LOUISIANA HOUSING CORPORATION

POLICY NO. 12

SUBJECT: FAMILY AND MEDICAL LEAVE ACT POLICY

PURPOSE:

The purpose of the Family and Medical Leave Act (FMLA) is to balance the demands of the workplace with the needs of the family. This policy is designed to inform our employees of the circumstances under which FMLA leave may be taken or required, and to provide a consistent procedure for implementing the requirements of the Act.

APPLICABILITY

Eligible employees of the Louisiana Housing Corporation (LFHA) are entitled to the benefits provided by this Act. To be an "eligible employee", you must have been employed by the State of Louisiana for at least twelve months **and** must have worked at least 1,250 hours during the previous twelve month period.[i] Special rules apply to employees returning from fulfilling National Guard or Reserve military obligations.[ii]

POLICY

I.
Duration of FMLA Leave

The FMLA provides job-protected leave for up to twelve (12) weeks in any twelve (12) month period. LHC calculates the twelve month period from the date of the employee's first use of such qualifying leave. If the employee normally works a part-time schedule or variable hours, the FMLA leave entitlement is determined on a pro rata or proportional basis.

II.
Circumstances Under which FMLA Leave May Be Taken

A) **For birth of a son or daughter of the employee for the purpose of caring for the newborn.** An employee's entitlement to this leave expires at the end of the twelve month period beginning on the date of birth.

B) **For placement of a child with the employee for adoption or foster care.** An employee's entitlement to this leave expires at the end of the twelve month period beginning on the date of placement.

C) **In order for the employee to care for one of the following family members when the family member suffers from a "serious health condition":**

1) **Spouse of the employee;**
"Spouse" is defined by state law where the employee resides. Louisiana does not recognize common law marriages.

2) **Son or daughter of the employee;**
"Son" or "Daughter" includes a biological, adopted or foster child; step-child; legal ward; or child of a person standing in the place of a parent. A son or daughter must be either under eighteen years of age **or** eighteen years of age or older and incapable of self-care because of a mental or physical disability; or

3) **Employee's parent.**
"Parent" includes biological parents as well as individuals who stood in the place of an employee's parent when the employee was under eighteen years of age.

NOTE: An employee's care for a family member with a serious health condition encompasses both physical and psychological care. It includes situations where, for example, because of a serious health condition, the family member is unable to care for his or her own basic medical, hygienic or nutritional needs or safety, or is unable to transport himself or herself to the doctor. This also includes providing psychological comfort and reassurance which would be beneficial to the family member who is receiving inpatient or home care. Also included are situations where the employee may be needed to fill in for others who are caring for the family member, or to make arrangements for changes in care, such as transfer to a nursing home.

D) **Because of a 'serious health condition" of the employee that renders the employee unable to perform the functions of his or her position**. An employee is "unable to perform the functions of his or her position" where a health care provider finds that the employee is unable to work at all or is unable to perform any one of the essential functions of the employee's position within the meaning of the Americans with Disabilities Act and the Code of Federal Regulations. An employee who must be absent from work to receive medical treatment for a serious health condition is considered to be unable to perform the essential functions of the position during the absence for treatment.[iii]

III.
Service Member Family Leave

Eligible employees may be entitled to FMLA leave to deal with exigent circumstances arising from the active duty or call to active duty of a family member who is not in the regular military or to care for a service member who has a serious injury or illness. The particulars concerning Service Member Family Leave are included in a supplement to this policy which can be obtained from the Human Resources Section. Leave entitlement for Service Member Family Leave ranges from five days to twenty-six weeks, depending upon the circumstance.

IV.
Spouses Employed By the State of Louisiana

In the event a husband and wife are both employed by the State of Louisiana and both are

entitled to FMLA leave, the combined total number of workweeks of FMLA leave to which they are jointly entitled is limited to twelve (12) workweeks during any twelve (12) month period if leave is taken:

A) For birth of a son or daughter of the employee for the purpose of caring for the newborn;

B) For placement of a son or daughter with the employee for adoption or foster care; or

C) In order to care for a sick parent when he or she suffers from a "serious health condition".

