

Nonindustrial Disability Insurance
Family Care Leave
(NDI-FCL)



NDI-FCL Training Goal²

To provide a basic overview of the criteria and requirements for an excluded employee enrolled in the Annual Leave Program (ALP) to file a Non-Industrial Disability Insurance Family Care Leave (NDI-FCL) bond/care claim.

Objectives:

By the end of this training, you will be able to:

- ❖ Recognize the difference between PFL, NDI and NDI-FCL programs
- ❖ Understand who qualifies for NDI-FCL program
- ❖ Complete the DE 8501F
- ❖ Recognize special circumstances

Defined:

Nonindustrial Disability Insurance - Family Care Leave

(NDI-FCL) is an employer-funded program that provides partial wages to eligible state government employees enrolled in the Annual Leave Program (ALP) due to the need to care for a seriously ill family member or to bond with a new child.

Excluded employees include those with the following CBID:

E99, E98, E97, E79, E78, E77, E68, E67, E59, E58, E48, M01-M21, M99, S01-S21, C01-C21

Includes exempt, managerial, supervisory, and confidential.

Eligible employees can provide care for the following family members:

- | | | |
|-------------|----------------|------------------------------|
| *Child | *Spouse | *Registered Domestic Partner |
| *Parent | *Parent-in-law | *Grandparent |
| *Grandchild | *Sibling | |

At A Glance

SDI-PFL	NDI / ENDI	NDI-FCL
Rank and file employees to bond and/or to care for ill family member	Non-SEIU, Exempt, Excluded, and Confidential employees who are out on disability	Exempt, Excluded, and Confidential employees <i>enrolled in ALP</i> who are bonding and/or caring for an ill family member
No waiting period	7 or 10 day waiting period (waiting period may be waivable)	No waiting period
42 calendar days per rolling year from start date. (July 2020 expanding to 8 weeks)	182 calendar days per claim	42 days per rolling year from start date. (No expansion at this time)
Timeliness required	No timeliness required	No timeliness required
Taxable	Taxable	Taxable
Funded by Employee Contribution	Employer Funded	Employer Funded
Payment authorized and issued by EDD-PFL	EDD authorizes periods of disability; Employer qualifies payments; SCO issues out checks	EDD authorizes periods of Care/Bond; Employer qualifies payments; SCO issues out checks

Not Eligible VS Eligible Employees

Employees Not Eligible	Employees Eligible
Covered under a Bargaining Unit: SEIU bargaining units R01 – R21 and CSU	Exempt, Excluded, Managerial, Supervisory, or Confidential Employees under CBID: E99, E98, E97, E79, E78, E77, E68, E67, E59, E58, E48, M01-M21, M99, S01-S21, C01-C21
No CA-SDI deductions	No CA-SDI deductions

What does NDI-FCL pay?

- ❖ NDI-FCL provides wages for up to 42 days per rolling year from the beginning date of the claim.
- ❖ Employees receive 50% of gross monthly salary. Leave credits may be used to supplement salary 75% or 100%.

Claim Length

- ❖ **CARE:** Qualifying period is decided by the physician/practitioner as to when care is needed up to 42 days.
- ❖ **BONDING:** Qualifying period is 1 year from birth or placement of child. Period is 42 days.
 - ❖ bonding qualification period ends day prior to child's 1st birthday or date of placement
- ❖ If a care claim and a bonding claim are filed in the same rolling year the 42 days is still the maximum available.
- ❖ It is the responsibility of the employer to track days used

Who is Eligible?

- ❖ Claimants must be a current employee of the State of California.
 - ❖ Eligible employees include exempt, managerial, supervisory, and confidential.
- ❖ Must be a participant in the Annual Leave Program prior to the claim effective date.
- ❖ Must be a current active PERS or STRS member
- ❖ Have a wage loss due to the need to bond with a new child or care for a seriously ill family member.

Benefit Payment Process

- ❖ EDD determines eligibility and authorizes dates.
- ❖ The employer's personnel office must process FCL payments or request the State Controller or paying agent to issue FCL payments to the employee.
- ❖ FCL benefits are paid as determined by the employer's payment schedule.
- ❖ Once FCL is authorized, all inquiries concerning payment status, weekly rates, payment amounts, deductions, etc., will be directed to the employee's attendance clerk or personnel office.

