

## **COVID-19 ONLY – IHSS/WPCS Provider Sick Leave Request Form**

**A new federal law, Families First Coronavirus Response Act (HR 6201), provides sick leave benefits for COVID-19 ONLY between now and December 31, 2020. If you meet one of the requirements below, please complete this form and submit it to your local county IHSS office. For WPCS providers please return your form to the Department of Health Care Services.**

### **PROVIDER REQUIREMENTS:**

The Families First Coronavirus (COVID-19) Response Act allows full-time workers (40 hours or more per week) to get 80 hours of paid leave, and part-time workers get the average number of hours they work in a 2-week pay period. COVID-19 sick leave may **only** be claimed if you meet one or more of the following criteria:

1. You are subject to a quarantine or isolation order;
  2. You have been advised by a health care provider to self-quarantine;
  3. You are having symptoms of COVID–19 and are seeking a medical diagnosis;
  4. You are caring for an individual who is subject to a quarantine or isolation order or has been advised to self-quarantine by a health care provider;
  5. You are caring for your child who’s school or childcare facilities has been closed due to COVID-19 precautions and there is no one else available to care for your child;
  6. You are experiencing any other substantially similar concerns.
- You may only submit one claim. You will be paid for your entire eligible sick leave benefit in one payment.
  - **By claiming this COVID-19 sick leave, you are attesting that you meet one or more of the criteria above and must select one of the boxes on the form.** If you are sick with, potentially sick with, or have been exposed to COVID-19, **you should not be providing IHSS/WPCS services for any recipient as specified by the Department of Public Health.**
  - Your completed form should be returned to your county IHSS office. For WPCS providers, please return your form to the Department of Health Care Services.

## COVID-19 ONLY PAID SICK LEAVE REQUEST FORM FOR IHSS/WPCS PROVIDERS

**Provider Information:**

Provider Name (Print):		
Street Address:		
City, State:	Zip Code:	Phone Number: (     )

**Provider Number (9 digits):**

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**Recipient Information:** Recipient(s) the provider is out sick from:

<u>Recipient Name:</u>	<u>Recipient Case Number (7 digits):</u>							
	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>							

(For additional recipients please write recipient name and case number on the back of this form)

I am requesting 2-weeks of paid sick leave for the following dates:

Begin Date: 

M	M
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D	D
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Y	Y	Y	Y
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    End Date: 

M	M
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D	D
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Y	Y	Y	Y
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I am claiming sick leave for one of the following reasons (**check one of the boxes below, if left empty this form cannot be processed**):

- I am subject to a quarantine or isolation order, have been advised by my health care provider to self-quarantine, or am having symptoms of COVID-19 and seeking medical diagnosis
- I am caring for a person who is subject to quarantine or isolation order, has been told to self-quarantine by a health care provider, and/or am caring for my child whose school or childcare facility has been closed due to COVID-19 or other COVID-19 concern.

**I hereby acknowledge that**

- I am claiming COVID-19 sick leave because I meet one or more of the criteria of the Families First Coronavirus (COVID-19) Response Act, listed above.
- I have spoken to my recipient(s), and he/she/they know that I will be taking sick leave on the dates indicated above.
- By claiming this leave, I understand that I should not be providing services to any IHSS/WPCS recipient if I have, or potentially have, been exposed to the COVID-19 virus.

Provider's Signature:	Date:
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**Please submit this completed form to your county IHSS Office for processing. WPCS providers should return their form to the Department of Healthcare Services.**