Additional Costs for STNC/Professional Expert Employees

Please complete this form and attach to the PAF for any STNC or Professional Expert employee working for 130 or more hours per month for greater than two months AND/OR any employee being PAF'ed for greater than 1,000 hours per fiscal year. Any PAFs that require this form will be rejected without it.

Medical Benefits Coverage

Under the Affordable Care Act (ACA), any employee who works 130 hours per month for greater than two months is entitled to medical coverage. Departments wanting to work employees 130 hours per month will be responsible for providing the funding for this coverage. Per the ACA legislation, this employee may be eligible for continuation of coverage beyond your department's assignment, regardless of hours worked. If this occurs, your department will continue to be responsible for those costs from your discretionary budgets. The current cost is approximately $6,400 per year.

Employee Name: _____Effective Date: _____ End Date: _____

Signature: _____Date:_____

Name: _____ Title: _____

VP approval: _____ Date: _____

By signing this form, the department is acknowledging that they will be responsible for funding the medical coverage of the employee while they are employed by the District unless the employee qualifies for coverage in another department by working 130 hours per month for longer than two months.

Retirement

If an employee is employed for greater than 1,000 hours in a fiscal year, they are mandated to be enrolled in CalPERS. If a department PAFs an employee for greater than 1,000 hours, the employee will be enrolled in CalPERS immediately. If the employee works greater than 1,000 hours on multiple PAFs, they will be enrolled into CalPERS when they have worked 1,000 hours. If this occurs while the employee works in your department, you will be responsible for the additional CalPERS costs (currently at 13.88% of salary) from your discretionary budgets.

Employee Name: _____Effective Date: _____ End Date: _____

Signature: _____Date:_____

Name: _____ Title: _____

VP approval: _____ Date: _____

By signing this form, the department is acknowledging that they will be responsible for funding the District's retirement costs of the employee.