Authorized Agent for an Incapacitated Claimant Form Instructions

SECTION 1: GENERAL INSTRUCTIONS

Complete and physically sign this form if **you are a family member of a claimant who is incapacitated** because of a serious health condition, and you are asking to represent the incapacitated claimant to act on their behalf.

You may request to represent an incapacitated claimant if you are a family member as defined in ORS 657B.010. You can find the definition of family member in section 3 of the instructions.

A health care provider treating the claimant because of their incapacitation must sign this form to confirm the claimant's serious health condition.

Paid Leave Oregon may discuss a current or pending Paid Leave claim with the authorized agent. It gives us permission to provide information from our records that would otherwise be confidential. This includes, but is not limited to information:

- About any benefits the claimant has received or will receive
- Provided in the claimant's initial application
- About any pending or issued decisions we made on a claim

It also gives the authorized agent permission to provide information to Paid Leave, including information needed to:

- Complete a claim for benefits
- File a new claim for benefits for the claimant
- Request a hearing to review a Paid Leave decision and appear in a hearing before the Office of Administrative Hearings on behalf of the claimant

Paid Leave only recognizes one authorized agent per claimant at a time. We will not accept a request for an authorized agent if a legal guardian or court-appointed conservator is authorized to act on behalf of the claimant. This is also true for claimants who have granted power-of-attorney to someone to act on their behalf for Paid Leave Oregon purposes.

Please provide all required information. Missing information can cause a delay in processing your request. Signatures on this form must be handwritten. We cannot accept electronic signatures.

If you are ready to send an application for benefits on the claimant's behalf, you may send it with this form.

Note: You, as the authorized agent, are the only person who can send a benefit application on behalf of the claimant.

Need help?

This information is vital. The Oregon Employment Department (OED) is an equal opportunity agency. OED provides free help so you can use our services. Some examples are sign language and spoken-language interpreters, written materials in other languages, large print, audio, and other formats. To get help, please call 833-854-0166 (toll-free). TTY users call 711. You can also send an email to access.paidleave@oregon.gov.

SECTION 2: INSTRUCTIONS FOR COMPLETING THE FORM

Family member: Fill out Parts A, B and C of this form. Give Part D to the claimant's health care provider to fill out.

- **Part A**: Complete this part with the claimant's information.
- **Part B**: Complete this part with your own information.
- **Part C**: Complete this part with the authorization start date. Leave the authorization end date blank if you do not know the end date of the claimant's incapacitation.
- The authorization automatically ends when:
  - The claimant is no longer incapacitated
  - The claimant's current benefit year ends
- If you do not send an application for Paid Leave benefits within 30 days of the department approving you as the authorized agent.
- In the event of the claimant's death, the authorization ends on the date of death.

  You must also complete, **physically** sign, and date this part. We cannot accept electronic signatures.
- **Part D**: Provide the claimant's health care provider with the definitions in section 3 of the instructions. Have the claimant's health care provider complete and **physically** sign this part to confirm the claimant's incapacitation.
- Attach documents that confirm your family relationship with the claimant and documents that show the claimant's identity and your own identity. You can find a list of acceptable documents that you can use for these purposes in Section 4.
- You must send this form and any other required documents to Paid Leave Oregon. You can either send them electronically through the 'Contact us' form at frances.oregon.gov, or by mail to this address:

  Attn: Paid Leave Oregon
  Oregon Employment Department
  875 Union St NE
  Salem, OR 97311

Claimant's health care provider:

- Review the definitions of health care provider, serious health condition, and incapacitation in Section 3 of the instructions.
- Fill out part D of this form and **physically** sign, and date this section.
    - By completing and signing this section, you confirm that the claimant:
        - Is incapacitated due to a serious health condition (OAR 471-070-1000),
        - Cannot apply for Paid Leave Oregon benefits, and
        - Cannot select a representative to act on their behalf.
    - We cannot accept electronic signatures.
- Return the completed and signed form to the family member asking to represent the incapacitated claimant. They will send this form to Paid Leave Oregon.

SECTION 3: DEFINITIONS

Family member definition

ORS 657B.010 defines family member as:

- The spouse of a covered individual;
- A child of a covered individual or the child's spouse or domestic partner;
- A parent of a covered individual or the parent's spouse or domestic partner;
- A sibling or stepsibling of a covered individual or the sibling's or stepsibling's spouse or domestic partner;
- A grandparent of a covered individual or the grandparent's spouse or domestic partner;
- A grandchild of a covered individual or the grandchild's spouse or domestic partner;
- The domestic partner of a covered individual; or
- Any individual related by blood or affinity whose close association with a covered individual is the equivalent of a family relationship.