The determination of spouses' entitlement to FMLA leave is complex and requires scrutiny of the particular circumstances. Notwithstanding the availability or limitations upon FMLA leave for certain circumstances, spouses jointly employed by LHC or the State of Louisiana may request and receive approval to use annual leave at the discretion of the Appointing Authority/Appointing Authority.

V.
What Is A "Serious Health Condition"?

A "serious health condition" is an illness, injury, impairment, or physical or mental condition that involves either inpatient care in a hospital, hospice, or residential medical care facility or continuing treatment by a health care provider. A "health care provider" is either a doctor of medicine or osteopathy certified to practice medicine or surgery or any other person determined by the Secretary of Labor to be capable of providing health care services.[iv] Leave due to a "serious health condition" can be categorized as follows:

A. "*Inpatient care*": Includes an overnight stay in a hospital, hospice or residential medical care facility, including any period of incapacity or any subsequent treatment in connection with the inpatient care. For purposes of the FMLA, "incapacity" means inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment thereof or recovery therefrom;

B. *Absence Plus Treatment:* Includes a period of incapacity of more than three consecutive calendar days, and any subsequent treatment or period of incapacity relating to the same condition that also involves:

i) Treatment two or more times by a health care provider; or

ii) Treatment on at least one occasion by a health care provider which results in a regimen of continuing treatment under the supervision of the health care provider;

C. *Pregnancy:* Any period of incapacity due to pregnancy or prenatal care;

D. *Chronic Condition Requiring Treatment:* Includes any period of incapacity or

treatment for such incapacity due to a chronic serious health condition. A "chronic serious health condition" is one which:

(i) Requires periodic visits for treatment;

(ii) Continues over an extended period of time, including recurring episodes of a single underlying condition; and

(iii) May cause episodic rather than a continuing period of incapacity (asthma, diabetes, epilepsy, etc.);

E. *Permanent/Long-Term Condition Requiring Supervision:* Includes a period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective (i.e. Alzheimer's disease, severe stroke, or terminal stages of a disease). The employee or family member must be under continuing supervision of a health care provider;

F. Multiple Treatment for Non-Chronic Condition: Any period of absence to receive multiple treatments (including recovery therefrom) either for a restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation), severe arthritis (physical therapy), kidney disease (dialysis), etc.

Excluded Conditions

The Code of Federal Regulations identifies certain conditions which are not considered to be "serious health conditions" and which are not covered by the Act. The following list of non-covered health conditions is not intended to be all-inclusive, but is intended simply to give an employee some insight as to ordinary conditions (which do not result in complications) that Congress did not contemplate in providing guaranteed leave for "serious health conditions": (i) conditions for which cosmetic treatments are administered (most acne treatments or plastic surgery) unless inpatient hospital care is required; (ii) common cold; (iii) flu; (iv) ear infections; (v) upset stomach; (vi) minor ulcers; (vii) headaches, other than migraine; (viii) routine dental or orthodontia problems; and (ix) periodontal disease.

The Code of Federal Regulations lists several other conditions which may be "serious health conditions" if all other requirements are met. These include (i) restorative dental or plastic surgery after an injury or removal of cancerous growths; (ii) mental illness resulting from stress; (iii) allergies; and (iv) substance abuse treatment.

Substance Abuse

Treatment for substance abuse under circumstances which meet the definition of a "serious health condition" is treated like any other illness under the FMLA. In other words, an employee will not be denied leave under the FMLA simply because the "serious health condition" for which leave is sought is treatment for substance abuse (rather than illness of any other nature). Absence because of an employee's use of the substance (rather than treatment)

does not qualify for FMLA leave. Treatment for substance abuse does not prevent LHC from taking action against any employee who violates the Corporation's substance abuse policy. Pursuant to that policy, which will be uniformly applied, an employee may be terminated whether or not the employee qualifies or seeks to use FMLA leave.

