

How to Apply for Intermittent Paid Family Leave to Care for an Ill Family Member in California

LEGAL
AID AT
WORK

Most workers in California are eligible for 8 weeks of Paid Family Leave (PFL) benefits each year while they take time away from work to:



- Care for a seriously ill family member,
- Bond with a new child, or
- Address needs related to a family member's overseas military deployment.

You can take your PFL benefits all at once or intermittently. "Intermittent leave" means instead of taking all 8 weeks of PFL benefits at one time, you take your leave in smaller amounts of time or you reduce your regular schedule to work less while you are caring for a loved one. For example, one way to take intermittent leave is to reduce your schedule by taking Fridays off to care for a spouse after chemotherapy treatments. Another way to take intermittent leave is to take a few weeks off to care for a parent recovering from surgery, and then to take one day per week for several months to take your parent to follow-up physical therapy appointments.

This guide gives step-by-step instructions for how you can apply for and receive intermittent Paid Family Leave to care for a seriously ill family member in California. Paid Family Leave does not protect your job, but many workers are eligible for job-protected leave under the California Family Rights Act, including intermittent or reduced-schedule leave. For more information about Paid Family Leave for family caregivers, see [FAQs about Paid Family Leave to Care for a Seriously Ill Family Member](#).

STEPS TO APPLYING FOR INTERMITTENT CAREGIVER PAID FAMILY LEAVE



Submit Form [DE 2501F](#) Claim for Paid Family Leave (PFL) Benefits, informing the EDD that you plan to use your benefits intermittently. You can apply for PFL [online or by mail](#). To view a tutorial on how to apply for PFL online, visit [SDI Online Tutorial: File a Paid Family Leave Claim](#). To order the paper claim form (DE 2501F) or view a sample claim form, visit [Paid Family Leave – Forms and Publications](#). Undocumented workers should apply using a paper application. See [Undocumented Workers' Guide to Applying for California Disability Insurance and Paid Family Leave](#). Your family member's health care provider will need to provide a medical certification.

IF APPLYING ONLINE (VIA SDI ONLINE):

- Complete the questions in Section 3 – Additional Questions.
- For "Date you last worked" enter the last day you worked your regular schedule before you reduced your hours or took time off to care for your family member.

STEP 1 CONTINUED

- For “Date you want your Paid Family Leave claim to begin,” enter the first day you reduced your hours or took time off to care for your family member.
- Answer **No** to “Do you want to claim the maximum amount of benefit weeks now?”
- Enter the date you want to be paid through (the last day you reduced your work schedule to care). If you don’t know yet, you can leave this blank.
- Enter the date you returned to work, or the date you plan to return to your regular schedule after your leave. If you don’t know yet when you will return, leave this question blank.
- Answer **Yes** to “Will you work at any time during your family leave?”
- Select type of pay you will receive from your employer during your leave. (E.g. enter “part-time.”)

Additional Questions

Personal Information Employment Information **3 Additional Questions** 4 Bonding Certification 5 Declaration

You are currently on Step 3 Additional Questions

*Indicates Required Field

Section 7 - Additional Questions

*Date you last worked: (MMDDYYYY)

The date you want your Paid Family Leave claim to begin should not be before the child's date of birth (or the Date of foster care or adoption placement).

*Date you want your Paid Family Leave claim to begin: (MMDDYYYY)

*Do you want to claim the maximum amount of benefit weeks now? Yes No

If "No," enter the date you want to be paid through: (MMDDYYYY)

Date you returned to work: (MMDDYYYY)

Or date you plan to return to work: (MMDDYYYY)

*Will you work at any time during your family leave? Yes No

If you will receive any type of pay from your employer(s) during your family leave, indicate type of pay:

Sick
 Employer Required Vacation
 Other Type of Pay

Specify if "Other type of pay": Select

*At any time during your Paid Family Leave, were you in the custody of law enforcement authorities because you were convicted of violating a law or ordinance? Yes No


*Have you claimed or do you plan to claim Workers' Compensation Benefits for any portion of the period covered by this claim? Yes No

Previous Cancel Save as Draft **Next**

IF APPLYING WITH THE PAPER FORM:

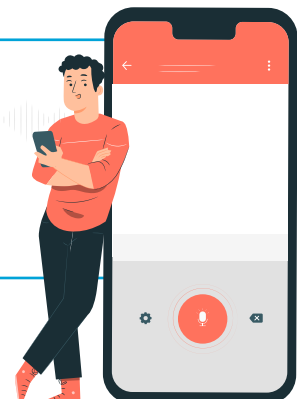
- For question A10, “Date you last worked,” write the last day you worked your regular schedule before you reduced your hours or took time off to care for your family member.
- For question A11, “Date you want your PFL claim to begin,” write the first day you reduced your hours or took time off to care for your family member.
- For question A12, enter the date you returned or will return to your regular schedule. If you don’t know yet when you will return to your regular schedule, leave this question blank.

