SDI ONLINE TUTORIAL

Apply for Paid Family Leave

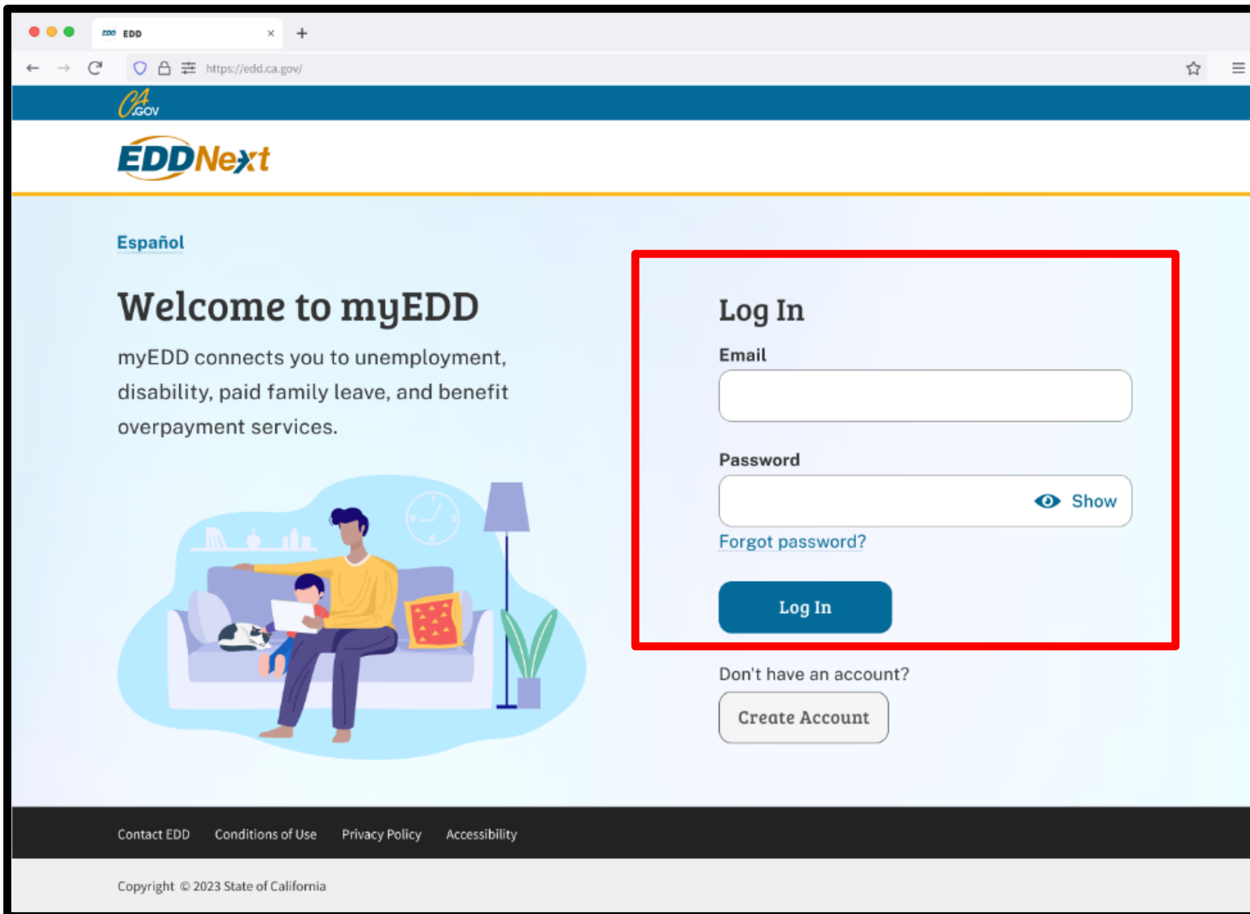
Care Benefits

Last Updated: April 2026

File a Care Application

Learn how to apply for care benefits if you need to provide care to a seriously ill or injured family member.

Get Started

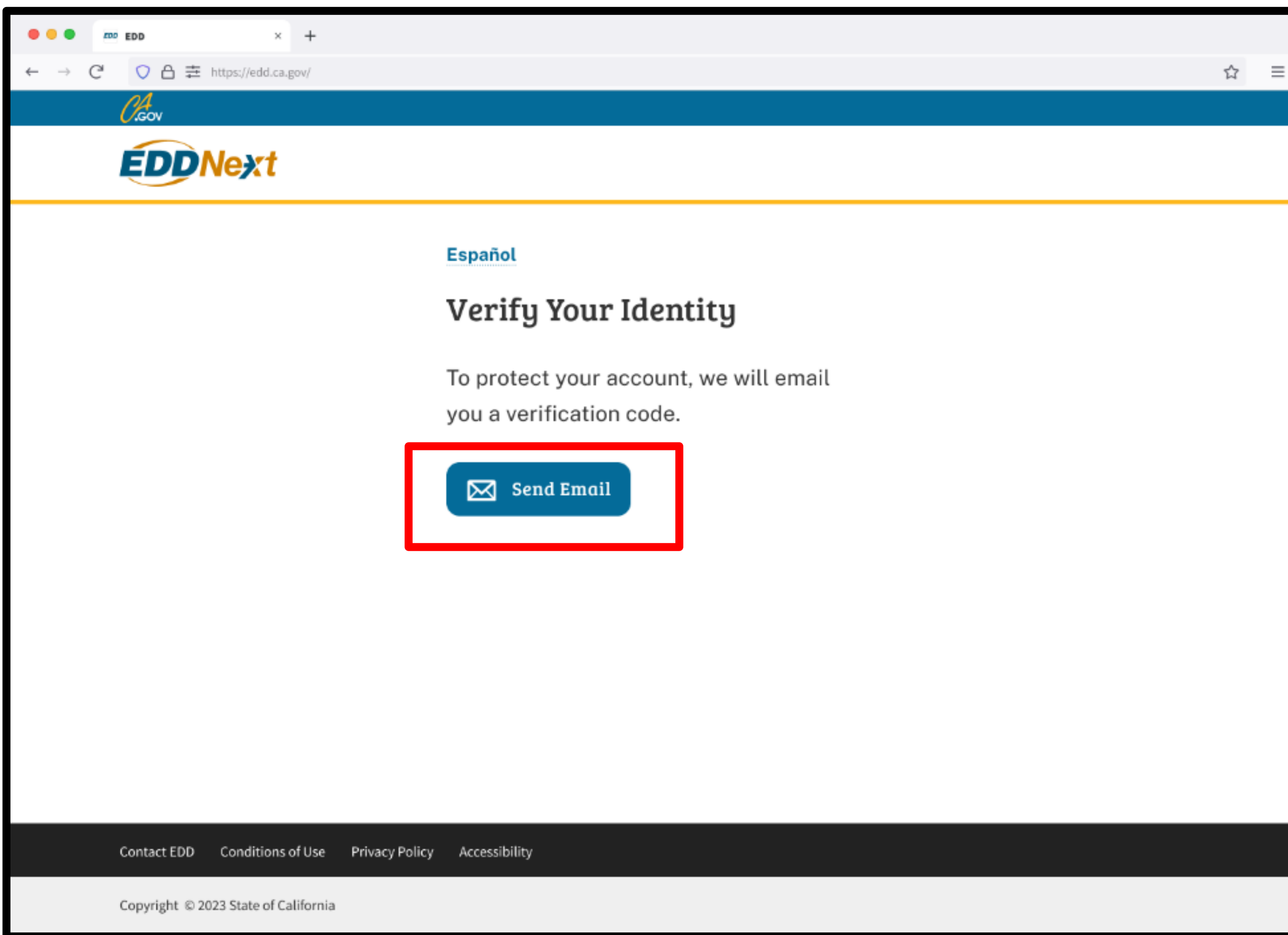


Note

For Spanish, select **Español**.

Log in to myEDD to access SDI Online, update your email, password, security question, or login verification option:

1. Visit myEDD.
2. Enter the email and password used to create your myEDD account.
3. Select **Log In**.



Note

You can verify your identity through email even if your preferred verification option is text or voice.

To protect your account, we ask you to verify your identity every time you log in. In this example, the identity verification option is by email.

Select **Send Email**.

If you set up the login verification option as text message or phone call, follow the instructions based on that option.

EDD

https://edd.ca.gov/

CA.GOV

EDDNext

Español

Enter Verification Code

Enter the verification code you received at {J*****@gmail.com}. This code expires in 5 minutes.

*Required Field

*Verification Code

Submit

Didn't get the email?

Check your spam folder or resend the email.

