CONSUMER DIRECT CARE NETWORK

# PAID SICK LEAVE REQUEST FORM - FEA

**Employee Name** (Please Print) | **Employee ID** | **Member Name** (Please Print) | **Member ID**

**Representative Name** (if applicable)

To ensure prompt payment, requests for Paid Sick Leave must be submitted by Monday at midnight following the Sunday – Saturday work week. Requested date and time must not overlap with regular hours worked as submitted by Electronic Visit Verification (EVV), and should follow the daily work scheduled as indicated in the member's Individual Plan of Care (IPoC).

Hours may be requested in 15-minute increments. Paid Sick Leave accrual balances are provided on your employee pay stub. Please ensure balances are sufficient prior to requesting payment.

Please see back of this form for additional information regarding eligibility and provisions.

## PAID SICK LEAVE REIMBURSEMENT REQUEST

| Request Date (Month / Day / Year) | Time In (Hour : Min) | Time Out (Hour : Min) | Total Hours | Service Code |
|---|---|---|---|---|
| / / | : O AM O PM | : O AM O PM | | SICK |
| / / | : O AM O PM | : O AM O PM | | SICK |
| / / | : O AM O PM | : O AM O PM | | SICK |
| / / | : O AM O PM | : O AM O PM | | SICK |
| / / | : O AM O PM | : O AM O PM | | SICK |

*Please ensure eligibility. Requests will be denied for:*

- *Exceeding employee's accrued Sick Leave balance. Any amount that exceeds available balance and cannot be processed will require a correction.*
- *Overlapping a regular shift submitted through EVV.*
- *Submittal more than 60-days after the Reimbursement Request Date.*

*Employee Signature* | *Date* | *Authorizing Signature** | *Date*

**Member or their representative must sign to authorize payment*

Please submit via email or fax.

**Email:** infocdnm@consumerdirectcare.com **Fax:** 1-866-344-2373

CONSUMER DIRECT CARE NETWORK

# PAID SICK LEAVE REQUEST FORM - FEA

## Additional Information Regarding Earned Paid Sick Leave

| | |
|---|---|
| Eligibility | All employees |
| Purpose | • Employee's treatment or diagnosis of illness, injury, or health condition, or preventative medical care.<br>• Care of employee's family members* for treatment or diagnosis of illness, injury, or health condition, or preventative medical care.<br>• Meetings related to employee's child's health or disability.<br>• Absence necessary because of and related to domestic abuse, sexual assault, or stalking suffered by the employee or their family member. |
| Notice to Employer | CDCN asks that you alert your employer as soon as practical with your request to use Sick Leave. |
| Provisions | • One hour of Sick Leave accrued for every 30 hours worked.<br>• Accruals begin on employee's start date or July 1, 2022, whichever is later.<br>• Employees may use up to 64 hours of accrued Sick Leave annually.<br>• CDCN will track Sick Leave accruals from July 1 to June 30, annually.<br>• Unused Sick Leave accruals carry-over from year to year (July-June tracking period). |
| Approval | Employer signature required on Sick Leave Request form. |
| Cash Out | Not permitted. Accrued Sick Leave balance is not paid to employee upon termination. |

*a "family member" means:

- an employee's spouse or domestic partner;
- a person related to an employee or an employee's spouse or domestic partner as a biological, adopted, or foster child, a stepchild or legal ward, or a child to whom the employee stands in loco parentis;
- a biological, foster, step, or adoptive parent or legal guardian, or a person who stood in loco parentis when the employee was a minor child;
- a grandparent or grandchild;
- a biological, foster, step, or adopted sibling; a spouse or domestic partner of a family member;
- an individual whose close association with the employee or the employee's spouse or domestic partner is the equivalent of a family relationship.