iLIFE
iLIFE, LLC Fiscal Agent

# Family Care and Children's Programs
## Home Care Worker FFCRA Claim Form

**Instructions:** This form should be used for home care workers who are unable to work and therefore requesting payment under the Families First Coronavirus Response Act (FFCRA) for paid sick leave and/or extended family leave beginning April 1, 2020.

If you have questions on whether you qualify, and to calculate the rate at which you could be paid, please visit https://www.dol.gov/agencies/whd/ffcra and https://www.iLIFEfms.com/iLife/COVID-19-Updates.htm.

## BASIC INFORMATION

| Home Care Worker Name: |
|---|
| Employer Name: |

## SECTION 1: PAID SICK LEAVE - *Unable to Work or Telework*

***Select the option below that you qualify for.***

☐ **Reason 1:** I qualify for paid sick leave because I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19.

**Provide the name of the government entity that issued the quarantine or isolation order.**

________________________________________

☐ **Reason 2:** I qualify for paid sick leave because I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

**Provide the name of the health care provider who advised you to self-quarantine.**

________________________________________

☐ **Reason 3:** I qualify for paid sick leave because I am experiencing symptoms of COVID-19 and am seeking medical diagnosis.

**Provide the name of the health care provider who you are seeking a diagnosis from.**

________________________________________

☐ **Reason 4:** I qualify for paid sick leave because I am caring for an individual who is subject to a Federal, State, or local quarantine or isolation order related to COVID-19 or an individual who has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

**Provide the name of the health care provider who you are seeking a diagnosis from.**

________________________________________

**Provide your relationship to the listed individual.**

________________________________________

**Please provide either (1) the government entity that issued the quarantine or isolation order to which the individual is subject or (2) the name of the health care provider who advised the individual to self-quarantine:**

________________________________________

☐ **Reason 6:** I qualify for paid sick leave because I am experiencing another substantially similar condition related to COVID-19.

**Provide the name of the health care provider who you are seeking a diagnosis from.**

______________________________

**I am claiming paid emergency sick time for Section 1 under FFCRA on the following dates:**

| Start Date | End Date |
|---|---|
| | |

***Note: The date range claimed cannot exceed 14 calendar days.*** *The FFCRA benefit will pay your average daily rate for up to two weeks. The specific amount you can receive is based on what you are normally scheduled in a workweek.*

## SECTION 2: PAID SICK LEAVE AND EXPANDED FAMILY AND MEDICAL LEAVE - *Unable to Work or Telework*

***Select the option below that you qualify for.***

☐ **Reason 5:** I qualify for expanded FMLA to care for my child, whose school or place of care is closed (or child care provider is unavailable), due to COVID-19 related reasons.

**Provide (1) the name of the child being cared for.**

______________________________

**Provide (2) the name of the school, place of care, or child care provider that closed or became unavailable due to COVID-19 reasons:**

______________________________

**And (3) do you confirm that no other suitable person is available to care for the child during the period of requested leave:** ☐ **YES** ☐ **NO**

**I am claiming paid emergency sick time for Section 2 under FFCRA on the following dates:**

| Start Date | End Date |
|---|---|
| | |

***Note: The date range claimed cannot exceed 14 calendar days.*** *The FFCRA benefit will pay 2/3rd of your average daily rate for up to two weeks. The specific amount you can receive is based on what you are normally scheduled in a workweek.*

**I am claiming paid extended family medical leave act time for Section 2 under FFCRA on the following dates:**

| Start Date | End Date |
|---|---|
| | |

***Note: The date range claimed cannot exceed 10 weeks or 70 calendar days.*** *The FFCRA benefit will pay 2/3rd of your average daily rate for up to ten weeks. The specific amount you can receive is based on what you are normally scheduled in a workweek.*

## SECTION 3: ATTESTATION

I understand that if my situation changes and I no longer qualify and/or return to work, I will notify iLIFE immediately. I cannot receive payment for time worked for my Employer while claiming sick time or FMLA. I attest that, for the reason above, I am unable to work, including telework, even though work is available. If it is found that I did not qualify for paid sick time or FMLA under FFCRA I will have to pay back the funds received and may be subject to punishment by governing authorities.

**Home Care Worker Signature:** ______________________________

**Employee #:** ______________________________

**Date:** ______________________________

**Please submit all completed FFCRA Claim Forms to FFCRA@iLIFEfms.com.**

**To submit the FFCRA Claim Form electronically, please visit our website by scanning the QR code to the right, or using the URL referenced throughout the FAQ.**