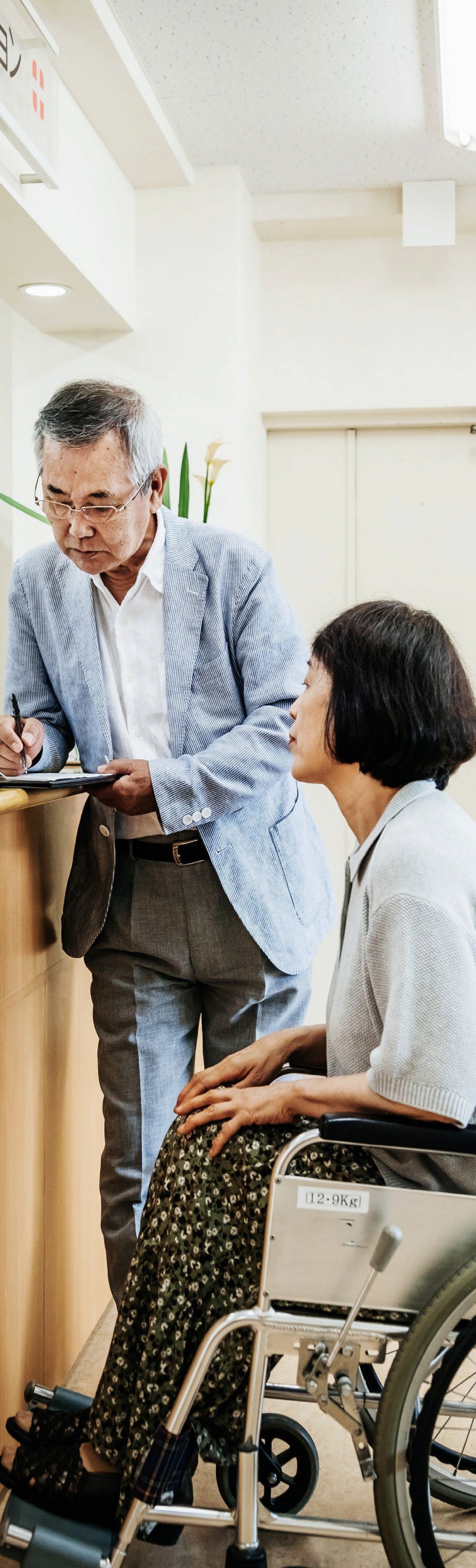


PFML 医疗保健提供者资源

带薪家庭和医疗假（PFML）是联邦 为马萨诸塞州雇员们提 供的一项福利 计划. 本指南将帮助您了解该计划 以及您在申请过程中的角色

PFML Paid Family & Medical Leave MASSACHUSETTS

里面

PFML 是什么?

PFML 是一个联邦计划规划为马萨诸塞州员工们提供资源来管理自己严重的健康状况 家人的严重健康状况,管理现役家人的事务或与孩子的親情.

PFML 为符合条件的员工们提供临时收入.

此外,符合条件的员工保障工作. 当员工休假回来时,雇主必须将恢复他们的工作职位,或者相同的薪资水平,就业福利 服务年限福利权利.

FMLA 相对	PFML
家庭和医疗休假法规 (FMLA) • 联邦法规 • 投保拥有 50 名 • 或以上员工的企业 • 雇员们符合资格如果他们受雇至少 12 个月而且工作时间达到 1,25 小时工作时间 • 雇主有必要承担责任何捐助 • 提供的福利包括保障工作以及无薪家庭假和医疗假	**带薪家庭假和医疗假 (PFML)** • 一项州计划 • 投保拥有 10 个或更多员工的企业 员工们如果符合收入要求就有资格 www.mass.gov/pfmlearnings • 雇主负责代表雇员们收费 和付给 PFML • 提供的福利包括保障工作, 和有薪酬的 家庭和病假

有哪些类型的假期?

家庭假

最多 12 周

休联系孩子親情假

有这类保险的个人在孩子出生后的前 12 个月内休假陪伴孩子或在收养或寄养孩子后的前 12 个月.

