Human Resources Administration
Department of Social Services

# FAMILY INDEPENDENCE ADMINISTRATION

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## POLICY BULLETIN #11-74-OPE

### REVISIONS TO FORMS M-687u, W-532, AND W-575T

| **Date:** August 16, 2011 | **Subtopic(s):** **Forms** |
|---|---|
| 💻 This procedure can now be accessed on the FIAweb. | The purpose of this policy bulletin is to inform Job Center staff that the following forms have been revised to reflect the Agency's most current terminology, software, and logo:<br><br>• Nonpayee Appointment Notice (**M-687u**)<br>• Letter to Past/Present Employer (**W-532)**<br>• Declaration of Employment (**W-575T**)<br><br>Additionally, the following language was added to Form **M-687u**: "If you have a physical, mental health, or learning problem that makes it difficult to travel to your center, please call the telephone number above."<br><br>Job Center Directors must ensure that all previous versions of Forms **M-687u, W-532, W-575T** and their multilingual equivalents are removed from circulation and recycled.<br><br>Samples of the revised forms are attached.<br><br>*Effective Immediately*<br><br>**Related Items:**<br>PD #04-26-EMP<br>PB #03-20-OPE<br>PB #01-96-EMP |

HAVE QUESTIONS ABOUT THIS PROCEDURE?
Call 718-557-1313 then press 3 at the prompt followed by 1 or
send an e-mail to *FIA Call Center Fax* or fax to: *(917) 639-0298*

Distribution: X

Please use Print on Demand to obtain copies of forms.

**Attachments:**

| | |
|---|---|
| **M-687u** | Nonpayee Appointment Notice (Rev. 8/16/11) |
| **M-687u (S)** | Nonpayee Appointment Notice (Spanish) (Rev. 8/16/11) |
| **W-532** | Letter to Past/Present Employer (Rev. 8/16/11) |
| **W-575T** | Declaration of Employment (Rev. 8/16/11) |
| **W-575T (S)** | Declaration of Employment (Spanish) (Rev. 8/16/11) |

Form M-687u LLF
Rev. 8/16/11

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

Caseload: _____

Job Center: _____

CIN: _____

Action Code: _____

# Nonpayee Appointment Notice

An appointment has been made for _____.
(nonpayee's name)

As an employable Family Assistance/Safety Net Non-Cash Assistance participant who is not working full-time, you are required to participate in HRA job search/work activities that will help you find employment. You must participate in order to remain eligible for cash assistance and/or food stamps. Therefore, you have been scheduled for an appointment with the JOS/Worker assigned to handle your cash assistance case.

You must attend this appointment. You should bring original copies of any documentation concerning your income, especially verification of earnings. All nonexempt income must be reported and included in the cash assistance budget for your household. If you believe that you should not participate in job search/work activities for any reason, you must bring to your appointment any and all relevant documentation that explains why you are unable to work. You cannot be excused from work requirements without proof of your inability to work. We will schedule you for a mandatory medical examination with an HRA-authorized medical practitioner to verify any claimed medical exemption.



**Appointment Information:**

Appointment Date: _____ Day: _____ Time: _____ Telephone: _____

Address: _____

City: _____ State: ____ Zip: _____

Travel Directions: _____

**This is a mandatory engagement appointment.**

If your situation has changed and you now believe that you are no longer employable, you must keep this appointment and bring original and detailed documentation with you to prove your claim. If you need to reschedule this appointment please call _____.

Note: If the nonpayee is assigned to work activities, carfare will be issued in the name of the casehead. Failure of the casehead to provide the nonpayee with the issued carfare will result in adverse action being taken on the case for noncompliance with work requirements.

If you have a physical, mental health, or learning problem that makes it difficult to travel to your center, please call the telephone number above.

