

# MARIPOSA COUNTY

Human Resources/Risk Management • (209) 742-1379



## **RESOLUTION - ACTION REQUESTED 2016-625**

MEETING: December 6, 2016

TO: The Board of Supervisors

FROM: Steve Johnson, Human Resources Director - Risk Manager

RE: Amend Catastrophic Leave Bank Policy

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### **RECOMMENDATION AND JUSTIFICATION:**

Approve Amendments to the Catastrophic Leave Bank Policy to Revise the Policy Title and Provide Greater Clarity on When and How Donations Are Received and Applied.

In October 2015, the County established a leave bank for full-time and permanent part-time employees who exhausted or nearly exhausted their paid leave accruals because of their own serious illness or to care for a family member with a serious illness. The hours in the bank could be used by these employees so that they could continue to receive a full paycheck for a certain period of time. A full year has passed since its implementation and the leave bank has been found to be a very successful tool for all employees, including those who benefited from the bank and those who donated to the bank.

During the administration of the leave bank, staff of the Auditor's Office and Human Resources Department fielded questions by employees who were interested in using the bank as well as employees who wanted to donate to the bank. As a result, it was determined that the current Policy needed to be fine-tuned, as follows:

- Changing the title from Catastrophic Leave Bank Policy to simply Leave Bank Policy to correspond with the County's Family and Medical Leave Act (FMLA) Policy. The FMLA Policy refers to employees who benefit from that Policy as those who have a "serious" illness or to care for family members who have a "serious" illness, not a "catastrophic" illness.
- Adding language that donations can only be accepted during the open donation period. This is for purposes of ease in administering the bank.
- Clarifying that there is no restriction on the number of hours an employee can donate during the open donation period, however, a certain number of hours must be maintained after the deduction of the donated hours.
- Clarifying that donated hours will be converted to a dollar amount based on the hourly wage of the employee donating the hours.

One of the provisions of the current Policy, which staff suggests continue, is for the Auditor's Office to provide a summary of donations for the prior twelve-month period. Staff of the Auditor's Office has compiled this information and it is attached.

**BACKGROUND AND HISTORY OF BOARD ACTIONS:**

On October 27, 2015, the Board of Supervisors approved the Catastrophic Leave Bank Policy. Prior to its adoption, the Board approved leave donation requests from time-to-time when an employee with a serious illness was in need of donation of hours because the employee had exhausted their leave accruals.

**ALTERNATIVES AND CONSEQUENCES OF NEGATIVE ACTION:**

A negative action would result in no clarifying changes to the current policy.

**ATTACHMENTS:**

**Leave Bank Policy-draft revision (PDF)**

**Leave Bank totals (PDF)**

**CAO RECOMMENDATION**

Requested Action Recommended

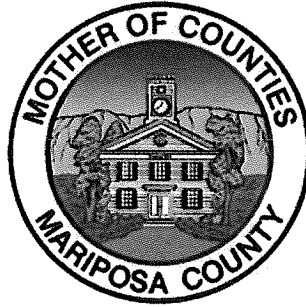
  
Dallin Kimble, Deputy CAO 11/30/2016

**RESULT: ADOPTED BY CONSENT VOTE [UNANIMOUS]**

**MOVER:** Marshall Long, District III Supervisor

**SECONDER:** Merlin Jones, District II Supervisor

**AYES:** Smallcombe, Jones, Long, Cann, Carrier



## **MARIPOSA COUNTY LEAVE BANK POLICY**

### **PURPOSE**

The purpose of this policy is to provide a method for full time and permanent part time employees to assist fellow full time and permanent part time employees who have exhausted, or nearly exhausted, their paid leave accruals due to a serious illness or injury in their lives. It is not the intent of this policy for an employee to be enriched, but to aid only those employees who are truly in need of assistance. All employee leave donations will be confidential and all employee requests for leave donations will likewise be confidential. Leave determinations are non-grievable.

### **ELIGIBILITY FOR RECEIVING LEAVE DONATIONS**

To be eligible to receive leave donations, an employee must meet all of the following criteria:

1. Has successfully completed their initial probationary period in accordance with the applicable Memorandum of Understanding (MOU).
2. Has exhausted or be within one (1) pay period of exhausting, all accrued vacation, sick leave, compensatory time off, and holiday time.
3. Has provided the required documentation (see attached form) to verify a serious occurrence as specified below. This type of occurrence is a serious illness, injury or condition to the employee or their family member as defined under the Family and Medical Leave Act (FMLA).
4. Is not receiving State Disability Insurance (SDI) benefits, social security, or similar benefits.
5. Is not eligible to receive benefits if the employee has received donated time under the Policy during the previous twelve (12) months measured from the date of the employee's first day on leave.
6. In the event that the SDI benefit, social security, or similar benefits overlap the payout of leave donations, the employee will be responsible for repayment of the donations. Repayment will be made through a salary reduction upon employee's return to work or through a payment agreement if employee is unable to return to work.

### **PROCEDURES FOR DONATING LEAVE**

The following are procedures for donating leave:

1. To be eligible to donate leave, an employee shall have successfully completed their initial probationary period in accordance with the applicable MOU.
2. The Human Resources Department shall post and circulate the Leave Bank Donation Form to all employees. Participation is strictly optional and will remain confidential.
3. Leave donations shall only be accepted during the open donation period. The donation period will remain open for two (2) weeks from the announcement time.
4. The Auditor's Office shall verify that donors have accrued sufficient hours to cover their intended donations. There is no restriction on the number of hours an employee can donate, however, donors will maintain accrued sick leave time of at least one hundred sixty (160) hours, and vacation time of at least forty (40) hours, after deduction of donated time at the time of the request. The Auditor's Office will coordinate the total donations to each recipient to ensure that an excessive number of hours are not donated.
5. The minimum donation shall be in increments of eight (8) hours, with the full eight (8) hour increment deducted from either sick leave or from vacation leave. There is no tax benefit to the donor.
6. Donated hours will be converted to a dollar amount based on the hourly wage of the employee donating the hours.
7. Once the Donation Form is verified by the Human Resources Department, the donations are **irreversible with no substitutions**.
8. In the event that the Leave Bank is exhausted while an employee is receiving leave donations, the Human Resources/Risk Management Department may make a subsequent posting.
9. Employees cannot donate unused sick leave hours upon separation from employment.

### **PROCEDURES FOR RECEIVING LEAVE DONATIONS**

1. The requesting employee must submit a request for leave donation in writing, supported by medical verification (see attached form), to the Human Resources Director/Risk Manager.
2. Donated hours will be paid after the request for leave has been approved by the Human Resources Director/Risk Manager and Auditor and the receiving employee's own paid leave accruals have been exhausted, consistent with this policy. Hours will not be paid on a retroactive basis.

3. Donated time does not alter the employment rights of the County or the recipient, nor extend or alter limitations otherwise applicable to Leaves of Absence or Annual Leave, except as noted in this policy.
4. The total leave donations received by the employee and paid at their current hourly rate shall not exceed two hundred forty (240) hours, or twenty (20) percent of the existing Leave Bank balance, whichever is greater, for any single occurrence within a twelve (12) month period.
5. If more than one employee is eligible to receive benefits in a pay period, available hours will be apportioned on a pro rata basis until the available hours are exhausted or the maximum number of hours referred to above have been reached by an eligible employee.

**ANNUAL REVIEW AND REPORTING REQUIREMENTS**

Once every fiscal year, the Auditor's Office will provide information to the Board of Supervisors that summarizes, for the prior twelve (12) months, the amount of hours that have been donated to, and used from, the County's Leave Bank and the dollar amount in the Bank.

Created: 10/15 (B/S Res. 15-506)  
Revised: 12/16 (B/S Res. 16-625)

**MARIPOSA COUNTY  
LEAVE BANK REQUEST FORM**

Employee Name \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_ Department \_\_\_\_\_

Indicate amount of hours to be requested: \_\_\_\_\_

***Acknowledgement***

I have read and understand the conditions listed below:

**CONDITIONS FOR RECEIVING LEAVE BANK TIME**

The total leave donations received by me and paid at my current hourly rate, shall not exceed two hundred forty (240) hours, or twenty (20) percent of the existing Leave Bank balance, whichever is greater, for any single occurrence within a twelve (12) month period.

I have attached documentation to verify a serious occurrence (see attached form). This type of occurrence is a serious illness, injury or condition to me or to a family member as defined under the Family and Medical Leave Act.

I acknowledge that the time donated will not be counted towards my retirement benefits, or cashed out by me at termination or retirement.

