Certification for a Serious Health Condition Form
Job Aid for Healthcare Providers

Each CT Paid Leave claim for a serious health condition requires the claimant's healthcare provider to complete the Certification for a Serious Health Condition form. This form is designed to ask healthcare providers specific questions to validate the patient's serious health condition. The following document is a resource to assist health care providers in completing this form.

How to use this job aid:

- Annotations are provided to assist you in filling out certain fields
- You may return the form to the patient or submit it directly to Aflac using the fax number or email address provided on the top of the form
- If there are any additional questions, please use the Contact Us feature at ctpaidleave.org.

1 Applicant Information
This section is to be completed by the patient/applicant.

2 Health Care Provider Information
Provide your information as the patient's health care provider. Include your business address, type of practice/specialty, and license number and state.

3 Form Instructions
Complete all relevant sections of the form. Limit your response to the medical conditions for which the employee is seeking CT Paid Leave.

Answers should be your best estimate based upon our medical knowledge, experience and examination of the patient.

Please complete Part A **and** Part B of the form. Missing or incomplete information may result in denial of the claim.

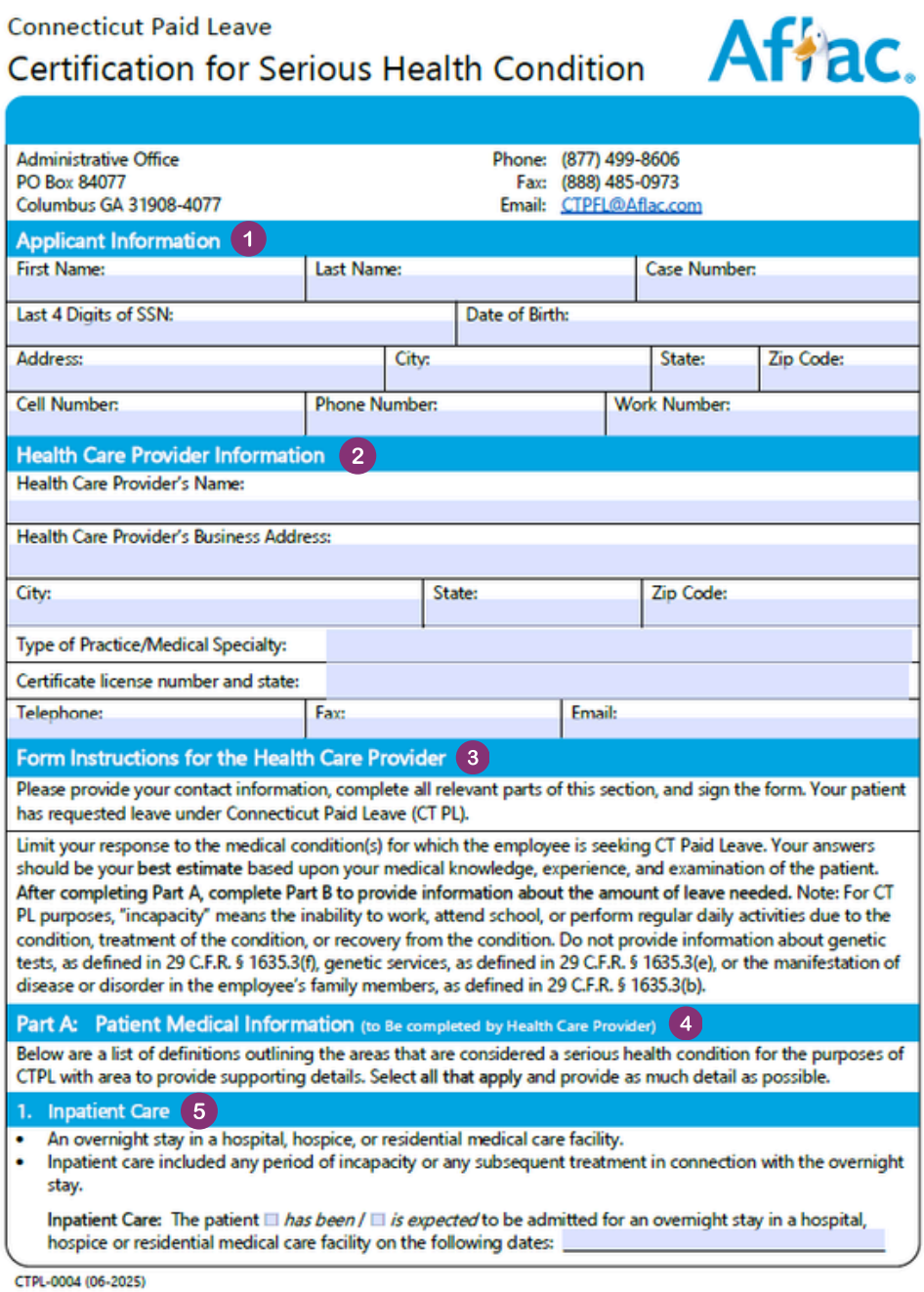
4 Part A: Patient Medical Information
Part A of the form is intended to simplify the process for determining if an individual has a serious health condition, as defined by the law.

