# PFML Health Care Provider Toolkit

Paid Family and Medical Leave, or PFML, is a benefit program for Massachusetts employees offered by the Commonwealth. This guide will help you understand the program and your role in the application process.

Paid Family & Medical Leave
MASSACHUSETTS

# *Inside*

# What is PFML?

PFML is a Commonwealth program designed to give Massachusetts employees the resources to manage their own serious health condition, the serious health condition of a family member, the affairs of a family member on active duty, or to bond with a child.

PFML provides temporary income replacement to eligible employees.

In addition, eligible employees are entitled to certain job protections. When an employee returns from leave, their employer is required to restore them to the same job they had before taking leave, or to a job that has the same pay status, employment benefits, length-of-service credit, and seniority.

## FMLA versus PFML

### Family and Medical Leave Act (FMLA)

- A **federal** law
- Covers businesses with **50 employees or more**
- Employees are eligible if they are employed for at least **12 months** with **1,250 hours worked**
- Employer is **not responsible** for any contributions
- Benefits provided include job protection, and **unpaid** family and medical leave

### Paid Family and Medical Leave (PFML)

- A **state** law
- Covers businesses with **1 or more employees**
- Employees are eligible if they have **earned $6,300 in 12 months** and earned **30 times their expected weekly benefit**
- Employer is responsible for **collecting and sending** PFML contributions on behalf of employees
- Benefits provided include job protection, and **paid** family and medical leave

# What types of leave are available?

## Family leave

### Up to 12 weeks

#### Leave to bond with a child

Leave to bond with the covered individual's child during the first 12 months after the child's birth or the first 12 months after the placement of the child for adoption or foster care with the covered individual.

#### Leave to care for a family member with a serious health condition

Leave to care for a family member with a serious health condition. Activities can include:

- Providing daily living needs that the family member cannot perform due to their serious health condition
- Providing transportation support for their serious mental health condition
- Helping make arrangements for changes in care

### Up to 26 weeks

#### Leave to manage affairs for active service members

- Leave to manage the affairs of a family member on active duty or who has been notified of an impending order to active duty in the Armed Forces or to care for a family member who is a covered service member who has been injured while on active duty.
- Leave to manage the affairs of a covered service member is for a total of 12 weeks and counts towards the 12-week allotment for family leave.

## Medical leave

### Up to 20 weeks

#### Leave to manage a serious health condition

Leave to care for an individual's own serious health condition.

# What is my role as a health care provider?

A health care provider is an individual licensed by the state, commonwealth, territory, or country in which the individual practices medicine, surgery, dentistry, chiropractic, podiatry, midwifery, or osteopathy.

This includes: podiatrists, dentists, clinical psychologists, optometrists, chiropractors, nurse practitioners, nurse midwives, clinical social workers, physician assistants, and Christian Science Practitioners listed with the First Church of Christ, Scientists in Boston, Massachusetts.

**Health care providers play a critical role in:**

- Informing patients and their families about PFML benefits right at the point of care, when and where they need it
- Helping patients and their families understand how their PFML benefits can help them with their recovery and family health
- Providing necessary certification or documentation to patients and their families

## *The application process*

### Medical leave application

Part of an employee's application is the Certification of Your Serious Health Condition form. You, as the medical provider, will need to attest to:

- Your patient's serious health condition and how it is affecting their ability to work
- The duration and frequency of leave - you only need to give an estimate
- Upcoming patient needs for medical events, such as medical leave that will either precede or follow childbirth before leave to bond with a newborn
- Conditions due to miscarriage, stillbirth or perinatal depression that prevents your patient from working

### Family leave application

Part of an employee's application is the Certification of Your Family Member's Serious Health Condition form. You will fill out this form to attest to:

- Your patient's serious health condition and how it is affecting their ability to take care of themselves
- The duration and frequency of leave - you only need to give an estimate
- Patient activities they might need help with, like driving to appointments or getting their meals and medication