Benefits are not Payable

- ❖ Any day of entitlement to Worker's Compensation benefits/industrial disability leave.
- ❖ Any wages that are received in the form of leave usage i.e. sick leave, vacation, compensatory time off, bereavement, or catastrophic leave (outside of supplementation).
- ❖ On or after separation/retirement from state service.

DE 8501F

- ❖ The employer fills out Part A
- ❖ Employee fills out Part B
- ❖ Bonding claim Part C completed by employee
 - ❖ Birth record, court adoption/placement documents must be attached
- ❖ Care claim Part D must be completed by care recipient
 - ❖ Care Recipient's Medical Provider must complete Part E for Care claim
- ❖ The original completed claim form must be MAILED to the EDD office for eligibility determination.
(Due to signature requirements and fraud prevention original signatures are required we are not accepting faxes or emails)
- ❖ Claims take approximately 7-10 days for eligibility determination



Claim for Nonindustrial Disability Insurance – Family Care Leave (NDI-FCL)

NOTE TO NDI-FCL APPLICANTS: KEEP THIS INSTRUCTION AND INFORMATION JACKET FOR REFERENCE. Nonindustrial Disability Insurance – Family Care Leave (NDI-FCL) benefits, an employer-funded program, provides benefits to eligible workers who have a full or partial loss of wages due to the need to care for a seriously ill family member or to bond with a new child.

To qualify for NDI-FCL benefits, you must be:

1. An Excluded California State Government Employee and
 2. A participant in the Annual Leave Program.
- NOTE:** See Nonindustrial Disability Insurance – Family Care Leave Provisions, DE 8502F, for details.

Instructions for completing the NDI-FCL claim form, DE 8501F

While completing the NDI-FCL claim form, write clearly using only upper case. Enter your Social Security number on all pages of the claim form, including attachments. Mail the completed form to the Employment Development Department (EDD) in the envelope provided. Submit your claim no earlier than the first day your family leave begins.

How to complete the DE 8501F:

1. Part A-Employee information to be completed by your Attendance Clerk or Payroll Officer.
2. Part B-Claim Statement of Employee to be completed when you have stopped working.
 - NOTE:** For box 3, the United States Postal Service will not deliver mail to a private mail box unless it is preceded by the initials "PMB."
3. **BONDING:** Part C-Bonding: Part C-Declaration and Signature on Part B-Claim Statement of Employee.
 - a. Sign and date box 15-Declaration and Signature on Part B-Claim Statement of Employee.
4. **CARE:**
 - a. Part D-Statement of Care Recipient to be completed by the care recipient. If the care recipient is a minor or incapacitated, an authorized representative may complete this part.
 - b. Part E-Physician/Practitioner's Certification to be completed by the treating physician/practitioner. Certification may be made by a licensed physician or practitioner authorized to certify to a patient's disability or serious health condition pursuant to California Unemployment Insurance Code, Section 2708. If the care recipient is under the care of an accredited religious practitioner, obtain a *Practitioner's Certification for Nonindustrial Disability Insurance – Family Care Leave*, (DE 2502FF), by calling 1-866-758-9768. **Rubber stamp signatures are not accepted.**
5. Place the completed, signed forms in the envelope provided. Claims are generally processed within 14 days after the EDD receives a completed claim.
 - For **bonding**, a claim is complete when parts A, B, C, and supporting documents are received.
 - For **care**, a claim is complete when parts A, B, D and E are received.
6. Keep these instructions and information pages for future reference.

NOTE: It is the employee's responsibility to see that this claim form and all sections that apply are filled out COMPLETELY and mailed to the EDD address listed below. If you do not understand this form you may call Nonindustrial Disability Insurance at 1-866-758-9768.

MAIL COMPLETED FORM TO: State of California
Employment Development Department
NDI-FCL
PO Box 2168
Stockton, CA 95201-2168

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Instruction & Information page A

Information Collection and Access

State law requires the following information to be provided when collecting information from individuals:

Agency Name: Employment Development Department (EDD)	Title of Official Responsible for Information Maintenance: Managers, EDD Disability Insurance Office
Local Contact Person: Manager, EDD Disability Insurance Office	Address and Telephone Number: PO Box 2168, Stockton, CA 95201-2168 1-866-758-9768

Maintenance of the information is authorized by:

California Unemployment Insurance Code, sections 2601 through 3272.
California Code of Regulations, title 22, sections 2706-1, 2706-3, 2708.1-1, 2710-1.
California Government Code, sections 19878 through 19886.2.

