PACKET A

TO BE USED BY ALL COUNTY EMPLOYEES WHO ARE NOT EMPLOYEES OF THE FOLLOWING COUNTY DEPARTMENTS:

1. **Children & Family Services**
2. **Fire**
3. **Health Services**
4. **Internal Services Department**
5. **Medical Examiner-Coroner**
6. **Mental Health**
7. **Probation**
8. **Public Health**
9. **Public Social Services**
10. **Public Works**
11. **Sheriff**

REQUEST FOR LEAVE OF ABSENCE
Related to COVID-19

Instructions:

1. Eligible Employees may request a leave of absence related to COVID-19 under the Families First Coronavirus Response Act (FFCRA), which includes leaves that may be taken under the Emergency Paid Sick Leave Act (EPSL) and/or the Emergency Family and Medical Leave (EFML) Expansion Act. A description of these leaves is provided on pages 2-3 of this document.

2. To request these leaves, employees are to complete the "Request Form for Leave of Absence, COVID-19 Related". The form is available as a PDF document or as a PDF Fillable document on the Department of Human Resources website at https://employee.hr.lacounty.gov/directors-message-2/

3. Employees are to submit the completed request form to their department's Human Resources Office.
    - Employees who do not know how to reach their department's Human Resource Office can check with their supervisor or their department's Administrative Services for assistance.
    - Departmental Human Resources Offices can provide employees with the e-mail address that can be used to electronically submit the completed request form.

4. If the completed request form is being submitted electronically and the employee is unable to submit the electronic copy of the form with their signature applied, the employee may submit the completed, unsigned request form as an attachment to an e-mail <u>from his or her work or personal e-mail address</u>. Unsigned request forms may not be submitted from an e-mail address that is not the employee's. An employee's submission of a completed, unsigned, request form from the employee's e-mail address will be deemed as his or her certification of the information listed in the form.

	FAMILY MEDICAL LEAVE ACT (FMLA) EXPANDED FAMILY & MEDICAL LEAVE	EMERGENCY PAID SICK LEAVE (EPSL)
Effective Date	Applies to leave taken between April 1, 2020 and December 31, 2020.	Applies to leave taken between April 1, 2020 and December 31, 2020.
Who is Eligible	Employees who have been employed by the County for at least 30 calendar days, regardless of the number of hours worked, except employees who work for one of the excluded departments and who may be excluded from this type of leave as permitted by law.	Employees regardless of how long they have been employed, except employees who work for one of the excluded departments and who may be excluded from this leave as permitted by law.
Amount of Leave	Up to 12 workweeks.	Full-time Employees: Up to 80 hours Part-Time Employees: Up to the average number of hours employee works over a 2-week period
Qualifying Reasons	Employee is unable to work or telework due to a need for leave to care for their son or daughter (under 18 years of age) if the child's school or place of care has been closed; or the child care provider of a son or daughter is unavailable, due to the COVID-19 pandemic. **Note**: Under the FFCRA, a "son or daughter" also includes an adult son or daughter (i.e., one who is 18 years of age or older), who (1) has a mental or physical disability, and (2) is incapable of self-care because of that disability.	Employee is unable to work or telework, and: 1) is subject to a federal, state, or local quarantine or isolation order related to COVID-19; 2) has been advised by a health care provider to self-quarantine due to concerns related to COVID-19; 3) is experiencing symptoms of COVID-19 and seeking a medical diagnosis; 4) is caring for an individual who: (1) is subject to a federal, state, or local quarantine or isolation order related to COVID-19; or (2) has been advised by a health care provider to self-quarantine due to concerns related to COVID-19; 5) is caring for a son or daughter if the school or place of care of the son or daughter has been closed, or the child care provider of the son or daughter is unavailable, due to COVID-19 precautions; or 6) is experiencing any other substantially similar condition as specified by the Secretary of Health and Human Services, in consultation with the Treasury and Labor Departments. **Note**: Under the FFCRA, a "son or daughter" also includes an adult son or daughter (i.e., one who is 18 years of age or older), who (1) has a mental or physical disability, and (2) is incapable of self-care because of that disability.

