



# MEDICAL PROVIDER'S TOOLKIT

The District of Columbia has implemented Paid Family Leave, so its workers do not have to choose between financial security and caring for loved ones. As trusted members of the community, your role in this program is vital. In collaboration with the Office of Paid Family Leave, you will aid District workers in securing Paid Family and Medical Leave when they need it most. Whether it is receiving prenatal medical care, bonding with a new child, taking care of a loved one, or tending to one's own health ailment, the Office of Paid Family Leave is committed to providing you with the necessary resources to educate your patients on how this program will impact their life.

In this toolkit, you will find the electronic resources needed to inform your patients about the program. The resources include:

- ☐ **Claims Verification Process:** This guide provides step-by-step instructions on what you need to do as a medical provider to verify your patients' claims.
- ☐ **Medical Certification Form (PFL-MMC):** This form will be filled out by both the patient and medical provider and determines whether the patient has a "serious health condition" as defined by the DC Paid Family Leave law.
- ☐ **Family Medical Certification Form (PFL-FMC):** This form will be filled out by both the patient and medical provider and determines whether the patient has received "prenatal medical care" as defined by the DC Paid Family Leave law.
- ☐ **Patient Resources, including:**
  - Paid Family Leave Parental Roadmap: A tool for parents explaining the steps to take when expecting a new child.
  - DC Paid Family Leave Program Information Overview
  - Information on Parental Leave (8 weeks), Family Leave (6 weeks), Medical Leave (6 weeks), and Prenatal Leave (2 weeks).

For more information, please contact the Office of Paid Family Leave Monday-Friday 9:00 AM to 5:00 PM ET or visit the dedicated healthcare providers' page on our website [dcpaidfamilyleave.dc.gov/healthcare-providers](https://dcpaidfamilyleave.dc.gov/healthcare-providers). Thank you for playing an essential role in our program!



# CLAIMS VERIFICATION PROCESS FOR MEDICAL PROFESSIONALS

As of July 1, 2020, the District of Columbia is administering Paid Family Leave benefits to eligible workers. As a medical professional, your patients need you to complete a medical certification form in order for them to receive Paid Family Leave benefits.

As trusted members of the community, your role in this program is vital. In collaboration with the Office of Paid Family Leave (OPFL), you will aid District workers in securing paid family and medical leave when they need it most. Whether it's receiving prenatal medical care, the birth of a child, taking care of a loved one, or one's health ailment, OPFL is committed to providing you with the necessary resources to educate your patients on how this program will impact their life.

## Paid Family Leave Overview

DC Paid Family Leave provides eligible workers paid leave benefits when they need time off to care for themselves and their families. DC's Paid Family Leave program ensures District workers don't feel the burden of having to choose between their job security and caring for themselves or their families.

## How Do I Get Notified that a Verification is Needed?

Your patient will give you a copy of the PFL medical certification form. The form has a series of questions that must be completed by a licensed health care provider.

## What Types of Documentation Am I Required to Provide?

You do not need to provide any additional or supporting documentation. You are only required to answer the series of questions on the medical certification form as it relates to the patient's health.

# 8-6-6-2

Paid Family Leave covers a portion of income for eligible workers for up to eight (8) weeks to bond with a new child, six (6) weeks to care for a family member with a serious health condition, six (6) weeks to care for their own serious health condition, and two (2) weeks to receive prenatal medical care.



## Your Responsibilities

- ☐ Determine if your patient is eligible for Medical Leave benefits under the Paid Family Leave law.
- ☐ Complete the PFL-MMC form for a claimant filing for Medical Leave
- ☐ Complete the PFL-FMC form for a claimant filing for Family Leave
- ☐ Complete the PFL-PMC form for a claimant filing for Family Leave

## Claim Process Timeline

1

**Application**

2

**Verification**

3

**Processing**

4

**Benefit Dispersal**

For more information, visit our website at [dcpaidfamilyleave.dc.gov](https://dcpaidfamilyleave.dc.gov) or call our contact center at **(202)899-3700**.





**INSTRUCTIONS FOR CLAIMANT:**

Use this form to file for Family Leave benefits with the DC Office of Paid Family Leave. This form is used to determine whether your family member has a “serious health condition” as defined by DC’s Paid Leave law and whether your family member requires your care or companionship. You must complete part 1 of the form, which asks for information about you (the claimant) and your family member. The doctor or licensed health care provider who is treating your family member must complete part 2 of the form. You may complete the filing process for Family Leave benefits only after this form is completed and signed by your family member’s doctor. ***Please ensure that the health care provider completes all sections of part 2 or your claim may be denied.***

You must scan and upload this form to the online Paid Family Leave benefits portal available at **does.pflbas.dc.gov**. This form is not an application for benefits. You must complete an application at **does.pflbas.dc.gov** to be considered for benefits.