VI.
Requests For And Notice Requirements for FMLA Leave

A. In any case in which the need for leave is foreseeable based on an expected birth or placement, the employee shall contact his/her supervisor to request leave and shall provide LHC with at least thirty (30) days' notice, before the date the leave is to begin, of the employee's need for leave under the Act. If the date of birth or placement necessitates that leave begin in less than thirty (30) days, the employee shall request leave as far in advance as is practicable.

When leave due to an employee's or family member's serious health condition is foreseeable or based on planned medical treatment, the employee shall notify his/her supervisor, request FMLA leave and shall:

1) Make a reasonable effort to schedule treatment so as not to unduly disrupt the operations of LHC; and

2) Provide LHC with at least thirty (30) days' notice, before the date the leave is to begin, of his or her intention to take leave. If the date of treatment requires leave to begin in less than thirty (30) days, the employee shall provide such notice as is practicable.

An employee shall initiate the leave request process and shall provide notice of foreseeable FMLA leave to his/her immediate supervisor, who shall be responsible for immediately providing notification to the Human Resources Section.

B. For leave that is unforeseeable, the regular LHC leave usage procedure should be followed (i.e. timely and properly contact a supervisor to request approval to use leave). Supervisors are not authorized to approve FMLA leave; rather, they must immediately provide notice of the request for FMLA leave to the Human Resources Section. Human Resources' personnel will be responsible for contacting the employee to obtain the information necessary to determine employee eligibility. Approval or denial of FMLA leave shall be handled by the Human Resources Section in consultation with the employee's Appointing Authority/Appointing Authority.

VII.
Placement of an Employee Off on FMLA Leave

LHC has the duty to determine whether a leave request is FMLA-qualifying, to designate it as such, and provide notice of the designation to the employee. In the case of intermittent or reduced schedule, only one notice is required unless circumstances regarding the leave have changed. In order to determine whether leave is FMLA-qualifying, LHC has the right to make reasonable and necessary inquiries of the employee regarding the reason for the leave.[v] The

employee must explain the reason for the leave sufficiently for LHC to determine whether the leave qualifies under the Act. If the employee fails to do so, additional leave may be denied. Once it is determined that leave is FMLA-qualifying, the procedures set forth in Section VIII below regarding health care provider certification will apply.

In most cases, the need to code an employee's absence as FMLA-qualifying will be readily discernable. However, supervisors are responsible for monitoring leave usage and notifying the Human Resources Section of employee absences that may be FMLA-qualifying and should be so designated. Accordingly, supervisors are required to contact the Human Resources Section when an employee has been absent due to illness for more than three consecutive days, routinely misses work for medical appointments, or routinely requests annual leave to care for a family member. Once notified, Human Resources' personnel will contact the employee to determine the propriety of coding the absences as FMLA-qualifying.

VIII.
Certification of Need and Eligibility for Leave

LHC will require that a request for leave due to the serious illness of an employee or an employee's designated relative be supported by written certification issued by a qualified health care provider. When the employee is requesting leave for his or her own serious health condition, LHC has the right to provide a statement of the essential functions of the employee's position to the health care provider for review. The employee shall provide certification to LHC at the time FMLA leave is requested, or as soon thereafter as practicable. The leave certification form is attached hereto. Additional forms may be obtained from the Human Resources Section.

In any case in which LHC has reason to doubt the validity of the certification provided by the health care provider, the Corporation may require, at its expense, that the employee obtain the opinion of a second health care provider designated or approved by LHC. Where the second opinion differs from the opinion in the original certification, the Corporation may require, at its expense, that the employee obtain the opinion of a third health care provider designated or approved jointly by the Corporation and the employee. Any such third opinion shall be considered final and binding on LHC and the employee.

LHC may require re-certification on a reasonable basis. Generally, once the employee has been off from work for six weeks, re-certification will be required every thirty days. Re-certification may be required more often if an extension of leave is requested or if a change in circumstance comes to the attention of LHC.

For purposes of confirmation of a family relationship, LHC may require the employee to provide reasonable documentation to support the family relationship.

