Authorized Agent for Incapacitated Claimant Instructions & Document List

This packet is for people who need authorization to act on behalf of an incapacitated claimant for Paid Leave Oregon purposes.

You can send the packet one of the following ways:

- Use our Contact us form at frances.oregon.gov
- Mail your completed form and all required documents to:

Attn: Paid Leave Oregon
Oregon Employment Department
875 Union St NE
Salem, OR 9731

To avoid delays, please send all required documents and forms together. If we don't receive all the claim information and documentation we need within 30 days from the approval of your authorization application, you may need to restart the process.

Note: Depending on your situation, you may not need all the forms in this packet. For example, if the claimant has already applied for all requested leave, you won't need to send an application.

For further information please visit our website at paidleave.oregon.gov or contact us at 833-854-0166 (toll-free). TTY users call 711.

PACKET FOR AUTHORIZED AGENT OF AN INCAPACIATED CLAIMANT

Authorized Agent Application

Please include the following documents:

1. A completed Authorized Agent for an Incapacitated Claimant Form that includes health care provider information and certification confirming the claimant is incapacitated
   Note: If you have a letter from the court granting authority **or** a power of attorney, you can send one of these instead of the form.
2. At least two forms of identity verification documents for the authorized agent (see form for instructions)
3. At least two forms of identity verification documents for the claimant (see form for instructions)
4. Document proving the relationship between the authorized agent and the claimant (not applicable if the representation is granted through legal proceeding).

Benefits Application (if the claimant hasn't already applied for all requested leave)

1. A completed Paid Leave Application for Benefits Form
2. A leave verification form (completed by a health care provider or other authorized person)

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.

Instructions for Application for Benefits

You can apply for Paid Leave Oregon benefits by completing this application and including the appropriate documentation for your type of leave. We recommend learning about all benefit eligibility requirements before completing your application. You can find this information at paidleave.oregon.gov or by calling us at 833-854-0166.

You can send your application 30 days before the start date of your leave, or up to 30 days after this date. If circumstances outside of your control prevent you from sending your application during this 60-day time frame, Paid Leave may accept your application up to one year after the start of your leave. If you experience circumstances outside of your control, you need to send documentation to Paid Leave explaining the cause of the delay. Paid Leave will review your documentation and make a decision.

The fastest and easiest way to file for benefits, see the status of your claim, and see your benefit payments is by creating a Paid Leave Oregon account at frances.oregon.gov.

VERIFICATION OF LEAVE

You must show verification for your specific life event by including the appropriate verification document. Paid Leave uses this documentation to decide if you qualify for benefits, meet the definition for the type of leave you request, and calculate the amount of leave as well as the time frame you can claim benefits. Visit our Employee Guidebook at paidleave.oregon.gov/resources/resources.html for a list of acceptable verification documents. Be sure to include a legible copy of an accepted verification document with this application.

INFORMATION ON OTHER BENEFITS

Unemployment Insurance and Workers' Compensation time loss benefits

In any week in which you receive Workers' Compensation time loss benefits or Unemployment Insurance benefits, you can't receive Paid Leave benefits for that week.

Time loss benefits are workers' compensation benefits that replace an employee's wages.

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.

Paid Leave Oregon

Application for Benefits

IDENTIFICATION

Social Security Number (SSN): _____ or

Individual Taxpayer Identification Number (ITIN): _____

Legal first name:

Legal middle name (if any):

Legal last name(s):

Preferred name:

Names your current or past employer(s) know you by:

Date of birth (MM/DD/YYYY): / /

Driver's license or state identification number (if you have one):

Issuing state:

What are your pronouns? (Select all that apply)

- ☐ He/him/his
- ☐ She/her/hers
- ☐ They/them/theirs
- ☐ Prefer not to say
- ☐ No preference
- ☐ Not listed: _____
- ☐ Not sure (for authorized representative)

What language do you want to get our services in?

- ☐ English
- ☐ Spanish

We provide free help so you can use our services. Some examples are sign language interpreters, spoken-language interpreters, written materials in other languages, large print, audio, and other formats.

Do you need help to use our services?

- ☐ Yes
- ☐ No

Name:	SSN/ITIN:

IDENTIFICATION (Continued)

When you apply for Paid Leave Oregon benefits, the Internal Revenue Code and Oregon Administrative Rules require that you provide your Taxpayer Identification Number (TIN). Your TIN is either your assigned Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN). The Oregon Employment Department (OED) uses it to confirm your identity and to report your benefit payments to the Internal Revenue Service and the Oregon Department of Revenue. If your TIN is a SSN, OED will confirm it with the Social Security Administration. If your TIN is an ITIN, OED may confirm it with the Internal Revenue Service. OED uses your TIN as a record for processing your claim and for statistical purposes related to Paid Leave Oregon. These statistics will not include personally identifiable information. OED may use your TIN to collect a debt.

