



**Houston Independent School District  
Leave Administration  
Hattie Mae White Educational Support Center  
4400 West 18<sup>th</sup> St., Houston, TX 77092**

**Ph: 713-556-6590 ♦ Fax: 713-556-6966 ♦ Email: [LeaveAdministration@HoustonISD.org](mailto:LeaveAdministration@HoustonISD.org)**

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## **Supplemental Sick Leave Bank (SSLB) Benefit Claim Information**

Houston ISD employees enrolled in the Supplemental Sick Leave Bank (SSLB) program are active participants and eligible to submit benefit claims. The SSLB program offers up to 30 paid leave days each plan year for absences due to catastrophic medical illness or injury, as outlined in the HISD Finance Procedures Manual, Section 1501. The SSLB plan year is September 1<sup>st</sup> through August 31<sup>st</sup>.

The SSLB program is claims-based, whereby a claim must be submitted and approved before any benefits will be dispersed. A claim may be filed by submitting claim forms. All requested information on the claims form is necessary to evaluate eligibility. Claimants are responsible for verifying the completion of each claim form prior to submission. **A claim will not be processed until both completed forms are received.** Completed claim forms should be submitted to HISD Leave Administration by fax, email, mail, or in person. In order to apply for SSLB benefits, claimants must submit claim forms I and II:

**I. Supplemental Sick Leave Bank (SSLB) Claim Form I: Confidential Claimant's Statement**

The claimant must complete all sections and sign the form. Please indicate unknown answers on the claim form, and we may contact you for further clarification. The space marked "Leave Administration Rep" is reserved for the Leave Administration representative who will process the form and sign it once complete.

**II. Supplemental Sick Leave Bank (SSLB) Claim Form II: Confidential Attending Physician's Statement**

Both the physician and the claimant must complete and sign their respective sections of this form. The form has specific sections for pregnancy/childbirth and intermittent absences, if applicable. Claimants must ensure **all required fields on the form are completed** prior to submission. It is the responsibility of the claimant to furnish the required information. Leave Administration will only contact a physician's office to verify information, not to request information that is missing from the form.

**IMPORTANT NOTE:** The member or their chosen representative may initiate a request for SSLB benefits by submitting the SSLB claim forms directly to the Leave Administration department. **The properly completed claim forms must be received within 30 days of the claimant's first unpaid leave day/absence.** It is the claimant's responsibility to ensure that each absence has been properly recorded. Failure to submit a timely request will constitute a waiver of benefits from the SSLB. Members must exhaust all accumulated vacation, state leave, local leave, and compensatory time prior to eligibility for payment from the SSLB. Additionally, claimants must be absent for seven (7) consecutive working days in order to be eligible for the program.

Claimants are **not required** to apply for FML to receive SSLB benefits. Claimants can apply for FML by logging in to their Employee Self-Service (ESS) account. Once logged in, click on the 'FML Request' button under the 'HISD Extended Leaves' header, and you will be taken to the 'Previous and Active FML Requests' page where a new application can be submitted. It is the responsibility of the claimant to verify the necessary forms have been received by the correct department.

The SSLB and FMLA are separate programs. The SSLB program is a membership-based program which requires employees to actively enroll to become eligible for benefits, whereas the FMLA program is available to an employee who has worked for the District a minimum of 12 months and has worked a minimum of 1,250 hours

during the previous 12 months. As a result, certain employees are eligible to apply for the FMLA program, but **only SSLB members may submit SSLB claims.** Employees are strongly encouraged, but not required, to apply for both programs.

The SSLB and the FMLA programs are governed by different policies and regulations. Consequently, the claim application requirements for each program may differ. **Employees may qualify for one, both, or neither program.** For example, an employee's SSLB claim may be approved, but his or her FML application may be denied. Also, FML can be used for time off to care for family members, while the **SSLB program covers only the member's medically required absences and does not extend coverage for time off to care for ill family members.**

The SSLB program **does not** grant participants an official leave status nor provide job protection. However, employees may be eligible for other benefits such as FML, Long Term Disability Insurance, or Workers Compensation Insurance which may provide job protection. For information about these programs please contact the appropriate program administrator listed below for assistance:

Benefit / Insurance	HISD Department	Phone Number
Family Medical Leave Act (FMLA)	Leave Administration	713-556-6590
Long-Term Disability Insurance	Benefits	713-556-6655
Worker's Compensation	Benefits	713-556-9200

All claimants must notify their work location supervisor of their absences prior to submitting a claim. All absences must be reported, even if unpaid. **Incorrect time reporting will cause processing delays.** A member may apply for benefits prior to exhausting all available leave. However, before any days will be awarded a claimant must exhaust all available vacation, state, local, and compensatory leave.

Claim processing time depends upon proper completion and signature of the forms. It is important to submit claim forms in a timely manner, once you are able to do so. For claims assistance and SSLB program questions please contact HISD Leave Administration. We are available Monday-Friday, 8:00 a.m. to 5:00 p.m., by calling 713-556-6590.

