Paid Family Leave for **Family Care**

Agenda

1. Why New York Needs Paid Family Leave
2. Eligibility, Benefits and Contributions
3. Taking Paid Family Leave for Family Care
4. Top Questions About Paid Family Leave for Family Care
5. Resources

Why Do We Need Paid Family Leave?

Why Do We Need Paid Family Leave?

- Employees struggle to maintain their jobs while caring for family in a specific time of need
- Employees face the stress of weeks of lost wages
- Employees fear losing their jobs

NY Leads the Nation

In April 2016, Governor Cuomo signed the nation's strongest and most comprehensive Paid Family Leave policy into law

Paid Family Leave Basics

- It provides paid time off and job protection so you can:

Bond with a child

Care for a family member with a serious health condition

Assist loved ones when a family member is deployed abroad

Helpline: (844) 337-6303

Website: PaidFamilyLeave.ny.gov

Paid Family Leave in 2018

8.5 million New Yorkers covered

128,000 working New Yorkers helped

150+ military claims

86,000+
babies benefitted from bonding leave in 2018

39,000+
family members received care in 2018

Helpline: (844) 337-6303

Website: PaidFamilyLeave.ny.gov

Paid Family Leave for Family Care

Caring for a Family Member with a Serious Health Condition

Quality of care for a family member

Improved pediatric, medical and surgical experience

Management of chronic diseases

Meaning and purpose for the caregiver

Length of hospital stays, readmissions, emergency room use

Stress regarding financial security

Caring for a Family Member with a Serious Health Condition

These family members **can live outside** of New York State and even outside the U.S.

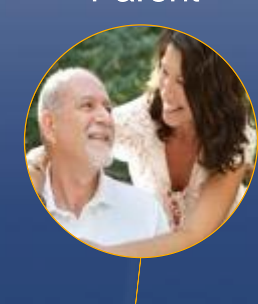
Spouse

Domestic Partner

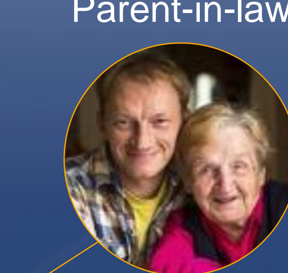
Child

Stepchild

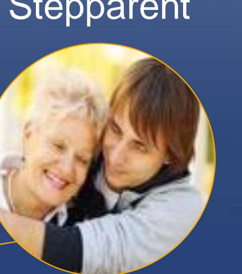
Parent



Parent-in-law



Stepparent



Grandparent

Grandchild

Employees Can Care For

Helpline: (844) 337-6303

Website: PaidFamilyLeave.ny.gov

Caring for a Family Member with a Serious Health Condition

- A serious health condition is defined in part as an illness, injury, impairment, or physical or mental condition requiring either:

Inpatient care

Continuing treatment or supervision by health care provider

Caring for a Family Member with a Serious Health Condition

Caring for or providing care to a family member with a serious health condition may include:

- Necessary physical care
- Emotional support
- Visitation
- Assistance in treatment
- Transportation
- Arranging for a change in care
- Assistance with essential daily living matters
- Personal attendant services

Caring for a Family Member with a Serious Health Condition

Examples of scenarios that may qualify as a serious health condition:

*Whether or not conditions like these qualify will depend on whether or not a qualified health care provider certifies them and whether the PFL insurer approves the leave

Employee Benefits and Contributions

Time Off and Wage Benefits

BENEFITS INCREASE THROUGH 2021		
YEAR	WEEKS OF LEAVE	BENEFITS
2019	10 weeks	55% of employee's AWW,* up to 55% of SAWW**
2020	10 weeks	60% of employee's AWW,* up to 60% of SAWW
2021	12 weeks	67% of employee's AWW,* up to 67% of SAWW

* Benefits will be capped at the designated percentage of the New York State Average Weekly Wage

*The Department of Financial Services will review the marketplace every year before benefits are increased

Wage Benefit Calculators

- Two wage benefit calculators are available:

PAID FAMILY LEAVE

2019 Wage Benefit Calculator

In 2019, employees who take Paid Family Leave will receive 55% of their average weekly wage (AWW), capped at 55% of the New York State Average Weekly Wage. Your AWW is the average of your last eight weeks of pay prior to starting Paid Family Leave. The maximum weekly benefit for 2019 is $746.41.

