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EMPLOYMENT DEPARTMENT

FILING CAPTION: Amending and adopting Paid Leave appeals, assistance grants, benefits, and equivalent plans rules

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RULES:
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AMEND: 471-070-1000

RULE TITLE: Benefits: Definitions

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule is being amended to align with changes to health care provider titles made by HB 4010 and HB 4130 during the 2024 legislative session, and to update the definitions for ‘Workday’ and ‘Work week’ to align with 471-070-1040, which provides clarity regarding the calculations of these work periods.

RULE TEXT:
(1) “Affinity,” as the term is used in ORS 657B.010, means a relationship that meets the following requirements:
(a) There is a significant personal bond that, when examined under the totality of the circumstances, is like a family relationship, and;
(b) The bond under section (a) of this rule may be demonstrated by, but is not limited to, the following factors, with no single factor being determinative:
(A) Shared personal financial responsibility, including shared leases, common ownership of real or personal property, joint liability for bills, or beneficiary designations;
(B) Emergency contact designation of the claimant by the other individual in the relationship, or vice versa;
(C) The expectation to provide care because of the relationship or the prior provision of care;
(D) Cohabitation and its duration and purpose;
(E) Geographical proximity; and
(F) Other factors that demonstrate the existence of a family-like relationship.
(2) “Application” means the process in which an individual submits the required information and documentation described in OAR 471-070-1100 to request benefits for a period of leave. Approval of an application establishes a claim.
(3) “Average weekly wage” means the amount calculated by the department as the state average weekly covered wage

under ORS 657.150 (4)(e) as determined not more than once per year. The average weekly wage is:
(a) Set for each fiscal year beginning July 1 and ending June 30 of the following year;
(b) Applied for the calculation of weekly benefit amounts starting the first full week following July 1;
(c) Applied for the entire benefit year after a new benefit year is established, even if the average weekly wage amount changes when the new fiscal year begins.
(4) "Benefit year" means a period of 52 consecutive weeks beginning on the Sunday immediately preceding the day that family, medical, or safe leave commences for the claimant, except that the benefit year shall be 53 weeks if a 52-week benefit year would result in an overlap of any quarter of the base year of a previously filed valid claim. A claimant may only have one valid benefit year at a time.
(5) "Bias," as the term is used for a safe leave purpose described in ORS 659A.272, means a bias crime as defined in ORS 147.380.
(6) "Calendar quarter" means the period of three consecutive calendar months ending on March 31, June 30, September 30, or December 31.
(7) "Care," as the term is used in ORS 657B.010(17)(a)(B), means physical or psychological assistance as used for leave taken to care for a family member with a serious health condition.
(a) "Physical assistance" means assistance attending to a family member's basic medical, activities of daily living, safety, or nutritional needs when that family member is unable to attend to those needs themselves, or transporting the family member to a health care provider when the family member is unable to transport themselves.
(b) "Psychological assistance" means providing comfort, reassurance, companionship to a family member, or completing administrative tasks for the family member, or arranging for changes in the family member's care, such as, but not limited to, transfer to a nursing home.
(8) "Child," as the term is used for family leave to care for and bond with a child during the first year after the child's birth, foster placement, or adoption, and as the term is used for a safe leave purpose described in ORS 659A.272, means an individual described in ORS 657B.010(6) and who is:
(a) Under the age of 18; or
(b) Age 18 or older as an adult dependent substantially limited by a physical or mental impairment as defined by ORS 659A.104.
(9) "Claim" means a period of Paid Family and Medical Leave Insurance (PFMLI) benefits that starts with an approved application for benefits and continues through the duration of the approved leave until the approved leave or benefit amount has been exhausted or the approved timeframe for the leave has been reached. A claimant may have multiple claims in a benefit year but may not be approved for more than the allowable benefit or leave amount as described in OAR 471-070-1030.
(10) "Claimant" means an individual who has submitted an application or established a claim for benefits.
(11) "Claimant Designated Representative" means an individual described in OAR 471-070-1250.
(12) "Consecutive" leave means leave taken for a continuous period of time, without interruption, based upon a claimant's regular work schedule from all employment for a single qualifying purpose. A claimant who is taking consecutive leave may not perform work for any employer or perform self-employed work during the leave period.
(13) "Domestic violence," as the term is used for a safe leave purpose described in ORS 659A.272, means abuse or the threat of abuse, as abuse is defined in ORS 107.705.
(14) "Eligible employee's average weekly wage" means an amount calculated by the department by dividing the total wages earned by an eligible employee during the base year by 52 weeks.
(15) "First year" after the child's birth, foster placement, or adoption means the timeframe beginning the day of the child's birth, foster placement, or adoption and ending the day before the child's first birthday or first anniversary of the foster placement or adoption.
(16) "Harassment," as the term is used for a safe leave purpose described in ORS 659A.272, means the crime of harassment described in ORS 166.065.
(17) "Health care provider" means a person, other than a claimant or a person for whom a claimant is providing care,

who is one of the following:
(a) A person who is primarily responsible for providing health care to the claimant or the family member of the claimant before or during a period of PFMLI leave, who is licensed or certified to practice in accordance with the laws of the state or country in which they practice, who is performing within the scope of the person's professional license or certificate, and who is:
(A) A chiropractic physician, but only to the extent the chiropractic physician provides treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated to exist by X-rays;
(B) A dentist;
(C) A direct entry midwife;
(D) A naturopathic physician;
(E) A nurse practitioner;
(F) A nurse practitioner specializing in nurse-midwifery;
(G) An optometrist;
(H) A physician;
(I) A physician associate;
(J) A psychologist;
(K) A registered nurse; or
(L) A regulated social worker.
(b) A person who is primarily responsible for the treatment of the claimant or the family member of the claimant solely through spiritual means before or during a period of PFMLI leave, including but not limited to a Christian Science practitioner.
(18) "Intermittent" leave means leave taken periodically in separate blocks of time or when leave is taken for two or more leave types simultaneously for an entire work day or work week from all employment. A claimant who is taking intermittent leave can perform work for any employer or perform self-employed work on work days they are not taking leave.
(19) "Offset" means the withholding of an amount from a benefit payment which would otherwise be payable to a claimant.
(20) "Self-employed individual's average weekly income" means the amount calculated by the department by adding the total of an individual's taxable income from self-employment, on which contributions have been paid under OAR 471-070-2030, and subject wages, if any, earned during the base year, and dividing by 52 weeks.
(21) "Serious health condition" means an illness, injury, impairment, or physical or mental condition of a claimant or their family member that:
(a) Requires inpatient care in a medical care facility such as, but not limited to, a hospital, hospice, or residential facility such as, but not limited to, a nursing home or inpatient substance abuse treatment center;
(b) In the medical judgment of the treating health care provider poses an imminent danger of death, or that is terminal in prognosis with a reasonable possibility of death in the near future;
(c) Requires constant or continuing care, including home care administered by a health care professional;
(d) Involves a period of incapacity. "Incapacity" is the inability to perform at least one essential job function, or to attend school or perform regular daily activities for more than three consecutive calendar days. A period of incapacity includes any subsequent required treatment or recovery period relating to the same condition. The incapacity must involve one of the following:
(A) Two or more treatments by a health care provider; or
(B) One treatment plus a regimen of continuing care.
(e) Results in a period of incapacity or treatment for a chronic serious health condition that requires periodic visits for treatment by a health care provider, continues over an extended period of time, and may cause episodic rather than a continuing period of incapacity, such as, but not limited to, asthma, diabetes, or epilepsy;
(f) Involves permanent or long-term incapacity due to a condition for which treatment may not be effective, such as, but