- Answer **Yes** to question A13 “Did you work or will you continue to work during your family leave period?”
- For Question A22, “If your employer(s) continued or will continue to pay you during your family leave, indicate type of pay,” write in “Part-Time.”

 Employment Development Department State of California		Claim for Paid Family Leave (PFL) Benefits	
PART A – STATEMENT OF CLAIMANT (CARE, BONDING, or MILITARY ASSIST PROVIDER)			
A1. YOUR SOCIAL SECURITY NO. 0 0 0 0 0 0 0 0 0 0		A2. YOUR DATE OF BIRTH M M D D Y Y Y Y 0 1 0 1 1 9 0 0	
A3. LANGUAGE YOU PREFER TO USE ENGLISH ESPAÑOL OTHER (PRINT BELOW) X			
A4. YOUR LEGAL NAME FIRST NAME MI LAST NAME S A M P L E C L A I M A N T			A5. YOUR GENDER MALE FEMALE X
A6. YOUR TELEPHONE NUMBER 9 9 9 0 2 3 6 7 8 9		A7. OTHER LAST NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED	
A8. YOUR MAILING ADDRESS (TO RECEIVE MAIL AT A PRIVATE MAIL BOX—NOT A US POSTAL SERVICE BOX—YOU MUST SHOW THE NUMBER IN THE “PMB#” SPACE) PMB# (IF APPLICABLE) 1 2 3 A N Y S T R E E T C I T Y S T A T E / P R O V . Z I P O R P O S T A L C O D E C O U N T R Y (I F N O T U . S . A .) A N Y T O W N C A 1 2 3 4 5			
A9. NAME OF YOUR EMPLOYER R O A D R U N N E R P A S T R I E S C I T Y S T A T E / P R O V . Z I P O R P O S T A L C O D E E M P L O Y E R ' S P H O N E N U M B E R A N Y W H E R E C A 6 6 2 2 2 4 9 9 3 1 1 1 1 1 1		MAILING ADDRESS 6 4 7 A R M I S T I C E W A Y	
A10. DATE YOU LAST WORKED M M D D Y Y Y Y 1 2 0 1 2 0 1 5	A11. DATE YOU WANT YOUR PFL CLAIM TO BEGIN M M D D Y Y Y Y 1 2 1 6 2 0 1 5	A12. DATE YOU RETURNED OR WILL RETURN TO WORK M M D D Y Y Y Y 0 1 2 7 2 0 1 6	A13. DID YOU WORK or WILL YOU CONTINUE TO WORK DURING YOUR FAMILY LEAVE PERIOD? NO YES X
A14. WHY DID YOU or WILL YOU REDUCE YOUR WORK HOURS OR STOP WORKING? CARE FOR FAMILY MEMBER BOND WITH CHILD MILITARY ASSIST OTHER (EXPLAIN) X		A15. WHAT IS YOUR OCCUPATION? P A S T R Y C H E F	
A16. SELECT YOUR PREFERRED PAYMENT METHOD <input type="checkbox"/> EDD DEBIT CARD SM <input type="checkbox"/> CHECK			
A17. LEGAL NAME OF CARE, BONDING, OR MILITARY ASSIST RECIPIENT (FIRST / MIDDLE INITIAL / LAST) C O O K I E A C L A I M A N T			
A18. THE ABOVE-NAMED CARE, BONDING, OR MILITARY ASSIST RECIPIENT IS YOUR: CHILD SPOUSE PARTNER REGISTERED DOMESTIC PARENT IN-LAW GRAND PARENT GRAND CHILD SIBLING OTHER (EXPLAIN) X			



Wait for phone call from the EDD to review details of your intermittent leave. Explain the schedule you are planning for your leave.



STEP



Wait for the EDD to send you Form DE 2580GF *Continued Claim Certification for Paid Family Leave*, and then fill it out and **return it by U.S. mail**, listing the days and hours you worked and how much you earned on those days. (See example below of a completed form showing a two-week period of reduced schedule leave.) The EDD will continue to send you these forms every two weeks during your leave, and you should fill out and return each form within 20 days of receiving them.



***NOTE:** The EDD will send you continuing claim certification forms by mail even if you applied for benefits online.



Continued Claim Certification For Paid Family Leave Benefits

For Office Use Only: _____

CED: _____

Mailing Date: _____

Important: No check can be issued until you complete, sign, date, and return this form on _____ (due date). If this date is past, please complete, sign, date, and return this form immediately.

You may lose benefits if this form is not mailed within 20 days starting on the due date OR 20 days after the day you received this form, if the due date is passed.