请假去照顾患有严重健康的家人

请假去照顾患有严重健康的家人. 护理可以包括:

- 提供家人因健康状况而无法满足的日常生活需求
- 为他们严重的精神健康提供交通服务.
- 帮助安排护理.

最多 26 周

休假去照顾现役家人的事务

- 休假照顾现役家庭成员的事务或已被告知即将返回军营服役的命令, 或照顾现役期间受伤了的受保家人,休假照顾受保服务家人事务的.
- 休假照顾受保服务家人事务的休假期共 12 周,计入 12 周的家庭假分配.

病假

最多 26 周

请假以治疗严重的健康状况

请假照顾个人严重的健康状况.

作为医疗保健提供者,我的角色是什么？

是获得州,联邦, 领地或国家许可的个人
个人从事医学,外科,牙科,脊椎按摩疗法,足病学,助产士或整骨疗法.

这包括: 足病医生,牙医,临床心理学家,验光师,脊椎按摩师,执业护士,助产士, 临床社工, 医师助理, 和基督教科学从业者被列入马萨诸塞州波士顿第一基督教会科学家名单

医务人员在以下方面发挥着关键作用:

- 在需要的时间和地点,在护理点告知病人及家属 PFML 的益处
- 帮助病人及家属了解他们的PFML福利如何帮助他们康复和家庭健康
- 提供证明或文件给病家人及家属

申请流程

病假申请

员工申请的一部分是您的严重健康状况证明表 *Certification of Your Serious Health Condition* 作为医疗服务提供者, 您需要证明: 您的病人的严重健康状况以及它如何影响他们的工作能力 休假多久和次数 - 你只需要提供一个估计.

患者的医疗需求,例如产前或产后的病假
流产, 死胎引起的病症或产前或产后抑郁症妨碍你的病人工作

家庭假申请 员工申请的一部分是您的家人严重健康状况证明表 *Certification of Your Family Member's Serious Health Condition* 您将填写此表格以证明:

- 您的家人的健康状况以及它正在如何影响他们自己的照顾能力
- 休假多久和次数- 你只需要提供一个估计
- 他们可能需要帮助比如开车去见医生或准备饭和吃药

什么是严重的健康状况?

严重的健康状况身体上或精神上状况,导致病人连续 3 日以上无法工作并且需要属于这些条件之一:

- 30 工作日内通过医生有 2 次或以上的治疗 (在诊所或电视观众诊医,电话诊医), 证明无法履行职责
- 在医院,临终中心或医疗机构过夜
- 30 工作日内通过医生有 1 次治疗由于无法履行职责,有继续治疗的计划,包括处方

严重的健康状况可能包括:

- 慢性病哮喘或糖尿病等,有时会导致病人无法工作，病会不时发生,并且需要每年去看医生 2 次以上
- 永久性或长期疾病.例如阿尔茨海默病,中风或晚期癌症,这可能无法治愈并且需要持续关注,但不一定需要积极治疗. 例如: 当一个人在临终中心
- 需要多种治疗的疾病,例如化疗,肾透析或事故后的物理治疗
- 经医疗保健提供者证明,因怀孕或产后恢复而导致患者无法工作的情况
- 流产,死胎引起的病症或产前或产后抑郁症妨碍患者无法工作
- 药物滥用障碍,如果患者正在接受医疗保健提供者的治疗, 由医疗保健提供者转介的医疗保健服务, 或通过由马萨诸塞州公共卫生部许可的计划
- 由医疗保健提供者认证与 COVID-19 诊断相关的病症阻止病人工

严重的健康状况可能不包括:

- 手术不被视为严重疾病并且不包括在家人假或病假内除非需要住院治疗或者除非出病情状况发展复杂

什么是日常照顾需求?

