University of Massachusetts Amherst

Office of Human Resources

To Care for Family Member

Dear USA/MTA Sick Leave Bank Member:

Thank you for your interest in the USA/MTA Sick Leave Bank. Please reference Article 10 of the Agreement between the University of Massachusetts' Board of Trustees and the University Staff Association (USA/MTA/NEA) which establishes a Sick Leave Bank for USA/MTA/NEA employees.

The Sick Leave Bank was created in part to provide income security to Sick Leave Bank members who:

- Are out of work for the purpose of caring for a qualified family member* who suffers from a serious health condition.
- Have a reasonable expectation and intention of returning to the position from which leave was granted after the leave period concludes.
- Are not receiving, or eligible to receive, income replacement from another source.

Please remember that you may not be absent from work without your department's approval. The University has established a standard procedure for requesting leave from your department. This process is described in the attached document titled Employee's Family/Medical Leave Request Checklist.

While on an approved leave, and after a member exhausts all of their own accrued time excluding two (2) weeks of a combination of compensatory, personal, and vacation time, a member may apply for income replacement via the attached application to the USA/MTA Sick Leave Bank for consideration.

A completed application will consist of:

- Section One: Completed by the member.
- Section Two: Completed by member and accompanied by a U.S. Department of Labor's Certification of Health Care Provider for Family Member's Serious Health Condition (WH-380-F) completed by the treating health care professional.
- Section Three: Completed by the member's departmental HR Representative.

For questions regarding the process of applying to the Sick Leave Bank please contact me via email at: rrgrzych@admin.umass.edu or by phone at (413) 545-1473.

Sincerely,

Randy Grzych
On behalf of the USA/MTA Sick Leave Bank

*Bank members may apply for leave required to care for a child, parent, or sibling of either a bargaining unit member or his/her spouse; the bargaining unit member's spouse, grandchild or grandparent; or a relative living in the immediate household of a bargaining unit member in the event that close relative is suffering a serious health condition.

University of Massachusetts Amherst

Office of Human Resources

Employee's Family / Medical Leave Request Checklist

Required: you may not be absent from work without approval from your department.

- ☐ You must submit a written, signed, and dated request for leave to your supervisor, cc your departmental Human Resources representative, indicating:

  1) That you are requesting a family / medical leave,

  2) The dates you anticipate being absent from work and the date you intend to return to work,

  3) Be clear with your department how you are requesting that time and attendance be submitted in order to secure income if your leave is approved (e.g., sick leave, unpaid leave, etc.), and

  4) If requesting an intermittent leave, the work schedule you propose.

  If you medically require accommodations in order to perform the essential functions of your job it is your responsibility to work with University's Accessible Workplace Office to secure those accommodations.

- ☐ You must provide your departmental Human Resources representative a completed Certification of Health Care Provider (HCP) form corresponding to the purpose for your leave (eg, Employee's Serious Health Condition, Family Member's Serious Health Condition, etc.) Certification of Health Care Provider forms are available at the Human Resources Employee Service Center (325 Whitmore Admin. Bldg.) and on-line at www.umass.edu/humres. If your leave is due to the birth of your child you may provide a medical note indicating the child's expected date of delivery in lieu of a Certification form. If your leave is due adoption or placement of a child in your foster care please provide corresponding legal documentation indicating the date of adoption or placement.

Voluntary: If you do not have enough accrued time to secure your income while on an approved leave you may complete and submit a completed Sick Leave Bank application to Human Resources (or AFSCME Extension of Sick Leave application). This is not applicable for work-related illness or injury that may be covered under Workers Compensation.

Required:

- ☐ If requesting an extension of your leave – follow steps above, submitting the required documents for receipt at two weeks prior to the expiration of your currently approved leave.
- ☐ During your leave you must remain in contact with the University regarding your intention to return to your University position and any changes in your anticipated return to work date.
- ☐ *Prior* to returning to your job you must provide your departmental human resources representative a written medical document releasing you to return to work and perform the essential functions of your job. If accommodations are required it is your responsibility to secure those accommodations through the University's Accessible Workplace Office prior to your return.