	FAMILY MEDICAL LEAVE ACT (FMLA) EXPANDED FAMILY & MEDICAL LEAVE	EMERGENCY PAID SICK LEAVE (EPSL)
Pay	First 10 days of leave is unpaid. However, employees may use accrued leave time for these 10 days (e.g., vacation, sick, non-elective or elective leave, EPSL, etc.) After the 10th day, employee is paid the greater of 1) two-thirds of their regular rate of pay, or 2) two-thirds of their current wage for the hours the employee would have regularly worked. Maximum Pay: An employee's pay cannot exceed $200 per day and $10,000 in total.	If leave is taken for reasons 1, 2 or 3 above: • Employee is paid their regular rate of pay or their current wage, whichever is greater. • An employee's maximum pay cannot exceed $511 per day and $5,110 in total. If leave is taken for reasons 4, 5 or 6 above: • Employee is paid two-thirds of their regular rate of pay or two-thirds of their current wage, whichever is greater. • An employee's maximum pay cannot exceed $200 per day and $2,000 in total. The remaining one-third is unpaid leave; employees may not use accrued leave time to supplement the unpaid hours.
Relationship with Other Leaves	Employees are only entitled to up to 12 workweeks FMLA leave in total. That is, an employee may only take a total of 12 workweeks of leave during a 12-month period under the FMLA, including the leave provided by the Emergency Family and Medical Leave Expansion Act. Thus, if an employee has already exhausted their FMLA leave for their 12-month FMLA leave-year period, leave under the Emergency Family and Medical Leave Expansion Act does not provide the employee with an additional 12 workweeks of leave. **NOTE:** If an employee elects to take EPSL concurrently with this expanded FMLA leave in order to receive pay during the first ten days, the maximum cap for this expanded FMLA leave does not extend beyond the 12 week maximum.	Employees are not required to use other accrued leave prior to using this leave. Use of this leave does not count against an employee's paid leave accrual balances, such as accrued vacation leave, sick leave, etc. **NOTE:** Employees are entitled to EPSL regardless of how much leave they have taken under the expanded FMLA leave.
Request for Approval	Employees requesting approval for this leave must submit a request form to their department's Human Resources Office. When the need for leave is foreseeable, employees must notify their department of the need for leave when it is practicable to do so. Expanded family and medical leave is available only until December 31, 2020.	Employees requesting approval for this leave must submit a request form to their department's Human Resources Office. Employees approved for this leave must follow daily notification procedures required for absences in their department. Any unused leave does not carry over past December 31, 2020. Employees are not entitled to reimbursement for unused leave upon retirement, resignation, termination or other separation from employment.

REQUEST FORM FOR LEAVE OF ABSENCE
Related to COVID-19

In order to be eligible for this leave, you must meet the requirements in the Families First Coronavirus Response Act (FFCRA).

Employee Name (Last, First):	Employee Number:
Department:	
Employee Information	
Payroll Title:	
Personal E-mail Address	Work E-mail Address
Home Telephone	Cell Telephone
Supervisor Information	
Name	Title
E-mail Address	Work Telephone

Section 1: Employee Leave Request

1. **I am requesting the following leave (check all that apply):**

☐ **Emergency Paid Sick Leave.** *If requesting this leave, complete Section 2.*

Requested Start Date:	Requested End Date:

Type of Leave Requested (check one):
☐ Continuous
☐ Intermittent. Please provide details of requested leave schedule:

_____

☐ **Family and Medical Leave Act (FMLA) Expanded Family & Medical Leave.** *If requesting this leave, complete Section 3.*

Requested Start Date:	Requested End Date:

Type of Leave Requested (check one):
☐ Continuous
☐ Intermittent. Please provide details of requested leave schedule:

_____

Section 1 (continued)

2. I currently have, or have had within the last twelve months, approval for FMLA leave time? (Yes/No): _____

3. Check one of the following

☐ This is my initial leave request.

☐ This is a supplemental request to extend previously requested and approved leave.

SECTION 2 – EMERGENCY PAID SICK LEAVE (EPSL)

Check in left column all qualifying reasons for leave request.

☐ 1. I am subject to a federal, state, or local quarantine or isolation order related to COVID-19.

A. Provide Government Agency that issued the order:

_____ Federal Centers for Disease Control and Prevention (CDC)
_____ State of California, Governor's Office
_____ Other: _____

☐ 2. I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

A. Provide name of health care provider that advised self-quarantine:

_____

☐ 3. I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis.

