LAFCO

Santa Barbara Local Agency Formation Commission
105 East Anapamu Street ◆ Santa Barbara CA 93101
805/568-3391 ◆ FAX 805/568-2249
www.sblafco.org ◆ lafco@sblafco.org

May 6, 2021 (Agenda)

Local Agency Formation Commission 105
East Anapamu Street
Santa Barbara CA 93101

Consider Resolution Approving the Filing of State Disability Insurance or Paid Family Leave Application for Elective Coverage under Section 710.5 of the Unemployment Insurance Code

Dear Members of the Commission

RECOMMENDATION

It is recommended that the Commission:

a) Approve the draft resolution; and
b) Authorize the Executive Officer to sign the application for Elective Coverage of State Disability Insurance form and any other documents that may be required to implement State Disability Insurance and Paid Family Leave for Santa Barbara Local Agency Formation Commission employees.

DISCUSSION

Per Executive Officer contract which became effective on November 22 2020, the Executive Office would participate in State Disability Insurance (SDI). Executive Officer may apply with the State for approval as soon as possible following the date of his eligibly for SDI benefits.

In order to implement SDI, the State requires a resolution by the Commission approving the filing of an application for elective coverage under Section 710.5 of the Unemployement Insurance Code.

Attachments

Attachment A – Draft Elective Coverage Resolution

Attachment B – Form DE1378n

Sincerely,

Mike Prater
Executive Officer

LAFCO 21-xx

RESOLUTION OF THE SANTA BARBARA LOCAL AGENCY FORMATION COMMISSION MAKING DETERMINATIONS AND APPROVING THE FILING AND ENROLLMENT OF STATE DISABILITY INSURANCE OR PAIDFAMILY LEAVE COVERAGE APPLICATION FOR ELECTIVE COVERAGE UNDER SECTION 710.5 OF THE UNEMPLOYMENT INSURANCE CODE FOR ITS EMPLOYEES

WHEREAS, the employees requested that they be allowed to participate in the California State Disability Insurance (SDI) Program and Paid Family Leave for Santa Barbara Local Agency Formation Commission employees; and

WHEREAS, the employees were informed of the State's requirements governing the implementation of such a program; and

WHEREAS, it is the desire of the Santa Barbara Local Agency Formation Commission to establish State Disability Insurance and Paid Family Leave for employees by providing such employees with an income during disability due to sickness or injury, care for new child or qualifying event because of an eligible family member and thereby providing such employees with an added incentive to continue their services with the organization; and

WHEREAS, in order to implement the State Disability Insurance and Paid Family Leave Program, the Commission must approve the filing of an application for elective coverage under Section 710.5 of the California Unemployment Insurance Code; and

NOW, THEREFORE, BE IT RESOLVED DETERMINED AND ORDERED by the Commission as follows:

(1) The Santa Barbara Local Agency Formation Commission elects to offer employees with State Disability Insurance coverage;

(2) That the application for Elective Coverage of State Disability Insurance is herby approved.

(3) That the appropriate officer of LAFCO be, and hereby are, authorized and directed to take such steps as necessary to establish said State Disability Insurance coverage and to make payments from the funds of the organization each year as may be required thereunder.

This resolution is hereby adopted this 6th day of May, 2021 in Santa Barbara, California.

ATTACHMENT A

AYES:

NOES:

ABSTAIN:

Santa Barbara County Local Agency
Formation Commission

By:_____
Etta Waterfield, Chair

ATTEST:

_____
Jacquelyne Alexander, Clerk
Local Agency Formation
Commission Santa Barbara County

Date: _____

ATTACHMENT A

EDD Employment Development Department
State of California

Taxpayer Assistance Center, Attention: Specialized Coverage Desk, P.O. Box 2068, Rancho Cordova, CA 95741-2068, 916-654-6288

Application for Elective Coverage of State Disability Insurance* ONLY

For Department Use Only
Account No. _____
Statistical Code _____
Effective Date _____
Approved By _____
Date _____
Employer Notified _____ (Date)
Send _____
Number of Employees _____

IMPORTANT

This form is not an application for an account number under the compulsory provisions of the California Unemployment Insurance Code (CUIC). Do not complete this form unless you wish to apply for State Disability Insurance coverage **ONLY** for your employees under Section 702.6, 710.4, 710.5, 710.6, or 710.9 of the CUIC. Coverage under these sections of the CUIC does not make provision for Unemployment Insurance benefits.