not limited to, Alzheimer's Disease, a severe stroke, or terminal stages of a disease. The employee or family member must be under the continuing care of a health care provider, but need not be receiving active treatment;
(g) Involves multiple treatments for restorative surgery or for a condition such as, but not limited to, chemotherapy for cancer, physical therapy for arthritis, or dialysis for kidney disease that if not treated would likely result in incapacity of more than three calendar days;
(h) Involves any period of disability due to pregnancy, childbirth, miscarriage or stillbirth, or period of absence for prenatal care; or
(i) Involves any period of absence from work for the donation of a body part, organ, or tissue, including preoperative or diagnostic services, surgery, post-operative treatment, and recovery.
(22) “Sexual Assault,” as the term is used for a safe leave purpose described in ORS 659A.272, means any sexual offense or the threat of a sexual offense as described in ORS 163.305 to 163.467, 163.472 or 163.525.
(23) “Stalking,” as the term is used for a safe leave purpose described in ORS 659A.272, means:
(a) The crime of stalking or the threat of the crime of stalking as described in ORS 163.732; or
(b) A situation that results in a victim obtaining a court’s stalking protective order or a temporary court’s stalking protective order under ORS 30.866.
(24) “Subject Wages” means PFMLI wages that are paid and reported for an employee, as defined in ORS 657B.010(13), or an employee of a tribal government who has elected coverage under ORS 657B.130.
(25) “Willful” and “willfully” means a knowing and intentional act or omission.
(26) “Willful false statement” means any occurrence where:
(a) A claimant or employer makes a statement or submits information that is false;
(b) The claimant or employer knew or should have known the statement or information was false when making or submitting it;
(c) The statement or submission concerns a fact that is material to the rights and responsibilities of either the claimant or the employer under ORS chapter 657B; and
(d) The claimant or employer made the statement or submitted the information with the intent that the department would rely on the statement or information when taking action.
(27) “Willful failure to report a material fact” means any occurrence where:
(a) A claimant or employer omits or fails to disclose information;
(b) The claimant or employer knew or should have known that the information should have been provided;
(c) The information concerns a fact that is material to the rights and responsibilities of either the claimant or the employer under ORS chapter 657B; and
(d) The claimant or employer omitted or did not disclose the information with the intent that the department would take action based on other information or a lack of information.
(28) “Work day” means any day on which an employee performs any work for an employer and is an increment of a work week.
(29) “Work week” means a seven day period beginning on a Sunday at 12:01 a.m. and ending on the following Saturday at midnight.

STATUTORY/OTHER AUTHORITY: ORS 657B.090, 657B.340, 657B.023

STATUTES/OTHER IMPLEMENTED: ORS 657B.010, ORS 657B.090, 657B.023, 657B.332, Chapter 73 Oregon Laws 2024

AMEND: 471-070-1010

RULE TITLE: Benefits: Eligibility and Qualification for Benefits

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule is being amended to align with statutory changes made by SB 1515 (2024), specifying that employees eligible for worker's compensation time loss benefits are disqualified from receiving Paid Leave benefits.

RULE TEXT:

(1) For an individual to be eligible to receive Paid Family and Medical Leave Insurance (PFMLI) benefits, the individual must:

(a) Be one of the following:

(A) An employee;

(B) A self-employed individual who has elected coverage under ORS 657B.130 and in accordance with OAR 471-070-2010 and whose coverage is currently in effect; or

(C) An employee of a tribal government, where the tribal government has elected coverage under ORS 657B.130 and where the tribal government's coverage is currently in effect.

(b) Earn at least:

(A) $1,000 in subject wages, as defined in OAR 471-070-1000, in either the base year or alternate base year;

(B) $1,000 in taxable income from self-employment, as defined in OAR 471-070-2000, in either the base year or alternate base year; or

(C) $1,000 in a combination of subject wages and taxable income from self-employment in either the base year or alternate base year.

(c) Contribute to the PFMLI Fund established under ORS 657B.430 in accordance with ORS 657B.150 and OAR 471-070-2030 during the base year or alternate base year, as applicable;

(d) Experience a qualifying purpose for benefits under ORS 657B.020;

(e) Have current Oregon employment or self-employment from which they are expected to be available to work but are taking leave from work as described in OAR 471-070-1015;

(f) Submit an application for benefits in accordance with all requirements under ORS 657B.090 and OAR 471-070-1100;

(g) Have not exceeded their maximum paid leave and benefit amounts under ORS 657B.020 and OAR 471-070-1030 in the active benefit year; and

(h) Have no current disqualifications from receiving benefits due to:

(A) The individual being eligible to receive workers' compensation time loss benefits under ORS chapter 656, or Unemployment Insurance benefits under ORS chapter 657; or

(B) A director determination under ORS 657B.332 that the individual previously willfully made a false statement or willfully failed to report a material fact in order to obtain benefits.

(2) An individual may not exceed 12 weeks of paid leave per child for the purpose of caring for and bonding with the child during the first year after the birth or initial placement of the child, regardless if a new benefit year starts during the first year following birth or initial placement.

(3) An individual may not take the two additional weeks of leave for limitations related to pregnancy, childbirth, or related medical condition more than once per pregnancy, regardless of whether the individual has started a new benefit year.

Example 1: Juan files an application for benefits for seven weeks of paid leave and is approved by the department to care for a family member with a serious health condition and begins a benefit year on November 5, 2023. After returning from this leave, Juan has five weeks of leave remaining in the balance of their benefit year. In March 2024, Juan and their partner adopt a child. Juan submits an application for benefits to the department and is approved for the

remaining five weeks of paid leave in the benefit year in order to care for and bond with the newly adopted child. Juan's benefit year expires on November 2, 2024, and Juan submits a new application for benefits to the department. Juan is approved for leave to care for and bond with the same child and starts a new benefit year. Because Juan already bonded with the same child for five weeks in the prior benefit year, Juan may only take leave to care for and bond with that child for up to an additional seven weeks in the new benefit year.

Example 2: Julie files an application for benefits and is approved for leave for their own serious health condition and begins a benefit year on September 17, 2023. Julie takes two weeks of leave to recover from the serious health condition and then returns to work. In June 2024, Julie gives birth to twins. Julie submits an application for benefits to the department and is approved for ten weeks of leave to care for and bond with the first twin. Julie's benefit year expires on September 14, 2024, and then Julie submits another application for benefits to the department and is approved for twelve weeks of leave to care for and bond with the second twin, starting a new benefit year.

STATUTORY/OTHER AUTHORITY: ORS 657B.340

STATUTES/OTHER IMPLEMENTED: ORS 657B.015, 657B.020, Chapter 20 Oregon Laws 2024

ADOPT: 471-070-1040

RULE TITLE: Benefits: Calculation of Days and Weeks Worked

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule explains the process for determining the correct number of workdays worked in a work week for the purposes of Paid Leave
Oregon benefits calculations.

RULE TEXT:
(1) The number of work days in a work week is based on the average number of work days worked by an employee at all places of employment.
(2) There is a maximum of seven work days in a work week.
(3) There is a maximum of 24 hours in a work day.
(4) When a work day spans two calendar days, such as a shift beginning on day one at 10 p.m. and ending on the next day at 5 a.m., the work day will count on the calendar day in which the shift began. For shifts longer than 24 hours, the first work day will count on the calendar day in which the shift began. The second and subsequent work days within that shift will begin after each 24 hour period thereafter.
(5) If a claimant works a variable or irregular schedule:
(a) The number of work days in a work week is determined by counting the total number of days worked in the preceeding 12 work weeks, dividing the total by 12, and rounding up to the nearest whole number.

Example 1: Joshua works on an on-call basis and wants to apply for benefits. Joshua worked 39 days during the preceding 12 work weeks, an average of 3.25 days per work week (39 work days/12 work weeks). Joshua rounds up and reports an average of four work days per work week.

(b) If the employee has not been employed by the employer for at least 12 weeks, the number of weeks the employee has been employed from the date of hire to the first day of leave shall replace 12 in the calculation in section (a).

Example 2: Nicky started work with a variable schedule and wants to apply for benefits after nine weeks of work. Nicky has worked a total of 27 work days. Nicky will report an average of three work days worked per work week (27 work days /9 work weeks).

STATUTORY/OTHER AUTHORITY: ORS 657B.090, 657B.340

STATUTES/OTHER IMPLEMENTED: ORS 657B.090

AMEND: 471-070-1100

RULE TITLE: Benefits: Application for Benefits

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule is being amended to align with changes made by SB 1515 (2024), clarifying that employees must provide information about their eligibility to receive workers' compensation time loss benefits.

RULE TEXT:

(1) To request Paid Family and Medical Leave Insurance (PFMLI) benefits provided under the state plan established in ORS 657B.340, a claimant must submit an application for benefits. An application must be submitted online or by another method approved by the department. For the application to be approved by the department, the application must be complete and must include, but is not limited to, the following:

(a) Claimant information, including:

(A) First and last name;

(B) Date of birth;

(C) Social Security Number or Individual Taxpayer Identification Number; and

(D) Contact information, including mailing address and telephone number.

(b) Documentation sufficient to establish the claimant's identity;

(c) Information about the claimant's current employment or self-employment for which they are requesting leave from work:

(A) Business name(s) and dates of employment or self-employment;

(B) Business address and contact information for all employers or self-employed businesses;

(C) Average number of work days worked per work week; and

(D) Any current breaks from work or anticipated future breaks from work that are unrelated to PFMLI leave.

(d) Information about the notice given to any employers under ORS 657B.040 and OAR 471-070-1310, if applicable, and the date(s) any notice was given;

(e) Information about the claimant's leave schedule, including:

(A) Employer(s) from which leave is being taken;

(B) Anticipated leave dates; and

(C) Whether the leave is to be taken in consecutive or intermittent periods.

