

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.

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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.
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SEE THE REVERSE SIDE

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(_____) _____