Upon receiving any request for leave under the Family and Medical Leave Act, LHC will advise the employee as soon as practicable (generally within five business days) of whether he or she is eligible for the requested leave.

IX.
When and How Leave Is To Be Taken

FMLA leave due to the birth of a child or the placement of a child with the employee for adoption or foster care cannot be taken intermittently; however, a reduced leave schedule for

these reasons may be approved by the Appointing Authority/Appointing Authority.[vi]

Leave due to an employee's or family member's serious health condition can be taken intermittently or on a reduced leave schedule when the health condition or need is only intermittent or the employee's condition necessitates a modified work schedule.

Employees needing intermittent FMLA leave or a reduced leave schedule must attempt to schedule leave so as not to disrupt the operations of LHC.

If an employee requests intermittent leave or a reduced leave schedule that is foreseeable based on planned medical treatment, LHC may require the employee to transfer temporarily to an available alternative position for which the employee is qualified and that: (a) has equivalent pay and benefits and (b) better accommodates recurring periods of leave than the employee's regular position. Any alternative position will be comparable in assignments and hours to the employee's regular position.

For leave requests under the FMLA in cases involving care of a newborn, child placement or the serious health condition of a son, daughter, spouse or parent, LHC will require the employee to utilize all accrued compensatory leave earned at the hour-for-hour rate and all annual leave before LWOP will be granted. Accumulated sick leave cannot be used for absences of this nature.

For leave requests under the Act in cases involving the employee's own serious health condition, LHC will require the employee to utilize all accrued sick leave, all accrued compensatory leave earned at the hour-for-hour rate and all annual leave before LWOP will be granted.

FMLA leave shall run concurrently with any leave usage qualifying under the worker's compensation laws of the State of Louisiana where the condition of the employee meets the criteria of a serious health condition. Under no circumstance can an employee be compelled to utilize compensatory leave earned at the time and one-half rate.

X.
FMLA Protections and Limitations

An eligible employee who takes FMLA leave shall be entitled, upon return from such leave, to be restored:

a) To the position of employment he or she held when the leave commenced; <u>or</u>
b) To an equivalent position with equivalent employment benefits, pay and other terms and conditions of employment.

The taking of FMLA leave shall not result in the employee's loss of any employment benefit accrued prior to the date on which the leave commenced. Restored employees are not entitled to any right, benefit or position of employment other than any right, benefit or position to which the employee would have been entitled had leave not been taken. An employee's use of FMLA leave cannot impact his/her entitlement to a merit increase.

If an employee is unable to perform an essential function of his or her position, he or she has no right under the FMLA to restoration to another position. Such employee's rights are

governed by the Americans with Disabilities Act.

The FMLA prohibits interference with an employee's rights under the law, and with legal proceedings or inquiries relating to an employee's rights. An employee cannot waive his/her rights under the FMLA.

In compliance with law, LHC has posted notices throughout its offices explaining the Act's provisions and providing information concerning the procedure for filing complaints of violations of the Act with the Wage and Hour Division of the U.S. Department of Labor.

XI.
Insurance Benefits

Upon an employee's commencement of FMLA leave, the employee will be provided written notice regarding the maintenance of insurance benefits. The Act requires maintenance of insurance policies which qualify as a benefit of employment (i.e. employer-sponsored group health and group life insurance) on the same terms and conditions as if leave had not been taken. Insurance which is not employer-sponsored need not be maintained at the employer's expense; instead, the employee must arrange with the insurer to maintain such benefits. LHC employees are responsible for maintenance of all non-group health and life insurance policies. The following provisions shall apply only to the Corporation's group health insurance policies:

A. **Maintenance:** For the duration of an employee's FMLA leave, his/her insurance coverage existing under the Corporation's group health plan on the date that leave commences shall be maintained at the same level and under the same conditions.

B. **Premium Payments:** When the employee's FMLA leave is unpaid, the employee must contact the Human Resources Section to arrange for payment of the employee portion of insurance premiums. An effort will be made to accommodate the financial situation of the employee and administrative concerns of the Corporation.

