EDD Employment Development Department State of California

Claim for Paid Family Leave (PFL) Care Benefits

Enter your receipt number here.
R1000001330936 95

PART C – INSTRUCTIONS FOR PFL CARE CLAIMS

The care recipient (the person for whom you are providing care) must do the following: Complete and sign "Part C – Statement of Care Recipient." If the care recipient is physically or mentally unable to sign, call PFL at 1-877-238-4373 for instructions.

The care recipient's physician/practitioner must complete "Part D – Physician/ Practitioner's Certification" either electronically in SDI Online, or by completing and signing page 3 of *Claim for Paid Family Leave (PFL) Care Benefits* (DE 2501FC). If the care recipient is under the care of an accredited religious practitioner, call PFL at 1-877-238-4373 for the proper form *Practitioner's Certification for Paid Family Leave Benefits* (DE 2502F).

The easiest way to have your claim processed is to submit the completed forms electronically in SDI Online as an attachment. If submitting by mail, send to the following address: Paid Family Leave, PO Box 997017, Sacramento, CA 95899-7017. If submitting electronically, return to the Homepage of your SDI Online account. Select **New Claim** from the Menu, and select **Submit Electronic Paid Family Leave Care Attachment**.

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. CARE PROVIDER SSN	C2. RECIPIENT'S DATE OF BIRTH	C3. RECIPIENT'S PHONE NUMBER	C4. RECIPIENT'S GENDER
611-98-9375	09/05/1957	925-300-8671	☒ MALE ☐ FEMALE

C5. LEGAL NAME OF CARE RECIPIENT (FIRST, MIDDLE INITIAL, LAST)
Maggy, M. Sleem

C6. CARE RECIPIENT'S RESIDENCE ADDRESS
784 WALHAVEN CT.

CITY WALNUT CREEK STATE/PROV. CA ZIP OR POSTAL CODE 94598 COUNTRY (IF NOT U.S.A.)

C7. **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)
Maggy S

Date Signed 8/1/22

C8. **Authorized Representative** signing on behalf of care recipient must complete the following: I, , represent the care 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