Job Protected Leave of Absence Update

Well Advised is WellSpan Health’s Third Party Administrator established to oversee the leaves of absence and Family and Medical Leave Act (FMLA) administration for employees of WellSpan Health.

**How Do I Apply For A Job Protected Leave?**

**Step 1:** Obtain and complete the leave of absence application packet
- The application packet can easily be obtained on the following WellSpan internet site: http://hr.wellspan.org and clicking on “Leave of Absence” under the “HR Quick Links” section or by calling Well Advised at 717-812-5018 or toll free at 1-877-466-2415.

**Step 2:** Submit all completed paperwork (Application and Certification of Health Care Provider Forms) to Well Advised via fax or mailed to the address above.

**Step 3:** Notify Well Advised immediately of any changes in your leave request.

**Rules for applying for a job protected leave:**
- When the need for leave is foreseeable (i.e. upcoming surgery), employees are required to give at least 30 days notice to both the supervisor/manager and Well Advised, or risk not having the leave approved.
- If the need for leave is not foreseeable—such as in an emergency, or the result of a flare of a chronic, serious medical illness, provide notice as soon as possible (generally on the same day as or next business day when the need for leave became known to the employee).
- Employees should notify both the supervisor/manager and Well Advised.

**Process for all job protected leave-related call offs:**
All employees are required to notify their employer when he or she is going to be absent from work. When an absence is leave (FMLA) related, the employee will need to follow the steps below.

*When possible, appointments are to be scheduled during non-working hours or at the least disruptive time for the department.

**Step 1:**
Employees calling their supervisor/manager for time off work for a leave related illness/issue must:
- Specify the amount of time off that is needed.
- Inform the supervisor/manager that the absence is leave related (i.e. “I am calling off for a leave related issue.”). The employee is not required to give specific medical information or reason for leave.

**Step 2:**
In addition to department/company policy, employees must notify Well Advised by calling 717-812-5018 (choose option 1) or toll free at 1-877-466-2415 for all job protected leave of absence requests.
- For a full shift call off: Notify Well Advised immediately following the call to the supervisor/manager regarding the absence.
- For a partial shift call off: Notify Well Advised immediately after leave hours are taken and the exact number of leave hours is known.
- For an appointment call off: Notify Well Advised immediately after the appointment due to the possibility of the appointment being cancelled or rescheduled.
About the Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act (FMLA) is a federal law that became effective in August, 1993. The law assists employees in balancing their work and family life. It was intended and designed to give workers assurance that they will not lose their jobs in order to meet their personal and family obligations or to tend to vital needs at home. It requires employers to provide 12 weeks in a 12-month period of unpaid leave, continue health care benefits and provide job protection.

An employer may grant leave for:

- the birth and care of a newborn child;
- the placement of a child with the employee for adoption or foster care and to care for the newly placed child;
- to care for an immediate family member (spouse, child or parent) with a serious health condition; and
- when the employee is unable to work because of their own serious health condition.

Employees must meet the eligibility requirements in addition to obtaining medical certification and approval for FMLA.

Leave of Absence (LOA) Policy and Process

<table>
<thead>
<tr>
<th>Administration of LOAs</th>
<th>Current Policy/Process</th>
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</thead>
<tbody>
<tr>
<td>Administration of LOAs</td>
<td>Well Advised (Workplace Absence Solutions) will administer LOAs to ensure:</td>
</tr>
<tr>
<td></td>
<td>• Consistent application of policy and process</td>
</tr>
<tr>
<td></td>
<td>• A more controlled process for call offs</td>
</tr>
</tbody>
</table>

| Recertification        | Required every 6 months (by law) for chronic conditions |

<table>
<thead>
<tr>
<th>Call Offs related to job protected leaves of absence</th>
<th>Employees are required to call Well Advised Workplace Absence Solutions as well as their department</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• If employee calls department but does not call Well Advised, the employee will not get paid and will be subject to corrective action</td>
</tr>
<tr>
<td></td>
<td>• If employee calls Well Advised but does not call their department, the employee will be subject to corrective action</td>
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</tbody>
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<thead>
<tr>
<th>Leaves related to pregnancy</th>
<th>A total of up to 12 weeks of leave available</th>
</tr>
</thead>
<tbody>
<tr>
<td>During first 90 days of employment</td>
<td>No approved LOAs during this timeframe</td>
</tr>
<tr>
<td>After 90 days of employment through 1 year of employment</td>
<td>Medically necessary: full leave of absence</td>
</tr>
<tr>
<td></td>
<td>Family: no leave of absence</td>
</tr>
<tr>
<td></td>
<td>Intermittent: no leave of absence</td>
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</tbody>
</table>
WELSPANN HEALTH LEAVE OF ABSENCE APPLICATION  
(Return completed packet to Well Advised Workplace Absence Solutions)

Please complete this application if you are requesting a job protected Medical Leave (Full or Intermittent) or a Family Leave (Full or Intermittent).