   Should the employee fail to pay the employee portion of the group health insurance premium, LHC shall continue to submit the employee's portion under the following conditions:

   i) LHC shall pursue repayment of premiums upon the employee's return to duty, as allowed by the FMLA; and

   ii) Repayment shall be pursued from employees who do not return to duty unless the failure to return was due to the continuation, recurrence or onset of a serious health condition or other circumstance beyond the employee's control, all as provided under the Act.

C. **When Coverage Is Dropped:** LHC shall cease payment of the employee portion of health insurance premiums under the following circumstances:

   i) The employee informs the Corporation of his/her intent to not return from leave;

ii) The employee fails to return from leave, thereby terminating employment; or

iii) The employee exhausts his/her FMLA leave entitlement.

(NOTE): In some situations, the employee may be entitled to continue health care coverage under COBRA.

XII.
Certification to Return to Duty Following Leave for Employee's Own Serious Health Condition

As a condition of an employee's restoration upon return to duty from FMLA leave taken due to his/her own serious health condition, LHC requires that the employee produce written certification from a health care provider that the employee is able to return to duty and resume his/her customary duties. Return to duty certification forms can be obtained from the Human Resources Section.

XIII.
Other Laws

Employees may be entitled to leave, accommodation, etc. under other state and federal laws. The purpose of this policy is to apprise employees of their rights as they exist solely under the FMLA. Questions concerning this policy or other rights afforded by law not answered after reference to this policy should be addressed to the Human Resources Section.

End Notes

1. "Hours worked" does not include hours spent on paid or unpaid leave. "Hours worked" are determined according to the principles established under the Fair Labor Standards Act for determining compensable hours of work.

2. USERRA requires that the employee be credited with the hours of service that would have been performed but for the period of military service in determining whether he/she worked the required 1,250 hours.

3. The term 'essential functions" means the fundamental job duties of the employment position the individual with a disability holds or desires. A function may be essential because the reason the position exists is to perform that function; because of the limited number of employees available among whom the performance of that job can be distributed; and/or the function may be highly specialized so that the incumbent in the position is hired for his/her expertise or ability to perform the particular function.

4. Others capable of providing healthcare services include only: (1) Podiatrists, dentists, clinical psychologists, optometrists, chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray)

authorized to practice in the State and performing within the scope of their practice under State law; (2) Nurse practitioners, nurse-midwives and clinical social workers authorized to practice under State law and who are performing within the scope of their practice as defined under State law; (3) Christian Science practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts. Where an employee receives treatment from a Christian Science practitioner, he or she cannot object to LHC's requirement that the employee or family member submit to examination to obtain a second or third certification from a healthcare provider other than a Christian Science practitioner except as provided under applicable State or local law or collective bargaining agreement; (4) Any healthcare provider from whom an employer or the employer's group health plan's benefits manager will accept certification of the existence of a serious health condition to substantiate a claim for benefits; and (5) A healthcare provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is performing within the scope of his or her practice as defined under such law.

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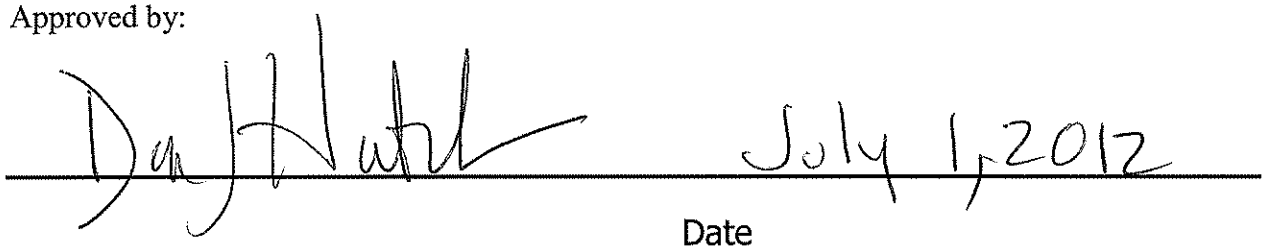
5. On occasion, it may be impossible for the employee to personally contact LHC regarding such leave requests. In such event, the employee's spokesperson must provide sufficient information and answer all inquiries necessary for a proper determination of whether the leave request is FMLA-qualifying.

