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700 EAST TEMPLE STREET  
LOS ANGELES, CA 90012

Margaret M. Whelan  
GENERAL MANAGER

## **CATASTROPHIC ILLNESS LEAVE DONATION PROGRAM**

Per your request, I have enclosed the following information regarding the City's Catastrophic Illness Leave Donation Program and an application to draw from the "time bank." You should have the following:

1. **PROGRAM SUMMARY** – a summary of the Catastrophic Illness Leave Donation Program and who is eligible to receive donations.
2. **APPLICATION FOR USE OF DONATED TIME** – this form must be completed and signed by you to have your request considered by the Joint Labor-Management Benefits Committee (JL-MBC) who reviews the application.
3. **AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION** – this form must be completed by the individual who has the catastrophic illness, whether that is you or your family member. This will permit the Program Coordinator to obtain relevant medical information related to the application to use the Program. If the individual with catastrophic illness has more than one treating physician, please list all the physicians, including their full name and complete mailing address, on a separate page. You may photocopy your original form.
4. **ATTENDING PHYSICIAN'S STATEMENT** – this form must be completed by the treating physician of the individual with the catastrophic illness. This will assist the Committee in verifying information related to the individual's application.
5. **INCOME/EXPENSE STATEMENT** – this worksheet will provide the Committee with a summary of the applicant's financial status to assist the Committee to determine the extent of the financial hardship caused by your or your family member's illness.

No applicant's name is revealed to the Joint Labor-Management Benefits Committee (JL-MBC) during its review. An applicant's name is used only in the process of assembling information for the Committee's review. If you have any concerns about confidentiality, please contact me for more information.

Individuals approved for this program have a specified number of hours (not to exceed 480 hours) credited to their balance of 100% sick leave. Distribution of this time, and

any other compensated time available to the employee may not exceed 40 hours per pay period. (This is equivalent to 50% sick leave, and the minimum compensation required to maintain your City health coverage without being required to make the premium payments.) Please be advised that you may qualify to request Family Medical Leave (FMLA). For more information regarding Family Medical Leave, contact your department's personnel section.

To apply for the Catastrophic Illness Leave Donation Program, please complete all of the enclosed documents and submit them in a sealed envelope to the following address:

Employee Benefits Division  
Room 867, City Hall  
200 North Spring Street  
Los Angeles, CA 90012

Attention: Catastrophic Program Coordinator

The JL-MBC reviews cases on a monthly basis. The Employee Benefits Division must receive your application by the fifteenth day of the month prior to the month in which you wish the Committee to review it. For example, in April the Committee will review those applications received by March 15.

If you have any further questions regarding the Program, please contact the coordinator at (213) 978-1588.

Thank you,  
Program Coordinator  
Catastrophic Illness Leave Donation Program

Enclosures

# CATASTROPHIC ILLNESS LEAVE DONATION PROGRAM

## WHAT IS THE CATASTROPHIC ILLNESS LEAVE DONATION PROGRAM?

The Catastrophic Illness Leave Donation Program is a benefit developed by the City of Los Angeles Joint Labor-Management Benefits Committee and approved by the Mayor and the City Council. It allows City civilian employees (excluding employees of Department of Water and Power, and Deputy and Assistant City Attorneys covered by MOU 29, 31, or 32) who are catastrophically ill, or who must care for a catastrophically ill family member, to draw up to 480 hours from a “bank” of time donated entirely by other City civilian employees. All donations of time are made anonymously, and the identities of those who apply to use the program are kept strictly confidential.

## WHO IS ELIGIBLE TO RECEIVE DONATED TIME?

To be eligible to receive time, an employee must have:

1. exhausted all sick leave time, vacation time, floating holidays, accumulated overtime, basic disability benefits (if you are requesting the time for yourself) and supplemental disability benefits (if you had chosen to buy this additional benefit for yourself).
2. passed probation and be a permanent full-time or half-time employee who is a contributing member of the City Employees’ Retirement System and is either:
  - a. suffering from a non-work related catastrophic illness/injury or life-threatening disease; or
  - b. required to care for a family member suffering from a catastrophic illness/injury or life-threatening disease where other types of reasonable care are not available.

Employees approved for the Program are limited to receiving no more than 40 hours of 100% sick leave per pay period.

## FOR MORE INFORMATION

To apply for this program or for more information, contact the Catastrophic Program Coordinator, Personnel Department/Employee Benefits Division, Room 867, City Hall, 200 North Spring Street, Los Angeles, CA 90012, Mail Stop 621 or call (213) 978-1588.

CITY OF LOS ANGELES  
JOINT LABOR-MANAGEMENT BENEFITS COMMITTEE

CATASTROPHIC ILLNESS LEAVE DONATION PROGRAM

APPLICATION

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ Day Phone: \_\_\_\_\_  
\_\_\_\_\_

Department: \_\_\_\_\_ Job Class: \_\_\_\_\_

This request is for: (Check one)

\_\_\_\_\_ My own catastrophic illness                      \_\_\_\_\_ Family Member Catastrophic Illness

Total Number of Hours Requested (480 maximum): \_\_\_\_\_

Please attach additional sheets if more room is necessary in responding to any of these questions.

