Champions of Homecare

Minnesota Paid Leave Notice- Accra Homecare

Minnesota Paid Leave provides payments and job protections when you need time off to care for yourself and your family. This includes:

- Medical leave to provide for your own serious health conditions, including care related to pregnancy, childbirth, and recovery
- Family leave including to care for a bond with a new child, to care for a family member with a serious health condition, to support a family member called to active duty, or to respond to issues related to domestic violence, sexual assault or stalking

Generally, conditions must last more than 7 days, and be certified by a healthcare provider or professional.

For a full list of covered reasons, and more information on how to apply, please visit Minnesota Paid Leave / Minnesota Paid Leave

Employees must apply for this leave through the State of Minnesota's website. Accra does not approve leave or issue payments. The State of Minnesota will require Accra to provide information related to the leave, and report any wages earned, including Paid Time Off or Sick and Safe Time payments.

It is your responsibility to inform your Responsible Party of your time away from work, with as much notice as is practical. Your Responsible Party is responsible for arranging care during your absence.

Employee Name: _____ Employee ID: _____

Medical Leave (care for yourself) ☐

Family Leave (Care for a family member) ☐

Provide a brief reason for the leave:

_____

_____

Anticipated Start Date of Leave: _____

Anticipated End Date of Leave: _____

Please check this box if you will be taking intermittent leave (not all at once) ☐

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What is your anticipated schedule of intermittent leave:

_____

_____

By signing below, I am verifying that:

- I have informed my Responsible Party of the dates I need to take leave
- I will apply for these benefits through the State of Minnesota's website at mn.deed.gov/paidleave
- I will inform Accra's Benefits team when I return from my leave. I will report any changes in my dates of leave to Accra's Benefits Team as soon as I am aware.

Employee Signature: _____ Date Signed: _____

Responsible Party Name: _____ Client Name: _____

Responsible Party Signature: _____ Date Signed: _____

Once signed, please return to employeebenefits@accracare.org