THE UNIVERSITY OF NEW MEXICO

CATASTROPHIC LEAVE FOR YOUR OWN MEDICAL CONDITION

Directions for completing catastrophic leave application.

If you are requesting catastrophic leave for an immediate family member, then download the packet titled Catastrophic Leave Application for Immediate Family Member.

These instructions cover how to complete the documents in the catastrophic leave application packet. If you have any questions about catastrophic leave, then refer to the catastrophic leave web page, University Administrative Policy 3430, Catastrophic Leave Program, or contact your HR Consultant.

This application consists of 5 parts:

1. Catastrophic Leave Program Application
2. Health Care Provider Statement
3. Informed Consent Form for Employee
4. Authority to Release Health Information and Medical Records
5. Authority to Release Health Information – University of New Mexico Health Sciences Center

IMPORTANT INFORMATION

Parts 3, 4, and 5 of the catastrophic leave application pertain to the release of your medical records to the Third Party Administrator (TPA). Your catastrophic leave application will be processed quicker if you provide your medical records at the time you submit your documents. Please attach medical records or health care provider summation from the last 2 or 3 appointments you had with your health care provider – we do not require your entire medical file. You can obtain your medical records or health care provider summation by accessing your MyChart, MyHealthUNM, or similar account or asking your health care provider.

The TPA will only reach out to your health care provider if the medical records you supply with this application do not provide the information needed for the TPA to make a determination.

If you do not provide your medical records at the time you submit your application, then the determination if you qualify for catastrophic leave may be delayed and result where you are not receiving pay.

1. Complete the Catastrophic Leave Program Application

Employee and Department Information

- Enter your demographic, employee, and department information.

Catastrophic Leave Information

In this section you will complete the following:

- Number of hours:
  - For continuous catastrophic leave, you can request up to 3 months of catastrophic leave (520 hours). If your condition is determined to be terminal, then you can request the full 6 months (1040 hours).
  - For intermittent catastrophic leave, the maximum request cannot exceed 3 months (520) hours.
- Anticipated start and end date.
- Select the type of catastrophic leave you are applying for:
  - Initial request:
    - First request, never used catastrophic leave previously, or

        - Used catastrophic leave previously, but this is a new case.
- Is this a request to re-certify for catastrophic leave?
    - Submitting application for continuation of catastrophic leave for the same illness or injury.
- Is this an appeal to a denied claim?
    - Re-submitting an application because your claim was denied.
    - Must be accompanied by additional supporting documentation.
- Is your medical condition or injury due to a work-related incident?
    - Work related illnesses or injuries are not qualified for catastrophic leave.
- Have you previously used catastrophic leave?
    - Do not use this section for recertification of the same illness or injury.
    - If used catastrophic leave for a previous illness or injury, then document the dates.
- If catastrophic leave is for a family member, then complete the packet of forms named catastrophic leave for your immediate family member. If this request if for your own medical condition, then leave this part blank.
- Provide the name and phone number of your health care provider.
- Sign the form and return your catastrophic leave application to your supervisor.

2. Health Care Provider Statement

The health care provider statement will be completed by your health care provider. A new health care provider statement will need to be completed for any recertifications.

3. Informed Consent and Authorization: Catastrophic Leave Program

This form authorizes UNM's Third Party Administrator to contact your health care provider to obtain additional medical information pertaining to your catastrophic leave request.

After reading the form, complete the information at the bottom of the form.

4. Authority to Release Health Information and Medical Records

This form authorizes your health care provider to release medical records pertaining to your catastrophic leave request to UNM's Third Party Administrator. If additional medical information is needed, then this form will be sent to your health care provider.

In the 'To' box enter then name of your health care provider or the name of your health care treatment facility. Ensure your health care provider enters their contact information on the Health Care Provider Statement.

5. Authority to Release Health Information University of New Mexico Health Sciences Center

This form is to be used if you are a patient of the University of New Mexico Health System. The vendor information has been pre-populated on the form. If additional medical information is needed, then this form will be sent to your health care provider.

Submit the Health Care Provider Statement, the Informed Consent form, the appropriate Authority to Release Health Information and Medical Records, and your medical records to your department's HR Consultant in a sealed envelope.

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Memo to Treating Health Care Provider:

The employee requesting this statement is applying to UNM's Catastrophic Leave Program regarding their medical condition or injury. As the treating health care provider (HCP) we are requesting the below information supporting the employees request for catastrophic leave. If approved for this program, then the employee will be provided PAID time. 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 qualifies. Please provide the University of New Mexico and its Third Party Administrator all of the information requested.

Please provide as much detail as possible. With this Health Care Provider Statement, **please attach medical records of the prior 2 or 3 last visits.** These records will be provided to the medical reviewers to determine if the employees medical condition or injury qualifies for the program. An incomplete Health Care Provider Statement or failure to attach medical records from the prior 2 or 3 last visits may result in UNM and/or the Third Party Administrator denying the request. Please print legibly.