(f) The type of leave taken by the claimant, which must be one of the following:

(A) Family leave;

(B) Medical leave; or

(C) Safe leave.

(g) Verification of the reason for the leave, including:

(A) For family leave to care for or bond with a child, verification consistent with OAR 471-070-1110;

(B) For family leave to care for a family member with a serious health condition, verification consistent with OAR 471-070-1120 and an attestation that the claimant has a relationship equal to "family member" under ORS 657B.010 and is caring for a family member with a serious health condition;

(C) For medical leave, verification consistent with OAR 471-070-1120; or

(D) For safe leave, verification consistent with OAR 471-070-1130.

(h) If the claimant is requesting up to two additional weeks of leave for limitations related to pregnancy, childbirth or a related medical condition, documentation that the claimant is currently pregnant or was pregnant within the year prior to the start of the additional two weeks of leave;

(i) Information about the claimant's eligibility to receive workers' compensation time loss benefits under ORS chapter 656 or Unemployment Insurance benefits under ORS chapter 657; and

(j) A written or electronically signed statement declaring under oath that the information provided in support of the application for PFMLI benefits is true and correct to the best of the individual's knowledge.

(2) An employee who has PFMLI coverage solely through an employer with an equivalent plan approved under ORS 657B.210 must apply for PFMLI benefits by following the employer's equivalent plan application guidelines.
(3) An employee who is simultaneously covered by more than one employer's equivalent plan approved under ORS 657B.210, or that is simultaneously covered by the state plan and at least one employer with an equivalent plan, must apply separately under all plans they are covered under and from which they are taking leave by following the respective application guidelines for each plan.
(4) A complete application for PFMLI may be submitted to the department up to 30 calendar days prior to the start of family, medical, or safe leave and up to 30 calendar days after the start of leave. Applications submitted outside of this timeframe, either early or late, will be denied, except in cases where a claimant can demonstrate an application was submitted late for reasons that constitute good cause under section (5) of this rule.
(5) Good cause exists when a claimant establishes by satisfactory evidence submitted to the department that factors or circumstances beyond the claimant's control prevented the claimant from submitting a completed application within the required timeframe under section (4) of this rule. Good cause for the late submission of an application is determined at the discretion of the department and includes, but is not limited to, the following:
(a) A serious health condition that results in an unanticipated and prolonged period of incapacity and that prevents an individual from timely filing an application; or
(b) A demonstrated inability to reasonably access a means to file an application in a timely manner, such as an inability to file an application due to a natural disaster or a significant and prolonged department system outage.
(6) If the department determines the claimant demonstrated good cause for late submission of an application, the department may accept the application up to one year after the start of leave.
[Publications: Contact the Oregon Employment Department for information about how to obtain a copy of the publication referred to or incorporated by reference in this rule.]

STATUTORY/OTHER AUTHORITY: ORS 657B.090, 657B.100, 657B.340

STATUTES/OTHER IMPLEMENTED: ORS 657B.090, 657B.100, Chapter 20 Oregon Laws 2024

AMEND: 471-070-1110

REPEAL: Temporary 471-070-1110 from ED 2-2024

RULE TITLE: Benefits: Verification of Family Leave to Care for and Bond with a Child

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule is being amended to clarify the allowable documents and information needed to verify Paid Leave Oregon claims for leave to care for and bond with a child in the first year after birth, or after placement through adoption, or foster care.

RULE TEXT:

(1) A claimant applying for Paid Family and Medical Leave Insurance (PFMLI) benefits to care for and bond with a child during the first year after the child's birth must provide one of the following forms of verification:

(a) The child's government issued birth certificate;

(b) A Consular Report of Birth Abroad;

(c) Court issued documents establishing paternity or guardianship;

(d) A Voluntary Acknowledgement of Paternity (form 45-31) signed and witnessed by a hospital representative and issued within 5 calendar days of the date of birth;

(e) A document issued by a health care provider of the child or pregnant parent. If issued before the date of birth, the document must be dated and signed within 60 calendar days before the expected date of birth;

(f) A hospital admission form associated with delivery;

(g) The Paid Leave Oregon Verification of Birth Form. If issued before the date of birth, the form must be dated and signed within 60 calendar days before the expected date of birth; or

(h) Another document approved by the department for this purpose. If issued before the date of birth, the form must be dated and signed within 60 calendar days before the expected date of birth.

(2) A claimant applying for PFMLI benefits to care for and bond with a child during the first year after the placement of the child through foster care or the first year after the placement of the child through adoption must provide one of the following forms of verification that includes the child's first and last name:

(a) A copy of a court order verifying placement;

(b) A letter signed by the attorney representing the foster or adoptive parent that confirms the placement;

(c) A document from the foster care, adoption agency, or social worker involved in the placement that confirms the placement;

(d) A document for the child issued by the United States Citizenship and Immigration Services; or

(e) Another document approved by the department for this purpose.

(3) The verification required in sections (1) and (2) of this rule must show the following:

(a) Claimant's first and last name as parent or guardian of the child after birth or placement of the child through foster care or adoption;

(b) If applying for PFMLI benefits under section (1) of this rule, the date of the child's birth or the expected date of the child's birth;

(c) If applying for PFMLI benefits under section (2) of this rule, the date of placement;

(d) Unless issued by a government entity, the document must also contain:

(A) The issuer's first and last name;

(B) The issuer's title or specialization;

(C) The issuer's contact information, such as mailing address or telephone number;

(D) The issuer's handwritten or electronic signature; and

(E) The date the document was signed or issued.

(4) If any of the documents listed in sections (1) and (2) of this rule do not include the full name of the claimant or the claimant's child or do not show the relationship of the child to the claimant, the claimant must submit one or more of the following documents to meet the verification requirements described in this rule:

(a) A legal marriage certificate;
(b) A certified Declaration of Domestic Partnership;
(c) A legal birth certificate;
(d) A notarized Voluntary Acknowledgement of Paternity Affidavit (Form 45-21); or
(e) One or more documents issued by an independent and verifiable third party that establishes the parent relationship to the child. The document must be issued within six months before the claimant's start of leave.
[Publications: Contact the Oregon Employment Department for information about how to obtain a copy of the publication referred to or incorporated by reference in this rule.]

STATUTORY/OTHER AUTHORITY: ORS 657B.340, ORS 657B.090

STATUTES/OTHER IMPLEMENTED: ORS 657B.090

AMEND: 471-070-1120

REPEAL: Temporary 471-070-1120 from ED 2-2024

RULE TITLE: Benefits: Verification of a Serious Health Condition

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule is being amended to clarify the allowable documents and information needed to verify Paid Leave Oregon medical or family
leave claims involving a serious health condition.

RULE TEXT:

(1) A claimant applying for Paid Family and Medical Leave Insurance (PFMLI) benefits for their own serious health condition or to care for a family member with a serious health condition must provide one of the following forms of verification:

(a) The Paid Leave Oregon Verification of a Serious Health Condition Form;

(b) The Oregon and Federal Family and Medical Leave Health Care Provider Certification issued by the Oregon Bureau of Labor and Industries (BOLI);

(c) The Family and Medical Leave Act (FMLA) certification of health care provider for a serious health condition form issued by the U.S. Department of Labor;

(d) A FMLA certification for a serious health condition form issued by an employer;

(e) A document issued by a health care provider; or

(f) Another document approved by the department for this purpose.

(2) The forms of verification listed in section (1) of this rule must include:

(a) The health care provider's:

(A) First and last name;

(B) Type of medical practice/specialization;

(C) Contact information, such as mailing address and telephone number; and

(D) Handwritten or electronic signature. If issued before the start of leave, the verification document must be signed by the health care provider within 60 calendar days before the claimant's leave start date;

(b) The patient's first and last name;

(c) The claimant's first and last name, when different from the patient identified in section (2)(b) of this rule;

(d) The approximate date on which the serious health condition commenced or when the serious health condition created the need for leave;

(e) A reasonable estimate of the duration of the condition or recovery period for the patient;

(f) A reasonable estimate of the frequency and duration of intermittent leave and estimated treatment schedule, if applicable; and

(g) Other information as requested by the department to determine eligibility for the PFMLI benefits; including:

(A) For medical leave, information sufficient to establish that the claimant has a serious health condition, including but not limited to a diagnosis; or

(B) For family leave, information sufficient to establish that the claimant's family member has a serious health condition, including but not limited to a diagnosis.

