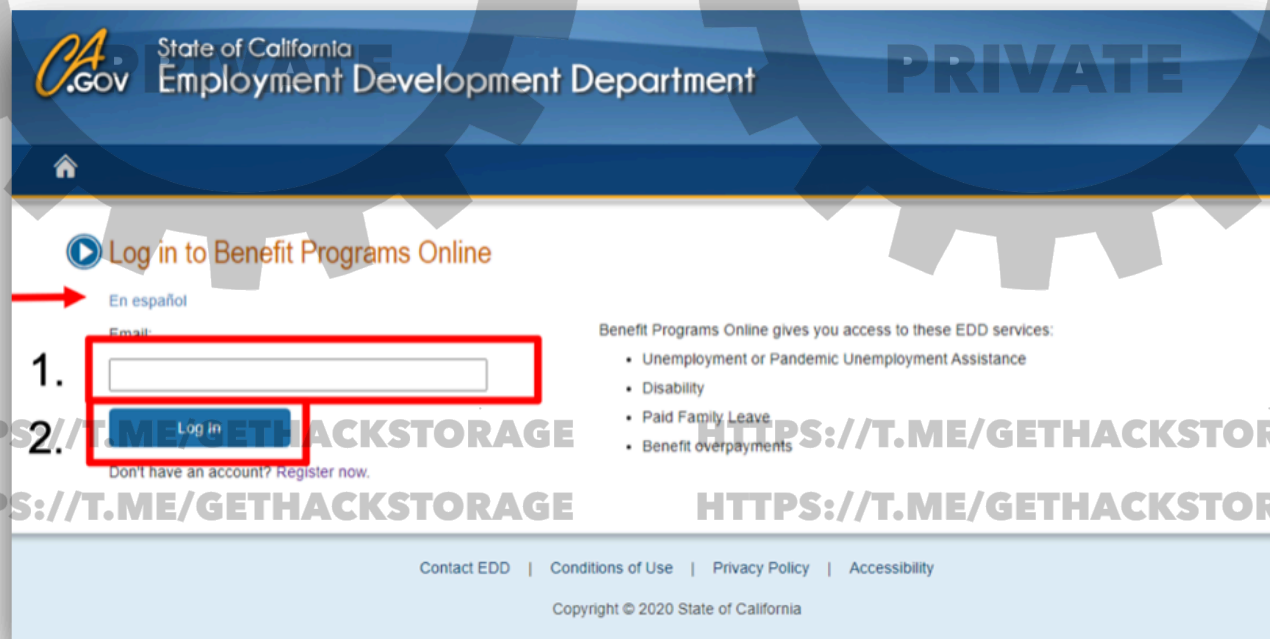


GET HACK STORAGE PRIVATE California SDI. Часть 2

Добрый вечер, друзья, продолжаем мануал по SDI. Приступим к оформлению заявки. Переходим на главный сайт портала Калифорнии EDD и начинаем процесс регистрации.



Тут хочу сделать небольшую пометку (информация не проверена, но есть такие предположения). Сейчас проблемы с тем, что многие холдеры уже зарегистрированы на гос. сайтах. Однако регистрацию у вас пропустит и даже даст возможность подать заявку, но в итоге вы получите деклайн и даже не узнаете о реальной причине, так как они попросту сошлутся на условия. Как поступать в данном случае?