Basic Eligibility:

- Nonindustrial Disability Insurance – Family Care Leave can be paid only after you meet all the following requirements:
- You must be **unable** to do your regular or customary work **due to the need to provide care or to bond with a new child.**
 - You must be an **Excluded Government Employee of the State of California** at the time your Nonindustrial Disability Insurance – Family Care Leave begins.
 - If working, you must have **lost wages** because you were caring for a seriously ill family member or bonding with a new child.
 - Must be a participant in the Annual Leave Program.

In addition, the following requirements must be met only if your NDI-FCL claim is to **care** for a seriously ill family member:

- The care recipient must be your child, parent, spouse, registered domestic partner, grandparent, grandchild, sibling, or parent-in-law.
- The care recipient must be **under the continuing treatment** or supervision of a licensed physician/practitioner or accredited religious practitioner while you are receiving benefits.
- The care recipient's **physician/practitioner must complete the certification** that he/she requires care. If the care recipient is under the care of an EDD accredited religious practitioner, obtain a *Practitioner's Certification for Nonindustrial Disability Insurance – Family Care Leave*, (DE 2502FF).

In addition to basic eligibility requirements, the following requirements must be met only if your NDI-FCL claim is to **bond** with a new child:

- Your leave must take place within 12 months of the birth, adoption, or foster care placement of your child.
- The new child must be either your or your registered domestic partner's biological child, adopted child, or foster child.

Your Responsibilities:

- File your claim and other forms completely, accurately and in a timely manner.
- Carefully read the instructions on this and all other forms you receive from NDI-FCL.
- Call or report in writing to NDI-FCL any:
 - Change of address or telephone number.
 - Return to work.
 - Need for care or bonding to stop.
- Include your name and Social Security number on all correspondence.

All information requested on the claim form is required to process your claim. Please note the following:

- Failure to supply any or all information may cause a delay in issuing benefits or may cause you to be denied benefits to which you are entitled.
- If you willingly make a false statement or representation or knowingly withhold a material fact to obtain or increase any benefit or payment, EDD will disqualify you from receiving benefits and/or services and may initiate criminal prosecution against you.

DE 8501F Instructions

This is the Claim for Nonindustrial Disability Insurance – Family Care Leave, DE 8501F's cover which provides instructions.

❖ Advises that you must be an excluded California State Government Employee and a participant in the Annual Leave Program.

Principal purposes for which the information is to be used:

- To determine eligibility for Nonindustrial Disability Insurance – Family Care Leave benefits.
- To be summarized and published in statistical form for the use and information of government agencies and the public. (Your name and identification will not appear in publications.)
- To be used to locate persons who are being sought for both an provide child or spousal support.
- To be used by other governmental agencies to determine eligibility for public social services under the provisions of California Welfare and Institutions Code, division 5.
- To be used by EDD to carry out its responsibilities under the California Unemployment Insurance Code.
- To be exchanged pursuant to California Unemployment Insurance Code, section 322, and California Civil Code, section 179B.14, with other governmental departments and agencies, both federal and state, which are concerned with any of the following:
 - (a) administration of an Unemployment Insurance program;
 - (b) collection of fees which may be used to finance Unemployment Insurance or Disability Insurance;
 - (c) relief of unemployed or disabled individuals;
 - (d) investigation of labor law violations or allegations of unlawful employment discrimination;
 - (e) the hearing of workers' compensation appeals;
- Whenever necessary to permit a state agency to carry out its standard responsibilities when the use of the information is compatible with the purpose for which it was gathered or
 - (a) where mandated by state or federal law. (Disclosures under California Unemployment Insurance Code, section 322, will be made only in those instances in which it furthers the administration of the program mandated by that Code.)
- Pursuant to California Unemployment Insurance Code, sections 1095 and 2714.
 - (a) information may be revealed to the extent necessary for the administration of public social services or to the Director of Social Services or his/her representatives; and
 - (b) claimant identity may be released to the Department of Rehabilitation.
- Information that has disclosed to authorized agencies in accordance with California Unemployment Insurance Code, sections 1095 and 2714.

Under California Civil Code, section 179B.14, you have the right to inspect records maintained on you by the agency unless exempted.

California Civil Code, section 179B (The Information Practices Act, imposes conditions on the gathering, maintenance, disclosure and correction of personal information by public agencies.)

