Department of Social Services
Human Resources Administration
Department of Homeless Services

Office of
Program Accountability

INVESTIGATION, REVENUE AND ENFORCEMENT ADMINISTRATION

Issued:
September 20, 2019

INFORMATIONAL 2019-06-IREA

Form Instructions: IREA-156 Employment and Wage Verification

Audience

Bureau of Fraud Investigation (BFI) and Supplemental Needs Trust (SNT).

Background

The BFI-130 Employment Wage Verification form requires employers to verify wages and medical coverage information for recipients, and/or relatives legally responsible for the support of such recipients, receiving Cash Assistance (CA), Supplemental Nutrition Assistance Program (SNAP) and Medicaid Assistance (MA). The BFI-130 informs employers that New York State Social Services Law §143 requires employers to cooperate with the Department of Social Services.

Process

The new IREA-156 Employment and Wage Verification (Attachment 1) replaces the BFI-130 and will be utilized by the Bureau of Fraud Investigation (BFI) and Supplemental Needs Trust (SNT).

The BFI-130 is now obsolete.

Attachment 1

IREA-156 (E) 09/18/2019

Department of Social Services
Human Resources Administration
Department of Homeless Services

Office of
Program Accountability

INVESTIGATION, REVENUE AND ENFORCEMENT ADMINISTRATION
Select Bureau/Division
Select Address
Select Phone Number Select Fax Number
Select Email

Employer Name
Employer Address
Employer City, State, Zip

EMPLOYMENT AND WAGE VERIFICATION

INSTRUCTIONS: The NYC Department of Social Services requires payroll and insurance information for the person named below as your employee. Please complete Part I, Part II, and Part III of this form and return to the address noted above within fifteen (15) business days.

PLEASE NOTE:
Employers are required by law to furnish to the NYC Department of Social Services information concerning wages, salaries, earnings, other income, and insurance benefits of any applicant for, or recipient of, public assistance, or of any relative legally responsible for the support of such applicant or recipient. See New York Social Services Law, SSL § 143.

Employee Name: [Employee First] [Employee Last]

Social Security Number: XXX-XX-9999 Date of Birth: 1/1/2000 IRIS Control Number: [Num]

Requested Payroll Period: From: _____ To: _____

PART I

Do you currently employ the person identified above? (check one)

☐ YES. Start Date: _____

☐ NO. Last Day Worked: _____

Employee Home Address: _____

PLEASE PROVIDE ACTUAL GROSS EARNINGS FOR ENTIRE PERIOD OF EMPLOYMENT ON THE CHART BELOW AND COMPLETE PARTS II and III.

PLEASE PROVIDE THE PERSONNEL RECORDS INCLUDING THE EMPLOYMENT APPLICATION AND W-4 FORMS

IN LIEU OF COMPLETING THE BOTTOM PORTION OF THIS FORM, YOU MAY ATTACH A PHOTOCOPY OF THE PAYROLL RECORD FOR THE PERIOD IN QUESTION IF IT PROVIDES THE SAME INFORMATION REQUESTED BELOW.

Pay Period From	Pay Period To	Date Paid	Actual Gross Earnings	Days Worked	Actual Hours Worked

Is this employment related to work study or training? ☐ YES ☐ NO

PART II
MEDICAL COVERAGE

What type of medical coverage is offered? ☐ None ☐ Family ☐ Individual

If Family or Individual, continue. If None, skip to PART III.

Did this employee accept the medical coverage? ☐ NO ☐ YES

If yes, answer questions a, b and c only. If no, skip to questions d and e.

a. Type of coverage: ☐ Individual ☐ Family Date coverage began: _____

b. Insurance Company Name: _____ Policy #: _____

c. Is anyone else covered by this policy? ☐ NO ☐ YES (If yes, please indicate who below)
   Name: _____ Relationship: _____
   Name: _____ Relationship: _____
   Name: _____ Relationship: _____
   Name: _____ Relationship: _____

d. Did the employee receive a monetary incentive to opt out? ☐ NO ☐ YES

e. If yes, how much did the employee receive to opt out? $

PART III
CERTIFICATION

I am an employee of _____ and have authority to make this certification.
[employer name]

I certify that…

(A) ☐ the information provided above is true and accurate

or

(B) ☐ the enclosed records are true and accurate copies or reproductions of original records maintained by personnel or staff of _____,
[employer name]
or persons under their control, in the regular course of business, at the time of the act, transaction, occurrence or event recorded in them, or within a reasonable time thereafter, and are in the possession, custody, or control of _____.
[employer name]

The attached records are hereby certified pursuant to CPLR 4518 and 4539.

Signature	
Print Name	
Title	
Phone Number	

☐ FAX the completed form to BFI Investigator [Investigator Name] at or return by mail to the address at the top of this letter as soon as possible. Thank you.

☐ Email the completed forms to , attention SNT Investigator within **15** days.

Thank you.