FAMILY INDEPENDENCE ADMINISTRATION

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POLICY BULLETIN #08-52-OPE

REVISIONS TO FORMS W-111H, W-274U, AND W-299

Date: May 29, 2008	**Subtopic(s):** Forms
This procedure can now be accessed on the FIAweb.	The purpose of this policy bulletin is to inform all Job Center staff that the following forms have been revised to conform to the Agency's formatting requirements and, have received minor updates to reflect current Agency terminology:

- Application Cases Assignment Log (**W-111H**)
- Attestation of Employment as an Informal Child Care Provider (**W-274U**)
- Notice to Applicants and Participants Regarding Third Party Health Insurance (**W-299**)

General updates to the above forms are as follows:

- The logo has been updated
- The forms are formatted in accordance with current Agency software requirements

Additional revision to Form **W-111H**:

- "Case Establishment Unit" has been removed

Additional revisions to Forms **W-274U** and **W-299**:

- "Public Assistance" has been changed to "Cash Assistance" in two places

Center Directors must ensure that all previous versions of these forms are removed from circulation and recycled.

Samples of the revised forms are attached.

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*

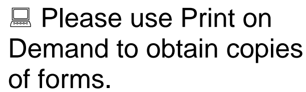
Distribution: X

Effective Immediately

Related Item:

PB #04-192-OPE
PD #05-22-OPE
PD #05-27-ELI

Attachments:


Please use Print on Demand to obtain copies of forms.

W-111H	Application Cases Assignment Log (Rev. 5/29/08)
W-274U	Attestation of Employment as an Informal Child Care Provider (Rev. 5/29/08)
W-274U (S)	Attestation of Employment as an Informal Child Care Provider (Spanish) (Rev. 5/29/08)
W-299	Notice to Applicants and Participants Regarding Third Party Health Insurance (Rev. 5/29/08)
W-299 (S)	Notice to Applicants and Participants Regarding Third Party Health Insurance (Spanish) (Rev. 5/29/08)

Form W-111H
Rev. 5/29/08

NYC Human Resources Administration
Department of Social Services
Family Independence Administration

Applicant Cases Assignment Log

Date:______________________

☐ Case Management Unit

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name
Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name
Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name
Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name
Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name

SAMPLE

Group 7	Group 8	Group 9	Group 10	Group 11	Group 12
Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name
Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name
Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name
Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name
Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name	Applicant's Name

Receptionist: ______________________________

NYC Human Resources Administration
Department of Social Services
Family Independence Administration

Date: ______________________

Case Number: ______________________

Case Name: ______________________

Center: ______________________

Caseload: ______________________

Attestation of Employment as an Informal Child Care Provider

(A separate W-274U must be completed for each parent/guardian who employs you as a child care provider.)

Number of parents/guardians you provide care for: __________

I, ______________________ ________ ______________________, am an informal child care
Applicant/Participant First Name M.I. Applicant/Participant Last Name

provider hired by ______________________ ________ ______________________, who resides
Parent/Guardian First Name M.I. Parent/Guardian Last Name

at ____, __________
Street Address Apt. No.

______________ ________ ____________ ______________.
Borough State Zip Code Telephone Number

SAMPLE

I provide care (check only one)

- ☐ in the child's home, listed above. I understand that if I provide care in a child's home, I am entitled to at least the prevailing minimum wage, from which may be deducted any applicable Federal and State taxes.
- ☐ in my own home. I understand that I am entitled to a Cash Assistance (CA) and Food Stamps (FS) income exemption of $5 per day per child in my care for children other than my own.
- ☐ in another location (Please provide address).

____
Address

______________ ________ ____________ ______________
Borough State Zip Telephone Number

Explain alternate location:

____

Check one:

- ☐ I am related to the child for whom I provide care. (State relationship ______________________.)
- ☐ I am not related to the child for whom I provide care.

I receive (enter the amount you receive) **$ __________ per month from this household to provide child care. I provide child care services a total number of** (enter the number of hours) **________ hours per week and charge $ ________ per hour.**

Is your employer in receipt of any of the following?

☐ Cash Assistance and Food Stamps ________________
Case Number (if known)

☐ Food Stamps only ________________
Case Number (if known)

Indicate the weekly schedule(s) of child care services for the child(ren) listed below:

Child's Name	________ Child's Full Name			________ Child's Full Name			________ Child's Full Name		
Date Care Began	Month	Day	Year	Month	Day	Year	Month	Day	Year
Date of Birth	Month	Day	Year	Month	Day	Year	Month	Day	Year
Sex	☐ Male	☐ Female		☐ Male	☐ Female		☐ Male	☐ Female	
Weekly Schedule	From	To	Total Hours per Day	From	To	Total Hours per Day	From	To	Total Hours per Day
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									
Total Hours per Week									

SAMPLE

Provider Certification

I will notify Family Independence Administration (FIA) immediately if the hours of care or the number of children in my care changes, or if any of the other information noted on this form changes.

