Department of Administrative Services
Empowering People
Collaboration
Customer Service

DONATED LEAVE FOR CATASTROPHIC ILLNESS
APPLICATION

Part A. TO BE COMPLETED BY THE EMPLOYEE

Name of Employee: _____ **Department:** _____

Last 4 Digits of SSN: _____ **Last Date Worked:** _____ **Last Date in Pay Status:** _____

Catastrophic donations will be used to pay health, dental and life insurance premiums, FSA, RIC & misc. deductions (Eyemed/Avesis, etc.)

☐ I understand if my donations are not sufficient to allow premium deductions, my premiums will be caught up by the payment in arrears process.

Employee Signature: _____ **Date:** _____

Part B. TO BE COMPLETED BY THE PROVIDER (FORM WILL BE RETURNED IF NOT FULLY COMPLETED)

Definition: "Catastrophic Illness" means a physical or mental illness or injury, as certified by a provider (MD, DO, PA, ARNP, or Psychiatrist), resulting in the inability of the employee to work for more than 30 work days on a consecutive or intermittent basis.

1. In your opinion, does the employee meet the "Catastrophic Illness" definition above? Yes ☐ No ☐
   If no, sign and date this form. If yes, answer questions 2-8. (If more space is needed, attach an additional sheet.)
2. Diagnosis description: _____
   _____
3. Is condition due to an injury or illness arising from your patient's employment? Yes ☐ No ☐
4. Method of treatment: _____
5. Has your patient been hospital confined? Yes ☐ No ☐ If yes, hospital name: _____
   _____
6. On what date was your patient first unable to work? _____
7. Prognosis: _____
8. When could employment resume and under what conditions? _____
   _____

Provider's Name(Print): _____

Provider's Signature: _____ **Date:** _____

Address: _____ _____ _____
Street City and State Zip Code

Phone Number: ( ) _____

Part C. TO BE COMPLETED BY THE DAS LEAVE ADMINISTRATION TEAM

Has the employee's diagnosis been previously filed? Yes ☐ No ☐ If Yes, application is denied. If no, move on to next criteria.

Please verify the following. The employee has:

- ☐ a catastrophic illness based on the physician's statement (above); and
- ☐ exhausted all paid leave; and
- ☐ been approved for or has exhausted Family and Medical Leave (FMLA), if eligible; and
- ☐ been approved for medical leave without pay during any hours for which he or she will receive donated leave.

I certify that the employee meets all of the criteria as stated in Section C above.

Leave Manager Signature: _____ **Date**: _____

This confidential form should be kept in Workday - Maintain Worker Documents

CFN 552-0611 10/21
DAS Leave Admin Team Fax # 515-242-5070