PART 1 (To be completed by the claimant before part 2)		
Last Name	First Name	Middle Name
Date of Birth (MM/DD/YYYY) ____/____/____		Phone Number
INFORMATION ABOUT THE CARE TO BE PROVIDED TO CLAIMANT’S FAMILY MEMBER		
Name of the family member for whom the claimant will provide care		
Last Name	First Name	Middle Name
Relationship of family member to claimant:		
Describe the nature of the care or companionship the claimant will provide to the family member.		
<hr/> <hr/> <hr/> <hr/>		
<input type="checkbox"/> I certify that the information I have provided on this form is true and complete.		
Signature: _____		Date: _____

**PART 2 (To be completed by the licensed health care provider)**

**INSTRUCTIONS FOR HEALTH CARE PROVIDER:**

The family member of your patient is requesting Paid Family Leave benefits from the District of Columbia in order to provide care or companionship to your patient. The purpose of this form is to determine whether the family member of your patient is eligible for Family Leave benefits under the Paid Family Leave law. Please complete sections **A** through **E**. Limit your responses to the medical condition(s) for which your patient's family member is seeking Paid Family Leave benefits. **Complete all sections of part 2 or the form will be returned to you for more information.**

**A. HEALTH CARE PROVIDER INFORMATION**

*All fields are required, except where noted*

Provider Last Name                      Provider First Name

Mailing Address    Street    City    State    Zipcode

Telephone Number                      Email Address

Type of Practice / Medical Specialty

License Number    National Provider Identifier (Optional)

**B. QUALIFYING MEDICAL CONDITION**

Name of the diagnosis or a statement of symptoms of the health condition

\_\_\_\_\_  
\_\_\_\_\_

Primary ICD-10 Code for Health Condition

Secondary ICD-10 Code (Optional)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(MM/DD/YYYY)    Date health condition was diagnosed

## B. QUALIFYING MEDICAL CONDITION (continued)

*Check the box for each statement that is applicable to your patient's medical condition. For each box that you check, provide the required additional information for that statement.*

- ☐ **Pregnancy:** Your patient's condition is pregnancy.  
The expected delivery date is \_\_\_\_\_ (mm/dd/yyyy).
- ☐ **Overnight inpatient care:** Your patient was admitted for inpatient care at a hospital, hospice, or residential medical care facility for at least one overnight period to treat this health condition on the following date(s): \_\_\_\_\_.
- ☐ **Incapacity plus treatment** (complete numbers 1, 2, and 3 below (required)):
1. Your patient's health condition caused a period of continuous incapacity during which your patient was unable to work, attend school, or perform other activities of daily living lasting at least three (3) full consecutive days from \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy).
  2. Your patient had (or will have) an in-person or telehealth appointment with a health care provider to treat or evaluate this health condition on the following dates (required):  
\_\_\_\_\_  
\_\_\_\_\_
  3. Your patient's condition (☐ has / ☐ has not) resulted in a regimen of continuing treatment under the supervision of a health care provider (e.g., taking prescription medications, attending therapy appointments). The regimen of continuing treatment involves:  
\_\_\_\_\_
- ☐ **Chronic Condition** (complete numbers 1, 2, and 3 below (required)):
1. Your patient's condition (☐ is / ☐ is not) a chronic health condition.
  2. Your patient (☐ does / ☐ does not) require two (2) or more medical visits annually to treat this health condition.
  3. You (☐ expect / ☐ do not expect) your patient to experience unpredictable episodes of the underlying chronic condition that cause episodic inability to work, attend school, or perform other activities of daily living.
- ☐ **Permanent incapacity:** Your patient is experiencing permanent or long-term incapacity due to the health condition and requires continuing supervision by a health care provider (e.g., Alzheimer's Disease or a terminal-stage cancer).
- ☐ **Restorative surgery:** Your patient requires restorative surgery to achieve functional (not cosmetic) capacity after an accident or injury and requires multiple such treatments related to the same accident or injury.
- ☐ **Preventative treatment:** Your patient requires treatments by health care providers on at least two dates in order to avoid the occurrence of a condition that without treatment would cause incapacity for at least 3 full days.
- ☐ **Stillbirth:** Your patient experienced a stillbirth on the following date: \_\_\_\_\_ (mm/dd/yyyy).
- ☐ **None of the above.** Your patient's condition does not fall within one of the above categories.

### C. AMOUNT OF LEAVE NEEDED

- ☐ **Continuous incapacity:** Your patient experienced (will experience) a period of continuous inability to work, attend school, or perform other activities of daily living beginning on \_\_\_\_\_ (mm/dd/yyyy) and ending on \_\_\_\_\_ (mm/dd/yyyy) (if in the future, provide your best estimate).
- ☐ **Planned medical treatments:** Your patient requires planned medical appointments to treat the health condition on the following dates (future or past):  
\_\_\_\_\_  
\_\_\_\_\_
- ☐ **Intermittent incapacity:** Your patient experienced (will experience) an intermittent inability to work, attend school, or perform other activities of daily living due to the health condition. If known, those dates were (will be):  
\_\_\_\_\_  
If unknown, your patient (☐ is / ☐ is not) expected to experience unpredictable episodes or flare ups of the underlying condition that cause episodic inability to work, attend school, or perform other activities of daily living.

Please provide any additional information about the condition and/or treatment.

