City and County of San Francisco

Department of Public Health

T.J. ANTHONY CATASTROPHIC ILLNESS PROGRAM (CIP)

Instructions for CIP Applicant

Use this form only if you are applying for CIP for yourself. If applying for CIP to care for a family member, use the CIP family member (CIP-FM) form

Eligibility:

Any employee of the City and County of San Francisco may participate in the CIP if the employee meets all of the following conditions:

- ❒ The employee is eligible to accumulate and use sick leave and vacation credits
- ❒ The employee is catastrophically ill
- ❒ The employee has exhausted all of his/her available paid leave
- ❒ The employee does not participate in a short or long-term disability program for which the City pays in whole, directly or indirectly, or if the employee participates in such a program, the employee agrees to, and does, apply for disability benefits immediately upon becoming eligible for such benefits.

Any employee who participates in a short or long-term disability program for which the City pays in whole, directly or indirectly, may participate in the CIP program until the employee receives or is qualified to receive benefits under the terms of the disability program for which the City pays.

Any employee who is receiving, or is qualified to receive, short or long-term disability benefits from a program for which the City pays in whole, directly or indirectly, may not participate in the CIP program until and unless the employee's disability benefits terminate.

Any employee who, while or after participating in the CIP program, retroactively receives, or is qualified to receive, short or long-term disability benefits from a short or long-term disability program for which the City pays in whole, directly or indirectly, must reimburse the City for the CIP payments received during the period for which short or long-term disability was paid. **Failure to do so will result in the City's placing a lien for the unreimbursed amount on the employee's future wages and benefits (not including workers' compensation or retirement).**

Form Instructions:

1) CIP applicant completes Section I (page 2). Sections II, III & IV are completed by Department of Public Health
2) CIP applicant obtains a verification of leave status from his or her departmental human resources/payroll offices. This verification must indicate the first date the applicant is unable to work due to the current medical condition
3) CIP applicant's physician completes page 4, physician's certification
4)  Required documentation checklist:

	Original application (including physician certification)
	Copy of approved leave from applicant's department

5) Submit original application with required documentation to:

Catastrophic Illness Program
Department of Human Resources
One S. Van Ness Street, 4th Floor
San Francisco, CA 94103
(415) 701-5889

NOTE: An incomplete application packet will delay review/approval of your CIP application.

FOR ASSISTANCE PLEASE CALL (415) 701-5889

APPLICATION FOR T.J. ANTHONY CATASTROPHIC ILLNESS PROGRAM (CIP)

(Administrative Code Section 16.9 – 29A)

I. Application (check one): ☐ New ☐ Extension (RIN # _____) Date: _____

Employee Name: _____ DSW: _____

Class #/Title: _____ Union: _____

Address: _____ City: _____

State: _____ ZIP Code: _____ Telephone: ( ) _____

Email (Personal):_____ Email (Work): _____

City Department: _____ 3-letter Dept. Code: _____

Supervisor: _____ Phone: _____

Email: _____

Payroll Manager: _____ Phone: _____

Email: _____

Personnel Manager: _____ Phone: _____

Email: _____

Applicants are required to disclose all benefits received from public sources, as well as whether they are covered by a short or long-term disability program.

Is the applicant eligible for, or receiving any of the following benefits?

☐ Unemployment Insurance ☐ State Disability Insurance ☐ Workers' Compensation ☐ Social Security ☐ Other

If other, please specify: _____

Is the applicant covered by a long or short-term disability policy paid for by the City? ☐ Yes ☐ No

Specify: _____

Applicants may be required to provide financial documentation to prove compliance with these provisions. Applicants must also inform Department of Human Resource (DHR) of any change in their health status, and if they return to work.

Authorization for release of medical records and notification to short-term disability (STD) or long-term disability (LTD) provider. Acknowledgement of requirement to reimburse overpayments:

I hereby authorize my physician to release my medical records to the San Francisco Department of Public Health and it's authorized designee at DHR for its evaluation of my application for the Catastrophic Illness Program. I also authorize the DPH and/or DHR to contact my physician as part of its evaluation. I authorize the City and County of San Francisco to contact my STD and LTD providers, notify them of approval of my application, and request and receive information from my STD and LTD providers regarding my coverage.

I understand that I must reimburse the City for any CIP payments received during any period in which short or long-term disability is received, including retroactive disability payments, and that *failure to do so will result in the City's placing a lien for the unreimbursed amount on my future wages and benefits.*

Employee Signature: _____ Date: _____

II. DPH Determination: ☐ **Approved** ☐ **Denied** ☐ **Hold/Pending**

DPH has provisionally determined that you are catastrophically ill. This determination of catastrophic illness is valid until _____ and must be re-evaluated at that time. If you wish to have your catastrophic illness determination extended beyond the above date, you must submit a new application through the Department of Human Resources

Name: _____

Your eligibility to receive donated sick pay and vacation credits is subject to the following:

1. You must be eligible to accumulate and use sick leave and vacation credits
2. You must have exhausted all available paid leave, including sick, vacation, compensatory, holidays and in-lieu time
3. You must provide DHR with a copy of your approved Request for Leave form or Family Medical Leave Act (FMLA) form
4. You must notify DHR if there is any change in your health status, or if your treating physician has released you to return to work. If your physician has released you to return to work full or part-time, your participation in the CIP program will be terminated. Failure to notify DHR of your return to work may result in overpayment
5. Upon removal from the program, CIP recipients with less than 64 donated hours remaining will retain the donated hours. CIP recipients with 64 or more hours will keep 64 hours, and the remainder of the donated hours will be transferred to the CIP pool.

Your recipient identification number (RIN) is: _____

DPH has determined that you are not catastrophically ill for the following reasons:

_____

_____

You may appeal this decision to the DPH Health Officer. Please call DHR at (415) 701-5889 for appeal procedures.

DHR Designee Signature: _____ Date: _____

III. Processing Instructions:

Call your payroll office if you have questions about your leave balances. Your department HR/payroll office must certify the following on this form:

Employee has exhausted all available paid leave, including sick, vacation, compensatory, other holidays and in-lieu time as of: _____ pay period ending: _____

CERTIFIED: _____ Department _____

Department Representative Name and Title

Department Representative Signature: _____ Date: _____

The department payroll office will submit this form to PPSD, SFUSD or SFCCD payroll once the above certification is made.

IV. Distribution:

Following completion of Part II, DHR will distribute the form to:

- Applicant
- Applicant's department head
- PPSD or SFUSD or CCSF payroll
- Retirement
- STD/LTD providers

Following completion of Part III, the departmental payroll office will distribute this form to:

- PPSD or SFUSD payroll office
- Department file
- Applicant

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PHYSICIAN'S CERTIFICATION OF CATASTROPHIC ILLNESS

Patient Name: _____

Patient Diagnosis: _____

Date patient was unable to work due to this illness: _____

Describe and explain the reported symptoms that result in the patient's inability to work:

_____
_____
_____
_____

Course of Treatment(s) and Date(s):

Treatment: _____ Date: _____

Treatment: _____ Date: _____

Treatment: _____ Date: _____

Treatment: _____ Date: _____

Current Prognosis:

_____
_____
_____

When do you expect improvement in the patient's ability to return to work?

_____
_____

Anticipated or exact date of return to work: _____

Attending Physician Only:

I certify that the above-named patient should be considered for approval of catastrophic illness determination. She/he has a life-threatening illness or injury.

Certified: _____

Name and Title

Physician Signature: _____ **Date:** _____

Address: _____ City: _____

State: _____ ZIP Code: _____ Telephone: ( ) _____

License #: _____