# CONTRA COSTA COUNTY
# CATASTROPHIC LEAVE APPLICATION *(CONFIDENTIAL)*

The Catastrophic Leave Committee meets on the **third** Wednesday of every month. Please have your application into the Human Resources Department, Employee Benefits Services Unit by the Friday before the meeting. Fully complete the application (pg.1&2) for consideration. **Please be advised that receiving wages for any hours worked while on Catastrophic Leave will cease your eligibility for the program.**

**I, or a member of my immediate family, (definition sick leave policy) have sustained a catastrophic illness, injury or condition and request assistance from the Catastrophic Leave Bank.**

I am a: Full Time ❑ Part time ❑ (_________hrs/wk) Permanent Intermittent ❑ Employee

My last day at work was: ____________________

I have exhausted all paid time or will do so by approximately: ____________________

I have applied for a medical or family care leave of absence on: ____________________

I anticipate returning to work on: ____________________

I have applied for and am receiving benefits from the following: **(mark all that apply)**

| | | Amount | Period | Reason |
|---|---|---|---|---|
| State Disability (SDI) | ❑ | $___________ | | |
| County Long Term Disability (LTD) | ❑ | $___________ | | |
| Labor Coalition Union LTD Insurance | ❑ | $___________ | | |
| Social Security Disability Payments | ❑ | $___________ | | |
| Workers Compensation | ❑ | $___________ | | |

I agree to notify the Committee immediately of any changes to my circumstances or condition which may affect my entitlement to Catastrophic Leave and to received funds from the above listed disability programs.

**I could perform light / limited duty or an alternate work assignment:** Yes ❑ No ❑
(Please explain)

**I have been offered light / limited duty/ alternate work assignment by my department:** Yes ❑ No ❑
(Please explain)



*CL Applicant #*________________

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**NOTE: THE COMMITTEE CONSIDERS ALL CATASTROPHIC LEAVE APPLICATIONS ANONYMOUSLY.**

Please describe details of the illness, injury or condition which your applications is based on. Include why you feel this is a catastrophic situation. **MEDICAL VERIFICATION of the condition described below that includes a prognosis and projected return to work date must be attached.**

| | | | |
|---|---|---|---|
| Employee Name: | ______________________ | Employee #: | ______________________ |
| Address: | ______________________ | Department: | ______________________ |
| | ______________________ | Work Ph. # | ______________________ |
| | ______________________ | Home Ph. # | ______________________ |
| **Employee Signature** | ______________________ | **Date** | ______________________ |

When complete, seal application in an envelope labeled **CONFIDENTIAL**. Mail or deliver to:

**Contra Costa County, Employee Benefits Service Unit**
**Attn: Catastrophic Leave Committee Coordinator**
**1025 Escobar Street, 2nd Floor**
**Martinez, CA. 94553**

For questions or concerns, email Benefits@hrd.cccounty.us or contact (925) 655-2100.



***CL Applicant #*** ________________