# What is a serious health condition?

A serious health condition is a physical or mental condition that prevents a patient from doing their job for more than 3 consecutive full calendar days, and requires 1 of these conditions:

- 2 or more treatments by a health care provider (in-person or during telehealth visits) within 30 calendar days of an inability to perform their duties
- Overnight stay in a hospital, hospice, or medical facility
- At least 1 treatment by a health care provider within 30 days of an inability to perform their duties, with plans for continued treatment, including prescriptions

## Serious health conditions can include:

- Chronic conditions such as asthma or diabetes, that stop a patient from working some of the time, go on for some time, and require going to the doctor more than twice a year
- Permanent or long-term conditions such as Alzheimer's disease, stroke, or terminal cancer, that might not be curable and will need ongoing attention but will not necessarily require active treatment. For example: when a person is in hospice
- Conditions requiring multiple treatments, such as chemotherapy, kidney dialysis, or physical therapy after an accident
- Conditions due to pregnancy or post-birth recovery that prevent a patient from working, as certified by a health care provider
- Conditions due to miscarriage, stillbirth or perinatal depression that prevents your patient from working
- Substance Use Disorder if the patient is receiving treatment from a health care provider, by a provider of health care services on referral by a health care provider, or by a program licensed by the MA Department of Public Health
- Complications related to a diagnosis of COVID-19 that prevent a patient from working, as certified by a health care provider

## Serious health conditions may not include:

- Cosmetic surgery is not covered for family or medical leave unless inpatient hospital care is required or unless complications develop

# What are caring leave activities?

**When caring for a family member with a serious health condition, activities can include but are not limited to:**

- Providing the daily living needs that the family member cannot perform due to their serious health condition, such as helping them get dressed or preparing meals
- Providing transportation to the doctor or other facilities for appointments and treatment
- Providing support for their serious mental health condition, such as taking them to therapy or medication appointments for major depression
- Helping make arrangements for changes in care, such as a transfer to a nursing home

**A patient can take leave to care for a family member for a variety of situations. Examples include:**

- If the patient's parent is having a hip replacement and needs help getting to and from physical therapy, they can take reduced leave, and work fewer hours per day, or fewer days per week in order to help them
- If the patient's partner is having surgery followed by extensive recuperation where they will not be able to shower without assistance, they can take up to 12 weeks of continuous leave to help them out
- If a patient's child is undergoing chemotherapy and has bouts of nausea, weakness, and pain, they can take intermittent leave when they need to care for them

# What documents will I need to complete?

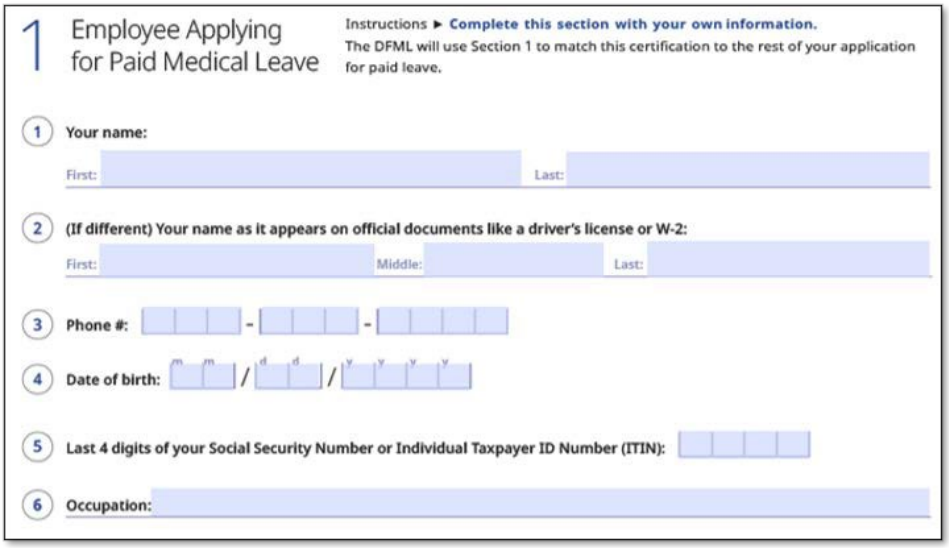
**Certification of Your Serious Health Condition Form** →