Health care provider definition

OAR 471-070-1000 defines a health care provider as either:

(a) A person who is primarily responsible for providing health care to the claimant or the family member of the claimant before or during a period of Paid Leave, who is licensed or certified to practice in accordance with the laws of the state or country in which they practice, who is performing within the scope of the person's professional license or certificate, and who is a(n):

- Chiropractic physician (only to the extent the chiropractic physician provides treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated to exist by X-rays)
- Dentist
- Direct entry midwife
- Naturopath
- Nurse practitioner
- Nurse practitioner specializing in nurse-midwifery
- Optometrist
- Physician
- Physician assistant
- Psychologist
- Registered nurse
- Regulated social worker (or)

(b) A person who is primarily responsible for the treatment of the claimant or the family member of the claimant solely through spiritual means before or during a period of Paid Leave, including but not limited to a Christian Science practitioner.

Serious health condition definition
OAR 471-070-1000 defines a "serious health condition" as:

An illness, injury, impairment, or physical or mental condition of a claimant or their family member that:

- Requires inpatient care in a medical care facility such as a hospital, hospice, or residential facility such as, but not limited to, a nursing home or inpatient substance abuse treatment center
- In the medical judgement of the treating health care provider poses an imminent danger of death, or that is terminal in prognosis with a reasonable possibility of death in the near future
- Requires constant or continuing care, including home care administered by a health care professional
- Involves a period of incapacity. "Incapacity" is the inability to perform at least one essential job function, or to attend school or perform regular daily activities for more than three consecutive calendar days. A period of incapacity includes any subsequent required treatment or recovery period relating to the same condition. The incapacity must involve one of the following:
    - Two or more treatments by a health care provider
    - One treatment plus a regimen of continuing care
- Results in a period of incapacity or treatment for a chronic serious health condition that requires periodic visits for treatment by a health care provider, continues over an extended period of time, and may cause episodic rather than a continuing period of incapacity, such as asthma, diabetes, or epilepsy
- Involves permanent or long-term incapacity due to a condition for which treatment may not be effective, such as Alzheimer's Disease, a severe stroke, or terminal stages of a disease. The employee or family member must be under the continuing care of a health care provider, but need not be receiving active treatment
- Involves multiple treatments for restorative surgery or for a condition such as chemotherapy for cancer, physical therapy for arthritis, or dialysis for kidney disease that if not treated would likely result in incapacity of more than three calendar days
- Involves any period of disability due to pregnancy, childbirth, miscarriage or stillbirth, or period of absence for prenatal care
- Involves any period of absence from work for the donation of a body part, organ, or tissue, including preoperative or diagnostic services, surgery, post-operative treatment, and recovery

Incapacitated definition

Per ORS 125.005 (5), "Incapacitated" means a condition in which a person's ability to receive and evaluate information effectively or to communicate decisions is impaired to such an extent that the person presently lacks the capacity to meet the essential requirements for the person's physical health or safety. "Meeting the essential requirements for physical health and safety" means those actions necessary to provide the health care, food, shelter, clothing, personal hygiene and other care without which serious physical injury or illness is likely to occur.

SECTION 4: ACCEPTABLE DOCUMENTS

Acceptable documents for confirming a family relationship:

- Certified Declaration of Domestic Partnership
- Legal Birth Certificate
- Legal Marriage Certificate
- Other documents, at the discretion of Paid Leave Oregon, issued by an independent third party that establish the marriage, domestic partnership, parenthood or other family relationship between the claimant and the person applying to act on behalf of the claimant.

Acceptable documents to establish the identity of the incapacitated claimant and the person applying to represent the claimant to act on their behalf include:

Note: You must send two primary identity documents or one primary and two secondary documents for yourself and for the claimant you will represent. They need to be full color scans and a PDF.

