FIRE & POLICE PENSION PLANS
TIERS 3, 4, 5, 6

DISABILITY RETIREMENT

GENERAL INFORMATION SUMMARY BOOKLET

Application - Processing - Options

CITY OF LOS ANGELES
Fire and Police Pension System

Department of Fire and Police Pensions

701 East 3rd Street, Suite 200
Los Angeles, California
90013

Revised May 2025

EVERY EFFORT HAS BEEN MADE TO PROVIDE ACCURATE INFORMATION IN THIS BOOKLET. IF THERE IS A DIFFERENCE BETWEEN THE CONTENTS OF THIS BOOKLET AND THE CHARTER/ADMINISTRATIVE CODE, THE PROVISIONS OF THE CHARTER/ADMINISTRATIVE CODE SHALL APPLY.

TABLE OF CONTENTS

DISABILITY RETIREMENT

TYPES OF DISABILITY PENSIONS

Pensions are granted for disabling impairments resulting from injuries or illnesses that are:

- DUTY RELATED - Service-Connected Disability Pension
- NOT DUTY RELATED - Nonservice-Connected Disability Pension

If you believe you are incapable of performing the duties of a sworn employee of the Fire, Police, Airport, or Harbor Department, including light or restricted duties, you may be eligible for disability pension benefits. Members who believe they are eligible for disability retirement should file an application with the Department of Fire and Police Pensions.

ELIGIBILITY FOR DISABILITY RETIREMENT

It is important to understand that the existence of impairment or a Workers' Compensation award does not guarantee a disability pension. You may have impairment(s) but not be disabled from performing the duties of an officer or firefighter if your department can accommodate your work restrictions. Decisions of the Workers' Compensation Appeals Board are not binding in disability claims involving applicants subject to the provisions of Tiers 3-6.

SERVICE-CONNECTED: For impairments that are determined by the Board of Fire and Police Pension Commissioners (Board) to be disabling and work related, members are eligible from the date they graduate from basic training. (Plan membership typically commences upon administration of the Oath of Office.) For an impairment to be considered work related there must be **clear and convincing evidence** that the discharge of duties is the predominant cause.

The exact amount of a service-connected disability pension depends on the percentage of disability determined by a rating schedule adopted and used by the Board. The range for service-connected disability pensions is 30% - 90% of your final average salary, but never less than 2% for each year of service.

In order for injuries received during basic training to be eligible for consideration as work related, you must purchase your recruit training time. See LENGTH OF SERVICE on the following page.

NONSERVICE-CONNECTED: For impairments that are determined by the Board to be disabling and non-work related, members are eligible following the completion of five years of service. The amount of a nonservice-connected disability pension is 30% - 50% of your final average salary, based on level of impairment/disability.

Members who elect to receive a refund of contributions forfeit any right to future benefits, including disability benefits.

LENGTH OF SERVICE

Length of service credit for service-connected disability pensions is calculated differently than length of service credit for service pensions. [For Tier 5, credit for service retirement is calculated at 50% at 20 years of service and 3% per year for each additional year after 20 years, except on the thirtieth year of service for which 4% shall be provided. For Tier 6, credit for service retirement is calculated at 40% at 20 years of service and 3% per year for each additional years up to 25, 4% shall be provided per year for years 26 - 30, and 5% per year shall be provided for years 31 – 33. The maximum percentage of Final Average Salary for 33 or more years of service for Tiers 5 and 6 shall be 90%]. Credit for service-connected disability retirement is calculated at 2% per year of service up to a maximum of 90%.

Members have the option to increase their total qualifying service time by purchasing service credit for the time spent in recruit training, prior LAFPP membership, time off on nonservice-connected disability pension, time off on Workers' Compensation State Rate, training time prior to paramedic certification and military/other government service time (maximum four years - Public Service Purchase Program). This purchase may have an impact on the minimum level of service-connected disability pension benefits you can receive, especially for members who have service credit that is near, equal to or in excess of 15 years. To exercise this option, you must:

- Apply before or at the time of filing for retirement
- Complete the purchase before your retirement becomes effective

If you are interested in pursuing this option, notify your Benefits Analyst as early in the application process as possible and you will be referred to Active Member Services who is responsible for coordinating all service credit purchases.

WHEN TO APPLY

It may take up to a year or more to process a disability pension application. Some applications may take longer as a result of circumstances or complications specific to your claim. The decision of when to file is yours.

Filing after using at least 6 months of your IOD time will most likely result in you spending some time on "State Rate". It is important that you plan ahead in order to avoid or prepare for the reduced level of monthly income. (Employees on State Rate may elect to use compensated time off to supplement State Rate to receive the equivalent of their regular salary. {Andersen v. Workers' Compensation Board}). Please see PENSION EFFECTIVE DATE on page 9.

SERVICE PENSION CONVERSION

Members applying for a disability pension must sign a service retirement waiver prior to the disability hearing because once a disability pension is awarded it cannot be converted to a service retirement at a later date.

Members retired on a service pension have one year from the date a service pension becomes effective to apply for a disability pension. If you have a pending/unresolved Workers' Compensation claim that was filed before or within one year of the effective date of your service pension, you have one year from the date the Workers' Compensation claim is resolved to file for disability pension benefits.

If you file your application for disability benefits and then take a service retirement before the disability application process is completed, or, if you are on service retirement and apply for disability benefits, you are required to demonstrate to the Board that the disabling condition(s) were present on the day of your service retirement and have been continuous to the day of the disability pension hearing. If you cannot, your application will be denied.

Impairments occurring **after** service retirement cannot be used to support a claim for disability pension benefits.

RESIGNED/TERMINATED MEMBER ELIGIBILITY FOR DEFERRED PENSION

A "resigned member" is a former Plan member who terminates employment for any reason except for death or disability. Tier 5 and 6 members who resign after completing 20 or more years of service (10 years for Tier 3) are considered "vested members". They may elect to leave their contributions in the fund in order to receive a deferred service pension upon reaching 50 years of age. (Tier 4 is not eligible for a deferred pension option.)

Resigned members have one year from the effective date of resignation/termination to apply for a disability pension. If you have a pending/unresolved Workers' Compensation claim that was filed before or within one year of the effective date of resignation, you have one year from the date the Workers' Compensation claim is resolved to file for disability benefits. If you have an open/unresolved administrative challenge to your discharge from duty, you have one year from the date it is resolved to file for disability benefits.

If you file your application for disability benefits and then resign before the disability application process is completed, if you resign and then apply for disability benefits, or if you file your application after you are discharged, you must demonstrate to the Board that the disabling condition(s) were present on the date of your resignation/discharge and have been continuous to the day of the disability pension hearing. If you cannot, your application will be denied.

Impairments occurring **after** resignation/termination cannot be used to support a claim for disability pension benefits.

A resigned member applying for a disability pension must sign an Acknowledgment and Waiver form prior to the disability hearing because once a disability pension is awarded it cannot be converted to a service pension at a later date.

THE DISABILITY APPLICATION PROCESS

MEDICAL DOCUMENTATION

You will be required to furnish the names and addresses of doctors, clinics, and hospitals previously examining or treating you. Processing time depends on the accuracy and completeness of this information. Prior reports and test results may become part of your file as well as any relevant documents from your Workers' Compensation file.

THE ADMINISTRATIVE FILE

Your claim file, known as the Administrative File, will be compiled by your Benefits Analyst. The Administrative File is the official record of your disability application and the Board will review its contents before making a decision on your application. The Administrative File may contain:

- Medical examination reports
- Medical test results
- Reports of X-rays or other diagnostic procedures
- Workers' Compensation records
- Surgical records and hospital stays
- Physical Therapy records
- Military records
- Documents from your department
- Other related information or documents determined to be relevant by LAFPP staff

The following parties will have access to your Administrative File:

- The applicant
- Department of Fire and Police Pensions Disability Pensions Section staff
- Your attorney or representative (if applicable)
- Your Department's Medical Liaison
- The City Attorney
- The Board of Fire and Police Pension Commissioners

MEDICAL EXAMINATIONS

The City Charter and Administrative Code require that a disability pension applicant be examined by at least three doctors selected and paid for by the Department of Fire and Police Pensions. Additional specialists may be required for multiple impairment claims. The Department of Fire and Police Pensions maintains an independent list of physicians separate from the Workers' Compensation process as much as possible. The doctors are monitored and evaluated to ensure an unbiased, accurate evaluation and report. Be advised that:

- Pension doctor evaluations will be conducted in the Southern California region. You are responsible for all travel costs for your appointments, including parking.
- If you miss a scheduled appointment, processing of your application will be suspended until you pay the cost of the missed appointment and any costs related to the rescheduling of that appointment.
- If you refuse to be examined, processing of your application will be suspended.
- The Department of Fire and Police Pensions will not pay for any tests, examinations, or reports that you or your representative request.
- Do not submit any documents to the pension doctors or attempt to contact them (except to confirm your appointment) unless you've been specifically directed to do so by your Benefits Analyst.

BEFORE THE HEARING

After the disability examination reports and other relevant information required to complete the Administrative File are received, your Benefits Analyst will schedule a date for the Board hearing with you or your attorney/representative. You will be notified of the date, time, and location several weeks in advance. Your Administrative File will be available for your review during normal business hours for at least one week prior to the hearing.

Your Benefits Analyst and LAFPP Management will formulate a recommendation regarding resolution of your application. This recommendation will be submitted to the Board along with your Administrative File. The recommendation will consist of 4 elements:

- Do the impairments constitute disability?
- Is the disability service- or nonservice-connected?
- Pension percentage rate
- Scheduling of a future review

You or your representative will be informed of the recommendation and requested to return a form stating your agreement or disagreement with the recommendation.

THE DISABILITY HEARING

THE BOARD OF FIRE AND POLICE PENSION COMMISSIONERS

The Board is composed of nine Commissioners. Five are appointed by the Mayor, two are elected employee representatives, one each from the Fire and Police Departments, and two are elected retired members, one each having retired from the Fire and Police Departments. Five Commissioners need to be present to establish a quorum for disability hearings. A minimum of five affirmative votes is always required to grant or deny an application for a disability pension.

A copy of your Administrative File will be given to each Commissioner for study prior to your hearing.

REPRESENTATION

You may have legal counsel appear before the Board on your behalf. However, it is not necessary that you be represented by an attorney. If you choose to represent yourself or be represented by someone other than legal counsel, you may suspend the proceedings at any time during the hearing, without prejudice to your claim, to obtain legal counsel. If you were not represented by legal counsel at your hearing, within 90 days of the Board's decision, you may request a rehearing specifically to obtain legal representation.

ADDITIONAL DOCUMENTS & WITNESSES

If you have additional documents to submit for the Board to consider, or if you have witnesses you wish to appear on your behalf, the documents and/or a list of witnesses and a summary of their testimony must be submitted to your Benefits Analyst no less than 10 working days prior to the hearing. You must pay any witness fees for witnesses you have called.

TYPE OF HEARING

If you agree with the staff recommendation, the Board will conduct an abbreviated hearing, commonly referred to as an "Alt 1," which the applicant and/or the applicant's representative are not required to attend. Attendance is optional.

If the Board rejects or wishes to alter one or more of the previously agreed to elements of the recommendation, resolution of your application will be deferred. Your Benefits Analyst will reschedule your hearing so you and/or your representative may be present.

If you do not accept the recommendation, the Board will conduct a regular hearing as described below.

AT THE HEARING

- You will be sworn in.
- Your hearing will be conducted by the Commissioner who has been assigned lead responsibility for your application.
- You will be asked to accept the Administrative File into evidence and if you have any objections to the contents of the file.
- You or your representative will be invited to present your case, which usually begins in a question/answer format.
- Witnesses will be sworn in and given the opportunity to testify regarding your application.
- You and the witnesses may also be questioned by any of the Board members.
- If requested by the Board, the medical liaison representative from your Department will be sworn in and will provide testimony concerning the availability of a job which can accommodate your impairment(s) or restriction(s) as reported by the pension doctors.
- You will be given an opportunity to speak on your own behalf.
- The Board will deliberate and render its decision.

NOTIFICATION OF DECISION

At the conclusion of your hearing, you will be informed of the Board's decision by your attorney, representative, or Benefits Analyst. You will receive official written notification, via U.S. Mail, of the Board's action shortly after the hearing.

PENSION EFFECTIVE DATE

You will be provided with a form to designate the 12-month period (24-month period for Tier 6) to establish your Final Average Salary for calculating your pension benefit, and your pension effective date. The effective date shall be no earlier than the latest of:

- The first day following the last day on payroll (i.e., salary/vacation/sick); or
- The first day following the last day on IOD or State Rate time; but
- Not later than the date of the Board hearing first granting a pension based on length of service or disability.

PLEASE BE REMINDED: Reinstatement to active payroll for any purpose permanently changes the earliest possible effective date of your pension. If you use your accrued/accumulated overtime/vacation/sick time because it provides more income than State Rate payments alone, your pension effective date shifts forward. You will not be eligible to receive retroactive pension benefits for any time prior to the new earliest date.

The designation form must be completed and returned before your hearing. Failure to do so could delay issuance of your first pension check by 1-2 months.

REHEARINGS

If your application is denied, or if you disagree with the percentage you were awarded, you may request a rehearing provided the request is made WITHIN 90 DAYS of the Board's Adoption of the Findings of Fact, subject to the following:

- If you represented yourself and choose to represent yourself again at the rehearing or you had an attorney, your rehearing can only be requested based on and supported by new or different evidence which, in the exercise of due diligence, could not have been made available by the applicant to the Board at the time of the original hearing. This new or different evidence, **submitted with your request**, will be reviewed by your Benefits Analyst and the City Attorney before it is forwarded with a staff recommendation to the Board for decision. The actual rehearing to consider the new or different evidence may take place immediately or be scheduled on a future agenda.

- If you were not represented by legal counsel at your original hearing (does not include Union representation), and you are requesting a rehearing on the basis of having retained legal representation, you will be required to submit a completed ATTORNEY AUTHORIZATION form to support your request.

  NOTE: IF YOU WERE REPRESENTED BY LEGAL COUNSEL at the first hearing, you can only request a rehearing based on and supported by the new or different evidence requirement stated above.

NEW APPLICATION OR REAPPLICATION

You may file a new application **after** 90 days from the Adoption of the Findings of Fact only if you are reinjured, a previously denied condition becomes worse, or you sustain a new injury. You must submit medical proof of the above along with your new application. (Note: Tier 6 terminated or resigned members cannot file a new application for a previously denied claim.)

DISABILITY PENSION REVIEWS

A disability pension is granted based on the existence of a physical or psychological impairment. Under the Charter/Administrative Code, the Board retains the right to review your disability pension at any time.

You also retain the right to request a review of your disability pension if you believe that the injury/illness for which you were originally granted a disability pension has deteriorated.

Only claimed impairments that were found to be disabling by the Board at your original hearing will be considered in the review process. Therefore, any adjustment to your percentage amount will be based only on improvement or deterioration of the original impairments. There are four possible outcomes of a review:

- If the disability is found to no longer exist -
  On disability pension for less than 5 years - If there is a job available for you in your original department, your disability pension will be terminated effective the date of your restoration to active duty or, if you fail to report, the date you were ordered to return to duty.

  On disability pension for 5 or more years - Your disability pension may be reduced to 30%. This will occur even if you are entitled to more than 30% based on your length of service (equal to or greater than 15 years of service at 2% per year).

  If your active status was terminated by reason of resignation or discharge, regardless of your length of service or time on a disability pension, your disability pension will be terminated.

- If the disability is still present, but to a lesser degree, the pension percentage could be lowered.

- If the disability is still present and has not changed, the pension percentage could remain the same.

- If the disability has worsened, the pension percentage could be increased.

Failure to cooperate with the review process may be cause for disability pension benefits to be withheld or terminated.

A disability pensioner returned to work may receive credit toward service retirement for the time spent on a disability pension. After remaining on the job continuously for one year, a returned disability pensioner restores disability time at a day for day conversion rate.

After three years of continuous duty, the entire disability pension time will be restored for purposes of calculating length of service. Pensioners who return from a nonservice-connected disability pension are required to pay pension contributions to purchase time spent on disability pension if that time is to be credited toward length of service.

If you return to duty from a disability pension you cannot receive a refund of contributions at a later date for service prior to receiving the disability pension.

WORKERS' COMPENSATION

The Board renders disability retirement decisions independently of Workers' Compensation. Even though you may have a Workers' Compensation award, it does not automatically entitle you to a disability pension, or if the Board finds you disabled, to a service-connected disability pension.

AWARD REPAYMENT

If you receive a disability pension, all Workers' Compensation awards you received or are currently receiving must be paid back to the City. This includes all injuries for which you filed a Workers' Compensation claim and received benefits, not just the one(s) for which you received your disability pension. Offset against your pension will be cash award(s) (which includes the amount the Workers' Compensation Appeals Board took out of your award(s) to pay your attorney for representing you) and State Rate/permanent disability payments. The two forms of recapture are described below: Workers Compensation award(s) received prior to your disability pension effective date shall be paid back either as a lump sum or in the form of a minimum 25% deduction from your total monthly gross disability pension benefit until the entire amount is repaid. (Up to 100% of any retroactive pension payment will be applied to Workers' Compensation offset.)

Workers Compensation award(s) that continued beyond your disability pension effective date shall be paid back as a dollar-for-dollar offset until the entire amount is repaid.

TAXES

SERVICE-CONNECTED DISABILITY PENSIONS - are not taxed up to the percentage the Board establishes using the disability rating worksheet. If you are granted an additional percentage based upon years of service, this amount is taxable. (For example: a member with 20 years of service is entitled to 40%, however, the Board determines their disability rating to be 10% based on the worksheet. The difference between 10% and 40% is taxable, therefore, 75% of your pension is taxable and 25% is tax-free.). Please note that any community property paid to a service-connected disability pensioner's former spouse will be fully taxable.

NONSERVICE-CONNECTED DISABILITY PENSIONS - are fully taxable.

QUALIFIED SPOUSE/DOMESTIC PARTNER'S ELIGIBILITY FOR SURVIVOR BENEFITS

If you are granted a service-connected disability pension you are required to be married to your spouse, or have declared a domestic partner, on the effective date of disability retirement in order for the spouse or domestic partner to be eligible for survivor benefits.

If you are granted a nonservice-connected disability pension, the date of your marriage, or declaration of domestic partnership, must be at least one year prior to the pension effective date in order for the spouse or domestic partner to be eligible for survivor benefits.

If your eligible spouse or domestic partner dies and you remarry while receiving a pension, your new spouse or domestic partner is not eligible for any survivor benefits, unless you elect to participate in the Survivor Benefit Purchase Program administered by the Retirement Services Section.

COMMUNITY PROPERTY AND YOUR PENSION

Whether or not there is a community property interest in your disability pension is an issue to be determined between you and your spouse (or State registered domestic partner) in any legal action involving your marriage (or State registered domestic partnership). Upon request, the Plan will provide a copy of the "Sample 'Domestic Relations Order' Provisions" prepared by the City Attorney's Office for the Fire and Police Pension Plan, which discusses this issue in some detail. If your marriage or State registered domestic partnership is legally terminated, a copy of the notice of entry of judgment (or other proof of termination of the relationship) should be filed with your pension records. You are not required to provide a copy of the judgment disposing of your pension benefits unless there is a community property claim on file with the Plan or the Plan has been joined.

DOMESTIC PARTNERSHIP

In order for a domestic partner to qualify for Plan benefits, a Declaration of Domestic Partnership or similar documentary proof of domestic partnership filed with another agency/City Department, must be submitted. Acceptable documentary proof includes a copy of a State of California Affidavit/Declaration of Domestic Partnership, a copy of an affidavit or declaration of domestic partnership filed with another City Department, or similar documentary proof of a domestic partnership filed in another jurisdiction, subject to legal review by the Office of the City Attorney.

A "Notice of Termination of Domestic Partnership" form must be similarly filed once a partnership that is on file with the Department of Fire and Police Pensions has ended. A State-registered domestic partnership can only be terminated as provided in the Family Code.

SURVIVOR RECORDS & DOCUMENTS

To facilitate the granting of survivor benefits, you are strongly advised to provide the Department of Fire and Police Pensions with copies of your current marriage certificate, Declaration of Domestic Partnership, divorce documents from prior marriages, termination(s) of prior domestic partnership(s), copies of birth certificates of children under age 18, or age 22 if the child is still in school (the ages at which minors benefits are terminated), or dependent children. A medical report documenting a dependent child's medical condition (i.e., disabled from earning a livelihood) and the onset of that condition is also critical. Copies of these documents are sufficient. Send documents to:

DEPARTMENT OF FIRE AND POLICE PENSIONS
701 East 3rd Street, Suite 200
Los Angeles, California 90013
ATTN: Disability Pensions Section
(Name of Your Benefits Analyst)

POST-RETIREMENT MEDICAL EXPENSES

The Department of Fire and Police Pensions does not pay medical expenses for any purpose other than Board-mandated review examinations after you retire. If you have questions regarding health insurance subsidies that you may be entitled to receive beginning at age 55, please contact the Medical and Dental Benefits Section at (213) 279-3115.

If you have questions regarding ongoing treatment of IOD injuries, please contact one of the following Workers' Compensation administrators:

Fire Claims:	**Sedgwick**	
	Telephone:	(855) 238-1500
	Fax:	(833) 784-2351
	Address:	P.O. Box 2450, Brea, CA 92822
Police Claims:	**Intercare**	
	Telephone:	(888) 434-0414
	Fax:	(818) 476-4401
	Address:	P.O. Box 4387, Glendale, CA 91222
Harbor Claims:	**ACME**	
	Telephone:	(213) 473-3400
	Fax:	(213) 473-3333
	Address:	700 E. Temple St., 2nd Floor, Los Angeles, CA 90012
Airport Claims:	**LAWA Risk Management – Workers' Comp. Division**	
	Telephone:	(424) 646-5480
	Email:	workcompclaims@lawa.org
	Address:	7301 World Way West, 2nd Floor, Los Angeles, CA 90045

DEPARTMENT OF FIRE AND POLICE PENSIONS

701 E. 3RD STREET
SUITE 200
LOS ANGELES, CA 90013

(213) 279-3000 (Main Line)
(844) 88-LAFPP (52377) - TOLL FREE
FAX (213) 628-7716
TDD (213) 628-7713

EMAIL: PENSIONS@LAFPP.COM

CITY OF LOS ANGELES
CALIFORNIA

KAREN BASS
MAYOR

JOSEPH SALAZAR
GENERAL MANAGER

MYO THEDAR
EXECUTIVE OFFICER

GREGORY MACK
ASSISTANT GENERAL MANAGER

BRYAN A. FUJITA
CHIEF INVESTMENT OFFICER

INITIATION OF APPLICATION

Attached please find the following forms necessary to apply for a disability pension:

_____ Application for Pension Benefits (DF151a) including a Color Copy of Valid Government Issued Driver's License or City Issued ID
_____ Applicant's Statement of Disability and Service-Connection (DF208 – 3 pgs)
_____ Report of Outside Employment (DF310)
_____ Authority to Release Medical and Psychiatric Records (DF210)
_____ Authority to Release Employment Records (DF211)
_____ Authority to Release Substance Abuse Patient Records (DF212)
_____ Acknowledgement and Waiver (DF218 – 3 pgs)
_____ Attorney Authorization (DF214)/Representative Authorization (DF214.2) if applicable

The documents below are to be completed and returned to the Benefits Analyst as soon as your Board date is scheduled. Your Board Hearing will be continued if these forms are not received.

_____ Final Average Salary Designation (DF220 – 6 pgs)
_____ Optional Pension for Qualified Surviving Spouse/Domestic Partner (DF222 – 6 pgs)
_____ Payroll Status Information/Pension Effective Date Designation (DF223 – 2pgs)

Complete them as legibly as possible and return them to the above address.

Also included is a 14-page General Information Summary Booklet. If you have any questions, please call (213) 279-3165 or email disability@lafpp.com. Thank you.

Kyle Susswain
Manager
Disability Pensions Section

APPLICATION FOR DISABILITY PENSION BENEFITS

Applicant Name: _____

Other Names Used: _____

Telephone: Cell ( )_____ Telephone: Home ( )_____ Telephone: Work ( ) _____

Email:_____ SSN: XXX -XX -_____

Home Address:_____ City/State/Zip Code: _____

Date of Birth:_____ Department: □ Police □ Fire □ Harbor □ Airport

Present Rank/Paygrade Level:_____ Date of Hire:_____ Pension Tier: _____

Type of Disability Pension Applying For: ☐ Nonservice-Connected ☐ Service-Connected

Effective date of: ☐ Service Pension ☐ DROP ☐ Resignation ☐ Termination____/____/_____

■ ———————————————————————————

CURRENT Spouse/Domestic Partner

_____ _____/_____/_____ XXX - XX -_____

Name DATE OF BIRTH SSN

_____/_____/_____

DATE OF MARRIAGE/DOMESTIC PARTNERSHIP AFFIDAVIT

■ ———————————————————————————

CHILDREN*:* Unmarried biological/legally adopted (Children remain eligible for survivor benefit up to age 22 if full-time student and unmarried. Disabled children may be eligible for lifetime survivor benefits.)

_____ _____ ____/____/_____XXX-XX-_____

Name PLACE OF BIRTH DATE OF BIRTH SSN

_____ _____ ____/____/_____XXX-XX-_____

Name PLACE OF BIRTH DATE OF BIRTH SSN

_____ _____ ____/____/_____XXX-XX-_____

Name PLACE OF BIRTH DATE OF BIRTH SSN

■ ———————————————————————————

FORMER Spouse/Domestic Partner

_____ _____/_____/_____ XXX -XX -_____

Name DATE OF BIRTH SSN

_____/_____/_____ _____/_____/_____

DATE OF MARRIAGE/DOMESTIC PARTNERSHIP AFFIDAVIT DATE OF DIVORCE/DOMESTIC PARTNERSHIP TERMINATION

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☐ I have attached a color copy of my valid government issued driver's license or City Issued ID. I declare under penalty of perjury that all of the foregoing is true and correct.