Each subpart of that definition is listed in Part A with questions designed to identify if the individual meets one or more of those subparts.

Please answer the questions related to the subpart or subparts that most closely matches your patient's condition.

5 Inpatient Care
An overnight stay in a hospital, hospice or residential medical care facility. This includes any period of incapacity or any treatment in connection with the overnight stay.

Elective surgery is considered a serious health condition if an overnight stay in the hospital is required.



Connecticut Paid Leave

Certification for Serious Health Condition

Aflac

Administrative Office
PO Box 84077
Columbus GA 31908-4077

Phone: (877) 499-8606
Fax: (888) 485-0973
Email: CTPFL@Aflac.com

Applicant Information 1

First Name: | Last Name: | Case Number:

Last 4 Digits of SSN: | Date of Birth:

Address: | City: | State: | Zip Code:

Cell Number: | Phone Number: | Work Number:

Health Care Provider Information 2

Health Care Provider's Name:

Health Care Provider's Business Address:

City: | State: | Zip Code:

Type of Practice/Medical Specialty:

Certificate license number and state:

Telephone: | Fax: | Email:

Form Instructions for the Health Care Provider 3

Please provide your contact information, complete all relevant parts of this section, and sign the form. Your patient has requested leave under Connecticut Paid Leave (CT PL).

Limit your response to the medical condition(s) for which the employee is seeking CT Paid Leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For CT PL purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, as defined in 29 C.F.R. § 1635.3(b).

Part A: Patient Medical Information (to Be completed by Health Care Provider) 4

Below are a list of definitions outlining the areas that are considered a serious health condition for the purposes of CTPL with area to provide supporting details. Select **all that apply** and provide as much detail as possible.

1. Inpatient Care 5

- An overnight stay in a hospital, hospice, or residential medical care facility.
- Inpatient care included any period of incapacity or any subsequent treatment in connection with the overnight stay.

Inpatient Care: The patient ☐ *has been* / ☐ *is expected* to be admitted for an overnight stay in a hospital, hospice or residential medical care facility on the following dates: _____

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Throughout the form, please include specific dates of when the patient was or is expected to be admitted, incapacitated, or seen for appointments.