(3) If any of the documents listed in section (1) of this rule do not include the full name of the patient or the claimant, when different from the patient identified in section (2)(b) of this rule, or do not show the family relationship of the claimant and the patient, the claimant must submit at least one of the following documents to meet the verification requirements described in this rule:

(a) A legal marriage certificate;

(b) A certified Declaration of Domestic Partnership;

(c) A legal birth certificate; or

(d) One or more documents issued by an independent and verifiable third party that establishes marriage, domestic

partnership, or a significant family relationship between claimant and patient. The document must be issued within six months before the claimant's start of leave.
[Publications: Contact the Oregon Employment Department for information about how to obtain a copy of the publication referred to or incorporated by reference in this rule.]

STATUTORY/OTHER AUTHORITY: ORS 657B.340, ORS 657B.090

STATUTES/OTHER IMPLEMENTED: ORS 657B.090

AMEND: 471-070-1130

REPEAL: Temporary 471-070-1130 from ED 2-2024

RULE TITLE: Benefits: Verification of Safe Leave

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule is being amended to clarify the allowable documents and information needed to verify Paid Leave Oregon safe leave claims.

RULE TEXT:

(1) A claimant applying for Paid Family and Medical Leave Insurance (PFMLI) benefits for safe leave must provide verification certifying the claimant or the claimant's child as defined in OAR 471-070-1000 is a survivor of domestic violence, harassment, sexual assault, bias, or stalking. Any of the following documents may be provided as verification:

(a) A copy of a federal agency or state, local, or tribal police report, or a formal complaint to a school's Title IX Coordinator indicating that the claimant or the claimant's child was a survivor of domestic violence, harassment, sexual assault, bias, or stalking;

(b) A copy of a protective order or other evidence from a federal, state, local, or tribal court, administrative agency, school's Title IX Coordinator, or attorney that the claimant or the claimant's child appeared in or was preparing for a civil, criminal, or administrative proceeding related to domestic violence, harassment, sexual assault, bias, or stalking;

(c) Documentation from an attorney, law enforcement officer, health care provider, licensed mental health professional or counselor, member of the clergy, employee of the Department of Justice division providing victim and survivor services, or victim services provider, verifying that the claimant or the claimant's child was undergoing treatment or counseling, obtaining services, or relocating as a result of domestic violence, harassment, sexual assault, bias, or stalking;

(d) The Paid Leave Oregon Safe Leave Verification Form; or

(e) Another document approved by the department for this purpose.

(2) The documentation listed in section (1) of this rule must include:

(a) The full name of the claimant, and

(b) The full name of the child of the claimant, if the claimant's child is a survivor of domestic violence, harassment, sexual assault, bias, or stalking.

(3) The documentation listed in section (1) of this rule must be dated no more than 12 months before the date the claimant applied for leave.

(4) If the documentation is dated earlier than 12 months before the date the claimant applied for leave, the claimant must provide a written statement in addition to documentation listed in section (1) of this rule that describes the current need for leave, along with any additional information requested by the department.

(5) In cases where a claimant can demonstrate good cause for not providing one of the forms of documentation in section (1) of this rule, the claimant may instead provide a written statement attesting that they are taking eligible safe leave, which includes a brief description of the purpose for taking leave. Good cause for not providing the documentation is determined at the discretion of the department and includes, but is not limited to, the following:

(a) Difficulty obtaining verification due to a lack of access to services; or

(b) Concerns for the safety of the claimant or the claimant's child.

[Publications: Contact the Oregon Employment Department for information about how to obtain a copy of the publication referred to or incorporated by reference in this rule.]

STATUTORY/OTHER AUTHORITY: ORS 657B.340, ORS 657B.090

STATUTES/OTHER IMPLEMENTED: ORS 657B.090

AMEND: 471-070-1205

RULE TITLE: Benefits: Weekly Claims

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule is being amended to align with changes made by SB 1515 (2024), clarifying that employees must include information in their weekly claims regarding their eligibility to receive workers' compensation time loss benefits.

RULE TEXT:

(1) A claimant taking Paid Family and Medical Leave Insurance (PFMLI) benefits on an intermittent leave schedule or for more than one qualifying purpose as described in OAR 471-070-1430, must file a weekly claim in order to receive PFMLI benefits for that week.

(2) For a weekly claim to be approved, the weekly claim must be complete and include, but is not limited to, the following information:

(a) The dates of the work week being claimed;

(b) The number of work days of leave taken for each leave type specified under 657B.020;

(c) The number of days worked during the work week;

(d) Claimant's eligibility to receive workers' compensation time loss benefits under ORS chapter 656 or Unemployment Insurance benefits under ORS chapter 657 for the work week;

(e) Any changes to current employment, including any new employment or employment that has ended since the benefit application or last weekly claim; and

(f) A written or electronically signed statement declaring under oath that the information provided in support of the weekly claim is true and correct to the best of the claimant's knowledge.

(3) The weekly claim must be submitted only after that work week has ended and no later than 30 calendar days following the end of the work week in which the family, medical, or safe leave was taken. Weekly claims submitted after 30 calendar days will be denied, except in cases where a claimant can demonstrate a weekly claim was submitted late for reasons that constitute good cause under section (5) of this rule.

(4) For claimants taking intermittent leave, the number of days of leave eligible in a work week may not exceed the average number of work days worked per week, as provided under ORS 471-070-1100(1)(c)(C) or OAR 471-070-1210(2), minus the number of days actually worked during the work week.

Example: Eddie submits an application for benefits that states their average work week consists of four work days. The weekly benefit amount is $875.00. Eddie submits their first weekly claim and reports three days worked and three days of leave, for a total combination of six days of work and leave reported. Eddie will only be paid for one of the three days of leave reported on the weekly claim report as Eddie worked three days out of a four day work week. The benefit amount paid for the first week of leave to Eddie is $218.75 [($875.00 weekly benefit amount divided by 4 work days) x 1 day of payable leave].

(5) Good cause exists when a claimant establishes by satisfactory evidence submitted to the department that factors or circumstances beyond the claimant's control prevented the claimant from submitting a weekly claim within the required timeframe under section (3) of this rule. Good cause for the late submission of a weekly claim is determined at the discretion of the department and includes, but is not limited to, the following:

(a) A serious health condition that results in an unanticipated and prolonged period of incapacity and that prevents a claimant from timely filing a weekly claim; or

(b) A demonstrated inability to reasonably access a means to file a weekly claim in a timely manner, such as an inability to file a weekly claim due to a natural disaster or a significant and prolonged department system outage.

(6) If the department determines the claimant demonstrated good cause for late submission of a weekly claim, the department may accept the weekly claim up to one year after the leave was taken.

STATUTORY/OTHER AUTHORITY: ORS 657B.340

STATUTES/OTHER IMPLEMENTED: ORS 657B.020, 657B.090, Chapter 20 Oregon Laws 2024

AMEND: 471-070-1210

RULE TITLE: Benefits: Updates to a Claim for Leave

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule is being amended to align with changes made by SB 1515 (2024), clarifying that employees must include information about their eligibility to receive workers' compensation time loss benefits, when they update a claim for leave.

RULE TEXT:

(1) After submitting an application for benefits as specified in OAR 471-070-1100, a claimant must notify the department within 10 calendar days of any changes to the information provided on their application and provide additional information as provided in OAR 471-070-1200, if applicable, including, but not limited to, changes to the claimant's:

(a) First and last name;

(b) Mailing address;

(c) Telephone number;

(d) Current employment or self-employment;

(e) Leave schedule;

(f) Type of leave taken; or

(g) Eligibility to receive workers' compensation time loss benefits under ORS chapter 656 or Unemployment Insurance benefits under ORS chapter 657.

(2)(a) A claimant may change their average number of work days worked per work week that they provided on the application for benefits only under the following circumstances in which the claimant:

(A) Added one or more new employer(s) since applying for benefits;

(B) Left one or more employer(s) since applying for benefits; or

(C) Applied for benefits for an additional qualifying purpose.

(b) Any approved change to the average number of work days worked per work week shall take effect beginning on the Sunday of the first week after the claimant experienced a change in employment or started an additional qualifying purpose for benefits.

(3) Failure to notify the department of any changes to the information provided on an application for benefits as specified in section (1) of this rule may result in a delay, denial, overpayment, or disqualification of weekly benefits.

[Publications: Contact the Oregon Employment Department for information about how to obtain a copy of the publication referred to or incorporated by reference in this rule.]

STATUTORY/OTHER AUTHORITY: ORS 657B.090, 657B.340

STATUTES/OTHER IMPLEMENTED: ORS 657B.090, 657B.100, Chapter 20 Oregon Laws 2024

AMEND: 471-070-1250

REPEAL: Temporary 471-070-1250 from ED 2-2024

RULE TITLE: Benefits: Claimant Designated Representative and Representation of Incapacitated Claimants

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule is being amended to include the process for recognizing representatives for incapacitated claimants who do not have a claimant designated representative, as well as for individuals who have a power-of-attorney granted by a claimant or are the court-appointed legal guardian or conservator for a claimant.

