FAMILIES FIRST CORONAVIRUS RESPONSE ACT REQUEST – Iowa County

Return completed form to Employee Relations Office

Email – allison.leitzinger@iowacounty.org Fax – 608-935-0325

SECTION 1: Employee Information	
Employee Name:	
Main Phone Number:	
Email Address:	
☐ Emergency Paid Sick Leave	☐ Emergency FMLA Expansion Act
☐ Intermittent Leave *(Note: this is only available for employees needing to care for child due to COVID-19 reasons of school/day care closures).*	
Anticipated Begin Date:	Anticipated End Date:

SECTION A. The **Emergency Paid Sick Leave Act** (EPSLA) of the FFCRA provides 10 days (80 hours) of limited paid sick leave benefit for full-time employees outside of FMLA or EFMLEA (below). This is prorated for part-time employees, including part-time employees who otherwise are not eligible for accrued benefits.

All employees actively employed by Iowa County are eligible, with the exclusion of health care providers and emergency first responders as defined in the FFCRA policy.

I am unable to work or telework for the following reason(s) (Check all applicable):

☐ Employee is subject to a Federal, State, or local quarantine or isolation order related to Coronavirus
Name of Government Entity that issued the order: _____

☐ Employee has been advised by a health care provider to self-quarantine due to concerns related to coronavirus
Name of health care provider that advised the self-quarantine: _____

☐ Employee is experiencing coronavirus symptoms and seeking a medical diagnosis

☐ Employee is caring for an individual who is subject to an order as described in reason 1 or 2 above
*Name of Gov't Entity or health care provider issuing order:*_____

☐ Employee is caring for a son or daughter of such employee if the school or place of care of the son or daughter has been closed, or the childcare provider of such son or daughter is unavailable, due to coronavirus
*Name of school or place of care that closed:*_____

Name of child: _____ Age: _____
Name of child: _____ Age: _____
Name of child: _____ Age: _____
Name of child: _____ Age: _____
Name of child: _____ Age: _____
Name of child: _____ Age: _____

**A statement representing that no other suitable person is available to care for the child during the period of requested leave is required.*

☐ Employee is experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.

For the first three reasons listed above, eligible employees will receive 100% of regular hourly rate, with a $511/day ($5,110 aggregate) cap.

For the last three reasons listed above, eligible employees will receive 2/3 of regular hourly rate, with a $200/day ($2,000 aggregate) cap.

Employees can substitute their own accruals to supplement their pay to make them "whole". Please indicate if you choose to supplement the EPSLA hours to receive your normal full pay by prioritizing in order the accruals you wish to use (i.e 1-Comp time; when gone use 2-MTO; when depleted, use 3-Sick Time; when depleted, do not further supplement):

_____ MTO (_____ hours)
_____ Comp Time (_____ hours)
_____ Sick Time (_____ hours)
_____ Unpaid Time (_____ hours)

Please use payroll code **SP** (COVID19 Paid Sick) on timesheet.

SECTION B. The **Emergency Family and Medical Leave Expansion Act** (EFMLEA) of the FFCRA is available for employees who have worked 30 calendar days and is caring for a son or daughter of such employee if the school or place of care of the son or daughter has been closed, or the childcare provider of such son or daughter is unavailable, due to coronavirus. Health care providers and emergency first responders are excluded as defined in the FFCRA policy.

Information Needed (only needed if Section A is not filled out):
*Name of school or place of care that closed:*_____

Name of child: _____ Age: _____
Name of child: _____ Age: _____
Name of child: _____ Age: _____
Name of child: _____ Age: _____
Name of child: _____ Age: _____
Name of child: _____ Age: _____

**A statement representing that no other suitable person is available to care for the child during the period of requested leave is required.*

Employees receive up to 12-weeks protected leave. Employees who have used FMLA already in 2020, will have the time available under this Act reduced by the FMLA hours already used. The first 10 workdays off will be unpaid, employees can substitute their own accruals to supplement their pay (employees can use the EPSLA during the first 10 days).

After the 10th workday off, the employee will be eligible for pay from the County equal to 2/3 of the employee's regular rate of pay for the remainder of the available EFMLEA leave associated with the qualifying COVID-19 reason, not to exceed a daily cap of $200 or aggregate cap of $10,000, per person.

DURING the first 10 days: If you wish to substitute your own accruals, please indicate the priority of time:
____ EPSLA from Section A (____ hours)
____ MTO
____ Comp Time
____ Sick Time
____ Unpaid Time

AFTER the first 10 days: Please indicate the priority of paid time you want used:
____ MTO
____ Comp Time
____ Sick Time

Please use payroll code **CF** (COVID19 EFMLEA Pay) on timesheet.

I authorize the appointing authority to obtain any necessary information regarding my request under the Families First Coronavirus Response Act. During the time period of the State's Emergency Declaration, the County will accept your electronic signature.

I attest that I am unable to work or telecommute because of the COVID-10 reason and understand falsification may result in disciplinary action.

Employee Signature:_____ Date: _____

Employer Use Only

Leave Request is Approved

Authorizing Signature: _____ Date: _____

If Leave is denied, a hard copy will be provided to the employee stating the reason(s) for the denial: