COVID-19 ONLY – IHSS/WPCS Provider Sick Leave Request Form

The State Coronavirus benefit is now available and provides sick leave benefits for COVID-19 ONLY between January 1, 2021 and September 30, 2021.
If you meet one of the requirements below, please complete this form and submit it to your local county IHSS office. For WPCS providers please return your form to the Department of Health Care Services.

PROVIDER REQUIREMENTS:

The Sick Leave allows full-time workers (40 hours or more per week) to receive 80 hours of paid leave, and part-time workers to receive the average number of hours they work in a 2-week pay period. COVID-19 sick leave may **only** be claimed if you meet one or more of the following criteria:

1. You are subject to a quarantine or isolation order;
2. You have been advised by a health care provider to self-quarantine;
3. You are having symptoms of COVID–19 and are seeking a medical diagnosis;
4. You are caring for an individual who is subject to a quarantine or isolation order or has been advised to self-quarantine by a health care provider;
5. You are caring for your child who's school or childcare facilities has been closed due to COVID-19 precautions and there is no one else available to care for your child;
6. You are experiencing any other substantially similar concerns;
7. You had a medical appointment to receive a COVID-19 vaccination;
8. You are experiencing COVID-19 vaccination related side effects.

- You can submit one claim for your entire eligible sick leave benefit, or multiple claims incrementally up to the total hours you are eligible for depending on your individual reason(s) for the leave.
- You can submit a claim for up to 2 hours per COVID-19 vaccination appointment.
- You can claim actual time away from work if you experience any side effects related to the COVID-19 vaccine you receive.

- **By claiming this COVID-19 sick leave, you are attesting that you meet one or more of the criteria above and must select one of the boxes on the form.** If you are sick with, potentially sick with, or have been exposed to COVID-19, **you should not be providing IHSS/WPCS services for any recipient as specified by the Department of Public Health**.

- Your completed TEMP 3021 (3/21) form should be returned to your county IHSS office. For WPCS providers, please return your form to the Department of Health Care Services.

CALIFORNIA COVID-19 ONLY PAID SICK LEAVE REQUEST FORM FOR IHSS/WPCS PROVIDERS

Provider Information:

Provider Name (Print):										
Street Address:										
City, State:	**Zip Code:**				**Phone Number:** ( )					
Provider Number (9 digits):										

Recipient Information: Recipient the provider is out sick from:

Recipient Name: ____________________________________

Recipient Case Number (7 digits):

I am requesting 2-weeks of paid sick leave for the following time:

Start Date (MM/DD/YY): ________________ **End Date (MM/DD/YY):** __________________

I am requesting paid sick leave for the date(s) and time (hours and minutes) listed below:

Date (MM/DD)	/	/	/	/	/	/	/
Sick Time (HH:MM)	___:___	___:___	___:___	___:___	___:___	___:___	___:___

I am claiming sick leave for the following reasons **(check box(es) below, if left empty this form cannot be processed)**:

- ❑ I am subject to a quarantine or isolation order, have been advised by my health care provider to self-quarantine, or am having symptoms of COVID-19 and seeking medical diagnosis.
- ❑ I am caring for a person who is subject to quarantine or isolation order, has been told to self-quarantine by a health care provider, and/or am caring for my child whose school or childcare facility has been closed due to COVID-19 or other COVID-19 concern.
- ❑ I had a medical appointment to receive a COVID-19 vaccination, or, I am experiencing COVID-19 vaccination related side effects.

I hereby acknowledge that

- **The information provided above is true and correct.**
- **I have spoken to my recipient(s), and he/she/they know that I took sick leave on the dates indicated above.**

Provider's Signature:	Date:

Please submit this completed form to your county IHSS Office for processing. WPCS providers should return their form to the Department of Healthcare Services.