<table>
<thead>
<tr>
<th>Employee Name ____________________________</th>
<th>Date of Birth ____ / ____ / _______</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address _________________________________</td>
<td>S.S. #__ __ - __ __ - __ __ __</td>
</tr>
<tr>
<td>City, State, Zip Code _____________________</td>
<td>Home Phone ________________________</td>
</tr>
<tr>
<td>Home e-mail _____________________________</td>
<td>Cell Phone ________________________</td>
</tr>
<tr>
<td>Job Title and Department __________________</td>
<td>Work Phone ________________________</td>
</tr>
<tr>
<td>Immediate Supervisor’s Name ______________</td>
<td>Supervisor’s Phone __________________</td>
</tr>
</tbody>
</table>

**Type of Leave:** (check all that apply) (Full LOA – Continuous absence of more than 3 days; Intermittent LOA – Occasional or episodic absence)

- **Medical** (Self, including maternity* pre-delivery and initial post-delivery period)
  - **Full** Leave Start Date ______________ Estimated Leave Time Frame ______________
  - **Interruption** Leave Start Date ______________ Estimated Leave Time Frame ______________

- **Family** (Care for spouse, child, parent, including maternity after initial post-delivery period, paternity and adoption*)
  - **Full** Leave Start Date ______________ Estimated Leave Time Frame ______________
  - **Interruption** Leave Start Date ______________ Estimated Leave Time Frame ______________

- **Military** (Care for spouse, child, or parent on active duty)
  - **Full** Leave Start Date ______________ Estimated Leave Time Frame ______________
  - **Interruption** Leave Start Date ______________ Estimated Leave Time Frame ______________

* I hereby request a leave of Absence as shown above to begin on the date(s) shown above. I understand my continuing obligation to pay my share of all premiums for insurance coverage in a timely manner during my Leave of Absence. If eligible for (FMLA) job protected leave, I acknowledge that I will be reinstated from an approved leave to the same or an equivalent position as provided in the leave policy subject to the terms, conditions, limitations and exceptions provided by law. I understand that a failure to return to work at the end of my leave period may be treated as my resignation unless an extension has been agreed to and approved in writing by WellSpan Health.

*If leave request is due to the birth or adoption of a child, be sure to call Well Advised Workplace Absence Solutions to report your delivery date or confirm your actual leave start date. Please remember you must enroll your new child within 30 days of the birth date or placement for adoption if you want to cover the child under WellSpan’s health, dental or vision coverage plans. Otherwise, in general, you will have to wait for an open enrollment to add the child to your plan.

| Employee Signature ____________________________ | Date ____ / ____ / _______ |

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Payment Request Form (Non-Physician)

Physicians need to contact the Leave Specialist at 717-851-2622

**Short Term Disability Plan: (Not available for Intermittent Medical Leaves)**

Your *full medical leave* begins with a waiting period before Short Term Disability payments begin. This is one half of your authorized hours (Ex: 40 hours for a full time 80 hour schedule) and you are required to use Paid Time Off (PTO), however, you have the option to save 40 or less of PTO as indicated below. Saving PTO may result in unpaid time.

After the waiting period, Short Term Disability pays 60% of your authorized hours. You must supplement the Short Term Disability payment with your PTO (unless you have elected to save 40 hours) or with Extended Illness Reserve Bank (EIR) hours, if available. The Short Term Disability benefit will continue up to 90 days, which includes the waiting period, with certification from your physician. Please note that Maternity/Paternity/Adoption second through sixth week only will qualify for Short Term Disability, unless certified otherwise.

Payroll will supplement with EIR banks, if available, until hours are depleted and then PTO will be used.

This will be processed as a regular paycheck with current deductions and taxes taken.

*Please specify the number of PTO hours you wish to save _____ (cannot exceed 40 hours).*

*Saving hours may result in unpaid time.*

**Intermittent Medical Leave:**

*Please specify the number of PTO hours you wish to save _____ (cannot exceed 40 hours).*

*Saving hours may result in unpaid time.*

**Family Leave - Full or Intermittent:** (Includes Weeks 7 -12 for birth/ adoption of a child)

EIR hours cannot be used

*Please specify the number of PTO hours you wish to save _____ (cannot exceed 40 hours).*

*Saving hours may result in unpaid time.*

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Employee’s Name (Printed) _______________________________ Date of Birth __________________

Employee Signature _______________________________ Date __________________

For questions in regards to pay and your timecard, call Leave of Absence Specialist (717) 851-2622
Fax form to Well Advised at (717) 812-5015

Revised 1/20/2017
Authorization for Release of Protected Health Information (PHI) to Determine Job Protection Under the Family and Medical Leave Act (FMLA)

The purpose of this form is to assist Well Advised Workplace Absence Solutions in obtaining the required medical information that is necessary to process your request for a job protected leave of absence under the FMLA. The use of this form is voluntary. If you choose to use this form, please complete the form and give it to the healthcare provider so the provider can comply with the Health Insurance Portability and Accountability Act privacy requirements (HIPAA).

