Sick-Leave Fund Request Process

1. Employee contacts payroll/hr clerk to request hours from the fund.

2. Payroll/hr clerk verifies the employee:

   a. has been a member of the Sick Leave Fund for at least 90 days.
   b. has completed the 90-day qualifying period to use sick leave.
   c. has been absent more than 10 consecutive working days due to an extensive illness or accident or providing necessary care as defined in the Sick Leave Fund Policy.
   d. has used all their accrued sick leave, annual leave, other accrued paid leave and compensatory time.
   e. has received leave approval for a leave of absence from the supervisor and approval from the agency director or designee to receive a Sick Leave Fund grant.
   f. has provided the appropriate physician's certification as required by the agency

3. If the above criteria are met, the payroll/hr clerk makes sure that the form (available below and online http://benefits.mt.gov/forms.mcpx) is complete in section I and II, with a request of up to 40 hours and what pay period the request is for. Once those sections are complete the payroll/hr clerk emails or faxes the form to HCBD (406-444-0080), who will then approve or deny the request. HCBD will email or fax the form back to the payroll/hr clerk with the decision.

   - If more than 40 hours (20 hours for part-time) are needed, attach documentation to the form explaining why the employee is requesting more than 40 hours.

4. After approval or denial HCBD will send via email or fax the form back to the payroll/hr clerk.

   - If the request is accepted, HCBD deducts the hours from the fund balance. The payroll/hr clerk will add the hours to the recipients leave balance by using the codes below.
   - If the request is denied, HCBD notifies via email or fax the payroll/hr clerk explaining why.

5. Once the payroll/hr clerk and employee have signed the request in section III, a hard copy must be sent to HCBD PO Box 200130 Helena, MT 59620.

Timesheet Entry Codes for Sick Leave Fund Requests, these are to be entered by the Payroll/Hr clerks

SLFP+ = Adds to the recipient's balance from the Sick Leave Fund Pool

SLFT= Sick Leave Fund Pool hours used by the recipient

SICK LEAVE FUND GRANT REQUEST FORM

SECTION I (INFORMATION FOR EMPLOYEES)

1. An employee participating in the Sick Leave Fund may request grants of up to 40 hours per pay period (240 hours total) of sick leave from the fund in a 12-month period.
2. You must meet the following eligibility requirements to receive a grant from the Sick Leave Fund. You must be able to answer **yes** to all the following statements at the time you receive the grant.

Yes	No	
☐	☐	I have been a member of the Sick Leave Fund for at least 90 days.
☐	☐	I have completed the 90-day qualifying period to use sick leave.
☐	☐	I have been absent more than 10 consecutive working days due to an extensive illness or accident or providing necessary care as defined in the Sick Leave Fund Policy.
☐	☐	I have used all my accrued sick leave, annual leave, other accrued paid leave and compensatory time.
☐	☐	I have received leave approval for a leave of absence from my supervisor and approval from my agency director or designee to receive a Sick Leave Fund grant.
☐	☐	I have provided the appropriate physician's certification as required by my agency.

3. If you have met the eligibility requirements for a Sick Leave Fund grant, complete section II of this form and return it to your agency's payroll office via email or fax. Once hours are approved or denied your payroll office will request your signature in section III. If you have questions about your eligibility for a Sick Leave Fund grant, contact your agency's payroll or Human Resources office.

SECTION II (to be completed by employee)

I have met the eligibility requirements to receive a Sick Leave Fund grant and request hours from the Sick Leave Fund for the pay period ending .

name (please print) agency

employee ID# work or personal phone number

SECTION III (to be completed by Health Care and Benefits Division)

The request for hours have been

☐ Approved by representing Health Care and Benefits Division
name (please print)

☐ Denied by representing Health Care and Benefits Division
name (please print)
Explanation for denial:

SECTION IV (to be completed by employee's agency payroll office)

Pursuant to the Sick Leave Fund Policy, I certify the above named employee is eligible to receive a grant from the Sick Leave Fund. I also certify that the employee's supervisor has approved the employee's leave of absence and my agency's director or designee has approved receipt of a Sick Leave Fund grant in the amount specified above. I have contacted Health Care and Benefits Division to confirm the Sick Leave Fund contains sufficient hours to meet this grant request.

hours of sick leave were added to the employee's account on pay period ending

____. ________________________________
payroll clerk's signature date agency code

____________________________________ ______________
Employee signature date

Health Care and Benefits Division: date input___________________. Input by __________________.