EDD Employment Development Department State of California

Claim for Paid Family Leave (PFL) Benefits

PART A – STATEMENT OF CLAIMANT (CARE, BONDING, or MILITARY ASSIST PROVIDER)

A1. YOUR SOCIAL SECURITY NO.: 594-29-5459

A2. YOUR DATE OF BIRTH (MM DD YYYY): 01/26/1993

A3. LANGUAGE YOU PREFER TO USE: ENGLISH ✓ | ESPAÑOL | OTHER (PRINT BELOW)

A4. YOUR LEGAL NAME: FIRST NAME: Kevni | MI: J | LAST NAME: Woodside

A5. YOUR GENDER: MALE ✓ | FEMALE

A6. YOUR TELEPHONE NUMBER: 754-837-1178

A7. OTHER LAST NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED:

A8. YOUR MAILING ADDRESS (TO RECEIVE MAIL AT A PRIVATE MAIL BOX—NOT A US POSTAL SERVICE BOX—YOU MUST SHOW THE NUMBER IN THE "PMB#" SPACE.): 1509 Wilcox Avenue | PMB# (IF APPLICABLE):

CITY: Los Angeles | STATE/PROV.: CA | ZIP OR POSTAL CODE: 90028 | COUNTRY (IF NOT U.S.A.):

A9. NAME OF YOUR EMPLOYER: Ambrosio Medical | MAILING ADDRESS: 7930 Vulcan Drive

CITY: Los Angeles | STATE/PROV.: CA | ZIP OR POSTAL CODE: 90046 | EMPLOYER'S PHONE NUMBER: 626-487-9099

A10. DATE YOU LAST WORKED (MM DD YYYY): 08/05/2021

A11. DATE YOU WANT YOUR PFL CLAIM TO BEGIN: 06/20/2021

A12. DATE YOU RETURNED OR WILL RETURN TO WORK: 11/20/2021

A13. DID YOU WORK OR WILL YOU CONTINUE TO WORK DURING YOUR FAMILY LEAVE PERIOD? NO ✓ | YES

A14. WHY DID YOU OR WILL YOU REDUCE YOUR WORK HOURS OR STOP WORKING? CARE FOR FAMILY MEMBER ✓ | BOND WITH CHILD | MILITARY ASSIST | OTHER (EXPLAIN)

A15. WHAT IS YOUR OCCUPATION? Video Editor

A16. SELECT YOUR PREFERRED PAYMENT METHOD: ☑ EDD DEBIT CARD℠ | ☐ CHECK

A17. LEGAL NAME OF CARE, BONDING, OR MILITARY ASSIST RECIPIENT (FIRST / MIDDLE INITIAL / LAST): Keithni E Woodside

A18. THE ABOVE-NAMED CARE, BONDING, OR MILITARY ASSIST RECIPIENT IS YOUR: CHILD | SPOUSE | REGISTERED DOMESTIC PARTNER | PARENT | PARENT IN-LAW | GRAND PARENT | GRAND CHILD | SIBLING ✓ | OTHER (EXPLAIN)

A19. IS ANY OTHER FAMILY MEMBER READY, WILLING, AND ABLE AND AVAILABLE TO PROVIDE CARE FOR THE SAME PERIOD YOU ARE CLAIMING PFL BENEFITS? NO ✓ | YES

A20. HAVE YOU CLAIMED OR DO YOU PLAN TO CLAIM WORKERS' COMPENSATION BENEFITS FOR ANY PORTION OF THE PERIOD COVERED BY THIS CLAIM? NO ✓ | YES

A21. DO YOU HAVE MORE THAN ONE EMPLOYER? NO ✓ | YES

A22. IF YOUR EMPLOYER(S) CONTINUED OR WILL CONTINUE TO PAY YOU DURING YOUR FAMILY LEAVE, INDICATE TYPE OF PAY: SICK | VACATION | OTHER (EXPLAIN): FMLA

