Catastrophic Leave Program
Employee Information

- The Catastrophic Leave Program is a State employee benefit established by Arkansas Code Annotated § 21-4-214. The purpose of the program is to provide paid leave for employees with a catastrophic illness who have exhausted all other paid leave. A catastrophic illness is defined as a medical condition, as certified by a physician or other appropriate healthcare provider, of an employee, spouse of an employee, parent of an employee, or child of an employee claimed as a dependent on the employee's Arkansas income tax return, which requires an employee's absence from duty for a prolonged period of time or an intermittent period of time and which, except for the Catastrophic Leave Program, would result in a substantial loss of income to the employee because of the exhaustion of all earned sick, annual, holiday, and compensatory leave time.

- The University of Arkansas, Fayetteville Catastrophic Leave Program is a pool of accrued leave donated by eligible employees that may be transferred to qualified recipients. Only the hours are transferred - the employee continues to be paid by the employing department while on catastrophic leave.

- The Catastrophic and Parental Leave policy, posted on the Human Resources website, provides guidelines that set out who is eligible to contribute to the program, who is eligible to participate in the program, and under what terms employees may participate.

FMLA IMPLICATIONS:

The Family and Medical Leave Act (FMLA) requires covered employers to provide up to twelve (12) weeks of unpaid, job-protected leave to eligible employees for certain family and medical reasons. This includes serious health conditions, defined as an illness, injury, impairment, or physical or mental condition that makes the employee unable to perform the employee's job. An employee who receives leave under the Catastrophic Leave Program may also be entitled to leave under the FMLA. In that case, leave taken under the Catastrophic Leave Program will run concurrently with leave taken under the FMLA.

CATASTROPHIC LEAVE PROGRAM ACKNOWLEDGMENT/REQUIREMENTS FORM:

☐ Yes ☐ No	1. I am requesting catastrophic leave for a medical emergency due to illness/injury puposes as stated on the Physician's Certification that prevents me from performing my job duties for a prolonged period of time or intermittent period of time (defined as 20 working days) and which will result in a substantial loss of income.
☐ Yes ☐ No	2. I am a current, full-time (100% appointed) benefit-eligible employee who has been employed by the participating entities or a state agency/institution for at least one (1) year. Service does not have to be continuous.
☐ Yes ☐ No	3. I have not been disciplined for misuse of inappropriate use of leave within the past one (1) year.
☐ Yes ☐ No	4. I have exhausted all accrued leave (annual, sick, holiday, and compensatory time).
☐ Yes ☐ No	5. I had at least eighty (80) hours combined sick and annual leave accrual at the onset of the illness or injury.
☐ Yes ☐ No	6. I understand if approved that it is my responsibility to follow up with the Leave Administrator in Human Resources by the 5th business day of the month from January through November and the 1st business day of the month of December.
☐ Yes ☐ No	7. I understand that catastrophic leave will not be granted retroactively to any prior month.

APPLICATION PROCEDURES: It is the employee's responsibility to ensure the application requirements are completed or to appoint a designee to complete the process.

1. Read the Catastrophic and Parental Leave Policy which is posted on the Human Resources website.
2. Contact the Leave Administrator in Human Resources to review eligibility requirements, the application process and to obtain a current application packet.
3. Read and complete the following in the application packet:
   - Catastrophic Leave Program Acknowledgment/Requirements Form
   - Part I - Application & Certification
   - Part IV - Explanation of Leave Usage
   - Catastrophic Leave Program Liability Agreement
4. Ask your supervisor or department head to complete and sign Part II: Supervisory Verification. The application should be returned to you or forwarded directly to the Leave Administrator in Human Resources, 222 Administration Building.
5. Obtain medical certification: Sign the Authorization to Release information section of the Physician's Certification for Catastrophic Leave form, and have your physician complete the rest of this form explaining your current medical condition. Be sure to include your current job description when providing paperwork to the physician for completion. The certification should be returned to you or forwarded directly to the Leave Administrator in Human Resources.
6. Submit the complete application packet to the Leave Administrator in Human Resources by the 5th business day of the month for the months of January through November, and the 1st business day of the month in December. If the employee meets the eligibility requirements, the Leave Administrator will present the application to the Catastrophic Leave Advisory Committee for review.

For additional information regarding this program, please contact the Leave Administrator at 575-5351.