6 Continuing Treatment by a Health Care Provider

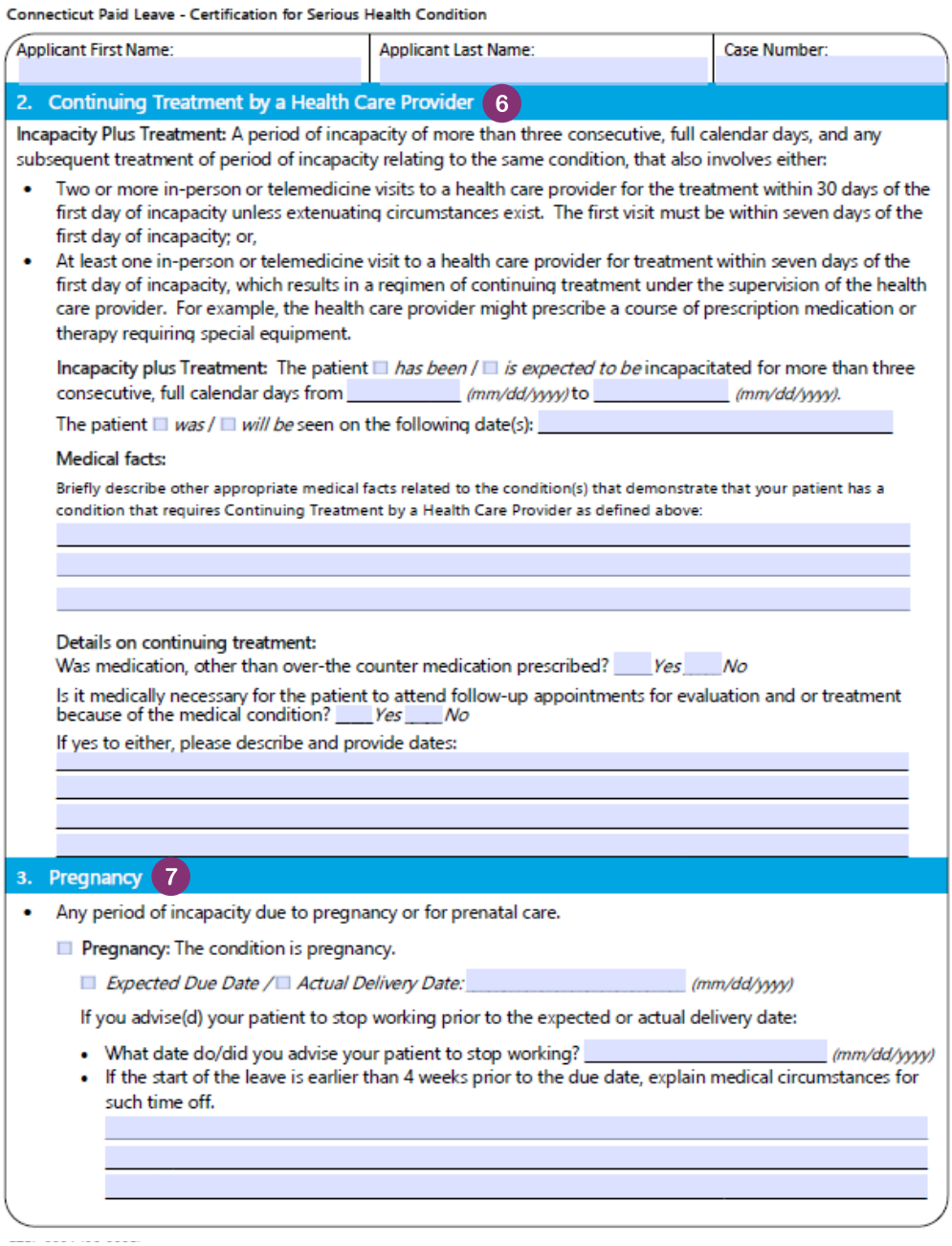
Incapacity plus treatment: This means a period of incapacity of more than three consecutive, full calendar days, and any subsequent period of treatment for incapacity relating to the same condition.

Subsequent treatment must involve either two or more in-person or telemedicine visits within 30 days of the first day of incapacity, with the first visit within 7 days of the first day of incapacity; or at least one in-person or telemedicine visit within 7 days of the first day of incapacity, which results in a regimen of continuing treatment.