RULE TEXT:

(1) A claimant may designate as a claimant designated representative an individual, 18 years of age or older, who is authorized by the claimant to represent the claimant by exchanging information with the Paid Family and Medical Leave Insurance (PFMLI) program on behalf of the claimant as specified in section (2) of this rule.

(2) A claimant designated representative, or an individual otherwise approved by the department to represent a claimant, is authorized to do the following:

(a) Receive information submitted to the PFMLI program by the claimant;

(b) Receive information about PFMLI benefits that the claimant has received or will receive;

(c) Receive information about pending or issued decisions made on the claimant's PFMLI claim;

(d) Provide information to the PFMLI program on behalf of the claimant, including information required to complete a PFMLI claim for benefits; and

(e) File a PFMLI claim for benefits on behalf of the claimant.

(3) Except as otherwise specified in this rule, to designate a representative, the claimant must complete and submit the department's Designated Representative Form, electronically or by mail. In order for the representative to be approved by the department to exchange information, the form must be complete. At a minimum, it must include the following:

(a) Claimant information:

(A) First and last name;

(B) Social Security Number or Individual Taxpayer Identification Number;

(C) Date of birth; and

(D) Contact information, including mailing address and telephone number;

(b) Claimant designated representative information:

(A) First and last name;

(B) Relationship to claimant; and

(C) Contact information, including mailing address, and telephone number;

(c) Authorization beginning and end dates;

(d) A dated attestation with a handwritten signature by the claimant declaring that the claimant understands the purpose of the authorization, that the claimant has not been pressured to sign the authorization, and that the designation can be revoked at any time; and

(e) A dated attestation with a handwritten signature by the claimant designated representative declaring that they are acting in the best interest of the claimant.

(4) The claimant may revoke the authorization at any time by providing written notification to the department.

(5) The authorization will automatically end on the last day of the claimant's current benefit year. If no application for benefits is submitted, authorization will end 30 days after the department has issued an approval of the designation. If a claimant's application for benefits is submitted more than 30 calendar days after the designation has been approved, the claimant must submit a new form to designate a representative.

(6) The claimant designated representative must maintain the confidentiality of any information they receive from the department on behalf of the claimant. The department is not responsible for any disclosure of the claimant's information by the claimant designated representative.

(7) If a claimant is incapacitated due to a serious health condition as defined in OAR 471-070-1000 and is physically or

mentally unable to designate a representative by filling out the department's Designated Representative Form, an individual who has a family relationship to the claimant as defined in ORS 657B.010 may request to represent the claimant as described in section (8) of this rule to exchange information with the PFMLI program on behalf of the claimant as specified in section (2) of this rule. For the purposes of this rule, 'incapacitated' has the meaning given that term in ORS 125.005.

(8) To request representation of a claimant who is incapacitated due to a serious health condition as provided in section (7) of this rule, the requesting individual must submit:

(a) The completed Designated Representative Form referenced in section (3) of this rule. At a minimum, the form must include:

(A) The information listed in section (3)(a) and (b) of this rule;

(B) An authorization beginning date;

(C) A dated certification with a handwritten signature from a health care provider as defined in OAR 471-070-1000 attesting, within the scope of their license, that the claimant is incapacitated and unable to complete the requirements for filing or providing information on a PFMLI claim and unable to independently designate a representative; and

(D) A dated attestation with a handwritten signature from the individual requesting to represent the incapacitated claimant, declaring that they will:

(i) Act in the best interest of the claimant;

(ii) Maintain claimant confidentiality, as outlined in section (6) of this rule; and

(iii) Inform the department within three calendar days of learning that the claimant is no longer incapacitated;

(b) One or more of the following documents that show the individual's family relationship to the claimant:

(A) Certified Declaration of Domestic Partnership;

(B) Legal marriage certificate;

(C) Legal birth certificate; or

(D) At the discretion of the department, other documents issued by an independent and verifiable third party that establish marriage, domestic partnership, parenthood, or other family relationship between the individual and claimant; and

(c) Documentation approved by the department for this purpose that is sufficient to establish the identity of the claimant and the individual requesting approval to represent the claimant.

(9)The authorization referenced in section (7) of this rule will automatically end on the date the department is informed that the claimant is no longer incapacitated, or on the last day of the claimant's current benefit year, whichever is earliest. The claimant may choose to continue the authorization by independently designating the representative as described in section (3) of this rule. If no application for benefits is submitted for the claimant, authorization will end 30 calendar days after the date the department has approved the individual to represent the incapacitated claimant.

(10) In addition to individuals referenced in sections (1) and (7) of this rule, the following individuals are authorized to provide information to and receive information from the PFMLI program as specified in section (2) of this rule:

(a) An individual who was court-appointed as a claimant's legal guardian or conservator with the authority to make decisions on the claimant's behalf, if the authorized individual provides a copy of the guardianship or conservatorship documentation to the department; or

(b) An individual with granted power of attorney by the claimant to act as the claimant's 'agent' or 'attorney-in-fact' with respect to the claimant's PFMLI benefits or contributions, if the authorized individual provides documentation to the department.

(11) The documentation referenced in section (10) of this rule, at a minimum, must:

(a) Show that the individual has specific authority to act on behalf of the claimant for PFMLI purposes;

(b) Provide dates that establish the period the individual has the authority to act on behalf of the claimant; and

(c) Include the name of the claimant and the name of the claimant's legal guardian or conservator or the individual with granted power of attorney.

(12) Individuals listed in section (10) of this rule must also provide documentation approved by the department for this

purpose that is sufficient to establish the identity of the claimant and the identity of the court-appointed legal guardian or conservator or the individual with granted power of attorney.
(13) If the claimant designated representative, the representative of an incapacitated claimant, the claimant's court-appointed legal guardian or conservator, or the individual with granted power of attorney by the claimant do not provide information required in this rule or provide inaccurate information to the department, the claimant is responsible for any resulting delay, denial, overpayment, or disqualification of PFMLI benefits.
[Publications: Contact the Oregon Employment Department for information about how to obtain a copy of the publication referred to or incorporated by reference in this rule.]

STATUTORY/OTHER AUTHORITY: ORS 125.025, ORS 127.002 to 127.045, ORS 657B.400

STATUTES/OTHER IMPLEMENTED: ORS 657B.400

AMEND: 471-070-1470

RULE TITLE: Benefits: Benefit Payment Offsets, Withholdings and Reductions

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule is being amended to align with changes made by SB 1515 (2024), clarifying that Paid Leave benefit offsets from garnishment can only be applied for child and spousal support and restitution for crime victims, and describing the order these garnishments are applied in.

RULE TEXT:

(1) After any benefit reduction under ORS 657B.040, a claimant's weekly benefit payment may be reduced, as applicable, according to the priority order set out in section (2) of this rule before the department issues the weekly benefit payment to the claimant.

(2) The priority of additional offsets against, withholdings from, or reductions to the weekly benefit payment is:

(a) Paid Family and Medical Leave Insurance benefit overpayments described under ORS 657B.332, ORS 657B.335 and OAR 471-070-1510.

(b) Federal personal income tax withholdings described under OAR 471-070-1480.

(c) State personal income tax withholdings described under OAR 471-070-1480.

(d) Child support and spousal support orders described under ORS 25.080.

(e) Restitution for crime victims. If multiple court orders for restitution exist, garnishments will be applied in the order the court orders were received.

(3) Weekly benefit payments of less than $1.00, after all offsets, garnishments or other reductions will not be issued to the claimant.

STATUTORY/OTHER AUTHORITY: ORS 657B.340

STATUTES/OTHER IMPLEMENTED: ORS 657B.050, Chapter 20 Oregon Laws 2024

AMEND: 471-070-1510

RULE TITLE: Benefits: Repayment of Overpaid Benefits; Interest

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule is being amended to align with changes made under SB 912 from the 2023 legislative session allowing Paid Leave Oregon to secure the repayment of an overpayment through offsets against state tax refunds.

RULE TEXT:

(1) The director may issue an assessment to a claimant for an overpayment each time a claimant receives Paid Family and Medical Leave Insurance (PFMLI) benefits to which the claimant was not entitled.

(2) If the director determines that a claimant has received benefits to which the claimant was not entitled:

(a) The claimant may be required to repay the amount of benefits that the claimant was overpaid;

(b) The claimant may be required to repay the amount of penalty and interest (if applicable);

(c) The director may secure the repayment of the overpaid benefits through the deduction from future benefits otherwise payable to the claimant under ORS 657B.100; and

(d) The director may secure the repayment of the overpaid benefits through the offset against any state tax refund owed to the claimant.

