DATE

Injured Employee’s Name

Address

City, State Zip Code

 **RE: NOTIFICATION OF OPTION TO SUPPLEMENT STATE RATE TEMPORARY DISABILITY PAYMENTS WITH ACCRUED COMPENSATED TIME (SICK LEAVE, VACATION, AND OVERTIME (CTO))**

 **CLAIM # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dear\_[name of employee],

Our payroll records indicate that (select one of the following):

[ ]  The temporary disability benefits you have been receiving in the form of IOD salary continuation will end shortly. At that time, if you remain unable to return to work, as determined by your treating physician, you will be placed on temporary disability payments at the State Rate.

[ ]  You are currently receiving temporary disability benefits at the State Rate; or your State Rate benefit has been exhausted but you are still disabled and remain off work.

State Rate is equal to two-thirds of your average weekly gross pay from all sources, subject to minimums and maximums set by State law. These payments are calculated by your assigned Workers’ Compensation Analyst and are processed through the Workers’ Compensation Claims Management System.

You may elect to use your accrued sick leave, accrued vacation time, or accumulated compensatory time off (CTO) up to the equivalent of your regular salary:

* To supplement your State Rate check; or
* To receive compensation in the event you become ineligible for temporary disability at the State Rate, either because you exhausted such benefits or you are no longer temporarily disabled, and remain off work due to this work-related injury.

See attached memo from the Office of the City Administrative Officer dated May 10, 2018 and answers to Frequently Asked Questions for additional information on supplementing your State Rate benefit.

Please complete and return the attached Use of Accrued Time Off Election Form to your Department Payroll Section. Contact your Department Payroll Section to determine your available time.

**USE OF ACCRUED TIME OFF ELECTION FORM**

Workers’ Compensation Claim # \_\_\_\_\_\_\_\_\_\_\_\_\_

Select from one of the following:

[ ]  I decline to supplement my State Rate benefit and elect to receive only those State Rate temporary disability payments provided under Workers’ Compensation law.

[ ]  I elect to supplement my State Rate benefit with accrued or accumulated compensated time up to the amount of my regular salary on the date and in the order indicated below.

[ ]  I elect to use my accrued or accumulated compensated time as indicated below, up to the amount of my regular salary, since I am no longer eligible for State Rate benefits but remain off work disabled due to this work-related injury.

***Note:*** *State Rate is not considered an “active” payroll status unless the State Rate is supplemented with at least 40 hours of sick, vacation, or other compensated time in a two-week, 80-hour pay period. If State Rate is supplemented with at least 40 hours of compensated time in a pay period (20 hours for half-time employees), the City will continue to pay the subsidy for your benefits.* ***If less than 40 hours*** *of compensated time will be used in a pay period (20 hours for half-time employees), please contact the Employee Benefits Division at (213) 978-1655 to learn about your coverage options and costs.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Start Date:**  |  | **End Date:**  |  |

(If no end date is selected, supplemental pay will terminate when accrued/accumulated time selected below is exhausted or is insufficient to cover the mandatory retirement deduction).

**Enter Total Number of Hours Requesting** (in all combined categories of time selected below) to Supplement up to My Regular Salary Each Pay Period (or enter “Maximum”):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please contact your Department Payroll Section if you need assistance in determining the maximum number of hours that represents the difference between your State Rate benefit and your regular salary per pay period. If supplementing with 75% (civilian and sworn employees) or 50% (sworn employees only) sick leave hours, supplemental pay will be provided only up to that percentage of your regular pay.)

**Indicate the order you wish to use time by entering the numbers 1-5 next to each type of compensated time listed below. If you do not want a particular category of time used, write “Do Not Use” on the line next to the category. 100% sick time must be used prior to use of partial pay sick time:**

|  |  |
| --- | --- |
| 100% Sick Time |  |
| 75% Sick Time |  |
| 50% Sick Time (sworn only) |  |
| Vacation Time |  |
| Overtime (CTO) |  |

Sign below, retain a copy for your personal records, and send the original back to your Department Payroll Section for further processing. This form must be received and approved by your Department at least 14 calendar days prior to your Supplementing start date selected above, in order for a Supplemental pay check to be issued for the pay period with the start date you selected.

|  |  |
| --- | --- |
| **Print Name:** |  |
| **Signature:** |  | **Date:** |  |

**By signing this form, I acknowledge that I have read the accompanying**

 **Notification Letter with attached Memorandum from the Office of the City Administrative Officer dated May 10, 2018 and Frequently Asked Questions document.**