CONTACT INFORMATION

Email address:_____

Note: If you would like to receive information from us electronically, create a Frances Online account at frances.oregon.gov.

Phone number #1	**Phone number #2** (optional)
☐ Cell phone	☐ Cell phone
☐ Home phone	☐ Home phone
☐ Business phone	☐ Business phone
Phone number: (____) _____ - _____	Phone number: (____) _____ - _____

PHYSICAL ADDRESS

Street line 1:			
Street line 2:			
Unit type:		Unit number:	
City:	State:	Zip:	County:
Attention:		Country:	

MAILING ADDRESS (If different from physical address)

Street line 1:			
Street line 2:			
Unit type:		Unit number:	
City:	State:	Zip:	County:
Attention:		Country:	

Name:	SSN/ITIN:

TYPE OF LEAVE & DATES

What type of leave are you requesting? (Select "Yes" to only one)

Bonding leave. Are you taking family leave to care for and bond with a child during the first year after the child's birth or during the first year after the placement of the child through foster care or adoption?

☐ Yes ☐ No

Family leave. Are you taking family leave to care for a family member with a serious health condition?

☐ Yes ☐ No

Medical leave. Are you taking medical leave for your own serious health condition? ☐ Yes ☐ No

Safe leave. Are you taking safe leave because you, your child, or dependent is a survivor of sexual assault, domestic violence, harassment, bias crimes, or stalking? ☐ Yes ☐ No

Pre-placement leave. Are you taking pre-placement leave for necessary activities before adopting a child or having a foster child join your home? (You must take leave on an intermittent schedule with this type of leave. You must file a weekly claim for each week of leave you take.) ☐ Yes ☐ No

What date do you plan to start your leave? ____ / ____ / _____ (MM/DD/YYYY)

What is the end date of your requested leave? ____ / ___ / _____ (MM/DD/YYYY)

Name:	SSN/ITIN:

ADDITIONAL TYPE OF LEAVE QUESTIONS

Answer questions that are related to the type of leave you selected in the section above. Not all types of leave have additional questions.

Family-Care leave

Which family member are you taking leave to care for? ☐ Child ☐ Grandchild ☐ Grandparent ☐ Parent ☐ Sibling ☐ Spouse or Domestic Partner ☐ Other

If "Other" – Please explain the relationship that is the same as a family member.

_____

_____

Contact information for the person you are caring for:

First name:

Last name:

Phone number:

Address for the person you are caring for:

Street line 1:

Street line 2:

Unit type:	Unit number:

City:	State:	Zip:	County:

What is the type of care or support you are providing for your family member? Select the option that best applies to your situation.

☐ Emotional support or comfort

☐ Making arrangements for medical care or completing other administrative tasks

☐ Medical or physical assistance

☐ Transportation to medical care

☐ Other

If "Other," please explain:

Name:	SSN/ITIN:

Safe leave

Who needs to take safe leave? ☐ For myself ☐ For my child or dependent

Note: Your child must be under the age of 18, and if they are 18 or older, they need to be a dependent adult with a physical or mental disability that limits their ability to live independently.

Please select the purpose(s) of your safe leave. (Select the option(s) that best applies to your situation.)

☐ To seek legal or law enforcement help for the health and safety of yourself, your child, or dependent, including preparing for and participating in court hearings that are related to sexual assault, domestic violence, harassment, bias crimes, or stalking

☐ To seek medical treatment for yourself, your child, or dependent or to recover from injuries caused by sexual assault, domestic violence, harassment, bias crimes, or stalking

☐ To get counseling for yourself, your child, or dependent from a licensed mental health professional because you, your child, or dependent are a survivor of sexual assault, domestic violence, harassment, bias crimes, or stalking

☐ To get services for yourself, your child, or dependent from a victim services provider because you, your child, or dependent are a survivor of sexual assault, domestic violence, harassment, bias crimes, or stalking

☐ To relocate or take steps to secure an existing home to protect yourself or the health and safety of your child or dependent

☐ None apply

EMPLOYMENT INFORMATION

Complete information about all the jobs you had in Oregon during the following time frames:

- During the 18 months before taking paid leave
- While taking paid leave

Note: If your leave has not started or if you are in the middle of taking your paid leave, only include the jobs you have had through today's date. Include any self-employed businesses if you chose Paid Leave Oregon coverage.