In order to pay you Paid Family Leave benefits for the period from 1/1/23 through 3/31/23, we need the following information:

- Did you provide family care during the period shown above? Yes No
If no, enter the date you stopped providing family care and explain why you stopped: _____
- Did you work or earn any wages during the period shown above? Yes No
If yes, did you work part-time or full-time? full-time part-time - please respond to the questions below
- Gross salary (before deductions including tips but excluding overtime) for the last full week you worked before your PFL began: (if you have more than one employer, please provide salary information for each employer on the back of this form including your name and Social Security number). _____ \$ 800

4. Date you began part-time work or work at less than full pay: 1/1/23 5. Number of hours you usually worked per week before your PFL began: 40

Date Worked	No. of Hours Worked	Gross Amount Earned	Date Worked	No. of Hours Worked	Gross Amount Earned
1/1/23	8	\$160	1/8/23	8	\$160
1/2/23	8	\$160	1/9/23	8	\$160
1/3/23	8	\$160	1/10/23	8	\$160
			1/11/23	8	\$160
			1/12/23	8	\$160

If you have received or expect to receive other types of payments (i.e., sick leave, vacation, pension pay, a loan, a gift, workers' compensation benefits, military reserve or National Guard pay) during the above period, show type and amount of payment(s), the period(s) covered by the payment(s), and the payer name(s) and telephone number(s). (Use the back of this form if you need more space. Include your name and Social Security number).

- Was anyone else available to provide care during the period shown above? Yes No
If yes, please explain: _____

I have reported on this form all money and wages I have received or will receive for the above certification period. My answers are true to the best of my knowledge.

Signature: _____ Date: _____

If your address and/or telephone number has changed, please enter the new information below.

No., Street and Apt. No., or PO Box	City	State	ZIP	Phone ()
-------------------------------------	------	-------	-----	-----------

If you have questions regarding this form, please call 1-877-238-4373 between the hours of 8:00 a.m. and 5:00 p.m.

PENALTIES: California Unemployment Insurance Code provides for penalties of fine, imprisonment, and loss of benefit rights for fraud against the Employment Development Department.

Versión en español adjunta

STEP 4

Receive your benefits via debit card or check.



- Payments are 60 to 70 percent of the wages you earned during the quarter in which you earned the most in the 5 to 18 months before the start date of your claim.
- *NOTE: Beginning in 2025, benefit rates will increase to 90 percent for low-to-middle income workers and 70 percent for higher earners.
- To calculate your weekly benefit amount, visit EDD's Benefits Calculator.
- For intermittent leave, the EDD will subtract what you are earning from your job on an intermittent schedule from what you were earning before you began your leave. The difference is your wage loss. If your wage loss is more than your weekly benefit amount (see [Benefits Calculator](#)), the EDD will pay you your full weekly benefit amount. If your wage loss is less than your weekly benefit amount, the EDD will pay you only the amount of your wage loss.

STEP 5

End your PFL period or certify to extend your PFL if you have remaining benefits.



- A *Notice of Final Payment* (DE 2525XF) will be issued with your final payment when your PFL claim indicates that you are now ready to return to work. EDD will also send you a *Paid Family Leave (PFL) Supplemental Claim Certification* (DE 2525XFA) with the *Notice of Final Payment* (DE 2525XF).
- If you still have benefits available and need to continue providing care for a family member, select the box that applies to your claim on the PFL Claimant's Certification section of the DE 2525XFA and have the care recipient's Licensed Health Professional complete the Physician's Supplementary Certificate section of the DE 2525XFA. Once completed, return this form to EDD.
- If you misplaced the DE 2525XFA, request the form using [AskEDD](#) or by calling 1-877-238-4373.
- If you use less than the full 8 weeks of benefits, and return to your regular schedule and then want to restart your claim later to use your remaining weeks, you must submit a new *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F).

- You must notify the EDD to stop your benefits if any of the following happens during your PFL period:
 - You return to work full-time.
 - The care recipient recovers from their illness or injury.
 - The care recipient dies.
- To stop benefits, complete the time card and note that you took no leave and want to return to work fully. Alternatively, visit AskEDD and follow these steps to send a message to EDD:
 - For category, select **Paid Family Leave**.
 - For sub-category, select **Miscellaneous Inquiry**.
 - For topic, select **Other (Questions)**. Select **Continue**, complete the electronic form, and note in the Additional Information box when you want your benefits to stop/when you returned or will return to work.

***NOTE:** If you already applied for 8 weeks of continuous PFL, but want to switch to intermittent leave, contact EDD in one of the following ways:

- Call **1-877-238-4373**
- Send a letter to:
Paid Family Leave Customer Service Center
PO Box 45011
Fresno, CA 93718-5011
- Visit [AskEDD](#) and follow these steps:
 - For category, select **Paid Family Leave**.
 - For sub-category, select **Miscellaneous Inquiry**.
 - For topic, select **Other (Questions)**.
 - Select **Continue**, complete the electronic form, stating in the Additional Information box that you want to switch to intermittent leave and noting your leave schedule, and select **Submit**.



Have Questions or Want More Information?

If you have questions about this fact sheet or your rights at work, contact Legal Aid at Work on our Work and Family Helpline: (800) 880-8047 or visit us online at legalaidatwork.org/wf.

**LEGAL
AID AT
WORK**

© 2023 Legal Aid at Work Created with the support of AARP Foundation. Legal Aid at Work cannot ensure this information is current or be responsible for any use to which it is put.

AARP Foundation
For a future without senior poverty.