A23. MAY WE DISCLOSE BENEFIT PAYMENT INFORMATION TO YOUR EMPLOYER(S)? NO | YES ✓

A24. AT ANY TIME DURING YOUR PFL LEAVE, WERE YOU IN THE CUSTODY OF LAW ENFORCEMENT AUTHORITIES BECAUSE YOU WERE CONVICTED OF VIOLATING A LAW OR ORDINANCE? ✓ NO | YES

A25. **Declaration and Signature.** By my signature on this claim statement I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was providing care for, bonding with, or participating in a qualifying event with the recipient named above (2) authorize EDD to release my personal information as shown on this claim to the care recipient's treating physician as they are respectively listed in Part C and Part D of this claim (3) authorize my employer(s) to disclose EDD all facts concerning my employment that are within their knowledge and (4) authorize release and use of information as stated in the Information Collection and Access portion of this form. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement including any accompanying statements is to the best of my knowledge and belief true correct and complete. I agree that photocopies of this authorization shall be as valid as the original and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.

Claimant's Signature (DO NOT PRINT): [signature] | If signature is made by mark (X), please place mark here.* | Date Signed (MM DD YYYY): 09/17/2021

If your signature is made by mark (X), it must be attested by two witnesses with their addresses

1st Witness Signature and Address | 2nd Witness Signature and Address

PART B – BONDING CERTIFICATION (TO BE COMPLETED BY PERSON CLAIMING PFL BENEFITS TO BOND WITH A CHILD)

B1. YOUR SOCIAL SECURITY NUMBER

B2. DATE OF FOSTER CARE OR ADOPTION PLACEMENT (M M D D Y Y Y Y)

B3. CHILD NAMED IN B8 IS MY: BIOLOGICAL CHILD | STEPCHILD | FOSTER CHILD | ADOPTED CHILD | OTHER

B4. YOUR LEGAL LAST NAME (NEEDED IN CASE PAGES OF THIS CLAIM BECOME SEPARATED)

B5. CHILD'S SOCIAL SECURITY NUMBER (IF AVAILABLE)

B6. CHILD'S DATE OF BIRTH (M M D D Y Y Y Y)

B7. CHILD'S GENDER: MALE | FEMALE

B8. LEGAL NAME OF CHILD (FIRST | MIDDLE INITIAL | LAST)

B9. CHILD'S RESIDENCE ADDRESS (IF DIFFERENT FROM CLAIMANT'S)

CITY | STATE/PROV. | ZIP OR POSTAL CODE | COUNTRY (IF NOT U.S.A.)

B10. AS EVIDENCE OF THE RELATIONSHIP IN B3, CHECK ONE OF THE FOLLOWING AND ATTACH A COPY OF THE DOCUMENT CHECKED.
(DO NOT SEND ORIGINAL DOCUMENT. IT WILL NOT BE RETURNED.)

- ☐ CHILD'S BIRTH CERTIFICATE
- ☐ ADOPTIVE PLACEMENT AGREEMENT, AD-907
- ☐ DECLARATION OF PATERNITY, CS-909
- ☐ INDEPENDENT ADOPTION PLACEMENT AGREEMENT, AD-924
- ☐ FOSTER CARE PLACEMENT RECORD, SOC-815
- ☐ OTHER

B11. **Declaration and Signature.** By my signature on this bonding certification, I authorize the medical provider, adoption agency, adoption party(ies), or foster care placement agency to disclose to the Employment Development Department all facts concerning the birth, adoption, or foster care placement of the above-named child. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements or documents, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.

Original Signature of Bonding Claimant – RUBBER STAMP IS NOT ACCEPTABLE | Date Signed (MM | DD | YYYY)

PART C – STATEMENT OF CARE RECIPIENT

(MAY BE COMPLETED BY CLAIMANT IF CARE RECIPIENT IS MENTALLY OR PHYSICALLY UNABLE TO DO SO. MUST BE SIGNED BY CARE RECIPIENT OR CARE RECIPIENT'S AUTHORIZED REPRESENTATIVE.)

