

Ohio Department of Medicaid
NOTICE OF ELIGIBILITY AND RIGHTS AND RESPONSIBILITIES
FAMILY MEDICAL LEAVE ACT

(Employee Name)
(Address)
(City, State, Zip)

(Date)

PART A – NOTICE OF ELIGIBILITY

On (insert date here) we were informed that you need leave beginning on (insert date here or undetermined) for:

- The birth of your child, or placement of a child with you for adoption or foster care;
- Your own serious health condition, which renders you unable to perform the essential functions of your job;
- The serious health condition of your spouse; child; parent for which you are required to provide care.
- 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.
- A serious illness or injury to a covered service member who is your spouse; son or daughter; parent; next of kin.

This notice is to inform that you:

- Are eligible for FMLA leave (see part B 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 the requested leave, you will have worked approximately _____ months towards this requirement.
 - You have not met the FMLA's 1,250 hours worked requirement.
 - You have exhausted your FMLA entitlement in the applicable 12 month period.
- Other, (insert here, untimely certification etc.)

If you have questions, please contact (insert analyst name here) at (insert analyst phone number here) or view the FMLA poster located online at <http://innerweb.odjfs.state.oh.us/oeps/WellnessManagement.stm>.

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 by (insert day here must be 15 calendar days after leave commences).** If sufficient information is not provided in a timely manner, your leave may be denied.

Please return:

- Sufficient FMLA certification to support your request for FMLA leave. The 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 (insert information here, disability application, military papers, guardianship etc).
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If your leave qualifies as FMLA leave, you will have the following responsibilities while on FMLA leave:

- Contact Payroll/Benefits at 614-995-1174 to make arrangements to continue to make your share of premium payments on your health insurance in order 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 premium during FMLA leave, and recover these payments from you upon your return to work.
- You will be required to use your available paid leave during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA and counted against your FMLA entitlement.
- While on leave, you will be required to furnish us with periodic reports of your status and intent to return to work every (indicate interval of reports, as appropriate for the leave situation).

If the circumstances of your leave change and you are able to return to work earlier than the date originally indicated, you will be required to notify us at least two work days prior to the date you intend to return to work.

If your leave qualifies 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 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 service member with a serious injury or illness.

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 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 service member’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 your FMLA leave.

Once we obtain information from you as specified above, we will inform you, within five business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have questions, please contact (insert analyst name here) at (insert analyst phone number here).