DLT Department of Labor and Training
RHODE ISLAND

TDI-1AE (12/24)

RHODE ISLAND DEPARTMENT OF LABOR AND TRAINING
TEMPORARY DISABILITY INSURANCE (TDI)
PO BOX 20100, Cranston, Rhode Island 02920 - 0241
Phone: (401)-462-8420 | **TTY via RI Relay 711**
Email: dlt.tdi@dlt.ri.gov | **Web:** dlt.ri.gov/tdi

APPLICATION FOR BENEFITS - TEMPORARY CAREGIVER INSURANCE

APPLICANT PERSONAL AND WORK INFORMATION

Name (First, Middle Initial, Last, Suffix)

Mailing Address (Street or PO Box) Include apartment number, if applicable

City/Town	State/Province	Zip/Postal Code	Email Address

Social Security Number	Date of Birth (Month/Day/Year)	Home Phone Number	Cell

Gender ☐M ☐F ☐X

Race (Optional): ☐Black, ☐White, ☐Asian ☐Indian, ☐Hawaiian/Pacific, ☐Multi-racial

Ethnicity (Optional): ☐Hispanic/Latinx ☐Not Hispanic/Latinx, ☐N/A

I prefer to receive information in: ☐English ☐Spanish ☐Portuguese (*phone calls only*)

Which program are you applying for?
☐Care for a Seriously Ill Family Member ☐Bond with Child

Please provide the following information if pertinent to you today

Date you returned to working normal hours (mm/dd/yyyy): _____

How many weeks are you requesting? _____

Date you returned to working reduced hours (mm/dd/yyyy): _____

Enter your last day of work or date you last performed services (mm/dd/yyyy): _____

Have you applied or received Temporary Caregiver Insurance in the last 12 months? ☐Yes ☐No

Have you applied or received Unemployment Insurance Benefits in the last 12 months? ☐Yes ☐No

If yes, the last week ending date you were paid from Unemployment Insurance: _____ From which state were you paid? _____

If you are caring for a family member **or** bonding with a child, what date would you like your claim to begin? (mm/dd/yyyy) _____

(NOTE: The date of this application must be no later than 30 days after the start of your claim).

Information of individual for whom you are caring or bonding with: Legal Name (First, Middle Initial, Last, Suffix)

Mailing Address (Street or PO Box) Include apartment number, if applicable

Care Recipient is your: ☐Spouse ☐Domestic Partner ☐Parent ☐Parent-in-law ☐Grandparent ☐Child ☐Adopted ☐Foster

Bonding Recipient is your: ☐Newborn Child ☐Adopted Child ☐Foster Child ☐Other (please explain):

Date of Birth (Month/Day/Year)	Phone Number	Gender	Child's Social Security Number (If over 12 months of age)
		☐M ☐F	

Date of Adoption (mm/dd/yyyy): Date Foster Child was placed with you (mm/dd/yyyy):

Copy of the following documents are required as proof of relationship for bonding claims (do not send originals). What proof and copy of document are you providing with application? The document mush show your name and child's name (check one):

☐Birth Certificate ☐Proof of Adoption ☐Proof of Foster Care Placement ☐Proof of Legal Guardianship

(Benefit payments will not be provided without proof of relationship; however, you must file within **30 days** of your first leave date.)

APPLICANT EMPLOYER INFORMATION - List all employers from the past two years. If you need more space, attach an extra sheet with your name and Social Security Number at the top.

Employer: _____	Employer: _____
Address: _____	Address: _____
City/Town: _____	City/Town: _____
Phone Number: _____	Phone Number: _____
Enployment Dates: _____	Employment Dates: _____
How many hours per week do you normally work? _____	How many hours per week do you normally work? _____
Job Title: _____	Job Title: _____
Was your work performed in RI? ☐Yes ☐No	Was your work performed in RI? ☐Yes ☐No
Are you a corporate officer, partner or owner? ☐Yes ☐No	Are you a corporate officer, partner or owner? ☐Yes ☐No

Check each day of the week you normally work: ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

Have you earned wages or performed services through self-employment in the last 2 years? ☐ Yes ☐ No

List beginning and ending dates of any period of self-employment during the past 2 years. Employment Dates: _____ To _____

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YOUR DEPENDENTS ALLOWANCE - REQUIRED TO CALCULATE THE CLAIM'S BENEFIT RATE

How many dependent children do you support? (Include children under 18 and those 18 and older who are incapacitated.)

List only the names of children who are your natural, adopted, or stepchildren, or are court-appointed wards to whom you provide support. (Documentation is required for court-appointed wards and for children over 18 who are incapacitated).

Name (First, Middle Initial, Last, Suffix)	Relationship to You	Birthdate (mm/dd/yyyy)	Social Security Number

Do you have legal custody of the above child(ren)? ☐ Yes ☐ No

Do all the children listed above live with you? ☐ Yes ☐ No

Is any other person claiming your child/children as dependents under the Rhode Island Temporary Disability Act? ☐ Yes ☐ No

If no, list the name, address, and Social Security number of the person they live with below.

Name (First, Middle Initial, Last, Suffix)

Address

Social Security Number

If yes, indicate the name, address, and Social Security Number of the person claiming such children.

Name (First, Middle Initial, Last, Suffix)

Address

Social Security Number

If any legal dependent named above is 18 or older, please indicate the type of incapacity (mental or physical).

Name: Incapacity Type:

WORKES' COMPENSATION INFORMATION - Complete if injury/illness is work connected

Do you currently have an illness connected to your job or as a result of your job, a Workers' Compensation Issue? ☐ Yes ☐ No

Have you filed a Workers' Compensation claim for this disability or any other disability? ☐ Yes ☐ No

Date of injury or start of illness (mm/dd/yyyy): _____

Name of company where injury occurred: _____ Address: _____

Have you received any Workers' Compensation payments for this or any other disability? ☐ Yes ☐ No

If yes, dates: From: _____ To _____

If yes, please provide the contact information for your Workers' Compensation Company.

Name: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

If no, please explain why not:

If you have a lawyer representing you in this matter, please provide his/her name and address

Lawyer Name: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

SELECT YOUR PREFERRED BENEFIT PAYMENT METHOD

☐ **Direct Deposit** into my account (Complete the Direct Deposit Form) or ☐ **Electronic Payment Card** - EPC (Works like a debit card, fees may apply if not used properly

SIGNATURE REQUIRED

I understand that all information I have provided regarding the **TCI Program** is true and correct. I agree to provide the medical certification required as proof of care needed for my seriously ill family member. I also understand that I am responsible to **pay taxes** on all benefit payments received from the TCI Program. I understand that I am responsible to report to TDI the date that I return to work part-time or full-time to prevent any overpayment of benefits.

☐ By signing this acknowledgement, I am indicating that I have been informed of the TDI Program requirements above and understand them.

Your Signature _____ Social Security Number _____ Date _____