照顾有严重健康状况的家人时,日常照顾可包括但不限于:

- 提供日常生活需要给家人因健康状况严重而无法无法做.例如帮助他们穿衣服或准备饭菜
- 提供交通服务去看医生或其他预约治疗
- 支援他们的严重精神健康状况,例如带他们接受严重抑郁症或药物治疗
- 协助安排护理,例如转移到疗养院

在各种情况下,您可以请假照顾家人, 例子包括:

- 如果您的母亲正在接受髋关节置换手术并且需要帮助来回物理治疗，您可以减少休假,减少每天的工作时间,或减少每周的工作天数为了帮助您们的母亲.
- 如果您的配偶在接受手术后进行全面休养,在没有帮助的情况下无法淋浴,您可能 休 12 周的连续假来帮助您们的配偶.
- 如果您的孩子正在接受化疗并且出现呕吐,虚弱和疼痛，您们可以歇性休假照顾您们的孩子.

我需要填写哪些文件?

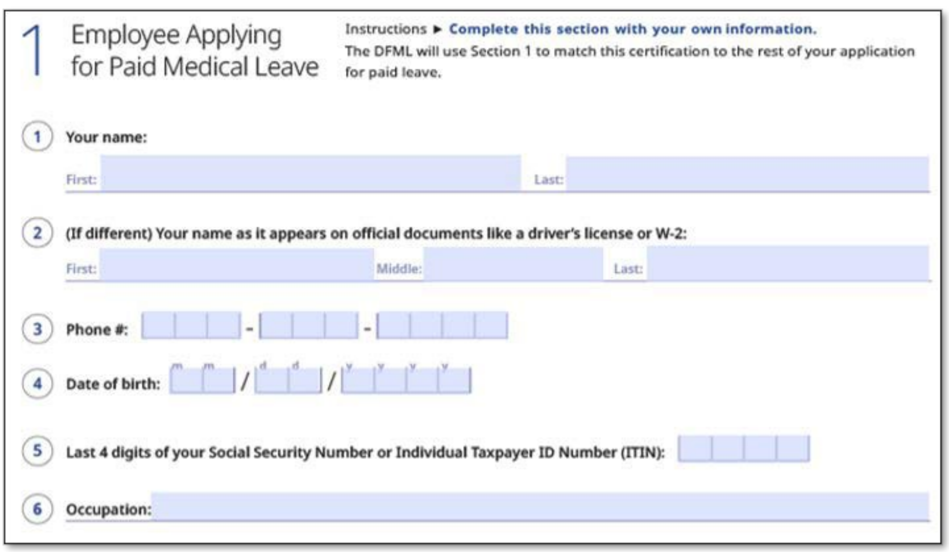
认证您自己的严重健康状况表 *Certification of Your Serious Health Condition Form*

- **因个人严重健康原因而请病假**

认证您家人的严重健康状况表 *Certification of Your Family Member’s Serious Health Condition Form*

- **员工因照顾患有严重健康状况的家人而请病假**
- **员工因照顾患有严重健康状况的受保家人而请病假**

认证您自己的严重健康状况表


1 Employee Applying for Paid Medical Leave

Instructions ► **Complete this section with your own information.**
The DFML will use Section 1 to match this certification to the rest of your application for paid leave.

1 Your name:
First: Last:

2 (If different) Your name as it appears on official documents like a driver’s license or W-2:
First: Middle: Last:

3 Phone #: - -

4 Date of birth: m m / d d / y y y y

5 Last 4 digits of your Social Security Number or Individual Taxpayer ID Number (ITIN):

6 Occupation:

01 **第一部分：职工申请带薪病假**

正在申请带薪休假的员工(您的患者) 负责填写第 1 部分.

02 **第 2 部分：患有严重健康状况**

作为医疗保健提供者,您应完成第 2 部分至5. 在第2部分中,确认您的病人有严重的健康状况以及适用哪些标准

8 Provide appropriate medical facts about the patient's serious health condition (*e.g., symptoms, prescriptions, referrals for evaluation or treatment*):

9 State at least one essential job function the patient is unable to perform due to their serious health condition (*e.g., specific tasks like sitting at a computer, performing manual labor, making decisions, or the ability to work at all*)

10 Is this serious health condition a job-related injury?

Yes No

11 Is the patient's serious health condition related to pregnancy or recovery from childbirth?

Yes No If yes, how much time will the patient need?