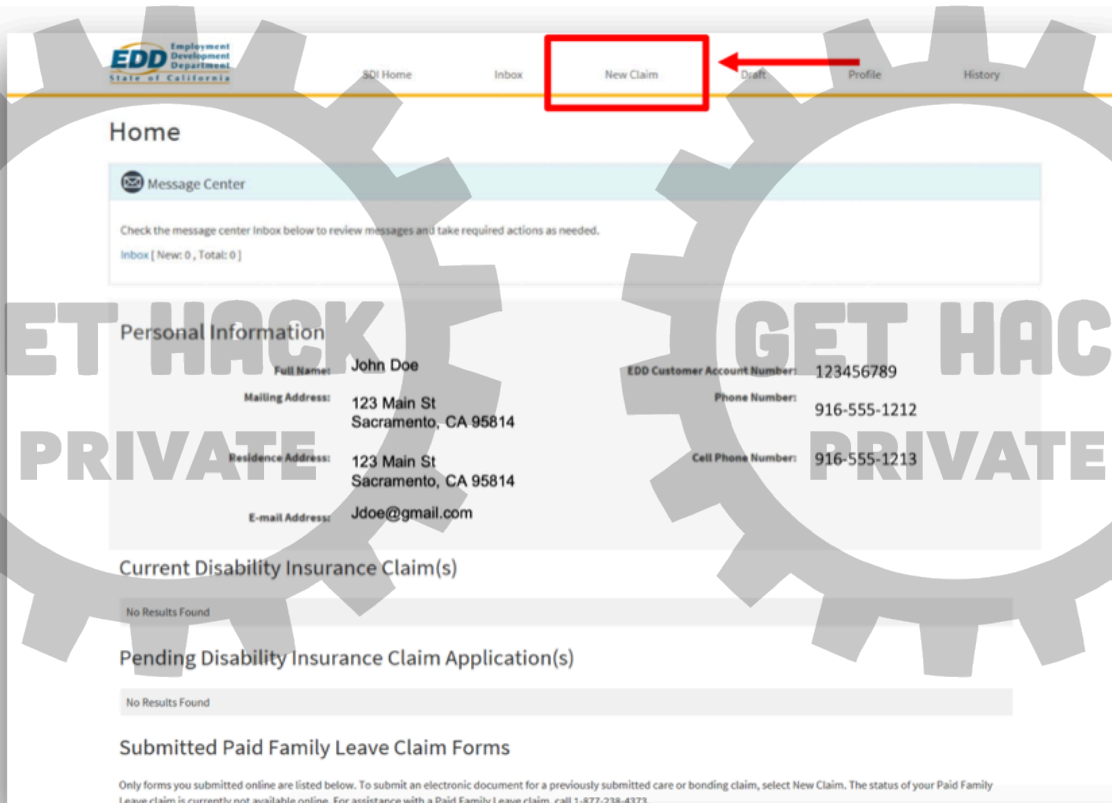
1. Брать/покупать логи/брут, наиболее глупый вариант, так как думаю у кого они есть сами их и отработывают, но всё же, мало-ли у вас есть доступ к приват-облаку или свой стилак, подавать с уже активного юзера гораздо проще и меньше фрода.
2. Подавать через почту/факс, в данном случае SDI так же можно подать по почте отправив им pdf файл, по времени затратите даже меньше чем в SDI online.
3. Прозванивать и уточнять по поводу действующего аккаунта. Задать вопросы по поводу подачи и прочее.

Но, так как никто точно не может сказать о правдивости той информации и по факту проходят заявки в большом % апрува, мы будем подавать стандартным образом.

Возвращаемся к регистрации, процесс идентичен как и при UI/PUA, пропустим его (кому интересно смотрите в архиве PUA/UI). После регистрации переходим на страницу программ.



Далее обращу ваше внимание на то, что перед подачей у вас уже должны быть вписанные персональные данные и тот мейлинг адрес, на который будете отправлять карту/чек. Переходим к началу заполнения.



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.

Disability Insurance Claim Filing Instructions

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.
- Date you began working at less than full duty or modified duty.
- 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.
- Workers' Compensation claim information, if applicable.
- The name, address, and telephone number, if any, of the Alcoholic Recovery Home or Drug-Free Facility where you are currently receiving in-patient treatment.
- You are responsible for obtaining a Physician/Practitioner Certification for your disability. Your claim will be returned if the Physician/Practitioner Certification is not received within 30 days. Please note that your employer will be notified that you have submitted a DI claim. However, your detailed claim information is confidential and will not be shared with your employer.

