PERSONNEL DEPARTMENT
PERSONNEL BUILDING
700 EAST TEMPLE STREET
LOS ANGELES, CA 90012
—
Dana H. Brown
GENERAL MANAGER

CITY OF LOS ANGELES
CALIFORNIA

KAREN BASS
MAYOR

EMPLOYEE BENEFITS DIVISION
CITY HALL
200 N. SPRING STREET, ROOM 867
LOS ANGELES, CA 90012
—
Paul Makowski
DIVISION CHIEF

CATASTROPHIC ILLNESS LEAVE PROGRAM

Thank you for your interest in the Catastrophic Illness Leave Program ("Catastrophic Program"). The Catastrophic Program is available to all civilian employee members of the City's LAwell Program. Enclosed are the following:

1. **PROGRAM SUMMARY** – a summary of the Catastrophic Program and who is eligible to receive Catastrophic Program benefits.

2. **CATASTROPHIC PROGRAM APPLICATION** – an application to be completed and signed by you so we can process your request.

3. **AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION** – an authorization to be completed by the individual with the catastrophic illness, whether this is you or your family member, to obtain relevant medical information related to your application.

4. **ATTENDING PHYSICIAN'S STATEMENT** – a statement from the treating physician of the individual with the catastrophic illness.

5. **INCOME/EXPENSE STATEMENT** – a worksheet to help us assess your financial status and the extent of the financial hardship related to the illness.

To apply for this program, complete all of the enclosed documents and submit them to the Catastrophic Program Coordinator, at the contact information below. Consideration of submitted applications and any award of hours will be done on a prospective basis only. All the information you provide will be kept strictly confidential.

Employee Benefits Division, City Hall, Room 867
200 North Spring Street
Los Angeles, CA 90012
Attention: Ted Vasquez, Catastrophic Program Coordinator
Email: ted.vasquez@lacity.org, Phone: (213) 978-1666

Enclosures

PROGRAM SUMMARY
CATASTROPHIC ILLNESS LEAVE PROGRAM

What is the Catastrophic Illness Leave Program?

The Catastrophic Illness Leave Program ("Catastrophic Program") is a benefit developed by the City of Los Angeles Joint Labor-Management Benefits Committee (JLMBC) and approved by the Mayor and City Council. It is a one-time only program that is intended for use when no other options are available for the purpose of continuing LAwell coverage. It allows full-time civilian employee members* of the LAwell Program who are catastrophically ill, or who must care for a catastrophically ill family member, to draw up to 480 hours of Catastrophic Leave time. Half-time employees can draw up to 240 hours.

How does the Catastrophic Program work?

Employees approved for the Catastrophic Program will have a specified number of hours (not to exceed 480 hours) credited to their balance of 100% sick leave. While on the Catastrophic Program, full-time employees are limited to receiving no more than 40 hours per pay period of any compensated time available to the employee, including sick leave (half-time receive no more than 20 hours). 40 hours per pay period is the minimum compensation required for full-time LAwell Program members to maintain the City's subsidy for health insurance. Catastrophic Program awarded hours cannot be used if the employee no longer meets a catastrophic situation.

Who is eligible to receive Catastrophic Leave time?

To be eligible for the Catastrophic Program, an employee must have:

1. passed probation as a permanent full-time or half-time civilian employee*, is a member of the City's LAwell Program, and is either:
    a. experiencing a non-work-related, catastrophic illness/injury or life-threatening disease; or
    b. required to care for a family member experiencing a catastrophic illness/injury or life-threatening disease where other types of care are not reasonably available.
2. exhausted all sick leave time, vacation time, floating holidays, and accumulated overtime.
3. exhausted all 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).

*Excluding employees of the Department of Water and Power, and Deputy and Assistant City Attorneys covered by MOUs 29, 31, or 32

CITY OF LOS ANGELES
JOINT LABOR-MANAGEMENT BENEFITS COMMITTEE
CATASTROPHIC ILLNESS LEAVE PROGRAM
(CATASTROPHIC PROGRAM)

CATASTROPHIC PROGRAM APPLICATION

Name: _____

Employee ID: _____

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 (Full-time 480 maximum; Half-time 240 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 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. What was the date you last attended work? (physical attendance) _____

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

   _____

   _____

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.

   _____
   _____
   _____

6. Are you currently enrolled in or collecting from a disability insurance program? _____

7. If you have a working spouse/domestic partner, do you presently have or are you presently eligible to obtain health coverage through your spouse's/domestic partner's health plan? _____

8. Are you currently or have you been on an approved Family Medical Leave from your position within the last year? _____

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

   _____

   _____

By signing this application, I understand and stipulate that:

A. I have passed probation and am a permanent full-time or half-time employee.

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 the Catastrophic Program and any disability insurance program concurrently.

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 OF RELEASE OF MEDICAL INFORMATION

_____
Physician or Health Facility

_____ Physician's Tel. No. _____
Street Address

_____
City, State, Zip Code

REGARDING:

_____
Name: (Last, First MI) Date of Birth

You are hereby authorized to furnish a written narrative regarding 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) 978-1666

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 PROGRAM
(CATASTROPHIC PROGRAM)

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name _____
Last First Middle

Date of Last Treatment _____

1. Please indicate the specific limitations resulting from the patient's illness/condition.
   _____
   _____
   _____
   _____
   _____

2. Please indicate the estimated length of time the limitations will be in effect and your best estimate of the date the patient could return to work (if applicable) and/or no longer require the assistance of a personal caregiver (if applicable, and not including assistance provided in a hospital or other full-time care facility).

   _____
   _____

To be eligible for the Catastrophic Program, the patient, if an employee of the City of Los Angeles, must have a catastrophic illness which prevents him/her/them 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/their medical condition must require continuous assistance not currently being provided in a hospital or other full-time care facility.

_____ _____
Date Signature of Attending Physician

PLEASE PRINT

Physician's Name: _____

Street Address: _____

_____

_____

Telephone No. _____

INCOME/EXPENSE STATEMENT

Please complete the following income/expense worksheet. Under "INCOME" indicate the amount of other household income (e.g. from a spouse or domestic partner) and/or income from investments. Under "MONTHLY EXPENSES" list all expenses including basic living expenses as well as payments on loans and credit cards. For any outstanding balances on a loan or credit card, indicate the current balance owed. Under "ASSETS" list current balances in your savings/checking accounts, and other assets.

INCOME	**MONTHLY**	**BALANCE OWED**
Other Household Income (Net)		
Misc. Income (Investments, etc.)		
Total Income		

MONTHLY EXPENSES		
Mortgage or Rent		
2nd Trust or Deed		
Property Taxes		
Auto Insurance		
Home Insurance		
Life/Disability Insurance		
Medical/Dental		
Food, Clothing, Household		
Utilities/Telephone		
Auto Maintenance		
Miscellaneous		
Total Regular Expenses		

DEBT/LOAN PAYMENTS		
Total Debt Pmt./Debts		

TOTAL EXPENSES		
DIFFERENCE (Income-Expenses)		

ASSETS		
Checking Account		
CDs, Savings, Mutual Funds		
Deferred Compensation		
Other		