<table>
<thead>
<tr>
<th>A. EMPLOYEE DEMOGRAPHICS (Please Print Clearly or Type)</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Employer: WellSpan Health</td>
<td></td>
</tr>
<tr>
<td>Family Members Name (if request is for a family member):</td>
<td></td>
</tr>
<tr>
<td>Date of Birth:</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>B. RELEASE OF INFORMATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Person or entity authorized to receive information:</td>
<td>Well Advised Workplace Absence Solutions</td>
</tr>
<tr>
<td>Address and telephone number: 3421 Concord Road, York, PA 17402</td>
<td>Phone: 717-812-5018, Fax: 717-812-5015</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. DESCRIPTION OF PROTECTED HEALTH INFORMATION TO BE RELEASED</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of information to be released:</td>
<td></td>
</tr>
<tr>
<td>• Certification of Healthcare Provider including diagnosis, medical facts, treatment plan, frequency and duration of leave.</td>
<td></td>
</tr>
<tr>
<td>• Other (please list):</td>
<td></td>
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</table>

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<thead>
<tr>
<th>D. AUTHORIZATION INFORMATION AND SIGNATURE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. This authorization will expire [Date]: / / (or) [Date]: until revoked in writing.</td>
<td></td>
</tr>
<tr>
<td>*Unless otherwise specified above, this authorization will expire one (1) year after the date this request was signed.</td>
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</tr>
<tr>
<td>2. This authorization is voluntary; however, your healthcare provider may not release the required medical information to Well Advised Workplace Absence Solutions without this authorization and lack of medical information may result in your request for a job protected leave of absence under the FMLA not being approved.</td>
<td></td>
</tr>
<tr>
<td>3. I understand that I have the right to revoke this authorization at any time by notifying Well Advised Workplace Absence Solutions in writing at: Well Advised Workplace Absence Solutions, 3421 Concord Road, York, PA 17402. I understand that the revocation is only effective after it is received and logged by Well Advised Workplace Absence Solutions. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.</td>
<td></td>
</tr>
<tr>
<td>4. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it.</td>
<td></td>
</tr>
<tr>
<td>5. I understand that I am entitled to receive a copy of this authorization.</td>
<td></td>
</tr>
<tr>
<td>6. I understand that this authorization will expire when my employment with WellSpan Health terminates.</td>
<td></td>
</tr>
</tbody>
</table>

Signature of Employee or Family Member (person in need of care)  Date

Printed Name and Signature of Responsible Party  Relationship to Family Member  Date

(If family member is a minor or unable to sign)
Certification of Health Care Provider
FMLA application form to apply for job protection
(for employee’s own medical condition)

SECTION I: Instructions for Employee
Please complete Section I before giving this form to your medical provider. The Family and Medical Leave Act (FMLA) permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for job-protected leave due to your own medical condition. Your response is required to obtain or retain the benefit of FMLA protections. You have up to 15 calendar days from the initial contact to Well Advised to return this certification. Please print below.

1. Employee’s Name

2. Employee’s Date of Birth
   ____ / ____ / ______

3. Employer and Employee’s Job Title

4. Employee’s Work Schedule (shift and hours per week)

This section must be completed by the health care provider

SECTION II: INSTRUCTIONS to HEALTH CARE PROVIDER
Your patient has requested a job protected leave under the Family and Medical Leave Act (FMLA). Please answer fully and completely all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answers should be based upon your objective, professional opinion, medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as “lifetime,” “unknown,” “tentative,” or “indeterminate” may not be sufficient to determine FMLA coverage. Limit your responses to the primary condition for which the employee is seeking leave. If there are multiple conditions that may result in a leave request, you must submit a separate certification form for each health condition. Please be sure to sign the form on the last page.