Note:

- ☐ If you are on approved, *unpaid* leave for two or more full payperiods and you purchase insurance through the MA Group Insurance Commission (GIC), the GIC will invoice you at home for your insurance premiums. Timely payment is required in order to secure continued coverage. If you are on an unapproved leave the Massachusetts Group Insurance Commission will invoice you for 100% of the health insurance premium.
- ☐ If you are on parental leave and wish to add your child(ren) to your insurance coverages you must complete the necessary paperwork with Human Resources (HR Service Center, room 325 Whitmore Administration Building) within thirty (30) days of the child(ren)'s date of birth or adoption.

Protections under the federal Family Medical Leave Act (FMLA) run concurrent with approved time off for qualifying circumstances.

University of Massachusetts Amherst

USA / MTA SLB

Application for Income Replacement

For Approved Leave for Caring for a Family Member with a Serious Health Condition

SECTION ONE: EMPLOYEE INFORMATION
(to be completed by applicant)

Please submit this application form and the requested information if you are applying for income security during a leave period that has been approved by your department in order for you to provide care for a qualified family member that is suffering from a serious health condition. The Sick Leave Bank is not intended to act as a substitute for, or supplement to other sources that may be securing your income during a leave period.

Name: _____ Employee ID Number: _____

Home Address: _____

Home Telephone Number: _____ Work Telephone Number: _____

Email Address: _____

Job Title: _____ Department: _____

Supervisor's Name: _____

Email Address: _____ Telephone Number: _____

Department Time and Attendance Keeper: _____

Email Address: _____ Telephone Number: _____

Have you applied for income replacement through any other source? ◯ YES ◯ NO

Last Day Worked: _____ Intended Date of Return to Current Position: _____

Please describe the situation for which you are requesting time from the Sick Leave Bank.

_____

_____

_____

_____

My signature below certifies that the information I provided in Section One of this application is true and accurate. I agree to notify the Committee prior to application for income replacement from another source for this leave instance.

Signature: _____ **Date:** _____

USA/MTA Sick Leave Bank * contact: Human Resources * phone (413) 545-1473 * fax (413) 545-0483
Thank you for taking the time to complete this form.

University of Massachusetts Amherst

USA / MTA SLB

Application for Income Replacement
For Approved Leave for Caring for a Family Member with a Serious Health Condition

Section Two: Medical Information

In support of your request for benefits from the USA/MTA Sick Leave Bank, please attach the Department of Labor's Form WH-380-F; Certification of Health Care Provider for Family Member's Serious Health Condition (attached). *This form must be completed by the medical professional treating your relative for his/her illness.*

I have attached the following documents in support of my application.

☐ Department of Labor Form WH-380-E: Certification of Health Care Provider for Family Member's Serious Health Condition for:

Patient Name: _____

Relationship to USA/MTA SLB Member: _____

University of Massachusetts Amherst

USA / MTA SLB

Application for Income Replacement
For Approved Leave for Caring for a Family Member with a Serious Health Condition

SECTION THREE: DEPARTMENTAL CONFIRMATION
(to be completed by applicant's departmental HR Representative)

I have approved _____ for up to _____ hours of
(employee name)

leave per week from _____ until _____ to
(date) **(date)**

provide care for a family member whom is suffering from a serious health condition.

If the leave request is part-time, the employee and I have agreed to the attached work schedule.

HR Coordinator Name: _____

Campus Address: _____

Campus Telephone Number: _____

Campus Email Address: _____

HR Coordinator Signature: _____ Date: _____

Please Note: When an employee will be out of work due to a medical issue, or when requesting parental leave, the employee and his/her supervisor must follow the University's Leave and Approval Process. These checklists may be viewed at https://www.umass.edu/humres/forms. Please contact the Sick Leave Bank Administrator in the Division of Human Resources with questions or assistance.

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

_____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her 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 to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care:_____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth:_____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ ____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address:_____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission: _____

   Date(s) you treated the patient for condition: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ___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. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? __ No __ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

   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 lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours or ___ day(s) per episode

   Does the patient need care during these flare-ups? ____ No ____ Yes.

   Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.