Contact EDD | Conditions of Use | Privacy Policy | Accessibility

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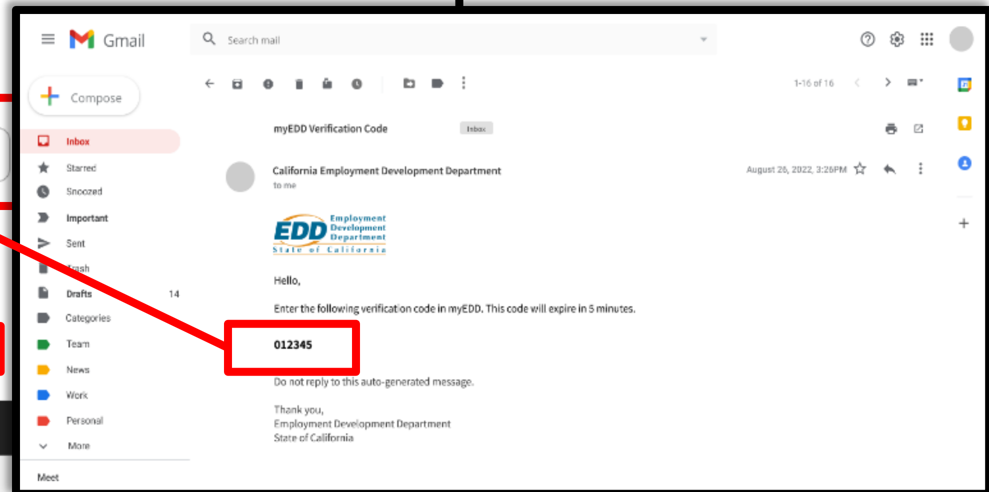

Check your email for your verification code. This code expires in five minutes. Check your spam or junk folder if you do not get this email.

- Enter your verification code and select **Submit**.
- Select **resend the email** if you do not get a code.

https://edd.ca.gov/

EDDNext

myEDD Home | My Profile | Log Out

Español

myEDD Home

Select your EDD service.

Unemployment

Apply for unemployment benefits, create an online account, or manage your claim.

UI Online

Disability and Paid Family Leave

Apply for disability or family leave benefits, create an online account, or manage your disability claim.

SDI Online

Benefit Overpayments

Apply for unemployment benefits, create an online account, or manage your claim.

Benefit Overpayment Services

Contact EDD | Conditions of Use | Privacy Policy | Accessibility

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Note

Select **Log Out** in the top right corner of any screen to exit your account.

From the myEDD homepage, select **SDI Online.**

SDI Online Home | myEDD | Utilities | Help | Liz Keen | Log Out

SDI Home | Inbox | New Claim | Draft | Profile | History

SDI Online Home

Message Center

Check the message center Inbox below to review messages and take required actions as needed.

Inbox [New: 1 , Total: 1]

Apply for Benefits

Start a new application or continue a draft application for disability or Paid Family Leave benefits.

Apply

Current Disability Claims

Claim ID	Status	Claim Effective Date
DI-1000-027-802	Payments Stopped	05-02-2025

Pending Disability Applications

Claim ID	Status	Date Submitted	Receipt Number
DI-1000-027-805	Signature Needed	05-30-2025	R100000000078788

Current Paid Family Leave Claims

Claim ID	Status	Claim Effective Date
PF-1000-027-806	Claim Active	04-02-2025

Pending Paid Family Leave Applications

Claim ID	Status	Date Submitted	Receipt Number
PF-1000-027-857	Medical Certification Needed	06-02-2025	R100000000078961

Share Your Feedback

We welcome feedback about your experience applying online for benefits.

Select **New Claim** from the main menu or **Apply** from the Apply for Benefits section.

Note

Submit your application earlier than the first day your family leave begins, but no later than 41 days after your family leave begins, or you may lose benefits.

SDI Online Home myEDD Utilities Help Jay Rai Log Out

EDD Employment Development Department State of California

SDI Home Inbox New Claim Draft Profile History

Apply for Benefits

Select the type of benefit you're applying for or continue your draft application.

Disability Benefits

Disability provides benefits if you are not able to do your regular work due to a disability.

Disability

A disability includes:

- An illness or injury, either physical or mental.
- Surgery, including elective surgery.
- Pregnancy and childbirth.

Apply for Disability

Paid Family Leave Benefits

Paid Family Leave (PFL) provides benefits if you need to take time off for your family.

Bonding

Bond with a child.

Apply for PFL Bonding

Add Bonding Document

Care

Care for a seriously ill family member.

Apply for PFL Care

Add Care Document

Military Assist

Participate in a qualifying event because of a family member's military deployment.

Apply for PFL Military Assist

Add Military Assist Document

To apply for care benefits, select **Apply for PFL Care** under Paid Family Leave Benefits.

Important

If you already submitted an application, do not submit another one. It may take up to 14 days for a completed application to be reviewed and processed.