Indicate specific start and end dates of incapacitation here, as well as when the patient was/will be seen for treatment. Provide specific medical facts related to the condition that demonstrate that it requires continuing treatment.

For example: patient breaks their leg and needs surgery, which incapacitates them from March 5 to March 9 (4 days). They then need to attend follow up visits for 3 months while their leg heals and will be seen on March 20, April 18 and May 23.

Details on continuing treatment: Provide information on continuing treatment, including whether medication was prescribed and if follow-up appointments are necessary.



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Applicant First Name: | Applicant Last Name: | Case Number:

2. Continuing Treatment by a Health Care Provider 6

Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment of period of incapacity relating to the same condition, that also involves either:

- Two or more in-person or telemedicine visits to a health care provider for the treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,
- At least one in-person or telemedicine visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health care provider might prescribe a course of prescription medication or therapy requiring special equipment.

Incapacity plus Treatment: The patient ☐ *has been* / ☐ *is expected to be* incapacitated for more than three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy).*

The patient ☐ *was* / ☐ *will be* seen on the following date(s): _____

Medical facts:

Briefly describe other appropriate medical facts related to the condition(s) that demonstrate that your patient has a condition that requires Continuing Treatment by a Health Care Provider as defined above:

Details on continuing treatment:

Was medication, other than over-the counter medication prescribed? ____*Yes* ____*No*

Is it medically necessary for the patient to attend follow-up appointments for evaluation and or treatment because of the medical condition? ____*Yes* ____*No*

If yes to either, please describe and provide dates:

3. Pregnancy 7

- Any period of incapacity due to pregnancy or for prenatal care.

☐ **Pregnancy:** The condition is pregnancy.

☐ *Expected Due Date* / ☐ *Actual Delivery Date:* _____ *(mm/dd/yyyy)*

If you advise(d) your patient to stop working prior to the expected or actual delivery date:

- What date do/did you advise your patient to stop working? _____ *(mm/dd/yyyy)*
- If the start of the leave is earlier than 4 weeks prior to the due date, explain medical circumstances for such time off.

7 Pregnancy

This includes any period of incapacitation due to pregnancy.

Include expected due date or, if completing the form after birth, include the actual delivery date.

A patient may be entitled to 2 additional weeks of CT Paid Leave benefits if you certify that they have a serious health condition that results in incapacitation during pregnancy.

These additional 2 weeks can be used for routine prenatal care and appointments, pregnancy complications, or any other serious health condition that occurs during the pregnancy.

8 Chronic Conditions

This includes any period of incapacity due to treatment for a chronic serious health condition.

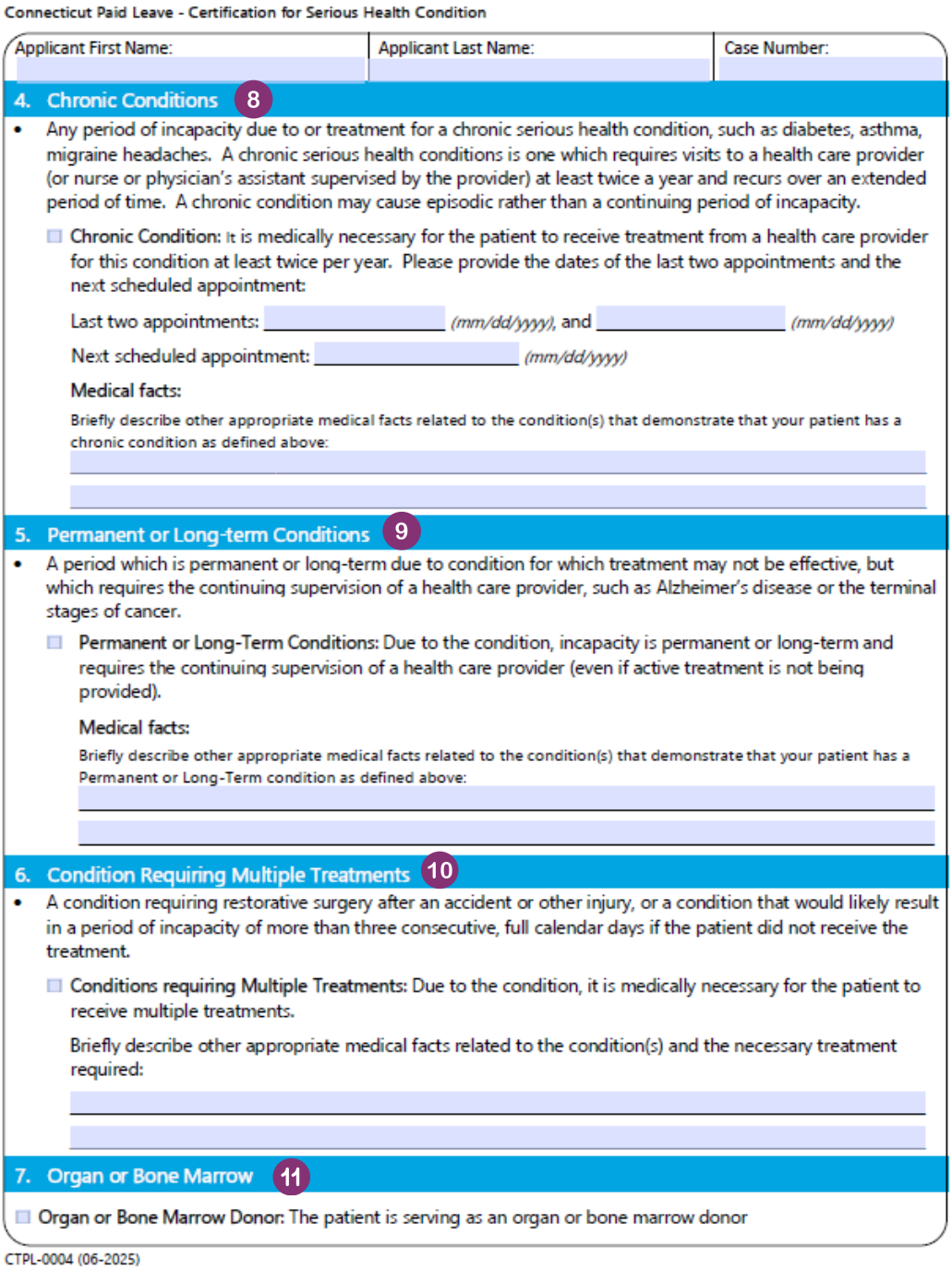
A chronic serious health condition requires visits to a health care provider related to the condition at least twice a year and recurs over an extended period of time.

A chronic condition may be episodic rather than a continuing period of incapacity.

Include dates of patient's last two appointments and next scheduled appointment. If no next appointment is scheduled, the condition may still qualify as chronic if there have been at least two appointments in the preceding twelve months.

Provide information related to the condition that demonstrate it is a chronic condition.

For example: patient has lupus and experiences occasional flare ups and seeks treatment at least twice a year.



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Applicant First Name:	Applicant Last Name:	Case Number:

4. Chronic Conditions 8

- Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health conditions is one which requires visits to a health care provider (or nurse or physician's assistant supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.

☐ **Chronic Condition:** It is medically necessary for the patient to receive treatment from a health care provider for this condition at least twice per year. Please provide the dates of the last two appointments and the next scheduled appointment:

Last two appointments: _____ *(mm/dd/yyyy)*, and _____ *(mm/dd/yyyy)*

Next scheduled appointment: _____ *(mm/dd/yyyy)*

Medical facts:

Briefly describe other appropriate medical facts related to the condition(s) that demonstrate that your patient has a chronic condition as defined above:

5. Permanent or Long-term Conditions 9

- A period which is permanent or long-term due to condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.