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### D. NEED FOR CARE OR COMPANIONSHIP

In your medical opinion, your patient (☐ does / ☐ does not) require care or companionship by the claimant.

In your medical opinion, the nature of the care or companionship described by the claimant above in part 1 (☐ is / ☐ is not) reasonable and necessary.

Please provide any additional information about the care to be provided by the family member.

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### E. CERTIFICATION

- ☐ I certify that I am a licensed health care provider that is treating this patient and the information I have provided on this form is true and complete.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## INSTRUCTIONS FOR CLAIMANT:

Use this form to file for Prenatal Leave benefits. This form is used to verify your pregnancy and eligibility for benefits. You must complete part 1 of the form. Your doctor or licensed health care provider must complete part 2.

**IMPORTANT NOTE:** Paid Prenatal Leave is for you to receive medical care related to your pregnancy. The Paid Family Leave law does not make paid Prenatal Leave available for other reasons such as staying home or being on work restrictions before your expected due date. If your doctor says that you must avoid work for a continuous period of time due to your pregnancy, your doctor must say that you need to be “on bedrest” for a period of time.

You must scan and upload this form to the online Paid Family Leave benefits portal available at [does.pflbas.dc.gov](https://does.pflbas.dc.gov). This form is not an application for benefits. You must complete an application at [does.pflbas.dc.gov](https://does.pflbas.dc.gov) to be considered for benefits.

### PART 1 (To be completed by the claimant)

Last Name	First Name	Middle Name
Date of Birth (MM/DD/YYYY) ____/____/____	Phone Number	

### PART 2 (To be completed by the licensed health care provider)

## INSTRUCTIONS FOR HEALTH CARE PROVIDER:

Your patient is requesting Paid Family Leave benefits from the District of Columbia. The purpose of this form is to determine your patient’s eligibility for benefits by verifying the diagnosis of your patient’s pregnancy. Please complete sections A through D.

### A. HEALTH CARE PROVIDER INFORMATION

*All fields are required, except where noted*

Provider Last Name	Provider First Name			
Mailing Address	Street	City	State	Zip code
Telephone Number	Email Address			
Type of Practice / Medical Specialty				
State License Number	National Provider Identifier (Optional)			

### B. INFORMATION ABOUT YOUR PATIENT’S PREGNANCY

What was the date you first confirmed by examination the existence of your patient’s pregnancy?

\_\_\_\_\_  
(MM/DD/YYYY)

What was the date you first provided treatment for your patient’s pregnancy, if any?

\_\_\_\_\_  
(MM/DD/YYYY)

What is your patient’s expected due date?

\_\_\_\_\_  
(MM/DD/YYYY)



### C. AMOUNT OF LEAVE NEEDED

*Check the box for each statement that is applicable to your patient's prenatal medical care.*

- ☐ **Prenatal Check-Up Appointments:** Your patient was seen, or will be seen, on the following date(s) for pregnancy check-up appointments:

\_\_\_\_\_ (mm/dd/yyyy)

- ☐ **Specialist Appointments:** Your patient did or will require routine or specialty exams or treatments associated with the pregnancy on the following date(s):

\_\_\_\_\_ (mm/dd/yyyy)

- ☐ **Diagnostic Appointments:** Your patient attended diagnostic appointment(s) in order to provide medical information about the health or well-being of the embryo or fetus (e.g., amniocentesis, ultrasounds, or blood tests) on the following date(s):

\_\_\_\_\_ (mm/dd/yyyy)

- ☐ **Treatment for Pregnancy Complications:** Your patient is experiencing complications with the pregnancy that did or will require treatment on the following date(s):

\_\_\_\_\_ (mm/dd/yyyy)

- ☐ **Treatment for High-Risk Pregnancy:** Your patient's pregnancy is considered "high-risk" and did or will require specialist treatment or evaluation on the following date(s):

\_\_\_\_\_ (mm/dd/yyyy)

- ☐ **Bedrest** (This box must be checked if applying for continuous leave): Your patient is medically required to remain on bedrest during the following period:

\_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy).

- ☐ **Physical Therapy:** Your patient did or will require physical therapy to treat symptoms of, or to relieve physical discomfort associated with, pregnancy on the following date(s):

\_\_\_\_\_ (mm/dd/yyyy)

- ☐ **None of the above.** None of the statements above describe your patient's pregnancy.

### D. CERTIFICATION

Please provide any additional information about your patient's condition or their need for leave.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- ☐ I certify that I am a licensed health care provider that is treating this patient and the information I have provided on this form is true and complete.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## INSTRUCTIONS FOR CLAIMANT:

Use this form to file for Medical Leave benefits with the DC Office of Paid Family Leave. This form is used to determine whether you have a “serious health condition” as defined by the DC Paid Family Leave law. You must complete part 1 of the form. Your doctor or licensed health care provider must complete part 2 of the form. You may complete the filing process for Medical Leave benefits only after this form is completed and signed by your doctor. ***Please ensure that your health care provider completes all sections of part 2 of the form or your claim may be denied.***

You must scan and upload this form to the online Paid Family Leave benefits portal available at [does.pflbas.dc.gov](https://does.pflbas.dc.gov). This form is not an application for benefits. You must complete an application at [does.pflbas.dc.gov](https://does.pflbas.dc.gov) to be considered for benefits.

