

**THIS FORM MUST BE COMPLETED IN FULL BY THE EMPLOYER, ONLY
 MONROE COUNTY DEPARTMENT OF HUMAN SERVICES
 111 WESTFALL ROAD
 ROCHESTER, NEW YORK 14620**

Client: _____
 Soc. Sec. #: _____

Date: _____
 Case No.: _____

Our client is or recently has been in your employ. We require the following information to determine initial and ongoing eligibility for the Temporary Assistance Program. This request for employment information is made in accordance with the provisions of Article 5 Section 143 of the Social Services Law. Thank you for your cooperation.

Address of Wage Earner: _____

Social Security Number: _____

Hire Date: _____

Employee is paid Weekly Biweekly Other

Date of first Pay: _____

Day of week pay is received by employee: _____

Normal work week has _____ hours
 at \$ _____ per hour.

Payday is _____ number of days after the pay period ends.

Was this person employed by you for any period prior to the most recent hire date listed above? YES NO

If yes, give the dates of previous employment. From: _____ To: _____

COMPLETE THIS SECTION ONLY IF CLIENT IS STILL EMPLOYED

Benefits available to Employee:

	Yes	No
Paid Sick Leave	<input type="checkbox"/>	<input type="checkbox"/>
Bonus Plan	<input type="checkbox"/>	<input type="checkbox"/>
Pension	<input type="checkbox"/>	<input type="checkbox"/>
Paid Vacation	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH INSURANCE

Yes No

If yes, Type: _____

Payroll Deduction Amount: _____

Single Family

COMPLETE THIS SECTION ONLY IF CLIENT IS NO LONGER EMPLOYED

Last Date Employed: _____

Date Last Pay Received: _____

Last Pay: \$ _____ (Gross)

Health Insurance Expires: _____

Reason for Separation:

- Voluntary Quit
- Lay-off
- Fired
- Other
- Medical Leave

Reason, if known: _____

Possible rehire? Yes No If yes, when? _____

Reason: _____

Explain: _____

Expected Date of Return: _____

Is employee is covered by any of the following:

	Yes	No
Unemployment Benefits	<input type="checkbox"/>	<input type="checkbox"/>
Workmen's Compensation	<input type="checkbox"/>	<input type="checkbox"/>
Disability	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Union Benefits	<input type="checkbox"/>	<input type="checkbox"/>
Sick Pay	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

Employer's Name and Address: _____

Telephone: _____ Information Provided by: _____ Date: _____

Please Return To: _____ Telephone: _____

Return By: _____

OVER PLEASE, FORM CONTINUED ON BACK

