**PERSONNEL ACTION**

**WOOD COUNTY COMMISSIONERS' DEPARTMENTS**

**DEPARTMENT**

FROM _____

TO _____

**RESOLUTION**

NO. _____

DATE _____

**NAME** _____
Last First MI

**EMPLOYEE NO.** _____

**POSITION TITLE**

FROM: _____

TO: _____

**RATE**

GRADE/STEP/RATE: _____

GRADE/STEP/RATE: _____

**EFFECTIVE DATE** _____ month/day/year

**ENDING DATE** _____ month/day/year

**APPOINTMENT**

- ☐ Emergency
- ☐ Full Time
  - ☐ Regular
  - ☐ Temporary
- ☐ Part Time
  - ☐ Regular
    _____ Hours/Week
  - ☐ Temporary
    _____ Hours/Week
- ☐ Intermittent
- ☐ Request to post
  - ☐ New
  - ☐ Vacant
- ☐ FLSA Exempt
  - ☐ Administrative
  - ☐ Professional
  - ☐ Executive
- ☐ Unclassified Position
- ☐ Conditional - SB 160
- ☐ Bargaining Unit

**CHANGE**

- ☐ Amend Resolution No. _____
- ☐ Department
- ☐ Position
- ☐ Effective Date
- ☐ Ending Date
- ☐ Rate
- ☐ Completed Probation
- ☐ Extend Probation
- ☐ Anniversary Increase
- ☐ Step Increase
- ☐ Status/Hours
- ☐ Prior Service
- ☐ Last Chance Agreement

**SEPARATION**

- ☐ Resigned
- ☐ Retired
- ☐ Disability Retirement
- ☐ Disability Separation
- ☐ Voluntary Separation (3 days no call/no show)
- ☐ Probationary Termination
- ☐ Terminated
- ☐ Deceased
- ☐ Laid Off
- ☐ Terminated - SB 160
- ☐ Cancel Appointment Resolution No.
- ☐ Last Day Worked _____

**INTERRUPTION**

- ☐ Medical Leave
  - ☐ With Pay
  - ☐ Without Pay
- ☐ Personal Leave
  - ☐ With Pay
  - ☐ Without Pay
- ☐ Military Leave
  - ☐ With Pay
  - ☐ Without Pay
- ☐ Suspension without Pay
- ☐ Administrative Leave with Pay
- ☐ FMLA

**SICK LEAVE BALANCE: Hours** _____

- ☐ Leave on Books
- ☐ Transfer to _____
- ☐ Retirement Payout (Hours) _____
  - ☐ State _____ % of payout to limit
  - ☐ County _____ % of payout to limit

**PRIOR SERVICE**

Completed payperiods _____

Agency _____

Sick Leave Hours Transferred To WC _____

**VACATION BALANCE: Hours** _____

- ☐ Leave on Books
- ☐ Transfer to _____
- ☐ Cash Payout (Not to exceed 2 year accrual limit)

**COMP TIME BALANCE: Hours** _____

- ☐ Cash Payout (Not to exceed limit)
- ☐ Transfer to _____
- ☐ Leave on Books

**PROBATIONARY PERIOD**

- ☐ 180 Days
- ☐ 1,000 Hours
- ☐ 120 Days
- ☐ Other (See Remarks)

**ADDITIONAL REMARKS:**

**APPROVAL OF DEPARTMENT HEAD**

Signature Date

REQUESTING DEPARTMENT -- RETAIN COPY - COPY EMPLOYEE UPON APPROVAL

Rev. 3/11

# ACA Compliance Report

To comply with the ACA employer mandates, employees' hours of service determine eligibility for insurance coverage. A full time employee is defined as an employee who works on average 30 hours of service or more per week. This **form and official documentation from the Appointing Authority** (journal entry, letter, etc.) designating employment status must be submitted to the Commissioners' Office **within three days of appointment or status change to determine eligibility.**