### PART 1 (To be completed by the claimant)

Last Name	First Name	Middle Name
Date of Birth (MM/DD/YYYY) ____ / ____ / ____	Phone number	

### PART 2 (To be completed by the licensed health care provider)

## INSTRUCTIONS FOR HEALTH CARE PROVIDER:

Your patient is requesting Paid Family Leave benefits from the District of Columbia. The purpose of this form is to determine whether your patient is eligible for Medical Leave benefits under the DC Paid Family Leave law. Please complete **Sections A through D**. Limit your responses to the medical condition(s) for which your patient is seeking Paid Family Leave benefits. **Please complete all sections of Part 2 or it will be returned to you for more information.**

### A. HEALTH CARE PROVIDER INFORMATION

*All fields are required, except where noted*

Provider Last Name	Provider First Name
Mailing Address	Street
City	State
Zip code	
Telephone Number	Email Address
Type of Practice / Medical Specialty	
State License Number	National Provider Identifier (Optional)

### B. QUALIFYING MEDICAL CONDITION

Name of the diagnosis or a statement of symptoms of the health condition

<p>_____</p> <p>_____</p>	
Primary ICD-10 Code for Health Condition	Secondary ICD-10 Code (Optional)
_____	_____
<p>_____ Date health condition was diagnosed (MM/DD/YYYY)</p>	

## B. QUALIFYING MEDICAL CONDITION (continued)

*Check the box for each statement that is applicable to your patient's medical condition. For each box that you check, provide the required additional information for that statement.*

- ☐ **Pregnancy:** Your patient's condition is pregnancy.  
The expected delivery date is \_\_\_\_\_ (mm/dd/yyyy).
- ☐ **Overnight inpatient care:** Your patient was admitted for inpatient care at a hospital, hospice, or residential medical care facility for at least one overnight period to treat this health condition on the following date(s): \_\_\_\_\_.
- ☐ **Incapacity plus treatment** (complete numbers 1, 2, and 3 below):  
1. Your patient's health condition caused a period of continuous incapacity during which your patient was unable to work, attend school, or perform other activities of daily living lasting at least three (3) full consecutive days from \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy).  
2. Your patient had (or will have) an in-person or telehealth appointment with a health care provider to treat or evaluate this health condition on the following dates (required):  
\_\_\_\_\_  
\_\_\_\_\_  
3. Your patient's condition (☐ has / ☐ has not) resulted in a regimen of continuing treatment under the supervision of a health care provider (e.g., taking prescription medications, attending therapy appointments). The regimen of continuing treatment involves:  
\_\_\_\_\_
- ☐ **Chronic Condition** (complete numbers 1, 2, and 3 below):  
1. Your patient's condition (☐ is / ☐ is not) a chronic health condition.  
2. Your patient (☐ does / ☐ does not) require two (2) or more medical visits annually to treat this health condition.  
3. You (☐ expect / ☐ do not expect) your patient to experience unpredictable episodes of the underlying chronic condition that cause episodic inability to work, attend school, or perform other activities of daily living.
- ☐ **Permanent incapacity:** Your patient is experiencing permanent or long-term incapacity due to the health condition and requires continuing supervision by a health care provider (e.g., Alzheimer's Disease or a terminal-stage cancer).
- ☐ **Restorative surgery:** Your patient requires restorative surgery to achieve functional (not cosmetic) capacity after an accident or injury and requires multiple such treatments related to the same accident or injury.
- ☐ **Preventative treatment:** Your patient requires treatments by health care providers on at least two dates in order to avoid the occurrence of a condition that without treatment would cause incapacity for at least 3 full days.
- ☐ **Stillbirth:** Your patient experienced a stillbirth on the following date: \_\_\_\_\_ (mm/dd/yyyy).
- ☐ **None of the above.** Your patient's condition does not fall within one of the above categories.

### C. AMOUNT OF LEAVE NEEDED

- ☐ **Continuous incapacity:** Your patient experienced (will experience) a period of continuous inability to work, attend school, or perform other activities of daily living beginning on \_\_\_\_\_ (mm/dd/yyyy) and ending on \_\_\_\_\_ (mm/dd/yyyy) (if in the future, provide your best estimate).

- ☐ **Planned medical treatments:** Your patient requires planned medical appointments to treat the health condition on the following dates (future or past):

\_\_\_\_\_  
\_\_\_\_\_

- ☐ **Intermittent incapacity:** Your patient experienced (will experience) an intermittent inability to work, attend school, or perform other activities of daily living due to the health condition. If known, those dates were (will be):

\_\_\_\_\_

If unknown, your patient (☐ is / ☐ is not) expected to experience unpredictable episodes or flare ups of the underlying condition that cause episodic inability to work, attend school, or perform other activities of daily living.