1. **Right to inspect and correct:** California Civil Code, section 179B.14, gives you the right to inspect any personal records maintained about you by the Employment Development Department. Section 179B.14 also gives you the right to obtain a hardcopy of your file. Section 179B.15 permits you to request that the record be corrected if you believe that it is not accurate, relevant, timely or complete.
2. **Exemptions:** Certain limited types of information that would generally be considered personal are exempt from disclosure to you:
 - (a) Medical or psychological records where knowledge of the contents might be harmful to the subject (Civil Code, section 179B.40);
 - (b) Records of active criminal, civil or administrative investigations (Civil Code, section 179B.40);
 - (c) Names of individuals undergoing inquest or inquest (Civil Code, section 179B.38).

NOTE: EDD will not disclose or provide copies of care recipient's medical information in care provisions.
3. **Appunal rights:** If you are denied access to records which you believe you have a right to inspect or if your request to amend your records is refused, you may file an appeal in writing with Nonindustrial Disability Insurance at PO Box 2168, Stockton, CA 95201-2168.

Federal Privacy Act

The Employment Development Department requires disclosure of Social Security account numbers on a mandatory basis to comply with California Unemployment Insurance Code, sections 1232 and 3227, with California Code of Regulations, Title 22, sections 3005, 1088 and 1234 with Code of Federal Regulations, Title 20, part 604 and with U.S. Code, Title 5, sections 1621, 1641 and 1642.

Benefit Amounts

Enhanced NDI benefits are provided to employees who participate under the State's Annual Leave Program (ALP) in the amount of 50% of gross pay that may be supplemented with leave credits at 75% or 100%. State and federal taxes will be withheld from NDI-FCL benefits. Voluntary deductions such as health insurance premiums, credit union loans, savings accounts, bonds, parking fees, etc. will automatically be deducted from NDI-FCL benefits unless cancelled by the employee. If the employee continues health insurance premium deductions, the State's employer contribution will also continue.

Benefit Payment Process

The EDD determines eligibility and authorizes benefit payments. The employer's personnel office then must request the State Controller or paying agent to issue benefit payments to the employee. Benefits are paid by your employer's payment schedule.

Once benefits are authorized by the EDD, inquiries concerning payment status, weekly rates, payment amounts, deductions, etc. should be directed to the employer's attendance clerk or personnel office.

Questions concerning eligibility for benefits should be directed to NDI-FCL at 1-866-758-9768. Any determination of eligibility by the EDD may be appealed before an administrative law judge by writing to NDI-FCL to request a hearing.

Benefits Are Not Payable:

- For any day of entitlement to temporary workers' compensation benefits or industrial disability leave.
- For any day wages are received in the form of sick leave, vacation, compensatory time off, or catastrophic leave.
- For any day Unemployment Insurance benefits are received.
- For any day on and after separation or retirement from state service. It is permissible to delay the effective date of a disability retirement until NDI-FCL benefits are exhausted.

Retirement Credit

You will not earn Public Employees' Retirement System (PERS) or State Teachers' Retirement System (STRS) service credit while you are receiving NDI-FCL. State employer contributions to your retirement account will not be made while you are receiving NDI-FCL. If supplementing or working while on NDI-FCL, contact CalPERS for information on retirement credit/contribution amounts.

Disqualification

All available information will be considered before issuing a benefit payment or disqualifying your claim. Benefits will be paid only for the days to which you are eligible. If payment of benefits is denied or reduced, you will receive a written notice stating the reason for the disqualification.

If you deliberately report incorrect information or if you willfully omit or withhold information, disqualifications will be assessed.

Fraud

Under the California Unemployment Insurance Code, sections 1143, 2101, 2116, 2122 and 3305, it is a violation to willfully make a false statement or knowingly conceal a material fact in order to obtain the payment of any benefits. Such violation is punishable by imprisonment, and/or by a fine not exceeding \$20,000, or both. To detect and discourage fraud, the EDD continually monitors claims, vigorously investigates suspicious activity, and will seek restitution and conviction through prosecution.

