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NEW YORK STATE | NY Power Authority

Family and Medical Leave & Paid Family Leave

Quick Reference Guide

Management Employees

If you need time off for a health or family situation and expect to be away from work for more than 5 consecutive workdays, a leave of absence may be needed. Please read the following information and submit the applicable forms to request a leave of absence. If you are unsure as to whether a leave is required, please submit a question in MyHR+ using the "General Leave of Absence Question" tile on the homepage.

Depending on the reason for your leave and your employee group, more than one policy may apply, including the Family Medical Leave Act (FMLA), Medical Leave, Disability, or NY Paid Family Leave (NYPFL). Many times, these different leaves will run at the same time. The info below is a brief overview of what to consider. A Benefits Specialist will meet with you to talk about your individual circumstances.

Things to consider:

- What is the reason for your leave?
- How long do you expect to be absent?
- How will you be paid while on leave? This could be a combination of NYPA policies, Paid Family Leave, or your accruals. In many cases, **you will be required to choose how you are paid from the available options on the leave request form**.
- Do you need to contact the Employee Assistance Program for support?

Before your leave:

☐ Request your leave at least 30 days before the planned start date or as soon as you know you would need time away from work by submitting the forms in this packet, starting a ticket with the Benefits team, and by informing your manager.

☐ HR will provide you with necessary paperwork to start the leave process. HR will advise if your leave may be covered under FMLA and whether you have met the 12 months and 1250 hours eligibility requirement.

☐ After a ticket has been opened, HR will inform you of your options and types of leave you are eligible for. They will also advise if your leave may qualify under FMLA. Complete and return the Leave Request Form as soon as possible in MyHR+.

For your own Health Condition:

If you are requesting a leave of absence for your own illness or condition, have your health care provider fill out the "Certification of Health Care Provider" and submit it as part of this package in MyHR+.

To care for a Family Member:

If you are requesting a leave of absence to care for a family member, have your family member's doctor complete the "Certification of Health Care Provider for Family Member's Serious Health Condition".

Parental Leave & Baby Bonding:

For birth parents, this can include medical recovery and family leave to care for a newborn. Starting January 1, 2025, birth moms may also receive up to 20 hours of sick time to be used for prenatal care.

Please note, if your leave is for baby bonding after the birth of the baby or to care for a family member with a serious health condition, you will need to take an additional step by calling Hartford to start a New York Paid Family Leave Claim.

Pay While on Leave

Some leaves, like NYPFL, have an income component. Others, like the FMLA address the absence, but do not provide any pay. The Benefits team will discuss the options with you. Employees may be able to use accrued time for an otherwise unpaid leave, or to supplement a paid leave like NY PFL.

After the request is submitted:

- Once all the necessary paperwork for the type of leave you have requested has been returned, you will receive a designation notice that will inform you if your leave was approved and if so, for what timeframe or frequency and duration.

- Additional information may be needed to make a final decision. If that is the case, Benefits will request it from you or ask you to follow up with your medical provider.
- If you are eligible for New York State Paid Family Leave you will receive a decision from The Hartford.

While out on Leave:

☐ Keep you manager up-to-date on your plans to return.
☐ Open a ticket in MyHR+ with the benefits team to keep them up-to-date on your leave if needed.

Returning to Work:

☐ Let your manager and benefits know at least 5 days prior to your return that you are ready to come back.
☐ If you are out for a medical leave for yourself, you will need your doctor to verify you are released to return to work. Please send Benefits a return-to-work authorization note through the ticket you have open with them in MYHR+. If you return to work and do not have the note, you will be sent home until you are released back to work.
☐ If there are any restrictions on your activities, we will notify the Office of Civil Rights & Inclusion to see if a reasonable accommodation is needed and can be made. This is separate from FMLA.

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Management
Employee Medical Leave – FMLA

The following provides initial information for employees that need time off for their own medical conditions. If you have 12 months of NYPA service, at least 1,250 hours over the past 12 months, this absence may qualify under the Family Medical Leave Act (FMLA). If you qualify, you may take up to 12 weeks of unpaid job protected leave in a 12-month period. You must complete and submit the following forms to be considered for a Leave of Absence.

Attached and listed below are the documents required to begin the leave process. These forms will be discussed with you during your leave consultation with a Benefits representative.

Leave Request Form

You must complete this form to initiate the leave process.

Healthcare Provider Certification

This form must be completed by you and your healthcare provider 30 days prior to the start of your leave or as soon as practicable.

Privacy Law Notification

This is a required notice under the Public Officers Law when collecting personal information about you for your
Family and Medical Leave.

Below are links to the NYPA policies relating to leaves.

- E.P. 3.3 Family & Medical Leave Act (FMLA)
- EP 3.12 Time away from work
- E.P 2.1 Salary Administration

Return-to-Work Requirements

You are required to provide certification or a letter from your healthcare provider to return to work from medical leave. This certification must be provided **5 business days prior to your return**. You will not be permitted to return to work without this medical release.

LEAVE REQUEST FORM – MANAGEMENT

EMPLOYEE INFORMATION

Employee Name: Employee Location:

REASON FOR LEAVE OF ABSENCE (check all that apply)

More than one type of leave may apply, and some leaves run concurrently.

