



Heluna Health

Supplemental Forms for

Family & Medical Leave

**Under the Family and Medical Leave Act
& California Family Rights Act**

This packet contains forms and instructions for FMLA/CFRA & Military leave.

This is supplemental to the Employee Guide to Family and Medical Leave.



Heluna Health

Instructions for Applying for Leave

1. Review the Guide to Family and Medical Leave
2. Complete Application Form and Form B (through employee signature) online and email to LOA@HelunaHealth.org. You can also print and submit to:

Human Resources / Leave Department
HELUNA HEALTH
13300 Crossroads Pkwy N., Suite 450
City of Industry, CA 91746

NOTE: Incomplete application will result in the delay or denial of leave. No need to complete the "I offered/mailed" section at the bottom of the application.

(562) 699-7320 x221 | (562) 695-8148 fax

3. If you do not receive an email response, confirm that your forms have been received by calling (562) 222-7821
4. Your application will be processed within 5 business days and notification will be mailed to you of your eligibility. When received, review your notification from Heluna Health of your eligibility and the required submission deadline for your medical certification.
5. If required, provide the medical certification to your/your eligible family member's healthcare provider. Be sure to complete all applicable parts prior to providing to physician.
6. If required, submit your medical certification by the deadline (if unable to submit by deadline, you are responsible for contacting the Leave of Absence department to request an extension). Failure to submit appropriate certification by the deadline will result in the denial of leave.
7. Confirm that your certification has been received by calling (562) 222-7821
8. Your medical certification will be processed and notification of your leave of absence time will be mailed to you.
9. You and your physician should complete FORM 2 and submit prior to return to work date.



Heluna Health

FAMILY AND MEDICAL LEAVE APPLICATION

THIS PAGE MUST BE COMPLETED AND SUBMITTED TO THE LEAVE DEPARTMENT AT HELUNA HEALTH IN ORDER TO BEGIN FMLA/CFRA ELIGIBILITY PROCESSING. ALL QUESTIONS MUST BE COMPLETED.

I understand/acknowledge the following:

- ✓ I will read and understand the contents of the Employee's Guide to Family and Medical Leave.
- ✓ I must be employed by my employer for one (1) year and have worked 1,250 hours in the prior 12 months to be eligible for this leave.
- ✓ Heluna Health uses a "rolling" 12-month period measured backward from the date I notify my employer of the need for FMLA/CFRA.
- ✓ My FMLA/CFRA has been conditionally approved for fifteen (15) calendar days upon notifying my employer of the need for FMLA/CFRA and the submission of the Certification of Physician.
- ✓ I must return the completed Medical Certification form to Heluna Health Headquarters on or before my conditionally approved fifteen (15) calendar days is exhausted. If delays are anticipated, I must contact the Leave of Absence department immediately to request an extension.
- ✓ I may be absent from work for up to fifteen (15) calendar days pending my FMLA/CFRA approval. Failure to submit a completed Certification of Physician within fifteen (15) calendar days may result in disciplinary action for unexcused absence.
- ✓ I must exhaust my accrued benefits before I may use "No Pay".
- ✓ When FMLA/CFRA time is taken, a note from the physician must be submitted upon my return to work.
- ✓ If there are any problems getting the necessary paperwork completed within 15 calendar days of signing this form, I can call Heluna Health and speak to the Human Resources Department at (562) 222-78221.
- ✓ It is my responsibility to make certain that any and all written verifications by physicians of illness or disability are received by Heluna Health.
- ✓ If I've sustained a work-related injury, I must also apply for FMLA/CFRA if available per Federal and State Labor Regulations.
- ✓ Heluna Health will notify me in writing regarding my eligibility.
- ✓ I am still an employee of Heluna Health while on leave. I will not accept employment with any other company.
- ✓ I must return to work on my scheduled return date. Failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by Heluna Health.
- ✓ A copy of this form will be placed in my personnel file.

Name _____ (PLEASE PRINT) Emp # _____ Phone #: _____

Mailing Address: _____
STREET CITY STATE ZIP

(We need a physical mailing address in instances where we need to send mail by expedited delivery. Carriers will not deliver to PO Boxes.)

Physical Address: _____
STREET CITY STATE ZIP

I am / am not applying for FMLA/CFRA. This is a new request / re-certification.

This is a Straight Intermittent Leave of Absence starting _____ and ending _____
(Date Required - Must Estimate) (Date Required - Must Estimate)

Reason: a serious health condition that makes me unable to perform the essential functions of my job
 the birth of a child, or placement of a child with you for adoption or foster care
 a serious health condition affecting a ___spouse, ___child or ___parent, for which I am needed to provide care

 Employee Signature: _____ Date: _____



I offered/mailed _____ Emp # _____ this FMLA/CFRA Packet on _____.
(PLEASE PRINT EMPLOYEE NAME) (DATE)

