LDSS-3707 (Rev.11/10)

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_____,
(Last 4 Digits)

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**

Effective December 31, 2010, the advanced Earned Income Credit was eliminated. As a result, eligible individuals will no longer be able to receive an advance on their expected Earned Income Credit as part of their regular paycheck. Eligible individuals will still be able to claim the credit on their personal income tax returns, but employers may no longer advance a portion of the credit on each paycheck.

SIGNATURE OF ELIGIBILITY WORKER:	UNIT	TELEPHONE NO.

SEE THE REVERSE SIDE

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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