APPLICATION FOR CATASTROPHIC LEAVE

(*INITIAL REQUEST*)

FORM CLPINIT; REVISED 09/2017

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: The purpose of the catastrophic leave program shall be to offer an employee who has exhausted his/her accumulated leave entitlements some level of assistance in the form of donated paid leave so that such an employee may attend to matters of necessity without suffering loss of pay. The program guidelines are dictated by Section 14-E of the Collective Bargaining Agreement and the Catastrophic Leave Policy.

<u>This application is only to be used for an INITIAL request for Catastrophic Leave.</u>

Please complete Section I before giving this form to two (2) different health care providers for completion of Section II-A and II-B. Upon completion of Sections I, II-A and II-B please return the fully completed application to:

CSEA Local 880
c/o Catastrophic Leave Committee
1580 Merrick Road, Suite 212
Merrick, NY 11566

If you have any questions regarding this application or the Catastrophic Leave policy please contact CSEA Local 880 at 516-868-0880.

EMPLOYEE INFORMATION:

1. NAME: ______________________ DATE OF BIRTH: ____________
LAST FIRST M.I. MM/DD/YYYY

ADDRESS: ______________________ TELEPHONE NUMBER: ____________
(XXX) XXX-XXXX

CITY: ______________________ STATE: ________ ZIP: ____________

TITLE: ______________________ TOH FULL-TIME START DATE: ____________
OFFICIAL CIVIL SERVICE TITLE ONLY; IN-HOUSE TITLES WILL NOT BE ACCEPTED

DEPARTMENT: ______________________ LOCATION: ____________

ANNUAL SALARY: $____________ ALTERNATE CONTACT: ____________

RELATIONSHIP: ____________ ALTERNATE CONTACT TELEPHONE NUMBER: ____________
(XXX) XXX-XXXX

2. HAVE YOU APPLIED FOR SUPPLEMENTAL SICK LEAVE (SSL)? (Y/N) _____ IF YES, WHAT IS THE STATUS OF YOUR APPLICATION? ______________________

____

4. HAVE YOU APPLIED FOR FAMILY MEDICAL LEAVE (FMLA)? (Y/N) _____ IF YES, WHAT IS THE STATUS OF YOUR APPLICATION? ______________________

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5. HAVE YOU APPLIED FOR A REDUCED WORK SCHEDULE? (Y/N) _____ IF YES, WHAT IS THE STATUS OF YOUR APPLICATION? ______________________

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CONTINUED ON NEXT PAGE

NATURE OF CATASTROPHIC INJURY OR ILLNESS:

7. DO YOU NEED CATASTROPHIC LEAVE FOR YOUR OWN INJURY OR ILLNESS OR TO BE THE PRIMARY CAREGIVER* FOR A FAMILY MEMBER? ____________________

IF CAREGIVER, FOR WHICH FAMILY MEMBER? ____________________

*(*PRIMARY CAREGIVER AS DEFINED BY THE FAMILY MEDICAL LEAVE ACT)*

8. DO YOU REQUIRE INTERMITTENT LEAVE OR CONTINUOUS LEAVE? ____________________

IF CONTINUOUS, FOR APPROXIMATELY HOW LONG? ____________________

9. WHAT IS THE CATASTROPHIC INJURY OR ILLNESS ____________________

____

10. PLEASE PROVIDE A BRIEF NARRATIVE AND THE DETAILS OF THE INJURY OR ILLNESS? (i.e. This would be any relevant information to help the committee understand the catastrophic nature of your illness or injury including but not limited to: 1) When or how the condition/injury commenced; 2) How the condition/injury has affected your life; 3) Duration and type of treatment is indicated; etc).

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11. CERTIFICATION:

I, ____________________, hereby acknowledge that I have received and read a copy of the Catastrophic Leave policy. I also certify that all information and statements described herein are true and correct to the best of my knowledge. I understand that any false information or statements may disqualify me for catastrophic leave benefits as described in Section 14-E of the Collective Bargaining Agreement.