SUPERVISOR / HR SIGNATURE DATE CLINIC LOCATION



Heluna Health

FORM #1: CERTIFICATION OF HEALTH CARE PROVIDER

FORM MUST BE COMPLETED IN ITS ENTIRETY BY A PHYSICIAN OR MEMBER OF THE PHYSICIAN'S STAFF PRIOR TO LEAVE BEING APPROVED

For completion by the EMPLOYEE

Instructions to the Employee: You must complete this section before giving this form to your medical provider. The law permits us to require that you submit a timely, complete, and sufficient medical certification to support your request for FMLA/CFRA protections. Failure to provide a complete and sufficient medical certification may result in denial of your leave request. **You have 15 calendar days to return this form.**

EMPLOYEE NAME

EMPLOYEE #

BEST CONTACT PHONE NUMBER

For Completion by the HEALTH CARE PROVIDER

Instructions for the HEALTH CARE PROVIDER: Your patient has requested leave. Please answer fully and completely all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answers should be your best estimate based upon your medical knowledge, experience and examination of the patient. Please be as specific as you can; terms such as "lifetime", "unknown", or "indeterminate/indefinite" may not be sufficient to determine leave coverage. **Please do not disclose the underlying diagnosis. Please limit responses to the condition for which the employee is seeking leave. Please be sure to sign and date the form on the last page.**

Provider Name (Please Print)

Business Address (Street, Suite, City, State, Zip Code)

Type of Practice/Medical Specialty

License Number

Telephone

Fax

Medical Facts

1. Patient's Name (If different from employee): _____
2. Does the patient have a serious health condition that qualifies under the categories described on the attached sheet? If so, please check the applicable category:
 No Yes: (1) (2) (3) (4) (5) (6)
3. Describe the medical facts which support your certification (**employee is the patient** - if not skip to Item 4).
 - a. If the **employee is the patient** (if not, skip to Item 4) please answer the following:
 Approximate Date Condition Commenced: _____
 Probable Duration of Medical Condition or Need for Treatment: _____
 Probable Duration of Patient's Present Incapacity (if different from above): _____
 - b. If the **employee is the patient** (if not, skip to Item 4): Will it be necessary for the employee to work only *intermittently* or to work on a *less than full schedule* as a result of the condition (including treatment described in Item 5)?
 No Yes; recommended reduction in schedule and probable duration: _____
 - c. If the **employee is the patient** (if not, skip to Item 4): If the condition is a chronic condition (condition 4) or pregnancy, state whether the patient is *presently incapacitated* and the likely duration and frequency of episodes of incapacity: _____



Heluna Health

Employee's Name: _____

Patient's Name: _____

Certification of Health Care Provider

4. If the **employee is NOT the patient** (SKIP if you answered section 3):
- a. The date, if known, on which the serious health condition commenced: _____
 - b. The probable duration of the condition: _____
 - c. An estimate of the amount of time which you believe the employee needs to care for the child, parent or spouse/domestic partner (frequency): _____
 - d. Does the serious health condition warrant the participation of the employee, including but not limited to providing psychological comfort and arranging third party care as well as directly providing or participating in medical care: No Yes
5. For additional treatments for the patient:
- a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments: _____
 - b. If any treatments will be provided by *another provider of health services* (e.g. physical therapist), please state the nature of the treatments: _____
 - c. If the patient will be absent from work or other daily activities because of treatment on an *intermittent or part-time basis*, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any: _____
 - d. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g. prescription drugs, physical therapy requiring special equipment): _____
6. For employee's absence (employee's own health condition):
- e. If medical leave is required for the employee's absence from work because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee not able to perform work of any kind? No Yes
 - f. Is the employee restricted from performing any one or more of the essential functions of the employee's job (the employee or employer should supply you with information about the essential job functions)? No Yes; the essential functions the employee is unable to perform: _____
 - g. If neither a or b applies, is it necessary for the employee to be absent from work for treatment? _____

ADDITIONAL INFORMATION (Identify Question Number With Any Additional Information to Your Answers)

Signature of Health Care Provider

Date



Heluna Health

Certification of Health Care Provider Definitions

A “Serious Health Condition” means an illness, injury, impairment, or physical or medical condition, whether work related or not, that involves one of the following:

Category 1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

Category 2. Absence Plus Treatment

A period of incapacity of more than three (3) consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

- a. Treatment two or more times by a health care provider, by a nurse or physician’s assistant under the direct supervision of a health care provider, or by a provider of health care services (i.e., physical therapist) under orders of, or on referral by, a health care provider, or
- b. Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

Category 3. Pregnancy

Any period of incapacity due to pregnancy, or for prenatal care.

Category 4. Chronic Conditions Requiring Treatments

A Chronic Condition which:

- a. Requires periodic visits for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider;
- b. Continues over an extended period of time (including recurring episodes of a single underlying condition): and
- c. May cause episodic rather than a continuing period of incapacity (i.e., asthma, diabetes, epilepsy, etc.).

Category 5. Permanent/Long Term Conditions Requiring Supervision

A period of incapacity which is permanent or long term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision or, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer’s, a severe stroke, or the terminal stages of a disease.

Category 6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three (3) consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc), severe arthritis (physical therapy), kidney disease (dialysis).