**Failure to keep this appointment without good cause or failure to cooperate with employment requirements may result in the reduction of your household's cash assistance and/or Food Stamp benefits.**

**There are no work requirements for Medicaid.**

Form M-687u (S) LLF
Rev. 8/16/11

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Unidad de Casos: _____

Centro de Trabajo: _____

CIN: _____

Código de Acción: _____

# Aviso de la Cita de la Persona No Beneficiaria

Se ha fijado una cita para _____.
(nombre del no-beneficiario)

Debido a que usted es participante de Asistencia No En Efectivo para Familias y de la Red de Seguridad (Family Assistance/Safety Net Non Cash Assistance) que no trabaja a tiempo completo a pesar de ser apto(a) para trabajar, se requiere que participe en actividades de trabajo/búsqueda de empleo de la HRA que le brindarán mejor posibilidad de conseguir empleo, además de mantener su elegibilidad respecto a asistencia en efectivo y/o cupones para alimentos. Por lo tanto, se le ha programado una cita con el Trabajador/JOS designado para administrar su caso de asistencia en efectivo.

Usted tiene que acudir a esta cita. Debe traer copias originales de toda documentación relativa a sus ingresos, especialmente verificación de ingresos. Los ingresos no exentos deben ser declarados e incluidos en el presupuesto de asistencia en efectivo de su hogar. Si usted considera que no debe participar en actividades de trabajo/búsqueda de empleo por alguna razón, usted tiene que traer a su cita cualquier y toda documentación pertinente que explique la razón por la cual no puede trabajar. Usted no puede ser dispensado(a) de los requisitos de trabajo sin prueba de su incapacidad para trabajar. Nosotros le programaremos una cita para un examen médico obligatorio con el médico general autorizado por la HRA para verificar cualquier limitación médica alegada.



**Información sobre la Cita:**

Fecha de la Cita: _____ Día: _____ Hora: _____ Teléfono: _____

Dirección: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Indicaciones de Viaje: _____

**Esta es una cita obligatoria de participación en actividades.**

Si usted considera que su situación ha cambiado y por consiguiente ya es apto(a) para trabajar, debe acudir a esta cita y traer documentación original y detallada para comprobar su reclamo. Si necesita programar una nueva cita por favor llame al _____.

Nota:Si se le asigna una actividad de trabajo a la persona no beneficiaria, a dicha persona se le expedirá el pago para el transporte a nombre de la persona encargada del caso. Sin embargo, si la persona encargada del caso no cubre los gastos de transporte del no beneficiario con los fondos expedidos para dicho propósito, puede que se tomen medidas para sancionar el caso por incumplimiento de los requisitos de trabajo.

Si usted tiene un problema físico, mental, o de aprendizaje que le dificulte transportarse a su centro, favor de llamar al número de teléfono más arriba.

**El no acudir a esta cita sin motivo justificado o no cooperar con los reglamentos laborales federales y estatales puede resultar en la reducción de los beneficios de su hogar de asistencia en efectivo/Cupones para Alimentos.**

**No existen requisitos de trabajo para Medicaid.**

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

Caseload: _____

Worker Name: _____

Worker Phone: _____

Check one: ☐ Applicant ☐ Participant

Address: _____

_____

Past/Present Employer:

Abstract of Section 143 of the New York State Social Service Law: "Employers are required to furnish the Human Resources Administration (HRA) with information regarding wages, salaries, earnings or other income of any applicant for, or participant of, assistance or of any relative legally responsible for the support of such person."

We are currently reviewing the assistance case of the above named person. In order to complete our review, we need information concerning the wages of _____, Social Security number _____,
(name of employed person)

Date of Birth_____, received for the period from _____ to _____ .
(date) (date)



Please complete both sides of this form; include information for any periods during which the employee received sick pay, vacation pay, and/ or compensation pay. 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 only the reverse of this form using his/her last week's earnings received.