- For patients requesting medical leave due to their own serious health condition

**Certification of Your Family Member's Serious Health Condition Form** →

- For employees requesting medical leave to care for a family member with a serious health condition
- For employees requesting medical leave to care for a family member who is a covered service member with a serious health condition

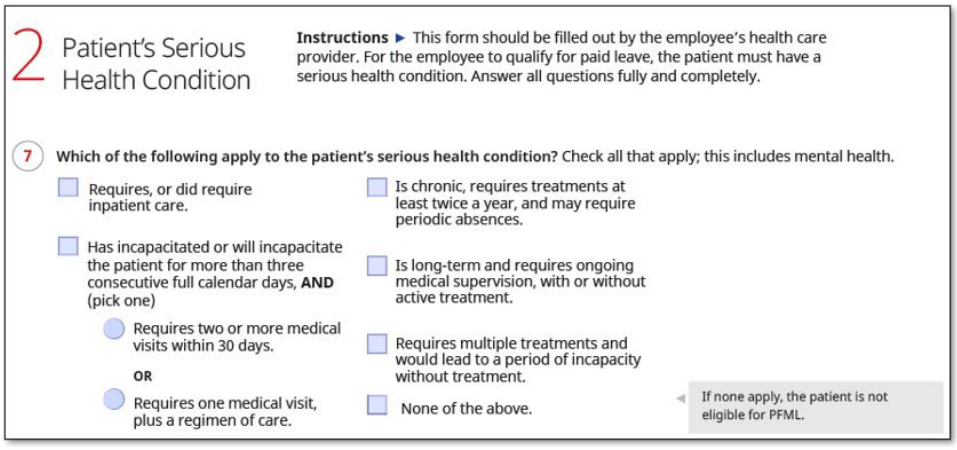
## *Certification of Your Serious Health Condition Form*



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:**



2 Patient's Serious Health Condition

**Instructions ▶** This form should be filled out by the employee's health care provider. For the employee to qualify for paid leave, the patient must have a serious health condition. Answer all questions fully and completely.

7. **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, the patient is not eligible for PFML.

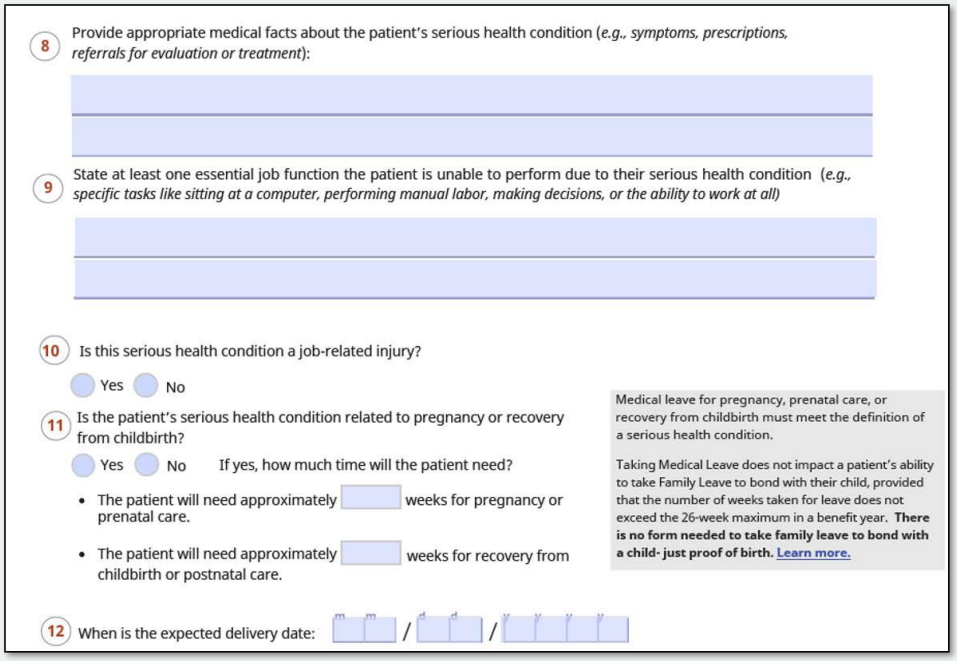
**01 Section 1: Employee Applying for Paid Medical Leave**

The employee, your patient, who is applying for paid leave, is responsible for completing Section 1.