Claim for Nonindustrial Disability Insurance – Family Care Leave (NDI-FCL)

Part A – Employee Information (To be completed by employer)						
1. NAME OF EMPLOYEE (EE)		2. SOCIAL SECURITY NUMBER		3. POSITION NUMBER		
				AGENCY UNIT CLASS SERIAL		
4. GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		5. OCCUPATION		6. CBID #		7. GROSS MONTHLY SALARY \$
8. LAST DAY PHYSICALLY AT WORK / /		9. PERSONNEL TRANSACTIONS OFFICE DEPARTMENT OR CAMPUS				
BRANCH OR DIVISION		10. APPOINTMENT/TIME BASE STATUS (CHECK ALL THAT APPLY)				
MAILING ADDRESS		<input type="checkbox"/> PERMANENT PROBATIONARY <input type="checkbox"/> FULL TIME <input type="checkbox"/> PT/INT-DID EE HAVE EQUIVALENT OF 6 MONTHS COMPENSATED PPS IN THE PAST 18 PPS? YES <input type="checkbox"/> NO <input type="checkbox"/> <input type="checkbox"/> PERS/STRS MEMBER <input type="checkbox"/> LT - DOES EE HAVE THE RIGHTS TO RETURN TO A PERMANENT, FULL-TIME POSITION? YES <input type="checkbox"/> NO <input type="checkbox"/> <input type="checkbox"/> TAU - DOES EE HAVE THE RIGHTS TO RETURN TO A PERMANENT, FULL-TIME POSITION? YES <input type="checkbox"/> NO <input type="checkbox"/> <input type="checkbox"/> CEA - DOES EE HAVE THE RIGHTS TO RETURN TO A PERMANENT, FULL-TIME POSITION? YES <input type="checkbox"/> NO <input type="checkbox"/> <input type="checkbox"/> LEAP - HAS EE SUCCESSFULLY COMPLETED THE TEMPORARY JOB EXAMINATION PERIOD? YES <input type="checkbox"/> NO <input type="checkbox"/> <input type="checkbox"/> SEASONAL <input type="checkbox"/> ANNUITANT <input type="checkbox"/> EMERGENCY				
NAME OF PAYROLL SPECIALIST (PLEASE PRINT)		13. FOR ANNUAL LEAVE PROGRAM (ALP) EMPLOYEES: DID EE ELECT TO USE FULL LEAVE CREDITS, INCLUDING CATASTROPHIC LEAVE? YES <input type="checkbox"/> NO <input type="checkbox"/>				
PUBLIC PHONE		EXTENSION		FAX		
11. ADDRESS OR LOCATION WHERE EMPLOYEE ACTUALLY WORKS.		14. WORKERS' COMPENSATION INFORMATION IS EE ENTITLED TO RECEIVE OR HAS EE RECEIVED WORKERS' COMPENSATION TEMPORARY DISABILITY OR INDUSTRIAL DISABILITY LEAVE FOR ANY DAY AFTER THE LAST DAY PHYSICALLY WORKED SHOWN ABOVE? YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING				
12. COMPLETED BY (PLEASE PRINT NAME)		IF YES, PROVIDE PERIODS PAID FROM _____ TO _____				
DATE COMPLETED		FOR WHAT BODY PARTS? _____				
SIGNATURE		FOR WHAT INJURY? _____				
PUBLIC PHONE		EXTENSION		15. HAS EE RETURNED TO WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>		
FAX		IF YES <input type="checkbox"/> PART TIME <input type="checkbox"/> FULL TIME GIVE DATE(S) _____				
NOTE TO EMPLOYER: While the NDI office determines the period of eligibility and authorizes payment on claims your personnel office has the responsibility for requesting payment from the State Controller.						



DE 8501F Part A

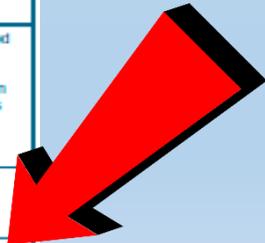
Shown here is the first page of the application itself. As mentioned, this page is completed by the Attendance Clerk or Payroll Officer of the applicant.