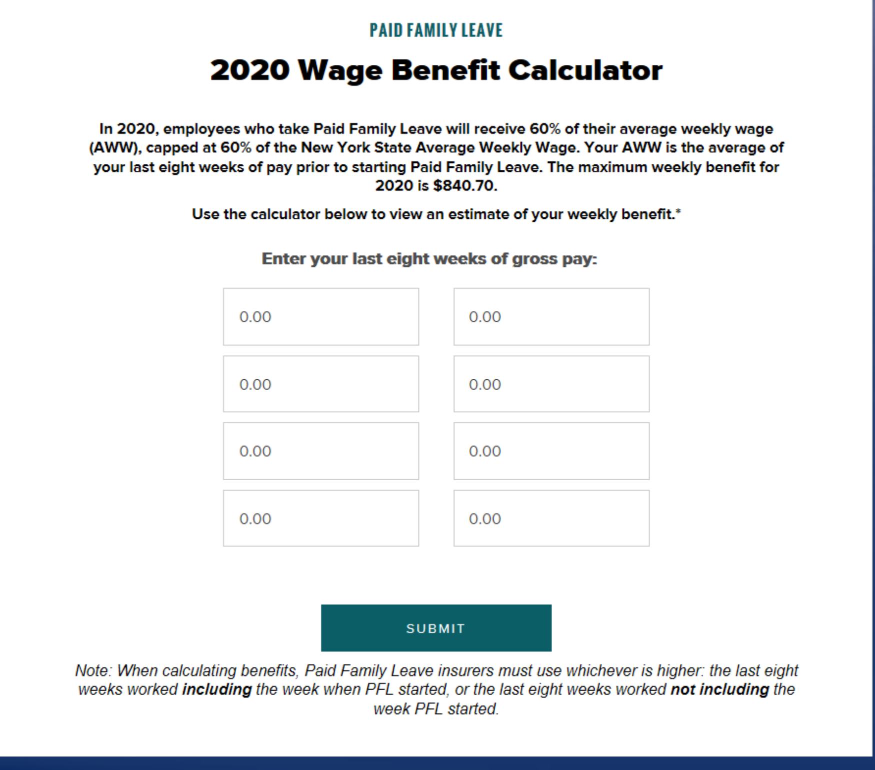
Use the calculator below to view an estimate of your weekly benefit.*

Enter your last eight weeks of gross pay:

0.00	0.00
0.00	0.00
0.00	0.00
0.00	0.00

SUBMIT

*Note: When calculating benefits, Paid Family Leave insurers must use whichever is higher: the last eight weeks worked **including** the week when PFL started, or the last eight weeks worked **not including** the week PFL started.*



PAID FAMILY LEAVE

2020 Wage Benefit Calculator

In 2020, employees who take Paid Family Leave will receive 60% of their average weekly wage (AWW), capped at 60% of the New York State Average Weekly Wage. Your AWW is the average of your last eight weeks of pay prior to starting Paid Family Leave. The maximum weekly benefit for 2020 is $840.70.

Use the calculator below to view an estimate of your weekly benefit.*

Enter your last eight weeks of gross pay:

0.00	0.00
0.00	0.00
0.00	0.00
0.00	0.00

SUBMIT

*Note: When calculating benefits, Paid Family Leave insurers must use whichever is higher: the last eight weeks worked **including** the week when PFL started, or the last eight weeks worked **not including** the week PFL started.*

Your Rights and Protections

Employees have paid time off and:

- Job Protection
- Health insurance continued while on leave
  - Employees continue paying their share, if any
- Protection from discrimination and retaliation for requesting or taking Paid Family Leave

How Much Do You Pay?

- You pay for these benefits through a small weekly payroll deduction
- The 2019 payroll contribution is 0.153% of your weekly wage
  - Contributions are capped at an annual maximum of $107.97
- The 2020 payroll contribution will be 0.270% of your weekly wage
  - Contributions will be capped at an annual maximum of $196.72
- If you earn less than the NYS Average Weekly Wage, your annual contribution will be less than the cap

Weekly Deduction Calculator

- A weekly deduction calculator is available: **Paidfamilyleave.ny.gov/paid-family-leave-calculator2020**

PAID FAMILY LEAVE

2020 Paid Family Leave Payroll Deduction Calculator

If you are eligible for Paid Family Leave, you pay for these benefits through a small payroll deduction equal to 0.270% of your gross wages each pay period. In 2020, these deductions are capped at the annual maximum of $196.72.