Signature_____ Date Signed: _____

Department of Fire and Police Pensions Use Only: Application Filed: _____

Original Date of Appointment/Plan Membership:_____/____/_____ □ Tier 3 □ Tier 4 □ Tier 5 □ Tier 6

Aggregate Years of Service: _____

APPLICANT'S STATEMENT OF DISABILITY AND SERVICE-CONNECTION

City of Los Angeles
DEPARTMENT OF FIRE AND POLICE PENSIONS
701 East 3rd Street, Suite 200
Los Angeles, CA 90013
P: (213) 279-3165 F: (213) 628-7782

1. NAME	2. RANK/PAYGRADE LEVEL	3. DEPARTMENT
4. WHERE ASSIGNED: Area, Division, Battalion	5. SOCIAL SECURITY # XXX-XX-	6. SERIAL #

7. DISABILITY (State the nature of the illness or injury that keeps you from performing your job duties):

A. Illness or Injury (Body Parts)	Date(s)

B. Doctors or Hospitals where Treated	Date(s)
Name	
Address	
Name	
Address	
Name	
Address	

8. SERVICE CONNECTION: If your illness or injury was caused by the performance of your duties as a firefighter, paramedic, or police officer please briefly describe. (If NONSERVICE- CONNECTED check here: ☐)

9. Doctors or hospitals where treatment has been rendered for other than those illnesses or injuries claimed (e.g., family physician, medical clinic, or Health Maintenance Organization such as Kaiser, Blue Cross, etc.).

NAME Address

NAME Address

NAME Address

PLEASE READ THE FOLLOWING CLOSELY BEFORE SIGNING

By initialing the following, I attest that I have read and understand that:

_____ 1. In order to receive disability pension benefits under the provisions of the City Charter, the Board of Fire and Police Pension Commissioners must have sufficient evidence to find that I am incapable of performing duties that may be assigned and that my incapacity is the result of work-related injuries if I am claiming service-connection. The Administrative File, created in the course of the disability application process, may also be supplemented by other evidence pertinent and relevant to the issues of disability and service-connection.

_____ 2. The medical and personnel information contained in my Administrative File will be available to individuals involved in the processing of my claim, including but not limited to, the Board of Fire and Police Pension Commissioners, City Attorney staff, physicians performing disability evaluations for the Board, Personnel Department and contracted Workers' Compensation staff, and my Department's Medical Liaison.

_____ 3. I have, at my own expense, the option to be represented by legal counsel in the proceedings before the Board of Fire and Police Pension Commissioners or I may request the assistance of an employee organization. Should I choose to secure representation, I shall notify the Department of Fire and Police Pensions in writing within ten (10) days of obtaining representation.

_____ 4. If I am granted a disability pension and also receive a Workers' Compensation award or have already received a Workers' Compensation award or Workers' Compensation payments, the amount of the award and/or payments will be fully recovered by the City of Los Angeles as provided in City Charter section 1212. The Manager-Secretary is authorized to reduce the monthly pension amount payable to me on an installment basis until the total amount of compensation has been offset. This installment reduction shall be at the discretion of the Manager-Secretary but shall not be less than twenty-five percent (25%) of the gross monthly pension amount which would be payable but for the offset. Up to 100% of any retroactive pension payment will be applied to Workers' Compensation offset.

_____ 5. Reinstatement to payroll for any purpose permanently changes the earliest possible effective date of my pension. If I use my accrued/accumulated overtime/vacation/sick time because it provides more income than State Rate payments, my pension effective date shifts forward. I will not be eligible to receive retroactive pension benefits for any time prior to the new earliest effective date. Also, it is my responsibility to contact Active Member Services if I wish to purchase service credit (Academy, State Rate, Lost Service Time, etc.)

_____ 6. If I am granted a disability pension, my medical and pension status are subject to review by the Board of Fire and Police Pension Commissioners at its discretion and upon its order. I also have the right to request a review of my medical status at any time I believe the medical condition(s) upon which my disability pension is based has deteriorated. Any work or daily activities that I perform after my pension is granted must be within the restrictions/limitations for which the disability pension is based. Any activities that are not consistent with these limitations may result in a review of my disability pension by Staff and the Board.

I declare under penalty of perjury that all of the foregoing is true and correct.

Date Signature

REPORT OF OUTSIDE EMPLOYMENT

I have had the following outside employment and/or work permits since the date I was hired by the City of Los Angeles to the present. If you have had no outside employment, write "NONE."

DATES OF EMPLOYMENT		NAME, ADDRESS & PHONE NO. OF EMPLOYER	JOB DESCRIPTION	NO. HOURS WORKED PER WEEK
FROM	TO			

THIS DOCUMENT WILL BE INCLUDED IN THE ADMINISTRATIVE FILE

The member declares under penalty of perjury that all of the foregoing is true and correct to the best of applicant's knowledge or information.

_____ SIGNATURE

_____ DATE

AUTHORITY TO RELEASE MEDICAL AND PSYCHIATRIC RECORDS
OF

_____ _____
(Print Full Name) (Cell/Home/Work Phone #)

_____ _____
(Last Four of Social Security #) (Birth Date)

Date:

To:

Send Records To:

THE CITY OF LOS ANGELES
DEPT. OF FIRE AND POLICE PENSIONS
Disability Pensions Section
701 E. 3rd Street, Suite 200
Los Angeles, CA 90013

This will be your authority to release to the Department of Fire and Police Pensions (LAFPP) and the Board of Fire and Police Pension Commissioners of the City of Los Angeles any information requested in connection with the medical history of the above-named individual, including all records relating to any Workers' Compensation claims. This information is to be used only in the processing or review of an application for disability pension benefits. I further authorize the Department of Fire and Police Pensions and the Board of Fire and Police Pension Commissioners to release such information to pension doctors on behalf of said Board. This authorization shall be considered valid for five (5) years from the date signed. (Copies of this authorization will be considered as valid as the original.)

_____ _____
(Date) (Authorized Signature)

Please release the following records:

☐ Emergency Room Reports
☐ All Hospitalization Records
☐ Admission Reports
☐ Physical Exam/History
☐ Operation Reports
☐ Discharge Summary
☐ Workers' Compensation Records
☐ Doctor's Reports
☐ Treatment Records
☐ Imaging Reports
☐ Test Results
☐ Psychiatric Records

Other:_____

LAFPP is not a healthcare provider, healthcare clearinghouse, or health plan, therefore, "is not" subject to HIPAA regulations. (Public Law 104-191: Section 1171)

Your prompt attention to this matter will be appreciated. If you have any questions, feel free to call Benefits Analyst_____at the Department of Fire and Police Pensions, Disability Section: (213) 279-3165, Fax (213) 628-7782.

[The person releasing the above-described records, as well as the patient to whom it pertains, are entitled to receive a copy of this authorization upon demand. (California Civil Code, Part 2.6 Section 56 et. seq. added by Stats 1981A "Confidentiality of Medical Information Act")].

DF210 (5/25)

AUTHORITY TO RELEASE EMPLOYMENT RECORDS
OF

_____
(Name)

_____ _____
(Social Security #) (Birth Date)

Date:

To:

Send Records To:

THE CITY OF LOS ANGELES
DEPT. OF FIRE AND POLICE PENSIONS
Disability Pensions Section
701 E. 3rd Street, Suite 200
Los Angeles, CA 90013

This will be your authority to release to the Department of Fire and Police Pensions and the Board of Fire and Police Pension Commissioners of the City of Los Angeles the following information requested in connection with the employment history of the above-named individual.

Please provide the below-named Benefits Analyst at the Department of Fire and Police Pensions with copies of any and all personnel records including all disciplinary files, job description, position title, performance evaluations, payroll records, length of employment, hours worked, sick or injury reports, pre-employment physical examination records, and date and time of absences from work.

This information is to be used only in the processing or review of an application for disability pension benefits. I further authorize the Department of Fire and Police Pensions and the Board of Fire and Police Pension Commissioners to release such information to pension doctors on behalf of said Board. This authorization shall be considered valid for five (5) years from the date signed. (Copies of this authorization will be considered as valid as the original.)

_____ _____
(Date) (Signature)

Your prompt attention to this matter will be appreciated. For clarification or further information, please feel free to contact Benefits Analyst_____at (213) 279-3165, Fax (213) 628-7782.

[The person releasing the above-described records, as well as the patient to whom it pertains, are entitled to receive a copy of this authorization upon demand. (California Civil Code, Part 2.6 Section 56 et. seq. added by Stats 1981A "Confidentiality of Medical Information Act")].

AUTHORITY TO RELEASE SUBSTANCE ABUSE PATIENT RECORDS
OF

_____
(Name)

_____ _____
(Last Four of Social Security #) **(Birth Date)**

Date:

To:

Send Records To:

THE CITY OF LOS ANGELES
DEPT. OF FIRE AND POLICE PENSIONS
Disability Pensions Section
701 E. 3rd Street, Suite 200
Los Angeles, CA 90013

I,_____, hereby authorize_____
(Name) (Name of Organization)

This will be your authority to release information and records pertaining to the treatment and/or hospitalization of the above-named individual for substance abuse or chemical dependency to the City of Los Angeles Department of Fire and Police Pensions and the Board of Fire and Police Pension Commissioners.

Disclosure of requested records shall be limited to the following specific types of information: admission summaries; history and physical examination reports; laboratory data including blood chemistries and urinalyses; treatment reports; pharmacy and prescription orders; physicians', therapists', and nurses' notes/orders; and discharge summaries.

The purpose of this request for records is to assist the Department of Fire and Police Pensions in the processing or review of an application for disability pension benefits. This authorization shall be considered valid for five (5) years from the date signed.

I certify that I have read, understand, and agree with the above provisions of this consent.

_____ _____
(Date) (Signature)

LAFPP is not a healthcare provider, healthcare clearinghouse, or health plan, therefore, "is not" subject to HIPAA regulations. (Public Law 104-191: Section 1171)

Your prompt attention to this matter will be appreciated. If you have any questions, feel free to call Benefits Analyst_____at the Department of Fire and Police Pensions, Disability Section: (213) 279-3165, Fax (213) 628-7782.

[The person releasing the above-described records, as well as the patient to whom it pertains, are entitled to receive a copy of this authorization upon demand. (California Civil Code, Part 2.6 Section 56 et. seq. added by Stats 1981A "Confidentiality of Medical Information Act")].

ATTORNEY AUTHORIZATION

The City of Los Angeles
Department of Fire and Police Pensions
Disability Pensions Section
701 E. 3rd Street, Suite 200
Los Angeles, CA 90013

I hereby authorize _____
(Name)

_____,
(Address) (Telephone #)

as the attorney of record, to act as my representative in all matters relating to the processing or review of my application for disability pension benefits and for the purpose of representing my claim before the Board of Fire and Police Pension Commissioners. This will be your authority to release to my attorney any information from my Administrative File.

I understand that I shall be held to all scheduled dates and times agreed to by my representative and a change in representation status will not automatically be sufficient cause to delay the processing of my claim.

_____ _____
Print Name Signature

_____
Date

The above-named attorney or law firm accepts the responsibility as the attorney of record for representing this applicant in all matters relating to the processing or review of the application for disability pension benefits and before the Board of Fire and Police Pension Commissioners.

_____
Signature of Attorney or
Authorized Law Office Staff

_____
Date

REPRESENTATIVE AUTHORIZATION

The City of Los Angeles
Department of Fire and Police Pensions
Disability Pensions Section
701 E. 3rd Street, Suite 200
Los Angeles, CA 90013

I hereby authorize _____,
(Name)

_____
(Organization registered with City Clerk's Office)

_____,
(Address) (Telephone #)

to act as my representative in matters relating to the processing or review of my application for disability/survivorship pension benefits and for the purpose of representing my claim before the Board of Fire and Police Pension Commissioners. This will be your authority to release to my representative any information from my Administrative File.

I understand that I shall be held to all scheduled dates and times agreed to by my representative and a change in representation status will not automatically be sufficient cause to delay the processing of my claim.

_____ _____
Print Name Signature

_____
Date

_____

The above-named representative accepts the responsibility for representing this applicant in matters relating to the processing or review of the application for disability/survivorship pension benefits before the Board of Fire and Police Pension Commissioners.

_____
Signature of Authorized Representative

_____
Date

TO: Disability Pension Applicant

Please read the attached ACKNOWLEDGEMENT AND WAIVER and sign below indicating that you have received a copy for your information. Retain the waiver form for further reference.

The conditions described affect only Fire and Police Pension Plan members that have more than 20 years of service. If these provisions apply to you, the Benefits Analyst assigned to process your application will answer any questions you may have and will provide you with tentative pension rates soon after your application has been received.

Calculation of your tentative pension rates will be based on your original appointment date through the date you file your application for disability retirement. Final pension rates, based on your total years of service, will be provided to you at the time your application is scheduled for hearing before the Pension Board.

Kyle Susswain
Manager
Disability Pensions Section

* * * *

TO: Board of Fire and Police Pension Commissioners

I have received the ACKNOWLEDGEMENT AND WAIVER---FIRE AND POLICE PENSION statement.

_____ _____

Applicant Signature Date

ACKNOWLEDGEMENT AND WAIVER
Fire and Police Pension Plan

I,_____, am a Plan member under the provisions of Fire and Police Pension Plan Tier ___ of the Charter/City Administrative Code. On _____ I applied for the benefit of a disability pension pursuant to Charter Sections 1506, 1606, 1706, and Section 4.2006 of the Administrative Code. Said section, in part, provides that:

> A Plan Member retired under the provisions of this subsection shall be paid thereafter a monthly service-connected disability pension in an amount which shall be equal to the same percentage of the Plan Member's Final Average Salary as the Board shall determine, from time to time, to be the percentage of his or her disability. Such pension shall be in an amount of not less than 30% and not more than 90% of the Retired Plan Member's Final Average Salary, but in no case shall the pension be less than the equivalent of 2% of Final Average Salary for each Year of Service of the Retired Plan Member. (Charter Sections 1506(a), 1606(a), 1706(a), and Administrative Code Section 4.2006(a)).
>
> After a Retired Plan Member whose active status as a Department Member has been terminated by reason of his or her retirement has been retired on a service-connected disability pension or on a nonservice-connected disability pension for five (5) years, and has been found to be no longer disabled, the Board shall adjust such Retired Plan Member's pension to 30% of his or her Final Average Salary. However, the pension of any Retired Plan Member, terminated by reason of his or her resignation or discharge as a Department Member, shall cease when the incapacity or disability for which he or she received a disability pension shall cease. (Charter Sections 1506(d), 1606(d), 1706(d), and Administrative Code Section 4.2006(d)).
>
> All Retired Plan Members on a disability pension shall undergo medical examinations at periodic intervals, as determined by the Board, for the first five (5) years of their disability retirement, except in those instances in which the Board has determined that, due to the nature of the disability, no purpose would be served. Retired Plan Members who receive service-connected disability pensions exceeding 30% of Final Average Salary and Plan Members who terminated City employment by reason of resignation or discharge prior to being granted a disability retirement, shall thereafter undergo medical examinations as determined by the Board. (Charter Sections 1506(e), 1606(e), 1706(e), and Administrative Code Section 4.2006(e)).

I acknowledge that I understand these provisions to mean that the maximum available disability pension legally authorized by the above provisions is 90%, or could be as low as____% (2% per year of service of my final average salary), but no less than the minimum of 30%.

I furthermore acknowledge that I know and have been advised that, as of the date of the Board's consideration of my claim, if I were to retire pursuant to:

- Tier 3, Section 1504 of the City Charter, having attained 50 years of age and a minimum 10 years of service,
- Tier 4, Section 1604 of the City Charter, having attained a minimum 20 years of service,
- Tier 5, Section 4.2004 of the Administrative Code, having attained 50 years of age and a minimum 20 years of service,
- Tier 6, Section 1704 of the City Charter, having attained 50 years of age and a minimum 20 years of service,

I would be entitled to a service pension equivalent to an amount representing_____% of my final average salary.

I further acknowledge that I understand that my disability pension percentage award could be reduced to as low as 30% regardless of my total years of service upon review of my disability status by the Board.

I have been counseled by a representative of the Department of Fire and Police Pensions with respect to these matters. I have nonetheless decided to go forward with my disability pension application.

I hereby state that I do not desire to apply for a service pension/deferred pension and, instead, have decided to pursue my disability pension application. I, therefore, expressly waive my rights to a pension based on years of service if I am granted a disability pension.

_____ _____

Date Time Applicant Signature

On_____ I,_____discussed

(Date) (Benefits Analyst)

the matters contained on pages 1, 2 and 3 of this Acknowledgement and Waiver - Fire and Police Pension Plan form. Upon conclusion of this discussion, the applicant was asked if he/she was willing to execute this document by signature. The applicant refused to sign the Acknowledgement and Waiver - Fire and Police Pension Plan form. The applicant was then advised that this document, with this statement, would be included in the Administrative File.

_____

Benefits Analyst Signature

INFORMATION SHEET

FINAL AVERAGE SALARY DESIGNATION

As a member of Tier 3, 4 or 5, of the Fire and Police Pension Plan, you have the right under Charter Section 1502(o) for Tier 3, Charter Section 1602(o) for Tier 4, and Administrative Code Section 4.2002(o) for Tier 5, to designate the 12 consecutive months of service as a Plan Member upon which your "Final Average Salary" is to be based, in the event you are granted a pension by the Board of Fire and Police Pension Commissioners. These sections further allow the designation to be determined by the surviving spouse if the Plan Member should die prior to making the election.

As a member of Tier 6 of the Fire and Police Pension Plan, you have the right under Charter Section 1702(s), to designate the 24 consecutive months of service as a Plan Member upon which your "Final Average Salary" is to be based, in the event you are granted a pension by the Board of Fire and Police Pension Commissioners. This section further allows the designation to be determined by the surviving spouse if the Plan Member should die prior to making the election.

Excerpts from the Charter/Administrative Code are attached for your information.

Please complete and return the Final Average Salary designation form to your Benefits Analyst as soon as your Board Hearing date is scheduled. Your Board Hearing will be continued if this form is not received.

If you have any questions, please contact your Benefits Analyst at (213) 279-3165 or toll free at (844) 88-LAFPP (52377).

Disability Pensions Section
Department of Fire and Police Pensions

EXCERPT

Fire and Police Pension Plan, 1500 Tier 3

Final Average Salary

Charter Section 1502(o) [Tier 3]

(o) "Final Average Salary" means an amount equivalent to a monthly average of salary actually received during any 12 consecutive months of service as a Plan Member as designated by the Plan Member. In the absence of such designation, the last 12 consecutive months preceding the date upon which retirement would become effective shall be used as the basis for the calculation of Final Average Salary.

For the purposes of determining Final Average Salary, periods during which the Plan Member receives less than full salary on account of injury or illness, pursuant to any applicable ordinance of the City, shall be included in the calculation of Final Average Salary based upon the salary, including any Length of Service Pay, Special Pay, Assignment Pay, or Hazard Pay, the Plan Member would have received but for the injury or illness.

Included in the calculation of Final Average Salary shall be Length of Service Pay, Special Pay, Assignment Pay, and Hazard Pay actually received during the 12 consecutive months used to determine Final Average Salary. The following provision shall be effective for Plan Members who retire on or after July 1, 2000, from the Fire Department while holding a rank no higher than Captain or from the Police Department holding a rank no higher than Lieutenant. If Hazard Pay was not received during all or any part of the 12 consecutive months used to determine Final Average Salary, then an amount equivalent to 10% of the Hazard Pay received at the time of the termination of the last assignment to hazardous duties for each year in the aggregate of the assignment to hazardous duties shall be added to the Final Average Salary, not to exceed 10 years in the aggregate. The total amount of Hazard Pay included in Final Average Salary may not exceed 100% of the amount the Plan Member would have received had the Plan Member been entitled to Hazard Pay during the entire 12-month period utilized in the calculation of Final Average Salary.

Overtime compensation or payments of money to the member not designated as salary by an ordinance of the City shall not be considered for purposes of calculating Final Average Salary.

Notwithstanding any of the foregoing, if a Retired Plan Member were to be restored to active duty as a Department Member and thereby again were to become a Plan Member and if he or she again were to retire or to be retired without having performed his or her duties for at least one (1) year subsequent to such restoration, which year shall not include any time off from work by reason of any injury or illness which had been caused by or contributed to by any injury or illness which had been sustained or suffered by him or her prior to such restoration, the Final Average Salary which shall be applicable to his or her later retirement shall be the Final Average Salary which had been applicable to his or her previous retirement.

Should a Plan Member not have completed 12 consecutive months of service as a Plan Member, then and in that event only shall the Final Average Salary be calculated as a monthly average of all consecutive calendar months completed, and, if the Plan Member has completed less than one (1) month of total service as a Plan Member, the salary actually received shall be used to calculate its monthly equivalent.

E X C E R P T

Fire and Police Pension Plan, 1600 Tier 4

Final Average Salary

Charter Section 1602(o) [Tier 4]

(o) "Final Average Salary" means an amount equivalent to a monthly average of salary actually received during any 12 consecutive months of service as a Plan Member as designated by the Plan Member. In the absence of such designation, the last 12 consecutive months preceding the date upon which retirement would become effective shall be used as the basis for the calculation of Final Average Salary.

For the purposes of determining Final Average Salary, periods during which the Plan Member receives less than full salary on account of injury or illness, pursuant to any applicable ordinance of the City, shall be included in the calculation of Final Average Salary based upon the salary, including any Length of Service Pay, Special Pay, Assignment Pay, or Hazard Pay, the Plan Member would have received but for the injury or illness.

Included in the calculation of Final Average Salary shall be Length of Service Pay, Special Pay, Assignment Pay, and Hazard Pay actually received during the 12 consecutive months used to determine Final Average Salary. The following provision shall be effective for Plan Members who retire on or after July 1, 2000, from the Fire Department while holding a rank no higher than Captain or from the Police Department holding a rank no higher than Lieutenant. If Hazard Pay was not received during all or any part of the 12 consecutive months used to determine Final Average Salary, then an amount equivalent to 10% of the Hazard Pay received at the time of the termination of the last assignment to hazardous duties for each year in the aggregate of the assignment to hazardous duties shall be added to the Final Average Salary, not to exceed ten years in the aggregate. The total amount of Hazard Pay included in Final Average Salary may not exceed 100% of the amount the Plan Member would have received had the Plan Member been entitled to Hazard Pay during the entire 12-month period utilized in the calculation of Final Average Salary.

Overtime compensation or payments of money to the member not designated as salary by an ordinance of the City shall not be considered for purposes of calculating Final Average Salary.

Notwithstanding any of the foregoing, if a Retired Plan Member were to be restored to active duty as a Department Member and thereby again were to become a Plan Member and if he or she again were to retire or to be retired without having performed his or her duties for at least one (1) year subsequent to such restoration, which year shall not include any time off from work by reason of any injury or illness which had been caused by or contributed to by any injury or illness which had been sustained or suffered by him or her prior to such restoration, the Final Average Salary which shall be applicable to his or her later retirement shall be the Final Average Salary which had been applicable to his or her previous retirement.

Should a Plan Member not have completed 12 consecutive months of service as a Plan Member, then and in that event only shall the Final Average Salary be calculated as a monthly average of all consecutive calendar months completed, and, if the Plan Member has completed less than one (1) month of total service as a Plan Member, the salary actually received shall be used to calculate its monthly equivalent.

EXCERPT

Fire and Police Pension Plan, Tier 5

Final Average Salary

Administrative Code, Division 4 – Chapter 20 Section 4.2002(o) – [Tier 5]

(o) Final Average Salary means an amount equivalent to a monthly average of salary actually received during any 12 consecutive months of service as a Plan Member as designated by the Plan Member. In the absence of such designation, the last 12 consecutive months preceding the date upon which retirement would become effective shall be used as the basis for the calculation of Final Average Salary.

For the purposes of determining Final Average Salary for periods during which the Plan Member receives less than full salary on account of injury or illness, pursuant to any applicable ordinance of the City, the Final Average Salary shall be based upon the salary, including any Length of Service Pay, Special Pay, Assignment Pay, or Hazard Pay, the Plan Member would have received but for the injury or illness.

Included in the calculation of Final Average Salary shall be Length of Service Pay, Special Pay, Assignment Pay, and Hazard Pay actually received during the 12 consecutive months used to determine Final Average Salary. For those Tier 5 Plan Members who retire from the Fire Department while holding a rank no higher than Captain or from the Police Department holding a rank no higher than Lieutenant: If Hazard Pay was not received during all or any part of the 12 consecutive months used to determine Final Average Salary, then an amount equivalent to 10% of the Hazard Pay received at the time of the termination of the last assignment to hazardous duties for each year in the aggregate of the assignment to hazardous duties shall be added to the Final Average Salary, not to exceed 10 years in the aggregate. The total amount of Hazard Pay included in Final Average Salary may not exceed 100% of the amount the Plan Member would have received had the Tier 5 Plan Member been entitled to Hazard Pay during the entire 12-month period utilized in the calculation of Final Average Salary.

Overtime compensation or payments of money to the member not designated as salary by an ordinance of the City shall not be considered for purposes of calculating Final Average Salary.

Notwithstanding any of the foregoing, if a Retired Tier 5 Plan Member were to be restored to active duty as a Department Member and thereby again were to become a Tier 5 Plan Member and if he or she again were to retire or to be retired without having performed his or her duties for at least one year subsequent to such restoration, which year shall not include any time off from work by reason of any injury or illness which had been caused by or contributed to by any injury or illness which had been sustained or suffered by him or her prior to such restoration, the Final Average Salary which shall be applicable to his or her later retirement shall be the Final Average Salary which had been applicable to his or her previous retirement.

Should a Plan Member not have completed 12 consecutive months of service as a Plan Member, then and in that event only shall the Final Average Salary be calculated as a monthly average of all consecutive calendar months completed, and, if the Plan Member has completed less than one month of total service as a Plan Member, the salary actually received shall be used to calculate its monthly equivalent.

EXCERPT

Fire and Police Pension Plan, 1700 Tier 6

Final Average Salary

Charter Section 1702(s) [Tier 6]

(r) Final Average Salary means an amount equivalent to a monthly average of salary actually earned during any 24 consecutive months of service as a Plan Member as designated by the Plan Member. In the absence of such designation, the last 24 consecutive months preceding the date upon which retirement would become effective shall be used as the basis for the calculation of Final Average Salary.

For the purposes of determining Final Average Salary for periods during which the Plan Member receives less than full salary on account of injury or illness, pursuant to any applicable ordinance of the City, the Final Average Salary shall be based upon the salary, including any Length of Service Pay, Special Pay, Assignment Pay, or Hazard Pay, the Plan Member would have received but for the injury or illness.

Included in the calculation of Final Average Salary shall be Length of Service Pay, Special Pay, Assignment Pay, and Hazard Pay actually earned during the 24 consecutive months used to determine Final Average Salary.

For those Tier 6 Plan Members who retire from the Fire Department while holding a rank no higher than Captain or from the Police Department holding a rank no higher than Lieutenant: If Hazard Pay was not earned during all or any part of the 24 consecutive months used to determine Final Average Salary, then an amount equivalent to 10% of the Hazard Pay earned at the time of the termination of the last assignment of hazardous duties for each year in the aggregate of the assignment to hazardous duties shall be added to the Final Average Salary, not to exceed 10 years in the aggregate. The total amount of Hazard Pay included in Final Average Salary may not exceed 100% of the amount the Plan Member would have earned had he or she been entitled to Hazard Pay during the entire 24-month period utilized in the calculation of Final Average Salary.

Overtime compensation or payments of money to the member not designated as salary by an ordinance or Memorandum of Understanding shall not be considered for purposes of calculating Final Compensation.

Should a Tier 6 Plan Member not have completed 24 consecutive months of service as a Plan Member, then and in that event only shall the Final Average Salary be calculated as a monthly average of all consecutive calendar months completed, and, if the Plan Member has completed less than one month of total service as a Plan Member, the salary actually received shall be used to calculate its monthly equivalent.

Notwithstanding any of the foregoing, if a Retired Tier 6 Plan Member were to be restored to active duty as a Department Member and thereby again were to become a Tier 6 Plan Member and if he or she again were to retire or to be retired without having performed his or her duties for at least one year subsequent to such restoration, which year shall not include any time off from work by reason of any injury or illness which had been caused by or contributed to by any injury or illness which had been sustained or suffered by him or her prior to such restoration, the Final Average Salary which shall be applicable to his or her later retirement shall be the Final Average Salary which had been applicable to his or her previous retirement. Should the Plan Member have performed the requisite one year subsequent to such restoration, but not have completed 24 consecutive months of service since being restored, then in that event Final Average Salary shall be calculated as a monthly average of all consecutive months completed after such restoration.

FINAL AVERAGE SALARY DESIGNATION

As a member of Tier 3, 4, 5, of the Fire and Police Pension Plan, you have the right under Charter Section 1502(o) for Tier 3, Charter Section 1602(o) for Tier 4, and Administrative Code Section 4.2002(o) for Tier 5, to designate the 12 consecutive months of service as a Plan Member upon which your "Final Average Salary" (FAS) is to be based, in the event you are granted a pension by the Board of Fire and Police Pension Commissioners. These sections further allow the designation to be determined by the surviving spouse if the Plan Member should die prior to making the election.

As a member of Tier 6 of the Fire and Police Pension Plan, you have the right under Charter Section 1702(s), to designate the 24 consecutive months of service as a Plan Member upon which your "Final Average Salary" (FAS) is to be based, in the event you are granted a pension by the Board of Fire and Police Pension Commissioners. This section further allows the designation to be determined by the surviving spouse if the Plan Member should die prior to making the election.

Initial each statement:

____ I acknowledge that it is my responsibility to obtain my Lost Service Time (LST), also known as "bad time" history from my Department's Accounting/Payroll Section. I have reviewed my LST history report and have been informed that the inclusion of any LST during the period I have selected below will result in a reduction of my FAS.

____ I understand that if there is a pending Memorandum of Understanding (MOU) at the time of my FAS election, any **increase or decrease** in my monthly salary as a result of the agreed negotiations will affect my FAS election and that my monthly pension entitlement will be adjusted accordingly. I understand that I will not be allowed to change my FAS election as a result of any MOU salary change.

____ **I understand that this is a <u>one-time</u>, irrevocable election**.

Initial appropriate choice:

_____ I elect to have my pension entitlement calculations based on the **<u>last</u>** twelve/twenty-four (12/24) consecutive months of my employment (based on my Tier).

_____ I elect to have my pension entitlement calculations based on the twelve/twenty-four (12/24) consecutive month period (based on my Tier) of:

From:_____ through_____
Month/Year Month/Year

Member's Name: _____
(Please Print)

Social Security Number: XXX-XX-_____

Signature of Member: _____

Date: _____

INFORMATION SHEET

Optional Pensions for Qualified Surviving Spouse and Qualified Domestic Partner

City Charter Sections 1508(b) [Tier 3], 1608(b) [Tier 4], 1214 [Domestic Partner], City Administrative Code, Division 4, Chapter 20, Section 4.2008(b) [Tier 5], and City Charter Section 1708(b) [Tier 6], provide for Optional Pensions for **Qualified** Surviving Spouse/Domestic Partner (hereinafter referred to as spouse/domestic partner). This provision enables you to elect to provide for more than the standard survivor's pension for your spouse or domestic partner in case you die first. The larger pension for your spouse/domestic partner is contingent on your agreeing to receive a lower pension amount during your lifetime.

Following is an example of the formula:

> Shortly after you apply for a service pension, you are advised that your monthly pension amount will be $1,000. If you die before your spouse/domestic partner and your standard provision is 60 percent, then your surviving spouse/domestic partner would receive 60 percent of your pension or $600 per month for the rest of her/his life.
>
> You decide that you want your spouse/domestic partner to receive 75 percent of your pension after your death to meet expected living expenses.
>
> Assuming you are 55 and your spouse/domestic partner is 51, using actuarial tables, it is determined that the 75 percent continuance to your spouse/domestic partner after your death can be provided if you agree to accept a monthly pension of $973 per month, or $27 less than what you would receive if you did not elect a higher than standard continuance to your spouse/domestic partner.

You may elect a higher continuance to your qualified surviving spouse/domestic partner in 5 percent increments up to 100 percent. The higher the continuance you elect, the lower your monthly pension amount will be during your lifetime. As another example, if you elect a 100 percent continuance and you are 55 and your spouse/domestic partner 51, your monthly pension would be $931 per month. Then, if you die before your spouse/domestic partner, he/she would continue to receive the same $931 per month for the rest of her/his life, plus any cost-of-living adjustments that may be provided in future years.

Once you have made the decision regarding the election of a higher continuance, your decision is **final and cannot be changed**, even if your spouse/domestic partner dies or your marriage/domestic partnership is dissolved.

Excerpts from the Charter/Administrative Code are attached for your information.

If you have any questions, please call the Retirement Services Section, Department of Fire and Police Pensions at (213) 279-3165 or toll free at (844) 88-LAFPP (52377).

E X C E R P T

CITY CHARTER ARTICLE XI – [Tier 3]

Sections 1508(b)

(b) **Optional Pensions for Qualified Surviving Spouse.** At any time before the first payment of a service pension, a service-connected disability pension, or a nonservice-connected disability pension, the Plan Member may elect to receive, in lieu of his or her pension as provided in Section 1504 or Section 1506, the actuarial equivalent at that time of such pension and of the pension for the Qualified Surviving Spouse as provided in subsection (a) of this section, by electing an optional pension payable throughout the balance of his or her life, with the provision that upon his or her death such optional pension shall be continued to the Plan Member's Qualified Surviving Spouse in the proportional amount designated by the Plan Member at the time of election of the option provided by this section.

The amount of such optional pension shall be so calculated that the liability of the Fire and Police Pension Plan – Tier 3 at the date of retirement under the optional pension shall be equal to the liability of the Fire and Police Pension Plan at the same date under the pension awarded in accordance with the provisions of Section 1504 or Section 1506 and of the survivorship pension provided by subsection (a) of this section. For the purpose of this section, the liability of the Fire and Police Pension Plan – Tier 3 is defined as the present value, in accordance with tables adopted by the Board, of the pensions or optional pensions calculated by approved actuarial methods, and recommended by the Board's actuary. In determining the actuarial equivalent of the pension for a Qualified Surviving Spouse as provided pursuant to subsections (a)(3), (4), and (5) of this section, the equivalent of a 60% survivorship pension shall be used in all cases.

The optional amounts, calculated in accordance with the foregoing paragraph, shall provide a range of optional values such that the amount to be paid to the Qualified Surviving Spouse of the Plan Member shall range from 60% to 100% of the pension payable to the Plan Member, varying by increments of 5%.

If a Retired Plan Member, previously retired on a disability pension pursuant to the provisions of Section 1506, should be reinstated to active duty upon termination of his or her disability, the election to receive the optional pension as herein provided, shall be deemed cancelled as of the effective date of such reinstatement.

A Retired Plan Member, previously retired on a disability pension pursuant to the provisions of Section 1506 and whose pension has subsequently been adjusted as provided for in Section 1506, shall have the right to cancel any option previously elected by him or her pursuant to the provisions of this subsection.

The Board shall by rule provide for a method in which the election to receive an optional pension shall be exercised.

E X C E R P T

CITY CHARTER ARTICLE XI – [Tier 4]

Sections 1608(b), 1214

(b) **Optional Pensions for Qualified Surviving Spouse.** At any time before the first payment of a service pension, a service-connected disability pension, or a nonservice-connected disability pension, the Plan Member may elect to receive, in lieu of his or her pension as provided in Section 1604 or Section 1606, the actuarial equivalent at that time of such pension and of the pension for the Qualified Surviving Spouse as provided in subsection (a) of this section, by electing an optional pension payable throughout the balance of his or her life, with the provisions that upon his or her death such optional pension shall be continued to the Plan Member's Qualified Surviving Spouse in the proportional amount designated by the Plan Member at the time of election of the option provided by this section.

The amount of such optional pension shall be so calculated that the liability of the Fire and Police Pension Plan – Tier 4 at the date of retirement under the optional pension shall be equal to the liability of the Fire and Police Pension Plan – Tier 4 at the same date under the pension awarded in accordance with the provisions of Section 1604 or Section 1606 and of the survivorship pension provided by subsection (a) of this section. For the purpose of this section, the liability of the Fire and Police Pension Plan – Tier 4 is defined as the present value, in accordance with tables adopted by the Board, of the pensions or optional pensions calculated by approved actuarial methods, and recommended by the Board's actuary. In determining the actuarial equivalent of the pension for a Qualified Surviving Spouse as provided pursuant to subsections (a)(3), (4) and (5) of this section, the equivalent of a 60% survivorship pension shall be used in all cases.

The optional amounts, calculated in accordance with the foregoing paragraph, shall provide a range of optional values such that the amount to be paid to the Qualified Surviving Spouse of the Plan Member shall range from 60% to 100% of the pension payable to the Plan Member, varying by increments of 5%.

If a Retired Plan Member, previously retired on a disability pension pursuant to the provisions of Section 1606, should be reinstated to active duty upon termination of his or her disability, the election to receive the optional pension as herein provided, shall be deemed cancelled as of the effective date of such reinstatement.

A Retired Plan Member, previously retired on a disability pension pursuant to the provisions of Section 1606 and whose pension has subsequently been adjusted as provided for in Section 1606, shall have the right to cancel any option previously elected by him or her pursuant to the provisions of this subsection.

The Board shall by rule provide for a method in which the election to receive an optional pension shall be exercised.

E X C E R P T

ADMINISTRATIVE CODE SECTION 4.2008(b) [Tier 5]

Section 4.2008(b)

(b) Optional Pension for Qualified Surviving Spouse or Surviving Domestic Partner.
At any time before the first payment of a service pension, a service-connected disability pension or a nonservice-connected disability pension, the Plan Member may elect to receive, in lieu of his or her pension as provided in Section 4.2004 or Section 4.2006, the actuarial equivalent at that time of such pension and of the pension for the Qualified Surviving Spouse or Qualified Surviving Domestic Partner as provided in subsection (a) of this section, by electing an optional pension payable throughout the balance of his or her life, with the provision that upon his or her death such optional pension shall be continued to the Plan Member's Qualified Surviving Spouse or Qualified Surviving Domestic Partner in the proportional amount designated by the Plan Member at the time of election of the option provided by this section.

The amount of such optional pension shall be so calculated that the liability of the Fire and Police Pension Plan at the date of retirement under the optional pension shall be equal to the liability of the Fire and Police Pension Plan at the same date under the pension awarded in accordance with the provisions of Section 4.2004 or Section 4.2006 and of the survivorship pension provided by subsection (a) of this section. For the purpose of this section, the liability of the Fire and Police Pension Plan is defined as the present value, in accordance with tables adopted by the Board, of the pensions or optional pensions calculated by approved actuarial methods, and recommended by the Board's actuary. In determining the actuarial equivalent of the pension for a Qualified Surviving Spouse or Qualified Surviving Domestic Partner as provided pursuant to subsections (a)(3),(4), and (5) of this section, the equivalent of a 60% survivorship pension shall be used in all cases.

The optional amounts, calculated in accordance with the foregoing paragraph, shall provide a range of optional values such that the amount to be paid to the Qualified Surviving Spouse or Qualified Surviving Domestic Partner of the Plan Member shall range from 60% to 100% of the pension payable to the Plan Member, varying by increments of 5%.

If a Retired Tier 5 Plan Member, previously retired on a disability pension pursuant to the provisions of Section 4.2006, should be reinstated to active duty upon termination of his or her disability, the election to receive the optional pension herein provided, shall be deemed canceled as of the effective date of such reinstatement.

A Retired Tier 5 Plan Member, previously retired on a disability pension pursuant to the provisions of Section 4.2006 and whose pension has subsequently been adjusted as provided for in Section 4.2006, shall have the right to cancel any option previously elected by him or her pursuant to the provisions of this subsection.

The Board shall by rule provide for a method in which the election to receive an optional pension shall be exercised.

E X C E R P T

Charter Section 1708(b) [Tier 6]

Section 1708(b)

(b) Optional Pensions for Qualified Survivor.

