Houston Independent School District
Employee Support Services

Williams Middle School - Annex Building
6100 Knox St., Houston, TX 77091 (Route 8)
Ph: (713) 695-5561 ◇ Fax: (713) 695-5723 ◇ Email: BenefitsESS@houstonisd.org

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 through August 31.

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.** Submit completed forms to HISD Employee Support Services by fax, email, mail, or in person. A claimant must submit claim forms I and II in order to apply for SSLB benefits:

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 later clarification. The space marked "Benefits Representative" is reserved for the Benefits Representative who will process the form and sign it once complete.

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. Employee Support Services will only contact a physician's office to verify information, not to request information that is missing from the form.

The SSLB set of claim forms also contains the Family Medical Leave (FML) application forms. Claimants are **not required** to apply for FML to receive SSLB benefits. Claimants must submit completed FML forms to HISD Human Resources (HR), or you contact HR for FML forms assistance. It is the responsibility of the claimant to verify the necessary forms have been received by the correct department. Please do not submit FML paperwork to Employee Support Services.

The SSLB and Family Medical Leave (FML) are separate programs which are administered by different HISD departments. The Benefits department administers the SSLB program and claims, while the Human Resources department administers the Family Medical Leave program. The Supplemental Sick Leave Bank program is a membership based program which requires employees to actively enroll to become eligible for benefits, whereas the Family Medical Leave program is available to an employee who has worked for the District a minimum of 12 months and 1,250 working hours during the previous 12 months. As a result, certain employees are eligible to apply for the Family Medical Leave program, but **only SSLB members may submit SSLB claims.** Employees are strongly encouraged, but not required to apply for both programs.

The Supplemental Sick Leave Bank and the Family Medical Leave 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 Family Medical Leave application may be denied. Also, Family Medical Leave can be used for time off to care for family members, while the **SSLB program covers only the member's medically required absences but 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 Family Medical Leave, 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 (FML)	Leave of Absence Mgt	877-780-4473, option 6
Human Resource Service Center	Human Resources	713-556-7383
Long Term Disability Insurance	Benefits	713-556-6655
Workers 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 Employee Support Services. We are available Monday-Friday, 8:00 a.m. to 5:00 p.m., by calling 713-695-5561.

Sincerely,
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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 #:	( ) -		Hm/Mobile Phone #:	( ) -	
Campus/Work Location:		Timekeeper Name:		Timekeeper Phone #:	( ) -
Information regarding claims is communicated <u>exclusively via e-mail</u>. Please provide an alternate e-mail address.	Your HISD E-mail Address:	@houstonisd.org			
	Other E-Mail Address				

- **Contact your time keeper or supervisor for information to complete this form.**
- **You must notify your work location supervisor of absences.**
- **All vacation, state and local leave must be exhausted before SSLB benefits will be approved.**
- **All absences must be reported, even if unpaid. Incorrect reporting will cause processing delays.**
- **Submit completed signed forms by fax, email, mail, or in person to Employee Support Services.**
- **You must notify Employee Support Services if you return to work before SSLB claim end date.**

1. Are you currently a member of the Supplemental Sick Leave Bank?	❑ Yes	❑ No
2. Prior to this claim, have you applied for benefits during **this** SSLB plan year?	❑ Yes	❑ No
2a. If yes, are you requesting a direct extension to your prior claim? ❑ Yes ❑ No		
3. Have you exhausted all available leave (vacation, state, local)?	❑ Yes	❑ No
3a. If no, what date do you expect to exhaust all paid leave? ____/____/____ month / day / year		
4. Provide **last date you worked** before absences due to medical condition began.	____/____/____ month / day / year	
5. Have you returned to work?	❑ Yes	❑ 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. **Note:** Maximum is 30 full days, no partial days will be awarded.	**Days**	

By signing, I hereby confirm all the information provided in the member's statement (Form I) and the physician's statement (Form II) is true and I am aware that false or misleading information may result in denial of my benefit claims. 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 permanantly terminated without payment.

Employee Signature: ________________________________ **Date**: ____________

Benefits 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:		Last 4 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 department and Employee Benefits as relavant 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?				❑ Yes ❑ No
Based on my medical diagnosis or opinion, the patient's condition is severe enough to require the patient's **absence from work for a minimum of seven (7) consecutive working days**?				❑ Yes ❑ No
Physician's recommended date for patient to **stop** working:				______/______/______ month / day / year
Physician's recommended date for patient to **return** to work:				______/______/______ month / day / year
ICD-10 CODE(s):				
Provide relevant information **not** identified by ICD-10 codes: ____________________				

Only Complete For Pregnancy And Childbirth Absences:			
Are absences related to pregnancy or childbirth?			❑ Yes ❑ No
Is patient's condition atypical of a normal pregnancy or childbirth?			❑ Yes ❑ No
If yes, are complications atypical of a normal:	❑ Gestation	❑ Delivery	❑ Post-partum Recovery
Was delivery by (or expected to be) a cesarean section?			❑ Yes ❑ 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 me and my staff is true and accurate to the best of my knowledge and based on my medical diagnosis or opinion the work absences are medically warranted.

Physician Signature:______________________________ **Date**: ____________________

Print Physician Name:______________________________ **Phone #**: ____________________

Office Address:______________________________ **Fax #**: ____________________