Sick Leave Fund Shortfall Contribution Form

Pursuant to the Sick Leave Fund and Direct Grant Policy, when the Sick Leave Fund (Fund) balance falls below 5,000 hours, Participating Employees must make additional Contributions to remain a Participating Employee of the Fund within 45 days of the request for Contributions by submitting a completed Sick Leave Fund Shortfall Contribution Form.

- If a Participating Employee does not submit a completed Sick Leave Fund Shortfall Contribution Form authorizing the requested Contribution, the Employee's participation in the Fund is terminated.
- Participating Employees who used the Fund within the previous 6 months, who are currently using the Fund, or who would have less than 40 sick leave hours after making a Contribution, are exempt from any required Contribution of hours.

Information for Contributing Employees

1. Your shortfall contribution must be at least 8 hours of accrued sick leave, accrued annual leave or a combination of both. You may contribute more than 8 hours of accrued sick and/or accrued annual leave, but you must contribute 8 hours.

2. Complete Section I of this form and return it to your Agency HR/payroll within 45 days of the date you received the shortfall notice.

3. Failure to make the required minimum shortfall contribution within the 45-day deadline will result in your termination as a Participating Employee in the Fund. You will then need to make another initial contribution to re-enroll in the Fund and satisfy a new 90-day qualifying period to request a grant of hours from the Fund.

4. All contributions are voluntary and irrevocable.

5. You must have a minimum balance of 40 hours in the account from which leave was donated (sick or annual leave). This amount is prorated for part-time employees.

6. Your Agency HR/payroll will send the completed form via email to BenefitsQuestion@mt.gov.

Section I

To be completed by the Contributing Employee

Contact Information for Contributing Employee

Last Name _____ First Name _____

Agency _____ Employee ID # _____

Sick Leave Fund Shortfall Contribution

You must contribute 8 hours to remain a Participating Employee of the Sick Leave Fund.

- ❑ I wish to contribute _____ hours of my **sick leave**.
- ❑ I wish to contribute _____ hours of my **annual leave**.
- ❑ I wish to contribute _____ hours of my **excess leave that is being forfeited** (Agency documentation must be attached).

Contributing Employee Signature: _____ Date: _____

Section II

To be completed by the Agency HR/Payroll

Sick Leave Fund Shortfall Contribution

- ❑ The Contributing Employee's **sick leave balance** has been debited _____ hours on pay period ending _____. Contributing Employee has a balance of _____ **sick leave hours** after contribution.
- ❑ The Contributing Employee's **annual leave balance** has been debited _____ hours on pay period ending _____. Contributing Employee has a balance of _____ **annual leave hours** after contribution.
- ❑ The Contributing Employee's **excess annual leave** balance has been debited _____ hours on pay period ending _____.

Agency HR/Payroll Signature: _____ Date: _____

Payroll Employee ID#: _____ Agency #: _____

Table 1: Time Reporting Codes Used for Sick Leave Fund Shortfall Contributions

Code	Name	Definition
ALFP-	**Current Member** – Annual Leave Donation for Sick Leave Fund	Current member wishes to donate annual leave to the Sick Leave Fund, including shortfall donations.
ELFP-	**Current Member** – Excess Annual Leave Donation for Sick Leave Fund	Current member wishes to donate excess annual leave to the Sick Leave Fund, including shortfall donations.
SLFP-	**Current Member** – Sick Leave Donation for Sick Leave Fund	Current member wishes to donate sick leave to the Sick Leave Fund, including shortfall donations.

Health Care & Benefits Division - Date Input _____ Input By _____

State of Montana Non-Discrimination Statement

State of Montana complies with applicable federal and state non-discrimination laws and does not discriminate on the basis of race, color, sex, pregnancy, childbirth or related medical conditions, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, national origin, ancestry, age, disability, military service, veteran status or marital status. State of Montana provides free aids and services to people with disabilities to communicate effectively, including qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). State of Montana provides free language services to people whose primary language is not English, including qualified interpreters and information written in other languages. If you need these services, contact HCBD at (800) 287-8266. If you believe that State of Montana has failed to provide these services or has discriminated against you in another way, you can file a grievance. If you need help filing a grievance, the State Diversity Coordinator is available to help you. You can file a grievance in person or by mail, fax, or email to: State Diversity Program Coordinator, Department of Administration State Human Resources Division, 125 N. Roberts, P.O. Box 200127, Helena, MT 59620, Phone: (406) 444-3871 Email: SABHRSHR@mt.gov.

Language Assistance - General Taglines

State of Montana is required by federal law to provide the following information.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-270-3877 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-270-3877 (TTY: 711).

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-866-270-3877 (TTY:711)。

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-866-270-3877 (TTY:711) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-270-3877 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-270-3877 (ATS : 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-270-3877 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-270-3877 (TTY: 711)번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร1-866-270-3877 (TTY: 711).

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-866-270-3877 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-270-3877 (TTY: 711).