Information for Before You Start and After You File

Before You Start and After You File

Please have the following information available while completing this form:

- Most current employer(s) business name, telephone number, and mailing address as stated on your W2 form and/or paycheck stub.
- Last date you worked your regular or customary duties and hours.
- Wages you received or expect to receive from your employer: sick leave, paid time off (PTO), vacation pay, annual leave, and wages earned after you stopped working.
- You are responsible for obtaining a Physician/Practitioner Certification to verify care is needed. A disqualification will be sent to you if the Physician/Practitioner Certification is not received within 10 days.
- Please note that your employer will be notified that you have submitted a PFL claim. However, your detailed claim information is confidential and will not be shared with your employer.

Cancel | Next

Review the Information for Before You Start and After You File. It has important information you need to file a care claim.

Select **Next.**

1 Personal Information | 2 Employment Information | 3 Additional Questions | 4 Care Certification | 5 Declaration

You are currently on Step 1 Personal Information

Section 1 - Personal Information

Social Security Number: XXX-XX-XXXX

EDD Customer Account Number: 123456789

Full Name: John Doe

Other Names (if any, under which you have worked):

Date of Birth: XX-XX-XXXX

Gender: Male

Mailing Address: 123 Main St
Sacramento, CA 95814

Phone Number: 916-555-1212

Preferred Language:

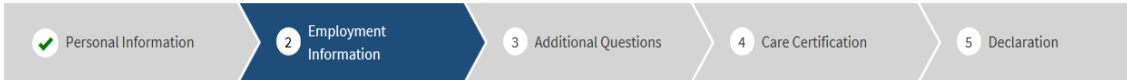
If your personal information has changed, select Save as Draft. To update your personal information before completing this form, select Profile.

Previous | Cancel | Save as Draft | Next

The system automatically fills certain portions of the application form.

- Make sure the information is correct. If your personal information has changed, select **Save as Draft** and update your SDI Online profile.
- Select **Next** to continue.

Employment Details



You are currently on Step 2 Employment Information

* Indicates Required Field

Section 2 - Employer Information

Enter your current employer. If unemployed, enter your most recent employer.

*** Name of Your Employer:**

*** Occupation:**

*** Are you a state government employee?** Yes No

If "Yes", Indicate Bargaining Unit Number:

*** May we disclose benefit payment information to your employer(s)?** Yes No

*** Do you have more than one employer?** Yes No

*** Reason for reducing work hours or stopping work:** Care for Family Member Other

Employer Mailing Address

US International

*** Address Line 1:**

Address Line 2:

*** City:**

*** State:** CA

*** ZIP Code:**

Employer Phone Number: (No dashes or spaces) **Ext:**

Check here if the phone number is international

Previous Cancel Save as Draft Next

Complete Section 2 - Employer Information with your current employer's

- Business name
- Phone number
- Mailing address as shown on your W-2 or paystub.

If you're unsure what address to enter, ask your employer.

You must complete the fields marked with a red asterisk (*).

Select **Next** to continue.

Additional Questions

Personal Information | Employment Information | 3 Additional Questions | 4 Care Certification | 5 Declaration

You are currently on Step 3 Additional Questions

*Indicates Required Field

Section 3 - Additional Questions

*Date you last worked: (MMDDYYYY)

*Date you want your Paid Family Leave claim to begin: (MMDDYYYY)

*Do you want to claim the maximum amount of benefit weeks now? Yes No

If "No," enter the date you want to be paid through: (MMDDYYYY)

Date you returned to work: (MMDDYYYY)

Or date you plan to return to work: (MMDDYYYY)

*Will you work at any time during your family leave? Yes No

If you will receive any type of pay from your employer(s) during your family leave, indicate type of pay: Sick / Employer Required Vacation / Other Type of Pay

Specify if "Other type of pay": Select

*At any time during your Paid Family Leave, were you in the custody of law enforcement authorities because you were convicted of violating a law or ordinance? Yes No

*Have you claimed or do you plan to claim Workers' Compensation Benefits for any portion of the period covered by this claim? Yes No

Previous | Cancel | Save as Draft | Next

Complete Section 3 - Additional Questions and confirm all dates are correct to avoid a delay or incorrect payment of benefits.

You must complete the fields marked with a red asterisk (*).

Select **Next**.

Care Recipient's Information

Personal Information | Employment Information | Additional Questions | 4 Care Certification | 5 Declaration

You are currently on Step 4 Care Certification

* Indicates Required Field

Section 4 - Care Recipient's Information

You must submit a signed "Care Recipient Authorization of Disclosure of Personal Health Information" form and a signed "Statement of Care Recipient" form. Details on how to submit these forms will be provided on the confirmation page.

These documents must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online care claim.