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

Date \_\_\_\_\_

Approval:

\_\_\_\_\_  
Department Head

\_\_\_\_\_  
Date

\_\_\_\_\_  
Human Resources Director/Risk Manager

\_\_\_\_\_  
Date

\_\_\_\_\_  
Auditor

\_\_\_\_\_  
Date

**MARIPOSA COUNTY  
LEAVE BANK DONATION FORM**

Employee Name \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_ Department \_\_\_\_\_

Check category/number of hours to be donated:

- Vacation: \_\_\_\_\_
- Sick leave: \_\_\_\_\_

***Acknowledgement***

I have read and understand the conditions listed below:

**CONDITIONS FOR DONATING TO THE LEAVE BANK**

As a donor, I will maintain accrued sick leave time of at least one hundred sixty (160) hours and vacation time of at least forty (40) hours, after deduction of donated time at the time of the request. I may donate leave time in eight (8) hour increments, either the full eight (8) hours from sick leave or the full eight (8) hours from vacation leave.

I acknowledge that the time donated will be deducted from my leave balances and will not be counted towards retirement benefits or cashed out at termination or retirement.

***Donations are irreversible with no substitutions.***

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

Date \_\_\_\_\_

Approval:

\_\_\_\_\_  
Department Head

\_\_\_\_\_  
Date

\_\_\_\_\_  
Human Resources Director/Risk Manager

\_\_\_\_\_  
Date

\_\_\_\_\_  
Auditor

\_\_\_\_\_  
Date

## MEDICAL CERTIFICATION – EMPLOYEE’S SERIOUS HEALTH CONDITION

**IMPORTANT NOTE:** The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with the Act, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic Information,” as defined by CalGINA, includes information about the individual’s or the individual’s family member’s genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. “Genetic Information” does not include information about an individual’s sex or age.

### SECTION I: For completion by the EMPLOYER

Employer’s name and contact person: \_\_\_\_\_

Employee’s job title: \_\_\_\_\_

Employee’s regular work schedule: \_\_\_\_\_

Employee’s essential job functions: \_\_\_\_\_

Check if job description is attached: \_\_\_\_\_

### SECTION II: For completion by the EMPLOYEE

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. Your employer must give you at least 15 calendar days to return this form.

Your name: \_\_\_\_\_  
First Middle Last

### SECTION III: For completion by the HEALTH CARE PROVIDER

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as “lifetime,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider’s name and business address: \_\_\_\_\_

Type of practice/Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_



**PART A: MEDICAL FACTS**

**[NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS]**

1. Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

**Mark below as applicable:**

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No  Yes. If so, dates of admission:

\_\_\_\_\_

**Mark below as applicable:**

If the patient was not admitted for an overnight stay in a hospital, hospice, or residential medical care facility, was the patient expected to remain overnight, even if the patient did not actually remain overnight?

No  Yes. If so, dates of expected admission:

\_\_\_\_\_

Date(s) you treated the patient for condition:

\_\_\_\_\_

Will the patient need to have treatment visits at least twice per year due to the condition?

No  Yes

Was medication, other than over-the-counter medication, prescribed?  No  Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?  No  Yes. If so, state the nature of such treatments and expected duration of treatment:

\_\_\_\_\_

2. Is the medical condition pregnancy?  No  Yes. If so, expected delivery date: \_\_\_\_\_

3. Is the employee able to perform work of any kind?  No  Yes.  
(If "No," skip next question.)

4. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition:

No  Yes

If so, identify the job functions the employee is unable to perform:

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**PART B: AMOUNT OF LEAVE NEEDED**

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?  No  Yes

If so, estimate the beginning and ending dates for the period of incapacity:

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6. Is it medically necessary for the employee to be off work on an intermittent basis due to the employee's serious health condition?  No  Yes

Yes      No

**Intermittent Leave:** Is it medically necessary for the employee to be off work on an intermittent basis or to work a reduced number of hours of work in order to deal with his/her serious health condition?

If yes, please indicate the estimated frequency of the employee's need for intermittent leave due to the serious health condition, and the duration of such leaves (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

Yes      No

**Reduced Schedule Leave:** Is it medically necessary for the employee to work less than the employee's normal work schedule due to his/her serious health condition?

If yes, please indicate the part-time or reduced work schedule the employee needs:

\_\_\_\_ hour(s) per day; \_\_\_\_ days per week, from \_\_\_\_\_ through \_\_\_\_\_

Yes      No

- Time Off for Medical Appointments or Treatment:** Is it medically necessary for the employee to take time off work for doctor's visits or medical treatment, either by the health care practitioner or another provider of health services?