I hereby acknowledge that I have reviewed the Acknowledgments/Requirements of the Catastrophic Leave Program and I agree that I meet and fulfill all of the requirements.

_____	_____	_____
Signature of Recipient of Designee	*If Designee, relationship to Recipient*	*Date*

University of Arkansas, Fayetteville
Catastrophic Leave Program
Application Form

Please Type or Print Legibly

Case#: _____

Instructions: **Complete Part I of the Application Form, then submit to your supervisor for completion of Part II. Make sure your supervisor completes all questions in Part II and returns the form to you or submits it to the Leave Administrator in Human Resources. Complete Part IV then attach all appropriate documentation of medical emergency including the Physician's Certification for Catastrophic Leave, the Catastrophic Leave Release from Liability, and Catastrophic Leave Acknowledgment/Requirement Form to the Leave Administrator in Human Resources.**

Catastrophic leave time to be awarded is based upon availability of hours within the University's Catastrophic Leave Bank. Employees on catastrophic leave remain subject to all applicable University policies.

Part I - Application & Certification (To be completed by the applicant employee or designee on his/her behalf)

Name of Employee: (Last, First) _____ Employee ID Number: _____

Home Address: _____ Home/Cell Phone: _____ Email: _____

Is this Catastrophic Leave for ☐ Yourself OR ☐ Immediate Family Member _____ (relation)

If the immediate family member is a child, do you certify that the child is claimed as a dependent on your most recent Arkansas income tax return? ☐ Yes ☐ No

Amount of Catastrophic Leave Requested (Total hours requested in One (1) hour increments): _____

Duration Dates of Catastrophic Leave Request:

Beginning Date: _____ Projected Ending Date: _____

Timekeeper's Name: _____ Phone Number: _____ Date: _____

_____ _____

Signature of Recipient or Designee | If Designee, relationship to Recipient

Part II – Supervisory Verification (To be completed by the employee's supervisor – all answers are required)

Does the employee have a Disciplinary Action for leave abuse on file during past one year? ☐ Yes ☐ No

Why has this employee's leave been exhausted? _____

Could this job be restructured temporarily to allow employee to return to work at an earlier date? ☐ Yes ☐ No

Does the department support the request for Catastrophic Leave? ☐ Yes ☐ No

If No, please list specific reason(s) why?

_____

_____

_____

_____

_____

_____ _____ _____

Name of Person Completing Part II | **Signature** | **Date**

Part III - Personnel/Payroll Verification (To be completed by Department of Human Resources)

Full Time? ☐ Yes ☐ No Career Service Date: _____ Last Hire Date: _____

Workers' Compensation Status: Applied? ☐ Yes ☐ No Approved? ☐ Yes ☐ No Pending? ☐ Yes ☐ No Denied? ☐ Yes ☐ No

Date Leave Exhausted: _____ Short Term Disability? ☐ Yes ☐ No

Applicant Title: _____ Date: _____

Signature of Leave Administrator in HR (Admin Bldg):

_____

Part IV - Explanation of Leave Usage (To be completed by the employee)

Please provide a written explanation of leave usage resulting in low leave balances that necessitate the need for catastrophic leave. Include any extenuating circumstances or situations that have required large amounts of leave to be taken, as well as reasons for frequent leave use over the course of the past five years (if applicable). If the requested leave is for the care of a family member, please explain why constant care is needed. If additional space is needed, please attach further explanation on a separate sheet of paper.

University of Arkansas, Fayetteville
Catastrophic Leave Program
Liability Agreement

Forfeiture of Benefits

I understand that I will forfeit the benefits of the University of Arkansas, Fayetteville Catastrophic Leave Program by:

- Resignation or end of employment with the State of Arkansas.
- Any fraud or misrepresentation of facts in making application for leave from the Catastrophic Leave Program (CLP).
- No employee will be eligible for catastrophic leave beyond the effective date of long-term disability (LTD) and/or Social Security disability benefits, whichever comes first.

I understand that alleged abuse of the CLP shall be investigated, and, on a finding of wrongdoing, I shall repay all of the leave hours drawn from the CLP and shall be subject to other disciplinary actions as is determined by University officials.

Release from Liability

I understand that the Catastrophic Leave Committee is not an agency, board, or other subdivision of the State of Arkansas and only makes recommendations to deciding officials. The Committee's recommendations and decisions by University officials are not subject to grievance, arbitration, or litigation. Decisions may be appealed only to the Chancellor or the Chancellor's designee.