____________________ Employee's Signature

____________________ Date

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SECTION II-A: For Completion by the HEALTH CARE PROVIDERS

INSTRUCTIONS to the HEALTH CARE PROVIDERS: Your patient has requested catastrophic leave under the collective bargaining agreement. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine qualification for catastrophic leave. Limit your responses to the condition for which the employee is seeking leave. If you need information regarding the patient's job specifications please contact Human Resources at 516-489-5000. DO NOT SEND COMPLETED FORM TO THE TOWN OF HEMPSTEAD; RETURN TO THE PATIENT.

PROVIDER'S PRINTED NAME: ______________________________

BUSINESS ADDRESS: ______________________________

TYPE OF PRACTICE/MEDICAL SPECIALTY: ______________________________

TELEPHONE: (_______)______________________ FAX:(________)______________________

1. LAST EXAMINATION DATE: ______________ (MM/DD/YYYY) NEXT EXAMINATION DATE: ______________ (MM/DD/YYYY)

2. NATURE OF ILLNESS OR INJURY (Description should be in medical lay terminology): ______________________________

____

3. APPROXIMATE DATE CONDITION COMMENCED: ______________________________

4. PROGNOSIS: ______________________________

5. BASED UPON THE EMPLOYEE'S CIVIL SERVICE JOB SPECIFICATION, IS THE EMPLOYEE UNABLE TO PERFORM ANY OF HIS/HER JOB FUNCTIONS DUE TO THE INJURY/ILLNESS? (Y/N) _____ IF YES, WHAT JOB FUNCTIONS CAN THE EMPLOYEE NOT PERFORM? ______________________________

____

6. DESCRIBE OTHER RELEVANT MEDICAL FACTS, IF ANY, RELATED TO THE CONDITION FOR WHICH THE EMPLOYEE SEEKS LEAVE (Such medical facts may include symptoms, diagnosis or any regimen of treatment):

____

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7. WILL THE EMPLOYEE BE INCAPACITATED FOR A SINGLE CONTINUOUS PERIOD OF TIME DUE TO HIS/HER INJURY/ILLNESS, INCLUDING FOR TREATMENT AND RECOVERY? (Y/N) _____ IF YES, ESTIMATE THE BEGINNING AND ENDING DATES FOR THE PERIOD OF INCAPACITY.

____

8. EMPLOYEE'S ESTIMATED RETURN TO WORK DATE WITH NO RESTRICTIONS: ______________________

9. HEALTH CARE PROVIDER'S ORIGINAL SIGNATURE REQUIRED; STAMPED SIGNATURES NOT PERMITTED.

______________________	______________________	__________
Health Care Provider's Signature	National Provider Identifier (NPI)	Date

SECTION II-B: For Completion by the HEALTH CARE PROVIDERS

INSTRUCTIONS to the HEALTH CARE PROVIDERS: Your patient has requested catastrophic leave under the collective bargaining agreement. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine qualification for catastrophic leave. Limit your responses to the condition for which the employee is seeking leave. If you need information regarding the patient's job specifications please contact Human Resources at 516-489-5000. DO NOT SEND COMPLETED FORM TO THE TOWN OF HEMPSTEAD; RETURN TO THE PATIENT.

PROVIDER'S PRINTED NAME: ______________________________

BUSINESS ADDRESS: ______________________________

TYPE OF PRACTICE/MEDICAL SPECIALTY: ______________________________

TELEPHONE: (______)______________________ FAX:(______)______________________

1. LAST EXAMINATION DATE: ______________ NEXT EXAMINATION DATE: ______________
MM/DD/YYYY *MM/DD/YYYY*

2. NATURE OF ILLNESS OR INJURY (Description should be in medical lay terminology): ______________________________

____

3. APPROXIMATE DATE CONDITION COMMENCED: ______________________________

4. PROGNOSIS: ______________________________

5. BASED UPON THE EMPLOYEE'S CIVIL SERVICE JOB SPECIFICATION, IS THE EMPLOYEE UNABLE TO PERFORM ANY OF HIS/HER JOB FUNCTIONS DUE TO THE INJURY/ILLNESS? (Y/N) _____ IF YES, WHAT JOB FUNCTIONS CAN THE EMPLOYEE NOT PERFORM? ______________________________