C1. RECIPIENT'S DATE OF BIRTH (M M D D Y Y Y Y): 01/12/1992

C2. RECIPIENT'S TELEPHONE NUMBER: 3052055279

C3. RECIPIENT'S GENDER: MALE ✓ | FEMALE

C4. LEGAL NAME OF CARE RECIPIENT (FIRST | MIDDLE INITIAL | LAST): Keithni E Woodside

C5. CARE RECIPIENT'S RESIDENCE ADDRESS: 308 Warwick Place

CITY: McDonough | STATE/PROV.: GA | ZIP OR POSTAL CODE: 30253 | COUNTRY (IF NOT U.S.A.)

C6. CONFIRMATION OF MEDICAL DISCLOSURE AUTHORIZATION. I authorize my physician/practitioner to disclose my current personal health information to my care provider and to the California Employment Development Department (EDD). I further understand that copies of my signature below are as valid as the original.

Care Recipient's Signature (DO NOT PRINT) | Date Signed (MM | DD | YYYY)

C7. **Authorized Representative** signing on behalf of care recipient must complete the following: I, _____, represent the care or bonding recipient in this matter as authorized by ☐ parental right ☐ power of attorney (attach copy) ☐ court order (attach copy) (For spouse or domestic partner, contact EDD.)

Authorized Representative's Signature (DO NOT PRINT) | Date Signed (MM | DD | YYYY)

☆ See attached letter from psychiatrist

Maria E. Johnson, MD
Diplomate, American Board of Psychiatry and Neurology
Telepsychiatry

September 17, 2021

Employment Development Department

To Whom It May Concern:

RE: Keithni Woodside

Date of Birth: 01/12/1992

I am Keithni's psychiatrist. Keithni is the older brother of Kevni Woodside. Keithni is diagnosed with Schizophrenia. Keithni has decompensated since the death of his father on February 27th, 2020. Since that time he has been behaving bizarrely- refusing to leave his room, refusing to speak to his family, and talking to himself. Keithni's mother, Leana Laurencin-Woodside has been doing her best to care for Keithni but the situation has become very difficult. Keithni refuses medication and does not respond to any interventions.

Kevni has made the decision to come home and get the situation with his brother sorted out. Kevni must find a way to get help for his brother despite his brother's refusal. Kevni must assist his family during this time.

Because of his psychotic state, Keithni refuses to sign the Claim for Paid Family Leave Benefits. Please accept this letter in place of his signature. Please let me know if you have any other questions.

Keithni resides with his mother, Mrs. Leana Laurencin Woodside at 308 Warwick Pl McDonough, GA 30253. Ms. Laurencin' Woodside's telephone number is 305-205-5274. She is also happy to answer any other questions you may have.

Sincerely,

M Johnson

Maria E. Johnson, MD

Board Certified Psychiatrist

INSTRUCTIONS FOR COMPLETING THIS FORM:
Please complete the information in the spaces provided in UPPER CASE using black ink. Do not use special characters (- , . / ').
If handwritten, print each letter or number in a separate box. Ignore the boxes provided if using a typewriter or printer.

PART D – PHYSICIAN/PRACTITIONER'S CERTIFICATION (DO NOT COMPLETE THIS PART IF YOU ARE BONDING OR PARTICIPATING IN A QUALIFYING EVENT)

D1. PFL CLAIMANT'S (CARE PROVIDER'S) SOCIAL SECURITY NUMBER

D2. PFL CLAIMANT'S NAME (FIRST | MIDDLE INITIAL | LAST): Kevni | J | Woodside

D3. PATIENT'S DATE OF BIRTH (M M D D Y Y Y Y): 01 12 1992

D4. DOES YOUR PATIENT REQUIRE CARE BY THE CLAIMANT? NO (SKIP TO D15) YES: X

D5. PATIENT'S NAME (FIRST | MIDDLE INITIAL | LAST): Keithni | E | Woodside

D6. DIAGNOSIS OR, IF NOT YET DETERMINED, A DETAILED STATEMENT OF SYMPTOMS: Schizophrenia

D7. PRIMARY ICD CODE: F20.9

D8. SECONDARY ICD CODES:

D9. DATE PATIENT'S CONDITION COMMENCED (M M D D Y Y Y Y): 02 08 2021

D10. FIRST DATE CARE NEEDED (M M D D Y Y Y Y): ~~09~~ req 08/20/21 → 08 08 2021

D11. DATE YOU EXPECT RECOVERY (M M D D Y Y Y Y) NEVER: X

D12. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CLAIMANT (M M D D Y Y Y Y) PERMANANT: 11 20 2021

D13. APPROXIMATELY HOW MANY TOTAL HOURS PER DAY WILL PATIENT REQUIRE CLAIMANT? HOURS | COMMENTS

D14. WOULD DISCLOSURE OF THIS CERTIFICATE TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL? ..... NO X YES

D15. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER: GA 057376

D16. STATE OR COUNTRY PHYSICIAN/PRACTITIONER IS LICENSED: Georgia

D17. PHYSICIAN/PRACTITIONER'S NAME (FIRST | MIDDLE INITIAL | LAST): MARIA | E | JOHNSON

D18. PHYSICIAN/PRACTITIONER'S ADDRESS (POST OFFICE BOX IS NOT ACCEPTABLE AS THE SOLE ADDRESS): 2296 Henderson Mill Rd.

CITY: Atlanta | STATE/PROV.: GA | ZIP OR POSTAL CODE: 30345 | COUNTRY (IF NOT U.S.A.):

D19. TYPE OF PHYSICIAN/PRACTITIONER: PSYCHIATRIST

D20. SPECIALTY (IF ANY): PSYCHIATRY

D21. PHYSICIAN/PRACTITIONER'S Certification and Signature: I certify under penalty of perjury that this patient has a serious health condition and requires a care provider. I have performed a physical examination and/or treated the patient. I am authorized to certify a patient disability or serious health condition pursuant to California Unemployment Insurance Code Section 2708.

Original Signature of Attending Physician/Practitioner – RUBBER STAMP IS NOT ACCEPTABLE: M Johnson

PHYSICIAN/PRACTITIONER'S PHONE NO.: 404 5080057

Date Signed (M M | D D | YYYY): 09 16 2021

Under sections 2116 and 2122 of the California Unemployment Insurance Code, it is a violation for any individual who, with intent to defraud, falsely certifies the medical condition of any person in order to obtain disability insurance benefits, whether for the maker or for any other person, and is punishable by imprisonment and/or a fine not exceeding $20,000. Sections 1143 and 3305 require additional administrative penalties.

MJ 9/16/21

PART E – MILITARY ASSIST CERTIFICATION (TO BE COMPLETED BY THE CLAIMANT)

E1. YOUR SOCIAL SECURITY NUMBER

E2. YOUR LEGAL NAME (FIRST / MIDDLE INITIAL / LAST)

E3. NAME OF MILITARY MEMBER ON COVERED ACTIVE DUTY OR IMPENDING CALL TO COVERED ACTIVE DUTY STATUS (FIRST / MIDDLE INITIAL / LAST)

E4. MILITARY MEMBER'S DATE OF BIRTH
M M D D Y Y Y Y

E5. MILITARY MEMBER'S GENDER
☐ MALE ☐ FEMALE

E6. MILITARY MEMBER'S MAILING ADDRESS

CITY | STATE/PROV. | ZIP OR POSTAL CODE | COUNTRY (IF NOT U.S.A.)