Include all these jobs, even if:

- You aren't taking leave from all of them
- One (or more) of your employers has an equivalent plan

Note: If all your employers offer their own equivalent paid leave plans, stop here. You will need to apply through your employer's plan instead of Paid Leave Oregon.

You must provide all the required information for each job.

Your employer (or you as a self-employed business if you chose coverage) must send your wage information quarterly. Paid Leave will use this information to calculate your weekly benefits. If we can't match or verify your wages, we will contact you for additional information.

Name:	SSN/ITIN:

Employer #1

Employer business name:

Federal Employer Identification Number (FEIN):

Business Identification Number (BIN):

Employer address

Street line 1:

Street line 2:

Unit type:	Unit number:

City:	State:	Zip:	County:

Attention:	Country:

Employer contact name:

Employer contact phone number:

Employer contact email address:

Work and leave information

Date of hire: ____ / _____ / _____ (MM/DD/YYYY)

Are you still working for this employer: ☐ Yes ☐ No

If "No," last day worked: ____ / _____ / _____ (MM/DD/YYYY)

Freque1ncy of pay:

☐ Hourly	☐ Semi-monthly
☐ Daily	☐ Monthly
☐ Weekly	☐ Annually
☐ Bi-weekly (every two weeks)	

For the frequency of pay you selected, what is your amount of pay?

Have you taken or do you plan to take leave from this employer? ☐ Yes ☐ No

If you are taking leave from this employer, how many days do you usually work per week for this employer? Circle one: 1 2 3 4 5 6 7

If you are taking leave from this employer, did you notify this employer about your leave? ☐ Yes ☐ No

If "Yes," when did you notify this employer? ____ / ____ / ____ (MM/DD/YYYY)

Name:	SSN/ITIN:

Employer #2

Employer business name:

Federal Employer Identification Number (FEIN):

Business Identification Number (BIN):

Employer address

Street line 1:

Street line 2:

Unit type:	Unit number:

City:	State:	Zip:	County:

Attention:	Country:

Employer contact name:

Employer contact phone number:

Employer contact email address:

Work and leave information

Date of hire: _____ / _____ / _____ (MM/DD/YYYY)

Are you still working for this employer: ☐ Yes ☐ No

If "No," last day worked: _____ / _____ / _____ (MM/DD/YYYY)

Frequency of pay:

☐ Hourly	☐ Semi-monthly
☐ Daily	☐ Monthly
☐ Weekly	☐ Annually
☐ Bi-weekly (every two weeks)	

For the frequency of pay you selected, what is your amount of pay?

Have you taken or do you plan to take leave from this employer? ☐ Yes ☐ No

If you are taking leave from this employer, how many days do you usually work per week for this employer? Circle one: 1 2 3 4 5 6 7

If you are taking leave from this employer, did you notify this employer about your leave?
☐ Yes ☐ No

If "Yes," when did you notify this employer? ____ / ____ / ____ (MM/DD/YYYY)

Name:	SSN/ITIN:

Employer #3

Employer business name:

Federal Employer Identification Number (FEIN):

Business Identification Number (BIN):

Employer address

Street line 1:

Street line 2:

Unit type:	Unit number:

City:	State:	Zip:	County:

Attention:	Country:

Employer contact name:

Employer contact phone number:

Employer contact email address:

Work and leave information

Date of hire: _____ / _____ / _____ (MM/DD/YYYY)

Are you still working for this employer: ☐ Yes ☐ No

If "No," last day worked: _____ / _____ / _____ (MM/DD/YYYY)

Frequency of pay:

☐ Hourly	☐ Semi-monthly
☐ Daily	☐ Monthly
☐ Weekly	☐ Annually
☐ Bi-weekly (every two weeks)	

For the frequency of pay you selected, what is your amount of pay?

Have you taken or do you plan to take leave from this employer? ☐ Yes ☐ No

If you are taking leave from this employer, how many days do you usually work per week for this employer? Circle one: 1 2 3 4 5 6 7

If you are taking leave from this employer, did you notify this employer about your leave?
☐ Yes ☐ No

If "Yes," when did you notify this employer? ____ / ____ / ____ (MM/DD/YYYY)

Name:	SSN/ITIN:

Self-Employment #1

Business name, if applicable:

Federal Employer Identification Number (FEIN), if applicable:

Business Identification Number (BIN), if applicable:

Address

Street line 1:

Street line 2:

Unit type:	Unit number:

City:	State:	Zip:	County:

Attention:	Country:

Employer contact name:

Employer contact phone number:

Employer contact email address:

Work and leave information

First day of work in this business: _____ / _____ / ____ (MM/DD/YYYY)

Are you still self-employed and working in this business: ☐ Yes ☐ No

If "No," last day worked: _____ / _____ / _____ (MM/DD/YYYY)

Occupation: (job title)

Frequency of income received from business:

☐ Hourly	☐ Semi-monthly (twice per month)
☐ Daily	☐ Monthly
☐ Weekly	☐ Annually
☐ Bi-weekly (every two weeks)	

For the frequency of income you selected, what is your net income from this business?

Have you taken or do you plan to take leave from this self-employment? ☐ Yes ☐ No

If you are taking leave from this business, how many days do you usually work per week in this business? Circle one: 1 2 3 4 5 6 7

Name:	SSN/ITIN:

Additional Employers or Self-Employment

☐ Check this box if you have more jobs or more self-employment. Then fill out and attach the Supplemental Employers Form (find it on the Paid Leave website at paidleave.oregon.gov/resources/forms-and-checklists.html).

ALL EMPLOYER (AND SELF-EMPLOYED BUSINESS) INFORMATION

On average, how many days per week do you work for all your employers in Oregon? Please include your work as a self-employed person if you chose coverage.

Note: If you are sending your application after your leave started, list the average number of days you worked in Oregon when your leave started.

Circle one: 1 2 3 4 5 6 7

ADDITIONAL PREGNANCY LEAVE

This option is only available if you are taking family-bonding leave or medical leave.

Are you currently pregnant or have you given birth in the last year, and are you asking for an additional two weeks of leave for health issues related to pregnancy, childbirth, or a related medical condition?

☐ Yes ☐ No

If you aren't currently pregnant, please provide the date that your pregnancy ended:

_____ / ____ / ____ (MM/DD/YYYY)

LEAVE SCHEDULE

What is your type of leave schedule? *(Select only one)*

☐ **Intermittent leave schedule.** You take leave between the start and end date of your leave, but may also work some days or weeks during this time frame. You may also be taking leave for two or more types of leave at the same time or you are taking pre-placement leave.

Note: By selecting this option, you must send us a Weekly Claim Form each week you take leave. You must send the form to us within 30 days from the end of each week you take leave. If your leave recently started, include the Weekly Claim Form with your application. See the Weekly Claim Form instructions for additional information. Call us at 833-854-0116 to ask for the form.

For faster weekly claim submissions and to see your weekly claim's status, create a Frances Online account at frances.oregon.gov.

☐ **Consecutive leave schedule.** You take leave for one qualifying event at a time, and you do not work for any of your employers (or self-employment) during your approved leave time frame.

Name:	SSN/ITIN:

To calculate your benefits, provide the following information. For Paid Leave, a week runs from Sunday through Saturday.

How many days of Paid Leave will you take during the **first week** you start leave?
Circle one: 1 2 3 4 5 6 7

How many days of Paid Leave will you take during the **last week** of your leave?
Circle one: 1 2 3 4 5 6 7

OTHER BENEFITS

Have you received or do you expect to receive Workers' Compensation time loss benefits during your leave?

☐ Yes ☐ No

Have you received or do you expect to receive Unemployment Insurance benefits during your leave?

☐ Yes ☐ No

Name:	SSN/ITIN:

VOLUNTARY DISCLOSURE

We won't use your answers in this section of the application to make decisions about your claim. We will only use your responses for group data analysis. To help us better understand the different communities we serve, we encourage you to answer the demographics information below. You can choose the option 'prefer not to say' for any questions.

What is the highest degree or level of school you have completed? (Choose one answer)

- ☐ No school
- ☐ Less than high school
- ☐ Some high school, no diploma
- ☐ High school graduate, including GED or equivalent
- ☐ Technical, trade, or vocational school
- ☐ Some undergraduate education or associate degree
- ☐ Bachelor's degree
- ☐ Postgraduate degree
- ☐ Prefer not to say
- ☐ Not sure (For authorized representative)

Do you have a disability?
(Choose one answer)

You would be considered to have a disability if you have a physical, intellectual, and/or developmental disability or medical condition that substantially limits a major activity, or if you have a history or record of a disability or medical condition. This also includes if you are regarded as having a disability.

