

## **Request for Sick Leave Fund Grant**

1. If an Employee needs access to a grant from the Sick Leave Fund (Fund), they should contact their employing Agency for the process to receive a grant. The Sick Leave Fund and Direct Grant Policy can be found at [benefits.mt.gov/Resources/Forms](http://benefits.mt.gov/Resources/Forms).
2. The Employee wishing to receive a grant from the Fund **must meet all the following criteria**. It is the responsibility of the employing Agency to verify eligibility. The Health Care & Benefits Division has a right to audit compliance.
  1. met the 90-day qualifying period (QP) to take sick leave, as provided in 2-18-618, MCA;
  2. have a Serious Health Condition or be providing necessary care to a spouse, child or parent with a Serious Health Condition, resulting in the Employee's absence from work of no less than two full consecutive weeks of regularly scheduled Working Days or 10 consecutive Working Days, whichever occurs first, for each Serious Health Condition. A Working Day means any day for which an Employee has regularly scheduled hours and does not include recognized holidays (including the floating holiday). If a recognized holiday for which the Employee would have been paid falls within the 2-week period, the Employee must be absent additional Working Day(s) up to the maximum of 10 consecutive Working Days. If the Employee works any partial (or full) Working Day(s) during the 2-week period, the 2-week period will start over on a regularly scheduled Working Day immediately following each partial or full Working Day that the Employee works. Days worked during the 90-day QP may accrue to the 10 consecutive working day requirement.
    - i. a Serious Health Condition is defined as an illness, injury, impairment, or physical or mental condition that involves either inpatient care or continuing treatment by a health care provider. A Serious Health Condition includes a maternity-related disability of the Employee during the prenatal period, delivery and post-partum period, miscarriage, abortion, or other treatment. To extend leave for a maternity-related disability beyond the first 6 weeks, either the Employee or new baby must have a Serious Health Condition. Alternatively, a Serious Health Condition may be a condition incurred by the Employee during the prenatal period that may require bedrest. If so, the combined prenatal and post-partum periods may result in an extension of the maternity-related disability.
  3. used all available and usable accrued sick leave, annual leave, other accrued paid leave, and compensatory time;
  4. received approval from the supervisor for leave of absence;
  5. received approval from the Agency head or designee to receive sick leave;
  6. when requested by the employing Agency, provided a physician's certification of a Serious Health Condition;
  7. if applying for a grant from the Sick Leave Fund, Employee must have been a Participating Employee for at least 90 calendar days. The 90-day period begins on the first day of the pay period following the pay period in which the Participating Employee's initial Fund Contribution was deducted from the Participating Employee's sick or annual leave accounts, or the first day of the pay period following the date of the Participating Employee's request to the employing Agency, whichever occurred first.

An eligible, full-time Employee may receive up to a maximum of 240 hours sick leave from the Fund, Direct Grants, or a combination of both in a 12-month period, even if the Employee has more than one Serious Health Condition during a 12-month period. Agencies shall calculate the 12-month period beginning with the first day an Employee uses sick leave obtained through the Fund or Direct Grants. If the Employee continues using sick leave hours from the Fund or a Direct Grant, another 12-month

period starts on the day immediately following the end of that initial 12-month period. If the Employee is not using sick leave hours at the end of that initial 12-month period, a new 12-month period starts with the first day that an Employee uses credits from the Sick Leave Fund or a Direct Grant.

3. If the Employee wishing to receive the grant from the Sick Leave Fund is eligible, the employing Agency documents on the Sick Leave Fund Grant Request Form the number of hours being requested for that pay period.

Agencies shall allot up to 40 sick leave hours a week for a full-time Employee, for a maximum allotment of 80 hours per 2-week pay period. Sick leave hours must be rounded up to the nearest half-hour increment, unless an Employee's collective bargaining agreement permits increments of less than one-half hour to be used. In that case, sick leave hours may be rounded up to the nearest partial hour permitted by the Employee's collective bargaining agreement for a grant of sick leave hours from the Fund.

Agencies shall prorate the available hours for a part-time Employee based on either:

1. the part-time Employee's regular schedule at the time the Employee became eligible for the Sick Leave Fund or a Direct Grant; or
2. the average amount of time the Employee is in a Pay Status when management cannot determine or has not assigned a regular schedule. For example, if during the two or more pay periods preceding the qualifying event an Employee was in a Pay Status an average of 20 hours per week, the maximum available sick leave is 120 hours in a 12-month period.

4. The employing Agency will submit the completed Sick Leave Grant Request Form to the Health Care & Benefits Division (HCBD) via email ([benefitsquestions@mt.gov](mailto:benefitsquestions@mt.gov)) by the Friday preceding the payday of the affected payroll period. This form is available at [benefits.mt.gov/Resources/Forms](http://benefits.mt.gov/Resources/Forms).
5. After approval or denial, HCBD will email the completed form back to the employing Agency and the employing Agency will process as outlined below.
  - o If the request is accepted, HCBD deducts the hours from the Fund balance. The payroll/hr clerk will add the hours to the Employee's leave balance by using the codes below.
  - o If the request is denied, HCBD notifies the employing Agency via email explaining why and the employing Agency should notify the Employee of the denial and provide a copy of the appeal process.

**Timesheet Entry Codes for Sick Leave Fund Requests,**

to be entered by the Agency Payroll/HR.

**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 (to be completed by Employee)

1. An Employee participating in the Sick Leave Fund may request grants of up to **80 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 or 2 full consecutive weeks of regularly scheduled working days**.

I have used all my available and usable 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 a Serious Health Condition or am providing necessary care to a spouse, child or parent with a Serious Health Condition, defined as an illness, injury, impairment, or physical or mental condition that involves either inpatient care or continuing treatment by a health care provider. A Serious Health Condition includes a maternity-related disability of the Employee during the prenatal period, delivery and post-partum period, miscarriage, abortion, or other treatment.

If you meet the eligibility requirements for a Sick Leave Fund grant, complete Section II of this form and return it to your employing Agency. If you have questions about your eligibility for a Sick Leave Fund grant, contact your employing Agency. Your employing Agency will notify you if you are ineligible for a Sick Leave Fund grant.

### SECTION II (to be completed by Employee)

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

Requesting Employee Name (please print) \_\_\_\_\_

Employee ID # \_\_\_\_\_ Agency # \_\_\_\_\_

Requesting Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

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

The request for \_\_\_\_\_ hours has 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 employing Agency)

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 the Health Care & Benefits Division to confirm the Sick Leave Fund contains sufficient hours to meet this grant request. I am aware the Health Care & Benefits Division shall establish and administer the Sick Leave Fund and Direct Grant program, including auditing for agency compliance.

\_\_\_\_\_ hours of sick leave were added to the Employee's account on pay period ending \_\_\_\_\_

Agency confirms Employee has taken the following days off to meet the 10 consecutive working days off rule:  
\_\_\_\_\_ to \_\_\_\_\_.

Recipient is a part-time  or full-time  Employee.

Agency also confirms Employee has used all available and usable accrued sick leave, annual leave, other accrued paid leave, and compensatory time. **Attach copy of time sheet (initial request only).**

Employing Agency Payroll Clerk's Signature

Payroll EID#

Date

Agency #

**Health Care & Benefits Division:** Date Input \_\_\_\_\_ Input By \_\_\_\_\_

Access this form at [benefits.mt.gov/Resources/Forms](http://benefits.mt.gov/Resources/Forms).

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