- The patient will need approximately ______ weeks for pregnancy or prenatal care.
- The patient will need approximately ______ weeks for recovery from childbirth or postnatal care.

Medical leave for pregnancy, prenatal care, or recovery from childbirth must meet the definition of a serious health condition.

Taking Medical Leave does not impact a patient's ability to take Family Leave to bond with their child, provided that the number of weeks taken for leave does not exceed the 26-week maximum in a benefit year. **There is no form needed to take family leave to bond with a child- just proof of birth.** Learn more.

12 When is the expected delivery date: m m / d d / y y y y

02 第 2 部分：患者的严重健康状况(继续)

详细说明病人的严重健康状况,包括就诊,护理方案和任何其他相关细节.

尽您所能告知我们病情何时开始.确认病情是与工作有关的受伤还是与怀孕有关.

Paid Medical Leave | **Certification of Your Serious Health Condition** Page 5

• Employee Your Name:

+ Health care provider

3 Estimate Leave Details

Instructions ► The following questions are about the frequency or duration of a condition. Check all that apply to the patient's condition but you must provide your **best estimate** of the start and end dates and the duration based on your medical knowledge, experience, and examination of the patient.

13 **Continuous Leave:** Due to the condition, the patient is/will be incapacitated for a continuous period of time (completely unable to work for consecutive, uninterrupted days).

Provide your **best estimate** of the beginning date ______ (mm/dd/yyyy) and end date ______ (mm/dd/yyyy) for the period of incapacity.

Do not use terms like "unknown" or "TBD" as it may result in delays and revisions to the form.

14 **Reduced Leave:** Due to the condition, it is medically necessary for the patient to work a reduced but consistent schedule.

Provide your **best estimate** of the reduced schedule the patient **is able to work.** From ______ (mm/dd/yyyy) to ______ (mm/dd/yyyy) the patient is able to work: (e.g., 5 hours/day, up to 25 hours a week) ______.

Do not use terms like "unknown" or "TBD" as it may result in delays and revisions to the form.

15 **Intermittent Leave:** Due to the condition, it is medically necessary for the patient to be absent from work on an intermittent basis (multiple episodes of time off, which may be irregular or unexpected). Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

From roughly ______ (mm/dd/yyyy) to ______ (mm/dd/yyyy) (over the next 6 months), episodes of incapacity are estimated to occur ______ times per (day/ week/ month) and are likely to last approximately ______ (hours/ days) per episode.

Do not use terms like "unknown" or "TBD" as it may result in delays and revisions to the form.

03 第 3 部分：估算休假详情

提供您对需要哪种类型的休假安排的最佳估计：连续的,减少的，没有固定的或者一起共同 3 种休假.

连续休假 无间断全日休假.

减少休假 同样的时间表,少于员工的正 常工作时间表.

没有固定休假

多次休假,这可能是不规则或意想不到的休假.

4 Provider's Certification & Information

Instructions ► Sign and date to agree to this declaration. Provide the relevant licensing and contact information about your practice or business. Before returning the form , review **Pages 3-6**.

I certify that the information provided in this form is true and correct, that I have examined the patient and answered the questions accurately and to the best of my ability, and that I am a health care provider authorized to certify their condition.

See **page 2** for the definition of a health care provider.

16 **Signature:** Date: mm / dd / yyyy

17 **Printed name and title:**

Name:

Title:

18 **Certificate/license to practice number:** State/Country:

Note ► The form will **not** be accepted unless a license number is provided.

19 **Area of practice or medical specialty:**

20 **Name of your practice or business:**

21 **Address:**

22 **Office phone #:** - -

23 **Office fax #:** - - (optional)

04 **第 4 部分:医疗提供者的认证和信息**

提供有关您的认证,执业领

域或医学专业的信.

认证您家人的严重健康状况表

2 Family member information

Instructions ► Complete Section 2 with your family member's information. DFML needs to know your relationship with the patient to certify leave eligibility.