- ☐ Yes
- ☐ No
- ☐ Prefer not to say
- ☐ Not sure (for authorized representative)

What is your veteran or military status?
(Choose one answer)

- ☐ I am a veteran of the U.S. Armed Forces, Military Reserves, or National Guard
- ☐ I am active U.S. Armed Forces, Military Reserves, or National Guard
- ☐ I am not a veteran or I do not have a military status
- ☐ Prefer not to say
- ☐ Not sure (for authorized representative)

Which of the following best describes you?
(Check all that apply)

- ☐ American Indian, Native American, or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic/Latino/a/x
- ☐ Native Hawaiian, Pacific Islander
- ☐ White
- ☐ Middle Eastern/North African
- ☐ Choose to self-describe:

  _____
- ☐ Prefer not to say
- ☐ Not sure (for authorized representative)

Name:	SSN/ITIN:
Are you Hispanic, Latino/a/x, or Spanish? (Choose one answer) ☐ Yes, I am Hispanic, Latino/a/x, or Spanish ☐ No, I am not Hispanic, Latino/a/x, or Spanish ☐ Prefer not to say ☐ Not sure (for authorized representative) **What is your sex?** (Choose one answer) ☐ Woman/female ☐ Man/male ☐ Prefer not to say **Are you transgender?** (Choose one answer) ☐ Yes ☐ No ☐ Questioning/exploring ☐ Prefer not to say ☐ I don't know what this question is asking ☐ Not sure (for authorized representative)	**What is your gender?** (Check all that apply) ☐ Agender/no gender ☐ Non-binary ☐ Woman/girl ☐ Man/boy ☐ Another gender not listed. Please specify: _____ ☐ Questioning/exploring ☐ Prefer not to say ☐ I don't know what this question is asking ☐ Not sure (for authorized representative) **How do you describe your sexual orientation or sexual identity?** (Check all that apply) ☐ Asexual ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Pansexual ☐ Queer ☐ Questioning/exploring ☐ Same-gender loving ☐ Same-sex loving ☐ Straight (attracted mainly to or only to other gender(s) or sex(es)) ☐ Another sexual orientation not listed. Please specify: _____ ☐ Prefer not to say ☐ I don't know what this question is asking ☐ Not sure (for authorized representative)

Name:	SSN/ITIN:

RECEIVING YOUR BENEFITS

How would you like to receive benefit payments if they are approved? (Select only one)

☐ **Direct deposit**

☐ Checking account ☐ Savings account

Financial institution: _____

Bank routing number: _____

Account number: _____

Please check the box below to confirm your choice of direct deposit as your payment method:

☐ I give the Oregon Employment Department Paid Leave Oregon program permission to electronically deposit payment in the above-listed financial institution. I give the above-named institution permission to accept this payment and deposit it into the account I have listed above

I understand that this permission will replace any previous permission and will remain in effect until I send Paid Leave Oregon written notice of its cancelation, or one year has passed since I last filed a claim.

I understand that if my benefit payments cannot be deposited into the above listed financial institution account, my benefit payments will automatically be paid on a U.S. Bank ReliaCard®. I have reviewed the included ReliaCard® disclosures before making my payment selection.

☐ **Debit card (ReliaCard®)**

Note: If you have received Paid Leave benefit payments on a ReliaCard® in the past, Paid Leave Oregon will use the same ReliaCard® for this claim. Please let Paid Leave know if you need a new card.

☐ I have reviewed the included ReliaCard® disclosure.

TAX WITHHOLDING ELECTION

How do you want your taxes from benefit payments withheld?

☐ I want BOTH 10% for my federal and 8% for my state personal income taxes withheld from my benefit payments.

☐ I want ONLY 10% of my benefit payments withheld for federal personal income taxes.

☐ I want ONLY 8% of my benefit payments withheld for state personal income taxes.

☐ I do not want taxes withheld from my benefit payments.

Name:	SSN/ITIN:

CERTIFICATION

☐ I certify under penalty of law that the information I have provided is true and correct to the best of my knowledge and belief. I understand the law provides penalties for making false statements to successfully get benefits through Paid Leave Oregon. By signing below, I am making a claim for Paid Leave Oregon benefits.

I authorize Paid Leave Oregon to release relevant claim information to my employer(s), including but not limited to, information about my application for leave; the approval or denial of my claim; the dates, duration, and frequency of leave; and my weekly benefit amount.

I authorize Paid Leave Oregon to release relevant claim information to health care providers related to my paid leave claim.

