# 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

August 3, 2023 (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 709 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

In order to adjust Santa Barbara Local Agency Formation Commission State EDD ID numbers for payroll purposes the EDD form De1738m most be completed. This will allow our two ID numbers to be merged into one, thereby allowing our payroller to file all tax filing for tax and wage reports each quarter. With this action LAFCO is fixing our already enrollment under Section 710.5 into SDI to meet the State requirements.

In order to implement SDI, the State requires a resolution by the Commission approving the filing of an application for elective coverage under Section 709 of the Unemployement Insurance Code.

Attachments

Attachment A – Draft Elective Coverage Resolution
Attachment B – Form DE1378m

Sincerely,

Mike Prater
Executive Officer

**Commissioners:** Cynthia Allen ◆ Jay Freeman, Vice Chair ◆ Craig Geyer ◆ Joan Hartmann, Chair ◆ James Kyriaco ◆ Bob Nelson ◆ Janelle Osborne ◆ Alice Patino ◆ Jim Richardson ◆ Shane Stark, Chair ◆ Das Williams **Executive Officer:** Mike Prater

LAFCO 23-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 709 OF THE UNEMPLOYMENT INSURANCE CODE FOR ITS EMPLOYEES

WHEREAS, the employees requested that they be allowed to participate in the California State Disability Insurance 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 709 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 hereby approved.

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

This resolution is hereby adopted this 3rd day of August, 2023 in Santa Barbara, California.

ATTACHMENT A

AYES:

NOES:

ABSTAIN:

Santa Barbara County Local Agency
Formation Commission

By:________________________
Joan Hartmann, Chair

ATTEST:

________________

Natasha Carbajal, Analysis/Clerk
Local Agency Formation
Commission Santa Barbara County

Date: ___________

ATTACHMENT A

Employment Development Department
State of California

# APPLICATION FOR ELECTIVE COVERAGE OF STATE DISABILITY INSURANCE* ONLY LOCAL PUBLIC ENTITIES AND INDIAN TRIBES

**Reference:** Section 709 of the California Unemployment Insurance Code (**CUIC**)

**IMPORTANT**

*Do not complete this form unless you wish to apply for State Disability Insurance only under Section 709 for **ALL** of your employees (excluding elected officials and appointees by the Governor). Coverage under this section of the CUIC **does not** make provision for Unemployment Insurance benefits.*

| FOR DEPARTMENT USE ONLY | |
|---|---|
| EMPLOYER ACCOUNT NUMBER | STATISTICAL CODE |
| EFFECTIVE DATE | DATE EMPLOYER NOTIFIED |
| APPROVED BY | DATE APROVED |
| SEND | NUMBER OF EMPLOYEES |

## *PLEASE TYPE OR PRINT*

| 1. Name of Government Entity or Indian Tribe | Business Phone |
|---|---|

2. Business Address (Number, Street, City, County, State, ZIP Code)

3. Mailing Address (Number, Street, City, County, State, ZIP Code)

4. Type of Local Public Entity
☐ County ☐ City ☐ Indian Tribe ☐ Other (Specify) ____________

5. Law under which agency was established: (Complete a, b, c, or d; does not apply to Indian Tribes.)

| | | | | |
|---|---|---|---|---|
| a. California Tax Law | Title of Act | | Number | Date |
| b. Califonia Codes | Title of Code | Division | Part | Chapter |
| c. Charter | Title of Charter | | | Date |
| d. Ordinance | Title of Ordinance | | | Date |

6. Members of governing body of local public entity or Indian Tribe, such as Board of Supervisors, City Council, District Directors, Tribal Council, etc.

| Name | Title | Residence Address | Phone | Social Security Number |
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NOTE: If your application is approved, the elective coverage agreement will be subject to all of the requirements and conditions outlined in *Information Concerning Elective Coverage Under Section 709 of the California Unemployment Insurance Code (CUIC)*, **DE 1378L**. Please retain your copy of the DE 1378L for reference.

* Includes Paid Family Leave (PFL).

Employment Development Department
State of California

# APPLICATION FOR ELECTIVE COVERAGE OF STATE DISABILITY INSURANCE* ONLY LOCAL PUBLIC ENTITIES AND INDIAN TRIBES

**Reference:** Section 709 of the California Unemployment Insurance Code (CUIC)

**IMPORTANT**

*Do not complete this form unless you wish to apply for State Disability Insurance only under Section 709 for* ***ALL*** *of your employees (excluding elected officials and appointees by the Governor). Coverage under this section of the CUIC* ***does not*** *make provision for Unemployment Insurance benefits.*

| FOR DEPARTMENT USE ONLY | |
|---|---|
| EMPLOYER ACCOUNT NUMBER | STATISTICAL CODE |
| EFFECTIVE DATE | DATE EMPLOYER NOTIFIED |
| APPROVED BY | DATE APROVED |
| SEND | NUMBER OF EMPLOYEES |

## *PLEASE TYPE OR PRINT*

1. Name of Government Entity or Indian Tribe — Business Phone
2. Business Address (Number, Street, City, County, State, ZIP Code)
3. Mailing Address (Number, Street, City, County, State, ZIP Code)
4. Type of Local Public Entity
   ☐ County ☐ City ☐ Indian Tribe ☐ Other (Specify) ____________
5. Law under which agency was established: (Complete a, b, c, or d; does not apply to Indian Tribes.)

| | | | | |
|---|---|---|---|---|
| a. California Tax Law | Title of Act | | Number | Date |
| b. Califonia Codes | Title of Code | Division | Part | Chapter |
| c. Charter | Title of Charter | | | Date |
| d. Ordinance | Title of Ordinance | | | Date |

6. Members of governing body of local public entity or Indian Tribe, such as Board of Supervisors, City Council, District Directors, Tribal Council, etc.

| Name | Title | Residence Address | Phone | Social Security Number |
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NOTE: If your application is approved, the elective coverage agreement will be subject to all of the requirements and conditions outlined in *Information Concerning Elective Coverage Under Section 709 of the California Unemployment Insurance Code (CUIC)*, **DE 1378L**. Please retain your copy of the DE 1378L for reference.

* Includes Paid Family Leave (PFL).

7. Appointive Positions: (These persons are eligible for coverage unless appointed by the Governor.)

| Title of Position | Number of Positions in This Category | By Whom Appointed | Number of Persons Desiring Coverage |
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8. Total number of employees to be covered, excluding elected officers and those appointed by the Governor: _______

9. 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

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

Attach a copy of the resolution in which the governing body described in Item 6 approved the filing of an application for elective coverage under Section 709 of the CUIC.

The governmental or tribal entity described in Item 1 hereby files its application under Section 709 of the CUIC to become an employer subject to the CUIC. It is understood that upon approval of the election by the Director, the governmental or tribal entity 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**. Thereafter, this election may be terminated as provided by the CUIC.

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

This certificate must be signed by one or more of the persons listed under Item 6.

| Signature | Title | Date |
|---|---|---|
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**Return completed application to:**

Employment Development Department
Analysis Resolution and Correspondence Organization
PO Box 2068
Rancho Cordova, CA 95741-2068

Questions may be directed to the above address or call 888-745-3886.

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 888-745-3886 (voice) or TTY 800-547-9565.