8 **The family member who is experiencing a serious health condition is my:**

- ○ Child
- ○ Spouse or domestic partner
- ○ Parent, or guardian who legally acted as my parent when I was a child
- ○ Parent of my spouse or domestic partner
- ○ Sibling
- ○ Grandchild
- ○ Grandparent

For more detailed definitions of what family members fall into each of these categories see **www.mass.gov/family-caring-leave-relationships**

9 **Family member's name:**

First: Last:

01 **第 1 部分: 员工申请家庭护理假**

正在申请带薪休假的员工为了护

理您的家庭患者,应填写第1部分.

1 Employee Applying for Family Caring Leave

Instructions ► Complete **Section 1** with your own information.

1 **Your name:**

First: Last:

2 **(If different) Your name as it appears on official documents like a driver's license or W-2:**

First: Middle: Last:

3 **Phone #:** - -

4 **Date of birth:** mm / dd / yyyy

5 **Last 4 digits of your Social Security Number or Individual Taxpayer ID Number (ITIN):**

6 **Why are you applying for leave?**

- ○ To care for a family member with a serious health condition
- ○ To care for a family member with a serious health condition related to military service

If you are applying for your own serious health condition, this is not the correct form. You need the **Certification of Your Serious Health Condition.**

7 **Occupation:**

第 2 部分: 家人信息

员工应输入有关家人

(即您的病人) 的信息应填写第 2

部分.

10 Family member's name as it appears on official documents such as a driver's license or insurance documents (if different):

First: Middle: Last:

11 Family member's address:

Street:

Address line 2:

City:

State: Zip: Country:

Where your family member lives does not affect your eligibility. You can take paid family leave to care for a family member with a serious health condition no matter where they are.

12 Family member's date of birth:

mm / dd / yyyy

13 Authorization:

I authorize The Department of Family and Medical Leave (DFML) to use the information on this form to determine my eligibility for Paid Family and Medical Leave. I attest that I am applying for paid leave to care for a family member with a serious health condition, and I agree that DFML can share this information with my employer, and employer affiliates, for the purpose of supporting my application for leave.

I certify that I have the authorization of the above-named family member to provide the information contained within this certification to the Department for purposes of determining my eligibility for paid family leave.

• Employee Signature: mm / dd / yyyy

02 **第 2 部分：家人信息(继续)**

(继续 员工应输入有关家人(即您的病人)的信息,应填写第 2 部分.

• Employee Employee applying for leave:

+ Health care provider **Health Care Provider Certification of a Serious Health Condition**

3 Family Member's Serious Health Condition

Instructions ► This form should be filled out by **the healthcare provider of the patient**. The patient is the family member of the employee. The patient must have a serious health condition for the employee to qualify for paid leave to care for them. Answer all questions fully and completely.

14 Which of the following apply to the patient's serious health condition? Check all that apply; this includes mental health.

- Requires, or did require inpatient care.
- Has incapacitated or will incapacitate the patient for more than three consecutive full calendar days, **AND** (pick one)
  - Requires two or more medical visits within 30 days.
  - OR
  - Requires one medical visit, plus a regimen of care.
- Is chronic, requires treatments at least twice a year, and may require periodic absences.
- Is long-term and requires ongoing medical supervision, with or without active treatment.
- Requires multiple treatments and would lead to a period of incapacity without treatment.
- None of the above.

If none apply to the patient, the employee is not eligible for PFML.

15 Is this health condition related to the patient's military service?

Yes No

16 Describe the relevant medical facts and appropriate information related to the condition for which the patient needs care.

Medical facts may include symptoms, prescriptions, or referrals for evaluation or treatment.

17 Will the employee be required to take time off work to care for the patient?

Yes No

18 Describe the kinds of care related to the patient's condition that the employee will provide.

Examples of care may include providing medical, hygienic, nutritional or safety needs that the patient is unable to perform themselves, e.g. transportation to the doctor.

03 **第 3 部分：家人的严重健康状况**

作为医疗保健提供者,您应填写第 3 部分至第 5 部分.

在第 3 部分中,确认您的病人患有严重的健康状况以及适用的标准.

估计病情开始的时间以及是否服兵役有关.

记下有关您病人的任何相关医疗信息这表明他们需要家庭护理.

.

