

FAMILIES FIRST CORONAVIRUS RESPONSE ACT LEAVE REQUEST [FFCRA]

Name & Location: _____

SECTION 1: EMPLOYEE INFORMATION

EMPLOYEE NAME: _____

EMPLOYEE ADDRESS: _____

HOME PHONE NUMBER: _____ CELL PHONE NUMBER: _____

PERSONAL EMAIL ADDRESS: _____

ANTICIPATED BEGIN DATE: _____ ANTICIPATED END DATE: _____

Are you able to work from home intermittently while on any leave?

No Yes, I am available to work from home _____ hours per week.

Are you able to work intermittently at your work place while on leave? (Note: this is only available for employees needing to care for a child due to COVID-19 reasons of school/daycare closures.)

No Yes, I am available to work at my workplace _____ hours per week.

Section A. The EMERGENCY PAID SICK LEAVE ACT (PSLA) of the FFCRA #1-3 provides 10 days [80 hours] of limited paid sick leave benefit for full-time employees outside of FMLA and EFMLEA [below]. This is prorated for part-time employees, including part-time employees who are not eligible for accrued benefits. **All** employees actively employed are eligible for numbers 1-3 below.

Employee is unable to work or work from home for the following reason[s]. Check all applicable:

1. Employee is subject to a Federal, State or local quarantine or isolation order related to COVID-19. *Name of Government Entity that issued the order:* _____

2. Employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19. *Name of health care provider that advised the self-quarantine:* _____

3. Experiencing symptoms of COVID-19 and seeking a medical diagnosis; seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of COVID-19 because of exposure; or obtaining a COVID-19 vaccination or recovering from any injury, disability, illness, or condition related to the vaccination.

For the first three reasons (#1-3) listed above, eligible employees will receive 100% of regular hourly rate with a \$511.00 per day cap [\$5,110.00 aggregate].

Section B. The EMERGENCY PAID SICK LEAVE ACT (PSLA) of the FFCRA #4-6 provides 10 days [80 hours] of limited paid sick leave benefit for full-time employees outside of FMLA and EFMLEA [below]. This is prorated for part-time employees, including part-time employees who are not eligible for accrued benefits.

I am unable to work or work from home for the following reason[s]. Check all applicable:

4. Employee is caring for an individual who is subject to an order as described in reason number 1 or 2 above. *Name of Government Entity or health care provider issuing order:* _____

Name of individual caring for and relationship: _____

5. Employee is caring for a child[ren] because the school is closed or childcare provider has been closed or is unavailable due to COVID-19 and attests that there is no other suitable person to care for my child[ren] during the period requested leave.

Name of school or place of care that closed: _____

Name of child: _____ Age: _____

Name of child: _____ Age: _____

Name of child: _____ Age: _____

Name of child: _____ Age: _____

For children needing care 15 and older ONLY: Please indicate what special circumstances exists, requiring you to provide care for a child 15 and older where you are unable to work:

6. Employee is experiencing a similar condition specified by the U.S. Department of Health and Human Services [HHS].

For the last three reasons {#4-6} listed above, eligible employees will receive 2/3 of regular hourly rate with a \$200.00 per day cap [\$2,000.00 aggregate].

Do you want to substitute your own paid leave [sick, vacation or personal days] to supplement your pay to make your paycheck "whole"?

No, do not substitute any time and just pay the 2/3 paid sick leave (PSLA).

Yes. Please indicate the priority on what time to use first and the maximum hours to use to supplement the **PSLA** hours to receive my normal full pay.

Prioritize in order the accruals you wish to use [i.e. 1-Sick Pay; when depleted use 2-Vacation Pay; when depleted use 3-Personal Day Pay; when depleted use 4-Unpaid Time]:

_____ Sick Leave [_____ Hours]
_____ Vacation Leave [_____ Hours]
_____ Personal Leave [_____ Hours]
_____ Unpaid Hours [_____ Hours]

Section C. The EMERGENCY FAMILY AND MEDICAL LEAVE EXPANSION ACT (EFMLEA)

of the FFCRA is available for employees who have worked thirty [30] calendar days and is caring for a child [ren], under the age of 18, if the child's school or childcare has been closed or is unavailable due to a public health emergency [COVID-19]. Employees who have used FMLA already in 2021, will have the time available under this Act reduced by the FMLA hours already used.

Employee is caring for a child[ren] because the school is closed or childcare provider has been closed or is unavailable due to COVID-19 and attests that there is no other suitable person to care for my child[ren] during the period requested leave.

Name of school or place of care that closed: _____

Name of child: _____ Age: _____

Name of child: _____ Age: _____

Name of child: _____ Age: _____

Name of child: _____ Age: _____

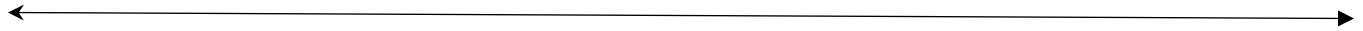
For children needing care 15 and older ONLY: Please indicate what special circumstances exists, requiring you to provide care for a child 15 and older where you are unable to work:

The 10-day unpaid waiting period has been eliminated. Employees may receive up to twelve [12] weeks protected leave for care for a child(ren) in Section B, #5. The cap for the reimbursable credit for EFMLEA has been increased to \$12,000 (from \$10,000).

Therefore, the employee will be eligible for pay equal to 2/3 of the employee's regular rate of pay for the FMLA leave associated with the qualifying COVID-19 reason not to exceed a daily cap of \$200.00 or aggregate cap of \$12,000.00 per person.

Regarding my request under the Families First Coronavirus Response Act (FFRCA), I will provide any necessary documentation such as a copy of any orders that were issued by Federal, State or Local Governments and copies of any documentation from a health care provider of advice to quarantine. I understand falsification of information may result in disciplinary action.

Employee Signature: _____ Date: _____



APPROVALS: DIOCESE OF SUPERIOR & PARISH (SCHOOL) USE ONLY

Leave Request: Approved Not Approved

Diocesan Benefits Office: _____ Date: _____

Parish/School Supervisor: _____ Date: _____