### D. CERTIFICATION

Please provide any additional information about your patient's condition or the need for leave.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- ☐ I certify that I am a licensed health care provider that is treating this patient and the information I have provided on this form is true and complete.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# PARENTAL LEAVE ROADMAP

DC Paid Family Leave provides paid time off when you need it most, so you don't have to choose between caring for yourself or your loved one and your job. Paid Family Leave covers a portion of your paycheck for up to two (2) weeks to receive prenatal care and up to eight (8) weeks to bond with a new child.

## 1. GROWING YOUR FAMILY?

Are you planning to grow your family soon? Learn more about options available to you at [dcpaidfamilyleave.dc.gov](https://dcpaidfamilyleave.dc.gov). You may be able to receive pay for sick days and time off for prenatal care received during pregnancy and the time taken off to bond with a new child.

## 3. WHAT COMES NEXT?

After you apply, you can expect to hear back from the Office of Paid Family Leave within 10 business days. Before your leave begins, ensure that you have communicated with your employer. You may not work while receiving DC Paid Family Leave benefits, but you may receive both employer-provided and DC Paid Family Leave benefits simultaneously.



## 2. WHAT DOES THIS MEAN FOR WORK?

Start by telling your employer that you are expecting a baby and will be applying for Paid Family Leave benefits. While pregnant, you can receive prenatal leave benefits to attend medical appointments for your pregnancy. After your new child arrives, you can apply for parental leave benefits. When you are ready to apply, you can do so online, by phone, or in person. Go to your website, call our call center, or visit the American Job Center at DOES Headquarters.



## 4. PAY DURING LEAVE

DC Paid Family Leave provides benefits of up to 90% of your weekly wage. You will receive your DC Paid Family Leave benefits every other week. You can take benefits in one-day periods to attend prenatal medical appointments or to bond with your child, but you may not work on any part of a day for which you receive Paid Family Leave Benefits.

Visit [dcpaidfamilyleave.dc.gov](https://dcpaidfamilyleave.dc.gov) to use the Benefits Calculator, learn more or apply for benefits. For more questions, email [does.opfl@dc.gov](mailto:does.opfl@dc.gov) or call 202-899-3700.





dc paid  
**family leave**



# PLAN FOR TOMORROW TODAY



You don't have to choose between caring for yourself or your loved one and your job. DC Paid Family Leave is here for you when you need time off to care for yourself and your family.

Paid Family Leave covers a portion of your income for up to eight (8) weeks to bond with a new child, six (6) weeks to care for a family member with a serious health condition, six (6) weeks to care for your own serious health condition, and two (2) weeks for you to receive prenatal medical care.

# 8-6-6-2

Paid Family Leave will provide 8 weeks to bond with a new child, 6 weeks to care for a family member with a serious health condition, 6 weeks to care for your own serious health condition, and 2 weeks for you to receive prenatal medical care.

## Who Qualifies for Paid Family Leave?

DC Paid Family Leave is for all private-sector workers in DC, including people who work in DC but live in another state.

## How Much Money Will I Receive?

DC Paid Family Leave provides wage replacement of 90% of wages up to 1.5 times DC's minimum wage and 50% of wages above 1.5 times DC's minimum wage. To determine your benefit, DC Paid Family leave uses your past five (5) quarters of income paid by your employer and reported to the DC Department of Employment Services (DOES).

Visit [does.dc.gov/page/dc-paid-family-leave](https://does.dc.gov/page/dc-paid-family-leave) to use the Benefits Calculator.

## PLAN FOR TOMORROW TODAY.

**Plan ahead.** Learn more about Paid Family Leave before you need it. Visit [dcpaidfamilyleave.dc.gov](https://dcpaidfamilyleave.dc.gov) or call the contact center at **202-899-3700**.

## How Do I Apply?

Start by telling your employer that you will be applying for Paid Family Leave benefits. You must wait until after the qualifying event has occurred to apply for benefits.

When you are ready to apply, you can do so online or calling into our contact center. Go to [dcpaidfamilyleave.dc.gov](https://dcpaidfamilyleave.dc.gov), call **202-899-3700**, or visit the American Job Center at DOES Headquarters. When you apply for Paid Family Leave benefits, DOES will request a medical certification from your health care provider for family, medical, and prenatal leave claims.

After you apply, you can expect to hear back from the Office of Paid Family Leave within ten (10) business days.



## Other Frequently Asked Questions:

**Q: Do I have to take all of my leave at once?**

**A:** No, you can schedule your leave based on the schedule you work. For example, if you take leave for three (3) days of your work week, and work the other two (2) days of your work week, you would receive leave benefits for the three (3) days that you were on leave, and not for the full week of leave. You may apply for DC Paid Family Leave benefits for all or a portion of the benefits you are allowed.

**Q: Is my job protected when I take DC Paid Family Leave?**

**A:** No, DC Paid Family Leave does not provide job protection. Other laws, such as the Family and Medical Leave Act (FMLA), provide job protection when workers take Paid Family Leave. It is important for you to notify your employer before applying for leave and to determine a schedule that works.

**Q: I live in Maryland but work in DC. Do I qualify?**

**A:** Yes, DC Paid Family Leave benefits are for all DC private-sector employees. You do not need to be a DC resident to qualify.







# EIGHT (8) WEEKS PARENTAL LEAVE

## Planning to grow your family soon?

DC Paid Family Leave is available to help ease the transition.