Use the calculator below to view an estimate of your deduction.

Enter your gross pay for the pay period, including estimated bonuses/commissions:

0.00

*This calculator is meant to give only an estimate of your PFL deduction. Your actual deduction amount may change depending on whether you receive bonuses and commissions or other forms of compensation as part of your wage.

SUBMIT

Employee Eligibility

Who is Covered?

- Most employees who work for private employers
- If you are a public employee, your employer may opt in
- Public employees represented by a union may be covered if Paid Family Leave is collectively bargained

Who is Eligible?

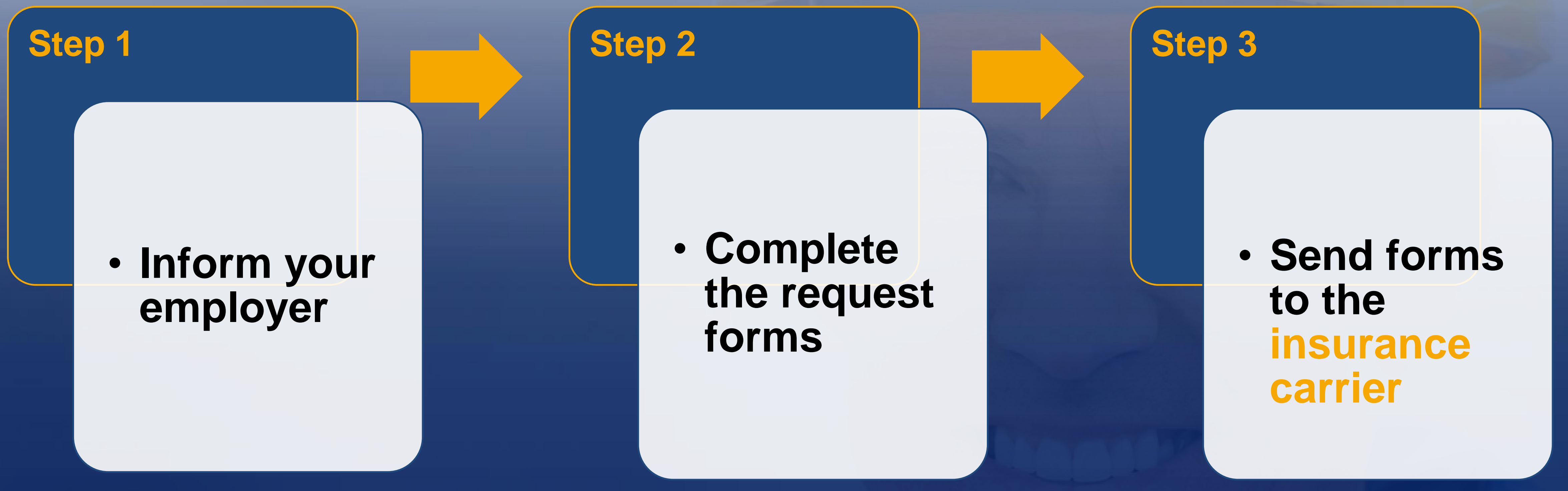
You are eligible if you regularly work:

- 20 or more hours per week
  - For 26 consecutive weeks of employment with the same employer
- Less than 20 hours per week
  - For 175 days

You are eligible regardless of your citizenship and/or immigration status

Taking Paid Family Leave for Family Care

How Employees Request Leave



- Insurers must pay or deny the request within 18 days of a completed request

Step 1: Inform Your Employer

- Let your employer know at least 30 days before your leave will start, if it's foreseeable

Step 2: Complete the Required PFL Request Forms

Family Care leave package includes three forms

- *Request for Paid Family Leave* (*Form PFL-1*)
- *Release of Personal Health Information* (*Form PFL-3*)
- *Health Care Provider Certificate* (*Form PFL-4*)

You can get request forms from:

- Your employer
- Your employer's insurance carrier
- PaidFamilyLeave.ny.gov

Completing the *Request for Paid Family Leave* (*Form PFL-1, Part A*)

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

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

Completing the *Request for Paid Family Leave* (*Form PFL-1, Part A*)

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:

Completing the *Request for Paid Family Leave* (*Form PFL-1, Part A*)

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 **weekly** 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.