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.

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Informed Consent and Authorization: Catastrophic Leave Program

Notice to University of New Mexico (UNM) Employee.

UNM's Catastrophic Leave Program allows salary and benefits continuation for eligible staff employees who are experiencing a catastrophic condition or whose immediate family members may be experiencing a catastrophic condition pursuant to the terms, conditions and requirements set forth in University Administrative Policy 3430 (Catastrophic Leave Program) (UAP 3430). UNM has contracted with a Third Party Administrator (TPA), Managed Medical Review Organization (MMRO), to provide an independent medical review of employee requests for catastrophic leave.

In accordance with UAP 3430, to request benefits, an employee (or individual acting on the employee's behalf) must complete and submit an Application for Catastrophic Leave Program and Health Care Provider Statement (the "Application') to the employee's immediate supervisor. The Application includes an "Authority to Request Health Information and Medical Records" ("UNM's Release") for the employee or the employee's immediate family member to sign. By signing UNM's Release, the employee or the employee's immediate family will be permitting MMRO to speak with the employee's health care provider or the health care provider of the employee's immediate family member, if additional information is needed. It also will permit MMRO to obtain medical/mental health records of the employee or employee's immediate family member, if needed. If the health care provider of the employee or the employee's immediate family member requires signature on its own form of release in addition to UNM's Release or instead of UNM's Release, UNM/MMRO requests the employee/employee's immediate family member do so in order for UNM/MMRO to obtain the information it needs for the evaluation of the employee's Application.

Social security numbers, addresses, birth dates, marital status information, spousal information, and medical/mental health information belonging to the employee and/or the employee's immediate family member, which are maintained in the employee's Catastrophic Leave File for the purpose of evaluating an application for UNM's Catastrophic Leave Program, are classified as private data ("Private Data"). Neither UNM nor MMRO will share the employee's Private Data or the Private Date of the employee's immediate family member with any person or agency except pursuant to the employee's Authorization below. The failure to provide the information requested by UNM and/or MMRO relating to the employee's own medical/mental health condition or the medical/mental health condition of the employee's immediate family member, may result in the denial or impair the processing of the employee's application for UNM's Catastrophic Leave Program.

UNM Employee's Authorization for UNM and MMRO to release Private Data.

I agree and warrant I have reviewed UAP 3430 and understand and agree to the terms and conditions set forth in this policy.

I agree and warrant I have reviewed the above "Notice to University of New Mexico (UNM) Employee and understand the information contained therein, including but not limited to the information regarding my Catastrophic Leave File and the Private Data contained in this file.

I give my informed consent and authorize UNM and MMRO to provide information maintained in my Catastrophic Leave File, including but not limited to Private Data maintained therein, to any independent medical examiners and consultants retained by UNM or MMRO to assist in evaluation of my application for Catastrophic Leave Program, as well as administrative law judge (ALJ) or district/circuit court judge for the purpose of evaluating my catastrophic leave application and appeals.

This authorization shall be in force and effective for one year from the date of signing or upon completion of the evaluation of my catastrophic leave application and all appeals, whichever is longer.

I understand that I may request a copy of this authorization.

This authorization shall become effective on the date appearing next to my signature below.

I understand I may revoke this authorization at any time prior to its expiration date by sending an email to catleave@unm.edu notifying UNM Human Resources in writing of my desire to revoke it. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

A photostatic copy of this authorization, which contains my signature, shall be considered as effective and valid as the original and shall be honored by those to whom it is sent or provided.

THE UNIVERSITY OF NEW MEXICO

AUTHORITY TO RELEASE HEALTH INFORMATION AND MEDICAL RECORDS

I, , , hereby authorize you or any member or employee of your office or association who has examined or treated me to (1) discuss my physical and mental condition, care and treatment with UNM's Third Party Administrator for its Catastrophic Leave Program: **Managed Medical Review Organization (MMRO), Post Office Box 1888, Albuquerque, New Mexico 87103-1888**; and (2) release complete and legible copies of written information/records concerning my physical and mental condition, care and treatment to MMRO as requested by MMRO.

This information will be used for the purpose of UNM's Catastrophic Leave Program/Application.

This Authority to Release Health Information and Medical Records ("Authorization") authorizes you or any member or employee of your office of association who has examined or treated me to discuss with MMRO information contained in and/or release my patient questionnaires, medical reports, clinical notes, history of injury, subjective and objective complaints, imaging studies/x-rays/films/scans reports and interpretations, other diagnostic tests/reports, diagnoses and prognoses, emergency room records or logs, discharge summaries, history and physical examination reports, psychological and psychiatric records, behavioral health records, substance abuse records, laboratory reports, operative/procedural reports, operating room logs, progress notes, provider orders, physical/occupational therapy records, out-patient records, pharmacy records and any other documents in your possession relative to my physical and mental condition.