* First Name:
Middle Initial:
* Last Name:
Suffix:
* Gender: Male Female
* Date of Birth: (MMDDYYYY)
* Is any other family member ready, willing, and able and available to provide care for the same period you are claiming Paid Family Leave benefits? Yes No
* Person you are caring for is your: Select
Other Relationship:

Residence Address

US International
* Address Line 1:
Address Line 2:
* City:
* State: CA
* ZIP Code:
Phone Number: (No dashes or spaces) Ext:
Check here if the phone number is international

Previous | Cancel | Save as Draft | Next

Complete Section 4 - Care Recipient's Information and Residence Address with information about the person you are caring for.

Details on how to submit a signed Statement of Care Recipient form are available on the Confirmation screen.

You must complete the fields marked with a red asterisk (*).

Select **Next**.

CA.GOV Log Out

EDD Employment Development Department State of California

SDI Home | Inbox | New Claim | Draft | Profile | History

Benefit Payment Options

✓ Personal Information › ✓ Employment Information › ✓ Additional Questions › ✓ Care Certification › 5 Declaration

You are currently on Step 5 Declaration

*Indicates Required Field

Section 5 – Select Your Option

If you're eligible for benefits, you have three options to receive your benefit payments.

***Select your payment option:**
- ○ Direct Deposit
- ○ Debit Card
- ○ Mailed Checks

☐ I have reviewed the Debit Card Fees and Disclosures.

Gather your bank routing and account numbers and select **Next** to continue.

[Previous] [Cancel] [Save as Draft] [Next]

Complete Section 5 to choose your benefit payment option.

Select the **“I have reviewed...”** box to confirm you have read the disclosures, then select **Next**.

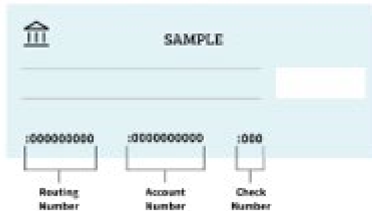
Enter Your Banking Information

*Required Field

First Name
STORMY

Last Name
WEATHER

Routing and Account Number Sample



*Routing Number
Routing number must be 9 digits.

*Account Number
Account number must be 5-17 digits.
Show

*Confirm Account Number
Show

*Account Type
- Checking
- Savings

Before You Submit

If your bank does not accept direct deposit, you will receive benefit payments on a prepaid debit card.

*You must read and agree to the following documents

Direct Deposit Terms of Use (PDF)
Prepaid Debit Card Disclosures (PDF)

*☐ I have read and agree to the terms of use and disclosures

Back Submit

Money Network Online Privacy Policy
Flagstar Bank, N.A. Privacy Policy

© 2024 Money Network Financial, LLC as processor on behalf of Flagstar Bank, N.A.

If you selected Direct Deposit, you will be asked to provide your banking information.

You must select and open the “terms of use” documents and disclosures before you can submit your information.

Select **Submit** to continue.

Section 6 - Declaration

Read the information below and check each box if you agree. A check in the box indicates an electronic signature executed by you, and is a legally binding equivalent of traditional hand-written signatures.

* ☐ By my electronic signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was providing care for the care recipient named above; (2) authorize EDD to release my personal information as shown on this claim to the care recipient and to the care recipient's treating physician/practitioner as they are listed on this claim; (3) authorize my employer(s) to disclose to EDD all facts concerning my employment that are within their knowledge; and (4) authorize release and use of information as stated in the EDD "Information Collection and Access" section of the Important Paid Family Leave Program Information page. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my electronic signature or the effective date of the claim, whichever is later.

Previous | Cancel | Save as Draft | Submit

In Section 6 – Declaration, select the box to authorize an electronic signature. You must select this box to complete your claim.

Note: You cannot modify the form after you select Submit.

Select **Submit** to send the online portion of your claim to us.

Important

Your application is not complete. The Confirmation screen provides instructions to order and submit the Statement of Care Recipient and the Physician's/Practitioner's Certification sections of the *Application for Paid Family Leave Benefits* (DE 2501F).

Paid Family Leave (PFL) Survey Questions

* Indicates Required Field

Paid Family Leave (PFL) Survey

The EDD has received your portion of your claim for Paid Family Leave benefits. There is one more step to complete before you receive your claim receipt number. Please answer the questions below and then select the "Submit" button for your receipt number.

*** Before you filed your Paid Family Leave (PFL) claim, how did you learn about the Paid Family Leave (PFL) benefit program? Please select the response that best applies:**

- ◯ From a brochure I received by U.S. mail.
- ◯ From a friend or family member.
- ◯ From an SDI Online Notification.
- ◯ From my employer.
- ◯ From a social worker or hospital employee.
- ◯ None of these.