Part B – Claim Statement of Employee			
1. PLEASE RE-ENTER YOUR SOCIAL SECURITY NUMBER		2. DATE OF BIRTH	
3. YOUR MAILING ADDRESS			
STREET, PO BOX, OR RFD		APT. NO.	CITY
STATE		ZIP CODE	
4. YOUR HOME ADDRESS (IF DIFFERENT FROM MAILING ADDRESS)		5. OTHER NAME(S) USED	6. OCCUPATION
7. INDICATE YOUR DESIRE TO SUPPLEMENT NDI-FCL WITH LEAVE <input type="checkbox"/> NO SUPPLEMENT <input type="checkbox"/> 75% <input type="checkbox"/> 100%		8. DATE YOU WANT YOUR NDI-FCL CLAIM TO BEGIN	9. LAST DAY PHYSICALLY WORKED
10. REASON YOU REDUCED YOUR WORK HOURS OR STOPPED WORKING <input type="checkbox"/> CARE FOR FAMILY MEMBER <input type="checkbox"/> BOND WITH CHILD <input type="checkbox"/> OTHER (EXPLAIN) _____			
11. LEGAL NAME OF PERSON FOR WHOM YOU ARE CARING OR WHOM YOU ARE BONDING (CARE OR BONDING RECIPIENT)			
12. THE ABOVE NAMED CARE OR BONDING RECIPIENT IS YOUR <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> REGISTERED DOMESTIC PARTNER <input type="checkbox"/> PARENT <input type="checkbox"/> PARENT-IN-LAW <input type="checkbox"/> GRANDPARENT <input type="checkbox"/> GRANDCHILD <input type="checkbox"/> SIBLING <input type="checkbox"/> OTHER (EXPLAIN) _____			
13. IS ANY OTHER FAMILY MEMBER READY, WILLING, AND ABLE AND AVAILABLE TO PROVIDE CARE FOR THE SAME PERIOD YOU ARE CLAIMING NONINDUSTRIAL DISABILITY INSURANCE - FAMILY CARE LEAVE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
14. HAVE YOU FILED A CLAIM FOR WORKERS' COMPENSATION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", PLEASE PROVIDE THE FOLLOWING INFORMATION			
NAME OF WORKERS' COMPENSATION INSURANCE CARRIER		CARRIER'S PHONE NUMBER	
ADDRESS OF CARRIER			
NAME OF ADJUSTER		DATE OF INJURY	CLAIM NUMBER
BODY PARTS			
ARE YOU RECEIVING WORKERS' COMPENSATION BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF "YES", DATES BENEFITS PAID FROM _____ TO _____	
15. DECLARATION AND SIGNATURE. By my signature on this claim statement for Nonindustrial Disability Insurance - Family Care Leave, I certify that (1) throughout the period covered by this claim, I was providing care for or bonding with the care recipient named above; (2) authorize the Employment Development Department (EDD) to release my personal information as shown on this claim to the care recipient and to the care recipient's treating physician as they are respectively listed in Part D and Part E of this claim; (3) authorize my employer(s) to disclose to the EDD all facts concerning my employment that are within their knowledge; and (4) authorize release and use of information as stated in the "Information Collection Access" portion of this form. I understand that willfully making a false statement or concealing a material fact in order to obtain payments of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements is to the best of my knowledge and belief true and correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.			
CLAIMANT'S SIGNATURE (DO NOT PRINT)		IF SIGNATURE IS MADE BY MARK (X), PLEASE PLACE MARK HERE.*	DATE SIGNED
*IF YOUR SIGNATURE IS MADE BY MARK (X), IT MUST BE ATTESTED TO BY TWO WITNESSES WITH THEIR ADDRESSES.			
1 st WITNESS SIGNATURE AND ADDRESS		2 nd WITNESS SIGNATURE AND ADDRESS	

DE 8501F Part B

The second page of the DE 8501F is completed by the claimant. In addition to personal information, this page enables the claimants to provide their requested Claim Effective Date, the supplementation rate, type of claim, who they are bonding or caring for and if they have a Worker's Compensation claim.

