

City of Madison
APPLICATION FOR FAMILY/MEDICAL LEAVE

An employee must provide all information requested on this form. Required supporting documentation must be provided to the Human Resources Department in order for this application to be considered. Failure to provide required information may result in leave being denied. Leaves provided by the City which also qualify as Family and Medical Leave (FMLA) will run simultaneously with the leave required under the FMLA laws.

PLEASE TYPE OR PRINT IN INK

Employee Name: _____ Home Telephone: _____

Other Telephone Numbers: _____

Position Title: _____ Department: _____

Date of Application _____ Date of Hire: _____

I have have not taken family medical leave in the preceding twelve (12) month period.

ELIGIBILITY

Federal Leave: An employee must have been employed by the City for at least 12 months, which need not be consecutive months, and must have worked for at least 1,250 hours (not including paid leave) during the preceding twelve (12) months in order to be eligible for the Federal Leave entitlement. Leave taken under the Federal FMLA will be tracked on a forward-measured 12 month basis from the date of the first FMLA use.

Wisconsin Leave: An employee must have been employed by the City for at least 52 consecutive weeks, and must have been paid for at least 1,000 hours (including paid leave) during the preceding 52-week period in order to be eligible for the State Leave entitlement. Leave taken under the Wisconsin FMLA will be tracked on a calendar-year basis, per the WFMLA.

FAMILY/MEDICAL LEAVE IS REQUESTED FOR THE FOLLOWING REASON (CHECK ONE):

- Employee's own serious health condition that makes the employee unable to perform the functions of their position. (Must submit "Health Care Provider Certification" to the Human Resources Department in accordance with APM 2-21.)
- The birth of a child or placement of a child for adoption with an employee and in order to care for such child. (Please submit application and Provider Certification well in advance and the expected date of birth or placement for adoption, in accordance with APM 2-21.) **The employee's department and the Human Resources Department must be notified of the actual date of birth or adoption as soon as possible after the event.**
- The placement of a child with the employee for foster care and in order to care for such child. (Please send documentation verifying the placement of a foster child to the Human Resources Department, in accordance with APM 2-21.)
- In order to care for a family member who has a serious health condition (check one): (Must submit "Health Care Provider Certification" to the Human Resources Department in accordance with APM 2-21.)
 - Child
 - Spouse
 - Parent
- In order to care for a domestic partner, parent-in-law, or parent of a domestic partner who has a serious health condition. (Leave is limited to two weeks.) (Must submit "Health Care Provider Certification" to the Human Resources Department in accordance with APM 2-21.)
- In order to care for a family member who has a serious injury or illness incurred as a member of the military while in the line of duty on active duty (check one): (Must submit "Health Care Provider Certification" to the Human Resources Department in accordance with APM 2-21 and official military documentation of qualifying basis for leave.)
 - Child
 - Spouse
 - Parent
 - Next of Kin
- "Qualifying exigency" arising out of a spouse's, child's or parent's active military duty or notification of impending call or order to active duty in support of a contingency operation (check one): (Please attach documentation describing the qualifying reason, in accordance with APM 2-21.)
 - Child
 - Spouse
 - Parent

Employee: Submit this Page 1 of Application to City Human Resources Department, Confidential/Benefits, with Health Care Provider Certification or documentation verifying expected date of birth or adoption.

APPLICATION FOR FAMILY/MEDICAL LEAVE: SCHEDULE, DEPARTMENT INFORMATION

Employee Name: _____ Department: _____

REQUESTED LEAVE WILL BE...(CONSECUTIVE, INTERMITTENT, OR REDUCED) AND SCHEDULED...(FROM, TO)

Consecutive Leave: From _____ To _____
Intermittent/Reduced Schedule Leave: From _____ To _____ (Provide proposed schedule details)
Reduced Schedule Leave: From _____ To _____ (Provide proposed schedule details)

Provide details and needed explanation. Note: When leave is foreseeable, the employee must ordinarily obtain approval for the proposed leave schedule at least thirty (30) days prior to the first day of leave, in accordance with APM 2-21.

REQUEST FOR AWOP AND/OR SUBSTITUTION OF PAID LEAVE

Type of Leave	Dates For Use of Leave	Number of Days Requested
<input type="checkbox"/> Absence Without Pay	_____	_____
<input type="checkbox"/> Substitute paid time (sick leave, vacation, floating holiday/personal days, compensatory time – show how time is to be charged)	_____ _____ _____	_____ _____ _____
<input type="checkbox"/> Paid Parental Leave	_____	_____

Note: Substitution of vacation, sick leave, compensatory time or floating days will be made up to the amount an employee has accumulated, and the employee shall be required to substitute such time in accordance with APM 2-21 XII.

CERTIFICATION

I certify that the information I have provided in this application is true. Any misrepresentation by me may subject me to disciplinary action. I understand that failure to supply the required information and Health Care Provider Certification(s) may result in denial of this leave application. I understand I must make arrangements with the Human Resources Department to pay for the employee portion of health insurance premiums prior to my leave.

Employee Signature: _____ Date: _____

Employee: Submit this Page 2 of application to your department head or designated employee (e.g., payroll clerk).

ELIGIBILITY ASSESSMENT (DEPARTMENT)

This employee has been employed for at least twelve (12) months and has worked at least 1,250 hours (not including paid leave) in the preceding 12 month period. (Eligibility for Federal FMLA) Yes No

This employee has been employed for at least 52 consecutive weeks and has been paid for at least 1,000 hours during the preceding fifty-two (52) week period. (Eligibility for Wisconsin FMLA) Yes No

Note: If the answer to both preceding questions is No, the employee is not eligible for FMLA. Please provide this information and send the form to HR for processing.