• Employee Employee applying for leave:

4 Estimate Leave Details

Instructions ► The following questions are about the frequency or duration of a condition. Check all that apply to the patient's condition but you must provide your best estimate of the start and end dates and the duration based on your medical knowledge, experience, and examination of the patient.

19 ☐ **Continuous Leave:** Due to the condition, the patient is/will be incapacitated and will need care from the employee for a continuous period of time (employee is completely unable to work for consecutive, uninterrupted days).

Provide your **best estimate** of the beginning date ______ (mm/dd/yyyy) and end date ______ (mm/dd/yyyy) for the period of incapacity.

Do not use terms like "unknown" or "TBD" as it may result in delays and revisions to the form.

20 ☐ **Reduced Leave:** Due to the patient's condition, it is medically necessary for the employee to work a reduced but consistent schedule.

Provide your **best estimate** of the reduced schedule the employee **is able to work.** From ______ (mm/dd/yyyy) to ______ (mm/dd/yyyy) the patient is able to work: (e.g., 5 hours/day, up to 25 hours a week) ______.

Do not use terms like "unknown" or "TBD" as it may result in delays and revisions to the form.

21 ☐ **Intermittent Leave:** Due to the condition, it is medically necessary for the employee to be absent from work on an intermittent basis to care for the patient (multiple episodes of time off, which may be irregular or unexpected). Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

From roughly ______ (mm/dd/yyyy) to ______ (mm/dd/yyyy),(over the next 6 months), episodes of incapacity are estimated to occur ______ times per (☐ day/☐ week/☐ month) and are likely to last approximately ______ (☐ hours/☐ days) per episode.

Do not use terms like "unknown" or "TBD" as it may result in delays and revisions to the form.

04 第 4 部分:估算休假详情

提供您对需要哪种类型的休假安排的最佳估计: 连续的,减少的, 没有固定的或者一起共同 3 种休假.

连续休假 无间断全日休假.

减少休假 同样的时间表,少于员工的正常工作时间表.

没有固定休假 多次休假,这可能是不规则或意想不到的休假由于一个合格理由.

• Employee Employee applying for leave:

5 Provider's Certification & Information

Instructions ► Sign and date to agree to this declaration. Provide the relevant licensing and contact information about your practice or business. Before returning the form to the employee, review to be sure you have signed it.

I certify that the information provided in this form is true and correct, that I have examined the patient and answered the questions accurately and to the best of my ability, and that I am a health care provider authorized to certify their condition.

See page 2 for the definition of a healthcare provider.

22 Signature: ______ Date: mm / dd / yyyy

23 Printed name and title:

Name:

Title:

24 Certificate/license to practice number: ______ State/Country:

Note ► The form will **not** be accepted unless a license number is provided.