DC offers Paid Family Leave benefits so you don't have to choose between caring for your loved ones and earning income. Parental Leave provides eight (8) weeks of benefits in a year to bond with a new child. This is a benefit provided by the DC Department of Employment Services (DOES) separate from any existing company benefits that your employer may provide.

## Who Qualifies for Parental Leave?

Parental Leave benefits apply to all DC employees who are taking time off from work to bond with a new child, including parents of newborns, adopted children, and foster children. You can receive Parental Leave benefits if you have experienced one of the following in the past year:

- Your biological child was born in the past year
- A child was placed with you for adoption in the past year
- A child was placed with you for foster care in the past year
- You legally assumed parental responsibility for a child in the past year

## How Much Can I Receive in Parental Leave Benefits?

DC Paid Family Leave provides wage replacement of 90% of wages up to 1.5 times DC's minimum wage and 50% of wages above 1.5 times DC's minimum wage. The maximum weekly benefit amount is \$1,000. To determine your benefit, DC Paid Family Leave uses your past five (5) quarters of income paid by your employer and reported to the DC Department of Employment Services (DOES).

Visit [does.dc.gov/page/dc-paid-family-leave](https://does.dc.gov/page/dc-paid-family-leave) to use the Benefits Calculator.

# 8

**PAID FAMILY  
LEAVE PROVIDES  
8 WEEKS  
OF PARENTAL  
LEAVE TO BOND  
WITH A NEW CHILD**



# EIGHT (8) WEEKS PARENTAL LEAVE

## How Do I Apply?

Start by telling your employer that you will be applying for Paid Family Leave benefits. Although you should notify your employer prior to the event of your intent to apply for benefits, you must wait until after the event has occurred to apply for benefits.

When you are ready to apply, you can do so online or calling into our contact center. Go to [dcpaidfamilyleave.dc.gov](https://dcpaidfamilyleave.dc.gov), call **202-899-3700**, or visit the American Job Center at DOES Headquarters. When you apply for Paid Family Leave benefits, DOES will request a medical certification from your health care provider for family, medical, and prenatal leave claims.

After you apply, the Office of Paid Family Leave will contact you within ten (10) business days.

## PLAN FOR TOMORROW TODAY.

**Plan ahead.** Learn more about Paid Family Leave before you need it. Visit [dcpaidfamilyleave.dc.gov](https://dcpaidfamilyleave.dc.gov) or call the contact center at **202-899-3700**.



## Other Frequently Asked Questions:

**Q: Do I have to take all of my leave at once?**

**A:** No, you can schedule your leave based on the schedule you work. For example, if you take leave for three (3) days of your work week, and work the other two (2) days of your work week, you would receive leave benefits for the three (3) days that you were on leave, and not for the full week of leave. You may apply for DC Paid Family Leave benefits for all or a portion of the benefits you are allowed.

**Q: Is my job protected when I take DC Paid Family Leave?**

**A:** No, DC Paid Family Leave does not provide job protection. Other laws, such as the Family and Medical Leave Act (FMLA), provide job protection when workers take Paid Family Leave. It is important for you to notify your employer before applying for leave and to determine a schedule that works.

**Q: My employer provides paid maternity leave. Can I use employer-provided paid maternity leave benefits and DC Paid Family Leave benefits?**

**A:** Yes. It is up to the discretion of your employer to determine how their employer-provided benefits will coordinate with DC Paid Family Leave benefits. Some employers may require employees to use DC Paid Family Leave benefits before applying for company-provided benefits. You may not work while receiving DC Paid Family Leave benefits, but you may receive both employer-provided and DC Paid Family Leave benefits simultaneously.







# SIX (6) WEEKS FAMILY LEAVE



## Focus on caring for your loved ones without worrying about your paycheck.

DC offers Paid Family Leave benefits so you don't have to choose between caring for your loved ones and earning income. Family Leave provides up to six (6) weeks of benefits in a year to care for a family member with a serious health condition. This is a benefit provided by the DC Department of Employment Services (DOES), separate from any existing company benefits that your employer may provide. You don't need to pay additional fees; you just need to file a claim.

### Who Qualifies for Family Leave?

You can receive Family Leave benefits if you will be providing care or companionship to a family member with a serious health condition. Eligible family members are:

- Your child
- Your parent
- Your spouse
- Your grandparent
- Your sibling

This includes biological, foster, step-, and some in-law family members from the list above.

### How Much Can I Receive in Family Leave Benefits?

DC Paid Family Leave provides wage replacement of 90% of wages up to 1.5 times DC's minimum wage and 50% of wages above 1.5 times DC's minimum wage. The maximum weekly benefit amount is \$1,000. To determine your benefit, DC Paid Family Leave uses your past five (5) quarters of income paid by your employer and reported to the DC Department of Employment Services (DOES).

Visit [does.dc.gov/page/dc-paid-family-leave](https://does.dc.gov/page/dc-paid-family-leave) to use the Benefits Calculator.