Submit

Complete the survey and select **Submit**.

Confirmation

Print this page for your records. If a printer is unavailable at this time, record the Form Receipt Number below. The Form Receipt Number is required to retrieve a copy of the *Paid Family Leave Claim Care* (DE 2501F) application. You will not be able to access your confirmation page and Form Receipt Number after this window is closed.

Most claims are processed and a decision is made within two weeks of the date the claim was submitted. If you have not received anything from PFL within 10 days or if you have any questions you may call 1-877-238-4373.

Confirmation Information

Claimant Name:	AARON B EVANS	**Social Security Number:**	XXX-XX-0003
Date you requested to have your Paid Family Leave claim begin:	01-01-2025	**Receipt Number**	R100000000332708

Instructions for Submitting Physician/Practitioner's Certification for Care Recipient

To be eligible for Paid Family Leave benefits to care for a family member, you must submit a "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information". These documents must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online care claim.

Failure to submit the "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information" will result in claim disqualification and no payment will be issued.

Mail

You may mail your "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information".

Mail your document to:
EDD - Paid Family Leave
PO BOX 997017
SACRAMENTO CA 95799-7017

We assign your claim a **Receipt Number** on the Confirmation screen.

Save the **Receipt Number** for future reference. You need this number to upload the supporting documentation to the correct online application.

Submit Supporting Documents

Learn how to submit supporting documents to complete your application for care benefits.

Get Started

Instructions for Submitting Physician/Practitioner's Certification for Care Recipient

To be eligible for Paid Family Leave benefits to care for a family member, you must submit a "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information". These documents must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online care claim.

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Mail your document to:
EDD - Paid Family Leave
PO BOX 997017
SACRAMENTO CA 95799-7017

You must order an *Application for Paid Family Leave Benefits* (DE 2501F) to obtain Part C and Part D. These are the required supporting care claim documents.

It is your responsibility to make sure Part C and Part D of this form are completed and signed by all parties and sent to us within 10 days.

Note

You can order the DE 2501F in English or DE 2501F/S in Spanish from Online Forms and Publications.

Instructions for Submitting Physician/Practitioner's Certification for Care Recipient

To be eligible for Paid Family Leave benefits to care for a family member, you must submit a "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information". These documents must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online care claim.

Failure to submit the "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information" will result in claim disqualification and no payment will be issued.

Mail

You may mail your "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information".

Mail your document to:
EDD - Paid Family Leave
PO BOX 997017
SACRAMENTO CA 95799-7017

- Complete the Part C and have it signed by the care recipient.
- Mail the completed, signed Part C via US mail to the address on the screen above.
- Your physician/practitioner can submit Part D using SDI Online.
- Or you may send a paper copy of the completed, signed Part D via US mail to the address on the screen above.

It is your responsibility to make sure Part C and Part D of this form are completed and signed by all parties and sent to us within 10 days.

SAMPLE, this page for reference only

Part B – Bonding Certification (to be completed by person claiming PFL benefits to bond with a child)

B1. Your Social Security Number: 0 0 0 0 0 0 0 0 0

B2. Date of foster care or adoption placement: M M D D Y Y Y Y

B3. Child named in B8 is my: Biological Child [X] Stepchild [ ] Foster Child [ ] Adopted Child [ ] Other [ ]

B4. Your Legal Last Name (needed in case pages of this claim become separated): Claimant

B5. Child's Social Security Number (if available):

B6. Child's date of birth: 1 2 0 1 2 0 2 4

B7. Child's Gender Identity: Male [ ] Female [X]

B8. Legal Name of Child | First Name: Cookie MI: A Last Name: Claimant

B9. Address where the child lives (if different from claimant's)

City | State/Prov. | Zip or Postal Code | Country (if not U.S.A.)

B10. As evidence of the relationship in B3, check one of the following and attach a copy of the document checked. (Do not send original document. It will not be returned.)

- [X] Child's birth certificate
- [ ] Declaration of paternity, CS-909
- [ ] Adoptive placement agreement, AD-907
- [ ] Independent adoption placement agreement, AD-924
- [ ] Other

B11. **Declaration and signature.** By my signature on this bonding certification, I authorize the medical provider, adoption agency, adoption party(ies), or foster care placement agency to disclose to the Employment Development Department all facts concerning the birth, adoption, or foster care placement of the above-named child. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements or documents, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of 15 years from the date of my signature or the effective date of the claim, whichever is later.

