

EXPANDED FAMILY AND MEDICAL LEAVE RELATED TO COVID-19

Allied Community Resources
 PO Box 479
 East Windsor, CT 06088
 Email: covid19@alliedgroup.org

Sunset Shores
 67 Bridgeport Avenue
 Milford, CT 06460-3931
 Email: covid19@sunsetshoresfi.com

Employee Name	Employer Name	Date
Employee Phone Number	Employer Phone Number	
Employee Email Address	Leave Start Date	Leave End Date

I CERTIFY THAT AM UNABLE TO WORK (OR TELEWORK) FOR THE FOLLOWING REASON:

I am subject to a **federal, state, or local quarantine or isolation** order related to COVID-19 that specifically prevents me from working.

Name of the government entity issuing the order:

I have been **advised by a health care provider to self-quarantine** because of concerns related to COVID-19.

Name of the advising healthcare provider:

I have **symptoms of COVID-19** and I am seeking (or have sought) a diagnosis.

I am **caring for another individual** who is subject to quarantine or has been advised by a health care provider to self-quarantine related to COVID-19.

Name of person I am caring for and our relationship:

Name of the government entity issuing the order:

OR

Name of the advising healthcare provider:

I **need to care for my child(ren)** because their school or childcare provider is closed or unavailable because of COVID-19. **I certify that no other suitable person is available to care for the child(ren) during the period of requested leave.** If listed child is over 14, I further certify that there are special circumstances that require me to provide care for them.

Name(s) and age(s) of child(ren):

Name of closed school(s) or place(s) of care:

I am **experiencing other conditions substantially similar to COVID-19** as specified by the Department of Health and Human Services.

I am **obtaining an immunization related to COVID-19 or recovering from any injury, disability, illness** or condition related to such immunization. Indicate amount of leave requested: **Part of workday (Specify number of hours) _____ Full workday(s) (Specify number of days) _____.**

I am **seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of, COVID-19, when such employee has been exposed to COVID-19 or the employer has requested such test or diagnosis.** Indicate amount of leave requested: **Part of workday (Specify number of hours) _____ Full workday(s) (Specify number of days) _____.**

Employee Signature _____ Date _____.

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THIS SECTION COMPLETED BY FI

Was information provided verbally over the phone Y N Name of Fiscal Intermediary Employee Recording Information and Certification from Employee Requesting Paid Leave _____ Date _____.

Non-discrimination clause - I certify that I understand that the American Rescue Plan Act disallows discrimination with respect to leave and that my decision to approve or deny a PCA leave for an employee who meets one of the above eligibility criteria must be fairly applied to all employees who request and qualify for such leave. My decision to offer the Paid Leave benefit under the ARPA must, by law, be applied across all of my employees. [EMPLOYER]

Name of FI Staff who recorded employer authorization _____
Employer Authorization Authorized Denied