(3)(a) If the department determines that a claimant is at fault for an overpayment, due to the claimant's error, false statement, or failure to report a material fact, then the claimant may be liable for interest on the overpayment amount. Interest that the claimant is liable for shall be paid and collected at the same time repayment of benefits is made by the individual, at the rate of one percent per month or fraction of a month. Interest will accrue, beginning on the first day of the month that begins 60 calendar days after the administrative decision establishing the overpayment becomes final.

(b) If the department determines that a claimant is not at fault for an overpayment, then the claimant shall not be liable for interest on the amount to be repaid as a result of the overpayment.

(4) If the director deducts the claimant's future weekly benefits under section (2)(b) of this rule, the deduction shall be from the claimant's future weekly benefits up to the amount of the prior overpayment, penalty, and interest (if applicable). The deduction will begin with the first benefit payment issued after the department's decision regarding the overpayment becomes final.

(5) If there are multiple benefit overpayments, the deduction described in section (4) of this rule will apply to the oldest unwarranted debt first. Once all unwarranted debt is paid, the deduction will apply to the most recent warranted debt.

(6) Deductions from PFMLI benefits under section (2)(b) of this rule shall be applied solely to the amount of overpaid benefits for which the claimant is liable.

(7) Deductions for the repayment of benefits paid erroneously may be deducted from benefits due to the claimant with no time limitations.

STATUTORY/OTHER AUTHORITY: ORS 657B.332, 657B.340

STATUTES/OTHER IMPLEMENTED: ORS 657B.332, ORS 293.250, 657B.338

AMEND: 471-070-1550

RULE TITLE: Benefits: Penalties for Employer Misrepresentation

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule is being amended to clarify that employer penalties for willful misrepresentation will be related to all employee claims, and not just the claims of eligible employees.

RULE TEXT:

(1) In accordance with ORS 657B.332(2), the director may assess a civil penalty of up to $1,000 against an employer each time the employer makes or causes to be made a willful false statement or willful failure to report a material fact regarding the claim of an employee or regarding an employee's eligibility for Paid Family and Medical Leave Insurance benefits.

(2) The director may consider the following mitigating and aggravating circumstances when determining whether to assess a civil penalty under section (1) of this rule and the amount assessed:

(a) Whether the employer knew or should have known they were making or causing to be made a false statement or failing to report a material fact;

(b) Prior violations, if any, of ORS chapter 657B by the employer;

(c) Whether a violation of ORS chapter 657B by the employer resulted in harm to an employee;

(d) Whether a violation of ORS chapter 657B by the employer resulted in erroneous or incorrect benefit or assistance grant payments;

(e) The magnitude and seriousness of a violation of ORS 657B.332(1).

(3) It is the responsibility of the employer to provide the director any mitigating evidence concerning liability for or the amount of the civil penalty to be assessed.

(4) The director shall consider all mitigating circumstances presented by the employer for the purpose of determining the amount of the civil penalty to be assessed.

(5) Any amount in penalties due under ORS 657B.332(2) and this rule may be collected by the director in a civil action against the employer brought in the name of the director.

STATUTORY/OTHER AUTHORITY: ORS 657B.332, 657B.340

STATUTES/OTHER IMPLEMENTED: ORS 657B.332

AMEND: 471-070-1560

RULE TITLE: Benefits: Disqualification and Penalties for Claimant Misrepresentation

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule is being amended to align with changes made under SB 912 (2023) specifying that claimants are liable for interest after making a willful false statement or willfully failing to report a material fact to obtain benefits.

RULE TEXT:

(1) In accordance with ORS 657B.332(3), it is unlawful for a claimant to willfully make a false statement or willfully fail to report a material fact in order to obtain Paid Family and Medical Leave Insurance (PFMLI) benefits.

(2) If the director determines that a claimant has made a willful false statement or a willful failure to report a material fact in order to obtain PFMLI benefits, then the claimant shall be:

(a) Disqualified from claiming benefits for a period of 52 consecutive weeks beginning from the date that the claimant made the willful false statement or willful failure to report the material fact;

(b) Assessed for any amount of benefits the claimant received to which the claimant was not entitled;

(c) Liable for a penalty under ORS 657B.332(3)(b); and

(d) Liable for interest under ORS 657B.332(8).

(3) When determining the rate of the penalty imposed under ORS 657B.332(3)(b), the department will review the number of occurrences of willful false statement or willful failures to report material facts. An occurrence shall be counted each time a claimant willfully makes a false statement or misrepresentation or willfully fails to report a material fact in order to obtain PFMLI benefits. There could be multiple occurrences in a single application for benefits. The department shall use the date the claimant failed to report a material fact or willfully made a false statement or misrepresentation as the date of the occurrence. The penalty shall be imposed as follows:

(a) For the first occurrence, or the second occurrence within five years of any previous disqualification or imposition of a penalty, 15 percent of the total amount of benefits the claimant received to which the claimant was not entitled;

(b) For the third or fourth occurrence within five years of any previous disqualification or imposition of penalty, 20 percent of the total amount of benefits the claimant received to which the claimant was not entitled;

(c) For the fifth or sixth occurrence within five years of any previous disqualification or imposition of penalty, 25 percent of the total amount of benefits the claimant received to which the claimant was not entitled;

(d) For the seventh or greater occurrence within five years of any previous disqualification or imposition of penalty, 30 percent of the total amount of benefits the claimant received to which the claimant was not entitled;

(e) In cases of forgery or identity theft, 30 percent of the amount of benefits the claimant received to which the claimant was not entitled, regardless of the number of occurrences.

(4) Any amount subject to recovery and any penalty due under this rule, OAR 471-070-1510, and ORS 657B.332 may be collected by the director in a civil action against the claimant brought in the name of the director.

STATUTORY/OTHER AUTHORITY: ORS 657B.332, 657B.340

STATUTES/OTHER IMPLEMENTED: ORS 657B.332

AMEND: 471-070-2210

RULE TITLE: Equivalent Plans: Application Requirements and Effective Date

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule is being amended to clarify the anniversary date of equivalent plans with an effective date of September 3, 2023.

RULE TEXT:

(1) An employer must submit a separate application and receive department approval for an employer administered equivalent plan or a fully insured equivalent plan for each Business Identification Number. The application must be submitted to the department online or by another method prescribed by the department. An incomplete application will not be reviewed by the department.

(2) For an equivalent plan to be reviewed by the department, the equivalent plan application must include the following:

(a) Information about the employer applying for the equivalent plan, including:

(A) Business Identification Number and Federal Employer Identification Number;

(B) Business name;

(C) Business address; and

(D) Business contact's name and contact information;

(b) A copy of the employer administered equivalent plan or in the case of a fully insured equivalent plan, a copy of the insurance policy or the insurance product and the selected variables the employer is choosing;

(c) A completed questionnaire attesting that the plan meets all requirements for equivalent plans; and

(d) Other information as required on the department's equivalent plan application form.

(3) Employers must pay a nonrefundable $250 application fee with every:

(a) Application for approval of a new equivalent plan; or

(b) Application for reapproval or amendment of an equivalent plan that has substantive amendments to the equivalent plan that was originally approved by the department.

(4) Employers must pay a nonrefundable $150 application fee with every application for reapproval of an equivalent plan that has no changes or only non-substantive amendments to the equivalent plan that was originally approved by the department.

(5) There is no fee for either of the following:

(a) Application for amendment of an equivalent plan that has substantive or non-substantive amendments to the equivalent plan that were required by Oregon, local, or federal law changes or changes to the contribution rate and maximum wage amount as described in OAR 471-070-3010;

(b) Application for amendment of an equivalent plan that has non-substantive amendments to the equivalent plan that was originally approved by the department.

(6) "Substantive amendments" to an equivalent plan that was originally approved by the department as used in sections (3), (5), and (11) of this rule include, but are not limited to, any of the following:

(a) Changing from a fully insured equivalent plan to an employer administered equivalent plan;

(b) Changing from an employer administered equivalent plan to a fully insured equivalent plan;

(c) Changing the fully insured equivalent plan insurance policy to reduce benefits or leave types, regardless of whether the new plan is from the same insurance provider or another insurance provider;

(d) Changing the questionnaire answers for the equivalent plan; o(e) Changing the employer administered equivalent plan to reduce benefits or leave types.

