Sierra County
Board of Supervisors’
Agenda Transmittal &
Record of Proceedings

**MEETING DATE:** October 15, 2019  
**TYPE OF AGENDA ITEM:** ☒ Regular  ☐ Timed  ☐ Consent

**DEPARTMENT:** Personnel  
**APPROVING PARTY:** Margaret Long, Personnel Director  
**PHONE NUMBER:** 530-289-2879

### Agenda Item: Resolution adopting the Sierra County Catastrophic Leave Policy.

**Supportive Documents Attached:**  
- ☐ Memo  
- ☐ Resolution  
- ☐ Agreement  
- ☒ Other

**Letter template**

**Background Information:**

**Funding Source:**  
- No General Fund Impact

**Other Fund:**  
- Amount: $ N/A

**Are Additional Personnel Required?**  
- Yes, --  
- ☒ No

**Is This Item Allocated in the Budget?**  
- ☐ Yes  
- ☒ No

**Is a Budget Transfer Required?**  
- Yes  
- ☒ No

### Board Action:

- ☐ Approved  
- ☐ Approved as amended  
- ☐ Adopted  
- ☐ Adopted as amended

**Set public hearing**  
- For: ____________________
- ☐ Direction to: ______________
- ☐ Referred to: ______________
- ☐ Continued to: ______________
- ☐ Authorization given to: ______________

Resolution 2019-  
Agreement 2019-  
Ordinance  

**Vote:**
- Ayes: ______________
- Noes: ______________
- Abstain: ______________
- Absent: ______________
- ☐ By Consensus

### Comments:

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**Clerk to the Board** ____________________  
**Date** ____________________
RESOLUTION ADOPTING THE
SIERRA COUNTY CATASTROPHIC LEAVE POLICY

Resolution 2019-

NOW, THEREFORE, BE IT RESOLVED that the Board of Supervisors, County of Sierra, State of California does hereby adopt the attached Sierra County Catastrophic Leave Policy.

ADOPTED by the Board of Supervisors of the County of Sierra on the 5th day of November, 2019, by the following vote:

AYES: Supervisors
NOES: None
ABSTAIN: None
ABSENT: None

COUNTY OF SIERRA

______________________________
PAUL ROEN, CHAIRMAN
BOARD OF SUPERVISORS

ATTEST: APPROVED AS TO FORM:

______________________________
HEATHER FOSTER
CLERK TO THE BOARD

______________________________
DAVID PRENTICE
COUNTY COUNSEL
CATASTROPHIC LEAVE POLICY

Catastrophic Leave is intended to provide an eligible employee authorized paid time-off through voluntary donation of sick leave, management leave, comp time earned and/or vacation hours. Donated leave must be specifically designated for the employee who has been approved for Catastrophic Leave Benefits. Catastrophic Leave shall not exceed a maximum of six months and must be used within one (1) year of the date the application for Catastrophic Leave is approved. Only one request for Catastrophic Leave will be approved in a twelve (12) month period. The recipient will not accrue CTO, holiday and seniority upon receiving Catastrophic Leave. The recipient will receive their normal rate of pay, be taxed normal payroll deductions, and the recipient must prepay the employee portion of the cost of the health premium each month if they wish to have this benefit.

1. The recipient of the Catastrophic Leave benefits must have a medically verifiable long-term illness or injury, or have an immediate family or household member who has a medically verifiable long-term illness or injury for which the employee is the primary caregiver as certified by the attending physician. Immediate family as used herein includes only the employee's spouse, children or stepchildren, grandchildren, brothers or stepbrothers, sisters or stepsisters, aunts, uncles, parents or stepparents or grandparents of either spouse or other persons who are living in the employee's household. The statement from the physician should protect the privacy of the employee's medical information by not identifying the prognosis and/or diagnosis.

2. The recipient must have exhausted all leave balances, to include sick leave hours, comp time (CTO) and vacation hours and be eligible for approved leave without pay.

3. The recipient cannot be receiving combined payments from the Catastrophic Leave Donation Program and: Workers' Compensation, State Disability Insurance, or any other source of income attributed to earnings that exceed the employee's gross bi-weekly salary.

The following procedure must be followed in order to apply for Catastrophic Leave payments:

1. The recipient must complete the "Catastrophic Leave Recipient Application" and attach a medical statement signed by a physician, along with any other documents which verify the long-term illness, or injury to recipient or immediate family. If the employee requesting Catastrophic Leave benefits will be taking care of an immediate family or household member as defined above, then the employee shall also provide documentation verifying the employee is the primary caregiver as certified by the attending physician. The application and supporting documents should be submitted to the Personnel Department. The application is available in the Personnel Department.
2. The Personnel Department will review the application based on the established policy for review and approval. If denied, the application will be returned to the recipient with an explanation.