Cancel

Next

Далее страница №1. Персональные данные уже заполнены. Секцию №2 оставляем пустую.

Personal Information

1 Personal Information

2 Initial Questions

3 Employment Information

4 Additional Information

5 Certification

You are currently on Step 1 Personal Information

Section 1 - Personal Information

Social Security Number: XXX-XX-XXXX

Legal Name: John Doe

Date of Birth: 01-01-XXXX

Preferred Language: English

Mailing Address: 123 Main St
Sacramento, CA 95814

Home Phone Number:

EDD Customer Account Number: 1234567890

California Driver License or ID Number: X1234567

Gender: Male

Residence Address: 123 Main St
Sacramento, CA 95814

Cell Phone Number: 555-123-4567

Section 2 - Other Names and Social Security Numbers Used

Please enter any other names or other Social Security Numbers under which you have worked. If you have never worked under another name or Social Security Number please leave this section blank.

First Name:

Middle Initial:

Секция №3, не самозанятый и не гос. работник. При заполнении дат помните про правила начала отсчета заявки. От 8 дней, но не более 49 ! На омпрос о возвращении на работу пишем - нет. На остальные вопросы индивидуально в зависимости от вашей придуманной истории.

EDD Employment Development Department STATE OF CALIFORNIA

SDI Home Inbox New Claim Draft Profile History

Section 3 - Employment Information

***Are you self employed?** Yes No

***Are you a State Government employee?** Yes No

If "Yes," indicate Bargaining Unit Number:

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

***Before your disability began, what was the last day you worked?**

***When did your disability begin?**

Date you want your Disability Insurance claim to begin if different than the date your disability began:

***Since your disability began, have you worked or are you working any full or partial days?** Yes No

***Have you recovered?** Yes No

If "Yes," enter date:

***Have you returned to work?** Yes No

If "Yes," enter date:

***What is your regular or customary occupation?**

***Why did you stop working?**

***How would you describe or classify your job?**

- Mostly sitting; occasionally standing and walking; occasionally lift, carry, push, pull or otherwise move objects that weigh 10 lbs. or less.
- Walking/standing most of the time; occasionally lift, carry, push, pull or otherwise move objects that weigh up to 20 lbs.
- Constantly lift, carry, push, pull or otherwise move objects that weigh up to 10 lbs.; frequently up to 20 lbs.; occasionally up to 50 lbs.
- Constantly lift, carry, push, pull or otherwise move objects that weigh up to 20 lbs.; frequently up to 50 lbs.; occasionally up to 100 lbs.
- Constantly lift, carry, push, pull or otherwise move objects that weigh up to 20 lbs.; frequently over 50 lbs.; occasionally over 100 lbs.

***Has or will your employer continue to pay you during your disability leave?** Yes No

Секции №4 A-B-C-D, вписываем данные работодателя.

Employment Summary

- Personal Information
- Initial Questions
- 3** Employment Information
- 4 Additional Information
- 5 Certification

You are currently on Step 3 Employment Information

Section 4A - List of Employers

Please click the "Add" button to add information about your last or current employer. You must add at least one employer.

No Results Found

-
-
-
-
-

Employer Search

- Personal Information
- Initial Questions
- 3 Employment Information**
- 4 Additional Information
- 5 Certification

You are currently on Step 3 Employment Information

* Indicates Required Field

Section 4B - Search Criteria

Please search for your current or most recent employer. After clicking the "Search" button, if your employer is not found, click the "Not Found" button to enter your employer information.

* Employer Name: Begins With

Reset

Section 4B - Search Criteria

Please search for your current or most recent employer. After clicking the "Search" button, if your employer is not found, click the "Not Found" button to enter your employer information.

* Employer Name: Begins With

Reset

Search Results

Employer Name	Action
B Dalton Bookseller	Select

Previous

Section 4C - Employer Contact Information

Enter your current or most recent employer's contact information as found on your W2 and/or paycheck stub. If you are a State government employee, enter the agency name (for example, Caltrans). If you are self-employed, enter "Self."