# 6

**PAID FAMILY  
LEAVE PROVIDES  
6 WEEKS  
OF FAMILY LEAVE TO  
TAKE CARE OF A  
FAMILY MEMBER WITH  
A SERIOUS HEALTH  
CONDITION**





# SIX (6) WEEKS FAMILY LEAVE

## How Do I Apply?

Start by telling your employer that you will be applying for Paid Family Leave benefits. Although you should notify your employer prior to the event of your intent to apply for benefits, you must wait until after the event has occurred to apply for benefits.

When you apply for Paid Family Leave benefits, DOES will request a medical certification from your family member's medical provider confirming your family member's condition and that care or companionship is required.

When you are ready to apply, you can do so online or by calling into our contact center. Go to [dcpaidfamilyleave.dc.gov](https://dcpaidfamilyleave.dc.gov), call **202-899-3700**, or visit the American Job Center at DOES Headquarters. When you apply for Paid Family Leave benefits, DOES will request a medical certification from your health care provider for family, medical, and prenatal leave claims.

After you apply, you can expect to hear back from the Office of Paid Family Leave within 10 business days.

## PLAN FOR TOMORROW TODAY.

**Plan ahead.** Learn more about Paid Family Leave before you need it. Visit [dcpaidfamilyleave.dc.gov](https://dcpaidfamilyleave.dc.gov) or call the contact center at **202-899-3700**.



## Other Frequently Asked Questions:

**Q: Can I apply for Family Leave benefits multiple times throughout the year?**

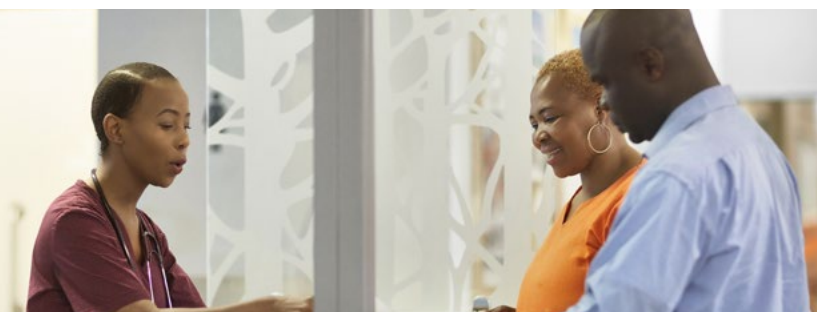
**A:** Yes, you may receive DC Paid Family Leave benefits multiple times throughout the year. You may receive a maximum to eight (8) weeks of benefits in a 52-week period of parental, family and medical leave. You may still take two (2) additional weeks of prenatal leave as long as you have not already taken six (6) weeks of medical leave. The date on which you first received benefits is when the year starts; it is not a calendar year. You will be eligible to receive benefits again one year after that date.

**Q: Is my job protected when I take DC Paid Family Leave?**

**A:** No, DC Paid Family Leave does not provide job protection. Other laws, such as the Family and Medical Leave Act (FMLA), provide job protection when workers take Paid Family Leave. It is important for you to notify your employer before applying for leave and to determine a schedule that works.

**Q: My employer provides paid family leave. Can I use employer-provided paid family leave benefits and DC Paid Family Leave benefits?**

**A:** Yes, it is up to the discretion of your employer to determine how their employer-provided benefits will coordinate with DC Paid Family Leave benefits. Employers may not reduce, in any way, the benefits provided by DC Paid Family Leave. Some employers may require employees to use DC Paid Family Leave benefits before applying for the employer-provided benefits. You may not work while receiving DC Paid Family Leave benefits, but you may receive both employer-provided and DC Paid Family Leave benefits simultaneously.



# SIX (6) WEEKS MEDICAL LEAVE

## Focus on taking caring of yourself without worrying about your paycheck.

DC offers Paid Family Leave benefits, so you don't have to choose between taking care of your health and earning income. Medical Leave provides up to six (6) weeks of benefits in a year to take care of your own serious health condition. This is a benefit provided by the DC Department of Employment Services (DOES), separate from any existing company benefits that your employer may provide.

## Who Qualifies for Medical Leave?

DC Paid Family Leave allows you to take the time you need to be healthy and well during a difficult time. Medical Leave benefits apply to all DC employees who have a serious health condition. Eligible health conditions include:

- Conditions that cause an overnight stay at a hospital
- Conditions that cause an extended period of incapacity and a need for treatment
- Chronic conditions
- Incurable conditions
- Restorative surgeries
- Preventative treatments

For more information about any of these eligible conditions, please visit [dcpaidfamilyleave.dc.gov](https://dcpaidfamilyleave.dc.gov) or call the contact center at **202-899-3700**.

