MEPSL PCA/WORKER Payment Voucher

Please complete this form if you are requesting paid sick leave under the Massachusetts Emergency Paid Sick Leave (MEPSL) program.

Payroll Period From: __ __ / __ __ / __ __ To: __ __ / __ __ / __ __

Consumer #: __ __ __ __ __ __ Telephone #: ____________________

Consumer Name (Print): ______________________________

PCA Name (Print): ______________________________

PCA Telephone #: ______________________________

PCA Last 4 Digits of SSN __ __ __ __ Unique ID: ______________

Week 1	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Weekly Total
Hours of Sick Time Requested:								

Week 2	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Weekly Total
Hours of Sick Time Requested:								

Note: Each payroll period runs for 2 weeks. Payroll periods always start on a Sunday at 12:00 AM (not Noon) and run through the second Saturday at 11:59 PM. Please check your payroll schedule for dates. **Only record the hours you were scheduled to work but instead are requesting Emergency Paid Sick Leave**. You may be eligible for Emergency Paid Sick Leave up to the average number of hours you have worked per week in the past six months, but not to exceed 40 hours.

Enter the total hours of sick time you are requesting for each day in the boxes above. Once complete, add up the daily totals for each week and enter the total weekly hours being requested. You do not need to record in and out times. Check with your Consumer if you have questions about the number of hours you were scheduled. A separate form needs to be submitted for each qualifying reason. Some qualifying reasons require you to provide additional information in the space below; this form will not be processed without all required information.

Reason for Request

I would like to request Emergency Paid Sick Leave for the following reason (**check the one that applies**):

☐ **I need to**:

- self-isolate and care for myself because I have been diagnosed with COVID-19;
- get a medical diagnosis, care, or treatment for COVID-19 symptoms; or
- get or recover from a COVID-19 immunization.

☐ **I need to care for a family member who**:

- must self-isolate due to a COVID-19 diagnosis;
- needs medical diagnosis, care, or treatment for COVID-19 symptoms; or
- needs to obtain or recover from a COVID-19 immunization

☐ **I am subject to a quarantine order or similar determination by a local, state, or federal public official, a health authority having jurisdiction, my employer, or a health care provider**. Please fill out the required information below:

Name of governmental entity, employer, or health care provider ordering or advising self-quarantine:

☐ **I need to care for a family member due to a quarantine order or similar determination regarding the family member by a local, state, or federal public official, a health authority having jurisdiction, the family member's employer, or a health care provider.** Please fill out the required information below:

Name of governmental entity, employer, or health care provider ordering or advising self-quarantine:

Name of person subject to quarantine, and relationship to person (such as spouse, parent, etc.):

PCA Signature and Attestation

By signing below, I attest that I am qualified for COVID-19 Sick Leave for the reason selected above and that, because of this reason, I am unable to work.
By signing below, I certify under pain and penalty of perjury that information supplied in this voucher is true.

PCA Signature: ____ **Date: ____________________**