☐ **Permanent or Long-Term Conditions:** Due to the condition, incapacity is permanent or long-term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

Medical facts:

Briefly describe other appropriate medical facts related to the condition(s) that demonstrate that your patient has a Permanent or Long-Term condition as defined above:

6. Condition Requiring Multiple Treatments 10

- A condition requiring restorative surgery after an accident or other injury, or a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

☐ **Conditions requiring Multiple Treatments:** Due to the condition, it is medically necessary for the patient to receive multiple treatments.

Briefly describe other appropriate medical facts related to the condition(s) and the necessary treatment required:

7. Organ or Bone Marrow 11

☐ **Organ or Bone Marrow Donor:** The patient is serving as an organ or bone marrow donor

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9 Permanent or Long-term conditions

This includes conditions for which treatment may not be effective but requires the continuing supervision of a health care provider.

Provide information related to the condition that demonstrate it is a permanent or long term condition.

For example: patient has Alzheimer's or terminal cancer.

10 Condition requiring multiple treatments

This includes a condition that would likely result in a period of incapacity of more than 3 consecutive full calendar days without treatment.

Describe the patient's condition and the necessary treatment required.

For example: patient needs reconstructive knee surgery after an accident; or patient is recovering from a serious illness like pneumonia.

11 Organ or bone marrow donation

The patient is serving as an organ or bone marrow donor.

If the patient is an organ or bone marrow donor, please also complete part 1 (inpatient care) to provide dates of hospitalization related to the procedure and/or part 2 (continuing treatment) with the expected dates of incapacity.

12 None of the above

If the above options do not explain the nature of the patient's condition, describe it here.

13 Part B: Patient leave requirements

Indicate what kind of leave the patient requires.

Consult with the patient about the leave type, (continuous, reduced schedule or intermittent), and frequency and duration you are recommending compared to the leave type, frequency and duration they have requested to ensure they understand the time period you are certifying for their serious health condition.

Include specific start and end dates, even if there is a possibility these dates will change.

For reduced schedule leave, include the number of hours the patient will need to be off from work.

For intermittent leave for a patient who needs leave for an episodic flare up of a condition, include the specific frequency and duration of leave that is needed.

If intermittent leave is necessary for planned medical leave treatment, include the dates of treatment that are planned.

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8. None of the Above 12

None of the above explains the nature of the patient's condition, please explain:

Part B: Patient Leave Requirements (to be completed by Health Care Provider) 13

Please complete all sections that apply.

1. Continuous	☐ The applicant *needed / will need* to be absent from work on a continuous basis due to their medical condition, including the need for treatment and recovery. Start Date: _____ End Date: _____ *(mm/dd/yyyy)*
2. Reduced Schedule	☐ The applicant *needed / will need* to work a part-time/reduced schedule due to their condition, including the need for treatment and recovery. If checked, please estimate the number of hours per week the patient will need time off from work: _____ Hour(s) per week Start Date: _____ End Date: _____ *(mm/dd/yyyy)*
3. Intermittent	☐ The applicant *needed / will need* to be out of work on an intermittent basis (periodically), including any episodes of incapacity (i.e. episodic flare-ups). Start Date: _____ End Date: _____ *(mm/dd/yyyy)* If checked, please indicate the intermittent frequency and duration required for the patient to be out of work over the next 6 months: Frequency: ____ time(s) every ____ week(s) OR ____time(s) every ____month(s) Duration: ____ hour(s) per episode OR ____day(s) per episode If intermittent leave is necessary for planned medical treatments (scheduled medical visits), such as: psychotherapy, prenatal appointments, please list those dates:

Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate, and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Health Care Provider Signature & Credentials 14	Date

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* Claims administered by Continental American Insurance Company (CAIC).

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14 Health Care Provider Signature & Credentials

Add your signature and your medical credentials here. If the form is not signed, it cannot be processed.