NEW CASTLE COUNTY

PERSONNEL POLICY

NUMBER	4.18
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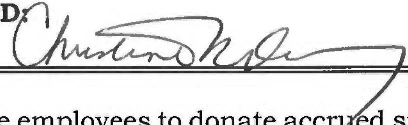
DATE	08/12/15

SUBJECT: SICK LEAVE BANK

APPROVED:



OBJECTIVE: The sick leave bank program is established to allow eligible employees to donate accrued sick days to other County employees who are members of the Bank, and who are unable to work due to the employee's own catastrophic health condition.

STATEMENT: New Castle County encourages employees to participate in a program designed to help employees who have encountered catastrophic personal medical situations resulting in an extended absence from work. A catastrophic illness means an extended illness or injury which is diagnosed and certified by a physician rendering an employee incapacitated for a period greater than four calendar weeks. Many times the employee in this situation has exhausted all of his or her own paid leave options while more time is needed to address the catastrophic health condition. The ability for an employee to request additional sick leave days through the sick leave bank is a way for affected employees to obtain paid time to care for their catastrophic health condition.

PROCEDURE:

1. Participation in the Bank is voluntary and the utilization of benefit is limited to Bank members only.

2. Eligible employees must be full-time employees with two (2) years or more credited service with New Castle County. Eligible employees are defined as:
   a. Full-time non-union classified and unclassified employees
   b. Full-time union employees who have negotiated this benefit into their union contracts

3. Excluded are part-time School Crossing Guards represented by IBEW Local 2270 (who are not eligible for sick leave benefits).

4. Membership in the Bank:
   a. Eligible employees must donate a minimum of one (1) day of accrued sick leave every year during the open enrollment period; a maximum of twelve (12) days of accrued sick leave per member per calendar year is permitted by any one (1) eligible employee

   b. Open enrollment period for participation in this program will be January 1 through January 31 in each calendar year.

   c. To continue active membership in the Bank, eligible employees must re-enroll each calendar year using the minimum and maximum criteria stated above.

   d. To enroll as a member, eligible employees may sign up by completing the sick leave bank enrollment/donation form as follows:
      - electronic form through the PeopleSoft Employee Self Service Module on the county intranet portal **OR**
      - hardcopy form that can be printed from HR Forms Section of the county intranet portal, obtained from your department's Human Resources liaison, or obtained from the Office of Human Resources

5. Withdrawal from the Bank:
   a. An eligible employee who is a member of the Bank may withdraw up to a maximum of six (6) months of continuous sick leave in a rolling twelve (12) month period

b. For an eligible employee who is a member of the Bank to receive sick leave from the Bank, he or she:
   - must have exhausted his or her own sick, vacation, personal, compensatory, furlough and special projects time;
   - be an active member and contributor to the Bank;
   - require a continued absence of four weeks or more due to the employee's own catastrophic health condition;
   - provide sufficient medical documentation certified by a physician substantiating such condition; and
   - have applied for, been granted and exhausted a two-week sick leave extension as detailed in New Castle County Personnel Policy 3.02 (Sick Leave Extension); and
   - obtain approval from the Chief Human Resources Officer prior to any utilization of sick leave from the Bank.

c. To request donated sick leave, the eligible employee must make the request to the union which will in turn bring the request to the attention of the Chief Human Resources Officer (non-union employees make request to their general manager or row officer). A copy of the written statement from the physician must be included with the request along with a New Castle County Authorization for Release of Protected Health Information. After the Chief Human Resources Officer determines the employee is a Bank participant, he or she will contact the department general manager or row officer and request any background information. Once this information is received, the Chief Human Resources Officer will use similar procedure used to determine requests for second sick leave extensions. The Office of Human Resources will communicate to the employee in writing whether the request for donated sick leave from the sick leave bank is approved or disapproved.

