FAMILY INDEPENDENCE ADMINISTRATION

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POLICY BULLETIN #06-74-OPE

OBSOLETE FORMS

Date: May 17, 2006	**Subtopic(s):** Forms

This procedure can now be accessed on the FIAweb.

The purpose of this policy bulletin is to inform all staff that the following forms are being made obsolete because of programmatic changes and/or the information now being captured electronically by the New York City Work, Accountability and You (NYCWAY) system.

- Travel Directions to the CIBC ID Card Pick-Up Site for Pick-Up of Replacement Medicaid ID Card Only (**W-608B**)

  The **W-608B** is no longer needed because the form was used exclusively for the issuance of Medicaid identification cards. The Travel Directions to the Manhattan/Brooklyn Common Benefit Identification Card (CBIC) Over-The-Counter (OTC) Sites (**W-608H**) is issued to applicants/participants to obtain a CBIC card for public assistance, food stamps and Medicaid benefits.

- Job Center Tracking System 1st Day Registration (**W-680E**)
- Job Center Tracking System I. Follow-Up (Employment Team) (**W-680K**)
- Job Center Tracking System Follow-Up (Financial Planning) (**W-680M**)

  Applicants'/Participants' information, which was reported on the **W-680E**, **W-680K** and **W-680M**, is now captured in NYCWAY.

Refer to PB #06-41-OPE

- Important Notice to All Food Stamp Recipients (**W-138XX**)

  Information from the **W-138XX** is captured on the New York State Office of Temporary Disability Assistance Food Stamp Change Report Form (**LDSS-3151**).

HAVE QUESTIONS ABOUT THIS PROCEDURE?
Call 718-557-1313 then press 2 at the prompt followed by 765 or
send an e-mail to *FIA Call Center*

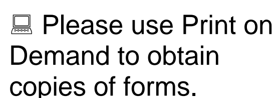
Distribution: X

- Consent for Disclosure of Medical, Mental Health and Alcoholism and Substance Abuse Treatment Records (**W-612CC**)

  The form has been replaced with Consent for Disclosure of Medical and Alcoholism and Substance Abuse Treatment Records (**M-76n**).

Center Directors/Office Site Managers must ensure that all versions of the **W-608B**, **W-680E**, **W-680K**, **W-680M**, **W-138XX** and **W-612CC** are removed from circulation and recycled.

Effective Immediately



Please use Print on Demand to obtain copies of forms.

Attachments:

W-608B	Travel Directions to the CBIC ID Card Pick-Up Site for Pick-Up of Replacement Medicaid ID Card Only (Obsolete)
W-680E	Job Center Tracking System 1st Day Registration (Obsolete)
W-680K	Job Center Tracking System I. Follow-Up (Employment Team) (Obsolete)
W-680M	Job Center Tracking System Follow-Up (Financial Planning) (Obsolete)
W-138XX	Important Notice to All Food Stamp Recipients (Obsolete)
W-612CC	Consent for Disclosure of Medical, Mental Health and Alcoholism and Substance Abuse Treatment Records (Obsolete)

Form W-608B (face)
9/8/98

Human Resources Administration
Family Independence Administration

TRAVEL DIRECTIONS TO THE CBIC ID CARD PICK-UP SITE

For Pick-up of Replacement Medicaid ID Card Only

Form DSS 4113-2, referral to the CBIC ID Card Pick-up Site, is stapled to the bottom portion of this page. You must take it to the CBIC ID Card Pick-up site. **You will NOT get an ID card unless you have Form DSS 4113-2.**

OBSOLETE

This is when you go:

Any day, Monday through Friday, except holidays, between 8AM and 4PM.

This is where you have to go:

CBIC ID Card Pick-up Site
419 Lafayette Street
New York, New York 10003

How to get there:

By Subway: #6 - to Astor Place
#N, R - to 8th Street

By Bus: M1, M2, M3, M5, M6 - to East 8th Street
M15 - to 2nd Ave. and East 6th Street
M8 - to Lafayette Street

Because space is limited, please do not bring anyone else with you unless absolutely necessary.

