**CFRA Denial Notification - Not Eligible – ADA/FEHA Conditional Designation (CAA2304)**

Send Certified And Regular Mail

Certification # \_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE

NAME

ADDRESS

Dear NAME:

COMPANY received information on DATE, indicating your request for leave under the California Family Right Act (CFRA) medical leaves.

This letter will serve to inform you that you are **not** eligible for CFRA leave because:

You have not met the CFRA’s 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately \_\_\_ months towards this requirement. \*

You have not met the CFRA’s 1,250-hours-worked requirement.\*

You do not work and/or report to a site with 50 or more employees within 75-miles.

\*Please note, in the future, if you successfully meet the 12-month worked service requirement and the 1250-hour per year worked requirement your eligibility can be re-evaluated. Please do not hesitate to request leave at that time. Refer to the CFRA policy guidelines for specific leave request requirements.

At this time:

You have [NUMBER OF HOURS/DAYS] available of accrued unused PTO/Vacation/Sick

OR

You do not have any PTO/Vacation/Sick available, and your current leave is unpaid.

Per COMPANY policy, you must use/may use PTO, sick and/or vacation prior to eligibility for an unpaid leave of absence [VERIFY]. If you are eligible for state disability insurance (SDI), and elect to use PTO, sick and/or vacation, your pay will be coordinated so that your SDI and PTO, sick and/or vacation leave payments do not exceed your normal rate of pay. Information about State Disability Insurance (SDI) benefits is enclosed with this letter. It is your responsibility to apply for such benefits through the local Employment Development Department (EDD).

If you are currently enrolled in healthcare benefits, and you are in an unpaid leave of absence, your benefits will end the first day of the month following the month in which the unpaid leave begins. COBRA information will follow under a separate cover at that time. [DELETE IF NOT APPLICABLE]

At this time, there are / there are no other options available to you under COMPANY’s policies. [BE SPECIFIC and SPELL OUT WHAT IS AVAILABLE OR WHAT THEY HAVE ALREADY UTILIZED]

**Although your benefits have been denied under the CFRA, you may be eligible for protection under the Americans with Disabilities Act (ADA) and the Fair Employment and Housing Act (FEHA). As a means of providing you full opportunity for protection under state and federal regulations, we are temporarily designating your leave as an ADA/FEHA leave accommodation, pending confirmation of your eligibility as a qualified individual with a disability.**

If you are either:

* Requesting the opportunity to continue a temporary leave of absences with the intention of returning to work at a designated date, as confirmed by your treating physician, or
* Requesting an accommodation which would allow you to perform the essential functions of your current job or an alternative position,

COMPANY requires additional documentation be provided to this office to determine your eligibility status as a qualified individual with a disability. Please have your health care provider use the enclosed job description in completing the enclosed FEHA/ADA - Essential Job Function Analysis - Health Care Provider Evaluation Form. We have scheduled a second Good Faith Interactive meeting with you, NAME, TITLE, COMPANY and [NAME OF ANY OTHERS ATTENDING THE MEETING], to discuss the ADA and FEHA eligibility and accommodation issues on:

Date and Time – DATE & TIME [15 CALENDAR DAYS FROM THE DATE OF THIS NOTICE]

Location – ADDRESS

Contact Phone – NAME, TITLE, PHONE NUMBER

Upon receipt of this letter, it is your responsibility to confirm your appointment time. You may return the FEHA/ADA Essential Function Job Analysis - Health Care Provider Form on or before the scheduled Good Faith Meeting.

Remember that if you are absent because of your own illness or injury, you must provide COMPANY with a Certification of Health Care Provider for Employee Return to Work (RTW) form when you return to work (see enclosed).

Name: NAME AND TITLE

Phone: CONTACT INFORMATION

Enclosures:

SDI Pamphlet

FEHA/ADA - Essential Job Function Analysis, Health Care Provider Evaluation

Certification of Health Care Provider for Employee to Return to Work Form

Job Description [Title of Job Description]

Authorization for Release of Medical Information