- ❖ Please ask the employee to add their phone number



Part C – Bonding Certification (To be completed by person claiming NDI-FCI to bond with a child)		
1. YOUR SOCIAL SECURITY NUMBER	2. YOUR LEGAL LAST NAME (NEEDED IN TWO PLACES ON THIS CLAIM BECAUSE SEPARATED)	3. CHILD'S SOCIAL SECURITY NUMBER (IF APPLICABLE)
4. LEGAL NAME OF CHILD		
5. CHILD'S DATE OF BIRTH	6. CHILD'S GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	7. DATE OF FOSTER CARE OR ADOPTION PLACEMENT
8. CHILD'S RESIDENCE ADDRESS (if different from claimant's)		
ADDRESS	CITY	STATE ZIP/ZIP+4 COUNTRY (IF NOT U.S.A.)
9. CHILD NAMED IN #4 IS MY	<input type="checkbox"/> BIOLOGICAL CHILD	<input type="checkbox"/> FOSTER CHILD
	<input type="checkbox"/> ADOPTED CHILD	<input type="checkbox"/> FOSTER CHILD
	<input type="checkbox"/> OTHER	
10. AS EVIDENCE OF RELATIONSHIP, CHECK <u>ONE</u> OF THE FOLLOWING AND ATTACH A COPY OF THE DOCUMENT CHECKED. (DO NOT SEND ORIGINAL DOCUMENTS, IT WILL NOT BE RETURNED)		
<input type="checkbox"/> CHILD'S BIRTH CERTIFICATE	<input type="checkbox"/> ADOPTION PLACEMENT AGREEMENT, AD 307	
<input type="checkbox"/> DECLARATION OF PARENTHOOD, CA 307	<input type="checkbox"/> INDEPENDENT ADOPTION PLACEMENT AGREEMENT, AD 310	
<input type="checkbox"/> FOSTER CARE PLACEMENT RECORD, SOC 883	<input type="checkbox"/> OTHER	
11. DECLARATION AND SIGNATURE. By my signature on this bonding certification, I authorize the medical provider, adoption agency, adoption court, or foster care placement agency to disclose to the employer's designated representative all data concerning the birth, adoption, or foster care placement of the above named child. I understand that willfully making a false statement or creating a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statements, including any accompanying statements or documents, are in the best of my knowledge and belief true, correct, and complete. I agree that the disclosure of the information shall be as valid as the original, and I understand that sanctions prescribed in the claim schedule are imposed for a period of three years from the date of my signature or the effective date of the claim, whichever is later.		
ORIGINAL Signature of Bonding Claimant ... (BOTH YOURS IS NOT ACCEPTABLE)		DATE SIGNED

DE 8501F Part C

The 3rd page of the DE 8501F contains 2 sections.

- ❖ The Upper half of the page is the Bonding Statement must be completed by employee.
- ❖ Birth record, court adoption/placement documents must be attached

Part D – Statement of Care Recipient <small>(May be completed by claimant if care recipient is mentally or physically unable to do so. Must be signed by care recipient or care recipient's authorized representative.)</small>		
1. CLAIMANT SOCIAL SECURITY NUMBER		2. YOUR LEGAL LAST NAME <small>(NEEDED IN CONNECTION OF THE CLAIM BEING SUPPORTED)</small>
3. LEGAL NAME OF CARE RECIPIENT		
4. CARE RECIPIENT'S DATE OF BIRTH	5. CARE RECIPIENT'S GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	6. CARE RECIPIENT'S PHONE NUMBER
7. CARE RECIPIENT'S RESIDENCE ADDRESS		
ADDRESS	CITY	STATE ZIP/ZIP+4 COUNTRY OF RESIDENCE
8. CONFIRMATION OF MEDICAL DISCLOSURE AUTHORIZATION. I authorize my physician or practitioner to disclose my current personal-health information to my care provider and to the California Employment Development Department (EDD).		
CARE RECIPIENT'S SIGNATURE (SEE INSTRUCTIONS)		DATE SIGNED
9. AUTHORIZED REPRESENTATIVE signing on behalf of care recipient must complete the following: I, _____, represent the care or bonding recipient in this matter as authorized by <input type="checkbox"/> parental rights <input type="checkbox"/> power of attorney (attach copy) <input type="checkbox"/> court order (attach copy) <small>(For spouse or domestic partner, contact the EDD.)</small>		
AUTHORIZED REPRESENTATIVE'S SIGNATURE (SEE INSTRUCTIONS)		DATE SIGNED

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DE 8501F

Part D

- ❖ The Lower half of the page is the Statement of Care Recipient must be completed by care recipient.
- ❖ Only one of these sections will be completed depending on type of claim.

Medical certifications must be completed by a licensed physician or practitioner authorized to certify to a patient's disability/serious health condition pursuant to California Unemployment Insurance Code Section 2708.

