UNM HUMAN RESOURCES

CATASTROPHIC LEAVE PROGRAM APPLICATION

Employee must complete this application AND submit this document and a SEALED Health Provider Statement to his/her manager or supervisor

Please print legibly. All fields must be complete. Illegible or incomplete applications will not be processed.

Name: ___________________________________ UNM ID: ____________________________Hire Date: ________________

Department: ____Job Title: ____

Supervisor: ____Supervisor Phone Number: ______________________________

Check the type of request that applies:

- ☐ This is an initial request for Catastrophic Leave.
- ☐ This is a request to re-certify and extend a previously approved Catastrophic Leave request (173.33 hours maximum).
- ☐ This is an appeal on a request for Catastrophic Leave that was denied by my supervisor.
- ☐ This is an appeal on a request for Catastrophic Leave that was denied based on medical review.
  Note: Additional medical information must be provided or this appeal will not be considered.

Is the request for a work-related condition?

- ☐ Yes – STOP. Work-related injuries and illnesses do not qualify for Catastrophic Leave. Please contact your manager about completing a First Report of Accident Form.
- ☐ No. Continue with the completion of the application.

Have you previously been on Catastrophic Leave?

- ☐ Yes. From Beginning Date: _______ to Ending Date: _______ Total Hours Used: _______
- ☐ No

Is this request for a condition related to yourself or that of an immediate family member as outlined in the policy?

- ☐ Self
- ☐ Family Member: Name of Family Member: __________________________ Relationship: ________________
  Note: If you are not the legal guardian of a family member, you must have that person, or his or her legal guardian, submit a signed letter that verifies that you will be providing for the individual's sole care.

If applying for a condition that relates to an immediate family member, please describe how you will be caring for the individual including physical care required and the hours/time periods you will be caring for the individual. You may attach the information if there is insufficient space.

____

____

Health Care Provider (for this specific illness/injury): ____________________________________Phone: _____________________

Number of hours requested: ___________ Beginning date: ______________________ Ending Date: ________________________

Note: An initial request for Catastrophic Leave cannot exceed 173.33 hours. To request additional hours requires the re-completion of this application, selecting the recertification option, and submitting an updated Health Provider Statement. Any overpayments will result in payroll deductions.

Any approved Catastrophic Leave will run concurrently with Family Medical Leave (FMLA), if available to the employee, and will be deducted from the 12 week allotment of FMLA. For more information regarding FMLA, please see Administrative Policies and Procedures Manual - Policy 3440: Family and Medical Leave.

Please attach completed Authorization to Request Health Information.

Employee Signature: ____ Date: ______________________

Forward the document to your Supervisor or Manager with the sealed Health Provider Statement. You will receive a letter with the final determination.

CATASTROPHIC LEAVE PROGRAM APPLICATION (Page 2)

For Supervisor/Manager use only:

Does employee have a written record of disciplinary action for leave abuse or misuse within the past 12 months?

☐ Yes (Employee does not qualify for Catastrophic Leave) ☐ No

Has the employee been, or will the employee be, out for at least 3 work days for this injury/illness?

☐ Yes ☐ No (Employee does not qualify for Catastrophic Leave)

Has the employee been employed at least 12 consecutive months as a regular employee working at least 20 hours per week?

☐ Yes ☐ No (Employee does not qualify for Catastrophic Leave)

Did the employee donate Catastrophic Leave to this year's program (confirm with your HR Consultant)?

☐ Yes ☐ No (Employee does not qualify for Catastrophic Leave)

Did the employee submit a First Report of Injury to you for this same injury?

☐ Yes (Employee does not qualify for Catastrophic Leave) ☐ No

Has the employee used any Family Medical Leave in the last 12 months? (See Administrative Policies and Procedures Manual - Policy 3440: Family and Medical Leave)

☐ Yes ☐ No

**Catastrophic Leave will run concurrently with any remaining FMLA leave. If FMLA is applicable, please give the employee a completed FMLA Designation and Rights and Responsibilities Notice for Catastrophic Leave. You may obtain this from your HR Consultant.*

Does the employee still have Annual Leave and/or Sick Leave available?

☐ Yes ☐ No

If yes, when will the employee exhaust all paid leave? ___________________________
Note: The employee should be close to exhausting all paid leave before this document is submitted. The employee cannot receive payment under this program unless all accrued Annual Leave and Sick Leave is used.

If the employee meets the basic requirements of Catastrophic Leave noted above, please mark "yes" below. If not, please mark "no" and add any additional information. Supervisors/managers do NOT review the medical evaluation.

☐ Yes

☐ No

If no, please explain. You may attach the information if there is insufficient space.