FORM DSS 4113-2

STAPLE FORM DSS 4113-2 HERE

Form W-608B (reverse)
9/8/98

Human Resources Administration
Family Independence Administration

INSTRUCCIONES PARA LLEGAR AL LOCAL DE TARJETAS DE IDENTIFICACION DE CBIC

Usted necesitará una tarjeta de identificación para obtener sus beneficios de asistencia pública y/o cupones de alimentos. El formulario DSS 4113-2, engrapado más abajo es un referimiento al local de Tarjetas de Identificación de CBIC. Usted tiene que llevarlo a ese local para recoger su tarjeta. **No podrá obtener su tarjeta si no tiene el Formulario DSS 4113-2.**

¿Cuándo puedo ir?

Cualquier día de lunes a viernes, excepto en los días feriados, entre las 8 am y las 4 pm.

¿Dónde tengo que ir?

CBIC ID Card Pick-up Site
419 Lafayette Street
New York, New Yo[illegible]00[illegible]

¿Cóm[illegible]e[illegible]o ll[illegible]ga[illegible]á?

Por T[illegible]e[illegible]: #[illegible]6 hast[illegible] Ho[illegible]treet
#[illegible]N, [illegible] hasta 8th Street

Por A[illegible]s: M1, M2, M3, M5, M6 - hasta East 8th Street

OBSOLETE

Debido al espacio limitado, por favor, no traiga a nadie con usted, a menos que sea absolutamente necesario.

FORMULARIO DSS 4113-2

STAPLE FORM DSS 4113-2 HERE

Form W-680E (face)
6/10/98

Human Resources Administration
Family Independence Administration

Job Center Tracking System

1st Day Registration

Job Center Walk-In Date: ______/ ______/ ______

Job Center # ______________________

OBSOLETE

Case No ______________________ App. Reg. No ______________ CIN No ______________________

Section I (Completed by the Financial Planner)

1. Financial Planner's Name ______________________________
(First four letters of last name & last four digits of S.S.#)

2. Participant's Name ______________________ ______________________ ____ (3) ____/ ____/ ____
Last Name First Name M.I.

4. Social Security Number ______________________

5. House No. ______________ Street Address ______________________ Apt. ________
City ______________ State ______________ Zip Code ______________

6. Telephone Number ( ) ______________________

7. Alternate Number ( ) ______________________ or Beeper Numbers ( ) ______________

8. Ethnicity Code (Check One)
   - A - Asian or Pacific Islander ☐
   - B - Black-Not of Hispanic origin ☐
   - H - Hispanic ☐
   - I - American Indian or Alaskan Native ☐
   - O - Other ☐
   - U - Unknown ☐
   - W - White-not of Hispanic origin ☐

9. Marital Status (Check One)
   - Married, Living Together ☐
   - Single, Never Married ☐
   - Married ☐
   - Married, But Separated ☐
   - Divorced ☐
   - Widowed ☐

10. Does the Participant have a High School Diploma: (Check One) Yes ☐ No ☐

11. Is the Participant Currently Employed: (Check One) Yes ☐ No ☐

12. If No, Has the Participant Worked Within the Past Twelve Months: (Check One) Yes ☐ No ☐

13. List Everyone Living in the Household Who Is Applying for Job Center Services (Include Adults and Children but Not Participant):

Last Name	First Name	M.I.	Date of Birth	Social Security #
			__/__/__	___/___/___
			__/__/__	___/___/___
			__/__/__	___/___/___
			__/__/__	___/___/___
			__/__/__	___/___/___
			__/__/__	___/___/___
			__/__/__	___/___/___

14. Type of Temporary Assistance (Check One): TANF ☐ Safety Net ☐

15. Disposition: (Must Check One) Seen by Financial Planning ☐ No Response/left Job Center ☐

16. Financial Planning Interview Completed: Yes ☐ No ☐

17. D.V. Referral: Yes ☐ No ☐

18. AFIS Referral Yes ☐ No ☐

19. EVR Referral Yes ☐ No ☐

20. Diverted by Financial Planning: Yes ☐ No ☐

21. If Yes, by What Means (Check one or More) F.S. ☐ M.A. ☐ Child Care ☐ OCSE ☐ One Shot Deal ☐
    Community Resources ☐ Family Resources ☐ Other Financial Resources/Income ☐
    Withdrew (comments): ______________________________

22. Referred to Employment Team: Yes ☐ No ☐

23. If No, Reason (Check One):
    Domestic Violence ☐
    Custodial Case ☐
    SSI Recipient ☐
    Pending SSI ☐
    P.S.A. Case ☐
    Diverted (Explain) ☐
    Other (Explain) ☐

Section II (Completed by the Employment Team)

24. Employment Planner's Name ______________________________
    (First four letters of last name & last four digits of S.S.#)

25. First Day Employment Interviews Completed: Yes ☐ No ☐

26. Appointments Scheduled: (Enter Dates Applicable)
    EC Date: ____________ Job Assignment Report Date: ____________
    HSS Date: ____________ SACC Date: ____________

27. Unassignable: (Check as Applicable)

	Verified	Unverified
Pregnant		
Child under Thirteen Weeks		
Serious Illness		
Approved Training		
Over 60 Years old		

28. Non Compliant Yes ☐ No ☐

29. Referred to Social Services Planner: Yes ☐ No ☐

30. Social Services Planner's Name ______________________________
    (First four letters of last name & last four digits of S.S. #)

31. If yes, Reason: (Check as Applicable)
    Child Care ☐
    Contesting (Non-Medical) ☐
    Community Referral ☐

32. Return Date ____________

33. Withdrew (diverted) Yes ☐ No ☐

34. Comments ______________________________

35. Seen by Social Services Planner: Yes ☐ No ☐ If Yes, and Child Care Was the Reason:

36. Child Care Provider Appointment Date: ____________

37. Child Care Return Date: ____________

38. Other Referrals: ______________________________

39. Referred to: ____________

40. Appointment Date: ____________

41. Return Date: ____________

42. Comments: ____________

43. Non-Compliant (Social Services Planner) Yes ☐ No ☐

44. Comments ______________________________

Entered by ______________________________ Date ____ / ____ / ____

OBSOLETE

Form W-680K
6/10/98

Human Resources Administration
Family Independence Administration

Job Center Tracking System

I.Follow-Up (Employment Team)

1. Participant Name ______________________ 2. SSN ______________________

3. Return Employment Appointment Kept Yes ☐ No ☐

4. EC Appointment Date: ____________

5. Job Assignment Report Date: ____________

6. Unassignable Due To (Check as Applicable):
   - HSS ☐
   - SACC ☐
   - D.V. ☐

7. Non-Compliant (Employment Planner) Yes ☐ No ☐

8. Child Care Return Appointment Kept: Yes ☐ No ☐

9. Child Care in Place: Yes ☐ No ☐

10. If No, Next Return Date: ____/____/____

11. Social Services Return Appointment Kept: Yes ☐ No ☐

12. Community Service Participant Yes ☐ No ☐

13. Non-Compliant (Social Services) Yes ☐ No ☐

14. If Yes, Comments

15. Outcome-Diverted Yes ☐ No ☐

16. Other Social Service Outcome:

Section II Follow-Up (Job Coordinator)

17. EC Orientation Completed Yes ☐ No ☐

18. Complied with EC (Check One) Yes ☐ No ☐ FTR ☐

19. Job Placement Yes ☐ No ☐

20. If Yes,
    Job Title: ______________________

21. Salary: ______________________

22. Salary Type: Hourly ☐ Weekly ☐ Yearly ☐ ☐ Other ____________

23. Hours Per Week ____________

24. Start Date: ____/____/____

Entered By Date / /

Obsolete

Form W-680M
6/10/98

Human Resources Administration
Family Independence Administration

Job Center Tracking System

Follow-Up (Financial Planning)

1. Participant Name ______________________ 2. SSN ______________________

3. Financial Planner ______________________
(First four letters of last name and last four numbers of SSN)

4. Emergency Cash Assistance Issued: Yes ☐ No ☐

5. If Yes,List All Amounts Issued and Codes:

Amount	Code

going TO BE MADE OBSolete

OBSOLETE

6. If Domestic Violence: Waiver(s) Granted (Check One or More)
   - OCSE ☐
   - OES ☐
   - SACC ☐
   - Learnfare ☐
   - Minor Parents ☐
   - None ☐

7. "I" Interview Scheduled Yes ☐ No ☐

8. "I" Interview Kept Yes ☐ No ☐

9.