Heluna Health

FORM #2: NOTICE OF DATE TO RETURN FROM LEAVE

Name: _____ Emp. #: _____

Supervisor: _____

Date Leave Began: _____

Date of Planned Return: _____

I understand that my restoration to employment is subject to the following conditions:

1. As a condition of restoration, each employee must provide a written certification from his/her health care provider that the employee is able to resume working.
2. Every attempt will be made to restore an employee returning from leave to his/her original position. If the employee's original position is unavailable, the employee will be placed in an equivalent position with equivalent pay and benefits.
3. An employee returning from family and medical leave shall not be entitled to the accrual of any seniority or employment benefits during the period of leave.

Employee Signature

Date

.....

I hereby certify that _____ is released to work as of _____
(print patient/employee name) (date)

with the following:

No restrictions.

With the following restrictions until _____
(date)

Signature of Health Care Provider

Type of Practice

Print Name of Health Care Provider

Telephone Number

Address

Fax Number

City, State, Zip

Date



Heluna Health

Sally Hoeng, GBA
Benefits Representative
(562) 699-7320 x239

Teresa Soto
Benefits Representative
(562) 699-7320 x272

FORM B: COMPANY BENEFITS

Heluna Health will pay for and maintain your insurance coverage for the length of your approved FMLA leave of absence. If you are making insurance contributions for other members of your family, you will need to continue to make these contributions during your leave. Unpaid family benefits may result in the cancellation of insurance benefits as a result of non-payment.

You have the option to use sick or vacation hours to cover part or all of your benefit premiums while on a leave of absence. You are advised to contact the Benefits Department to discuss your benefit premiums and determine how many hours may be used to cover all or partial premium amounts. It is your responsibility to check with the State Employment Development Department (EDD) to understand how using sick or vacation hours may impact your benefit claim under Disability Insurance or Paid Family Leave.

In the event that your medical benefits are no longer paid by Heluna Health during your leave, you will be notified of your right to continued medical coverage under COBRA. Premium information will be included with the COBRA information that is sent to you. Please read the benefit information carefully as your rights for continued medical coverage is explained in detail including how to apply for COBRA continuation coverage.

Should you fail to return to work after the expiration of the leave, you will be required to reimburse Heluna Health for payment of health insurance premiums during the family leave, unless the reason you fail to return is the presence of a serious health condition which prevents you from performing your job or due to circumstances beyond your control.

Per ERISA Regulations, FMLA/CFRA does not require Heluna Health to maintain any employee non-health benefits during an employee's leave of absence. If you are making contributions into a Flexible Spending Account (FSA), you are advised to contact the Benefits Department to discuss maintaining your FSA contributions during your leave of absence.

The use of accrued sick, vacation, and PTO will be required/allowed during leave of absences as follows:

- o **Medical Leave (FMLA/CFRA):** Required to exhaust accrued sick, vacation and PTO hours.
 - *Exception:* If claiming State Disability Insurance (SDI) through the Employment Development Department (EDD), the employee must notify the Leave of Absence department and will be required to use time for the first five days only.
- o **Pregnancy Leave (FMLA/PDL):** Option to use accrued sick, vacation, PTO or no pay during pregnancy leave.
- o **Baby Bonding Leave (FMLA/CFRA or Only CFRA when following FMLA/PDL):** Required to exhaust accrued vacation and PTO hours – sick hours are optional.
 - *Exception:* If receiving supplemental income paid directly to the employee (such as through EDD Paid Family Leave, EDD State Disability Insurance, or AFLAC), an employee must notify the Leave of Absence Department prior to the leave start date to elect not to use accrued time. Supplemental income received from an individual to the employee and not from an established business entity is not considered under this exception.
- o **ADA Leave:** Required to exhaust accrued sick, vacation and PTO hours.

It is the responsibility of the employee going on leave to determine how the use of accrued sick, vacation, or PTO hours as described above may impact other benefits (such as from EDD).

PLEASE PRINT NAME: _____ EMP #: _____

INITIALS _____ I understand the information about benefits during a leave of absence as stated above.

INITIALS _____ I understand that failure to contact the benefits department regarding benefits for members of my family may result in the cancellation of insurance benefits as a result of non-payment.

INITIALS _____ I understand that while Heluna Health will pay and maintain my employee insurance coverage during my approved FMLA leave of absence, I will still be responsible to pay for my portion of my coverage if applicable.

INITIALS _____ I understand that if I have outstanding premiums when I return to work, it will be deducted from my paycheck unless I contact the benefit department to coordinate payment arrangements.

INITIALS _____ I understand that Heluna Health may require or I may have the option to use sick or vacation hours (please review policy) to help cover all or partial benefit premiums while on a leave of absence and that I am responsible for contacting EDD to determine how it could affect my benefit amount through Disability Insurance or Paid Family Leave.

I WILL BE RECEIVING SUPPLEMENTAL INCOME DURING MY LEAVE:
 BENEFIT PAYMENTS FROM THE STATE DISABILITY/PAID FAMILY LEAVE PROGRAM
 OTHER: _____

I AUTHORIZE HELUNA HEALTH TO USE _____ HOURS SICK AND/OR _____ HOURS VACATION DURING MY LEAVE OF ABSENCE.

SPECIAL INSTRUCTIONS: _____

SIGNATURE: _____ DATE: _____