A. Provide name of health care provider that will be providing medical diagnosis:

_____

☐ 4. I am caring for an individual who is subject to a federal, state, or local quarantine or isolation order related to COVID-19, or who has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

A. Provide Name of Individual Being Cared For and their relationship to you:

_____

B. Provide Government Agency that issued the order:

_____ Federal Centers for Disease Control and Prevention (CDC)
_____ State of California, Governor's Office
_____ Other: _____

C. Provide name of health care provider that advised self-quarantine:

_____

Section 2 (continued)

☐ 5. I am caring for my son/daughter* whose school or place of care has been closed, or whose child care provider is unavailable, due to COVID-19 precautions; and there is no other suitable person to care for my son/daughter.

A.1 Provide Name of Child(ren) Being Cared For:_____

Provide Name of School/Care Center/Care Provider that is closed or unavailable due to COVID-19:_____

A.2 Provide Name of Child(ren) Being Cared For:_____

Provide Name of School/Care Center/Care Provider that is closed or unavailable due to COVID-19:_____

A.3 Provide Name of Child(ren) Being Cared For:_____

Provide Name of School/Care Center/Care Provider that is closed or unavailable due to COVID-19:_____

☐ 6. I am experiencing a substantially similar condition specified by the Secretary of Health and Human Services, in consultation with the Treasury and Labor Departments.

Provide specified substantially similar condition: _____

_____

SECTION 3 – FAMILY AND MEDICAL LEAVE ACT (FMLA) EXPANDED FAMILY & MEDICAL LEAVE

Check in left column all qualifying reasons for leave request.

☐ 7. My son or daughter's school or place of care has been closed due to COVID-19; and there is no other suitable person to care for my son/daughter.

A.1 Provide Name of Child(ren) Being Cared For:_____

Provide Name of School/Care Center/Care Provider that is closed or unavailable due to COVID-19:_____

A.2 Provide Name of Child(ren) Being Cared For:_____

Provide Name of School/Care Center/Care Provider that is closed or unavailable due to COVID-19:_____

A.3 Provide Name of Child(ren) Being Cared For:_____

Provide Name of School/Care Center/Care Provider that is closed or unavailable due to COVID-19:_____

Section 3 (continued)

☐ 8. My son or daughter's care provider is unavailable due to COVID-19; and there is no other suitable person to care for my son/daughter.

A.1 Provide Name of Child(ren) Being Cared For:_____

Provide Name of School/Care Center/Care Provider that is closed or unavailable due to COVID-19:_____

A.2 Provide Name of Child(ren) Being Cared For:_____

Provide Name of School/Care Center/Care Provider that is closed or unavailable due to COVID-19:_____

A.3 Provide Name of Child(ren) Being Cared For:_____

Provide Name of School/Care Center/Care Provider that is closed or unavailable due to COVID-19:_____

*"son or daughter" includes someone:

A) under 18 years of age, or
B) 18 years of age or older who (1) has a mental or physical disability, and (2) is incapable of self-care because of that disability

Certification: I hereby request leave/approved absence from duty as indicated above and certify that such leave/absence is requested for the purpose(s) indicated. I understand that I must comply with my employing department's procedures for requesting leave/approved absence (and provide additional documentation, including medical certification, if required) and that falsification on this form may be grounds for disciplinary action, including discharge. I understand and fully acknowledge that, should an overpayment occur, I am required to repay the number of hours of paid leave I was not entitled to.

_____ _____

Employee Signature Date

Privacy Act

Section 6311 of Title 5, United States Code, authorizes collection of this information. The primary use of this information is by management and your payroll office to approve and record your use of leave. Additional disclosures of the information may be: to the Department of Labor when processing a claim for compensation regarding a job connected injury or illness; to a State unemployment compensation office regarding a claim; to Federal Life Insurance or Health Benefits carriers regarding a claim; to a Federal, State, or local law enforcement agency when your agency becomes aware of a violation or possible violation of civil or criminal law; to a Federal agency when conducting an investigation for employment or security reasons; to the County of Los Angeles Department of Human Resources or the Chief Executive Office when the information is required for evaluation of leave administration; or the Internal Services Department in connection with its responsibilities for records management.

FOR DEPARTMENTAL USE ONLY

☐ Approved as requested by employee.

☐ Request is approved with the following modification:

_____
_____
_____
_____
_____
_____

☐ Request is NOT approved.

_____ _____
DEPARTMENT HEAD/DESIGNEE SIGNATURE DATE

_____
DEPARTMENT HEAD/DESIGNEE NAME