1. Please provide a general description of the nature, severity, and anticipated duration of your or your family member's illness. If a family member, please include name and relationship to you.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. If this is your own illness, what activities does it specifically restrict or limit you from doing?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. If your illness is not completely debilitating, have you explored the possibility of a modified duty assignment with your department for the duration of your illness? If yes, what was the result? If no, why not?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. What was the date you last attended work? (physical attendance) \_\_\_\_\_

5. Please explain specifically what will be the consequences to you (financial or other) of being without pay for whatever length of time you are off from work for your illness or the illness of your family member.

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6. Do you have other resources of income available to you during this period of illness? If yes, please describe nature and amount.

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7. Are you currently enrolled in or collecting from a disability insurance program? -

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8. If you have a working spouse, do you have or could you have health coverage through your spouse's health plan? \_\_\_\_\_

9. Are you currently or have you been on Family Medical Leave from your position within the last year? \_\_\_\_\_

10. Do you have dependents? If yes, please list relationship and age of each dependent.

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By signing this application, I understand and stipulate that:

- A. I have passed probation and am a permanent full-time or half-time employee who contributes to the City Employee's Retirement System.
- B. I have exhausted or will shortly exhaust all my potential paid leave hours (sick leave, vacation time, overtime, and floating holidays).
- C. I have exhausted all basic and supplemental disability benefits available to me.
- D. I am suffering from or must care for a family member ("family member" as defined by my MOU or, if non-represented, as defined in the Administrative Code Section 4.127) suffering from a non-work related catastrophic illness/injury that is likely to prevent my returning to work for a prolonged period of time.
- E. I agree to promptly notify the Employee Benefits Division when my personal emergency ends or if I file for disability retirement.
- F. I understand that I may not draw from this Program and any disability insurance program concurrently.
- G. The City's Joint Labor-Management Benefits Committee will review this application and any action the Committee takes upon it will be final.

I declare, under the penalty of perjury, that the assertions in this Affidavit are true and correct to the best of my knowledge.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

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**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

\_\_\_\_\_  
Physician or Health Facility      Patient's Soc. Sec. No. \_\_\_\_\_

Facility MR No. \_\_\_\_\_

\_\_\_\_\_  
Street Address      Physician's Tel. No. \_\_\_\_\_

\_\_\_\_\_  
City, State, Zip Code

REGARDING:

\_\_\_\_\_  
Name: (Last, First MI)      Date of Birth

\_\_\_\_\_  
Description of Condition, Illness, or Injury

You are hereby authorized to furnish a written narrative regarding the diagnosis and prognosis for the undersigned on the attached Attending Physician's Statement Form.

Please send the information clearly marked in bold and clear lettering, "PERSONAL AND CONFIDENTIAL" to:

**PERSONNEL DEPARTMENT  
EMPLOYEE BENEFITS DIVISION  
Room 867, City Hall  
200 North Spring Street  
Los Angeles, CA 90012**

**Attention:** Catastrophic Program Coordinator  
**Telephone Number:** (213) 978-1588

I understand that you ordinarily retain this information in confidence and hereby release you from all liability arising from the release of such information. I have received a copy of this authorization (Division 1, Civil Code). This authorization is in effect immediately and for a period of one (1) year hereafter.

\_\_\_\_\_  
Signature of Authorizing Individual

\_\_\_\_\_  
Date

City of Los Angeles  
Joint Labor-Management Benefits Committee

CATASTROPHIC ILLNESS LEAVE DONATION PROGRAM

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name \_\_\_\_\_  
Last First Middle

Patient's Soc. Sec. No. \_\_\_\_\_

Date of Last Treatment \_\_\_\_\_

1. What is the patient's medical condition? (If using medical terms not commonly understood, please provide an additional description or definition.)

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2. What specific work duties does the patient's condition restrict him/her from doing?

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3. Is the condition life-threatening? If yes, please be specific about severity.

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4. Is the condition permanently disabling? If yes, please be specific about severity.

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5. Is the condition temporary, but totally disabling? If yes, please be specific about the severity.

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6. What is your best estimate of the date the patient could return to work?

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To be eligible for this program, the patient, if an employee of the City of Los Angeles, must have a catastrophic illness which prevents him/her from coming to work for a significant length of time. If the patient is not an employee of the City of Los Angeles, his/her medical condition must require continuous assistance that is not currently being provided in a hospital or other full time care facility.

Based on this information, I believe the patient is catastrophically ill.

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Date

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Signature of Attending Physician

PLEASE PRINT

Physician's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone No. \_\_\_\_\_

