COVID-19 Supplemental Paid Sick Leave - IHSS/WPCS Provider Request Form

COVID-19 Supplemental Paid Sick Leave is now available and provides sick leave benefits between January 1, 2022 and September 30, 2022.

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:

IHSS/WPCS Providers who meet the qualifying conditions listed below are entitled to the benefit. Full-time providers who work on average 40 hours or more per week can receive up to 40 hours of **Part A** COVID-19 Supplemental Paid Sick Leave. Part-time providers who work on average less than 40 hours per week can receive up to the number of hours they work in a 2-week pay period.

1. You are having symptoms of COVID–19 and are seeking a medical diagnosis;
2. You are having COVID-19 symptoms and are subject to quarantine or have been advised to self-quarantine by a health care provider;
3. You are caring for your child whose school or childcare facility has been closed due to COVID-19 precautions and there is no one else available to care for your child;
4. You or your family member that you care for had a medical appointment to receive a COVID-19 vaccination, or COVID-19 vaccination booster;
5. You are experiencing COVID-19 vaccination or COVID-19 vaccination booster related side effects (up to 3 days or up to 24 hours for each vaccination. Part-time providers who work on average less than 40 hours per week will receive reduced hours based on how many hours the providers work in a 2-week pay period).

The California COVID-19 Supplemental Paid Sick Leave benefit allows a provider to receive **Part B** COVID-19 Supplemental Paid Sick Leave for up to 40 hours for full-time workers, and part-time workers receive up to the average number of hours they work in a 2-week pay period. **Part B** COVID-19 Supplemental Paid Sick Leave may only be claimed if you or a family member you are caring for have tested positive for COVID-19.

- You can submit one claim for your entire eligible sick leave benefit **(Part A and Part B)**, or multiple claims incrementally up to the total hours you are eligible for depending on your **individual reason(s) for the leave.**
- **By claiming this COVID-19 Supplement Paid 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 TEMP 3021 (2/22) form should be returned to your county IHSS office. For WPCS providers, please return your form to the Department of Health Care Services.

CALIFORNIA COVID-19 SUPPLEMENTAL 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):									

Recipient Information: Recipient associated with the provider's sick leave request

Recipient Name: _____

Recipient Case Number (7 digits):

I am claiming sick leave for the following reasons. Check box(es) below, if left empty, this form cannot be processed:

Part A: COVID-19 Supplemental Paid Sick Leave hours

I am requesting COVID-19 Supplemental Paid Sick Leave for the following time (up to 40 hours):

Start Date (MM/DD/YY): _____ **Total Hours:** _____

- ❑ I am having symptoms of COVID–19 and I am seeking a medical diagnosis.
- ❑ I am having COVID-19 symptoms and I am subject to quarantine or have been advised to self-quarantine by a health care provider.
- ❑ I am caring for my child whose school or childcare facility has been closed due to COVID-19 precautions and there is no one else available to care for my child.
- ❑ I had my own medical appointment or travelled with my family member to a medical appointment to receive a COVID-19 vaccination, or COVID-19 vaccination booster.
- ❑ I am experiencing COVID-19 vaccination or COVID-19 vaccination booster related side effects (up to 24 hours sick time may be claimed. See "Provider Requirements" for details).

Part B: Additional COVID-19 Supplemental Paid Sick Leave hours

- ❑ I am requesting additional COVID-19 Supplemental Paid Sick leave for the following time (up to 40 hours) because I have or a family member I am caring for has tested positive for COVID-19.

Start Date (MM/DD/YY): _____ **Total Hours:** _____

I hereby acknowledge that

- **The information provided above is true and correct.**
- **I have spoken to my recipient(s), and he/she/they know that I took sick leave on the dates indicated above.**

Provider's Signature:	Date:

Please submit this completed form to your county IHSS Office for processing. WPCS providers should return their form to the Department of Healthcare Services.