**02 Section 2: Patient's Serious Health Condition**

You, as the health care provider, should complete Sections 2 through 5.

In Section 2, confirm that your patient has a serious health condition and what criteria apply.



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

## Section 2: Patient's Serious Health Condition (Cont.)

Detail your patient's serious health condition, including regimen of care, job functions the patient is unable to perform, and any other pertinent details.

Confirm if the condition is a job-related injury or related to pregnancy or recovery from childbirth. Estimate how many weeks will be needed for recovery for pregnancy and/or recovery from childbirth.

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 Section 3: Estimate Leave Details

Provide your best estimate on what type of leave schedule will be needed: continuous, reduced, intermittent, or a combination of the three.

### Continuous Leave

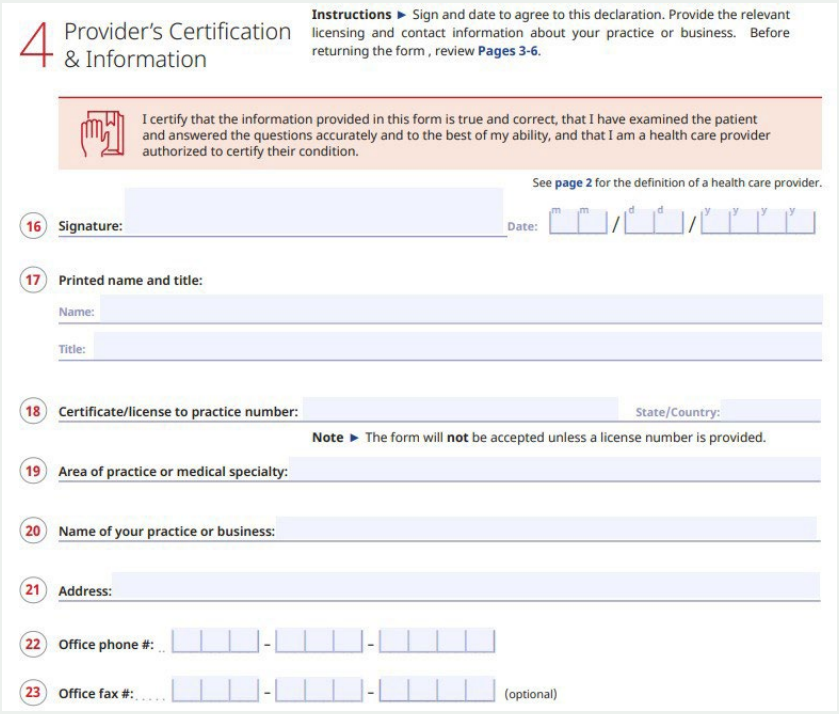
Full-time leave taken without interruptions

### Reduced Leave

Consistent schedule that is less than an employee's regular work schedule

### Intermittent Leave

Leave taken in multiple episodes of time off, which may be irregular or unexpected