Family Medical Leave **Paid Family Leave**

- ❑ Employee Medical Leave ❑ Baby Bonding
- ❑ Care for Family Member (FMLA) ❑ Care for Family Member (PFL)
- ❑ NYPA Parental Leave ❑ Service Member Care/ Exigency Leave
- ❑ Military Leave ❑ **Other**

- ❑ Service Member Care/ Exigency Leave ❑ Personal Leave not covered by any other options
- ❑ Employee Medical Leave(non-FMLA)

LEAVE TIMEFRAME

1. ❑ I am requesting consecutive leave (2 weeks or longer) for the following dates:

   Beginning on (date): Ending on (date):

2. ❑ I am requesting intermittent leave per the following schedule:
   (Intermittent leaves should have a set schedule and duration. Ex: Work 3 days, M-W-F for 1 month, starting ___ date.)

PAY WHILE ON LEAVE (check all that apply)

To be sure you can plan appropriately, you must specify what type of pay you wish to receive, based on the type of leave and your eligibility. Please select from the following option(s):

1. ❑ Employee Medical Leave

    a. Required – Use Sick Accruals until depleted then,
    b. Salary Continuation @ 50% (Applies after sick leave is exhausted, within the first 12 weeks of the leave)
    c. Optional--Subsidize 50% Salary Continuation for 100% pay total with: (select all that apply)

        ❑ Half-day Vacation
        ❑ Half-day Floating Holiday

2. ❑ NYPA Parental Leave/Salary Continuation--12 weeks at 100% Pay

    • **Required** – You must also apply for NY PFL through the Hartford.

3. ❑ Paid Family Leave to care for a family member with a serious health or condition (or other applicable):

    • **Required** – You must also apply for NY PFL through the Hartford.

    Pay options:

    ❑ Receive Paid Family Leave (PFL) benefit only (administered by The Hartford)

    OR

    ❑ Receive PFL and Subsidize with ❑ Sick ❑ Vacation ❑ Floating Holiday

4. ❑ Family Leave – Using Accruals Only

    • **Required** – You must also apply for NY PFL through the Hartford.

    Check all that apply: ❑ Sick ❑ Vacation ❑ Floating Holiday

5. ❑ Unpaid Leave – not covered by any policy and no accrued time available

EMPLOYEE CERTIFICATION AND SIGNATURE

I understand I am responsible for the cost of my insurance benefits if on unpaid leave and authorize Human Resources to make up insurance premiums owed upon my return to work.

Signature: _____ Date: _____

Please provide a personal email and preferred phone # where we can reach you while on leave.

Email: _____ Phone # _____

MANAGER ACKNOWLEDGEMENT

The employee above has notified me of their intent to take a leave of absence.

Manager's Signature: _____ Date: _____

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Health Care Provider Medical Certification

Your patient has requested an Employee Medical Leave for a serious health condition requiring sufficient medical certification to support this leave. Please complete this form and submit it as part of the packet.

SECTION 1 - EMPLOYEE

Employee Name:_____ Employee Position:_____

Essential Job Functions:_____

_____

Job description (❑ is/ ❑ is not) attached

SECTION II – HEALTHCARE PROVIDER)

Provider Details

Provider Name: _____ Address: _____

Specialty: _____ _____

Email:

_____ _____

EIN Number: _____ Phone: _____

License Number: Fax:

Medical Information

Limit your response to the medical condition(s) for which the employee is seeking medical leave.

(1) What is the first date the employee will be unable to work due to this condition: _____

(2) Provide your **best estimate** of when the employee will be able to return to work (complete all that apply):

- Full capacity return date: _____
- Intermittent Leave or Reduced Work Schedule (*must include days per week/hours per day*):_____

  _____
- Other Accommodations or Restrictions (e.g., remote work, ergonomic modifications, physical limitations):

  _____

  _____

Health Care Provider Signature _____ Date_____

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IMPORTANT NOTICES CONCERNING MEDICAL INFORMATION

Privacy Law Notification

SECTION 94(1)(d) OF THE NEW YORK PUBLIC OFFICERS LAW REQUIRES THIS NOTICE TO BE PROVIDED WHEN COLLECTING PERSONAL INFORMATION FROM APPLICANTS FOR FAMILYAND MEDICAL LEAVE.

This information is requested pursuant to the Family Medical Leave Act of 1993. The principal purpose for which the information is collected is for the approval of family or medical leave and the maintenance of employee records in Human Resources in accordance with Section 96(1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e), and (1).

Failure to provide the requested information may result in a denial of an employee's request for family or medical leave.

This information will be maintained by the Vice President of Human Resources at the Power Authority of the State of New York located at 123 Main Street, White Plains, New York 10601 (914-681-6200), or when appropriate, at one of the various Authority facilities.

Genetic Information Nondiscrimination Act of 2008 (GINA)
Employee's Serious Health Condition and Family Member's Serious Health Condition

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits the New York Power Authority and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an Individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Please provide medical history information regarding your patient only to extent necessary to fully respond to all relevant items and/or the attached form.