Federal Medical Leave Act & WA Paid Family and Medical Leave

Family member intake form

KAISER PERMANENTE®

Patient information

Name: _____ Kaiser Permanente number: _____

Date of birth: _____ Today's date: _____

Family member information

Family member name:

_____

Family member's phone:

_____

The patient is the family member's:

- ☐ Spouse
- ☐ Parent
- ☐ Minor child
- ☐ Adult child

Describe the care provided by the family member and estimated duration:

- ☐ Assistance with basic needs
- ☐ Transportation
- ☐ Physical care
- ☐ Psychological comfort
- ☐ Other:

_____

Estimated amount of leave needed to provide care:

_____

Delivery method/recipient

☐ Secure member account on kp.org/wa

☐ In person pick up ☐ Self ☐ 3rd party: _____

☐ Fax Attention: _____ Fax number: _____

☐ Mail ☐ Self ☐ 3rd party: Mail to: _____

Address: _____

City: _____ State: _____ ZIP: _____

About your condition

Your Kaiser Permanente clinician's name: _____

Where are you seen for this condition? _____

Provide a brief description of the condition, injury or diagnosis: _____

Approximate start date of condition:_____ Estimation of condition's duration: _____

Request type

Which documents are you requesting? ☐ FMLA ☐ WA PFML

Have you been seen for this condition at least twice in the last year? ☐ Yes ☐ No (schedule an office visit)

Work status history

Family member's employer name: _____

Type of leave

☐ **In patient care** (hospitalization, hospice, or residential care)
Overnight stays on: _____(m/d/yy)

☐ **Incapacity plus treatment** You were incapacitated for more than three consecutive, full calendar days
Start Date: _____ End Date: _____
When were you seen for treatments?_____
☐ Has continuing treatment ☐ Doesn't have continuing treatment

☐ **Pregnancy** Expected delivery date: _____

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☐ **Chronic conditions (e.g., asthma, migraine headaches)** Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or long term conditions: (e.g., Alzheimer's, terminal stages of cancer)** 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)

☐ **Conditions requiring multiple treatments: (e.g., chemotherapy treatments, restorative surgery)** Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above** If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed.

Leave information

☐ Planned treatment Dates: _____

☐ Referral information Start date: _____ End date: _____

Referred treatment: _____

Estimated duration of treatment: _____

Estimated leave

☐ **Continuous incapacity**
(A continuous period you're unable to work)

Start Date: _____

End Date: _____

☐ **Intermittent incapacity**
(Condition causes occasional flare-ups)

Estimate frequency and duration of flare-ups over the next 6 months:

Frequency: _____ episode(s) per

- ☐ day
- ☐ week
- ☐ month

Lasting: _____

- ☐ hour(s) per episode
- ☐ day(s) per episode

☐ **Reduced schedule**
Reduced work hours:

Start Date: _____

End Date: _____

_____ # hour(s) per day

_____ # day(s) per week

Please note Certified time off is based on medical need and may be different than the time requested.

Forms Processing Acknowledgment

- This acknowledgment must be signed by the patient, parent, legal guardian, or person with legal power of attorney prior to the completed form being picked up, mailed, or faxed.
- Kaiser Permanente Washington requires up to **fifteen (15) calendar days** for processing all forms.
- This form complies with 45 CFR 164.524 (c) 3 (also known as HITECH Act)

I have read, understand, and agree to the above forms processing acknowledgment statements.

_____ _____

Signature of patient, parent, legal guardian, or person with legal power of attorney Date