6. Administration of the Bank:
   a. The Chief Human Resources Officer is responsible for establishing policies and procedures regarding the administration of the Bank, which shall be subject to approval by the members of the Benefits Committee.
   b. The Chief Human Resources Officer approves active member utilization of sick leave from the Bank.
   c. The Benefits Committee shall be responsible for monitoring the solvency of the Bank and issuing depletion notices. Once a depletion notice is communicated to the members of the Bank, a one (1) month donation window shall be opened. Donation during this sick leave bank "depletion window" is voluntary and opened to only the active Bank members and governed by the same limitations.
   d. At the end of each calendar year, unused days that have been donated shall remain in the sick leave bank for future use.
   e. If a sick leave bank request is denied by the CHRO, an appeal may be filed with the CAO within 10 business days. The appeal shall include a written statement detailing the serious medical condition and any supporting documentation. The CAO will review and render a final decision.

REQUIRED ACTION: The Chief Human Resources Officer, Benefits Committee, department general managers, row officers and payroll processors shall be responsible for the implementation of and compliance with this policy.

Established: 01/01/06
Revised: 08/12/15

NEW CASTLE COUNTY

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Part 1: **Name of person whose health information will be disclosed:** *[please print]*

Part 2: **Person or Entity that has the health information to be released:**

- ☐ New Castle County
- ☐ New Castle County Employee Health Care Plan *(as defined in New Castle County's Privacy Policy)*
- ☐ Other: ______________________ *[please print the name of the entity that has the record to be disclosed; e.g., Dr. Jane Doe, XYZ Insurance Company, ABC Laboratories, etc.]*

Part 3: **Description of the health information to be released:**

- ☐ Lab results (including drug screening and blood-alcohol test results)
- ☐ Psychiatric/psychological evaluation
- ☐ Physical examination results and notes
- ☐ History, treatment and progress notes
- ☐ Other: ______________________ *[describe the health information that may be disclosed]*

Are the records to be released limited to records created during a **specific period of time:** ☐ No ☐ Yes
If "Yes" indicate specific time period: From *[insert date]* to *[insert date]*

Part 4: **Person or Entity that will receive the health information:**

- ☐ New Castle County
- ☐ New Castle County Employee Health Care Plan *(as defined in New Castle County's Privacy Policy)*
- ☐ Other: *[please print the name of the entity that will receive the record]*:

Part 5: **Description of the purpose for the release of the health information:**

- ☐ At the request of the person whose name appears in Box 1
- ☐ Pre-employment or periodic controlled substance screen or psychoanalysis evaluation
- ☐ Other *[insert description of the purpose]*:

Part 6: **Duration of Authorization:**

This Authorization will remain effective *[choose an expiration period or event]*:

Expiration period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☐ ___ days

Expiration event: *[insert description of an event upon which the Authorization will expire]*:

Part 7: **Certification and Acknowledgement:** I certify that I am the person (or the personal representative of the person) designated in Part 1. I agree that my individually identifiable health information described in Part 3, and held by the person or entity listed in Part 2, may be disclosed to the person or entity listed in Part 5 for the purpose(s) designated in Part 6. ***I understand that, if the information to be disclosed is needed by a health care plan in order to determine my eligibility for plan benefits; or is needed by New Castle County to consider me for medical, sick or other leave; or to consider my eligibility or claim for short- or long-term disability or life insurance coverage or benefits, workers' compensation benefits, or similar fringe benefits; or to consider me for employment or continued employment, my failure to provide this Authorization may prevent me from receiving the benefit or leave, or preclude me from being considered for employment or continued employment.*** I understand that I have the right to revoke this Authorization, in writing, at any time, by sending the revocation to the person or entity who received the Authorization, and that the revocation will be effective except to the extent that the person or entity releasing the information has already taken action in reliance on my Authorization. I understand that, once disclosed, it is possible that the health information may be further disclosed by the recipient and no longer subject to protection under federal privacy rules. ***I have received a copy of my signed Authorization.***

Signature: ______________________ **Date:** ______________

[If signing as the personal representative of the person in Box 1, print your name and describe your authority to sign for the person]:
Name: ______________________ Authority: ______________________

For office use:

- ☐ Authorization fully completed and signed
- ☐ Copy of Authorization provided to Individual or Personal Representative