Complete this form only for:

1. **Employing units with eligible employees who are California residents whose services are covered by the unemployment compensation laws of another state that does not have a disability insurance program under Section 702.6 of the CUIC. OR**
2. **Employees of any of the following:**
   - **A public school employer under Section 710.4 of the CUIC.**
   - **A public agency employer under Section 710.5 of the CUIC.**
   - **An Indian tribe under Section 710.6 of the CUIC.**
   - **A community college district under Section 710.9 of the CUIC.**

NOTE: If your application is approved, the elective coverage agreement will be subject to all of the requirements and conditions outlined in the *Information Concerning Elective Coverage for State Disability Insurance **ONLY** Under Section 702.6, 710.4, 710.5, 710.6, or 710.9 of the California Unemployment Insurance Code* (DE 1378P) form. Please retain your copy of the DE 1378P for reference.

****

Please Type or Print

1. Name of Employer Santa Barbara Local Agency Formation Commission (805) 568-3391 (Phone)
2. Business Address 105 E. Anapamu St (Number and Street) Santa Barbara (City) Santa Barbara (County) CA (State) 93101 (ZIP Code)
3. Mailing Address _____ (Number and Street) (City) (County) (State) (ZIP Code)
4. Type of Employer – (Check one)
   - ☐ Employing Unit With Eligible Employees – Section 702.6
   - ☐ Public School – Section 710.4
   - ☐ Indian Tribe – Section 710.6
   - ☒ Public Agency – Section 710.5
   - ☐ Community College District – Section 710.9
5. Law under which agency/employer was established. (Does not apply to Indian Tribes.)
   (a) California General Laws
   Title of Act Corteese Knox Hertzberg Number 56000 Year Enacted 2000
   OR
   (b) California Codes
   Title of Code _____ Number _____ Part _____ Chapter _____
   Sections _____ to _____
6. Members of governing body of the employer.

Name	Title	Residence Address
Michael Prater	Executive Officer	8484 Carmelita Ave Atascadero, CA 93422

*Includes Paid Family Leave (PFL).

ATTACHMENT B

7. This application covers employees of the following appropriate units:

	Show Name of Bargaining Unit or Describe Type of Services
☐ Bargaining Unit	Governmnetal services
☐ Management	
☐ Confidential	
☐ Unrepresented	
☐ Academic	
☒ Other	

8. Complete this schedule covering all elected officers and appointees who perform services for the agency named in Item 1. Exclude individuals listed in Item 6.

(a) Elected offices: (These individuals are ineligible for coverage.)

Title of Position

Commissioners

(b) Person holding appointive positions: (These individuals are eligible for coverage unless appointed to fill a vacant elected office.)

Title of Position	No. of Positions in this Category	By Whom Appointed	No. of Such Individuals Desiring Coverage

(c) Total number of employees to be covered (excluding elected officers and those appointed by the Governor).

1

9. Deductions should not be made from your employees' wages for the purpose of paying employee contributions required under the CUIC until your election is approved.

10. On what date do you wish elective coverage to commence? Keep in mind that the commencement date of an elective coverage agreement shall not be prior to the first day of the calendar quarter in which the application is filed, nor later than the first day of the following calendar quarter.

☐ First day of current quarter ☒ First day of next quarter

11. Attach a copy of either:
- The negotiated agreement between the employer and the recognized employee organization or written petition signed by a majority of the eligible employees to be covered by the election under Section 702.6 of the CUIC.
  OR
- The resolution in which the governing body described in Item 6 approved the filing of an application for elective coverage under Section 710.4, 710.5, 710.6, or 710.9 of the CUIC.

****

The employing unit with eligible employees or governmental or tribal entity described in Item 1 hereby files its application under Section 702.6, 710.4, 710.5, 710.6, or 710.9 of the CUIC to become an employer subject to the CUIC. It is understood that upon approval of the election by the Director, the Employing Unit/Public School/Public Agency/Indian Tribe/Community College District will be an employer subject to the CUIC for State Disability Insurance purposes **ONLY** to the same extent as other employers as of the date specified in the approval, and will remain a subject employer for at least two complete calendar years and thereafter, until this election is terminated as provided by the CUIC.

I declare that this application has been examined by me, and to the best of my knowledge, it is true and correct and made in good faith under the provisions of the CUIC.

This declaration must be signed by one or more individuals shown under Item 6.

(Signed) Mike Prater Date 05/06/2021

(Signed) _____ Date _____

(Signed) _____ Date _____

ATTACHMENT B