Report of: ☐ **NEW HIRE** ☐ **CHANGE IN EMPLOYMENT STATUS/SEPARATION**

**Department** _____ **SS#** _____ **Payroll #** _____

**First Name** _____ **M.I.** _____ **Last Name** _____
As printed on Social Security Card

**NEW HIRE: APPOINTMENT CATEGORY** **Date of Hire:**_____

☐ **FULL TIME** Check if Temporary (less than 120 days) ☐ Temporary End Date _____ Hours compensated per week _____

☐ **PART TIME** Check if Temporary (less than 120 days) ☐ Temporary End Date _____

☐ Fixed Schedule: Est. Hours/Week: ☐ 30 hours or more ☐ Less than 30 hours

☐ Varied Schedule: Average hours _____ per ☐ week ☐ month

☐ **INTERMITTENT** (less than 1,000 hours per year) or **SEASONAL** (less than six months per year) End Date _____

Check if any of the following apply: ☐ Transferring directly from another County Department: Dept. _____
☐ Continuing employment with another County Department: Dept. _____
☐ Rehired by County within 13 weeks ☐ Hired directly from temporary agency

| Sub Group No. Ex. 106-1 | Insurance Line Item (Cannot split between two line items) Ex. 1001-01-109-50100 general fund | Paycode(s) Ex. 15001 | Salary Line Item Ex. 1001-01-100-510100 | Bi-Weekly Hours Ex. 80 |
|---|---|---|---|---|
| | | | | |
| ☐ Check if split funding is needed for grant funding or other indirect cost purposes | | | | |

**CHANGE IN EMPLOYMENT STATUS - Includes Transfers to Another Department and Separations**

If employee is a monthly measurement, verify that employee will meet 130 hours of service during month(s) of reported event.
If under 130 hours for the month, coverage will terminate retroactive to the last day of the prior month. Forward timesheet(s) for the month with insurance report.

Effective Date of Change/Separation_____

☐ Part Time to Full Time Hours compensated per week _____ *If benefit eligible, note Sub Group & Insurance Line Item above.*

☐ Part Time Hours Change Estimated Scheduled Hours/Week: ☐ 30 hours or more ☐ Less than 30 hours

☐ Full Time to Part Time Estimated Scheduled Hours/Week: ☐ 30 hours or more ☐ Less than 30 hours

☐ Unpaid Leave of Absence ☐ FMLA ☐ Military ☐ Other: _____

Unpaid Leave: Start Date: _____ End Date: _____

Check Wages for Premium Collection: Month: _____ 1st payroll deduction ☐ Yes ☐ No / 2nd payroll deduction ☐ Yes ☐ No

☐ Self Pay Required for Month(s) _____ ☐ Not enrolled in benefits

☐ **TRANSFER TO ANOTHER DEPARTMENT**: New Department _____

☐ **SEPARATION OF EMPLOYMENT** Last Day in Active Pay Status_____

☐ Benefit Eligible at Separation: ☐ Ongoing ☐ Monthly: Hours of Service for Month _____ (*If less than 130, not eligible for month.)*

☐ Not Benefit Eligible/Enrolled

**Department Head Signature**_____ **Date** _____

**DETERMINATION OF BENEFIT ELIGIBILITY -- For Commissioners' Office Use** _____

☐ **New Hire:** ☐ Benefit-Eligible Insurance Checklist attached - Monthly Measurement through _____
Effective Date for Coverage _____
☐ Non-Benefit Eligible Insurance Checklist attached – Variable Hour: IMP End Date _____

☐ **Status Change/Separation:** Current Measurement: ☐ Ongoing ☐ Monthly ☐ Variable Hour
☐ Change to Monthly through _____ ☐ Insurance Checklist Attached *See New Hire noted above*
☐ Term: Coverage Termination Eff. Date _____ ☐ No Change

Note: _____

cc: Group Rep with appropriate Insurance Checklist Group Rep to provide final copy provide to employee: Date provided _____