Resolution	Date	WMS Reason Code
Case Accepted	/ /	
Case Rejected	/ /	
Case Closed	/ /	
Case Withdrawn	/ /	

Form W-138XX (face)
1/22/92

Human Resources Administration
Income Support Programs

IMPORTANT NOTICE TO ALL FOOD STAMP RECIPIENTS

Every individual who receives Food Stamps is required, by law, to report to their Food Stamp office any changes that occur in their circumstances. These may include changes in:

- earnings
- income
- household expenses
- residence
- living arrangements (individuals leaving or coming into the family unit)
- assets (bank accounts, checking accounts, stocks, bonds, certificates of deposit, etc.).

Changes must be reported as soon as they occur. We need to know about any changes in your circumstances so we can determine the correct amount of your Food Stamps. Reporting changes may make you eligible to receive more Food Stamp benefits.

The information reported by you is subject to verification by federal, state and local officials. If any is found inaccurate, or not reported promptly, you may be denied Food Stamps and/or be subject to criminal prosecution for knowingly providing false information.

You can report a change by calling your Food Stamp office, by returning the change report form, or by writing to us.

OBSOLETE

I have read this notice and understand its contents. I agree to inform the agency promptly of any change in my needs, income, property, living arrangements or address, to the best of my knowledge or belief.

Applicant/ Representative/Recipient Signature   Date Signed

Form W-138XX (reverse)
1/22/92

Human Resources Administration
Income Support Programs

AVISO IMPORTANTE PARA TODOS LOS BENEFICIARIOS DE CUPONES DE ALIMENTOS

Se requiere a cada persona que recibe Cupones de Alimentos que reporte a su oficina de Cupones de Alimentos cualquier cambio que ocurra en sus circunstancias. Esto puede incluir cambios en:

- ganancias
- ingresos
- gastos domésticos
- residencia
- arreglos de vivienda (personas que entran o se van de la unidad familiar)
- bienes (cuentas bancarias, cuentas de cheques, acciones, bonos, certificados de depósito, etc.)

OBSOLETE

Los cambios deben ser reportados tan pronto como ocurran. Necesitamos saber sobre cualquier cambio en sus circunstancias para poder determinar la cantidad correcta de beneficios de Cupones de Alimentos. El reportar estos cambios le puede hacer elegible para recibir más beneficios de Cupones de Alimentos.

La información reportada por usted es sujeta a verificación por oficiales locales, estatales y federales. Si se encuentra que no es verídica o que no se reportó a tiempo, se le pueden negar Cupones de Alimentos y/o/ ser sujeto(a) a persecución criminal por intencionalmente proveer información falsa.

Usted puede reportar un cambio llamando a su oficina de Cupones de Alimentos, enviando de vuelta por correo el formulario de reportar cambios, o escribiendo a nosotros.

He leído este aviso y entiendo su contenido. Estoy de acuerdo en informar a la agencia inmediatamente de cualquier cambio en mis necesidades, ingresos, propiedades, arreglos de vivienda o dirección, de acuerdo a mis mejores conocimientos o creencias.

Firma de Aplicante/Representante/Beneficiario

Fecha de la Firma

FormW-612CC (face)
6/26/02

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Consent for Disclosure of Medical, Mental Health and Alcoholism and Substance Abuse Treatment Records

Federal law and regulations protect confidentiality of medical and alcohol and substance abuse treatment records. In general, the program to which you were referred to or are now attending, or attended in the past may not disclose to anyone, any program information regarding your diagnoses or treatment unless you consent to that disclosure in writing.

The Personal Roads for Individual Development and Employment (PRIDE) Program provides access to vocational rehabilitation and work-based education to individuals receiving public assistance who may have special needs and disabilities, including temporarily disabled, learning disabled, substance abuse, physical or mental disabilities, have been denied SSI or have other employment limitations.

The primary objective of PRIDE is to reduce and/or eliminate participants' dependence on public assistance through improved skills and unsubsidized employment by offering services such as skills training, job development, job placement and post-employment support.

PRIDE will engage you in appropriate work activities suitable for your abilities and ongoing well-being. The NYC Human Resources Administration (HRA), along with NYS Department of Labor, NYS Education Department (SED), VESID, the Office of Workforce Preparation and SED-contracted providers (PRIDE Provider), will work cooperatively to support you in achieving your highest level of economic self-sufficiency.