____

6. DESCRIBE OTHER RELEVANT MEDICAL FACTS, IF ANY, RELATED TO THE CONDITION FOR WHICH THE EMPLOYEE SEEKS LEAVE (Such medical facts may include symptoms, diagnosis or any regimen of treatment):

____

____

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7. WILL THE EMPLOYEE BE INCAPACITATED FOR A SINGLE CONTINUOUS PERIOD OF TIME DUE TO HIS/HER INJURY/ILLNESS, INCLUDING FOR TREATMENT AND RECOVERY? (Y/N) _____ IF YES, ESTIMATE THE BEGINNING AND ENDING DATES FOR THE PERIOD OF INCAPACITY.

____

8. EMPLOYEE'S ESTIMATED RETURN TO WORK DATE WITH NO RESTRICTIONS: ______________

9. HEALTH CARE PROVIDER'S ORIGINAL SIGNATURE REQUIRED; STAMPED SIGNATURES NOT PERMITTED.

______________________	______________________	__________
Health Care Provider's Signature	National Provider Identifier (NPI)	Date

SECTION III: For Completion by the CATASTROPHIC LEAVE COMMITTEE

INSTRUCTIONS to the CATASTROPHIC LEAVE COMMITTEE: The purpose of the catastrophic leave program shall be to offer an employee who has exhausted his/her accumulated leave entitlements some level of assistance in the form of donated paid leave so that such an employee may attend to matters of necessity without suffering loss of pay. The program guidelines are dictated by Section 14-E of the Collective Bargaining Agreement. Please review Sections I, II-A and II-B of this employee's application and render a decision as to the whether or not the employee shall be entitled to Catastrophic Leave.

1. THE FULLY COMPLETED INITIAL APPLICATION WAS RECEIVED BY CSEA LOCAL 880 ON ________________.
INSERT DATE

2. A MEETING WAS HELD BY THE CATASTROPHIC LEAVE COMMITTEE ON ________________________________
INSERT DATE AND TIME
AT ____.
NAME OF LOCATION, CITY AND STATE

3. IT WAS DETERMINED BY A VOTE OF THE CATASTROPHIC LEAVE COMMITTEE THAT THE EMPLOYEE:

__________ IS APPROVED FOR CATASTROPHIC LEAVE UNTIL THE ESTIMATED RETURN TO WORK DATE OR SIXTY (60) WORKING DAYS, WHICHEVER IS SHORTER.

__________ IS DENIED FOR CATASTROPHIC LEAVE.

__________ IS REQUIRED TO PROVIDE MORE INFORMATION (DETAILS BELOW).

4. (IF APPROVED) THE EMPLOYEE WILL BE ADVANCED _________ DAYS OF CATASTROPHIC LEAVE FROM THE CATASTROPHIC LEAVE BANK.

5. (IF DETAILS ARE REQUIRED) WHAT ARE THE NATURE OF THE DETAILS REQUIRED FROM THE EMPLOYEE?

____

____

6. ANY ADDITIONAL COMMENTS WITH REGARDS TO THIS APPLICATION? (i.e. The employee does not want to solicit for time). ____

____

7. AS OF THIS DATE, THE EMPLOYEE HAS THE FOLLOWING ACCRUED LEAVE TIME REMAINING:

_________ VACATION (HOURS) _________ PERSONAL (HOURS) _________ COMPENSATORY (HOURS)

_________ FLOATING HOLIDAY (DAY) _________ HOLIDAY OWED (DAYS) _________ SICK (HOURS)

8. SIGNATURES OF THE CATASTROPHIC LEAVE COMMITTEE MEMBERS PRESENT:

1 . ______________________________ 2 . ______________________________
CHAIRPERSON *MEMBER*

3 . ______________________________ 4. ______________________________
MEMBER *MEMBER*

5 . ______________________________ 6 . ______________________________
MEMBER *MEMBER*

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