Please complete and return this form by _____
(date)

| Check Release Date | Pay Period | | Gross Pay (Excluding EIC*) | EIC* | Health Insurance Deductions | Number of Hours Scheduled to Work | Actual Hours Worked |
|---|---|---|---|---|---|---|---|
| | From | To | | | | | |
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NOTE: FOR THOSE WITH TIP INCOME, PLEASE INCLUDE TIPS IN THE GROSS PAY COLUMN.
* Earned Income Credit
We thank you for your cooperation.

(see reverse side)

# Employer Questionnaire

## EMPLOYEE INFORMATION

| Employee Name | Social Security Number |
|---|---|
| | |

| Home Address While in Your Employ |
|---|
| |

| Date Employment Began | Position |
|---|---|
| | |

| Date Employment Ended | Reason for Leaving |
|---|---|
| | |

## PAYROLL INFORMATION

Rate of Pay $_____ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Other Hours per week_____ Number of Exemptions_____

| Miscellaneous Payments | | | Date Paid |
|---|---|---|---|
| Overtime Pay | $ | | |
| Comp. Pay | $ | | |
| Vacation Pay | $ | | |
| Sick Pay | $ | | |
| Pension | $ | | |
| Name of Union from which the person may receive benefits: | | | |

| Deductions | $ | |
|---|---|---|
| Earned Income Credit | $ | |
| Federal Income Tax Withheld | $ | |
| NYC Tax Withheld | $ | |
| FICA Deduction | $ | |
| Pension | $ | |
| Union Dues | $ | |
| Health Insurance | $ | |

| | | |
|---|---|---|
| Life Insurance | $ | |
| Disability Insurance | $ | |
| Payroll Savings | | |
| ☐ Bonds ☐ Credit Union | | |
| ☐ IRA ☐ Other (specify below) | | |
| ☐ 401K | | |
| Other Payroll Deductions: | | |



## HEALTH INSURANCE INFORMATION

Does/did employee have health insurance? ☐ No ☐ Yes If Yes, through employer? ☐ through union? ☐

| Name of Carrier | Policy or ID Number | Group Number |
|---|---|---|
| | | |

| Names of Covered Individuals | Date of Coverage From | To |
|---|---|---|
| | | |
| | | |
| | | |

If no longer in you employ, is health insurance coverage still available? ☐ No ☐ Yes

If Yes, can policy be converted to an individual policy? ☐ No ☐ Yes If Yes, cost of conversion to employee $_____per_____

| Types of coverage when in your employ: (Check ☑ appropriate code) | MAJOR MEDICAL | IN-PATIENT HOSPITAL | SENIOR CARE | OUT-PATIENT | DRUG/ PHARMACY | HOME CARE | DENTAL | NURSING HOME | OPTICAL |
|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

## LIFE INSURANCE INFORMATION

Does/did employee have life insurance? ☐ No ☐ Yes If Yes, through employer? ☐ through union? ☐

| Name of Carrier | Policy or ID Number | Group Number |
|---|---|---|
| | | |

| Names of Covered Individuals | Date of Coverage From | To |
|---|---|---|
| | | |
| | | |
| | | |

**Completed by:**

Company/Organization Name _____ Address _____

Signature _____ Date _____ Employer ID Number _____

Name (print) _____ Title _____ Telephone Number _____

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Date: _____

Case Number: _____

Name: _____

Center: _____

Telephone Number: _____

# Declaration of Employment

**Please print all information and return this form, with a copy of your pay stub or a letter from your employer, in the enclosed business-reply envelope.**

## Personal Information

Employee's Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Social Security Number: _____

Age of Employed Person: _____



## Employment Information

Job Title: _____ Date Job Began: _____

If recently started, date of first paycheck: _____

Gross salary (before tax deductions): $ _____

Frequency of pay (check [☑] one): ☐ weekly ☐ biweekly ☐ monthly

Other (please specify): _____

Total number of hours worked per week: _____

Employer's Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Telephone: _____ Date job ended (if no longer employed): _____