Original signature of bonding claimant – rubber stamp is not acceptable: *Sample Claimant*

Date Signed: 0 1 2 5 2 0 2 5

Part C – Statement of Family Member Receiving Care

May be completed by claimant if the family member receiving care is mentally or physically unable to do so. Must be signed by the family member receiving care or their authorized representative.

C1. Date of Birth of Family Member Receiving Care: M M D D Y Y Y Y

C2. Phone Number of Family Member Receiving Care

C3. Gender Identity of Family Member Receiving Care: Male [ ] Female [ ]

C4. Legal Name of Family Member Receiving Care | First Name | MI | Last Name

C5. Address of Family Member Receiving Care

City | State/Prov. | Zip or Postal Code | Country (if not U.S.A.)

C6. Confirmation of medical disclosure authorization.
I authorize my Physician/practitioner to disclose my current personal health information to my care provider and to the California Employment Development Department (EDD). I further understand that copies of my signature below are as valid as the original.

Signature of Family Member Receiving Care (Do Not Print) | Date Signed: M M D D Y Y Y Y

C7. **Authorized Representative** signing on behalf of family member receiving care must complete the following I, ______________________, represent the family member receiving care or bonding in this matter as authorized by [ ] parental right [ ] power of attorney (attach copy) [ ] court order (attach copy) (for spouse or domestic partner, contact EDD).

Authorized Representative's Signature (Do Not Print) | Date Signed: M M D D Y Y Y Y

Application for Paid Family Leave Benefits (DE 2501F)

Part C - Statement of Care Recipient, is Page 2.

- Make sure you answer all questions in Part C.
- The care recipient or their authorized representative must sign and date the bottom of this page.
- You cannot upload this form online.
- **Mail the completed, signed Part C via US mail to:**

EDD - Paid Family Leave
PO Box 997017
Sacramento CA 95799-7017

Application for Paid Family Leave Benefits **(DE 2501F), cont.**

SAMPLE, this page for reference only

Medical certifications must be completed by a licensed Physician or Practitioner authorized to certify to a patients disability or serious health condition pursuant to California Unemployment Insurance Code Section 2708.

Instructions for completing this form:

Complete the information in the spaces provided in UPPER CASE using black ink. Do not use special characters (- , . / ').
If handwritten, print each letter or number in a separate box. Ignore the boxes provided if using a typewriter or printer.

Part D – Physician/Practitioner's Certification (Do not complete this part if you are bonding or participating in a qualifying event.)

D1. PFL claimant's (care provider's) Social Security Number

D2. PFL claimant's name — First Name, MI, Last Name

D3. Patient's date of birth — M M D D Y Y Y Y

D4. Does your patient require care by the claimant? — No (skip to D15) / Yes

D5. Patient's Name | First Name, MI, Last Name

D6. Diagnosis or, if not yet determined, a detailed statement of symptoms

D7. Primary ICD Code

D8. Secondary ICD Codes

D9. Date when the patient's condition started — M M D D Y Y Y Y

D10. First date patient needed care — M M D D Y Y Y Y

D11. Date you expect patient to recover — M M D D Y Y Y Y — NEVER

D12. Date you estimate patient will no longer need care by the claimant — M M D D Y Y Y Y — PERMANENT

D13. Approximately how many total hours per day will the patient need the claimant for care? — Hours, Comments

D14. Would disclosure of this certificate to your patient be medically or psychologically detrimental? — No / Yes

D15. Physician/Practitioner's license number

D16. State or Country Physician/Practitioner is licensed

D17. Physician/Practitioner's Name | First Name, MI, Last Name

D18. Physician/Practitioner's Address (Post Office Box is not acceptable as the sole address)
City, State/Prov., Zip or Postal Code, Country (if not U.S.A.)

D19. Type of Physician/Practitioner

D20. Specialty (if any)

D21. Physician/Practitioner's certification and signature: I certify under penalty of perjury that this patient has a serious health condition and requires a care provider. I have performed a physical examination and/or treated the patient. I am authorized to certify a patient disability or serious health condition pursuant to California Unemployment Insurance Code Section 2708.

Original Signature of Attending Physician/Practitioner – rubber stamp is not acceptable | Physician/Practitioner's Phone Number | Date Signed — M M D D Y Y Y Y

Under sections 2116 and 2122 of the California Unemployment Insurance Code, it is a violation for any individual who, with intent to defraud, falsely certifies the medical condition of any person in order to obtain disability insurance benefits, whether for the maker or for any other person, and is punishable by imprisonment and/or a fine not exceeding $20,000. Sections 1143 and 3305 require additional administrative penalties.

