



SDI ONLINE TUTORIAL

Apply for Paid Family Leave Care Benefits

Last Updated: January 2026

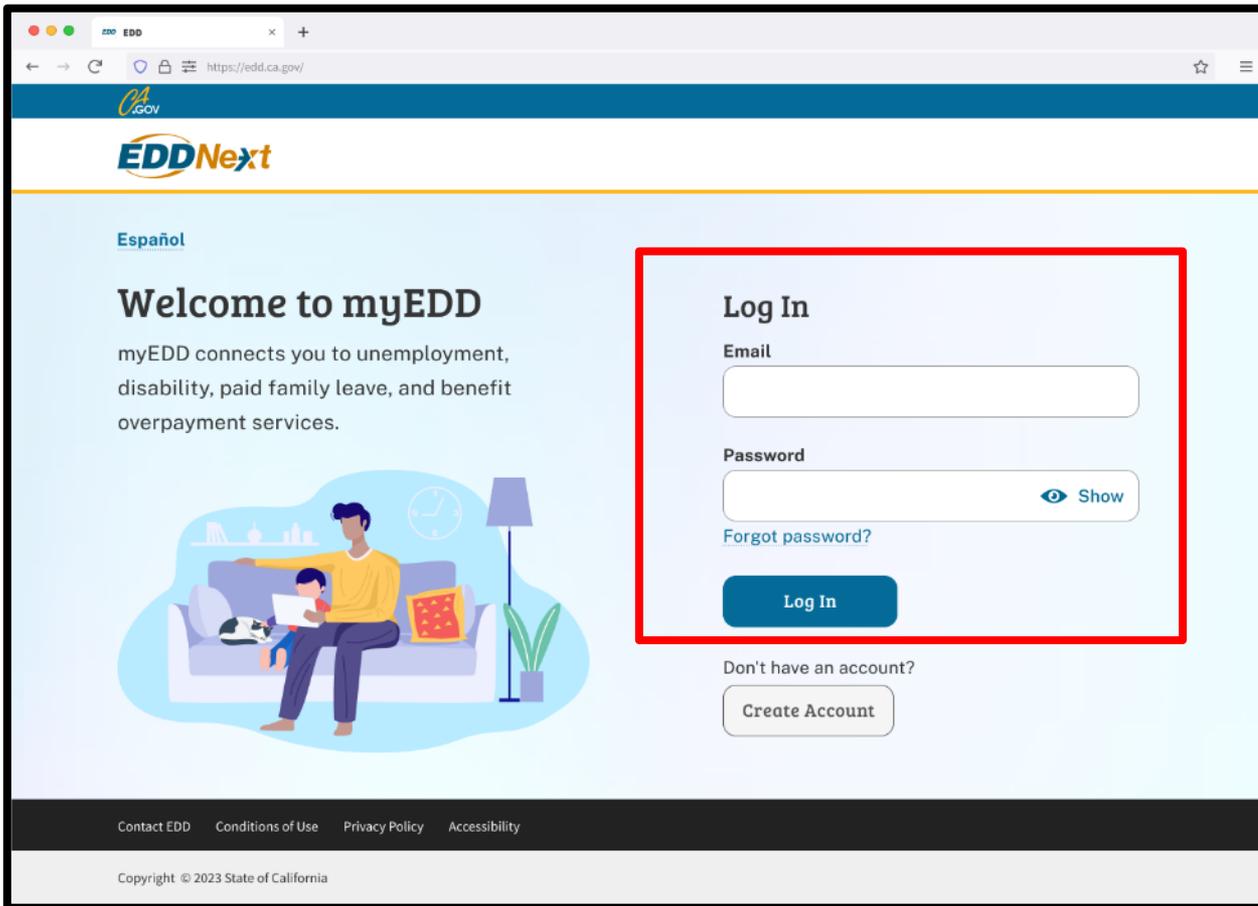


File a Care Application

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



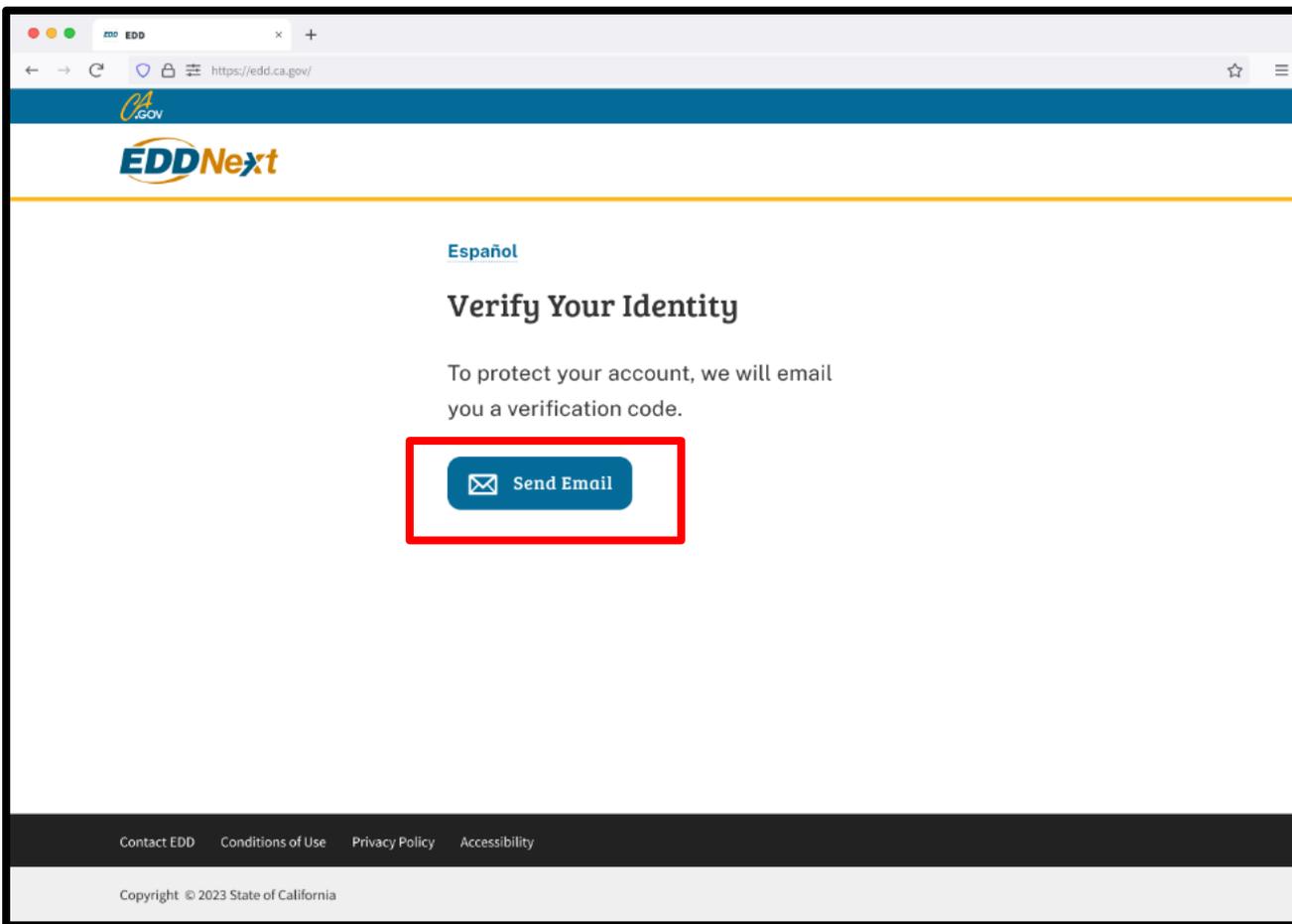
[Get Started](#)



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**.



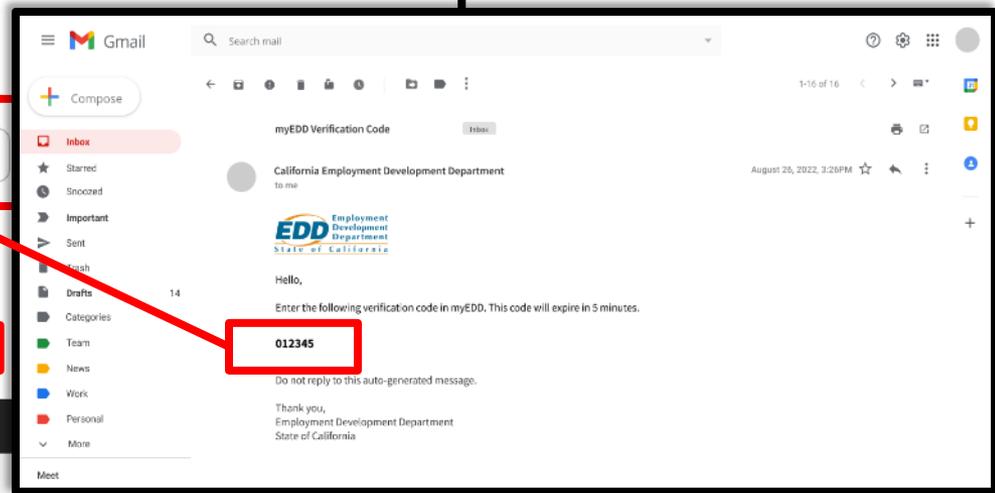
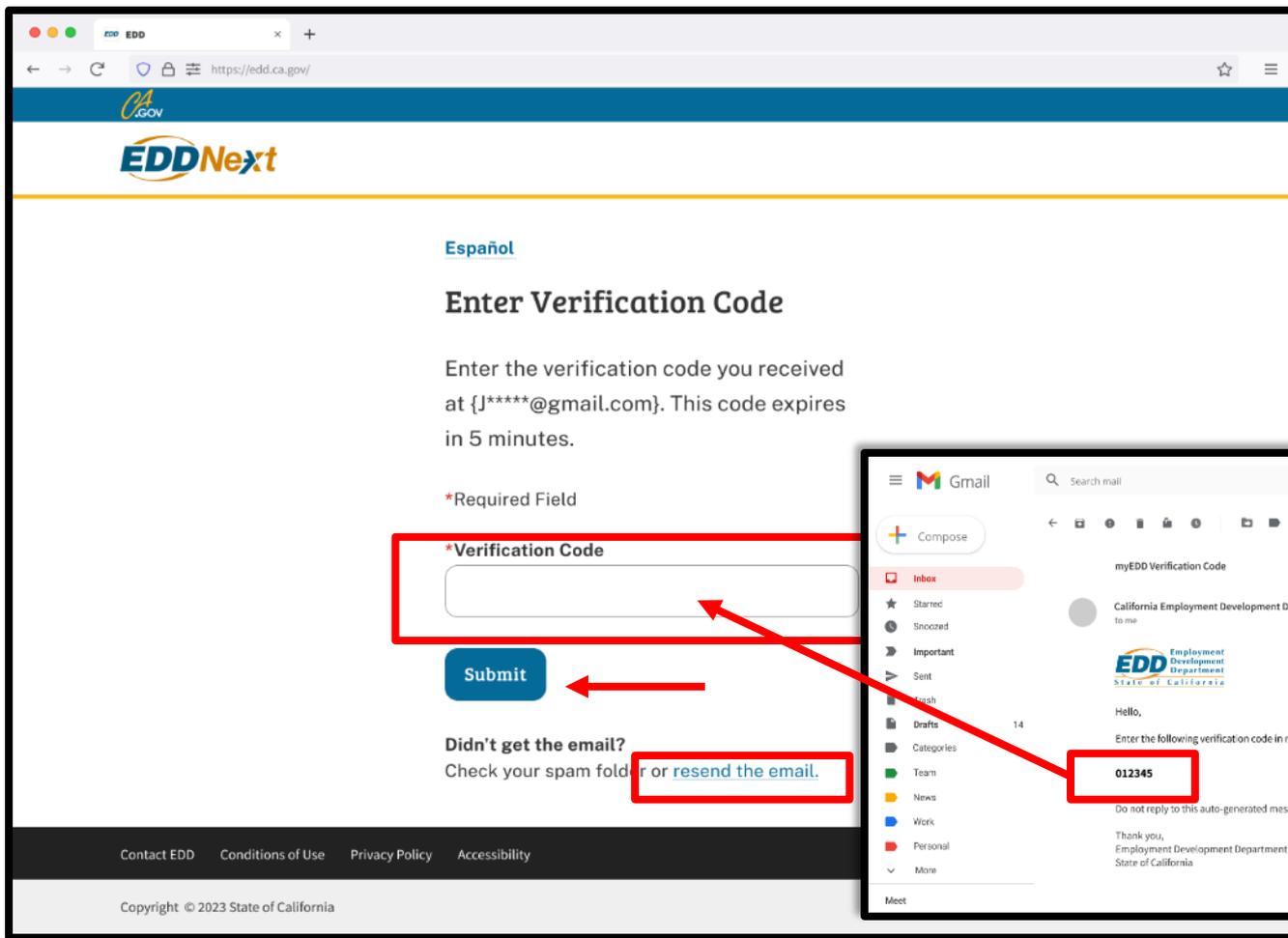
Note