E7. LAST FOUR DIGITS OF MILITARY MEMBER'S SOCIAL SECURITY NUMBER

E8. PERIOD OF MILITARY MEMBER'S COVERED ACTIVE DUTY
M M D D Y Y Y Y TO M M D D Y Y Y Y

E9. DATE MILITARY MEMBER WAS NOTIFIED OF COVERED ACTIVE DUTY
M M D D Y Y Y Y

E10. PLEASE SELECT ONE OF THE FOLLOWING AND ATTACH THE INDICATED DOCUMENT TO SUPPORT THAT THE MILITARY MEMBER IS ON COVERED ACTIVE DUTY OR IMPENDING CALL OR ORDER TO COVERED ACTIVE DUTY STATUS

☐ COVERED ACTIVE DUTY ORDERS
☐ LETTER OF IMPENDING CALL OR ORDER TO COVERED DUTY
☐ DOCUMENTATION OF MILITARY LEAVE SIGNED BY THE APPROVING AUTHORITY FOR MILITARY MEMBER'S REST AND RECUPERATION

E11. THE QUALIFYING EVENT FOR THE PFL CLAIM IS TO: (One or more reasons may be selected)

☐ PROVIDE/ARRANGE CHILDCARE FOR MILITARY MEMBER'S CHILD
☐ PROVIDE/ARRANGE CARE FOR MILITARY MEMBER'S PARENT
☐ ATTEND COUNSELING
☐ MAKE FINANCIAL/LEGAL ARRANGEMENTS
☐ ASSIST MILITARY MEMBER DURING REST AND RECUPERATION LEAVE
☐ ATTEND MILITARY EVENT
☐ REPRESENT MILITARY MEMBER AT FEDERAL, STATE, OR LOCAL AGENCIES
☐ ADDRESS ISSUES DUE TO MILITARY MEMBER'S DEATH
☐ OTHER:

E12. WRITTEN DOCUMENTION SUPPORTING THIS REQUEST FOR LEAVE IS AVAILABLE AND ATTACHED?

☐ YES ☐ NO ☐ NONE AVAILABLE

NOTE: A complete and sufficient certification to support a request for PFL leave due to a qualifying event includes any available written documentation that supports the need for leave. Documentation may include; a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming the military member's Rest and Recuperation leave, an appointment with a third party (i.e., a counselor, school official, or staff at a care facility), or a copy of a bill for services for the handling of legal or financial affairs. If leave is requested to meet with a third party, the employee must provide the supporting documentation of the meeting that includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either phone number, fax number, or email address of the individual or entity).

E13. **Declaration and Signature.** By my signature on this military assist certification, I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements or documents, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.

Original Signature of Military Assist Claimant (DO NOT PRINT)

Date Signed (MM | DD | YYYY)

QUALIFYING EVENT FOR LEAVE - DOCUMENTATION

If leave is requested to meet with a third party, the employee must provide supporting documentation of the meeting that includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the phone number, fax number or email address of the individual or entity). The reason for a meeting can include: arranging for child or parental care, counseling, making financial or legal arrangements, acting as the military member's representative before a federal, state or local agency for purposes of obtaining, arranging or appealing military service benefits, or attending any event sponsored by the military or military service organizations.

PLEASE SUBMIT SUPPORTING DOCUMENTATION, IF APPLICABLE
(Attach an additional sheet if more space is required)

YOUR SOCIAL SECURITY NUMBER	YOUR LEGAL NAME (FIRST / MIDDLE INITIAL / LAST)

NAME OF INDIVIDUAL WITH WHOM CLAIMANT IS MEETING: _____

TITLE: _____

ORGANIZATION: _____

PHONE NUMBER (provide area or country code): _____

FAX NUMBER (provide area or country code): _____

EMAIL ADDRESS: _____

MAILING ADDRESS

Mailing Address			
City	State/Prov	ZIP or Postal Code	Country (if not U.S.A.)

DESCRIBE NATURE OF MEETING. INCLUDE DATES, IF KNOWN: