Yvette Talley

Mark Wiechman

REVIEW OF THE BASICS

- Leave Without Pay
- Leave Buy Back
- Other wage loss
  - Premium Pay
    - ✓Night/Shift Differential
    - ✓Saturday/Sunday
  - Change to Lower Grade
- Schedule Award

REVIEW OF THE BASICS

- Rates of Compensation
- Waiting Period
- Intermittent Absences
- Timely Submission
- OWCP Decision and Payment
- Schedule Award

FORMS REQUIRED

LEAVE WITHOUT PAY

- ✓CA-7
- ✓CA-7a if intermittent

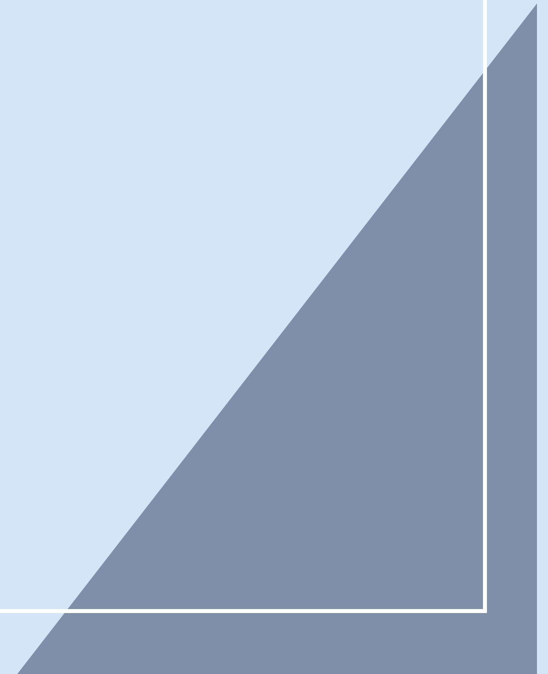
* The period covered on CA-7 and CA-7a should be the same

LEAVE BUY BACK

- ✓CA-7a
- ✓CA-7b
- ✓CA-7 if electing to repurchase leave

* The period covered on the CA-7a, CA-7b and CA-7 should be the same

Exercise



SCENARIO

DOI: 01/23/2009 @ 8:00 pm

Employed since 06/30/2007as a LPN

Annual Salary: GS-5 Step 4, $36,937.00

- Salary effective date 01/04/2009

Premium Pay Earned 1 Year Prior to 01/23/2009

- $3304.14 Night Differential
- $3295.73 Saturday/Sunday
- $1362.23 Holiday Pay

Work Schedule: 3:30 pm – 12 mid

- Week 1: Days off - Wednesday and Saturday
- Week 2: Days off - Tuesday and Saturday

One dependent (spouse)

Benefits Enrolled

- Retirement System: FERS
- FEHB: 105
- FEGLI: Basic only

SCENARIO

Date Stopped Work: 01/23/2009 @ 8:00 pm

Authorized COP 01/24/2009 thru 03/09/2009

Remained Off Work - Requested Sick Leave Post-COP

- 03/10/2009 8 hours
- 03/11/2009 8 hours
- 03/12/2009 8 hours
- 03/13/2009 8 hours
- 03/16/2009 8 hours
- 03/17/2009 8 hours
- 03/18/2009 8 hours
- 03/19/2009 8 hours

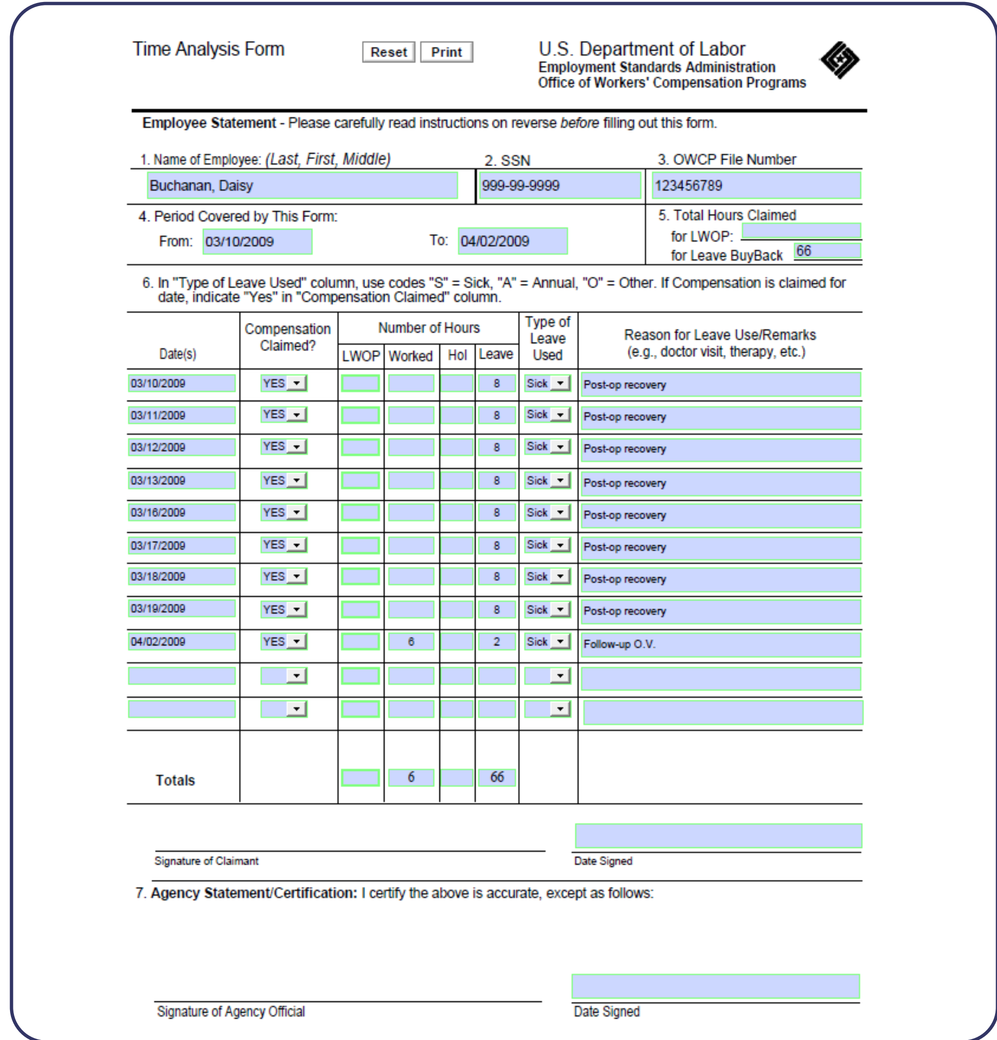
Returned to Work 03/20/2009 Limited Duty

Requested Sick Leave for Follow Up Medical Appointment

- 04/02/2009 2 hours

SAMPLE CA-7a

- Period covered "From" should be the first date claimed
- Period covered "To" should be the last date claimed
- Total hours claimed should be the grand total of hours marked "yes" for compensation claimed
- If multiple forms are required, 1-5 should be the same on all forms



Time Analysis Form   Reset   Print

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee Statement - Please carefully read instructions on reverse *before* filling out this form.

1. Name of Employee: *(Last, First, Middle)* Buchanan, Daisy
2. SSN 999-99-9999
3. OWCP File Number 123456789
4. Period Covered by This Form: From: 03/10/2009 To: 04/02/2009
5. Total Hours Claimed for LWOP: for Leave BuyBack 66
6. In "Type of Leave Used" column, use codes "S" = Sick, "A" = Annual, "O" = Other. If Compensation is claimed for date, indicate "Yes" in "Compensation Claimed" column.

Date(s)	Compensation Claimed?	Number of Hours: LWOP	Worked	Hol	Leave	Type of Leave Used	Reason for Leave Use/Remarks (e.g., doctor visit, therapy, etc.)
03/10/2009	YES				8	Sick	Post-op recovery
03/11/2009	YES				8	Sick	Post-op recovery
03/12/2009	YES				8	Sick	Post-op recovery
03/13/2009	YES				8	Sick	Post-op recovery
03/16/2009	YES				8	Sick	Post-op recovery
03/17/2009	YES				8	Sick	Post-op recovery
03/18/2009	YES				8	Sick	Post-op recovery
03/19/2009	YES				8	Sick	Post-op recovery
04/02/2009	YES		6		2	Sick	Follow-up O.V.
Totals			6		66		

Signature of Claimant   Date Signed

7. **Agency Statement/Certification:** I certify the above is accurate, except as follows:

Signature of Agency Official   Date Signed

SAMPLE CA-7b

Parts A-D should be the same as Section 1-4 on the CA-7a

Leave Buy Back (LBB) Worksheet/
Certification and Election

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee Statement - Please carefully read instructions on pages 3 and 4 *before* filling out this form.

A. Name of Employee: *(Last, First, Middle)*	B. OWCP File Number:
Employee, Injured	987654321
C. Social Security Number:	
123-45-6789	

D. Period for Which Compensation is Claimed to Repurchase Leave

From: 03 / 10 / 2009 To: 04 / 02 / 2009

SAMPLE CA-7b

- Weekly Pay Rate = Annual salary divided by 52
- Additions to Base Pay
- Total Weekly Payrate
- Compensation Rate
- Total Hours Claimed
- Total hours worked per week is 40 if full-time
- Complete the formula to obtain the estimated payment from OWCP

I. Agency Estimate of FECA Entitlement:

A. Weekly Base Payrate *(excluding overtime)*

• Date of Injury	01 /	23 /	2009	$ 710.33
• Date Stopped Work	01 /	23 /	2009	$ 710.33
• Date of Recurrence	/	/		$

Enter the greatest amount and the effective date of that amount on line 1. 1. 710.33

01 / 04 / 2009 *(effective date)*

B. Additions to Base Pay:
If employee works a regular schedule, state the amount earned weekly. If irregular schedule, state amount earned 1 year prior to date entered on line 1 ÷ by 52.

• Night Differential	2.	63.54
• Sunday Premium	3.	63.38
• Subsistence/Quarters	4.	
• Other *(Specify)*	5.	26.20

C. Total Weekly Payrate *(Add lines 1 through 5)* 6. 863.45

D. Compensation Rate *(Circle either 2/3 or 3/4)* 7. 2/3 3/4

E. Total Hours Claimed on CA-7a 8. 66

F. Total Hours Worked per Week 9. 40

G. Formula ***(for FECA Entitlement)***

$ 863.45 (Weekly Payrate See Line 6) X .75 (Compensation Rate See Line 7) X 66 (Hours See Line 8) ÷ 40 (Hours Wkd/Wk See Line 9) = 10. $ 1068.52

SAMPLE CA-7b

- Total Amount Due to Repurchase Leave (total gross salary received by employee for the leave used)
- Estimated OWCP payment (Line 10)
- Balance Due from Employee
- OWCP will mail a check to agency address provided for the approved LBB hours

II. Agency Certification:

H. Total Amount Due Agency to Repurchase Leave	11.	$ 1424.69
I. Estimate of FECA Entitlement *(See Line 10)*	12.	$ 1068.52
J. Balance Due Agency from Employee *(Line H minus Line I)*	13.	$ 356.17

I hereby certify that the above is consistent with agency payroll records.

The employing agency agrees to allow the employee to repurchase his/her leave. Leave records will be, or have been, changed from "Leave with Pay" to "Leave without Pay" for the period shown on the leave analysis.

I further certify that if this claim is signed by the employee, the employee has made arrangements to pay the agency the balance between the total amount the agency requires to recredit leave and the amount of the FECA entitlement.

(Signature of Agency Official)

(Title/Position)

Phone No

Date Signed:

Employing Agency Address for Check:

- Maximum rate of compensation must be taken into consideration when determining the estimated FECA payment
- Salaries exceeding the maximum rate of compensation will significantly impact the balance due to the agency

EMPLOYEE COUNSEL & ELECTION

- Meet with employee to discuss:
  - Estimated monies due to the agency before leave can be re-credited
  - Leave accrual reductions
  - Reduced retirement & TSP contributions
  - Potential forfeiture of use/lose leave
  - Requirement to file amended tax return
- Employee makes an election on the CA-7b, Section III, to repurchase or not repurchase the leave used:
  - Not purchasing: Stop - Do not submit to OWCP
    - Retain forms CA-7a and CA-7b in the case file
  - Elects to repurchase: Request employee complete CA-7

ESTIMATED REPAYMENT & LEAVE ACCRUAL REDUCTION

- If there are additional reversals such as taxes (Federal, State, or local) or premium pay, the agency may owe the employee
- LBB would have to be completed in same tax year as the leave used to be eligible for taxes to be reversed
- Leave accrual reduction is pro-rated
  - Pro-rated annual leave reduction is based on leave group

LEAVE BUY BACK ESTIMATED REPAYMENT WORKSHEET

Employee: ____________Employee, Injured____________________

DOI: ________01/23/2009___________

Total Amount Due to Agency to Repurchase Leave (Line 11):	$ 1424.69
LESS:	
Estimated OWCP Payment (Line 10):	$ 1068.52
Balance Due to Agency from Employee (line 13):	$ 356.17
LESS:	
FERS (.8%)/CSRS (7%) Retirement Deduction:	$ 11.40
OASDI (6.2%) *FERS only:	$ 88.33
Medicare (1.45%):	$ 20.66
ROUGH ESTIMATE DUE FROM EMPLOYEE:	$ 235.78

Estimated Leave Accrual Reduction:

SL = ____66______/20 = Loss of ___3.3_____ SL hours
Total # LBB Hrs

AL = ____________/*__________ = Loss of __________ AL hours
Total # LBB Hrs

*Leave Group 1 = 20
Leave Group 2 = 13
Leave Group 3 = 10

SAMPLE CA-7

Employee Portion

Claim for Compensation

Reset | Print

U.S. Department of Labor
Office of Workers' Compensation Programs

SECTION 1 — **EMPLOYEE PORTION**

a. Name of Employee — Last: **Employee** — First: **Injured** — Middle:

OMB No. 1240-0046
Expires: 05/31/2024

b. Mailing Address (*Including City State, ZIP Code*)
123 Main Street
Anytown **FL** **67890**

c. OWCP File Number
987654321

d. Date of Injury
Month Day Year
01/23/2009

e. Social Security Number
123-45-6789

E-Mail Address *(Optional)*

f. Telephone No./FAX No.
(222) 333-4444

SECTION 2 Compensation is claimed for:

		Inclusive Date Range From	To	Intermittent?		
a.	☐ Leave without pay			☐ Yes	☐ No	*Go to Section 3*
b.	☒ Leave buy back	03/10/2009	04/02/2009	☒ Yes	☐ No	*Go to Section 3, and Complete Form CA-7b*
c.	☐ Other wage loss; specify type, such as downgrade, loss of night differential, etc.			☐ Yes	☐ No	*Go to Section 3*
		Type:				
d.	☐ Schedule Award (*Go to Section 4)*					

If intermittent, complete Form CA-7a, Time Analysis Sheet

SAMPLE CA-7

SECTION 3 You must report **any and all** earnings from employment (**outside** your federal job); include any employment for which you received a salary, wages, income, sales commissions, or payment of **any** kind during the period(s) claimed in Section 2. Include self-employment, odd jobs, involvement in business enterprises, as well as service with the military. Fraudulently concealing employment or failing to report income may result in forfeiture of compensation benefits and/or criminal prosecution. ***Have you worked outside your federal job for the period(s) claimed in Section 2? Refer to the Instructions which provide further clarification.***

☐ Yes — Name and Address of Business:

Name | Address | City | State | ZIP Code

☒ No — *Go to section 4*

Dates Worked: | Type of Work:

SECTION 4 Is this the first CA-7 claim for compensation you have filed for this injury?

☒ Yes — *Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up"*

☐ No — If changes to dependent status, direct deposit information, or if a claim has been filed with the U.S. Civil Service Retirement, another federal retirement/disability law, or with Department of Veteran Affairs, complete Sections 5 through 7 or a new SF-1199A. If no, complete Section 7.

☐ Yes - *Complete Sections 5 through 7 or a new SF-1199A to reflect change(s)* ☐ No - *Complete Section 7*

SECTION 5 List your dependents (including spouse). If additional space is necessary, provide same information requested below on separate page(s) and include your name/claim number at the top of the page(s).

Name	Social Security #	Date of Birth	Relationship	Living with you? Yes	Living with you? No
Dependent Name	**666-55-4444**	**01/01/1960**	**Spouse**	☒	☐
				☐	☐

For dependents not living with you complete items a and b below. ,

a. Are you making support payments for a dependent noted above or on your attachment(s)? ☐ Yes ☒ No If Yes, support payments are made to:

Name | Address | City | State | ZIP Code

b. Were support payments ordered by a court? ☐ Yes ☒ No If Yes, attach copy of court order.

SECTION 6 a. Was/Will there be a claim made against a 3rd party? ☐ Yes ☒ No

b. Have you ever applied for or received disability benefits from the Department of Veterans Affairs?

☐ Yes ☒ No	Claim Number	Full Address of VA Office Where Claim Filed	Nature of Disability and Monthly Payment

c. Have you applied for or received payment under any Federal Retirement or Disability law?

☐ Yes ☒ No	Claim Number	Date Annuity Began	Amount of Monthly Payment	Retirement System (CSRS, FERS, SSA, Other)
				☐ CSRS ☐ FERS ☐ SSA ☐ Other

SAMPLE CA-7

Agency Portion

Employing Agency Portion
For first CA-7 claim sent, complete sections 8 through 15.
For subsequent claims, complete sections 12 through 15 only.

SECTION 8 Show Pay Rate as of	Additional Pay	Additional Pay	Additional Pay
Date of Injury: Base Pay Date: ______ $ ______ per ______ Grade: ______ step: ______	Type ______ $ ______ per ______	Type ______ $ ______ per ______	Type ______ $ ______ per ______
Date Employee Stopped Work: Date: ______ $ ______ per ______ Grade: ______ step: ______	Type ______ $ ______ per ______	Type ______ $ ______ per ______	Type ______ $ ______ per ______

Additional pay types include, but are not limited to: Night Differential (ND), Sunday Premium (SP), Holiday Premium (HP), Subsistence (SUB), Quarter (QTR), etc. (List each separately)

SAMPLE CA-7

Agency Portion

Employing Agency Portion
For first CA-7 claim sent, complete sections 8 through 15.
For subsequent claims, complete sections 12 through 15 only.

SECTION 8 Show Pay Rate as of	Additional Pay	Additional Pay	Additional Pay
Date of Injury: Date: 01/23/2009 — Base Pay $ 710.33 per week — Grade: 5 step: 4	Type ND $ 63.54 per week	Type SP $ 63.38 per week	Type HP $ 26.2 per week
Date Employee Stopped Work: Date: 01/23/2009 — $ 710.33 per week — Grade: 5 step: 4	Type ND $ 63.54 per week	Type SP $ 63.38 per week	Type HP $ 26.2 per week

Additional pay types include, but are not limited to: Night Differential (ND), Sunday Premium (SP), Holiday Premium (HP), Subsistence (SUB), Quarter (QTR), etc. (List each separately)

SAMPLE CA-7

Agency Portion

SECTION 9

a. Does employee work a fixed 40-hour per week schedule? ☐ Yes ☐ No

1. If Yes, circle scheduled days: ☐ S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S
2. If No, show scheduled hours for the two week pay period in which work stopped. Circle the day that work stopped.

FOR EXAMPLE ONLY

	S	M	T	W	TH	F	S
WEEK 1 From 5/14 to 5/20		8	4	6	(6)		
WEEK From 5/21 to 5/27		8		6	6		4

	S	M	T	W	TH	F	S
From ____ To ____							
From ____ To ____							

b. Did employee work in position for 11 months prior to injury? ☐ Yes ☐ No

If No, would position have afforded employment for 11 months but for the injury? ☐ Yes ☐ No

SECTION 10 On date pay stopped, was employee enrolled in:

a. Health Benefits under the FEHBP? ☐ No ☐ Yes Code ____

b. Basic Life Insurance? ☐ No ☐ Yes

c. Optional Life Insurance? ☐ No ☐ Yes Class ____ *(D-Z only)*

d. A Retirement System? ☐ No ☐ Yes Plan ____ *(Specify CSRS, FERS, Other)*

SAMPLE CA-7

Agency Portion

SECTION 9

a. Does employee work a fixed 40-hour per week schedule? ☐ Yes ☒ No

1. If Yes, circle scheduled days: ☐ S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S

2. If No, show scheduled hours for the two week pay period in which work stopped. Circle the day that work stopped.

FOR EXAMPLE ONLY

	S	M	T	W	TH	F	S
WEEK 1 From 5/14 to 5/20		8	4	6	(6)		
WEEK From 5/21 to 5/27		8		6	6		4

	S	M	T	W	TH	F	S
From 01/18 To 01/24	8	8	8		8	8	
From 01/25 To 1/31	8	8		8	8	8	

b. Did employee work in position for 11 months prior to injury? ☒ Yes ☐ No

If No, would position have afforded employment for 11 months but for the injury? ☐ Yes ☐ No

SECTION 10 On date pay stopped, was employee enrolled in:

a. Health Benefits under the FEHBP? ☐ No ☒ Yes Code **105**

b. Basic Life Insurance? ☐ No ☒ Yes

c. Optional Life Insurance? ☒ No ☐ Yes Class ______ *(D-Z only)*

d. A Retirement System? ☐ No ☒ Yes Plan **FERS** *(Specify CSRS, FERS, Other)*

SAMPLE CA-7

Agency Portion

SECTION 11 Continuation of Pay (COP) Received (*Show inclusive dates*):

From ______ To ______

Intermittent? ☐ Yes - Complete Time Analysis Sheet, Form CA-7a ☐ No

SECTION 12 Show pay status and inclusive dates for period(s) claimed:

		Intermittent?
Sick Leave From ______	To ______	☐ Yes ☐ No
Annual Leave From ______	To ______	☐ Yes ☐ No
Leave without Pay From ______	To ______	☐ Yes ☐ No
Work From ______	To ______	☐ Yes ☐ No

If intermittent, complete Form CA-7a, Time Analysis Sheet.

If leave buy back, also submit completed Form CA-7b.

SECTION 13 Did employee return to work? ☐ Yes ☐ No
If Yes, date ______

If returned, did employee return to the pre-date-of-injury job, with the same number of hours and the same duties?

☐ Yes ☐ No If No, explain: ______

SECTION 14 Remarks: ______

SAMPLE CA-7

Agency Portion

SECTION 11 Continuation of Pay (COP) Received (*Show inclusive dates*):

From **01/24/2009** To **03/09/2009**

Intermittent? ☐ Yes - Complete Time Analysis Sheet, Form CA-7a ☒ No

SECTION 12 Show pay status and inclusive dates for period(s) claimed:

	From	To	Intermittent? Yes	Intermittent? No
Sick Leave From	**03/10/2009**	**04/02/2009**	☒ Yes	☐ No
Annual Leave From			☐ Yes	☐ No
Leave without Pay From			☐ Yes	☐ No
Work From			☐ Yes	☐ No

If intermittent, complete Form CA-7a, Time Analysis Sheet.

If leave buy back, also submit completed Form CA-7b.

SECTION 13 Did employee return to work? ☒ Yes ☐ No

If Yes, date 03/20/2009

If returned, did employee return to the pre-date-of-injury job, with the same number of hours and the same duties?

☐ Yes ☒ No If No, explain: **Returned limited duty**

SECTION 14 Remarks:

SAMPLE CA-7

Agency Portion

SECTION 15 An employing agency official who knowingly certifies to any false statement, misrepresentation, or concealment of fact with respect to this claim (or impedes the filing of a claim) may also be subject to appropriate criminal prosecution.

I certify that the information given above and that furnished by the employee on this form is true to the best of my knowledge, with any exceptions noted in Section 14, Remarks, above.

Signature ______________________ Title ____________ Date __/__/__

(*Agency Official*)

Name of Agency ______________________

Date Claim Form Received from Employee __/__/__

If OWCP needs specific pay information, the person who should be contacted is:

Name ______________________ Title ______________________

Telephone No. __________ Fax No. __________ E-Mail Address __________

Questions ?

CONTACT INFO

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