25 Area of practice or medical specialty:

26 Name of your practice or business:

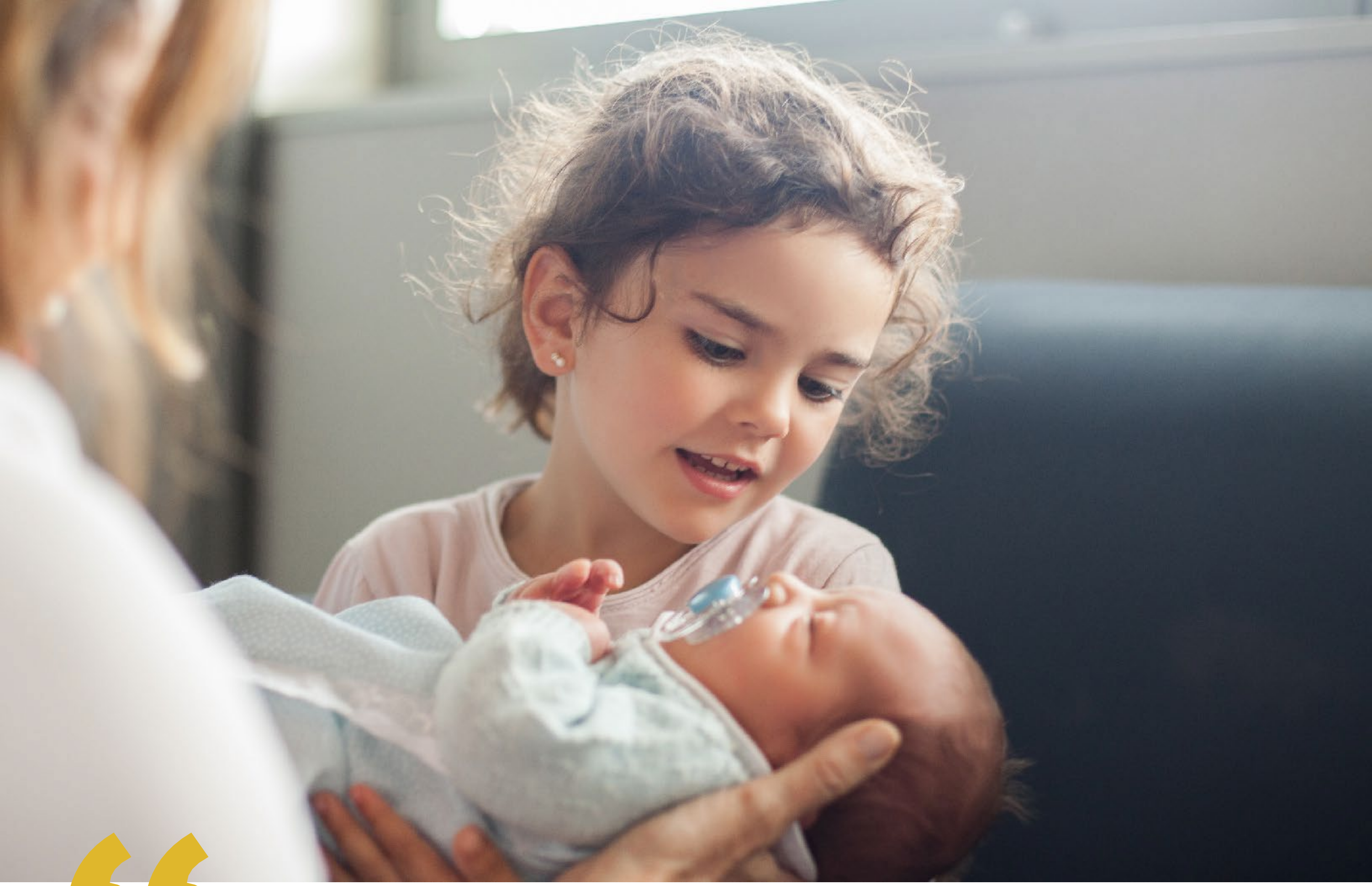
27 Address:

28 Office phone #: ___ - ___ - ____

29 Office fax #: ___ - ___ - ____ (optional)

05 第 5 部分: 提供者的认证和信息

提供有关您的认证,执业领域或医学专业的信.



我还有什么需要知道的吗?

我的病人可以一起请病假和孩子親情家庭假吗?

如果孕妇有严重的健康状况,则有资格在怀孕期间或怀孕后休病假以及医疗保健提供者的证明,证明他们因严重的健康状况而无法工作.

I如果作为他们的医疗保健提供者，您认为他们在怀孕期间或怀孕后需要休病假, 此外, 他们 还需要12周的孩子親情家庭假,您需要为他们填写一份严重健康状况证明表.

亲生母亲应先申请病假之后申请带薪孩子親情家庭假. 他们可以打 (833) 344-7365 致电 PFML 联络中心以启动申请孩子親情家庭假.

我的病人可以延长他们的假期吗？我需要再次为他们填写表格吗?

如果您的患者计划延长休假,他们必须在休假结束日期后三十(30)天内通知 DFML,并且此时通知他们的雇主.

如果在此期限内提交，医疗保健提供者可以使用相同的表格确认延期. 如果他们在 30 天后提出申请,他们将需要开始新的申请并获得由您填写的新医疗表格.

新的和期待家长信息表

电话
Department of Family and Medical Leave PFML Contact Center
833-344-PFML (7365)

在线
mass.gov/dfml