# FFCRA

# FAMILIES FIRST CORONAVIRUS RESPONSE ACT

*LA County Employee Packet*

# LEAVE BENEFITS BY DEPARTMENT

## FFCRA ELIGIBLE DEPARTMENTS

Proceed to **Page 3**

Agricultural Comm./W&M
Alternative Public Defender
Animal Care & Control
Art & Culture
Assessor
Auditor-Controller
Beches & Harbor
Chief Executive Office
Child Support Services
Consumer & Business Aff.
County Counsel
Development Authority
District Attorney
Exec Office, Board of Superv.
Human Resources
Library
Military & Veterans Aff.
Museum of Art
Natural History Museum
Parks & Recreation
Public Defender
Regional Planning
Registrar-Recorder/CC
Treasurer & Tax Collector
Workforce Dev., Aging & CS

## DISCRETIONARY LEAVE ELIGIBLE DEPARTMENTS

Children & Family Services
Fire
Health Services
Internal Services
Medical Examiner-Coroner
Mental Health
Probation
Public Health
Public Social Services
Public Works
Sheriff

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Packet A

# FFCRA

## ELIGIBLE COUNTY DEPARTMENTS

# About FFCRA

Congress recently passed the *Families First Coronavirus Response Act* (FFCRA), which provides new emergency paid sick leave and childcare leave for employees affected by COVID-19 from **April 1, 2020 to December 31, 2020**.

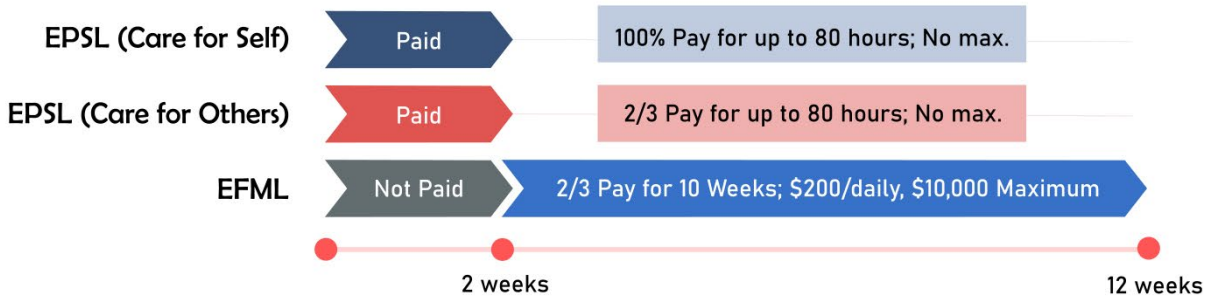
The County is allowing many of its eligible employees to telework during this public health crisis. If employeees are not able to work or telework due to COVID-19 related issues, as detailed below, then this new federal benefit may be a valuable option for you.

The County of Los Angeles has granted COVID-19 Discretionary Leave to employees from 11 departments which provide essential services to our constituents. For the list of departments, please refer to Page 2 in this packet.

