COOK COUNTY BUREAU OF HUMAN RESOURCES
COVID-19 HARDSHIP BENEFIT TIME REQUEST FORM

Download the form in order to complete

Employee Name (Last, First, MI): _____

Employee ID #: _____ Position Title: _____

Department Name: _____ Supervisor Name: _____

Absence Start Date: _____ Absence End Date: _____

Employees approved for this benefit will be placed on paid administrative leave for a period not to exceed 14 days.

Eligibility– place a check mark on each item that applies:

- ☐ I have been diagnosed with COVID-19;
- ☐ I have exhausted all of my accrued benefit time;
- ☐ I have exhausted all leave available under the Emergency Paid Sick Leave and Emergency Family and Medical Leave;
- ☐ I am unable to qualify for disability.

Calculation of Hardship Benefit Time Pay Rate

Employees who meet the eligibility requirements will be placed on a paid leave of absence for a period not to exceed 14 days. Eligible part-time employees will receive an amount equal to the average number of hours they work over a two-week period at their normal rate of pay. Eligible full-time employees will receive up to 80 hours of Hardship Benefit at their regular rate of pay. The amount of Hardship Benefit Time can be extended with sufficient notification and upon approval of the Chief of the Bureau of Human Resources (or designee).

Acceptable Medical Documentation

1. A Positive COVID-19 test result; and

2. A written correspondence from the physician's office on their letterhead indicating that the employee has not been cleared by the office to return to work

   A medical certification can be submitted directly to BHR, Personnel Services Division by facsimile, mail, or electronic upload:

a. Facsimile: (312) 603-3747
b. Mail: Cook County, Bureau of Human Resources, Room 834 – Attention: Personnel Services, 118 N. Clark Street, Chicago, IL 60602
c. Upload your medical certification, send the certification to the attached link, and follow the instructions provided - https://cookcounty.sharepoint.com/sites/BHRReturntoWork

By my signature, I certify that the information provided in this Form is true, correct, and complete to the best of my knowledge. Further, I acknowledge that falsification or misrepresentation of information provided in this form will be a violation of Personnel Rules 8.2(b) (18) and 8.2(b) (33) and may lead to discipline, up to and including, discharge.

Employee Signature **Date**

Hardship Benefit Time Extension

- ☐ **I am requesting additional time**
- ☐ **I have submitted a secondary positive test result for COVID-19**
- ☐ **I have submitted correspondence from my physician that I am not authorized to work**

_____

Employee Signature

_____

Bureau of Human Resources Signature

Bureau of Human Resources ☐ Approval ☐ Denial

_____

Bureau of Human Resources (or Designee) Date

Please send this form to Bureau of Human Resources Personnel Services