6. A "reduced leave schedule" is a part-time work schedule whereby the employee regularly works less than a full-time schedule. Reduced leave schedules are most commonly utilized when an employee is ill or recovering from illness and cannot physically manage a full-time schedule.

Approved by:



July 1, 2012

Date

LOUISIANA HOUSING CORPORATION
FAMILY AND MEDICAL LEAVE ACT
PHYSICIAN'S CERTIFICATE TO RETURN TO DUTY

1. Employee's Name: _____ Date: _____

2. The Employee named above has been off from work due to a "Serious Health Condition" within the meaning of the Family and Medical Leave Act. The employee has requested to return to work. In regard to that request, please answer the following questions:

   A) Have you reviewed a written description of the essential functions of the employee's job prepared by the Louisiana Housing Corporation? ~~No~~ ~~Yes~~

   If "Yes" please go to "C" below.

   B) Has the employee described his position to you and related to you the essential functions of his/her position? _____No _____Yes

   If "Yes" please describe what essential functions were related to you: _____

   _____

   _____

   C) Based upon your examination of the employee, is he/she able, without accommodation, to perform all of the essential functions of his/her position? _____No _____Yes

   Is he/she released to return to full duty without restriction? _____No _____Yes

   If the answers to both subparts of "C" are "Yes", please sign this form where indicated below.

   If either answer is "No", please describe the essential functions of the employee's position he/she cannot perform and/or the restrictions you are placing on the employee's return to duty: _____

   _____

   Please state the duration of time any such restrictions and/or limitations will persist:

   _____

   Please describe the accommodation(s), if any, which would enable the employee to perform the essential functions of his/her position: _____

   _____

   _____
   Printed Name/Signature of Health Care Provider

   _____
   Type of Practice/Specialization Date

   _____
   Address Telephone Number

HRFMLA1

LOUISIANA HOUSING CORPORATION
FMLA CERTIFICATION OF HEALTH CARE PROVIDER
FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

SECTION I: For Completion by the EMPLOYER

Employer name: _____

Employer contact: _____ Telephone Number: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Is job description attached: _____ No _____ Yes

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits the employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. Your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. This form must be completed and returned within 15 calendar days.

Your name:

_____

First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's business address: _____

_____

Type of practice / Medical specialization: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ___No ___ Yes.

If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ____No _____Yes.

If so, state the nature of such treatments and expected duration of treatment: _____

_____

_____

2. Is the medical condition pregnancy? ___No ___Yes.

If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If a list of the employee's essential functions or a job description is not provided, answer these questions based upon the employee's own description of his/her job functions:

Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

If so, identify the job functions the employee is unable to perform: _____

_____

_____

_____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___ Yes.

If so, estimate the beginning and ending dates for the period of incapacity.

Beginning: _____ Ending: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?
_____No _____ Yes

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

_____

_____

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week, hours from _____ a.m./p.m. through _____ a.m./p.m.

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? _____No _____Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups? _____ No _____Yes. If so, explain:

_____

_____

_____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):
Frequency: _____ times per _____ week(s) _____ month(s).
Duration: _____ hours or ___ day(s) per episode.

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____
Signature of Health Care Provider

_____
Printed Name of Health Care Provider

_____
Date

HRFMLA4

LOUISIANA HOUSING CORPORATION
FMLA CERTIFICATION OF HEALTH CARE PROVIDER
FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION

SECTION I: For Completion by the EMPLOYER

Employer name: _____

Employer contact: _____ Telephone Number: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the **EMPLOYEE**: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits the employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. Your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. This completed form must be returned within 15 calendar days.

Your name:

_____

FIRST MIDDLE LAST

Name of family member for whom you will provide care: _____

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care.

_____

_____

_____ _____

Employee Signature Date

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and xamination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee will be providing care for your patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's business address: _____

Type of practice / Medical specialization: _____

Telephone:
(_____)_____Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of
condition:_____

Vas the patient admitted for an overnight stay in a hospital, hospice, or residential medical care ıacility? ___No ___ Yes.

If so, dates of admission: _____

Date(s) you treated the patient for condition:_____

Was medication, other than over-the-counter medication, prescribed? ___No _____Yes.

Will the patient need to have treatment visits at least twice per year due to the condition?

___No ___ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g.,

physical therapist)?_____ No _____Yes.

If so, state the nature of such treatments and expected duration of treatment:

_____

_____

Is the medical condition pregnancy? ___No ___Yes.

If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

Estimate the beginning and ending dates for the period of incapacity:

Beginning: _____ Ending: _____

During this time, will the patient need care? __ No __ Yes.

Explain the care needed by the patient and why such care is medically necessary:

_____

_____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

_____

_____

Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

Estimate the hours the patient needs care on an intermittent basis, if any: _____ hour(s) per day; _____ days per week, hours from ____ a.m./p.m. through _____ a.m./p.m.

Explain the care needed by the patient and why such care is medically necessary:

_____

_____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

Does the patient need care during these flare-ups? ____ No ____ Yes.

Explain the care needed by the patient, and why such care is medically necessary:

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

Signature of Health Care Provider Date

_____

Printed Name of Health Care Provider

HRFMLA2

LOUISIANA HOUSING CORPORATION
FAMILY AND MEDICAL LEAVE ACT
NOTICE OF ELIGIBILITY AND RIGHTS AND RESPONSIBILITIES

Part A - NOTICE OF ELIGIBILITY

TO: _____
Employee

FROM: _____
Employer Representative

DATE: _____

On _____, you informed us that you needed leave beginning

on _____for:

_____ The birth of a child, or placement of a child with you for adoption or foster care;

_____ Your own serious health condition;

_____ Because you are needed to care for your _____ spouse; _____child; _____ parent due to his/her serious health condition;

_____ Because of a qualifying exigency arising out of the fact that your _____ spouse; _____son or daughter; _____ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves;

_____ Because you are the _____ spouse; _____son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

_____ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

_____ Are not eligible for FMLA leave, because:

_____ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately ___ months towards this requirement.

_____ You have not met the FMLA's 1,250-hours-worked requirement.

If you have any questions, contact the Human Resources Division.

PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us in ifteen days or by _____.

If sufficient information is not provided in a timely manner, your FMLA leave request may be denied.

____ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request ____**is/**____ **is not** enclosed.

____ Sufficient documentation to establish the required relationship between you and your family member.

Other Information needed: _____

_____

_____

If your leave does qualify as FMLA leave, you will have the following responsibilities while on FMLA leave (only checked blanks apply):

____ Contact _____ at _____ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

____ You will be required to use your available paid _____ sick, _____ annual, and/or _____other leave during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

____ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work upon notice.

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave, you will have the following rights while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as a "rolling" 12-month period measured backward from the date of any FMLA leave usage.

- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on _____.

- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.

- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)

- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact Human Resources.

HRFMLA6

LOUISIANA HOUSING CORPORATION
FAMILY AND MEDICAL LEAVE ACT
DESIGNATION NOTICE

To: _____

Date: _____

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided.

We received your most recent information on and decided:

_____

_____ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

_____ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: _____

_____ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

_____ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

_____ We are requiring you to substitute or use paid leave during your FMLA leave.

_____ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ___ is ___ is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

Additional information is needed to determine if your FMLA leave request can be approved:

_____ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information within seven calendar days, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

_____

_____

(Specify information needed to make the certification complete and sufficient)

_____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

_____

_____ Your FMLA Leave request is Not Approved.

_____ The FMLA does not apply to your leave request.

_____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

_____

EMPLOYER REPRESENTATIVE DATE