I understand that I must notify Paid Leave Oregon about any change to the information I provided in this application, including the dates and amount of leave, and changes to my employment.

Signature:	Date (MM/DD/YYYY):
Claimant-designated representative signature:	Date (MM/DD/YYYY):
Claimant-designated representative (print name:)	
Authorized agent of an incapacitated or deceased claimant signature:	Date (MM/DD/YYYY):
Authorized agent of an incapacitated or deceased claimant (print name:)	

Note: You need to have approval from the department to act on behalf of a claimant as a claimant-designated representative or authorized agent before we can accept an application or other information from you. The forms to ask for this status are available on our website.

Missing information or documents can cause a delay in processing your application for benefits.

Mail your completed application and all required documents to:

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

U.S. Bank ReliaCard® Pre-Acquisition Disclosure
Program Name: Oregon State Government Programs

You have options as to how you receive your payments, including direct deposit to your bank account or this prepaid card. Ask your agency for available options and select your option.

Monthly fee	Per purchase	ATM withdrawal	Cash reload
$0	**$0**	**$0** in-network **$2.00*** out-of-network	**N/A**

ATM Balance Inquiry (in-network or out-of-network)	$0
Customer Service (automated or live agent)	$0 per call
Inactivity (after 365 days with no transactions)	$2.00 per month

We charge 3 other types of fees. Here are some of them:

International Transaction	3%
Card Replacement (standard or expedited delivery)	$0 or $15.00

* This fee can be lower depending on how and where this card is used.

See the accompanying Fee Schedule for free ways to access your funds and balance information.

No overdraft/credit feature.
Your funds are eligible for FDIC insurance.

For general information about prepaid accounts, visit *cfpb.gov/prepaid.*
Find details and conditions for all fees and services inside the card package or call **1-855-282-6161** or visit **usbankreliacard.com**.

U.S. Bank ReliaCard® Fee Schedule
Program Name: Oregon State Government Programs

All fees	Amount	Details
Get cash		
ATM Withdrawal (in-network)	$0	This is our fee per withdrawal. "In-network" refers to the U.S. Bank or MoneyPass® ATM networks. Locations can be found at *usbank.com/locations* or *moneypass.com/atm-locator.html* .
ATM Withdrawal (out-of-network)	$2.00	This is our fee per withdrawal. This fee is waived for your first 2 ATM withdrawals per month, which includes both ATM Withdrawals (out-of-network) and International ATM Withdrawals."Out-of-network" refers to all the ATMs outside of the U.S. Bank or MoneyPass ATM networks. You may also be charged a fee by the ATM operator even if you do not complete a transaction.
Teller Cash Withdrawal	$0	This is our fee for when you withdraw cash off your card from a teller at a bank or credit union that accepts Visa®.
Using your card outside the U.S.		
International Transaction	3%	This is our fee which applies when you use your card for purchases at foreign merchants and for cash withdrawals from foreign ATMs and is a percentage of the transaction dollar amount, after any currency conversion. Some transactions, even if you and/or the merchant or ATM are located in the United States, are considered foreign transactions under the applicable network rules, and we do not control how these merchants, ATMs and transactions are classified for this purpose.
International ATM Withdrawal	$2.00	This is our fee per withdrawal. This fee is waived for your first 2 ATM withdrawals per month, which includes both ATM Withdrawals (out-of-network) and International ATM Withdrawals.You may also be charged a fee by the ATM operator even if you do not complete a transaction.
Other		
Card Replacement	$0	This is our fee per card replacement mailed to you with standard delivery (up to 10 business days).
Card Replacement Expedited Delivery	$15.00	This is our fee for expedited delivery (up to 3 business days) charged in addition to any Card Replacement fee.
Inactivity	$2.00	This is our fee charged each month after you have not completed a transaction using your card for 365 consecutive days.

Your funds are eligible for FDIC insurance. Your funds will be held at U.S. Bank National Association, an FDIC-insured institution, and are insured up to $250,000 by the FDIC in the event U.S. Bank fails. See *fdic.gov/deposit/deposits/prepaid.html* for details.

No overdraft/credit feature.

Contact Cardholder Services by calling **1-855-282-6161**, by mail at P.O. Box 551617, Jacksonville, FL 32255 or visit ***usbankreliacard.com***.

For general information about prepaid accounts, visit *cfpb.gov/prepaid*. If you have a complaint about a prepaid account, call the Consumer Financial Protection Bureau at 1-855-411-2372 or visit *cfpb.gov/complaint*.

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