1. Identification of “Serious health condition” under the Family and Medical Leave Act
   Page 3 describes what is meant by a “serious health condition” under the Family and Medical Leave Act. Does the patient’s condition qualify under any of the categories described? If so, please check the applicable category.
   (1*)_____ (2)_____ (3**) _____ (4)_____ (5)_____ (6)_____, or None of the above _____
   *If “serious health condition” is related to the patient being admitted for an overnight stay in hospital, hospice, or residential medical care facility, please provide admission date(s): ____________________________
   **If “serious health condition” is related to pregnancy, please provide expected delivery date: ____________________________

2. Serious Health Condition Facts
   Please provide the diagnosis/medical facts of the “serious health condition” that will require the employee to be absent from work.

3. Initial date you examined the patient for this condition ___________. Did patient require follow-up visit? ☐ Yes or ☐ No

4. Last two dates you examined the patient for this condition ______________ and ______________

5. Probable duration of this condition ______________

6. Is the reason for leave related to a chronic condition? ☐ Yes or ☐ No. If yes, date this condition commenced? __________

Form 2
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REV 8/5/2015
7. **Treatment Plan and/or Surgery Name**

Please provide description of treatment plan\(^1\) (i.e. prescription drugs, physical therapy requiring special equipment, chemotherapy, radiation therapy, psychological counseling, name of surgery) and treatment schedule, if applicable.

8. **Type Of Leave And Time Being Requested For Employee** (check leave type and add information requested below leave type)

☐ **FULL LEAVE** – Patient will be incapacitated for a single continuous period of time of more than 3 days with this “serious health condition.”

Leave Start Date _________________                         Estimated Leave End Date _________________

-and/or-

☐ **INTERMITTENT LEAVE** – Patient will be incapacitated intermittently (separate blocks of time) or work less than a full schedule during episodic flare-ups of this “serious health condition.”

An intermittent leave requires completion of frequency and duration criteria along with the leave start and end date to give the employer a guideline on the employee’s absence. Use professional judgment and employee’s condition/history to estimate absences (i.e. 1 episode every 3 months lasting 1-2 days). Chronic conditions (migraines, diabetes, asthma, etc.) may be certified up to 6 months, if appropriate.

**Dates & Frequency and Duration of Intermittent Leave**

Leave Start Date _________________                         Estimated Leave End Date _________________

Frequency: ______ episode(s) every ______ Week(s) or ______ Month(s)

Duration: ______ hour(s) or ______ days per episode

9. **Provider Signature, Information and Date**

Signature of Health Care Provider __________________________

Specialty of Health Care Provider __________________________

Print Name of Health Care Provider _________________________

Telephone Number _________________________________

Address ________________________________________

Fax Number ___________________________________

_____ / _____ / __________ Date

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\(^1\)Treatment under FMLA includes examinations to determine if a serious health condition exists and evaluation of the condition. Treatment does not include routine physical examinations, eye examinations or dental examinations. A regimen of treatment includes for example, a course of prescription medication or therapy requiring special equipment to resolve or alleviate the condition. It does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a healthcare provider.
SECTION III: Definitions of Serious Health Conditions

A. “Serious Health Condition” means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. **Hospital Care**
   
   Inpatient Care *(i.e. an overnight stay)* in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. **Absence Plus Treatment**
   
   A period of incapacity of **more than three consecutive calendar days** (including any subsequent Treatment or period of incapacity relating to the same condition), that also involves:
   
   (1) **Treatment two or more times** by a health care provider, by a nurse or physician’s assistant under direct supervision of a health care provider, or by a provider of health care services *(e.g. physical therapist)* under orders of, or on referral by, a health care provider; or
   
   (2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment** under the supervision of the health care provider.

3. **Pregnancy**
   
   Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. **Chronic Conditions Requiring Treatments**
   
   A **chronic condition** which:
   
   (1) Required **periodic visits** for treatment by a health care provider, or by a nurse or physician assistant under direct supervision of a health care provider;
   
   (2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and
   
   (3) May cause **episodic** rather than a continuing period of incapacity *(e.g. asthma, diabetes, epilepsy, etc.).*

5. **Permanent/Long-term Conditions Requiring Supervision**
   
   A period of **incapacity** which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider**. Examples include Alzheimer’s, a severe stroke, or the terminal stages of a disease.

6. **Multiple Treatments (Non-Chronic Conditions)**
   
   Any period of absence to receive **multiple treatments** *(including any period of recovery there from)* by a health care provider or by a provider of health care services under order of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, or for a condition that **would likely result in a period of incapacity of more than three consecutive calendar days** in the absence of medical intervention or treatment, such as cancer *(chemotherapy, radiation, etc.)*, severe arthritis *(physical therapy)* and kidney disease *(dialysis)*.

**Thank you.**

Please return this completed form to Well Advised Workplace Absence Solutions at:

PO Box 1827, York, PA 17405 or by fax at (717) 812-5015