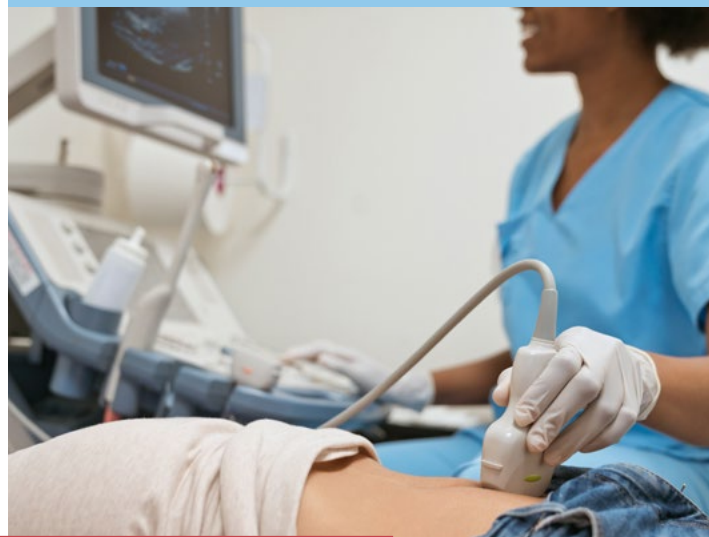
## How Much Can I Receive in Medical Leave Benefits?

DC Paid Family Leave provides wage replacement of 90% of wages up to 1.5 times DC's minimum wage and 50% of wages above 1.5 times DC's minimum wage. The maximum weekly benefit amount is \$1,000. To determine your benefit, DC Paid Family Leave uses your past five (5) quarters of income paid by your employer and reported to the DC Department of Employment Services (DOES).

Visit [does.dc.gov/page/dc-paid-family-leave](https://does.dc.gov/page/dc-paid-family-leave) to use the Benefits Calculator.

# 6

**PAID FAMILY  
LEAVE PROVIDES  
6 WEEKS  
OF MEDICAL LEAVE  
TO CARE FOR YOUR  
OWN SERIOUS  
HEALTH CONDITION**



# SIX (6) WEEKS MEDICAL LEAVE

## How Do I Apply?

Start by telling your employer that you will be applying for Paid Family Leave benefits. Although you should notify your employer prior to the event of your intent to apply for benefits, you must wait until after the event occurs to apply for benefits.

When you apply for Paid Family benefits, DOES will request a medical certification from your medical provider confirming your qualifying health condition and your need for leave.

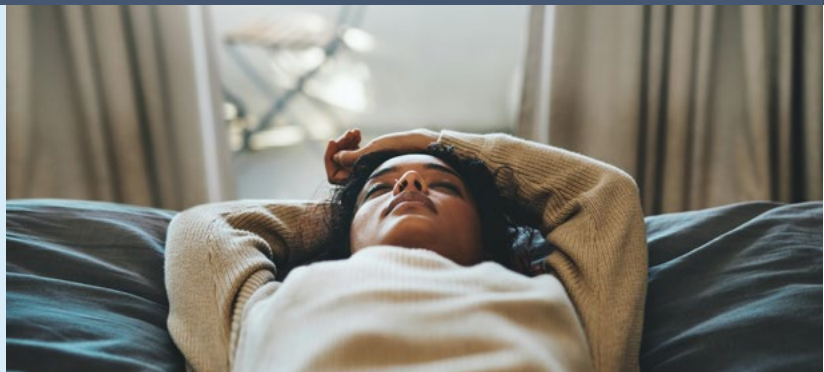
When you are ready to apply, you can do so online or calling into our contact center. Go to [dcpaidfamilyleave.dc.gov](https://dcpaidfamilyleave.dc.gov), call **202-899-3700**, or visit the American Job Center at DOES Headquarters. When you apply for Paid Family Leave benefits, DOES will request a medical certification from your health care provider for family, medical, and prenatal leave claims.

After you apply, the DC Office of Paid Family Leave will contact you within ten (10) business days.

## PLAN FOR TOMORROW TODAY.

**Plan ahead.** Learn more about Paid Family Leave before you need it.

Visit [dcpaidfamilyleave.dc.gov](https://dcpaidfamilyleave.dc.gov) or call the contact center at **202-899-3700**.



## Other Frequently Asked Questions:

**Q: Can I apply for Medical Leave benefits multiple times throughout the year?**

**A:** Yes, you may receive DC Paid Family Leave benefits multiple times throughout the year. You may only receive a maximum of six (6) weeks of Medical Leave benefits and may only receive a maximum of eight (8) weeks of DC Paid Family Leave benefits (for other events, such as Parental Leave or Family Leave) per year. The date for which you first received benefits is when the year starts; it is not a calendar year. You will be eligible to apply for benefits again one year after that date.

**Q: Is my job protected when I take DC Paid Family Leave?**

**A:** No, DC Paid Family Leave does not provide job protection. Other laws, such as the Family and Medical Leave Act (FMLA), provide job protection when a person takes Paid Family Leave. It is important for the employee to notify their employer before applying for leave and to determine a schedule that works.

**Q: My employer provides sick leave benefits. Can I use employer-provided sick leave benefits and DC Paid Family Leave benefits?**

**A:** Yes, it is up to the discretion of your employer to determine how their employer-provided benefits will coordinate with DC Paid Family Leave benefits. Some employers may require employees to use DC Paid Family Leave benefits before applying for the employer-provided benefits. You may not work while receiving DC Paid Family Leave benefits, but you may receive both employer-provided and DC Paid Family Leave benefits simultaneously.