# QUICK FACTS

## FFCRA LEAVE BENEFITS

## FFCRA At-A-Glance




Usage of FFCRA leave does not affect Sick Buyback

May use EPSL concurrently with EFML if qualified for both

May not use accrued leave to supplement the 1/3 unpaid portion

May be used on a continuous or intermittent basis

View calculated FFCRA hours on ESS Leave Balances

Must be used from Apr 1 to Dec 31, 2020 Does not carry over to next year

Unused leave balances will not be cashed out for any reason

# Summary of FFCRA Leave Benefits

| Leave Benefit | Hours | Pay Rate | Qualifying Reason<br>Unable to work or telework because employee: |
|---|---|---|---|
| **Emergency Paid Sick Leave (EPSL)**<br>- For Self - | **Full Time**<br>2 weeks (up to 80 hours)<br>**Part Time**<br>2 weeks based on average actual hours worked | Full Employee's Regular Pay Rate<br>No Maximum | Is under federal, state, or local quarantine order related to COVID-19. **OR**<br>Has been advised to self-quarantine by a health care provider due to concerns related to COVID-19. **OR**<br>Is experiencing symptoms of COVID-19 and seeking a medical diagnosis. |
| **Emergency Paid Sick Leave (EPSL)**<br>- For Others - | **Full Time**<br>2 weeks (up to 80 hours)<br>**Part Time**<br>2 weeks based on average actual hours worked | 2/3 of Employee's Regular Pay Rate<br>No Maximum<br>May not use accrued leave to supplement the 1/3 unpaid portion | Is caring for an individual* subject to a federal, state, or local quarantine or isolation order OR has been advised by a health care provider to self-quarantine due to concerns related to COVID-19. **OR**<br>* An individual (18+) can be a family member, or someone who is unable to care for themselves, AND genuinely needs care from employee.<br>Is caring for a child (or disabled adult child) whose school or child care provider is closed or unavailable for reasons related to COVID-19. **OR**<br>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. |
| **Emergency Family & Medical Leave (EFML)**<br>- For Child - | **All Employees**<br>Must be employed by the County for at least 30 calendar days<br>May qualify for up to 12 weeks | First 2 weeks - Unpaid<br>10 weeks - 2/3 of Employee's Regular Pay Rate<br>$200/day Max<br>$10,000 in Total<br>May not use accrued leave to supplement the 1/3 unpaid portion | Is caring for a child (or disabled adult child) whose school or child care provider is closed or unavailable for reasons related to COVID-19.<br>EFML does not provide employee with another 12 weeks in addition to the 12 weeks under "Classic" FMLA.<br>EFML provides an additional qualifying reason to take the pre-existing FMLA leave benefit, but with 10 weeks partially paid.<br>If an employee has already exhausted their 12 weeks of "Classic" FMLA leave this year, then the employee will NOT be provided with an additional 12 weeks even if impacted by COVID-19. |

# How to Apply?

Eligible employees may request a leave of absence related to COVID-19 under the 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.

To request these leaves, employees are to complete:
**REQUEST FORM FOR LEAVE OF ABSENCE (Related to COVID-19)**

Employees are to submit the completed request form to their department's Human Resources Office. If employee does not know how to reach their HR Office, they should contact their supervisor or department's Administrative Services for assistance.

The employee may submit an unsigned completed form as an attachment from employee's work or personal email address, and it will be deemed as his or her certification of the information listed in the form. Unsigned request forms received from an email address other than the employee's will not be accepted.

**COUNTY OF LOS ANGELES**
Department of Human Resources | Occupational Health/Leave Management

# 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<br>(  ) | Cell Telephone<br>(  ) |
| **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


# DISCRETIONARY LEAVE

## ELIGIBLE COUNTY DEPARTMENTS

# Discretionary Leave

The County of Los Angeles has granted COVID-19 Discretionary Leave to employees from 11 departments which provide essential services to our constituents. For the list of departments, please refer to Page 2 in this packet.

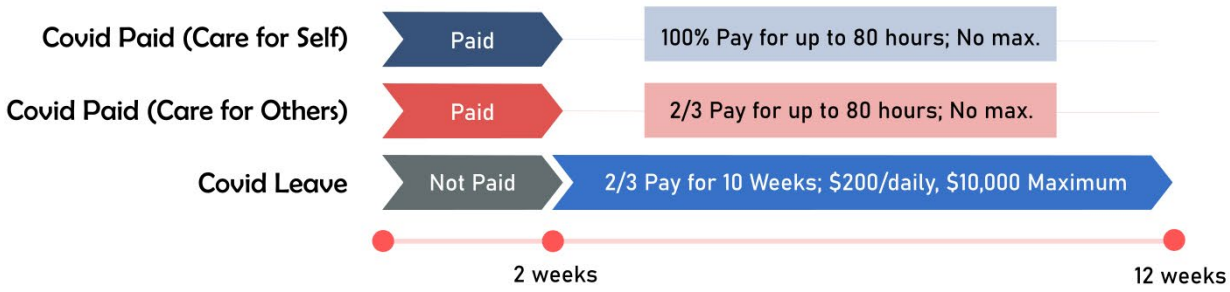
The discretionary leave is not a protected leave. Employees must be pre-approved by their Department Head or designee(s) to use the discretionary leave.

The use of discretionary leave without pre-approval from the employee's Department Head may result in administrative action.