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: m m / d d / y y y y

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:**

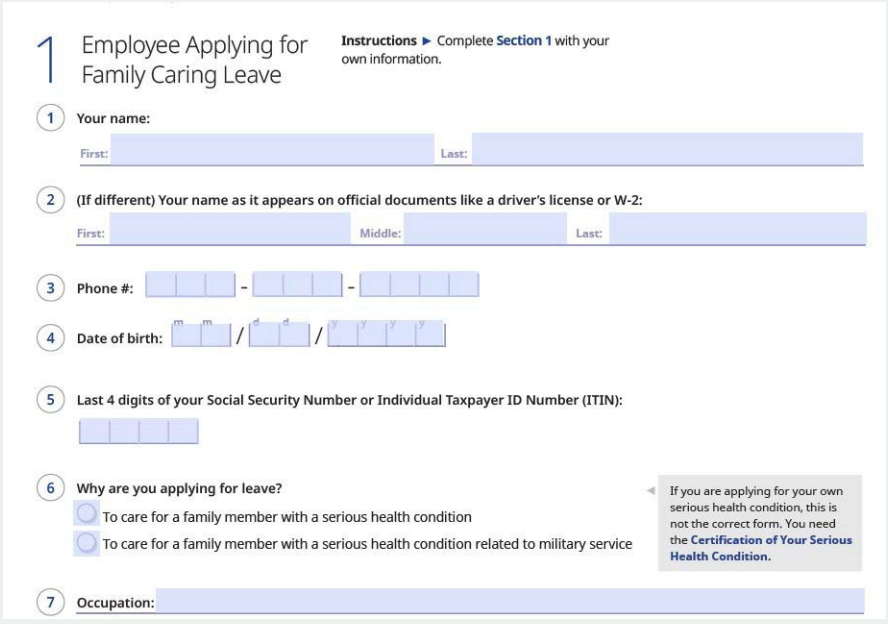
22 **Office phone #:** - -

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

## 04 Section 4: Provider's Certification & Information

Provide information on your certification, and area of practice or medical specialty. The form will not be accepted unless a license number is provided.

# *Certification of Your Family Member's Serious Health Condition Form*



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:** m m / d d / y y y y

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

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

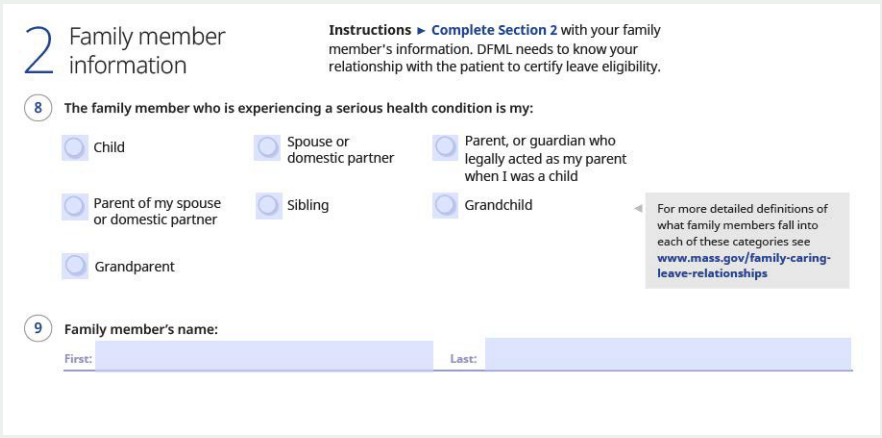
- ○ To care for a family member with a serious health condition
- ○ To care for a family member with a serious health condition related to military service

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:**

## 01 Section 1: Employee Applying for Family Caring Leave

The employee who is applying for paid leave to care for your patient should complete Section 1.



