

# CATASTROPHIC ILLNESS PROGRAM CIP

# **Instructions for CIP Applicant**

\*\* <u>DO NOT</u> use this form, if you are applying for CIP-FM (Catastrophic Illness-To care for Family Members) \*\*

- 1.) CIP APPLICANT COMPLETES PAGE 1
- 2.) SKIP PAGE 2.
- 3.) CIP APPLICANT'S PHYSICIAN MUST COMPLETE PAGES 3 AND 4 PHYSICIAN'S CERTIFICATION.
- 4.) PLEASE MAIL OR SUBMIT **ORIGINAL** APPLICATION TO:

Catastrophic Illness Program Department of Public Health Human Resource Services 101 Grove Street, Room 212 San Francisco, CA 94102

FOR ASSISTANCE, PLEASE CALL (415) 554-2580



#### APPLICATION FOR CATASTROPHIC ILLNESS PROGRAM (CIP)

(Administrative Code Section 16.9 – 29A)

\*\*\* DO NOT USE THIS FORM FOR FAMILY MEMBER. USE CIP-FM (FAMILY MEMBER)\*\*\*

INSTRUCTIONS: Applicant must complete Section I; Sections II, III & IV are completed by Department of Public Health; Employee's Physician must complete the entire page 3; Mail complete form to: Catastrophic Illness Program - Department of Public Health (DPH), Human Resource Services/Personnel, 101 Grove Street, Room 212, San Francisco, CA 94102.

I. Application (Check One) 

New 

Extension (Recipient # \_ \_ \_ \_ \_ \_ ) Date: \_\_\_\_\_ Employee Name: \_\_\_\_\_ SSN: \_\_\_\_ Class #: \_\_\_\_\_ Address: City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_ Telephone: ( )\_\_\_\_\_ City Department: \_\_\_\_\_ Dept. #: \_\_\_\_ (2 digit) Phone: **Immediate Supervisor:** Email: Phone: Payroll Manager: Email: Phone: **Personnel Manger:** Email: Applicants are required to disclose all benefits received from public sources. These benefits include but are not limited to payment for unemployment, disability, workers compensation and social security. Applicant may be required to provide financial to prove compliance to this Are you covered by a City paid long or short term disability (premiums paid by the City) Specify: **Eligibility of Employee to Participate in CIP Program:** Any employee of the City and County of San Francisco may participate in the CIP if the employee meets all of the following conditions: 1) the employee is eligible to accumulate and use sick leave and vacation credits; 2) the employee is catastrophically ill; 3) the employee has exhausted all of his/her available paid leave; and 4) 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 a short or long-term disability program for which the City pays in whole, directly or indirectly. Any employee who is receiving 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, 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 which the short or long term disability program applies. 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 worker's compensation or retirement). This paragraph does not apply to employees who are active participants in the CIP as of the effective date of this Amendment and have been active participants since March 29, 2002. AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/NOTIFICATION TO SHORT TERM DISABILITY (STD)/LONG TERM DISABILITY (LTD) PROVIDER: I hereby authorize my physician to release my medical records to the San Francisco Department of Public Health for its evaluation of my application for Catastrophic Illness Status. I also authorize the DPH 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. Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_

Updated: 01/01/08 Page 2 of 5

# City and County of San Francisco



# **Department of Public Health**

II.	<u>DPH Determination</u>	ed 🗆 Deni	iea	⊔ Hola/Pending			
	DPH has provisionally determined that you ar			·			
	have your Catastrophic Illness Status extende	ed beyond the above	e date, y	ou <u>must</u> submit a new applic	cation.		
	Name						
Your	r eligibility to receive donated sick pay and va	acation credits is s	subject t	o the following:			
1. 2.	You must be eligible to accumulate and use sick leave and vacation credits; and, You must have exhausted all available paid sick, vacation, compensatory and in-lieu time. See instructions in Part III below.						
	Your Recipient Identification Number RIN) is: (six digit number)						
		(SIX digit i	numbe	7)			
	DPH has determined that you are not Catastrophically III for the following reasons:						
	may appeal this decision to the Director of F 5) 554-2580 for appeal procedures.	lealth. Please call	I the DP	H Personnel Office			
DPH	l Designee:						
	Signature			Date			
ĪII.	INSTRUCTIONS FOR PROCESSING						
	Call your payroll Office if you have questi	ons on your balan	ces.				
1.	Your Department Payroll Office must cert	Your Department Payroll Office must certify the following on this form.					
	Employee has exhausted all available paid sick, vacation, compensatory and in-lieu time.						
	CERTIFIED:						
	Name and Title			Department			
2.	The Department Payroll Office will submit the certification above is made.	t this form to either	r PPSD	, SFUSD or SFCCD Payro	oll once		
IV. 1.)	DISTRIBUTION Following completion of Part II, DPH will distri	hute the form to:					
1.)	Applicant (with RIN)						
	Applicant's Department Head (w/o RIN) PPSD or SFUSD or CCSF Payroll (with RIN)						
	DPH File Copy (w/o RIN)						
	Retirement (w/o RIN) STD/LTD Providers						
2.)	following completion of Part III, Department P	ayroll Office distribu	utes this	form to:			
	PPSD or SFUSD Payroll Office Applicant						
	Department File Copy						

**Updated: 01/01/08** Page 3 of 5



## PHYSICIAN'S CERTIFICATION OF CATASTROPHIC ILLNESS

Date Physician Completes this form:
Patient Name:
Patient Diagnosis:
Onset of Catastrophic Illness:
Course of Treatment(s) and Date(s):
Symptoms which result in inability to work (Explain):
Current Prognosis:
When do you anticipate Patient will be able to return to work? (Please provide the anticipate
or exact date of return to work)

**Updated: 01/01/08** Page 4 of 5

## **City and County of San Francisco**



## **Department of Public Health**

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

Attending Physician	n Only	
Signature:		Date: _
Physician's Name/Title	(print):	
Business Address/Stree	et:	
City:	State:	Zip Code:
Work Phone Number a	nd Extension:	License #: