DISABILITY, FMLA & Paid Family Leave QUESTIONNAIRE

Allow 5 Days for processing

An AUTHORIZATION FOR USE AND DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION must be attached

In order to process your claim; please **COMPLETE ALL** the information below.

Step1: Check all that apply:

☐ State Disability ☐ Private Disability ☐ FMLA ☐ Paid Family Leave (PFL)

Step 2:

- **Member/Patient must provide a Visit Verification of Treatment (VOT) from the treating physician for dates of disability. Claim may be delayed if VOT is not available.**
- **A new VOT is required for extensions and should have a new return to work date.**

Do you have a VOT from the treating Physician? ☐ Yes ☐ No

Patient Name: _____ Medical Record Number: _____

Phone Number: _____ SSN# _____

Name of Treating Physician: _____

What is the specific condition? _____

If Pregnancy:
Due date_____ Delivery date_____ Type: ☐ Normal ☐ C-Section

Step 3: State or Private Disability

First Date unable to Work: _____Estimated or Actual Return to work date: _____

Step 4: Family Medical Leave Act (FMLA)

Do you agree for Kaiser to provide medical facts or specific condition information at the request of your employer? ☐ Yes ☐ No Initials_____

Is the FMLA to care for a Family member other than yourself? ☐ Yes ☐ No

If Yes, provide your name and relationship to the patient _____

Dates of FMLA: Starting:____/___/_____ To:____/___/_____

Is FMLA for a block of time? ☐ Yes ☐ No

If FMLA is for an ongoing CHRONIC CONDITION requiring INTERMITTENT TIME OFF:
How many episodes per month?_____ How many hours or days off per month?_____

Step 5: Paid Family Leave (PFL): For Care of a Family Member

How many hours per day is required to care for the Family Member?_____

Dates of Care: Start:___/___/____ End Date of Care:___/____/_____