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

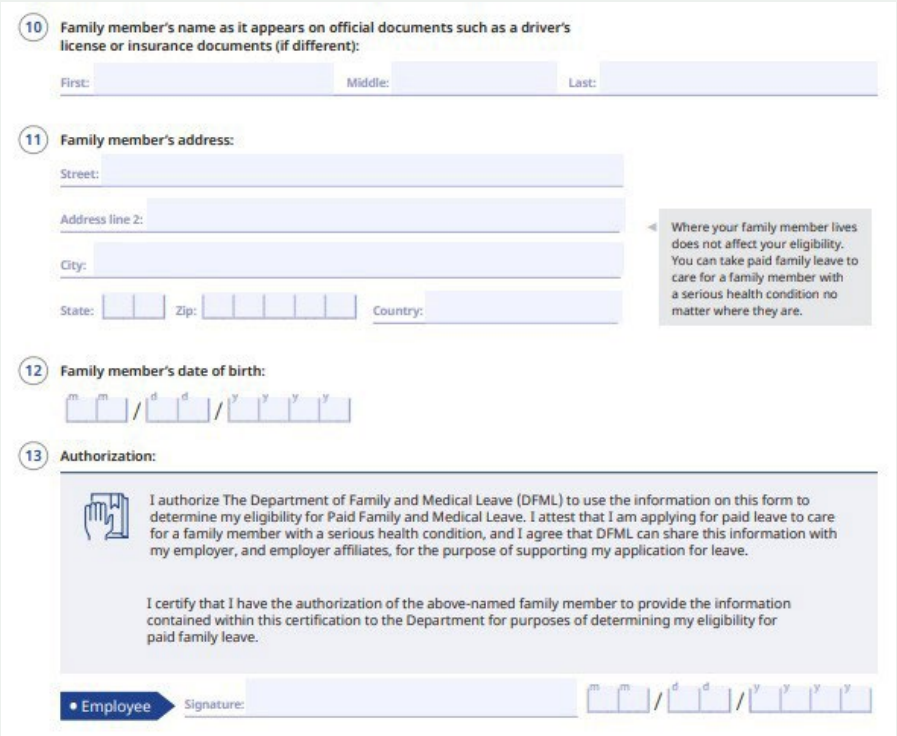
For more detailed definitions of what family members fall into each of these categories see **www.mass.gov/family-caring-leave-relationships**

9 **Family member's name:**

First: Last:

## 02 Section 2: Family Member Information

The employee should enter information about their family member, your patient, to complete Section 2.



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:

m m / d d / y y y y

13 Authorization:

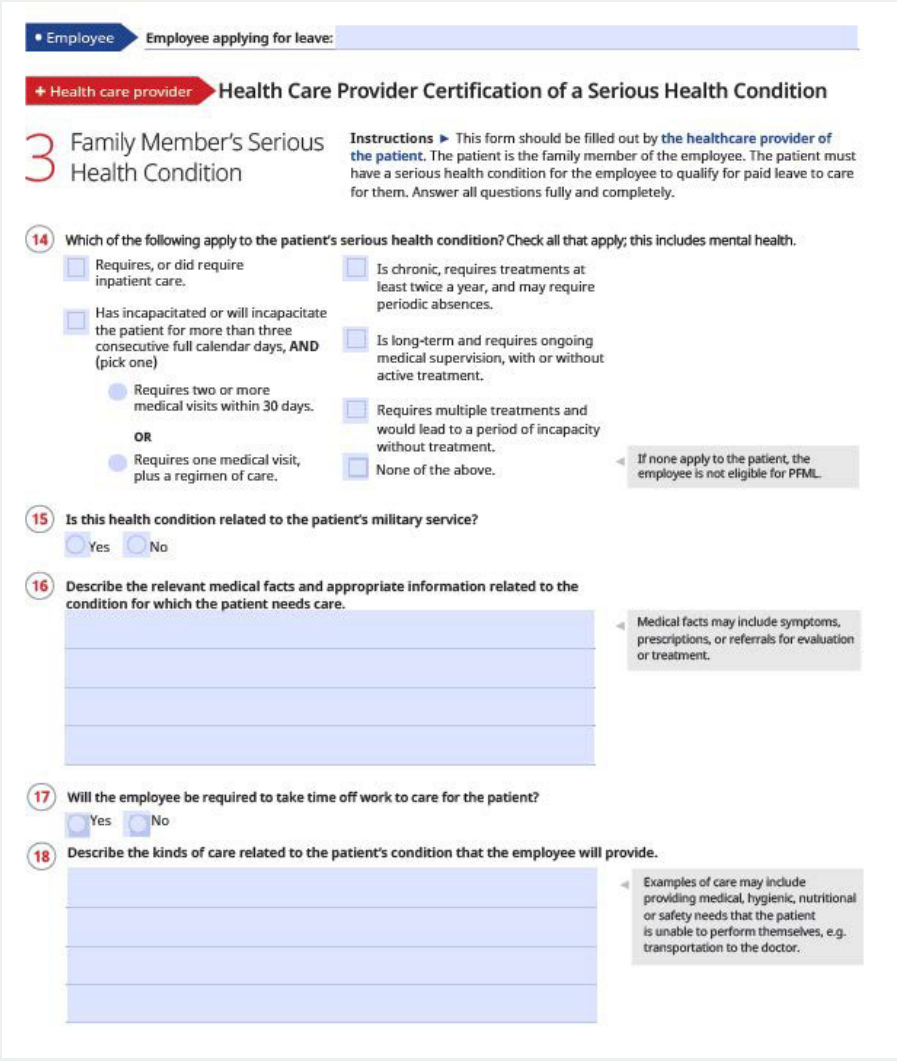
I authorize The Department of Family and Medical Leave (DFML) to use the information on this form to determine my eligibility for Paid Family and Medical Leave. I attest that I am applying for paid leave to care for a family member with a serious health condition, and I agree that DFML can share this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

## 02 Section 2: Family Member Information (Cont.)

The employee should enter information about their family member, your patient, to complete Section 2.



• 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.

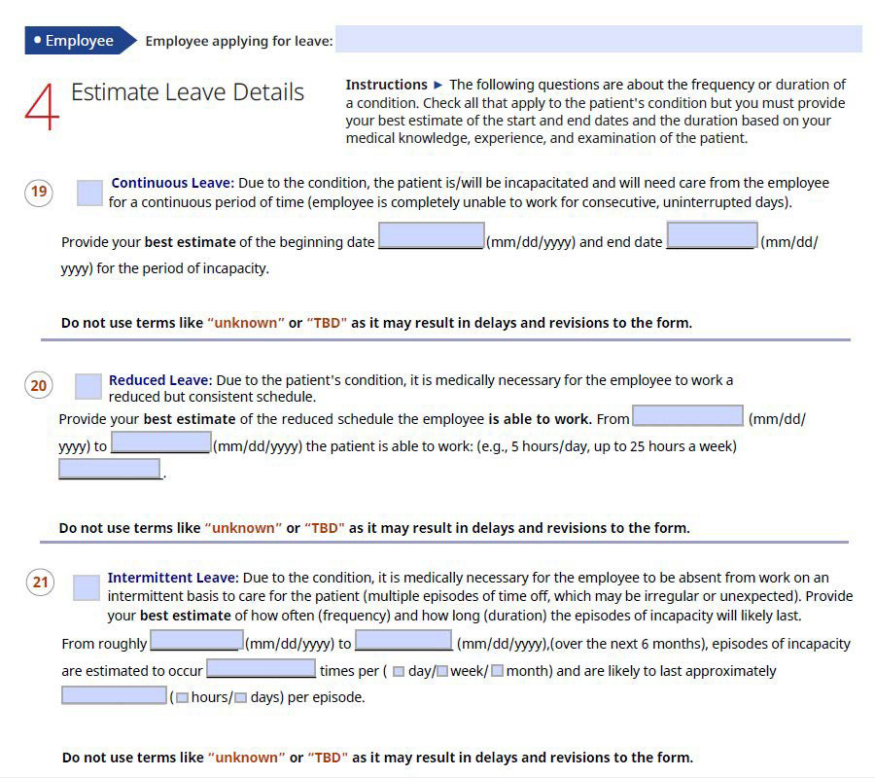
## 03 Section 3: Family Member's Serious Health Condition

You, as the health care provider, should complete Sections 3 through 5.

In Section 3, confirm that your patient has a serious health condition and what criteria apply.

Estimate when the condition began and if it is related to the patient's military service.

Note any relevant medical information about your patient that shows that they will require care.



• 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

## Section 4: Estimate Leave Details

Provide your best estimate on what type of leave schedule will be needed: continuous, reduced, intermittent, or a combination of the three.