(7) "Non-substantive amendments" as used in section (4), (5), and (11) of this rule include, but are not limited to, any of the following:

(a) Updating solvency documents for employer administered plans;

(b) Updating the application for an equivalent plan that does not amend the equivalent plan, includes, but is not limited to, the following:

(A) Changing business or contact information, or
(B) Correcting typographical error
(c) Increasing benefits or leave types, regardless of whether the new plan is from the same insurance provider or another insurance provider.
(8) Approved equivalent plans become effective:
(a) For new equivalent plans, on the first day of the calendar quarter immediately following the date of approval by the department; and
(b) For amendments to a previously approved equivalent plan, on the first day of the calendar quarter immediately following the date of approval of the amendment by the department. If approval of the amendment is denied, the employer must continue to follow the originally approved equivalent plan.
(9) An application for reapproval must be submitted by an employer annually for a three-year period following the original effective date of the plan. The application for reapproval is due 30 days prior to the anniversary of the original effective date of the approved equivalent plan. For equivalent plans with an effective date of September 3, 2023, the anniversary date will be October 1 for any subsequent calendar years, in accordance with section (8) of this rule.

Example: ABC Corporation submitted an equivalent plan application to the department on February 4, 2024. The department sent an approval letter for the equivalent plan that was dated March 5, 2024 and the equivalent plan becomes effective on April 1, 2024. The application for reapproval is due on March 1 of 2025, 2026, and 2027; 30 days prior from the original anniversary of the effective date of April 1st.

(10) For the purposes of determining the reapproval requirement, the equivalent plan approval date and effective date are the first day of the calendar quarter immediately following the date of the original approval letter from the department.
(11) After the three-year period following the original effective date of the plan, an application for reapproval must be submitted anytime a substantive amendment occurs as described in section (9) of this rule. For a non-substantive amendment, a copy of the revised equivalent plan must be submitted to the department at the time the change becomes effective.
(12) The department may request any information necessary to establish facts relating to eligibility for an equivalent plan. Unless a timeframe is otherwise specified under statute or administrative rule or is specified by an authorized department representative, the employer must respond to all requests for information within the following time frames:
(a) 14 calendar days from the date of the request for information, if the request was sent by mail to the employer's last known address as shown in the department's records.
(b) 10 calendar days from the date of the request for information, if the request was sent by telephone, email, or other electronic means.
(13) When the response to the request for information is sent to the department by mail, the date of the response shall be the date of the postmark affixed by the United States Postal Service. In the absence of a postmarked date, the date of the response shall be the most probable date of mailing as determined by the department.
[Publications: Contact the Oregon Employment Department for information about how to obtain a copy of the publication referred to or incorporated by reference in this rule.]

STATUTORY/OTHER AUTHORITY: 657B.340, ORS 657B.210

STATUTES/OTHER IMPLEMENTED: ORS 657B.210, 657B.230

AMEND: 471-070-2220

RULE TITLE: Equivalent Plans: Plan Requirements

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule is being amended to clarify that the written notice poster, which is required of all equivalent plan employers, must be provided to all employees, regardless of their eligibility for benefits.

RULE TEXT:

In order for an equivalent plan to be approved by the department, the plan must at a minimum:

(1) Cover all Oregon employees who have been continuously employed with the employer for at least 30 calendar days, regardless of hours worked, including full-time, part-time, temporary workers hired by the employer, and replacement employees hired to temporarily replace eligible employees during PFMLI leave. Any employees who were eligible for benefits under their previous Oregon employer's equivalent plan, who begin working for a new employer with an approved equivalent plan, must be automatically covered for benefits under the equivalent plan offered by the new employer as described in ORS 657B.250;

(2) Provide family leave as described in ORS 657B.010(17) and applicable administrative rules;

(3) Provide medical leave as described in ORS 657B.010(19) and applicable administrative rules;

(4) Provide safe leave as described in ORS 657B.010(21) and applicable administrative rules;

(5) Allow eligible employees to take family leave, medical leave, or safe leave in a benefit year for periods of time equal to or longer than the duration of leave provided under ORS 657B.020;

(6) Provide eligible employees weekly benefit amounts equal to or greater than benefits provided under ORS 657B.050;

(7) Allow family leave, medical leave, or safe leave to be taken in increments or nonconsecutive periods as provided under ORS 657B.090;

(8) Impose no additional conditions or restrictions on the use of family leave, medical leave, or safe leave beyond those explicitly authorized by ORS chapter 657B and applicable administrative rules;

(9) Provide that the employee contributions withheld by an equivalent plan shall not be greater than the employee contributions that would be charged to employees under ORS 657B.150 and determined annually under OAR 471-070-3010;

(10) Ensure employee contributions that are received or retained under an equivalent plan are used solely for equivalent plan expenses, are not considered part of an employer's assets for any purpose, and are held separately from all other employer funds;

(11) Meet all equivalent plan requirements provided in ORS 657B.210 and applicable administrative rules;

(12) Provide for decisions on benefit claims, to be in writing, either in hard copy or electronically if the employee has opted for electronic notification. Decisions on benefit claim approvals must include the amount of leave approved, the weekly benefit amount, and a statement indicating how the employee may contact the department to request the eligible employee's average weekly wage amount if the employee believes the benefit amount may be incorrect. Denial decisions must include the reason(s) for denial of benefits along with an explanation of an employee's right to appeal the decision and instructions on how to submit an appeal.

(13) Provide an appeal process to review benefit decisions when requested by an employee that also requires the employer or administrator to issue a written decision. The employee must have at least 60 calendar days from the date of the written denial to request an appeal with the employer or administrator, if applicable, or as soon as practicable if there is good cause for the delay beyond the 60 calendar days as described in OAR 471-070-2400(7). The employee, and the employer, or administrator have 20 calendar days from the date the appeal is received, or as soon as practicable if there is good cause as described in OAR 471-070-2400(7), to resolve the appeal and for the employer or administrator to issue a written appeal determination letter along with an explanation of the department's dispute resolution process as described in OAR 471-070-2400 if an appeal is denied;

(14) Provide that the equivalent plan employer or administrator must make all reasonable efforts to make a decision on whether to allow the claim and issue the first payment of any benefits to an employee within two weeks after receiving

the claim or the start of leave, whichever is later. Subsequent benefit payments must be provided weekly by a fully insured equivalent plan and benefit payments may be paid according to the existing paycheck schedule for employees under an employer administered equivalent plan; and

(15) Ensure a written notice poster for the equivalent plan as described in OAR 471-070-2330, will be given to all employees, at the time of hire and each time the policy or procedure changes, in the language that the employer typically uses to communicate with the employee.

STATUTORY/OTHER AUTHORITY: ORS 657B.340

STATUTES/OTHER IMPLEMENTED: ORS 657B.210

AMEND: 471-070-3710

REPEAL: Temporary 471-070-3710 from ED 2-2024

RULE TITLE: Assistance Grants: Application Requirements

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule outlines the application requirements for small employers seeking assistance grants and is being amended to clarify the requirements for an individual to qualify as a temporary worker for the purpose of an assistance grant.

RULE TEXT:

(1) An employer may apply for an assistance grant only:

(a) After an eligible employee has been approved by the department for family leave, medical leave or safe leave; and

(b) Prior to the end of the fourth month following the last day of the eligible employee's period of leave.

(2) An application for a grant must be submitted online or by another method approved by the department. The grant application must be complete and include the following:

(a) Information about the employer applying for the grant, including:

(A) Business Identification Number or Federal Employer Identification Number;

(B) Business name;

(C) Business address; and

(D) Business contact person's name and contact information;

(b) Information about the eligible employee taking leave for which the employer is requesting the grant, including but not limited to:

(A) First and last name;

(B) Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN);

(C) Start date of the leave; and

(D) End date or expected leave end date;

(c) Information about the grant being requested, including:

(A) Type of grant requested; and

(B) Grant amount requested, when applicable;

(d) Written documentation demonstrating that the employer:

(A) Hired a temporary worker to replace an eligible employee on family leave, medical leave, or safe leave, including the temporary worker's name, start date, SSN or ITIN, and documentation demonstrating that the worker qualifies as a temporary worker for an assistance grant under section (7) of this rule; or

(B) Incurred significant additional wage-related costs due to an eligible employee's use of leave and the amount, including, but not limited to, receipts, personnel or payroll records, or sworn statements; and

(e) Acknowledgement that:

(A) The employer is required to pay the employer contribution for a period of eight calendar quarters in accordance with OAR 471-070-3750; and

(B) The employer could be required to repay an assistance grant if the employer is later deemed to be ineligible in accordance with OAR 471-070-3850.

(3) An employer that receives a grant under ORS 657B.200(1)(b) may submit another grant application requesting an additional grant under ORS 657B.200(2).

(a) The new grant application must contain:

(A) A new leave end date or new expected leave end date showing an extension of the initial period of leave requested; and

(B) Written documentation demonstrating that a temporary worker was hired to replace an eligible employee on family leave, medical leave or safe leave including the temporary worker's name, start date, SSN or ITIN, and documentation demonstrating that the worker qualifies as a temporary worker for an assistance grant under section (7) of this rule.