At any time before the first payment of a service pension, a service-connected disability pension, or a nonservice-connected disability pension, the Tier 6 Plan Member may elect to receive, in lieu of his or her pension as provided in Section 1704 or Section 1706, the actuarial equivalent at that time of such pension and of the pension for the Qualified Survivor, as provided in subsection (a) of this section, by electing an optional pension payable throughout the balance of his or her life, with the provisions that upon his or her death such optional pension shall be continued to the Tier 6 Plan Member's Qualified Survivor in the proportional amount designated by the Plan Member at the time of election of the option provided by this section.

The amount of such optional pension shall be so calculated that the liability of the Fire and Police Pension Plan at the date of retirement under the optional pension shall be equal to the liability of the Fire and Police Pension Plan at the same date under the pension awarded in accordance with the provisions of Section 1704 or Section 1706 and of the survivorship pension provided by subsection (a) of this section. For the purpose of this section, the liability of the Fire and Police Pension Plan is defined as the present value, in accordance with tables adopted by the Board, of the pensions or optional pensions calculated by approved actuarial methods, and recommended by the Board's actuary. In determining the actuarial equivalent of the pension for a Qualified Survivor as provided pursuant to subsection (a)(4) of this section, the equivalent of a survivorship pension of 80% of the retiree's pension shall be used in all cases.

The optional amounts, calculated in accordance with the foregoing paragraph, shall provide a range of optional values such that the amount to be paid to the Qualified Survivor of the Plan Member shall range from 75% to 100% of the pension payable to the Tier 6 Plan Member, varying by increments of 5%.

If a Retired Tier 6 Plan Member, previously retired on a disability pension pursuant to the provisions of Section 1706, should be reinstated to active duty upon termination of his or her disability, the election to receive the optional pension as herein provided, shall be deemed cancelled as of the effective date of such reinstatement.

A Retired Tier 6 Plan Member, previously retired on a disability pension pursuant to the provisions of Section 1706, shall have the right to cancel any option previously elected by him or her pursuant to the provisions of this subsection in the event his or her pension is subsequently adjusted as provided for in Section 1706.

The Board shall by rule provide for a method in which the election to receive an optional pension shall be exercised.

ELECTION FORM FOR OPTIONAL PENSION
FOR QUALIFIED SURVIVING SPOUSE OR QUALIFIED DOMESTIC PARTNER

I have been provided with information regarding the optional pension for a qualified surviving spouse or a qualified surviving domestic partner including the text of Charter Sections 1508(b) [Tier 3], 1608(b) [Tier 4], Administrative Code, Division 4, Chapter 20, Section 4.2008(b) [Tier 5] and Charter Section 1708(b) [Tier 6].

Initial each statement:

_____ I understand that I can decide to provide a greater percent survivorship pension for my qualified surviving spouse or qualified surviving domestic partner by reducing the monthly pension benefit paid to me during my lifetime.

_____ I understand that my decision as indicated above is **final and cannot be changed** once I sign this document even if my spouse/domestic partner dies or my marriage/domestic partnership is dissolved.

Initial appropriate choice:

____ I do not wish to provide for an increased pension continuance to my qualified surviving spouse or qualified surviving domestic partner in the event I predecease her/him.

____ I wish to provide for a___% survivorship pension for my qualified surviving spouse or qualified surviving domestic partner in the event I predecease her/him. I understand that this election will result in my initial monthly pension amount being $_____instead of the $_____I would receive if I did not elect the higher than standard survivorship pension for my qualified surviving spouse/domestic partner.

Member's Name: _____
(Please Print)

Social Security Number: XXX-XX-_____

Signature of Member: _____

Spouse or Domestic
Partner's Name: _____

Date: _____

PAYROLL STATUS INFORMATION

Please be advised that employees on State Rate may elect to use compensated time off to supplement State Rate to receive the equivalent of their regular salary. (Andersen v. Workers' Compensation Board). The use of sick time, vacation time, overtime, etc., while you are injured constitutes a return to payroll status for pension purposes, it is important that you understand such action will impact the effective date of your disability pension.

A Disability Pension Effective Date Designation form (DF223) is included in the disability pension application package. The designation form details the window period available for a **one-time** selection of a pension effective date. The window period is defined as follows:

The effective date of your disability pension can be **no earlier than the latest of**:

- The first day following the last day on payroll (i.e., salary/vacation/sick), or;
- The first day following the expiration of IOD or State Rate time, but;
- **Not later than** the date of the Board hearing first granting a pension based either on length of service or disability.

Reinstatement to payroll for any purpose permanently changes the earliest possible effective date of your pension. If you start using your accrued/accumulated/compensated time because it provides more income than State Rate payments, your pension effective date window shifts forward. Your new earliest date becomes the new first day following the last day on payroll (i.e., stopped receiving sick, vacation or overtime compensation). You will not be eligible to receive retroactive pension benefits for any time prior to the new earliest date.

If you have any questions regarding the effect your current payroll status will have on your pension effective date options, please contact your Benefits Analyst at your earliest convenience.

Print Member Name: _____

Signature of Member: _____

Date: _____

DISABILITY PENSION EFFECTIVE DATE DESIGNATION

It is Department policy that disability pension effective dates must occur on either the first day subsequent to the expiration of IOD time (or other pay status) or the Board hearing date. System/Plan members are entitled to a **one-time** designation of the specific disability pension effective date.

When selecting the pension effective date, members are advised to consider the following information:

- Charter Section ***1406(m)(4) [Tier 2]*** does not require payment of pension contributions for periods of temporary disability (City Attorney Opinion No. 81-40; Memorandum from City Attorney Ferrell dated 3/30/92).

- Pursuant to Charter Sections ***1502(m)(4) [Tier 3 members], 1602(m)(4) [Tier 4 members], Administrative Code, Section 4.2002(m)(4) [Tier 5 members], and 1702(q)(4) [Tier 6],*** "Years of Service" includes those periods of time during which a Department member did or shall receive Workers' Compensation benefits for temporary disability due to injury or illness arising out of the course of employment (State Rate).

- Charter Section ***1502(m)(4) [Tier 3], 1602(m)(4) [Tier 4], Administrative Code, Section 4.2002(m)(4) [Tier 5 members], and 1702(q)(4) [Tier 6],*** requires payment of pension contributions for inclusion of periods of temporary disability in years of service.

ELECTION

If I am granted a disability pension, I hereby elect the following disability pension effective date:

___ First day after expiration of IOD time (unless other pay status is used) but no later than Board Hearing Date. [Returning to payroll status or supplementing State Rate with VC/SK/OT/etc. will eliminate any retroactive payment back to the expiration of IOD.]

_____ First day after expiration of State Rate, but no later than Board Hearing Date.

_____ _____ but no later than Board Hearing Date.
Month/day/year

_____ Board Hearing Date

I understand that this is a **one-time** election and that no changes to my effective date will be permitted after the Board's final action on my claim.

Member's Name: _____
(Printed)

Member's Signature: _____

Social Security Number: XXX-XX-_____ Date: _____

NOTE: This document is to be completed and returned to the Benefits Analyst as soon as your Board date is scheduled. Your Board Hearing will be continued if this form is not received.

Checklist

Prior to submitting your disability pension application to LAFPP, please review the checklist below.

Your application for disability pension benefits will be considered incomplete until the following documents are fully completed and submitted to LAFPP's Disability Pensions Section.

☐ Application for Disability Retirement (to be completed by member, attorney, or authorized representative)

☐ Color Copy of Valid Government Issued Driver's License or City Issued ID

☐ Applicant's Statement of Disability and Service-Connection, if applicable

☐ Report of Outside Employment

☐ Signed Authorizations for the Release of Medical and Psychiatric Records, Release of Employment Records, and Release of Substance Abuse Records

☐ Acknowledgement and Waiver

☐ Attorney or Representative Authorization, if applicable

☐ Completed BSS Release (LAPD) or BHP PHI Release (LAFD)

☐ Copy of Request for Military Records Release, if applicable

INSTRUCTION AND INFORMATION SHEET FOR SF 180, REQUEST PERTAINING TO MILITARY RECORDS

1. General Information. The Standard Form 180, Request Pertaining to Military Records (SF180) is used to request information from military records. Certain identifying information is necessary to determine the location of an individual's record of military service. Please try to answer each item on the SF 180. If you do not have and cannot obtain the information for an item, show "NA," meaning the information is "not available". Include as much of the requested information as you can. Incomplete information may delay response time. To determine where to mail this request see Page 2 of the SF180 for record locations and facility addresses.

Online requests may be submitted to the National Personnel Records Center (NPRC) by a veteran or deceased veteran's next-of-kin using eVetRecs at http://www.archives.gov/veterans/military-service-records/ .

2. Personnel Records/Military Human Resource Records/Official Military Personnel File (OMPF) and Medical Records/Service Treatment Records (STR). Personnel records of military members who were discharged, retired, or died in service **LESS THAN 62 YEARS AGO** and medical records are in the legal custody of the military service department and are administered in accordance with rules issued by the Department of Defense and the Department of Homeland Security (DHS, Coast Guard). STRs of persons on active duty are generally kept at the local servicing clinic. After the last day of active duty, STRs should be requested from the appropriate address on page 2 of the SF 180. (See item 3, Archival Records, if the military member was discharged, retired or died in service more than 62 years ago.)

a. Release of information: Release of information is subject to restrictions imposed by the military services consistent with Department of Defense regulations, the provisions of the Freedom of Information Act (FOIA) and the Privacy Act of 1974. The service member (either past or present) or the member's legal guardian has access to almost any information contained in that member's own record. The authorization signature of the service member or the member's legal guardian is needed in Section III of the SF180. Others requesting information from military personnel records and/or STRs must have the release authorization in Section III of the SF 180 signed by the member or legal guardian. If the appropriate signature cannot be obtained, only limited types of information can be provided. If the former member is deceased, the surviving next-of-kin may, under certain circumstances, be entitled to greater access to a deceased veteran's records than a member of the general public. The next-of-kin may be any of the following: unremarried surviving spouse, father, mother, son, daughter, sister, or brother. Requesters **MUST provide proof of death**, **such as a copy of a death certificate, newspaper article (obituary) or death notice, coroner's report of death, funeral director's signed statement of death, or verdict of coroner's jury.**

b. Fees for records: There is no charge for most services provided to service members or next-of-kin of deceased veterans. A nominal fee is charged for certain types of service. In most instances, service fees cannot be determined in advance. If your request involves a service fee, you will receive an invoice with your records.

3. Archival Records. Personnel records of military members who were discharged, retired, or died in service **62 OR MORE YEARS AGO** have been transferred to the legal custody of NARA and are referred to as "archival records".

a. Release of Information: Archival records are open to the public. The Privacy Act of 1974 does not apply to archival records, therefore, written authorization from the veteran or next-of-kin is not required. In order to protect the privacy of the veteran, his/her family, and third parties named in the records, the personal privacy exemption of the Freedom of Information Act (5 U.S.C. 552 (b) (6)) may still apply and may preclude the release of some information.

b. Fees for Archival Records: Access to archival records are granted by offering copies of the records for a fee (44 U.S.C. 2116 (c)). If a fee applies to the photocopies of documents in the requested record, you will receive an invoice. Photocopies will be sent after payment is made. For more information see http://www.archives.gov/st-louis/archival-programs/military-personnel-archival/ompf-archival-requests.html.

4. Where reply may be sent. The reply may be sent to the service member or any other address designated by the service member or other authorized requester. If the designated address is NOT registered to the addressee by the U.S. Postal Service (USPS), provide BOTH the addressee's name AND "in care of" (c/o) the name of the person to whom the address is registered on the NAME line in Section III, item 3, on page 1 of the SF 180. The COMPLETE address must be provided, INCLUDING any apartment/suite/unit/lot/space/etc. number.

5. Definitions and abbreviations. DISCHARGED -- the individual has no current military status; SERVICE TREATMENT RECORD (STR) -- The chronology of medical, mental health, and dental care received by service members during the course of their military career (does not include records of treatment while hospitalized); TDRL – Temporary Disability Retired List.

6. Service completed before World War I. National Archives Trust Fund (NATF) forms must be used to request these records. Obtain the forms by e-mail from *inquire@nara.gov* or write to the Code 6 address on page 2 of the SF 180.

PRIVACY ACT OF 1974 COMPLIANCE INFORMATION

The following information is provided in accordance with 5 U.S.C. 552a(e)(3) and applies to this form. Authority for collection of the information is 44 U.S.C. 2907, 3101, and 3103, and Public Law 104-134 (April 26, 1996), as amended in title 31, section 7701. Disclosure of the information is voluntary. If the requested information is not provided, it may delay servicing your inquiry because the facility servicing the service member's record may not have all of the information needed to locate it. The purpose of the information on this form is to assist the facility servicing the records (see the address list) in locating the correct military service record(s) or information to answer your inquiry. This form is then retained as a record of disclosure. The form may also be disclosed to Department of Defense components, the Department of Veterans Affairs, the Department of Homeland Security (DHS, U.S. Coast Guard), or the National Archives and Records Administration when the original custodian of the military health and personnel records transfers all or part of those records to that agency. If the service member was a member of the National Guard, the form may also be disclosed to the Adjutant General of the appropriate state, District of Columbia, or Puerto Rico, where he or she served.

PAPERWORK REDUCTION ACT PUBLIC BURDEN STATEMENT

Public burden reporting for this collection of information is estimated to be five minutes per request, including time for reviewing instructions and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to National Archives and Records Administration (ISSD), 8601 Adelphi Road, College Park, MD 20740- 6001. *DO NOT SEND COMPLETED FORMS TO THIS ADDRESS.* SEND COMPLETED FORMS TO THE APPROPRIATE ADDRESS LISTED ON PAGE 2 OF THE SF 180.

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REQUEST PERTAINING TO MILITARY RECORDS

Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/military-service-records/
To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

1. NAME USED DURING SERVICE (last, first, full middle)	2. SOCIAL SECURITY #	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT *(For an effective records search, it is important that ALL service be shown below.)*

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE						
b. RESERVE						
c. STATE NATIONAL GUARD						

6. IS THIS PERSON DECEASED? ☐ NO ☐ YES - ***MUST*** *provide Date of Death if veteran is deceased:* _____

7. DID THIS PERSON RETIRE FROM MILITARY SERVICE? ☐ NO ☐ YES

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

☐ **DD Form 214 or equivalent.** Year(s) in which form(s) issued to veteran: _____

This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next-of-kin, or other persons or organizations, if authorized in Section III, below. **An UNDELETED DD214 is ordinarily required to determine eligibility for benefits**. If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost.
An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box: ☐ I want a **DELETED** copy.

☐ **Medical Records** Includes Service Treatment Records, Health (outpatient) and Dental Records. ***IF HOSPITALIZED (inpatient)*** *the FACILITY NAME and DATE (month and year) for EACH admission* ***MUST*** *be provided:* _____

_____

☐ **Other** (Specify): _____

2. PURPOSE: (Providing information about the purpose of the request is **strictly voluntary;** however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

☐ Benefits (explain) ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal ☐ Other (explain)

Explain here: _____

1. REQUESTER NAME: _____

2. ☐ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section I, above.

☐ I am the DECEASED VETERAN'S NEXT-OF-KIN ***(MUST submit Proof of Death.*** *See item 2a on instruction sheet.)*

☐ I am the VETERAN'S LEGAL GUARDIAN ***(MUST submit copy of Court Appointment)*** or AUTHORIZED REPRESENTATIVE ***(MUST submit copy of Authorization Letter or Power of Attorney)***

☐ OTHER

(Relationship to deceased veteran) *(Specify type of Other)*

3. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

Name

Street Apt.

City State Zip Code

* This form is available at ***http://www.archives.gov/veterans/military-service-records/standard-form-180.html*** on the National Archives and Records Administration (NARA) web site. *

4. AUTHORIZATION SIGNATURE: I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct and that I authorize the release of the requested information. *(See items 2a or 3a on accompanying instruction sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request if for archival records.)*

Signature Required - Do not print **Date**

Daytime phone Fax Number

Email address

The various categories of military service records are described in the chart below. For each category there is a code number which indicates the address at the bottom of the page to which this request should be sent. Please refer to the Instruction and Information Sheet accompanying this form as needed.

BRANCH	CURRENT STATUS OF SERVICE MEMBER	Personnel Record	Medical or Service Treatment Record
AIR FORCE	Discharged, deceased, or retired before 5/1/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 9/30/2004	14	11
	Discharged, deceased, or retired 10/1/2004 – 12/31/2013	1	11
	Discharged, deceased, or retired on or after 1/1/2014	1	13
	Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay	1	
	Reserve, IRR, Retired Reserve in non-pay status, current National Guard officers not on active duty in the Air Force, or National Guard released from active duty in the Air Force	2	
	Current National Guard enlisted not on active duty in the Air Force	2	13
COAST GUARD	Discharge , deceased, or retired before 1/1/1898	6	
	Discharged, deceased, or retired 1/1/1898 – 3/31/1998	14	14
	Discharged, deceased, or retired 4/1/1998 – 9/30/2006	14	11
	Discharged, deceased, or retired 10/1/2006 – 9/30/2013	3	11
	Discharged, deceased, or retired on or after 10/1/2013	3	14
	Active, Reserve, Individual Ready Reserve or TDRL	3	
MARINE CORPS	Discharged, deceased, or retired before 1/1/1895	6	
	Discharged, deceased, or retired 1/1/1905 – 4/30/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 12/31/1998	14	11
	Discharged, deceased, or retired 1/1/1999 - 12/31/2013	4	11
	Discharged, deceased, or retired on or after 1/1/2014	4	8
	Individual Ready Reserve	5	
	Active, Selected Marine Corps Reserve, TDRL	4	
ARMY	Discharged, deceased, or retired before 11/1/1912 (enlisted) or before 7/1/1917 (officer)	6	
	Discharged, deceased, or retired 11/1/1912 – 10/15/1992 (enlisted) or 7/1/1917 – 10/15/1992 (officer)	14	
	Discharged, deceased, or retired 10/16/1992 – 9/30/2002	14	11
	Discharged, deceased, or retired (including TDRL) 10/1/2002 – 12/31/2013	7	11
	Discharged, deceased, or retired (including TDRL) on or after 1/1/2014	7	9
	Current Soldier (Active, Reserve (including Individual Ready Reserve) or National Guard)	7	
NAVY	Discharged, deceased, or retired before 1/1/1886 (enlisted) or before 1/1/1903 (officer)	6	
	Discharged, deceased, or retired 1/1/1886 – 1/30/1994 (enlisted) or 1/1/1903 – 1/30/1994 (officer)	14	14
	Discharged, deceased, or retired 1/31/1994 – 12/31/1994	14	11
	Discharged, deceased, or retired 1/1/1995 – 12/31/2013	10	11
	Discharged, deceased, or retired on or after 1/1/2014	10	8
	Active, Reserve, or TDRL	10	
PHS	Public Health Service - Commissioned Corps officers only	12	

ADDRESS LIST OF CUSTODIANS and SELF-SERVICE WEBSITES (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form

1 **Air Force Personnel Center**
HQ AFPC/DPSIRP
550 C Street West, Suite 19
Randolph AFB, TX 78150-4721

2 **Air Reserve Personnel Center**
Records Management Branch (DPTSC)
18420 E. Silver Creek Avenue
Building 390 MS 68
Buckley AFB, CO 80011

3 **Commander, Personnel Service Center**
(BOPS-C-MR) MS7200
US Coast Guard
2703 Martin Luther King Jr Ave SE
Washington, DC 20593-7200
MR_CustomerService@uscg.mil

4 **Headquarters U.S. Marine Corps**
Manpower Management Records & Performance (MMRP-10)
2008 Elliot Road
Quantico, VA 22134-5030

5 **Marine Forces Reserve**
2000 Opelousas Avenue
New Orleans, LA 70146-5400

6 **National Archives & Records Administration**
Research Services (RDT1R)
700 Pennsylvania Avenue NW
Washington, DC 20408-0001

7 **US Army Human Resources Command's web page:**
https://www.hrc.army.mil/TAGD/Accessing%20or%20Requesting%20Your%20Official%20Military%20Personnel%20File%20Documents
or 1-888-ARMYHRC (1-888-276-9472)

8 **Navy Medicine Records Activity (NMRA)**
BUMED Detachment St. Louis
4300 Goodfellow Boulevard, Building 103
St. Louis, MO 63120

9 **AMEDD Record Processing Center**
3370 Nacogdoches Road, Suite 116
San Antonio, TX 78217

10 **Navy Personnel Command (PERS-313)**
5720 Integrity Drive
Millington, TN 38055-3120

11 **Department of Veterans Affairs**
Records Management Center
ATTN: Release of Information
P.O. Box 5020
St. Louis, MO 63115-5020

12 **Division of Commissioned Corps Officer Support**
ATTN: Records Officer
1101 Wooton Parkway, Plaza Level, Suite 100
Rockville, MD 20852

13 **AF STR Processing Center**
ATTN: Release of Information
3370 Nacogdoches Road, Suite 116
San Antonio, TX 78217

14 **National Personnel Records Center**
(Military Personnel Records)
1 Archives Drive
St. Louis, MO 63138-1002

***e*VetRecs:**
http://www.archives.gov/veterans/military-service-records/

Behavioral Health Program
Los Angeles Fire Department
201 N. Figueroa St, Suite 1375
Los Angeles, CA 90012

www.lafd.org

(Official Use Only)

Received On:_____

Incident Date:_____

Account Number:_____

RTS Number: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(45 C.F.R. §164.508(c) and 514(h))

Terms and conditions of this authorization - I understand that:

By signing this document I am authorizing Behavioral Health Program to use or disclose my Protected Health Information (PHI), for the purpose stated herein, which may contain personal and medical collected in relation to the medical service(s) provided by Behavioral Health Program of LAFD.

- The person(s)/organization(s) authorized to receive my PHI may not further use or disclose this information without specific written authorization from me or as otherwise specifically required or permitted by law (Cal. Civ. Code § 56.13).
- Unless revoked earlier, this authorization will end on the date/condition/event specified in Section "C" below.
- I may revoke this authorization by providing written notice to the Behavioral Health Program, except to the extent that action has been taken in reliance upon this authorization.
- Behavioral Health Program may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization.

A. Patient Information (All fields in this section are <u>REQUIRED</u>, unless noted otherwise)

Name:_____ Email (optional):_____

Birth Date:_____ SSN_____/_____/_____

Phone (Day)_____ (Evening) _____

Address:_____
Street Apt# City State Zip Code

B. Person/Organization authorized to receive the PHI - Please tell us who you are authorizing to receive your PHI by completing the information below. For "Relationship" please provide a general description such as "self", "spouse" or "attorney."

Name (**required**):_____ Relationship (**required**): _____

Phone - Day (**required**)_____ Email:_____

Address (**required**):_____
Street Apt# City State ZIP Code

C. Authorization Duration

- The "Start Date" is the date that this authorization will begin. If "Start Date" is left blank, the date the authorization was signed in Section F will be the "Start Date."
- The "End Date" is the date that this authorization will end. If "End Date" is left blank, this authorization will remain valid for one (1) year, until the condition set forth below ("Termination Condition/Event") has been met, or until we receive a written revocation from you.
- The "Termination Condition/Event" will automatically revoke this authorization.

Start Date:_____ End Date:_____Termination Condition/Event:_____

D. Description of information to be released (please provide a description that is specific and meaningful) - I hereby authorize LAFD Behavioral Health Program to release the following PHI:

Date(s) of Treatment (**required**):_____

Description (**required**): ☐ Psychotherapy treatment ☐ Psychotherapy notes ☐ Other_____

E. Purpose for which this release is to be made (NOTE: You are not required to provide a specific purpose; if left blank, Behavioral Health Program will presume the release is simply made **at your request**.):

_____

F: Signature of Patient, Parent or Guardian, or Personal Representative (All fields are REQUIRED)

Name (Print):_____ Relationship:_____

Signature:_____Date: _____

By signing this document, I declare under penalty of perjury that all statements contained in this form and accompanying document(s) are true and correct.

******Required Documentation –** All parents, guardians, and personal representatives must submit copies of official documentation evidencing their authority to act on behalf of the patient (e.g. minor's birth certificate, Medical Power of Attorney or Advance Health Care Directive, court order granting guardianship, marriage or death certificate, etc.). All submitted documents are subject to verification.*

G: Identity Verification (45 C.F.R. § 164.514(h)) – You (the person identified in Section F) must provide:

- A copy of your photo identification which shows your signature (e.g., State Driver's License, State Identification Card, Passport, Matricula Consular, or City/State/Federal Employment ID Card).

Please return this form and supporting documents to:

Los Angeles Fire Department
Attention: Behavioral Health Program
201 N. Figueroa Street, 1375
Los Angeles, CA 90012

OR

Email: lafd.bhp@lacity.org
FAX (213) 202-5485

If you have questions, or need additional information or assistance in completing this form, please contact us at the above address or call (213) 202-5403

Los Angeles Police Department
Behavioral Science Services
221 North Figueroa Street, Suite 650
Los Angeles, CA 90012

(213) 486-0790 tel
(213) 482-9596 fax

Authorization for Disclosure of Protected Health Information

This form authorizes BSS to **disclose** information from your clinical record to a person you designate or to **request** records from another health provider. You have the right to refuse to sign the authorization form. You have the right to modify or revoke this authorization by notifying BSS. The revocation or modification is not effective until BSS receives it. You have the right to review the information to be disclosed. The information disclosed may be subject to re-disclosure by the party who receives it. You are entitled to a copy of this authorization.

Client Name: _____ Date of Birth: _____

I Authorize:	Release of Information To:
_____ Name of Person Providing Information	_____ Name of Recipient
_____ Name of Entity (Medical Office/Hospital, Law Office, etc.)	_____ Name of Entity (Medical Office/Hospital, Law Office, etc.)
_____ Street Address	_____ Street Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ Phone Fax	_____ Phone Fax

Information to be Disclosed* (check all that apply):

- ☐ Treatment Summary (verbal)
- ☐ Case Activity Record
- ☐ Intake Evaluation
- ☐ Progress Notes
- ☐ Phone consult
- ☐ Discharge Summary
- ☐ Medical Records
- ☐ Symptom Inventory (specify): _____
- ☐ Psychological testing/reports: _____
- ☐ Other* (specify): _____

Dates of treatment: from _____ to _____
Purpose*: The information is being disclosed for the following purpose _____

Duration: This authorization shall become effective immediately and shall remain in effect until _____ (date) or one year from the date signed or until the following event has taken place: _____

*Continue on Supplemental Progress Note if necessary

Signature: _____ Date: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Failure to provide all information may invalidate this authorization

Authorization for copies of medical record: ☐ Paper ☐ Electronic ☐ Other: _____

Patient Information

Patient name (first, middle, last) (please print): _____

Date of birth (MM/DD/YYYY): _____ Phone: _____

Street address: _____

City: _____ State: _____ ZIP code: _____

Who do you want to request records from?