Part E – Physician/Practitioner's Certification (Do NOT complete this part if claim is for bonding.)		
1. CLAIMANT'S (CARE PROVIDER'S) SOCIAL SECURITY NUMBER	2. CLAIMANT LAST NAME (inserted in case folder of this claim become approved)	
3. PATIENT'S NAME		
4. PATIENT'S DATE OF BIRTH	5. DOES THE PATIENT REQUIRE CARE BY THE CLAIMANT? <input type="checkbox"/> NO (SRPT 0114) <input type="checkbox"/> YES	
6. DIAGNOSIS OR, IF NOT YET DETERMINED, A DETAILED STATEMENT OF SYMPTOMS		
7. PRIMARY ICD CODE	8. SECONDARY ICD CODES	
9. FIRST DATE CARE NEEDED	10. DATE YOU EXPECT RECOVERY <input type="checkbox"/> NEVER	11. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CLAIMANT <input type="checkbox"/> PERMANENT
12. APPROXIMATELY HOW MANY TOTAL HOURS PER DAY WILL PATIENT REQUIRE CARE BY CLAIMANT?		
HOURLY	COMMENTS:	
13. WOULD DISCLOSURE OF THIS CERTIFICATE TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL? <input type="checkbox"/> NO <input type="checkbox"/> YES		
14. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER	15. STATE OR COUNTRY PHYSICIAN/PRACTITIONER IS LICENSED	
16. PHYSICIAN/PRACTITIONER'S NAME		
17. PHYSICIAN/PRACTITIONER'S ADDRESS		
ADDRESS CITY STATE ZIP CODE COUNTRY (IF APPLICABLE)		
18. TYPE OF PHYSICIAN/PRACTITIONER	19. SPECIALTY (IF ANY)	
20. PHYSICIAN/PRACTITIONER'S certification and signature: I certify under penalty of perjury that the patient has a serious health condition and requires a care provider. I have performed a physical examination and/or treated the patient. I am authorized to certify a patient's disability or serious health condition pursuant to California Unemployment Insurance Code Section 2708.		
CURRENT SIGNATURE OF ATTENDING PHYSICIAN/PRACTITIONER - SUBMIT WITH EMPLOYEE APPROVAL	PHYSICIAN/PRACTITIONER LICENSE NUMBER	DATE SIGNED

Under sections 2714 and 2722 of the California Unemployment Insurance Code, it is a violation for any individual who, with intent to defraud, falsely certifies the medical condition of any person in order to obtain disability insurance benefits, whether for the maker or for any other person, and is punishable by imprisonment and/or a fine not exceeding \$20,000. Section 1143 and 3305 require additional administrative penalties.

DE 8501F Part E

Finally, the fourth page of the DE 8501F is completed by the care recipient's treating Physician for a Care Claim.

❖ Medical is not needed for a Bonding Claim

Special Circumstances:

- ❖ **Simultaneous Coverage (PFL and NDI-FCL):**
 - ❖ Excluded employees may be eligible for both PFL and NDI-FCL if the employee has prior earnings in the base period that are subjected to SDI contributions and/or if they have a 2nd employer that pays into SDI.
- ❖ **Overlapping Claims:**
 - ❖ The employee cannot collect benefits for both NDI and NDI-FCL for the same periods. One claim must end for the other to begin.
- ❖ **Incomplete Applications**
 - ❖ Any applications not completed correctly will be returned to the employee.

Special Circumstances:

❖ Ineligible employees

- ❖ Employee will receive a notice of disqualification

“You are not an excluded employee and therefore do not meet the Nonindustrial Disability Insurance – Family Care Leave (NDI-FCL) program criteria.”

- ❖ Employees covered under a Bargaining Unit are not eligible

Helpful Hints for Personnel Specialists:

- ❖ When completing Part A of the DE 8501F:
 - ❖ Include claimants phone number on the page.
 - ❖ Save a copy of 8501F Part A with NDI-FCL notated so that when HR receives the DE 8500A, it is known which program to track dates for.
 - ❖ Example: NDI is up to 182 calendar days or as indicated on the DE 8500A, for NDI-FCL it is up to 42 days. NDI-FCL claims will be authorized for a 1 year period from claim state date for Bonding. Care claims will be authorized for the period care is determined based on the medical provider.
- ❖ NDI-FCL is recorded in one-day increments.
- ❖ To check NDI-FCL approvals please email: DI217@EDD.CA.GOV

References:

Questions regarding claim status call
State Employees Office: (866)758-9768.

CalHR NDI Policy:

<http://hrmanual.calhr.ca.gov/Home/ManualItem/1/1411>

EDD NDI-FCL informational website:

<https://edd.ca.gov/Disability/nonindustrial/family-care-leave.htm>

To order DE 8501F: <https://forms.edd.ca.gov/forms>

Questions concerning eligibility for benefits will be directed to
State Department personnel offices