

CATASTROPHIC ILLNESS PROGRAM – FAMILY MEMBER CIP-FM

Instructions for CIP-FM Applicant:

** <u>Use</u> this form, only if you are applying to care for Family Member***

1.) CIP-FM APPLICANT COMPLETES PAGE 1

Attach a copy of Marriage Certificate, or Registration of Domestic Partnership, or first page of IRS form (delete income information) and FMLA Request

- 2.) SKIP PAGE 2.
- 3.) CIP-FAMILY MEMBER'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

City and County of San Francisco



Department of Public Health

APPLICATION FOR CATASTROPHIC ILLNESS PROGRAM <u>FAMILY MEMBER</u> (CIP-FM) (Administrative Code Section 16.9 – 29B)

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 Cod	e: Telep	phone: ()
City Department:		Dept. #: (2 digit)
Immediate Supervisor:	Phone:	
inineulate Super visor.	Email:	
Payroll Manager:	Phone:	
	Email:	
Personnel Manger:	Phone: _ Email:	
individual CIP-FM employee, subject to the following transferring employee may transfer hours to the CI	uncisco who is eligible to accumulate a ng conditions: 1) Transfers must be in IP-FM only once per pay period; 4) The transfer a maximum of 480 hours per fis	mployees: Ind use vacation credits may transfer vacation credits to an units of eight hours; 2) All transfers are irrevocable; 3) The transferring employee may transfer a maximum of 80 hours cal year to the CIP-FM program; and 6) neither a transferring
Employee's Signature	Date	
Family Member Information		
Name:	Relation	onship:
AUTHORIZATION FOR RELEASE O	OF MEDICAL RECORDS:	
- San Francisco Department of 1	Public Health for its ev I also authorize the Cit	the City and County of San Francisco raluation of this application for my and County of San Francisco - con.
Signature:	Date:	



II.	DPH Determination	Approved	Denied	☐ Hold/Pending	
DPH	has provisionally determined	that your family meml	ber is Catastrophic	cally III. This determination o	f
have	strophic Illness is valid until Catastrophic Illness Status ex plication Extension" after DA	ktended beyond the a	bove date, please	submit a new application. W	
Your	eligibility to receive donated s	ick pay and vacation	credits is subject t	o the following:	
2.)	ou must be eligible to accumu ou must have exhausted all a See instructions in Part III belo	vailable paid sick, vac		ory and in-lieu time.	
١	our Recipient Identification Nu	umber is:		_	
	our Recipient Identification Nu	(six digit	number)		
DPH	has determined that you are r	not Catastrophically III	for the following	reasons:	
for a	may appeal this decision to the ppeal procedures. Designee:		Please call the DF		 I-2580
_	Signati	ıre		Date	=
III.	INSTRUCTIONS FOR PI Call your payroll office if you		on your balances		
1.	Your Department Payroll O	ifice must certify the f	ollowing on this fo	rm:	
	Employee has exhausted a	ll available paid sick,	vacation, compen	satory and in-lieu time.	
CER	TIFIED:				
	Name ar	nd Title		Department	
2.	The Department Payroll Off certification above is made.		m to either PPSD	, SFUSD or SFCCD Payroll o	once the
V.	DISTRIBUTION				=
1.	Following completion of Part II, D Applicant Applicant's Department Head PPSD or SFUSD Payroll Retirement	PH will distribute the form	to:		
2.	DPH File Copy following completion of Part III, Do PPSD or SFUSD Payroll Office Applicant Department File Copy	epartment Payroll Office di	istributes this form to:		



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 anticipated exact date of return to work)

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 Only						
Signature:		Date:				
Physician's Name/Title (print):						
Business Address/Street:						
City:	State:	Zip Code:				
Work Phone Number and Extension:		License #:				