Healthcare Provider or Facility Name: _____

Street address: _____

City: _____ State: _____ ZIP code: _____

Phone: _____ Fax: _____

Where do you want records sent to? (Note: we can only release information you authorize)

☐ Check box if records are being sent to patient only. No further action in this section needed.

Healthcare Provider or Facility Name: _____

Street address: _____

City: _____ State: _____ ZIP code: _____

Phone: _____ Fax: _____ Email: _____

What is the purpose of this release?

☐ Continuing care ☐ Insurance ☐ Legal

☐ Personal use ☐ Other (please specify): _____

continued

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Failure to provide all information may invalidate this authorization

Information to Release

Treatment dates: _____

- ☐ History and physical report
- ☐ Radiology report
- ☐ X-ray film/Images CD
- ☐ EKG/ECHO
- ☐ Operative report
- ☐ Laboratory report
- ☐ Discharge summary
- ☐ Consultation report
- ☐ Emergency record
- ☐ Pathology report
- ☐ Billing record
- ☐ Other (please specify): _____
- ☐ Outpatient/Clinic record - Clinic/Provider name: _____

State/Federal laws require specific authorization to release the following types of information:

- ☐ Mental health
- ☐ Alcohol/Drug abuse
- ☐ HIV test results
- ☐ Genetic testing information
- ☐ Sexually transmitted diseases
- ☐ Reproductive health
- ☐ Gender affirming care

I understand that my reproductive health records are protected under state law and cannot be disclosed without written consent unless otherwise provided for by the regulations (CA Civ. §56.110, CA Health & Safety Code § 130290, CA AB 352).

A separate authorization is required for psychotherapy notes.

Fees

Based on California Evidence Code Sections 1560-1567 Fees may be charged for medical record copies.

Delivery Instructions

- ☐ Mail records directly to person or organization specified
- ☐ Call requestor when records are ready for pickup:

  I authorize (please print name) _____ to pick up my medical record copies.

  Relationship to patient (please print): _____
- ☐ My CS-Link™ (patient portal)
- ☐ Email: _____
- ☐ Other: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Failure to provide all information may invalidate this authorization

Notice of Rights

I understand that:

1. If I refuse to sign this authorization my refusal will not affect my ability to obtain treatment.
2. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
3. I may revoke this authorization at any time in writing, **signed by me or on my behalf and delivered to:**
   Cedars-Sinai Medical Center, Health Information Department
   8700 Beverly Blvd., Room 2800
   Los Angeles, CA 90048
4. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation.
5. I have a right to receive a copy of this authorization.
6. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
7. If this ☐ is checked, the requester will receive compensation for the use or disclosure of my information.

Expiration

Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified:

_____

_____

Signature (patient, power of attorney for healthcare or legal representative)

_____ _____

Date (MM/DD/YYYY) Legal representative relationship

OPTUM®

Authorization for Release of Health Information

Individual's Full Name	Date of Birth	Member or Subscriber ID #
Individual's Street Address	City	State / Zip Code

I understand and agree that:

- this authorization is voluntary;
- my health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
- this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying Optum in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Who May Receive and Disclose my Information:

I authorize Optum and its affiliates to disclose my individually identifiable health information to the following person(s) or organization(s):

_____
(Full Name of Person(s) or Organization(s))

_____
(Full Address &/or Phone number of Person(s) or Organization(s))

Type of Information to be Disclosed:

☐ I authorize disclosure of all my health information, including information relating to claims, medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; **or**

☐ I authorize only the disclosure of the following information:

_____
(Type of Information)

Purpose of Disclosure:

☐ My health information is being disclosed at my request or at the request of my personal representative; **or**

☐ My health information is being disclosed for the following purpose:

_____
(Explain Purpose)

****

_____ _____
Signature of Individual Date

_____ _____
Witness Signature *(For Illinois Residents Only)* Date

Please note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member.

_____ _____
Signature of Individual's Representative Date

Personal Representative's:

_____ _____
Name Phone Number

_____ _____ __ _____
Street Address City State Zip Code

(*For California and Georgia residents only*) I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS

Fax: **866-322-0051**
or
Mail: ATTN Optum ROI Processing
11000 Optum Circle
MN103-0600
Eden Prairie, MN 55344

UCLA Health

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

MRN:
Patient Name:

(Patient Label)

Patient Information	Patient Name: _____ MRN: _____ Address: _____ City, State & Zip Code: _____ Date of Birth (MMDDYYYY): _____ Phone: (____) _____
Specify Healthcare Facility	☐ UCLA Health Hospitals/Clinics ☐ Jules Stein Eye Institute ☐ Resnick Neuropsychiatric Hospital
Release Records to *Where do you want records sent?* *Who do you want to receive records?*	I authorize **UCLA Health** to release PHI to: Name of Hospital/Clinic/Person: _____ Address: _____ City, State & Zip Code: _____ Phone: (____) _____ FAX: (____) _____ *E-Mail Address: _____ *Note: Please provide your email address to receive an email status of your request. If you would like a designee** to pick up your records, please fill out section below: I authorize _____ to pick up my medical record copies. Relationship to patient: _____ **Note: Designee must provide valid photo ID
Delivery Instructions *(please select one)*	☐ CD ☐ E-Mail (NPH/BHS does not release via email) ☐ Paper Copy ☐ Call Requestor when records are ready for pick up ☐ myUCLAhealth* **Note:** If left blank, a CD will be provided. *See page 2 for myUCLAhealth information
Purpose *What is the purpose of this release?*	☐ At the request of the patient/patient representative ☐ Other (state reason) _____

Health Information to be Released: *What records are being requested?*

Type of Records:

☐ Billing Statements	☐ Emergency Reports (ER)	☐ Pathology Reports
☐ Consultations	☐ History & Physical Exams	☐ Progress Notes
☐ Discharge Summary	☐ Jules Stein Images	☐ Radiology Images (x-rays)
☐ EEG Video	☐ Laboratory Reports	
☐ EKG	☐ Operative Reports	Radiology Reports
☐ Other:		
☐ Mental Health (NPH Psychiatric Hospital & Clinic Records)		

UCLA Health

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

MRN:
Patient Name:

(Patient Label)

Sensitive Information	**Sensitive information will not be released unless specifically authorized below:** ☐ Drug and Alcohol Abuse Results ☐ Genetic Testing Information ☐ HIV/AIDS Test Results ☐ Psychological/Vocational Results
Specify Date/Time Period	SPECIFY DATE / TIME PERIOD FOR INFORMATION SELECTED ABOVE: FROM MM / DD / YYYY TO MM / DD / YYYY
Expiration of Authorization	Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event). If no date is indicated this Authorization will expire 12 months after the date signed.
Signature(s)	_____ _____ (Signature of Patient / Legal Representative) Date _____ _____ Printed Name Area Code/Phone Number If signed by someone other than the patient, indicate relationship to the patient _____ _____ _____ Signature of Witness (only if patient unable to sign) or Interpreter Date Interpreter ID #_____

Mailing Addresses	
☐ Please check box for medical records	☐ Please check box for radiology images
UCLA HIMS, Release of Information 10833 Le Conte Ave, CHS BH-902 Los Angeles, CA 90095-1776 Fax: (310) 983-1468 | Phone: (310) 825-6021 Email: roi@mednet.ucla.edu	**Image Management, Release of Information** 200 Medical Plaza B1- Level | Suite 165-11 Los Angeles CA 90095 Fax 310-825-3205 | Phone 310-825-6425
☐ Please check box for mental health records **Mental Health Records** RNPH/BHS HIMS 10833 Le Conte Ave BH239A Los Angeles CA 90095 Fax 310-206-7682 Phone 310-267-2661 or 310-794-1530	**Request medical records via myUCLAhealth** **Visit our website for information:** **https://www.uclahealth.org/medical-records** **Call for Assistance: 855-364-7052**

UCLA Health

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

MRN:
Patient Name:

(Patient Label)

COMPLETING AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

To protect our patient's confidential medical information we must have a valid, complete and legible authorization to disclose their health information.

All sections of this authorization must be completely filled out before UCLA Health is permitted to disclose your protected health information.

Notice

UCLA Health and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Revocation

I may revoke this authorization at any time, provide that I do so in writing and submit it to:

UCLA Health
Health Information Management Services
10833 Le Conte Avenue, CHS BH-902
Los Angeles, CA 90095-7305

The revocation will take effect when UCLA Health receives it, except to the extent that UCLA Health or others have already relied on it.

My Rights

I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for:

1) conducting research-related treatment,
2) obtaining information in connection with eligibility or enrollment in a health plan,
3) determining an entity's obligation to pay a claim, or
4) creating PHI to provide to a third party.

I am entitled to receive a copy of this Authorization.

Requesting records using the UCLA Health patient portal is available for patients and their proxies. Visit myUCLAhealth at: https://www.uclahealth.org/medical-records or call (855) 364-7052 for more information.

KAISER PERMANENTE®

(*Kaiser Permanente entities are listed on reverse side of this form)

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Note: Fees may apply to certain requests

Patient Name: _____

Medical Record Number: _____ Birth Date: _____

Address: _____

City: _____ State: _____

Zip Code: _____ Phone #: ( ) _____

Email: _____

Kaiser Permanente may release this information to: ❑ Check if same as above

Recipient Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone # ( ) _____ Email: _____

This disclosure can be used for the following purpose(s): ❑ Personal Use ❑ Legal ❑ Insurance
❑ Medical Treatment ❑ Medical Condition Verification ❑ Disability ❑ FMLA ❑ Workers' Comp

Check ONLY one of the following three options to identify the health information to be released.

❑ **Option 1:** Form Completion (a substitute form or relevant medical records may be released)

❑ **Option 2:** Last 2 years of Kaiser Permanente Medical Office and Kaiser Foundation Hospital records

❑ **Option 3:** Records as specified. You must complete Step 1 and Step 2 below.

Step 1. Enter date range or date(s) of the records to be released: _____

Step 2. Select types of records to be released:

❑ KP Medical Office ❑ Kaiser Foundation Hospital ❑ Immunization ❑ Lab Results
❑ Diagnostic Images ❑ Copays & Deductibles ❑ Itemized Billing ❑ Pharmacy
❑ Other (provider, department, specialty): _____

NOTE: Hospital and Medical Office records released as part of this authorization may contain references related to mental health, addiction, and HIV medical conditions.

Check the boxes below if you want this release to include the following information, Otherwise, this information will be excluded.

❑ **Mental Health Treatment Records** ❑ **Addiction Medicine Treatment Records** ❑ **HIV Test Results**

For records from Kaiser Permanente Oregon locations only, Genetic Testing information will not be included unless you check this box ❑

Media Type: ❑ Electronic ❑ Paper **Delivery Preference:** ❑ Electronic ❑ Mail ❑ Pickup

DURATION: Authorization shall remain in effect for one year from the date of signature below. However, in Washington, D.C. permission to release addiction medicine treatment records expires after six (6) months.

REVOCATION: You or your personal representative may cancel this authorization for future releases by submitting a written request to the Release of Information Unit listed for your region of service on the reverse side of this form. Your cancellation will not affect information that was released prior to receipt of the written request.

REDISCLOSURE: Once this information is released, it may not be protected under federal privacy law (HIPAA). State or other federal law may require the recipient to obtain your authorization before further disclosure.

Kaiser Permanente may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization. This disclosure is made at your request. For Virginia patients, a copy of this authorization, and a note stating to whom your information was disclosed will be included in your medical record. A copy of the original authorization is valid. You have a right to a copy of this completed authorization.

Date _____ Signature _____ If personal representative, print name/relationship _____

"Kaiser Permanente" means both your insurance company (a Kaiser Permanente health plan) and your doctors (a Permanente medical or dental group). It also includes different groups depending on where you live.

You can contact all Kaiser Permanente regions via **kp.org/requestrecords.**

All states where we do business:
• Kaiser Foundation Hospitals

California:
• Kaiser Foundation Health Plan, Inc., Northern California Region
• The Permanente Medical Group
• Kaiser Foundation Health Plan, Inc., Southern California Region
• Southern California Permanente Medical Group

Colorado:
• Kaiser Foundation Health Plan of Colorado
• Colorado Permanente Medical Group, P.C.

Georgia:
• Kaiser Foundation Health Plan of Georgia, Inc.
• The Southeast Permanente Medical Group, inc.

Hawaii:
• Kaiser Foundation Health Plan, Inc., Hawaii Region
• Hawaii Permanente Medical Group, Inc.

Mid-Atlantic States:
• Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
• Mid-Atlantic Permanente Medical Group, P.C.

Oregon and Southern Washington:
• Kaiser Foundation Health Plan of the Northwest
• Northwest Permanente, P.C.
• Permanente Dental Associates, P.C.

Washington:
• Kaiser Foundation Health Plan of Washington
• Kaiser Foundation Health Plan of Washington Options, Inc.
• Washington Permanente Medical Group, P.C.