Part D - Physician/Practitioner's Certification is Page 3.

- The care recipient's physician/practitioner must complete all relevant information including ICD codes.
- Get a signature from the care recipient's physician/practitioner before you mail the form.

Note

You may also give your **Receipt Number** to your care recipient's physician/practitioner to submit the medical certificate using SDI Online.

Ask the physician/practitioner how they submit a claim certification. Some submit them differently than others.

Mail your supporting documents

Mail your completed, signed Part C and/or Part D to:

EDD - Paid Family Leave
PO Box 997017
Sacramento CA 95799-7017

It is your responsibility to make sure Part C and Part D of this form are completed and signed by all parties and sent to us within 10 days.

Do not submit the same claim more than once. This may delay your benefits.

CONTACT US

1-877-238-4373

– Helpful Links –

Order Forms

Schedule a Webinar

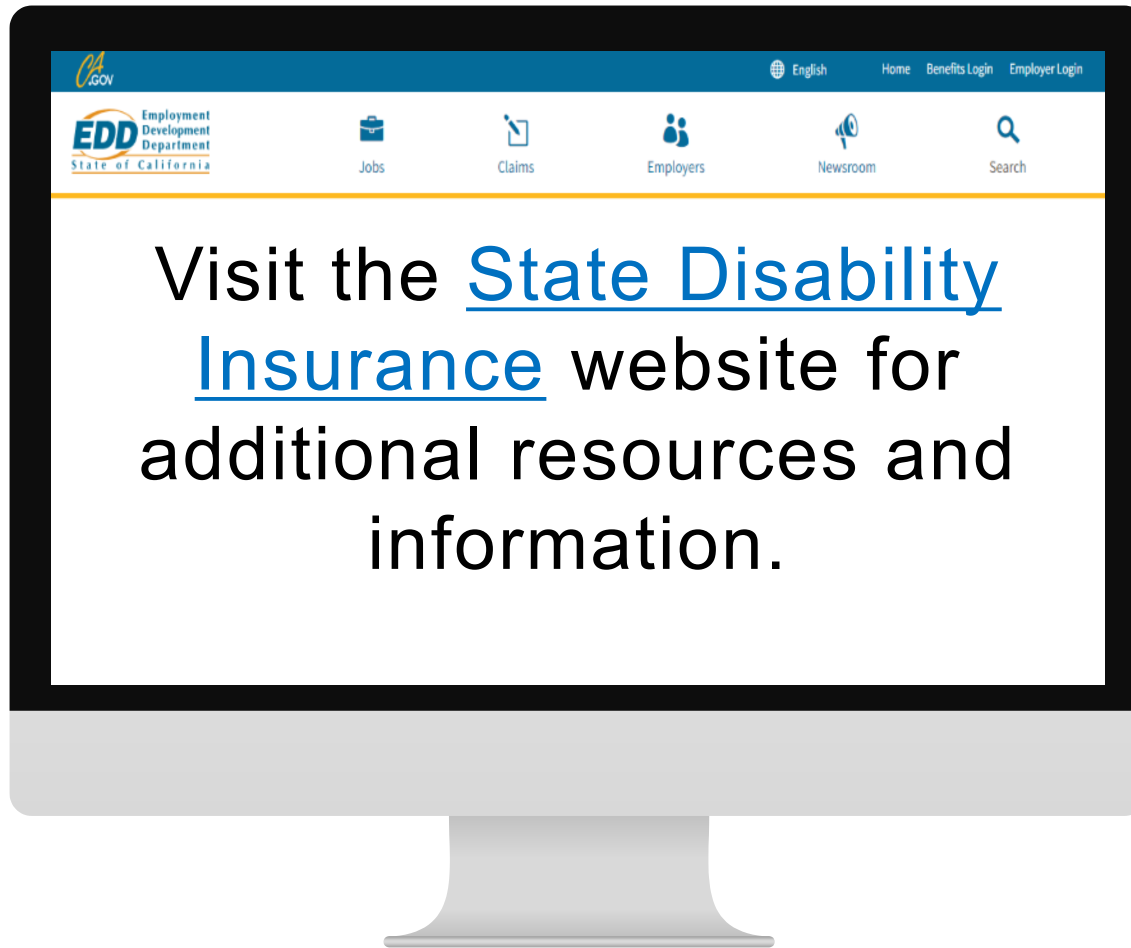
Help Fight Fraud

Contact Us

Accessibility

Language Resources

– Follow us –



EDD is an equal opportunity department for this information. If you need help or services because of a disability, call 1-866-490-8879. TTY users, please call the California Relay Service at 711.