3. If an application has been rejected under the Catastrophic Leave Policy, the applicant can make any necessary modifications to the application and provide any additional information to support their request for leave under the Catastrophic Leave Policy. The application can then be resubmitted to the Personnel Department in compliance with the policy for reconsideration.

4. Upon approval, the Personnel Department will advertise to all departments the request for Catastrophic Leave donations and will re-advertise as needed.

5. County employees who wish to voluntarily donate must complete the "Catastrophic Leave Donation Certificate." All donations must be in whole numbers (1, 2, 3) and the minimum donation is one (1) hour. The certificate must be submitted to the Personnel Department.

6. The donating employee must have a minimum sick leave in his or her account following the donation of 120 hours. An employee may not make a donation of more than 40 hours within two months of his or her separation from county employment.

7. Hours donated to the recipient are irrevocable, will not be returned or repaid to the donor and will be deducted from the donor's management leave, comp time earned and/or vacation balance. Hours donated may be used to meet the mandatory use hours' requirement. The donor will receive verification of the deduction and the amount of the time the donor employee has remaining from the Personnel Director.

8. Any requests for exceptions to this policy will be reviewed by the Personnel Department for review and approval.
Please accept this application for the Catastrophic Leave provision as listed in the County’s Catastrophic Leave Policy dated________, 2019. I understand, in order to qualify as a recipient, I must meet all of the following criteria:

1. I have, or will have, exhausted all of my accrued sick leave, comp time, and vacation leave. I am eligible for approved leave without pay beginning ____________________________.

2. I believe that my circumstances qualify as a long-term illness or injury of self or immediate family members as defined in the Catastrophic Leave Policy.

3. I have attached a medical statement signed by a physician, and or other documents to verify the long-term illness or injury of self or immediate family for which the employee is the primary caregiver as certified by the attending physician. The attached document also includes the approximate duration of illness or injury. Immediate family as used herein includes only employee's spouse, children or stepchildren, brothers or step-brothers, sisters or step-sisters, aunts, uncles, parents or step-parents or grandparents of either spouse or other persons who are living in the employee's immediate household.

4. I understand this application must be reviewed and approved by the Personnel Department before I receive benefits under the Catastrophic Leave Policy.

5. I understand upon approval and receipt of the Catastrophic Leave payments, I will not accrue leave and seniority. I also understand I am eligible to receive only my normal rate of pay, and be taxed normal payroll deductions for any payments received for the Catastrophic Leave Program. I understand I must prepay the employee cost of the health premium each month, as applicable.

6. I understand I cannot receive combined payments from the Catastrophic Leave Donation Program and Workers' Compensation, State Disability Insurance or any other source of income attributed to earnings that exceed my gross bi-weekly salary.

7. I understand the Personnel Department will advertise to all departments requesting donations for the catastrophic leave to be donated to a blind pool.

8. I understand that, even though I may be eligible to receive donated hours in the Catastrophic Leave Program, donated time may not be sufficient to meet any or all of my needs.
I have received, read and understand the Catastrophic Leave Policy and, in the event I am determined to be eligible as a recipient, I agree to the terms of the policy.

__________________________________  ____________________________________ Signature
Date
__________________________________  ____________________________________ Print Name
Department
__________________________________  ____________________________________ Home
Telephone Number  Message Telephone Number

_______________________________
Personnel Department

( ) approved  ( ) denied and reason:

________________________________________________________________________
________________________________________________________________________

__________________________________  ____________________________________ Signature
Date
CATASTROPHIC LEAVE DONATION CERTIFICATE

I agree to donate management leave, sick leave, comp time earned or vacation hours under the Catastrophic Leave. I understand the following conditions:

I, the donor, understand all hours donated and used are irrevocable, and will not be returned or repaid. I also understand all hours used will be deducted from my sick leave, comp time earned or vacation hours leave balances. Hours donated may be used to meet the mandatory use hours’ requirement. The recipient will be responsible for all taxes through normal payroll deductions.

_________________________  ___________________________  ___________________________
Donor’s Name  Social Security Number  Department of Donor

_________________________  ___________________________  ___________________________
Sick Leave Hours Donated  CTO Hours Donated  Vacation Hours Donated

I agree to the conditions as listed on this certificate. Please deduct the hours indicated from my management leave, comp time earned and/or vacation balances and donate to the recipient.

_________________________  ___________________________
Signature of Donor  Date

Payroll will verify the donated leave of the donor and attach a copy of this certificate to the donor’s time sheet. The original will be kept by the Personnel Department for placement in the donor’s personnel file.