

Human Resources Policy Bulletin

City of Lincoln

Number: 2009-1 Addendum

Date: April 2, 2020

Reference:	Title:
Families First Coronavirus Response Act Family and Medical Leave Act of 1993 (FMLA) and 29 C.F.R. Part 825	Expanded Family Medical Leave under the FFCRA

I. Purpose

To conform with the Families First Coronavirus Response Act and temporarily expand coverage of FMLA to a new category of leave related to COVID-19.

II. Coverage

This expansion will apply to employees who are unable to work or telework due to a need to care for a child under the age of 18 whose school or place of care has been closed due to COVID-19. Employees should apply using the modified FMLA application form.

III. Eligibility

This category of leave will apply to employees who have been employed for 30 calendar days and not eligible for TeleWork. Excluded from this policy are employees who are categorized as health care providers or emergency responders as defined by the DOL FFCRA Questions and Answers.

IV. Compensation

The first 10 days of FMLA under this addendum will be considered unpaid. The employee may use any accumulated leave time as allowed for by the City. Days 11 and forward will be paid at no less than 2/3 of the employee's regular rate of pay not to exceed \$200 per day and \$10,000 in the aggregate as required by law.

V. Limitations

Nothing in this addendum shall expand total FMLA entitlement beyond the original intent of 12 weeks of leave per the City's established 12-month period as defined in the Family Medical Leave Act of 1993.

VI. Expiration

This addendum to the FMLA will expire on 12-31-2020.


Douglas McDaniel
Human Resources Director

4-2-2020
Date


Leirion Gaylor Baird
Mayor

April 2, 2020
Date

CITY OF LINCOLN
APPLICATION FOR FAMILY OR MEDICAL LEAVE

Name of Employee: _____
(Please Print Legibly)

Last 4 Digits of Social Security Number: ___ XXX - XX - ___ ___ ___

Department: _____

Home Address: Street: _____

City: _____ State: _____ Zip: _____

Start Date of Anticipated Leave: _____

Expected Date of Return to Work: _____

Reason for Leave (Mark One):

_____ A serious health condition that renders me unable to perform the essential functions of my job; or

_____ A serious health condition affecting my ___ spouse, ___ child, or ___ parent for which I am needed to provide care; or

_____ The birth of a child, or the placement of a child with me for adoption or foster care.

_____ To care for a child under 18 years of age if the child's school or place of care has been closed, or the child care provider is unavailable due to a public health emergency with respect to the COVID-19 pandemic (only for the period April 1, 2020, through December 31, 2020)

Note: All leave requests must be accompanied by a verifying medical certification from a health care provider **except** for those leave requests to care for a child under 18 years of age if the child's school or place of care has been closed, or if the child care provider is unavailable due to a public health emergency with respect to the COVID-19 pandemic.

**I hereby authorize the City of Lincoln to contact my health care provider to verify the reason for my requested leave, or to authenticate and/or clarify any information contained in my medical certification statement concerning my requested family and medical leave.

**I understand that to maintain my health insurance benefits during this leave I must continue to pay my share of my health insurance as it comes due.

**I understand that failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by the Human Resources Director.

**The City's Paid Pandemic Leave; the Emergency Paid Sick Leave; and the Expanded Paid Emergency Family Medical Leave as provided by the Families First Coronavirus Response Act (FFCRA) are NOT compensation or wages for purposes of FICA withholding as defined by the Internal Revenue Code.

Accordingly, the pay received associated with these three paid leaves will not have accruals such as sick leave or vacation, but will apply toward retirement match or pension contributions.

Employee's Signature: _____ Date: _____

Approved By:

Department Head or Designee

Date

Human Resources Director

Date