Federal FMLA time used in the last year: Anniversary Date _____ FMLA used since Anniv. Date _____

Wisconsin FMLA time used this calendar year: Employee _____ Family Member _____ Birth/Adoption _____

This request is: Eligible Not Eligible Modified

Suggested modifications or reason for denial: _____

Department Head Signature: _____ Date: _____

Title: _____ Department: _____

Benefits at a Glance:

Benefit	Billing	If payment is not received by due date
Health Insurance	Billed on 1st pay day of each month to home address for next month's coverage. Payment is due 2 weeks from date of bill.	Cancellation
Life Insurance	Billed on 1st pay day of each month to home address for current month's coverage. Payment is due 2 weeks from date of bill.	Cancellation
Dental/Vision Insurance	Billed on 2nd pay day of each month to home address for next month's coverage. Payment is due 2 weeks from date of bill.	Cancellation
Flexible Spending (Health and/or Dependent)	No Bill. Per pay period amount is automatically adjusted based on the number of remaining pay periods and annual election amount.	Employee must contact HR or City Payroll if not returning to work within calendar year
Income Continuation (Wage Insurance)	No bill and no coverage if leave is not medical. Coverage is cancelled for a non-medical leave or upon entering Layoff status.	N/A

Benefits in Detail:

Health Insurance: You will receive a monthly bill sent to your home address from Central Payroll. You will be billed the employee portion while on a qualified medical leave. *If your leave of absence is not medically related, you may be responsible for the entire premium.* Premiums are due two weeks from the date of the bill for the following month's coverage. Bills are usually sent out on the first pay date of each month. Please contact HR at 608-266-4615 or Payroll at 608-266-4677 with any questions or if you do not intend to retain coverage.

Life Insurance: You will receive a monthly bill sent to your home address from Central Payroll. You will be billed the entire monthly premium while on leave. Premiums are due two weeks from the date of the bill for the current month's coverage. Bills are usually sent out on the first pay date of each month. Please contact HR at 608-266-4615 or Payroll at 608-266-4027 with any questions.

Dental/Vision Insurance: You will receive a monthly bill sent to your home address from Central Payroll. You will be billed the entire monthly premium while on leave. Premiums are due two weeks from the date of the bill for the following month's coverage. Bills are usually sent out on the second paycheck date of each month. Please contact HR at 608-266-4615 or Payroll at 608-266-4522 with any questions or if you do not intend to retain coverage.

Flex Medical/Dependent: Please contact HR at 608-266-4615 to discuss your options. By default, we will automatically adjust your per pay period amount based on the number of remaining pay periods and your total annual election. For questions regarding this change, please contact Payroll at 608-267-8659.

Disability Wage Insurance: We do not bill for disability wage insurance. If your leave is not medically related or you are in layoff status, you will not have coverage. Please contact HR at 608-266-4615 or Payroll at 608-266-4027 with any questions.

If benefits are cancelled it will be your responsibility to contact HR to complete re-enrollment paperwork within 30 days of returning to work. If you do not re-enroll within 30 days, you will not have another opportunity to enroll until the next open enrollment period unless you have a qualifying event.

For general assistance, you may also reach out to benefits@cityofmadison.com and/or payroll@cityofmadison.com.

NOTES FOR EMPLOYEES AND SUPERVISORS

1. When leave will be for birth or adoption of a child, the employee needs to submit the family leave application well in advance, showing the expected start date of leave and documenting eligibility. Documentation of eligibility should come from the health care or adoption provider and show the employee name, that the employee is the expectant mother or father, and expected date of birth or adoption. The employee's department and the Human Resources Department must be notified of the actual date of birth or adoption as soon as possible after the event.
2. All leave to which an employee is entitled, including Federal FMLA, Wisconsin FMLA, and disability leave under Madison General Ordinances, will run concurrently as applicable.
3. If an employee is requesting intermittent leave for a chronic health condition, the employee will be required to submit medical certification after six (6) months of FMLA in addition to the medical certification required at the time of application.
4. An employee requesting leave to take care of a domestic partner or parent of a domestic partner must certify on the health care provider application that the domestic partner is someone as defined in the Wisconsin Statutes 40.02(21c) or 770.01(1). See APM 2-21 for more details.
5. An employee using intermittent leave must follow regular department procedures for calling in and using family leave. An employee using intermittent leave for medical appointments must make a reasonable effort to schedule such appointments around the needs of the City. This generally means that appointments will be made and the City informed at least 30 days in advance, or otherwise as soon as practicable. An employee who fails to provide 30 days notice may be required to provide an explanation for why he/she was unable to schedule the appointment without greater notice.
6. **An employee who has approved intermittent FMLA and calls in according to approved procedures should inform their supervisor at the time of calling in that the leave should be counted as family leave.** The City has the right to follow up on any absence for which the employee does not provide the information about whether the absence is to be considered family leave, and the employee is obligated to respond. Failure to do so will result in the absence not being covered by family leave provisions.
7. Medical information is to be sent directly to Human Resources. Supervisors and other department representatives do not have a right to inquire about the medical information, and are prohibited under the Family and Medical Leave Act from contacting an employee's health care provider to ask about an employee's medical information.
8. Employees using leave pursuant to the Federal FMLA may be required to substitute paid leave time, including sick leave, vacation time, and floating holiday time, as outlined in APM 2-21.
9. Absences may affect City employment benefits. Questions should be directed to Human Resources, 266-4615, or email hr@cityofmadison.com

An employee's original application and supporting medical documentation will be maintained in confidential medical files in the Human Resources Department.