I authorize HRA and HRA's medical provider, their respective attorneys, authorized agents or employees to release information in my case record concerning medical diagnoses and history, alcoholism and substance abuse treatment information, clinical psychological or psychiatric records that are required to assist in assessing my condition and identifying appropriate treatment; to make copies of documents, including computer printouts, to give answers to all questions, and to cooperate with requests for information concerning my referral to screening and assessment, and/or receipt of services from any approved PRIDE Provider.

OBSOLETE

I understand that I may revoke my consent at any time, except to the extent that the program or person which is to make the disclosure, has already taken action in reliance on my consent. If not previously revoked, this consent will terminate upon the closing of my public assistance case.

This consent does not cover a release of confidential HIV/AIDS related information.

Name: ______________________________

Social Security Number: ______________________________

Date of Birth: ______________________________

PA Case Number: ______________________________

Address: ______________________________

____

______________________________ ______________________________
Signature of PRIDE Participant | Date of Signature

Form W-612CC (reverse)
6/26/02

Human Resources Administration
Family Independence Administration

OBSOLETE

Consentimiento de Divulgación de Expedientes Médicos, de Salud Mental, y de Tratamientos para Alcoholismo y Adicción a Drogas

Bajo las leyes y reglas federales se protege la confidencialidad de expedientes médicos y de tratamientos para alcoholismo y adicción a drogas. Por lo general, el programa al cual usted fue referido(a) o al cual usted asiste actualmente o asistió en el pasado, no está en libertad de divulgar a nadie ninguna información relacionada con diagnosis o tratamientos suyos a menos que usted haya autorizado dicha divulgación por escrito.

El Programa de Vías Personales de Desarrollo y Empleo (Personal Roads for Individual Development and Employment - PRIDE) provee acceso a rehabilitación vocacional y a educación relacionada con el trabajo a individuos que reciban asistencia pública y que tengan necesidades especiales e incapacidades, incluyendo a las personas temporalmente incapacitadas, con dificultades de aprendizaje, adicción a drogas, incapacidades físicas o mentales, o que hayan sido denegadas SSI o que tengan otros límites en su capacidad de trabajo.

El objetivo principal de PRIDE es reducir y/o eliminar la dependencia del participante de la asistencia pública a través del mejoramiento de habilidades y empleo no subsidiado, ofreciendo servicios tales como entrenamiento de habilidades, desarrollo de empleo, ubicación de empleo y apoyo después de ser empleado.

PRIDE le compromete en actividades apropiadas de empleo aptas para su capacidad y su continuo bienestar. La Administración de Recursos Humanos de la ciudad de Nueva York (NYC Human Resources Administraion - HRA), conjuntamente con el Departamento de Trabajo del Estado de Nueva York (NYS Labor Department), el Departamento de Educación del Estado de Nueva York (NYS Department of Education - SED), VESID, La Oficina de Preparación de la Fuerza Laboral y de los proveedores por contrato de SED) (Proveedor PRIDE - PRIDE Provider), trabajarán en cooperación para apoyarlo en lograr sus más altos niveles de autosuficiencia económica.

Yo autorizo a HRA y al proveedor médico de la HRA, a los respectivos abogados, los agentes autorizados o empleados a proveer información de mi expediente de caso referente a diagnosis e historiales médicos, alcoholismo e información de tratamiento para adicción a drogas, psicología clínica o expedientes psiquiátricos que sean requeridos para asistir en asesorar mi condición e identificar tratamientos apropiados; a hacer copias de documentos, incluyendo impresos de computadoras; a proveer respuestas a todas las preguntas; y a cooperar con la petición de información concerniente a mi referencia a clasificación y asesoría y/o recibimiento de servicios de algún proveedor aprobado de PRIDE.

Yo entiendo que yo puedo derogar este consentimiento en cualquier momento, excepto hasta el punto que el programa o la persona, que haga la divulgación, haya tomado acción basándose en mi consentimiento. Si no ha sido derogado anteriormente, este consentimiento terminará tan pronto se cierre mi caso de asistencia pública.

Este consentimiento no cubre la divulgación de información relacionada con el VIH/SIDA.

Nombre: ______________________________

Número de Seguro Social: ______________________________

Fecha de Nacimiento: ______________________________

Número de Caso: ______________________________

Dirección ______________________________

____

______________________________ ______________________________

Firma del participante PRIDE

Fecha de la Firma