### Continuous Leave

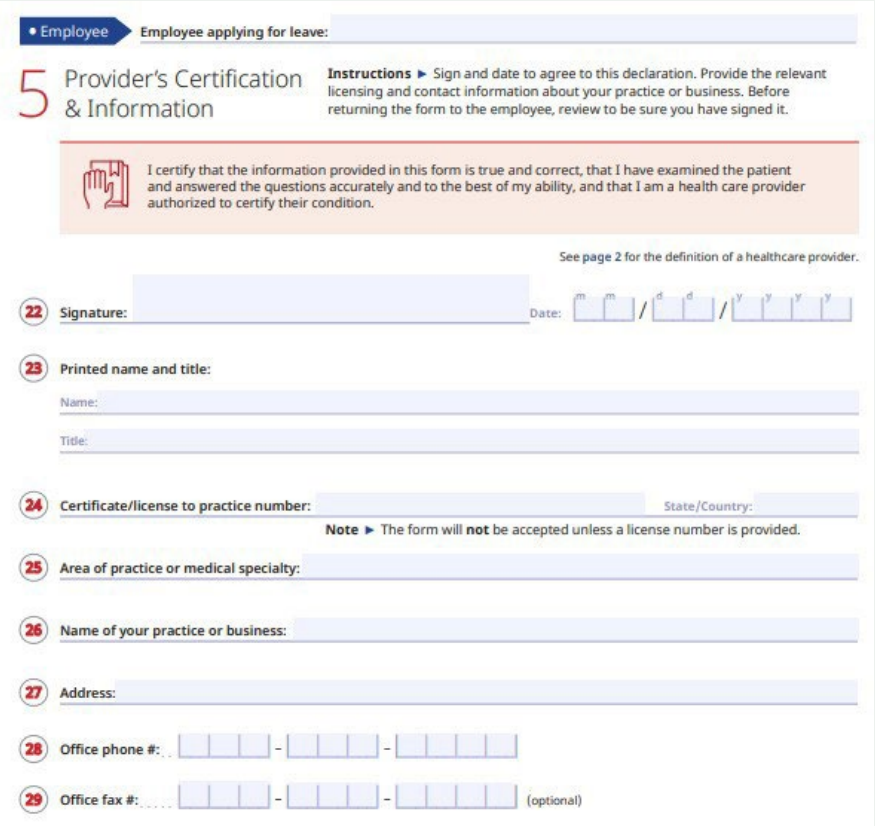
Full-time leave taken without interruptions

### Reduced Leave

Consistent schedule that is less than an employee's regular work schedule

### Intermittent Leave

Leave taken in separate periods of time due to a single qualifying reason



• 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: m m / d d / y y y y

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

## Section 5: Provider's Certification & Information

Provide information on your certification, and area of practice or medical specialty. The form will not be accepted unless a license number is provided.

# Is there anything else I should know?

### Can my patients combine medical and bonding leave?

A pregnant individual is eligible to take medical leave during or after their pregnancy if they have a serious health condition and certification from their health care provider that they are incapacitated from work due to the serious health condition.

If, as their health care provider, you feel they needs to take medical leave during or after pregnancy in addition to the 12 weeks of family leave to bond with a child, you will need to fill out a Certification of Your Serious Health Condition form for your patient.

The birth parent should apply for medical leave first prior to applying for family leave to bond with a child. They can then go online or call the DFML Contact Center at (833) 344-7365 to start an application for family leave to bond with a child.

### Can my patients extend their leave, and do I need to fill out the form for them again?

If your patient plans to extend their leave, they must notify DFML within thirty (30) days of their leave end date and notify their employer at this time.

Health care providers can confirm the extension with the same form if it is filed within this time period. If your patient files after 30 days, they will need to start a new application and get a new medical form filled out by you.

New and Expectant Parent Information sheet

DFML
MA Department of Family and Medical Leave

PFML Paid Family & Medical Leave MASSACHUSETTS

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

**Online**
mass.gov/dfml