Last or Current Employer Name: B Dalton Bookseller

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

Employment Information

* Before your disability began, what was the last day you worked for this employer? (MMDDYYYY)

* Do you currently have another employer that you have not yet reported? Yes No

Previous

Employment Details (Add Employer)

* Indicates Required Field

Section 4D - Employer Contact Information

Enter your most recent employer first. If your employer has a PO Box, please use that as their mailing address. If you have more than one employer, you must provide the information for each additional employer. If you are a State government employee, enter the agency name (for example Caltrans). If you are self employed, enter "Self."

* Last or Current Employer Name:

Please provide your most current employer's mailing address as found on your W2 form and/or paycheck stubs. If your employer has a PO Box please use that as their mailing address.

US International

* Address Line 1:

Address Line 2:

* City:

* State:

* ZIP Code:

Employer Phone Number: Ext:

Check here if the phone number is international

Employment Information

* Before your disability began, what was the last day you worked for this employer?

* Do you currently have another employer that you have not yet reported? Yes No

Employment Details (Add Employer)

* Indicates Required Field

Address Validation

The address you have provided has been updated to meet USPS standards. Please verify the address is correct.

Entered Address

800 Capitol Mall
Sacramento CA 95814

Updated Address

800 Capitol Mall
Sacramento CA 95814 - 4807

Would you like to proceed with the standardized address? Select 'Yes' to proceed or 'No' to return to correct the address.

Далее переходим на страницу по получению выплат. Выбираем нужный нам способ отправки.

Declaration

- Personal Information
- Initial Questions
- Employment Information
- Additional Information
- 5** Certification

You are currently on Step 5 Certification

*Indicates Required Field

Section 9 - Payment Choice

If you are eligible to receive benefits, you have two options to receive your benefit payments: by the EDD Debit CardSM, through Bank of America, or by check, which is mailed to you from the Employment Development Department (EDD). You do not have to accept the EDD Debit Card. Select your preferred payment method below.

*Preferred Payment Method:

EDD Debit Card

Check

Disclosures Agreement: [EDD Debit Card Fee Disclosures, DE 5617PD \(PDF\)](#)

I acknowledge that I have reviewed the EDD Debit Card Fee Disclosures.

Далее ставим галки и вписываем фио нашего доктора.

Section 10 - Declaration

By my signature on this claim statement, I claim benefits and certify that for the period covered by this claim I was unemployed and disabled. 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 and that such violation is 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. By my signature on this claim statement, I authorize the California Department of Industrial Relations and my employer to furnish and disclose to State Disability Insurance all facts concerning my disability, wages or earnings, and benefit payments that are within their knowledge. By my signature on this claim statement, I authorize release and use of information as stated in the "Information Collection and Access" section of the [Important Disability Insurance Program Information](#) page. 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 fifteen years from the date of my signature of the effective date of the claim, whichever is later.

Health Insurance Portability and Accountability Act (HIPAA)

I authorize the below named Physician/Practitioner to furnish and disclose all my health information and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability for which this claim is filed that are within their knowledge to the following employees of the California Employment Development Department (EDD): Disability Insurance Branch examiners, their direct supervisors/managers and any other EDD employee who may have a need to access this information in order to process my claim and/or determine eligibility for State Disability Insurance benefits. I understand that EDD is not a health plan or health care provider, so the information released to EDD may no longer be protected by federal privacy regulations. (45 CFR Section 164.506(c)(2)(iii)). EDD may disclose information as authorized by the California Unemployment Insurance Code. I agree that photocopies of this authorization shall be as valid as the original. I understand I have the right to revoke this authorization by sending written notification stopping this authorization to the EDD, Di Branch MIC 29, PO Box 826880, Sacramento, CA 94280. The authorization will stop on the date my request is received. I understand that the consequences for my revoking this authorization may result in denial of further State Disability Insurance benefits. I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by EDD or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled. I understand that I am signing this authorization voluntarily and that payment or eligibility for my benefits will be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization may result in an incomplete claim form that cannot be processed for payment of State Disability Insurance benefits. I understand I have the right to receive a copy of this authorization.

