FAMILY AND MEDICAL LEAVE

NOTICE OF ELIGIBILITY AND RIGHTS & RESPONSIBILITIES

SECTION I – FOR COMPLETION BY HARRIS COUNTY

In general, to be eligible to take leave under the Family and Medical Leave Act (FMLA), an employee must have worked for Harris County for at least 12 months and has at least 1,250 hours of service during the 12-month period immediately preceding the leave. A fully completed 455B provides employees with the information required by 29 C.F.R. §§ 825.300(b), (c) which must be provided within five business days of the employee notifying the department of the need for FMLA leave.

Date:_____*(mm/dd/yyyy)*

From:_____*(Harris County)* To:_____*(Employee)*

On_____*(mm/dd/yyyy)*, we learned that you need leave *(beginning on)*_____*(mm/dd/yyyy)* for one of the following reasons: *(Select as appropriate)*

☐ The birth of a child, or placement of a child with you for adoption or foster care, and to bond with the newborn or newly-placed child

☐ Your own serious health condition

☐ You are needed to care for your family member due to a serious health condition. Your family member is your:

☐ Spouse ☐ Parent ☐ Child under age 18 ☐ Child 18 years or older and incapable of self-care because of a mental or physical disability

☐ A qualifying exigency arising out of the fact that your family member is on covered active duty or has been notified of an impending call or order to covered active duty status. Your family member on covered active duty is your:

☐ Spouse ☐ Parent ☐ Child of any age

☐ You are needed to care for your family member who is a covered servicemember with a serious injury or illness. You are the servicemember's:

☐ Spouse ☐ Parent ☐ Child ☐ Next of kin

SECTION II – FOR COMPLETION BY HARRIS COUNTY

PART A: NOTICE OF ELIGIBILITY
This Notice is to inform you that you are:

☐ **Eligible** for FMLA leave. *(See Part B for information on your Rights and Responsibilities.)*

☐ **Not eligible** for FMLA leave because: *(Only one reason need be checked)*

☐ 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:_____towards this requirement.
(months)

☐ You have not met the FMLA's 1,250 hours of service requirement. As of the first date of requested leave, you will have worked approximately:_____towards this requirement.
(hours of service)

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

PART B: NOTICE OF RIGHTS AND RESPONSIBILITIES

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, ELIGIBILITY DOES NOT MEAN YOUR LEAVE IS DESIGNATED. In order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by** _____*(mm/dd/yyyy).* (If a certification is requested, employees must be given least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) It is your responsibility to furnish all information required to determine whether your leave qualifies for protections under FMLA. If sufficient information is not provided in a timely manner, your leave may be denied.

SECTION II CONTINUED – FOR COMPLETION BY HARRIS COUNTY

(Select as appropriate)

☐ No additional information requested. If no additional information requested, go to page 3.

☐ We request that the leave be supported by a certification, as identified below.

☐ Health Care Provider for the Employee ☐ Health Care Provider for the Employee's Family Member

☐ Qualifying Exigency ☐ Serious Illness or Injury (Military Caregiver Leave)

Selected certification form is ☐ attached ☐ not attached

If requested, medical certification must be returned by_____*(mm/dd/yyyy) (Must allow at least 15 calendar days from the date the employee was requested to provide certification, unless it is not feasible despite the employee's diligent, good faith efforts.)*

☐ We request that you provide reasonable documentation or a statement to establish the relationship between you and your family member, including in loco parentis relationships (The in loco parentis relationship exists when an individual intends to take on the role of a parent to a child who is under 18 or 18 years of age or older and incapable of self-care because of a mental or physical disability). The information requested must be returned to us by (mm/dd/yyyy). You may choose to provide a simple statement of the relationship or provide documentation such as a child's birth certificate, a court document, or documents regarding foster care or adoption-related activities. Official documents submitted for this purpose will be returned to you after examination.

☐ Other information needed (e.g. documentation for military family leave):_____. The information requested must be returned to us by _____ (mm/dd/yyyy).

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 the calendar year (January-December).
- 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.

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

☐ Decide whether you want to continue benefits coverage for any period of unpaid FMLA leave. See County Auditor's Form 459, *Family and Medical Leave Insurance Coverage Statement for Continuous Unpaid FMLA*. You are responsible for your share of the premium payments on your health insurance while you are on unpaid 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 canceled, 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 ☐ compensatory time, ☐ sick leave, ☐ vacation 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. (If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.) As a reminder, you may not take sick leave if the leave is for a family member's serious medical condition, but you may use available family sick leave, as applicable.

☐ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every _____(frequency such as week or month). You must make oral contact with _____(name of person) at _____(phone no./address) every _____ (must be filled in, day of week and frequency, i.e., "first Friday of the month" or "other Monday". **(If continuous leave, you may leave blank.)**

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

SECTION II CONTINUED – FOR COMPLETION BY HARRIS COUNTY

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 an questions, please do not hesitate to contact:

_____ at _____

(name of person) phone # or address, as appropriate)

I acknowledge receipt of the FMLA Notice of Eligibility and Rights & Responsibilities. I understand the Rights & Responsibilities as they have been explained herein.

_____ _____

Employee Signature Date

_____ _____

Human Resources Representative Date