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.



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.

The screenshot shows the myEDD Home page. At the top, there is a navigation bar with the EDDNext logo and three icons: a home icon labeled 'myEDD Home', a person icon labeled 'My Profile', and a back arrow icon labeled 'Log Out'. Below the navigation bar, there is a section for 'Español' and 'myEDD Home'. The main content area is titled 'Select your EDD service.' and contains three service cards. The first card is 'Unemployment' with a 'UI Online' button. The second card is 'Disability and Paid Family Leave' with an 'SDI Online' button, which is highlighted with a red border. The third card is 'Benefit Overpayments' with a 'Benefit Overpayment Services' button. At the bottom, there is a footer with links for 'Contact EDD', 'Conditions of Use', 'Privacy Policy', and 'Accessibility', and a copyright notice for 2023 State of California.

Note

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

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

Home

Message Center

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

Inbox [New: 0 , Total: 0]

Personal Information

Full Name:	John Doe	EDD Customer Account Number:	123456789
Mailing Address:	123 Main St Sacramento, CA 95814	Phone Number:	916-555-1212
Residence Address:	123 Main St Sacramento, CA 95814	Cell Phone Number:	916-555-1213
E-mail Address:	Jdoe@gmail.com		

Current Disability Insurance Claim(s)

No Results Found

Pending Disability Insurance Claim Application(s)

No Results Found

Submitted Paid Family Leave Claim Forms

Only forms you submitted online are listed below. To submit an electronic document for a previously submitted care or bonding claim, select New Claim. The status of your Paid Family Leave claim is currently not available online. For assistance with a Paid Family Leave claim, call 1-877-238-4373.

No Results Found

Select **New Claim** from the main menu.

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

Note: It may be necessary to send some documents via US Postal Service.

Apply for Disability Insurance Benefits

[Disability Insurance](#)

Apply for Paid Family Leave Benefits

[Paid Family Leave Bonding](#)

[Submit Electronic Paid Family Leave Bonding Attachment](#)

[Paid Family Leave Care](#)

[Submit Electronic Paid Family Leave Care Attachment](#)

[Paid Family Leave Military Assist](#)

[Submit Electronic Paid Family Leave Military Assist Attachment](#)

Saved Drafts

To open and complete a form that you saved, select the **Form Name**. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the **Delete** button.

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

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.

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:

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

*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:

Date you returned to work:

Or date you plan to return to work:

*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":

*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:

* 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:

Other Relationship:

Residence Address

US International

* Address Line 1:

Address Line 2:

* City:

* State:

* ZIP Code:

Phone Number: 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.

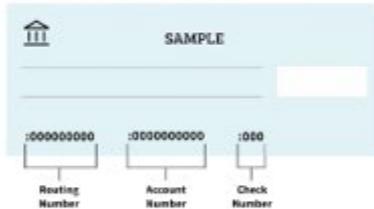
Enter Your Banking Information

*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.

[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 handwritten 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 more about 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

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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

Application for Paid Family Leave Benefits (DE 2501F)

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 0

B2. Date of foster care or adoption placement
M M M M M M M M M M

B3. Child named in B1 is my
Biological Child Stepchild Foster Child Adopted Child Other

B4. Your Legal Last Name
(recorded in case pages of this claim become separated)
C l a i m a n t

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

B8. Legal Name of Child | First Name MI Last Name
C o o k i e A C l a i m a n t

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.)
 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 0 0 0 0 0 0 0

Part C - Statement of Care Recipient, is Page 8.

- 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

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 M M M M M M M M

C2. Phone Number of Family Member Receiving Care
0 0 0 0 0 0 0 0 0 0

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 M M M M M M M M

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 M M M M M M M M

SAMPLE, this page for reference only

Medical certifications must be completed by a licensed Physician or Practitioner authorized to certify to a patient's 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	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
D10. First date patient needed care	D11. Date you expect patient to recover	D12. Date you estimate patient will no longer need care by the claimant
	NEVER	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

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.

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

Part D - Physician/Practitioner's Certification is Page 9.

- 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](#)



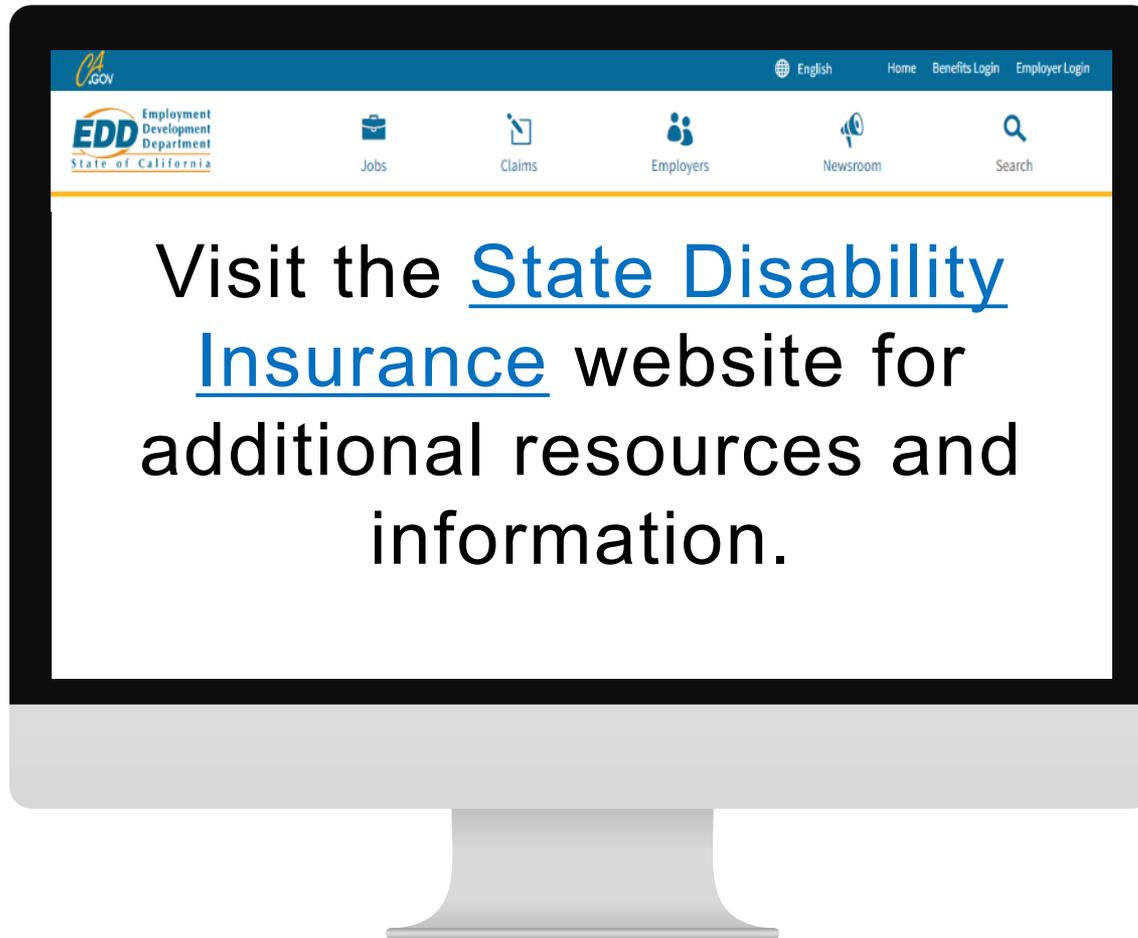
[Contact Us](#)

[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.