VACATION DONATION PROGRAM APPLICATION

This application is to be used by employees applying for one or both of the State's vacation donation programs, authorized by M.S. § 43A.181 and § 43A.1815 and Administrative Procedures 18A and 18B. Complete Part One of this form and submit to your agency's human resources office. Required supplementary documentation must be included.

Part One – To be completed by Vacation Donation Program Applicant (please type or print legibly)

Full Name: _____

Application is for: ❑ Self ❑ Spouse/Dependent

Vacation Donation Program applying for:

- ❑ Continued Salary; **and/or**
- ❑ Unreimbursed Medical Costs (for unreimbursed expenses of at least $10,000)

You MUST attach the following documentation, depending on the program for which you are applying:

Continuing Salary: A signed and dated statement from a physician that provides the following information:

1. Nature of the applicable illness/injury, prognosis, and anticipated return to work date; and
2. Physician's opinion as to whether the illness/injury is life threatening, including explanation. (Explanations regarding "potentially" life-threatening surgeries, accidents etc. will not be accepted. The actual illness/injury must be life-threatening.)
3. Medical documentation which verifies that a life threatening illness/injury necessitates absence from work for a minimum of six weeks from the date the application is approved.
4. If applying due to an injured/ill spouse or dependent child, the medical statement must include the reason your attendance is necessary to provide direct care and the type of direct care required.

Unreimbursed Medical Costs:

1. A signed and dated statement from a physician that provides the nature of the illness/injury for which unreimbursed medical expenses have been incurred; and
2. Documentation showing unreimbursed medical expenses of at least $10,000 that have been incurred due to the specified illness/injury.

Note: For both programs, the employee may not be receiving or pending receipt of workers' compensation benefits for the same time period.

If additional information/clarification is needed, you may be asked to provide further documentation.

The above requested documentation will be used by representatives of Minnesota Management & Budget (MMB) to determine your eligibility for the State's Vacation Donation Program noted above. You are required to provide this information by MMB Administrative Procedures 18A and 18B. If you do not provide the necessary information sufficient to make an eligibility determination, you will not be approved for the Program. The following other entities are authorized by law to receive the information, provided the situation calls for such release: Minnesota Legislative Auditor, Minnesota Office of Attorney General, law enforcement and state and federal enforcement agencies with legal authority to access the data, and any other person or entity authorized by law or court order.

I agree to provide the above designated documentation to my human resources office and authorize them to provide it to representatives of Minnesota Management & Budget for their use in determining my eligibility for the State's Vacation Donation Program. This authorization expires upon completion of the above stated purpose.

Signature of Employee: _____ **Date:** ___/___/___

Part Two – To be completed by Agency Human Resources Office (please type or print legibly)

Employee's Class Title: _____ Employee I.D. #: _____ FTE: _____

Length of State Service: _____ Is Employee Eligible for Employer Insurance Contribution? ❑ Yes ❑ No
(must be at least six consecutive months)

Is Employee Eligible to accrue and use vacation (or personal days) and sick leave? ❑ Yes ❑ No

Date when all forms of paid leave (e.g. vacation, sick, comp) will be/were exhausted: ___/___/___

Signature of HR Director/Designee: _____ **Date:** ___/___/___

Email address: _____ **Phone #:** _____

(Submit completed form and cover memo to the MMB Vacation Donation Program Administrator)