____

____

Supervisor/Manager Signature: ____Date: ______________________

HR Consultant Signature:____Date: _______________________

Instruction to manager/supervisor:
1) Forward this document to your HR Consultant. The HR Consultant will review/sign the form before forwarding it to EOHS.
2) If denied by management due to basic requirements, please obtain the denial template from your HR Consultant and send it to the employee.

After the application is reviewed for supporting medical information, HR will send a letter with the specific reasons for the determination to the employee, and notify the Supervisor/Manager of approval or denial. For more information regarding FMLA, please see the Administrative Policies and Procedures Manual - Policy 3440: Family and Medical Leave .

HEALTH CARE PROVIDER STATEMENT

Memo to Treating Health Care Provider:

The employee requesting this statement is applying to UNM's Catastrophic Leave Program regarding this illness. You have been identified as the treating health care provider (HCP). This program will provide PAID time via a donation program to cover absences due to catastrophic illness or injury. A catastrophic illness or injury is an acute or prolonged illness or injury that is considered life-threatening or with the threat of serious residual disability which results in the employee's inability to work. Missing work for medical reasons does not necessarily meet the level of a catastrophic event. Employees who have an eligible immediate family member with an illness as defined above, that requires attendant care and results in the employee's inability to work, also qualify. Please provide the University of New Mexico all of the information requested. **An incomplete statement may result in UNM denying the leave**. Thank you for your cooperation. **Please print legibly**.

This section is to be completed by treating health care provider after reviewing memo above. (Additional information may be attached.)

Employee applying for Catastrophic Leave name____

This is the (check one):

☐ Initial Request ☐ Recertification Request

This is for (check one):

☐ Employee's Medical Condition

☐ Employee's Immediate Family Member. Name of family member ____

Date Employee was first out for this condition: _____________ Date expected to be released to return to work:________________
Note: Please signify a specific date even if estimated. If this is unknown, you may also list the minimal amount of time you believe the employee needs off.

If this Catastrophic Leave request is denied, do you still recommend that the employee not return to work?

☐ Yes ☐ No

What limitations do you believe requires the patient to be absent from work? ____

____

____

____

DIAGNOSIS AND TREATMENT PLAN:

Date of onset of condition: _____________________

Primary Diagnosis **(must include the ICD code(s) resulting in the catastrophic medical condition)**:

____

____

____

____

Secondary Diagnosis (es):

____

____

____

Prognosis: ____________________________________ Progress: ☐ Recovering ☐ Unchanging ☐ Retrogressing

Was the patient hospitalized for this condition?

☐ Yes Date Admitted: __________________ Date Discharged: __________________

☐ No

What is the current, active treatment plan? (Please check and explain all that apply)

☐ Continued inpatient treatment or long-term facility care. Estimated discharge date: ________________________________

☐ Medications. List: ____

____

____

☐ Clinic Visits. List frequency and duration of appointments: ____

____

____

____

☐ Therapy (PT, OT, myotherapy, acupuncture, etc.) List type and frequency of appointments: ________________________

____

____

____

☐ Surgery or other invasive procedures. List procedure, date scheduled, and whether it is required or elective:

____

____

____

☐ Referral to other health care provider(s) for treatment. List name, specialty, and specific consultation request made:

____

____

____

☐ Patient Self-Treatment: List type, frequency, and duration: ____

____

____

____

☐ Other. Please specify:

____

____

____

____

____

CURRENT LIMITATIONS:

1. What is the current psychiatric limitation?

☐ Not applicable: good functioning in occupational and social skills.
☐ Inadequate information to make an assessment.
☐ Moderate limitations in occupational and/or social functioning.
☐ Inability to function in most areas.
☐ Other: ____

Comments:
____

____

____

2. What are the patient's current physical limitations?

☐ No limitations of functional capacity.

☐ Limitations in lifting/pushing/carrying as noted here: ____

☐ Limitations in standing/sitting/walking as noted here: ____

☐ Other physical limitations: ____

Comments: ____

____

____

3. If psychiatric or physical limitations exist, when do you anticipate the limitations will end? __________________________

4. FOR CARE OF FAMILY MEMBER ONLY: Please explain why the employee must provide full-time attendant care for a family member during this time period:

____

____

____

I hereby certify that the above statements, in my opinion, truly describe the patient's limitations and the estimated duration of the limitations. I understand that I may be asked to provide further documentation to verify that the patient is suffering from a catastrophic medical condition.

Health Care Provider's Signature: ____ Date: __________

Health Care Provider's Name and Address: **Please print legibly.**

____

____

____

Health Care Provider's Phone: _____________________________

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members with certain exceptions including requests for family medical history to comply with the certification provisions of the FMLA or State or local family and medical leave laws, or pursuant to a policy (even in the absence of requirements of Federal, State, or local leave laws) that permits the use of leave to care for a sick family member and that requires all employees to provide information about the health condition of the family member to substantiate the need for leave.". If this exception provision is not applicable in your case, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.