY) / /

Military Leave Form

NEW YORK STATE | Paid Family Leave

Request For Paid Family Leave
Military Qualifying Event (Form PFL-5)

INSTRUCTIONS INCLUDED WITH FORM

TO BE COMPLETED BY THE EMPLOYEE

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

Employee's date of birth (MM/DD/YYYY) / /

Other last names, if any, under which employee has worked

Employee's Social Security Number or TIN - -

Employee's mailing address

Mailing address

City, State | Zip code | Country (if not U.S.A.)

MILITARY QUALIFYING EVENT (to be completed by the employee)

1. **Name of military member on covered active duty or impending call to covered active duty status (international deployment)** (first name, middle initial, last name)
2. **Military member's date of birth** (MM/DD/YYYY) / /
3. **Military member's gender** ☐ Male ☐ Female ☐ Not designated/Other
4. **Military member's mailing address**

   Mailing address

   City, State | Zip code | Country (if not U.S.A.)
5. **The above-named military member is employee's:** ☐ Spouse ☐ Domestic partner ☐ Child ☐ Parent
6. **Period of military member's covered active duty** (MM/DD/YYYY)

   / / to / /
7. **Please select one of the following and attach the indicated document to support that the military member is on covered active duty or impending call or order to covered active duty status:**

   ☐ Covered active duty orders ☐ Letter of impending call or order to covered duty ☐ Documentation of military leave signed by the approving authority for military member's Rest and Recuperation

Qualifying Reason For Leave (to be completed by the employee)

8. **What is the reason employee is requesting PFL?** (One or more reasons may be selected.)

   ☐ Arranging for child care
   ☐ Arranging for parental care
   ☐ Counseling
   ☐ Making financial arrangements
   ☐ Making legal arrangements
   ☐ Acting as military member's representative before a federal, state, or local agency for purpose of obtaining, arranging, or appealing military service benefits
   ☐ Attending any event sponsored by the military or military service organizations
   ☐ Other

Form PFL-5 continued on next page

If you need assistance, please call (844) 337-6303
www.ny.gov/PaidFamilyLeave

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FORM PFL-5 - CONTINUED FROM PRIOR PAGE

TO BE COMPLETED BY THE EMPLOYEE

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

Employee's date of birth (MM/DD/YYYY)

MILITARY QUALIFYING EVENT (to be completed by the employee) - continued from prior page

Form PFL-5 continued from prior page

9. Written documentation supporting this request for leave is available and attached?

☐ Yes ☐ No ☐ None Available

Note: A complete and sufficient certification to support a request for PFL leave due to a qualifying event includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. If leave is requested to meet with a third party, the employee must provide the supporting documentation of the meeting that includes the name, address, appropriate contact information of the individual or entity with whom you are meeting (i.e., either telephone number, fax number, or email address of the individual or entity).

Declaration and signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I am hereby making a request for paid family leave benefits under the NYS Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee's signature

Date signed (MM/DD/YYYY)

TO BE COMPLETED BY THE EMPLOYEE

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

Employee's date of birth (MM/DD/YYYY)

Other last names, if any, under which employee has worked

Employee's Social Security Number or TIN

Employee's mailing address

Mailing address

City, State | Zip code | Country (if not U.S.A.)

QUALIFYING REASON FOR LEAVE - DOCUMENTATION

If leave is requested to meet with a third party, the employee must provide supporting documentation of the meeting that includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone number, fax number or email address of the individual or entity). The reason for a meeting can include: arranging for child or parental care, counseling, making financial or legal arrangements, acting as the military member's representative before a federal, state or local agency for purposes of obtaining, arranging or appealing military service benefits, or attending any event sponsored by the military or military service organizations.

Please submit this documentation for each required meeting/event.

Name of individual with whom employee is meeting

Title

Organization

Telephone number (provide area or country code)

Fax number (provide area or country code)

Email address

Mailing address

Mailing address

City, State | Zip code | Country (if not U.S.A.)

Describe nature of meeting. Include dates, if known:

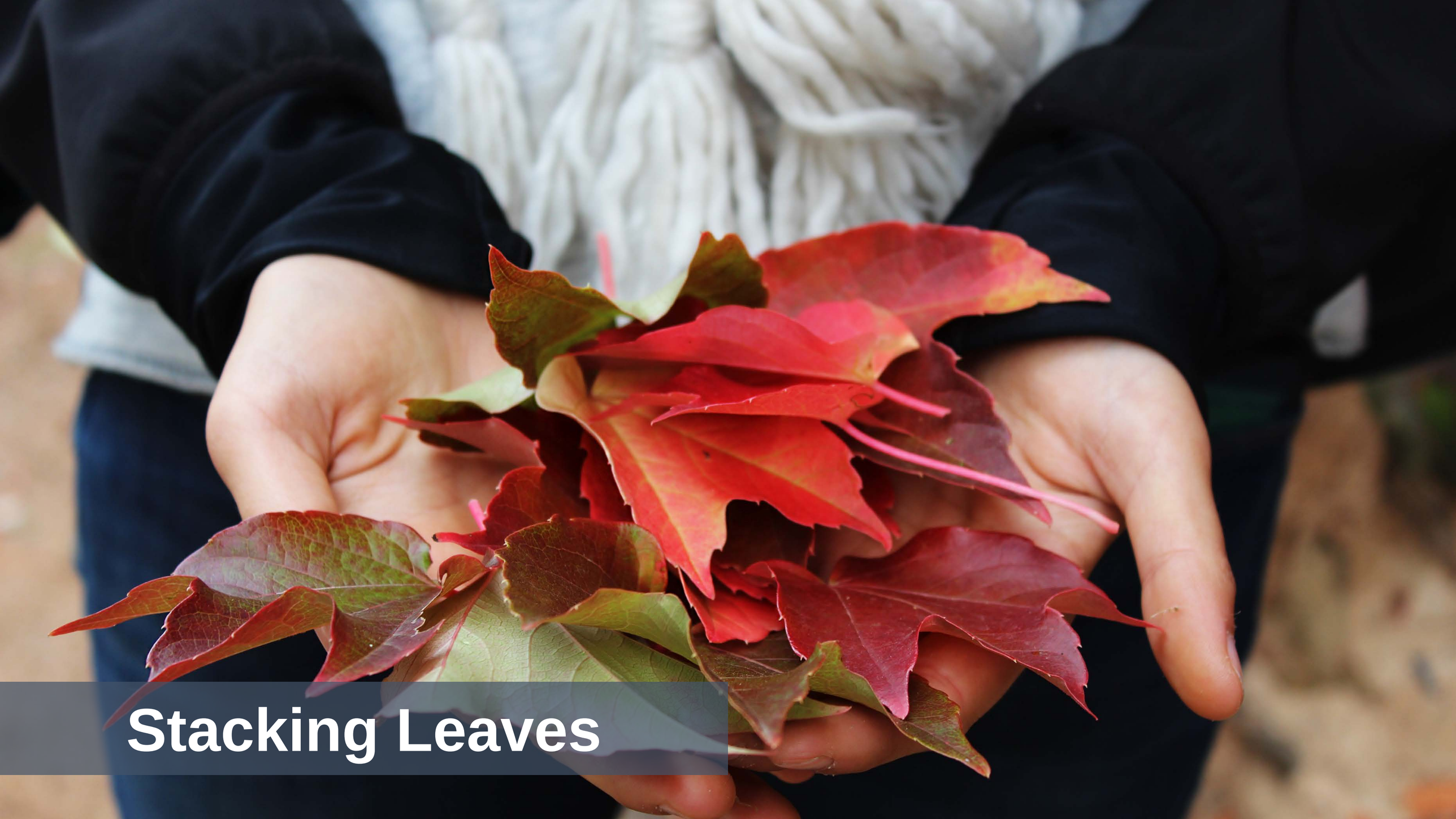
PFL Policies

PFL Policy - Overview

- Employee Handbook or Other Written Guidance
- Separate from FMLA Policy
- Some Optional Elements

PFL Policy – Suggested Elements

- Reference to New York Law
- Employee Eligibility
- Qualifying Reasons for Leave
- Description of Benefits
- Impact on Other Leave Benefits
- Health Insurance Continuation
- Request Procedures
- Waivers
- Coordination of FMLA
- Contact Information
- No Retaliation



Stacking Leaves

Covered Family Members

PFL

- Child (any age)
- Parent
- Spouse
- Step-Parent & Parent-in-law
- Grandparent (incl., step/in-law)
- Grandchild
- Domestic Partner

FMLA

- Child (<18 or “incapable of self-care”)
- Parent
- Spouse

Use of PTO

PFL

- Can **ALLOW** employees to use during PFL leave

FMLA

- Can **REQUIRE** employees to use during FMLA leave

Leave Increments

PFL

- Full-day increments
- Employer can aggregate shorter FMLA leaves

FMLA

- Smallest increment employer allows for other forms of leave
- At least as small as one hour

Reinstatement Rights

PFL

- Same job or “a comparable position with comparable employment benefits, pay and other terms and conditions of employment.”

FMLA

- Same job or an "equivalent job."

An equivalent job means a job that is virtually identical to the original job in terms of pay, benefits, and other employment terms and conditions (including shift and location).

Other PFL/FMLA Differences

- Intermittent Leave
- Leave “Year”
- Key Employees

Thanks for your time!

Questions?

Are You Ready for New York Paid Family Leave?

A Last-Minute Guide to Implementation and Integration

Scott P. Horton, Esq.
Horton Law PLLC
4955 Chestnut Ridge Rd., Suite 203
Orchard Park, New York 14127

scott@hortonpllc.com
(716) 508-7748
HortonPLLC.com

HORTON
Management Law