If yes, please indicate the estimated frequency of the employee's need for doctor's visits or medical treatment, and the time required for each appointment, including any recovery period:

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per appointment/treatment

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?  No  Yes

Is it medically necessary for the employee to be absent from work during the flare-ups?  
 No  Yes. If so, explain:

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Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months last 1-2 days):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month (s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR  
ADDITIONAL ANSWER.**

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**SIGNATURE OF HEALTH CARE PROVIDER**

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**DATE**

## **MEDICAL CERTIFICATION – EMPLOYEE’S FAMILY MEMBER’S SERIOUS HEALTH CONDITION**

**IMPORTANT NOTE:** *The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with the Act, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic Information,” as defined by CalGINA, includes information about the individual’s or the individual’s family member’s genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. “Genetic Information” does not include information about an individual’s sex or age.*

1. Employee’s Name: \_\_\_\_\_

2. Patient’s Name: \_\_\_\_\_

Patient’s relationship to employee: \_\_\_\_\_

If the patient is the employee’s child, is the patient either under 18 or an adult dependent child:         Yes     No

3. Does the employee’s child, parent, spouse, or domestic partner have an illness, injury, impairment, or physical or mental condition which constitutes a “serious health condition?” Below is a description of what constitutes a “serious health condition” under both the FMLA and the CFRA. Does the patient’s condition qualify as a serious health condition:

Yes     No

If employee will be caring for an adult child, a health care provider must certify the following:

Patient is Employee’s Adult Child

Patient is Incapable of Self Care\*\*

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Signature of Health Care Provider

4. Date medical condition or need for treatment commenced: \_\_\_\_\_

5. Probable duration of medical condition or need for treatment: \_\_\_\_\_

6. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation?

7. After review of the employee’s signed statement (See Item 10 below), does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member.)     Yes     No

8. Estimate the period of time care needed or during which the employee's presence would be beneficial: \_\_\_\_\_

9. Please answer the following question only if the employee is asking for intermittent leave or a reduced work schedule.

Yes      No  
     

**Intermittent Leave:** Is it medically necessary for the employee to be off work on an intermittent basis or to work a reduced number of hours of work in order to deal with the serious health condition of the employee or family member?

If yes, please indicate the estimated frequency of the employee's need for intermittent leave due to the serious health condition, and the duration of such leaves (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

Yes      No  
     

**Reduced Schedule Leave:** Is it medically necessary for the employee to work less than the employee's normal work schedule due to the serious health condition of the employee or family member?

If yes, please indicate the part-time or reduced work schedule the employee needs:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week, from \_\_\_\_\_ through \_\_\_\_\_

Yes      No  
     

**Time Off for Medical Appointments or Treatment:** Is it medically necessary for the employee to take time off work for doctor's visits or medical treatment, either by the health care practitioner or another provider of health services?

If yes, please indicate the estimated frequency of the employee's need for doctor's visits or medical treatment, and the time required for each appointment, including any recovery period:

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per appointment/treatment

ITEM 10 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE

\*\*\*\* TO BE PROVIDED TO THE HEALTH CARE PROVIDER UNDER SEPARATE COVER

10. When family care leave is needed to care for a seriously ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule:

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11. Printed name of health care provider: \_\_\_\_\_ Signature of Health Care Provider: \_\_\_\_\_

Date: \_\_\_\_\_

12. Employee Signature:

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Date: \_\_\_\_\_

“Serious Health Condition” means an illness, injury (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent, or spouse of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse. A serious health condition may involve one or more of the following:

1. ***Hospital Care***

Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care. A person is considered an “inpatient” when a health care facility formally admits him or her to the facility with the expectation that he or she will remain at least overnight and occupy a bed, even if it later develops that such a person can be discharged or transferred to another facility and does not actually remain overnight.

\*\*A child is “incapable of self-care” if he/she requires active assistance or supervision to provide daily self-care in three or more of the activities of daily living or instrumental activities of daily living, such as caring for grooming and hygiene, bathing, dressing and eating, cooking, cleaning,

shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, etc.

2. ***Absence Plus Treatment***

- (a) A period of incapacity of more than three consecutive, full calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
- (1) Treatment<sup>i</sup> two or more times within 30 days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider, by a nurse, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
  - (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment<sup>ii</sup> under the supervision of the health care provider. The in-person treatment visit must take place within seven days of the first day of incapacity.

3. ***Pregnancy***

Any period of incapacity due to pregnancy or for prenatal care.

4. ***Chronic Conditions Requiring Treatments***

A chronic condition which:

- (a) Requires periodic visits (defined as at least twice a year) for treatment by a health care provider, or by a nurse;
- (b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- (c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. ***Permanent/Long-term Conditions Requiring Supervision***

A period of incapacity which is permanent or long term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. ***Multiple Treatments (Non-Chronic Conditions)***

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three full consecutive calendar days in the absence of medical intervention or



treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

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- i Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.
  - ii A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.