Sincerely,

*Leave Administration*

**Leave Administration**

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**Supplemental Sick Leave Bank (SSLB) Benefit Claim Form I: Confidential Member's Statement**

Last Name:				First Name:				
Employee ID #:				Position:				
Work Phone #:		(      )      -		Home/Mobile Phone #:		(      )      -		
Campus/Work Location:		Timekeeper Name:		Timekeeper Phone #:		(      )      -		
<i>Information regarding claims is communicated <b>exclusively</b> via <b>e-mail</b>. Please provide an alternate e-mail address.</i>		Your HISD E-mail Address:		@houstonisd.org				
		Personal E-Mail Address:						
<ul style="list-style-type: none"><li>Contact your timekeeper or supervisor for information to complete this form.</li><li>You must notify your work-location supervisor of absences.</li><li>You must be absent for seven (7) consecutive working days in order to be eligible for the program.</li><li>All state, local, vacation, and compensatory leave must be exhausted before SSLB benefits will be approved.</li><li>Requests for intermittent SSLB leave days will need to meet additional criteria, as outlined in Finance Procedures Manual: Section 1501 a-d.</li><li>All absences must be reported, even if unpaid. Incorrect reporting will cause processing delays.</li><li>Submit completed signed forms by fax, email, mail, or in person to Leave Administration.</li><li>You must notify Leave Administration if you return to work before your SSLB claim end date.</li></ul>								
1. Are you currently a member of the Supplemental Sick Leave Bank?					<input type="checkbox"/> Yes		<input type="checkbox"/> No	
2. Prior to this claim, have you applied for benefits during <b>this</b> SSLB plan year?					<input type="checkbox"/> Yes		<input type="checkbox"/> No	
2a. If yes, are you requesting a direct extension to your prior claim?					<input type="checkbox"/> Yes		<input type="checkbox"/> No	
3. Have you exhausted all available leave (vacation, state, local)?					<input type="checkbox"/> Yes		<input type="checkbox"/> No	
3a. If no, what date do you expect to exhaust all paid leave?					____/____/____ month / day / year			
4. Provide <b>last date you worked</b> before absences due to medical condition began.					____/____/____ month / day / year			
5. Have you returned to work?					<input type="checkbox"/> Yes		<input type="checkbox"/> No	
6. Provide the date you returned or expect to return to work.					____/____/____ month / day / year			
7. Provide the number of days you are requesting payment from the SSLB. <b>Note:</b> Maximum is 30 full days, no partial days will be awarded.								<b>Days</b>
<b>By signing below, I hereby confirm that all the information provided in the member's statement (Claim Form I) and the physician's statement (Claim Form II) is true, and I am aware that false or misleading information may result in denial of my benefit claim(s). False actions on my part or on my behalf may be considered misuse of the Supplemental Sick Leave Bank program and my membership may be permanently terminated without payment.</b>								

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Leave Administration Rep. Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



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Supplemental Sick Leave Bank (SSLB) Benefit Claim Form II: Confidential Attending Physician's Statement

HISD EMPLOYEE			
Last Name:		First Name:	
Home Address:		SSN #:	
Phone #:		Employee ID:	

I hereby authorize my medical practitioners, facilities, and other entities as necessary to release my medical and mental health information to the HISD Benefits/Leave Administration department as relevant to this claim. I understand I have a right to receive a copy of this authorization, and agree a copy is as valid as the original.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PHYSICIAN			
Required For All Patients			
Is patient currently under your care?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Based on my medical diagnosis or opinion, the patient's medical condition is severe enough to require the patient's <b>absence from work for a minimum of seven (7) consecutive workdays</b> ?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Physician's recommended date for patient to <b>stop</b> working:		____/____/____ month / day / year	
Physician's recommended date for patient to <b>return</b> to work:		____/____/____ month / day / year	
<b>ICD-10 CODE(s):</b>			
<b>**REQUIRED**</b> Provide additional relevant information <b>not</b> identified by ICD-10 codes: _____ _____			

Only Complete For Pregnancy And Childbirth Absences:			
Are absences related to pregnancy or childbirth?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is patient's condition atypical of a normal pregnancy or childbirth?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, are complications atypical of a normal:	<input type="checkbox"/> Gestation	<input type="checkbox"/> Delivery	<input type="checkbox"/> Post-partum Recovery
Was delivery by (or expected to be) a cesarean section?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Only Complete For Ongoing Care/Treatment Requiring Intermittent Work Absences:		
Provide period of intermittent absences:	From: ____/____/____ month / day / year	To: ____/____/____ month / day / year
Provide frequency of absences (daily, weekly, etc.):		
Expected length of each absence (in hours):		

By signing below, I confirm the information provided on this form by my staff and I is true and accurate to the best of my knowledge, and based on the medical diagnosis or opinion, the work absences are medically warranted.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Office Address: \_\_\_\_\_ Fax #: \_\_\_\_\_