Authorized Physician/Practitioner Name:

To print or view your application in a new window, select [Claim for Disability Insurance \(DI\) Benefits \(DE 2501\)](#). To save and file your claim, select Submit.

[View Claim: Claim for Disability Insurance \(DI\) Benefits \(DE 2501\)](#)

Previous

Cancel

Save as Draft

Submit

Нажимаем подтвердить и теперь мы должны ждать апрува от доктора.

Далее по поводу доктора. Если вы воспользовались чужим сервисом по предоставлению данных, то в этом у вас не будет проблем, просто ожидайте апрува. Если же вы пробили/купили фуллку холдера сами, то потребуется регистрация его в системе SDI. Ещё раз повторю, что для регистрации доктора понадобится :

- Valid e-mail address.
- Date of birth.
- Last four digits of your Social Security number.
- California Driver License or California Identification Card number.
- A valid physical address.
- A valid phone number.
- Medical license type.
- Medical license number.

Если нужна информация по поводу какие доктора допускаются для выдачи справок, можете ознакомиться тут : edd.ca.gov/pdf_pub_ctr/de2548.pdf

Далее после регистрации для апрува заявления клиента нам понадобится :

- Physician/practitioner's phone number. (мобильный номер врача)
- Patient's receipt number or last four digits of Social Security number. (SSN клиента)
- Patient's last name. (Фамилия клиента) Patient's treatment information, including treatment start date. (Инфа о лечении и дате начала)
- Claim information: disability start date, International Statistical Classification of Diseases (ICD) 9 or 10 code(s), diagnosis, etc. (Инфа о болезни, дате начала и код диагноза (код диагноза можно пробить в гугле))

После этого доктор сможет дать апрув своему клиенту и тот начнет получать свои выплаты через 2-3 недели.

Так же, при подаче через почту, доктор может заполнять файл вручную в форме, в секции "B". То есть мы сможем без регистрации подать заявку, но тут мы не тестили данный способ, возможно запросят доп. документы по почте.

Claim for Disability Insurance (DI) Benefits - Physician/Practitioner's Certificate
PLEASE PRINT WITH BLACK INK.

PART B - PHYSICIAN/PRACTITIONER'S CERTIFICATE	
B1. PATIENT'S SOCIAL SECURITY NUMBER 0000000000	B2. PATIENT'S FILE NUMBER 69-642-38
B3. IF YOU KNOW THE PATIENT'S ELECTRONIC RECEIPT NUMBER, ENTER IT HERE R	B4. PATIENT'S DATE OF BIRTH 01011900
B5. PATIENT'S NAME (FIRST) (MI) (LAST) Sample Claimant	
B6. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER 634-027930	B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED IN B6 STATE CA COUNTRY
B8. PHYSICIAN/PRACTITIONER LICENSE TYPE MD	B9. SPECIALTY (IF ANY)
B10. PHYSICIAN/PRACTITIONER'S NAME AS SHOWN ON LICENSE (FIRST) (MI) (LAST) SUFFIX Geoffrey Booker	
B11. PHYSICIAN/PRACTITIONER'S ADDRESS	

Подведём итог. Гос. программы данного типа, как UI и SDI всегда делать муторно, очень много мелочей и для разовой подачи на авось точно не подойдет, в отличие от SBA, где то окупаются суммой выплаты. Тут вариант только ставить дело на поток, так как зарегав одного доктора, на него можно оформить несколько заявок, а там к доктору можно добавить ассистента, на которого закинуть еще пару штук. Так же, если у вас есть люди со своими докторами в юсе - этот вариант точно для вас, в данном случае регистрацию можно вообще автоматизировать. На этом в прицнпе всё, будут вопросы, пишите в чат. Всем удачи !