Completing the *Request for Paid Family Leave* (*Form PFL-1, Part A*)

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.

PFL-1 (11-17)
Page 2 of 4

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

Employer to Complete *Request for Paid Family Leave* (*Form PFL-1, Part B*)

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/2018/major_groups.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

Completing the *Release of Personal Health Information* (*Form PFL-3*)

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)

/ /

Completing the *Release of Personal Health Information* (*Form PFL-3*)

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

FORM PFL-3 - CONTINUED FROM PRIOR 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.

Helpline: (844) 337-6303 Website: PaidFamilyLeave.ny.gov

Completing the *Health Care Provider Certification* (*Form PFL-4*)

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)
__ __ / __ __ / __ __ __ __

Completing the *Health Care Provider Certification* (*Form PFL-4*)

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)

/ /

Completing the *Health Care Provider Certification* (*Form PFL-4*)

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

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) / /

Step 3: Send Forms to Insurance Carrier

- Send all forms and documentation to your employer's insurance carrier
- The insurance carrier must pay or deny your completed request within 18 calendar days of receiving your completed request

OCTOBER						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Handling Disputes

- If your Paid Family Leave request is denied, or you have another claim-related dispute, you may request arbitration

- Arbitration for Paid Family Leave is handled by NAM (National Arbitration and Mediation) **www.nyspfla.com**

Protection from Discrimination

If your employer:

- does not reinstate you to the same or comparable position,
- terminates you,
- reduces your pay and/or benefits, or
- disciplines you in any way for requesting or taking Paid Family Leave,

you can file a discrimination claim with the Workers' Compensation Board

Top Questions About Paid Family Leave for Family Care

How are Paid Family Leave and FMLA Similar?

Both Paid Family Leave and the federal Family and Medical Leave Act provide:

- Leave for:
  - bonding with a child
  - caring for a family member with a serious health condition
  - assisting when a family member is called to active military service abroad
- Job protection
- Continued health insurance during leave on the same terms as if the employee had continued to work

How do Paid Family Leave and FMLA Differ?

Law	PFL	FMLA
Benefits	**Paid**	**Unpaid**
Coverage	• Almost all private employers • Public employers may opt in • **One or more employees** in employment on each of at least 30 days in a calendar year	• Public and private employers • **50 or more employees** in a 75-mile radius
Eligibility	• After **26** consecutive weeks of employment with that employer if regularly working **20** or more hours per week • After **175** days worked for the same employer if regularly working less than **20** hours per week	• **12** months of employment • **1,250** hours of work in the **12**-month period preceding leave
Reason for Leave	• You **cannot** use for own serious health condition • Can be used to care for a child of any age	• You **can** use for own serious health condition • Can only be used to care for a child if the child is under 18 years old, or "incapable of self-care because of a mental or physical disability"
Length of Leave	• Only in full-day increments	• Hourly basis
Paid Time Off	• Employers cannot require you use paid time off while on PFL	• Employer can compel you to use paid time off while on FMLA

If I Have a Sick Family Member in Another Country, What Do I Need to Do?

- Location of your family member does not matter as long as the employee giving care is in close proximity during the majority of the leave period

- Complete and submit all required documents
  - Out-of-state/out-of-country health care provider responsible for completing medical certification

What is Needed to Demonstrate a Domestic Partnership?

- Common ownership of property
- Children in common
- Sign of intent to marry
- Shared budgeting
- Length of personal relationship

What If I Can't Get My Medical Certification On Time?

You have 30 days from the beginning of your leave to submit your completed request without losing benefits.

- If you cannot get documentation to support a leave request within this timeframe, the insurance carrier can deny the request
- You can reapply once you have supporting documentation

Paid Family Leave Support

Employee Resources

Visit PaidFamilyLeave.ny.gov to access:

- Detailed information on Paid Family Leave
- Weekly payroll deduction and benefit calculators
- Paid Family Leave request forms for Family Care Leave
- Updates for 2020

Learn More

Helpline:
(844) 337-6303

Website:
PaidFamilyLeave.ny.gov

Get Email Updates:
Select "Get Paid Family Leave Updates" on the bottom of PFL website

GET UPDATES

Questions?