Primary documents

- Driver's license (or learner's permit) from a U.S. state or territory (We will accept an expired license if it expired in the last 12 months and is intact.)
- Other government-issued photo ID (Must be a permanent document with a photo. Military IDs, temporary or paper documents are not accepted.)
- State-issued photo ID (We will accept expired ID if it expired in the last 12 months and is intact.)
- US Passport or US Passport Card
- U.S. Permanent Resident Card (I-551
- USCIS-issued Employment Authorization Card (I-766) (No employer-issued ID cards)
- Foreign passport
- Veteran's Health ID Card
- DHS Trusted Traveler Cards (Global Entry, NEXUS, SENTRI)
- Canadian driver's license
- Certificate of Naturalization (Form N-550 or N-570)
- National ID card (only if residing outside of the U.S.)
- Federally recognized, Tribal-issued photo ID
- Non-immigrant visa issued by the U.S. Department of State (not expired more than five years)
- Temporary immigrant visa (I551) issued by the U.S. Department of State (not expired more than five years)

Secondary documents (Full-color scans and PDFs of the following documents are acceptable as secondary documents)

- Social Security Card
- U.S. Certification of Birth Abroad (FS-545)
- U.S. Certification of Report of Birth (DS-1350)
- Canadian Indian and Northern affairs card
- College or university student photo ID
- College or university transcript

- U.S. Consular Report of Birth Abroad (FS-240)
- U.S. health insurance card
- U.S. birth certificate with official seal (first and last name)
- W-2 form
- 1098 form
- Auto insurance card
- Border crossing card
- U.S. Coast Guard merchant mariner card
- U.S. Citizen Identification Card form (I-197)
- DOD certificate of discharge
- Auto or home insurance statement
- Letter attesting state residency
- Supplemental Nutrition Assistance
- Program recipient certification
- Native American tribal document
- Non SSA-1099 form
- SSA-1099 form
- U.S. or U.S. territory voter registration card or certificate
- Women, Infants, and Children (WIC) Puerto Rico recipient certification

Secondary documents (Must be less than 90 days old)

- **Utility bill** (showing your account number, full name, and current address)
- **Medical bill** (showing your account number, full name, and current address)
- **Bank, loan, or financial institution statement** (showing your account number, full name, and current address; issued by the bank)
- **Pay stub** (showing your full name, employer or company name, current address; must be an actual pay stub not a paycheck)

Paid Leave Oregon

Authorized Agent for Incapacitated Claimant Form

PART A - CLAIMANT INFORMATION	
First name:	Last name:
Social Security Number (SSN): _____ or Individual Taxpayer Identification Number (ITIN): _____	
Date of birth (MM/DD/YYYY): / /	Phone number:
Physical address:	Mailing address (If different from physical address):
Email address (optional):	

PART B – AUTHORIZED AGENT INFORMATION	
First name:	Last name:
Date of birth (MM/DD/YYYY): / /	Relationship to claimant:
Physical address:	Mailing address (If different from physical address):
Phone number:	Email address (optional):

PART C – AUTHORIZED AGENT FOR INCAPACITATED CLAIMANT AUTHORIZATION AND SIGNATURE

This authorization is valid from (MM/DD/YYYY): / / through: / /
(Leave end date blank if not known)

How your approved status as an authorized agent for an incapacitated claimant may end:

- **Your authorization will automatically end (whichever comes first):**
  - **When the claimant is no longer incapacitated, or**
  - **When the claimant's current benefit year ends**
- **If you do not apply for Paid Leave benefits for the claimant within 30 days of your approval as the authorized agent, your authorization will end.**
- **In the event of the claimant's death, your authorization will end on the date of death.**

Authorized agent of incapacitated claimant certification: I am acting in the best interest of the claimant and will maintain confidentiality of any information I receive from Paid Leave Oregon on behalf of the claimant. I understand that my authority to act on behalf of the claimant will end when the claimant is no longer incapacitated. I agree to inform Paid Leave Oregon within three calendar days of learning that the claimant can act on their own behalf.

Authorized agent of incapacitated claimant signature: Date: / /

You must physically sign this form. We cannot accept electronic signatures.

Claimant name:	Claimant SSN/ITIN:
PART D – HEALTH CARE PROVIDER INFORMATION AND CERTIFICATION	
Claimant's name:	Date of birth: / /
Health care provider name:	Title:
Certificate license number (optional):	State or country:
License area or area of practice	Phone:
Email address (optional):	
Business name:	
Address:	

☐ I have read the definitions of health care provider, serious health condition (OAR 471-070-1000), and incapacitation (ORS 125.005).

Health care provider certification: I declare under penalty of perjury that:

- The claimant listed on this form is incapacitated (ORS 125.005) because of a serious health condition as defined in OAR 471-070-1000.
- The claimant cannot complete the steps needed to apply for Paid Leave Oregon benefits and cannot choose a representative to act on their own behalf;
- I am a health care provider authorized to certify the claimant's condition as defined in OAR 471-070-1000 and I am treating the claimant due to their incapacitation.
- The information provided in this form is true and correct.

Health care provider signature: Date: / /

You must physically sign this form. We cannot accept electronic signatures.