Arkansas School For The Blind
Catastrophic Leave Bank Program
APPLICATION for BENEFITS

Please type or print legibly

Case# _____

Authorized by A.C.A. §§ 21-4-203, 21-4-214, 6-63-601 &6-63-602

Instructions

Complete this form to apply for Catastrophic Leave. **Catastrophic Leave is leave needed for prolonged period of time. Prolonged Period of Time means a continuous period of time (minimum of thirty (30) working days) whereby a medical condition prevents the employee from performing the employee's duties.** Attach all appropriate documentation of the medical emergency. Include the Physician's Certification for Catastrophic Leave and the Catastrophic Leave Bank (CLB) Liability Agreement. Present forms to your supervisor.

NOTE

The award of Catastrophic Leave is dependent upon its availability within the Catastrophic Leave Bank. The program does not create any expectation or promise of continued employment.

Part 1 – Application and Certification *(To be completed by applicant employee or designee on his/her behalf).*

Patient Name (*Last, First, Middle Initial)*	Relationship to Employee

If applicant has any qualifying family member(s) employed by the State, list their name(s) in the following sections

Name of family member	Agency of family member	Social Security Number of family member

Applicant's Name (Last, First, Middle Initial)	Applicant's Social Security Number

Applicant's Personnel Number	Applicant's Position Number

Applicant's Position Class Code	Applicant's Position Title	Pay Grade	Applicant's Hourly Rate of Pay

Agency/Institution	Work Phone Number	Home Phone	Birthday: Year/Month/Day

Retirement and Social Security/Social Security Disability Benefits

☐ Yes ☐ No I am eligible for Retirement or Social Security benefits.
☐ Yes ☐ No I have applied for Retirement. If yes, date applied:
☐ Yes ☐ No I have applied for Social Security/Social Security Disability. If yes, date applied:

Applicant Certification: *(Check ✓ all appropriate sections)* ***I certify that:***

☐ 1. I have been affected by a medical emergency described on the attached Physician's Certification.
☐ 2. I have, or will have, exhausted all Leave and Compensatory Time as of the date indicated.
☐ 3. I expect to be absent from work without paid leave because of this medical emergency.
☐ 4. I had at least 80 hours of combined sick and annual leave at the onset of this illness/injury, or I have attached the required documentation to receive an "extraordinary circumstance" waiver.
☐ 5. I have made application and am receiving Workers' Compensation Benefits in connection with this work-related condition.
☐ 6. I have made application but am not receiving Workers' Compensation Benefits in connection with this work-related condition.
☐ 7. I agree that any leave that I accrue while on Catastrophic Leave will be returned to the Catastrophic Leave Bank.

Signature of Employee Receiving Catastrophic Leave or His/Her Designee	If Designee, state your relationship to Recipient	Date

Part II – Supervisory Verification *(To be completed by Applicant's Supervisor.)*

Disciplinary Action for Leave Abuse During past 2 years? ☐ Yes ☐ No	Explain why this employee's leave has been exhausted. **Be specific:**

Could this job be restructured temporarily to allow employee to return to work at an earlier date? ☐ Yes ☐ No **If Yes, attach revised job duties.**

Signature of Supervisor	Position Title	Phone Number	Date

Arkansas School For The Blind

Catastrophic Leave Bank Program

APPLICATION for BENEFITS Continued

Authorized by A.C.A. §§21-4-203, 21-4-214, 6-63-601 & 6-63-602

Employee/Applicant Name *(Last, First, Middle Initial)*	Social Security Number

Part III – Personnel/Payroll Verification *To be completed by Agency Personnel/Payroll Officer.)*

Full-Time ☐ Yes ☐ No	Career Service Date	Latest Hire Date	Date Employee Would Go on LWOP	Case Number

Date Leave Exhausted – Attach Leave Calendar(s) *(Includes Annual, Sick, Holiday and Comp- verified by Timekeeper)*	**Amount of Catastrophic Leave Requested**	**Duration Dates of Catastrophic Leave Request**	
Date Time ☐ AM ☐ PM	Last Day Worked	Total Hours Requested *In one (1) hour increments*	Beginning Date / Projected Ending Date
Timekeeper's Name *(Print)*	Timekeeper's Signature	Phone Number	Date

WORKERS' COMPENSATION STATUS

Applied Date ☐ Yes ☐ No	Approved? Date ☐ Yes ☐ No	Pending? ☐ Yes ☐ No	Denied? Date ☐ Yes ☐ No

Amount of Workers' Compensation Weekly Benefits	Hourly Rate on Date of Accident	Hours of Catastrophic Leave Requested Weekly
Date Workers' Compensation Commenced	Expected Duration	Date

DISABILITY INSURANCE (FOR INSTITUTION EMPLOYEES ONLY)

Does institution provide Employee Disability Insurance? * ☐ Yes ☐ No	Has employee filed for coverage? ☐ Yes ☐ No	Date Insurance begins/# of Months required for eligibility

Signature of Authorized Agency/Institution Representative	Position Title	Phone Number

Part IV – Catastrophic Leave Committee Review and Recommendation

Date Received	Date Reviewed	**Dates of Duration of Approved Catastrophic Leave**	
		Beginning Date	**Projected Ending Date**

APPLICATION APPROVED ☐ Yes* ☐ No ☐ **Extraordinary Circumstance Waiver of "80-hour" Rule*	Total Hours Awarded	Total Dollar Value of Leave Received	***INSTRUCTIONS*** *After review, recommendation and signature of Committee Chairperson, forward to Agency Director for final review and consideration of recommendation.*
Signature of CLB Committee Chairperson/Designee		Date	

Part V – Director's Review and Action **FINAL ACTION ☐ Approved ☐ Denied ☐ Concurred**

Signature of Agency Director	Name of Agency	Date

Return originals to:
ASD Catastrophic Leave Bank
2400 W. Markham
P.O. Box 3188
Little Rock, AR 72203-3188

Part VI – Completed by CLB Record Keeper

Signature of CLB Record Keeper	Date

**Institution may provide Disability Insurance at no cost to employee.*

Exceptional Circumstance Waiver

I, _____, (ASB Superintendent) do hereby grant an exceptional circumstance waiver waiving the eligibility requirement of 80 hours of leave at the onset of the illness to _____ (employee) due to an occurrence of one of the following conditions:

☐ **If the illness or injury is that of an employee and is covered by workers' compensation, the compensation based on catastrophic leave when combined with the weekly workers' compensation benefit received by the employee shall not exceed the compensation being received by the employee at the onset of the illness or injury.**

☐ **If a recurrence of the same illness necessitates a subsequent catastrophic leave request, the eligibility that the employee have eighty (80) hours of combined sick and annual leave at the onset of the illness will not be required on the illness recurrence date.**

_____ _____

ASB Superintendent **Date**

By my signature below I understand that the Superintendent has granted an exceptional circumstance waiver waiving the eligibility requirement of having 80 hours of leave at the onset of my illness therefore allowing me to apply for catastrophic leave.

_____ _____

Employee Signature **Date**