City and County of San Francisco

Department of Public Health

T.J. ANTHONY CATASTROPHIC ILLNESS PROGRAM (CIP)

Instructions for CIP Family Member (CIP-FM) Applicant

Use this form only if you are applying for CIP to care for a family member

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 has exhausted all of his/her available paid leave
- The employee has a catastrophically-ill family member
- The employee must take time off from work to care for the catastrophically ill family member.

Definition of family member:

"Family member" means a spouse, registered domestic partner, or another dependent as dependent is defined in the Internal Revenue Code (26. U.S.C. sec. 152 as amended from time to time).

Form Instructions:

1) CIP-FM applicant completes Section I (page 2). Sections II, III & IV are completed by the Department of Public Health. The following documents must be attached to this application:
   a. Birth certificate **or** copy of marriage certificate, or registration of domestic partnership, and
   b. Proof of FM dependency (copy of official filed current year IRS tax form 1040 and signed IRS form 4506T-EZ short form request for individual tax return transcript (strikeout income information)
   c. Completed FMLA forms. Applicants on intermittent FMLA do not meet the CIP-FM eligibility criteria per ordinance section 16.9-29 D3 because they accrue sick leave and vacation while working
2) CIP-FM 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
3) CIP-FM applicant's family member physician completes page 4, physician's certification
4)  Required documentation checklist:

	Original application (including physician certification)
	Copy of approved leave from applicant's department
	Proof of relationship (birth certificate, marriage certificate, etc.)
	Proof of FM dependency (see above)

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

City and County of San Francisco

Department of Public Health

APPLICATION FOR T.J. ANTHONY CATASTROPHIC ILLNESS PROGRAM FAMILY MEMBER (CIP-FM)(Administrative Code Section 16.9 – 29B)

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: _____

Employee Signature: _____ Date: _____

Family Member Information

Name: _____ Relationship: _____

Authorization for release of medical records:

I hereby authorize my physician to release my medical records to the San Francisco Department of Public Health and it's authorized designee at Department of Human Resource 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.

Family Member Signature: _____ Date: _____

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

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

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 be off work to take care of your catastrophically ill family member
5. You must notify DHR if there is any change in your family member's health status while you are on CIP-FM
6. You must attach completed and approved FMLA forms.

Your recipient identification number (RIN) is: _____

DHR has determined that you family member is 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
- DPH file

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

- PPSD or SFUSD payroll office
- Department file
- Applicant

PHYSICIAN'S CERTIFICATION OF CATASTROPHIC ILLNESS (CIP-FM)

Patient Name: _____

Patient Diagnosis: _____

Onset of Catastrophic Illness (date): _____

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 #: _____