In addition to the release of information/records contained in the general health records, I also authorize you or any member or employee of your office of association who has examined or treated me to discuss with MMRO information contained in and/or release the health records pertaining to the following conditions: sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). This release also permits disclosure of information regarding behavioral or mental health services and treatment for alcohol and drug abuse.

I hereby expressly waive any laws, regulations and rules of ethics, which might prevent any hospital, doctor, or other person, who has treated or examined me in a professional capacity, or otherwise, from releasing the information/records requested.

I understand that authorizing the disclosure of this health information is voluntary; that I can refuse to sign this Authorization and need not sign this Authorization to obtain health care treatment. Because the purpose of this Authorization is for the use and/or disclosure of health information/records for UNM's Catastrophic Leave Program, I understand that the refusal to sign this Authorization may result in (1) the denial or impaired processing of my application for UNM's Catastrophic Leave Program; or (2) the denial or impaired processing of my immediate family member's application for UNM's Catastrophic Leave Program.

This Authorization shall be in force and effective for one year from the date of signing. I understand I may revoke this authorization at any time prior to its expiration date by sending an email to catleave@unm.edu notifying UNM Human Resources in writing of my desire to revoke it. I understand that any action already taken in reliance on this Authorization cannot be reversed, and my revocation will not affect those actions.

Information/records used or disclosed pursuant to this Authorization may be subject to redisclosure by MMRO and no longer protected under the Health Insurance Portability and Accountability Act.

A photostatic copy of this Authorization, which contains my signature, shall be considered as effective and valid as the original and shall be honored by those to whom it is sent or provided.

THE UNIVERSITY OF NEW MEXICO
HEALTH SCIENCES CENTER

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name: ______________________________ **Date of Birth:** _____________________ **Medical Record #:** _______________

1. I hereby authorize the UNM Health Sciences Center to disclose information from my health record at:

[ ] University Hospital
[ ] UNM Psychiatric Center
[ ] Carrie Tingley Hospital
[ ] Children's Psychiatric Hospital
[ ] UNM Cancer Center
[ ] Ambulatory Care Center
[ ] UNM Medical Group, Inc.
[ ] UNM Sandoval Regional Medical Center
[ ] Other--please specify____

To: **Name:** MMRO/Corevisory
Street Address: 44090 West 12 Mile Road **City:** Novi
State: Michigan **Zip:** 48377 **Phone:** (866) 516-6676 Ext 135 **Provider/Facility Fax :** (248) 704-8969

Would you like a CD/DVD of your records? Yes / No **Would you like a CD/DVD of your radiology films/images? Yes / No**

For the purpose of: ____

2. Information to be disclosed:

[ ] most recent visit/admission
[ ] outpatient clinic records
[ ] immunization records
[ ] history & physical exam
[ ] laboratory tests
[ ] psychological records
[ ] discharge summary
[ ] radiology reports
[ ] consultation reports
[ ] physical / occupational therapy records
[ ] pathology reports
[ ] speech & language records
[ ] operative reports
[ ] ER records
[ ] all records

Covering the period(s) of healthcare: From (date): ______________________ To (date): ___________________________
From (date) : ______________________ To (date):___________________________

3. I further authorize that this disclosure of health information will include information relating to (initial if applicable):
(Please initial and check "yes" if labs and/or behavioral health records are requested.)

[ ] Yes [ ] No Laboratory tests. ________ *initials.*
[ ] Yes [ ] No Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection or other sexually transmitted diseases. ______ *initials.*
[ ] Yes [ ] No Behavioral health services/psychiatric care. _____ *initials.*
[ ] Yes [ ] No Treatment for alcohol and/or drug abuse. ______ *initials.*
[ ] Yes [ ] No Genetic test results and related patient information. _____ *initial*s.

4. I understand that I have a right to revoke this Authorization at any time. I understand that if I revoke this Authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _________________. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months from the date on which it was signed.
5. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
6. I understand that authorizing the disclosure of this health information is voluntary; that I can refuse to sign this authorization and need not sign this authorization to obtain health care treatment; and that if I authorize the disclosure of this health information, I have the right to examine and copy the information to be disclosed. A copy of this signed authorization will be provided to me.

____
Signature, Patient, or legal representative (Relationship to patient) (Date)

____
Signature of Witness (Date) (Parent, if CPH/PFC&A patient over 14) (Date)

PROHIBITION OF REDISCLOSURE: Federal regulations (42 CFR Part2) and State Laws (NMSA 1978 ## 43-1-19, 32A-6A-24-2B-7 and 24-1-9.5) prohibit further disclosure of mental health or alcohol and/or drug abuse treatment information and of the results of tests for HIV/AIDS and other sexually transmitted diseases to any person or agency without securing another proper written authorization for that purpose, or as otherwise permitted by Federal regulations or State laws.