I have read and understand the rules and regulations of the Catastrophic Leave Program.

Signature of Recipient or Designee

Date

University of Arkansas, Fayetteville
State of Arkansas
Catastrophic Leave Program
Physician's Certification for Catastrophic Leave

Name: _____
(Print or Type) Last First Middle

Address: _____
Street City/State Zip

Authorization to Release Information: I hereby authorize the undersigned physician to release any and all information acquired in the course of my examination or treatment for the purpose of consideration by the Catastrophic Leave Committee.

_____ _____
(Employee's Signature or Legal Representative) **Date**

Brief Description of Employee's Job Duties: (See attached job description for full details)

_____
_____
_____
_____
_____

The employee is responsible for the completion of this form at his/her own expense. All information listed on this form will be kept confidential.

(To be Completed by the Attending Physician)

The following questions apply only to this illness/injury:

1. **History**
   - **a.** Is the below medical information for the employee or immediate family member of the employee?
     - **i.** ☐ Employee
     - **ii.** ☐ Immediate Family Member_____(relation)
       Why is constant care of the family member needed? _____
       _____
   - **b.** When did patient first seek treatment for illness/injury?_____(Date)
   - **c.** Could this illness/injury be work related? Yes ☐ No ☐
   - **d.** To your knowledge, has patient ever had the same or similar condition? Yes ☐ No ☐
     - **i.** If "Yes" state when and describe: _____
       _____
       _____
       _____

2. **Present Condition**
   (a) Would the employee performing any of their job duties result in a direct safety or health threat to the employee, employer, or other people (e.g. co-workers, the general public, etc.)? Yes ☐ No ☐

(b) Does the impairment or medical condition substantially limit a major life activity? Yes ☐ No ☐

(i) If yes, what major life activity is/are affected?

☐ Bending	☐ Interacting with others	☐ Performing manual tasks	☐ Sleeping
☐ Breathing	☐ Learning	☐ Reaching	☐ Speaking
☐ Caring for oneself	☐ Lifting	☐ Reading	☐ Standing
☐ Concentration	☐ Organic brain syndrome	☐ Seeing	☐ Thinking
☐ Eating	☐ Digestive	☐ Sitting	☐ Walking
☐ Hearing	☐ Endocrine	☐ Lymphatic	☐ Working
☐ Bladder	☐ Genitourinary	☐ Musculoskeletal	☐ Reproductive
☐ Bowel	☐ Hemic	☐ Neurological	☐ Respiratory
☐ Brain	☐ Immune	☐ Normal cell growth	☐ Special sense organs & skin
☐ Cardiovascular		☐ Operation of an organ	
☐ Circulatory			
☐ Other:			

(c) Is surgery: ☐ Required? ☐ Elective? Date of Surgery_____

If surgery is elective, can the procedure be scheduled at the convenience of the employee and is it not medically necessary? ☐ Yes ☐ No

When was the patient informed of surgery by the attending physician? _____(Date)

(d) Is patient? (Check One) ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospitalized

3. Diagnosis: Give a complete narrative of the nature and extent of the present illness/injury which is creating the need for the Catastrophic Leave Program. For example: stating the employee/ patient has skin cancer is not sufficient; further stating the cancer is basal cell or melanoma is needed, or stating the employee/patient requires or has had abdominal surgery is not sufficient; further stating whether the surgery is/was laparoscopic or open surgery is needed.

_____
_____
_____
_____
_____
_____
_____
_____
_____

4. Treatment for this illness/injury

(a) Date of first visit/treatment: _____

(b) Frequency of visits/treatments: ☐ weekly ☐ monthly _____other

(c) When did you last examine the patient?_____(Date)

(d) Give a brief description of the continuing treatments required by this illness/injury:

_____
_____
_____

5. Prognosis

(a) If there are no further complications, what is the minimum recovery time to return to work? Approximate return date: _____

(b) What is the maximum recovery time to return to work? Approximate return date:_____

(c) Would there be the possibility of this patient returning to work on a part-time basis with job duties altered within reason to better fit his/her needs? ☐ Yes ☐ No If yes, Approximate return date:_____

Explain limitations: _____

_____

_____

Please feel free to attach any additional documentation

_____	_____	_____
Clinic Name	Signature of Attending Physician	Telephone
_____	_____	_____
Address	Date	Fax Number