(b) The additional grant application submitted under this section will not count against an employer's application limit under ORS 657B.200(3).
(4) An incomplete application will not be considered by the department until and unless it is completed and will not count against an employer's application limit under ORS 657B.200(3).
(5) The department may deny an application for a grant for reasons that include, but are not limited to, the employer's failure to demonstrate that:
(a) The employer hired a temporary worker or incurred significant additional wage-related costs; or
(b) The temporary worker hired or significant additional wage-related costs incurred was due to an employee's use of family leave, medical leave or safe leave.
(6) A denied grant application will count against an employer's application limit under ORS 657B.200(3).
(7) A worker hired to replace an eligible employee during the eligible employee's family leave, medical leave or safe leave qualifies as a temporary worker for an assistance grant under ORS 657B.200(1)(a) or (2) if all of the following are true:
(a) The worker was hired on or after the date an eligible employee provided notice of expected qualifying leave;
(b) The worker was hired to perform the same or substantially similar duties and responsibilities as the eligible employee on leave, entailing equivalent skill, effort, responsibility, and authority; and
(c) The worker was not initially hired for a period extending more than 30 calendar days beyond the expected end of the eligible employee's qualifying leave.
[Publications: Contact the Oregon Employment Department for information about how to obtain a copy of the publication referred to or incorporated by reference in this rule.]

STATUTORY/OTHER AUTHORITY: ORS 657B.200, 657B.340

STATUTES/OTHER IMPLEMENTED: ORS 657B.200

AMEND: 471-070-3730

RULE TITLE: Assistance Grants: Grant Amounts

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule, which explains the amounts provided under approved Paid Leave assistance grants, is being amended to replace the term "replacement worker" with "temporary worker," to align with statute and with changes to OAR 471-070-3710.

RULE TEXT:

The amount paid for an approved assistance grant is as follows:

(1) An employer that hired a temporary worker to replace an eligible employee on family leave, medical leave or safe leave receives a grant of $3,000.

(2) An employer that incurred significant additional wage-related costs due to an eligible employee's use of family leave, medical leave or safe leave receives a grant equal to the actual costs incurred and provided with the application approved by the department, up to $1,000.

(3) An employer that received a grant in accordance with section (2) of this rule may receive the difference between the amount received in section (2) of this rule and $3,000, if the employee taking leave extended the period of leave beyond the initial expected period of the leave and the employer hires a replacement worker.

STATUTORY/OTHER AUTHORITY: ORS 657B.200, 657B.340

STATUTES/OTHER IMPLEMENTED: ORS 657B.200

AMEND: 471-070-8005

RULE TITLE: Appeals: Request for Hearing

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule is being amended to note a change in the final date to appeal a department decision. When a decision's finality date occurs on a weekend or holiday, that date will be extended to the next business day.

RULE TEXT:

(1) A request for hearing may be filed on forms provided by the department. Use of the form is not required provided the party specifically requests a hearing or otherwise expresses a present intent to appeal and it can be determined what issue or decision is being appealed.

(2) A claimant's request for hearing on an administrative decision related to Paid Family and Medical Leave Insurance (PFMLI) benefits under ORS chapter 657B and applicable administrative rules must be in writing and filed within 60 calendar days after the administrative decision is issued and may be filed:

(a) By mail, email, or other means, as designated by the department in the notice of administrative decision that is being appealed;

(b) In person at any publicly accessible Employment Department office in Oregon; or

(c) By a method approved by the department, including use of the department's secured website, as provided on the notice of administrative decision that is being appealed.

(3) An employer, self-employed individual, or tribal government's request for hearing on an administrative decision related to PFMLI contributions, employer assistance grants, equivalent plans, or penalties under ORS chapter 657B and applicable administrative rules, must be in writing and filed within 20 calendar days after the administrative decision is issued. The request for hearing may be filed:

(a) By mail, email, or other means, as designated by the department in the notice of administrative decision that is being appealed;

(b) In person at any publicly accessible Employment Department office in Oregon; or

(c) By a method otherwise approved by the department, including through the use of the department's secured website, as provided on the notice of administrative decision that is being appealed.

(4) The filing date for any request for hearing shall be determined as follows:

(a) When delivered in person to any Employment Department office in Oregon, the filing date is the date of delivery to the department, as evidenced by the receipt date stamped or written by the department employee who receives the document.

(b) When filed by mail, the date of filing is the postmarked date affixed by the United States Postal Service. In the absence of a postmark date, the date of the response shall be the most probable date of mailing as determined by the department.

(c) When filed by email, the date of filing is the date of delivery, as evidenced by the receipt date on the department's email system.

(d) When filed through the department's secured website, the date of filing is the date indicated in OAR 471-070-0850(3).

(e) When filed by any other means, the date of filing is the date of delivery, as evidenced by the receipt date stamped or written by the employee of the department who receives the document.

(5) In computing the period of time by which a party must submit an appeal, the day the administrative decision is issued shall not be counted. The last day of the time period shall be included, unless it is a scheduled day of office closure, in which case the time period extends to the next day the office is open. Scheduled days of office closure include, but are not limited to, Saturdays, Sundays, and legal holidays identified in ORS 187.010 and 187.020.

(6) A request for hearing with respect to a claim for benefits shall not stay the payment of any benefits not placed in issue by the request for hearing, nor shall it stay an order previously entered allowing benefits.

[Publications: Contact the Oregon Employment Department for information about how to obtain a copy of the publication referred to or incorporated by reference in this rule.]

STATUTORY/OTHER AUTHORITY: ORS 657B.340

STATUTES/OTHER IMPLEMENTED: ORS 657B.410, ORS 187.010, 187.020

AMEND: 471-070-8520

RULE TITLE: One-Percent Penalty

NOTICE FILED DATE: 05/29/2024

RULE SUMMARY: This administrative rule is being amended to clarify that the department will use the contested case process outlined in the Paid Leave Oregon program's rules rather than the model rules for contested cases in OAR chapter 137, division 3.

RULE TEXT:

(1) If an employer has failed to file or complete all required reports or pay all required contributions for the calendar year as described in 471-070-3030, the department shall assess the penalty authorized by ORS 657B.910 on the Paid Family and Medical Leave Insurance (PFMLI) subject wages. The department shall send notice of the assessment of such penalty to the employer's last known address or electronically when permitted, if the employer has opted for electronic notification, as shown in the department's records on or before October 20 of the year. The penalty shall become due on November 10 immediately following the assessment.

(2) On or after the date of the assessment, but prior to November 10 immediately following the assessment, the employer may request waiver of the penalty based on good cause as defined in OAR 471-070-8530.

(3) If an employer makes a request for waiver of the penalty within the time prescribed in section (2) of this rule, the department shall make a decision, either granting or denying the waiver, and mail notice of the decision to the employer's last known address or electronically when permitted, if the employer has opted for electronic notification, as shown in the department's records. If, prior to November 10 immediately following the assessment, the department determines that the employer had good cause for the failure to file all reports or pay all contributions due by September 1, the department shall grant the request for waiver and remove the penalty from the employer's account. If the employer fails to establish good cause prior to November 10 immediately following the assessment, the department shall deny the request for waiver. If the request for waiver is denied, the department shall notify the employer that a request for a contested case hearing may be filed within 20 calendar days after the date that the penalty waiver decision is sent to the employer.

(4) Hearings held and administrative law judge decisions issued pursuant to section (3) of this rule shall be in accordance with the provisions in the Oregon Administrative Rules (OAR) located in chapter 471, division 70.

(5) Judicial review of administrative law judge decisions issued pursuant to this rule shall be as provided for review of orders in contested cases under ORS chapter 183 and under any applicable appeals provisions in the Oregon Administrative Rules (OAR) located in chapter 471, division 70. The director is designated as a party for the purposes of hearings under this rule.

(6) Upon motion of the director or upon application of an interested employer, the director may reconsider a penalty imposed under ORS 657B.910 irrespective of whether it has become final:

(a) Such reconsideration shall be restricted to penalties resulting from clerical errors or errors of computation and may include a new decision upon any grounds or issues not previously ruled upon or new facts not previously known to the director;

(b) A new decision issued after reconsideration shall be subject to hearing and judicial review in accordance with this rule.

(7) A request for waiver of the penalty for good cause must be in writing. The date of any request for waiver under this rule shall be:

(a) The postmarked date on the request, if mailed;

(b) The date specified in OAR 471-070-0850, if electronically filed; or

(c) In the absence of a postmark, submittal date or machine imprinted date, the most probable date of mailing as determined by the director.

(8) The employees listed in OAR 471-070-0550 may act on behalf of the director for the purposes of sections (1), (2) and (3) of this rule.

STATUTORY/OTHER AUTHORITY: ORS 657B.340

STATUTES/OTHER IMPLEMENTED: ORS 657B.910