# QUICK FACTS

## DISCRETIONARY LEAVE BENEFITS

### Covid Leave At-A-Glance




Usage of Covid Leave does not affect Sick Buyback

May use Covid Paid Leave Concurrently with Covid Leave if qualified for both

May not use accrued leave to supplement the 1/3 unpaid portion

May be used on a continuous or intermittent basis

Must be used from Apr 1 to Dec 31, 2020 Does not carry over to next year

View calculated leave hours on ESS Leave Balances

Unused leave balances will not be cashed out for any reason

# Summary of Covid Leave Benefits

| Leave Benefit | Hours | Pay Rate | Qualifying Reason<br>Unable to work or telework because employee: |
|---|---|---|---|
| **Covid Paid Leave**<br>- For Self - | **Full Time**<br>2 weeks (up to 80 hours)<br>**Part Time**<br>2 week based on average actual hours worked | Full Employee's Regular Pay Rate<br>No Maximum | Is under federal, state, or local quarantine order related to COVID-19 **OR**<br>Has been advised to self-quarantine by a health care provider due to concerns related to COVID-19 **OR**<br>Is experiencing symptoms of COVID-19 and seeking a medical diagnosis |
| **Covid Paid Leave**<br>- For Others - | **Full Time**<br>2 weeks (up to 80 hours)<br>**Part Time**<br>2 weeks based on average actual hours worked | 2/3 of Employee's Regular Pay Rate<br>No Maximum<br>May not use accrued leave to supplement the 1/3 unpaid portion | Is caring for an individual* subject to a federal, state, or local quarantine or isolation order OR has been advised by a health care provider to self-quarantine due to concerns related to COVID-19. **OR**<br>* An individual (18+) can be a family member, or someone who is unable to care for themselves, AND genuinely needs care from employee.<br>Is caring for a child (or disabled adult child) whose school or child care provider is closed or unavailable for reasons related to COVID-19. **OR**<br>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. |
| **Covid Leave**<br>- For Child - | **All Employees**<br>Must be employed by the County for at least 30 calendar days<br>May qualify for up to 12 weeks | First 2 weeks - Unpaid<br>10 weeks - 2/3 of Employee's Regular Pay Rate<br>$200/day Max<br>$10,000 in Total<br>May not use accrued leave to supplement the 1/3 unpaid portion | Is caring for a child (or disabled adult child) whose school or child care provider is closed or unavailable for reasons related to COVID-19.<br>Covid Leave does not fall within FMLA, and does not reduce employee's available FMLA hours.<br>Approval of an employee's request for this leave is within the discretion of the Department Head or their designee(s). |

# How to Apply?

The 11 essential County departments' employees may request a leave of absence related to COVID-19 under the new County discretionary leave. The request is subject to the approval of the Department Head or designee(s).

To request these leaves, employees are to complete:
**REQUEST FORM FOR LEAVE OF ABSENCE (Related to COVID-19)**

Employees are to submit the completed request form to their department's Human Resources Office. If employee does not know how to reach their HR Office, they should contact their supervisor or department's Administrative Services for assistance.

The employee may submit an unsigned completed form as an attachment from employee's work or personal email address, and it will be deemed as his or her certification of the information listed in the form. Unsigned request forms received from an email address other than the employee's will not be accepted.

**COUNTY OF LOS ANGELES**
Department of Human Resources | Occupational Health/Leave Management

# 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 discretionary leave being requested.*

| Employee Name (Last, First): | Employee Number: |
|---|---|
| Department: | |
| **Employee Information** | |
| Payroll Title: | |
| Personal E-mail Address | Work E-mail Address |
| Home Telephone<br>(  ) | Cell Telephone<br>(  ) |
| **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):**

☐ **COVID Paid 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:
_____

☐ **COVID 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 – COVID PAID LEAVE

**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:_____

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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 – COVID 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:_____

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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***

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**FOR DEPARTMENTAL USE ONLY**

☐ Approved as requested by employee.

☐ Request is approved with the following modification:

_____

_____

_____

_____

_____

_____

☐ Request is NOT approved.
This employee works for a department which has been excluded from FFCRA leave, and the request cannot be approved at this time due to the immediate business needs of the department.

_____ _____

DEPARTMENT HEAD/DESIGNEE SIGNATURE DATE

_____

DEPARTMENT HEAD/DESIGNEE NAME