Mail Job #468

**School Attendance Information**

If you are also attending school while working, please enter the information below:

Full-time school attendance ☐ Part-time school attendance ☐

Days/hours of attendance: _____

Course description(s): _____

_____

School Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Telephone: _____ School Contact Person: _____

**Other Income**

Check (☑) all that apply. Please attach income verification, such as a check or income statement.



| Income Type | Amount ($) | Frequency | | |
|---|---|---|---|---|
| | | Weekly | Biweekly | Monthly |
| ☐ Social Security Income (SSI) | _____ | ☐ | ☐ | ☐ |
| ☐ Social Security Disability | _____ | ☐ | ☐ | ☐ |
| ☐ New York State Disability | _____ | ☐ | ☐ | ☐ |
| ☐ Unemployment Benefits | _____ | ☐ | ☐ | ☐ |
| ☐ Other Income | _____ | ☐ | ☐ | ☐ |

In signing this Declaration of Employment, I certify that the above information is correct and that I understand that the income I am reporting will be evaluated by the Agency.

Employed Person's Signature: _____ Date: _____

Please print name: _____

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre: _____

Centro: _____

Número de Teléfono: _____

# Declaración de Empleo

**Favor de apuntar todos los datos en letra de molde y devolver este formulario, con una copia de su talón de pago o una carta de su empleador, en el sobre de vuelta adjunto.**

## Información Personal

Nombre del Empleado: _____ _____ _____

Dirección: _____

_____

Ciudad: _____ Estado: ____ Código Postal: _____

Número de Teléfono: _____ Número de Seguro Social: _____

Edad del Empleado: _____



## Información del Empleo:

Función del Empleado: _____ Fecha de comienzo: _____

Si comenzó recientemente, fecha del primer cheque de paga: _____

Salario bruto (antes de las deducciones de impuestos): $ _____

Frecuencia de pago (marque [☑] una casilla): ☐ semanalmente ☐ quincenalmente ☐ mensualmente

Otro caso (favor de especificar): _____

Número total de horas trabajadas por semana: _____

Nombre del Empleador: _____ _____ _____

Dirección: _____

_____

Ciudad: _____ Estado: ____ Código Postal: _____

Fecha en que terminó su empleo

Teléfono: _____ (si ya no está empleado): _____

**Información de Asistencia Escolar**

Si usted también asiste a la escuela mientras trabaja, favor de anotar esta información más abajo:

Asistencia escolar a tiempo completo ☐ Asistencia escolar a tiempo parcial ☐

Días/horas de asistencia: _____

Descripción de los cursos: _____

_____

Nombre de la Escuela: _____

Dirección: _____

_____

Ciudad: _____ Estado: _____ Código Postal: _____

Teléfono: _____ Persona Contacto en la Escuela: _____

**Otros Ingresos**

Marque (☑) todas las casillas que correspondan. Favor de adjuntar comprobantes de ingresos, como cheques o estados e ingresos.



| Tipo de Ingreso | Cantidad ($) | Frecuencia | | |
|---|---|---|---|---|
| | | Semanal | Quincenal | Mensual |
| ☐ Ingreso del Seguro Social (Social Security Income – SSI) | _____ | ☐ | ☐ | ☐ |
| ☐ Seguro Social para Incapacitados | _____ | ☐ | ☐ | ☐ |
| ☐ Beneficios para Incapacitados del Estado de Nueva York | _____ | ☐ | ☐ | ☐ |
| ☐ Beneficios por Desempleo | _____ | ☐ | ☐ | ☐ |
| ☐ Otros Ingresos | _____ | ☐ | ☐ | ☐ |

Al firmar esta Declaración de Empleo, doy fe de que la información antedicha es correcta y que soy consciente de que el ingreso que estoy declarando será evaluado por la Agencia.

Firma del Empleado: _____ Fecha: _____

Favor de escribir su nombre en letras de molde: _____