LDSS-3707 (Rev.4/01) FRONT

EMPLOYMENT VERIFICATION

LOCAL DISTRICT NAME AND ADDRESS:	CASE NUMBER	WORKER ID
	CASE NAME AND ADDRESS	

EMPLOYER'S NAME AND ADDRESS

DATE: ___________________________________

Abstract of Section 143 of the N.Y.S. Social Services Law
Employers are required to furnish to the N.Y.S. Office of Temporary and Disability Assistance information concerning wages, salaries, earnings or other income of any applicant for, or recipient of public assistance or care, or any relative legally responsible for the support of such applicant or recipient.

--fold *fold --*

Dear Sir/Madam;

We are currently reviewing the assistance case of the above named person. In order to complete our review of this case, we need information concerning wages of________________________, SSN____________________________, Date of Birth ___________________, received for the period_____________________ to ______________________.

Please provide us with the information requested at your earliest convenience by completing this form and returning it. Please include any information for periods when the employee was paid by sick time, vacation time, compensation, etc. A copy of the employee's pay ledger or a computer printout of the pay record is acceptable, as long as all of the requested information is clearly presented. If this person is no longer working for you, please complete this form using his/her last weeks' earnings.

CHECK RELEASE DATE	PAY PERIOD		GROSS PAY EXCLUDING EIC*	EIC*	HEALTH INSURANCE DEDUCTIONS	NO. OF HOURS SCHEDULED TO WORK	ACTUAL HOURS WORKED
	FROM	TO					

NOTE: FOR THOSE WITH TIP INCOME, PLEASE INCLUDE TIPS IN THE GROSS PAY COLUMN.

***EARNED INCOME CREDIT**

SIGNATURE OF ELIGIBILITY WORKER:	UNIT	TELEPHONE NO.

SEE THE REVERSE SIDE

EMPLOYMENT VERIFICATION

PLEASE COMPLETE THE QUESTIONS BELOW WHICH ARE CHECKED (✓):

1. Date Employment began:________________________________ Rate of Pay_______________________________
2. Date Employment ended:____
   Reason for termination ____
   ____
3. Does employee have life insurance through your company? YES NO
   Or, through the union? YES NO
4. Does employee have health insurance through your company? YES NO
   Or, through the union? YES NO
   a. Is health insurance available to:
      The employee? YES NO
      The employee's family? YES NO
   b. Is the employee and/or his/her family enrolled? YES NO
      If yes, who is covered?____
      ____
   c. Name and address of Insurance Carrier ____
      Effective date of coverage ____
      Policy Number: ____
5. Does employee have disability benefits through your company? YES NO
   Or through the union? YES NO
   Name and address of Insurance Carrier____
6. Does employee have payroll savings through your company? YES NO
   If yes, please specify (i.e., bonds, credit union, IRA, deferred compensation, etc.): ______________________
   ____
7. To your knowledge, is the employee working anywhere else? YES NO
   If yes, where: ____
   ____
8. If this person has left your employ, did he/she indicate a new job? YES NO
   If yes, where: ____
   ____
9. According to your records, what is employee's address if different from the address on the reverse side
   ____
10. Is your company a temporary employment agency? YES NO
    If yes, is the employee on-call? Please specify ____
    ____
11. Other (Specified below):

REQUEST: ______________________________ RESPONSE: ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Please print your name:____Date__________________________

Signature:____

Title:____

Telephone Number(________)________________________

PLEASE RETURN THIS FORM TO THE ADDRESS IN THE TOP LEFT CORNER OF THE OTHER SIDE OF THIS FORM

THANK YOU FOR YOUR COOPERATION