I certify that the statements above are accurate and true to the best of my knowledge. I understand that providing false information may lead to the suspension or termination of payments and the recovery of any payments to which I was not entitled, or assignment to a work-related activity if I am not actually working and being paid to work during the hours indicated above.

I understand that representatives of FIA may visit me during the hours child care is provided and I authorize FIA to contact my employer to confirm that the information as reported on this form is true and accurate.

Applicant's/Participant's Name (print clearly): ________________________________

Signature: ____________________ Telephone Number: ____________________

JOS/Worker's Name: ____________________________ Date: ________________

NYC Human Resources Administration Department of Social Services
Family Independence Administration

Fecha: ______________________

Número del Caso: ______________________

Nombre del Caso: ______________________

Centro: ______________________

Unidad de Casos: ______________________

Atestación de Empleo como Proveedor de Cuidado Infantil Informal

(Se debe llenar un formulario W-274U [S] separado para cada padre/madre/tutor que le contrata como proveedor de cuidado infantil.)

Número de padres/madres/tutores a los cuales usted brinda cuidado: __________

Yo, ______________________ ________ ______________________, soy proveedor informal
Nombre del Solicitante/Participante I. Apellido del Solicitante/Participante

de cuidado infantil contratado por ______________________ ________ ______________________,
Nombre del Padre/Madre/Tutor I. Apellido del Padre/Madre/Tutor

quien reside en ____, __________
Dirección Apto.

______________________ ________ ______________ ______________________.
Condado Estado Código Postal Número de Teléfono

SAMPLE

Proveo cuidado (marque sólo una casilla)

- ☐ en el hogar del niño listado más arriba. Entiendo que si proveo cuidado en el hogar de un niño, tengo derecho a, por lo menos, el salario mínimo corriente del cual se puede deducir cualquier impuesto Federal o Estatal correspondiente.
- ☐ en mi propio hogar. Entiendo que tengo derecho a una exención de Asistencia en Efectivo y Cupones para Alimentos de $5 al día por niño que no sea mío propio bajo mi cuidado.
- ☐ en un local alterno (favor de proporcionar la dirección).

____
Dirección

______________________ ________ ______________ ______________________
Condado Estado Código Postal Número de Teléfono

Detalles del local alterno:

____

Marque una casilla:

- ☐ Soy pariente del niño a quien le brindo cuidado (Indique el parentesco ______________________).
- ☐ No soy pariente del niño a quien le brindo cuidado.

Recibo (anote la cantidad que usted recibe) **$** ______________ **mensuales de parte de este hogar por brindar cuidado infantil. Brindo servicios de cuidado infantil por un total de** __________ **horas semanales y cobro $** ________ **por hora.**

¿Recibe su empleador algo de lo siguiente?

☐ Asistencia en Efectivo y Cupones para Alimentos ___________ Número del Caso (si lo sabe) ☐ sólo Cupones para Alimentos ___________ Número del Caso (si lo sabe)

Indique el horario semanal de servicios de cuidado infantil respecto a los niños listados más abajo:

Nombre del Niño	Nombre Completo del Niño			Nombre Completo del Niño			Nombre Completo del Niño		
Fecha de Comienzo del Cuidado	Mes	Día	Año	Mes	Día	Año	Mes	Día	Año
Fecha de Nacimiento	Mes	Día	Año	Mes	Día	Año	Mes	Día	Año
Sexo	☐ Masculino	☐ Femenino		☐ Masculino	☐ Femenino		☐ Masculino	☐ Femenino	
Horario Semanal	De	A	Total de Horas al Día	De	A	Total de Horas al Día	De	A	Total de Horas al Día
Lunes									
Martes									
Miércoles									
Jueves									
Viernes									
Sábado									
Domingo									
Total de Horas a la Semana									

SAMPLE

Certificación del Proveedor

Le avisaré a la Administración de Independencia Familiar (Family Independence Administration – FIA) de inmediato en caso de que las horas de cuidado o el número de niños bajo mi cuidado o asimismo cualquier otro dato indicado en este formulario cambien.

Doy fe de que las declaraciones más arriba son exactas y veraces según mi leal saber y entender. Entiendo que el proporcionar información falsa puede llevar a una suspensión o terminación de pagos y de la recuperación de cualquier pago al cual yo no tenía derecho, o a ser asignado a una actividad relacionada con el trabajo si en realidad no estoy trabajando ni se me está pagando durante las horas indicadas más arriba.

Entiendo que puede ser que representantes de la FIA me visiten durante las horas en que se esté brindando cuidado infantil. Además, autorizo a la FIA a que se comunique con mi empleador para comprobar que los datos indicados en el presente formulario sean verídicos y exactos.

Nombre del Solicitante/Participante (en letras de molde clara): ________________________________

Firma: ______________________ Número de Teléfono: ______________________________

Nombre del JOS/Trabajador: ______________________________ Fecha: __________________

Human Resources Administration
Department of Social Services
Family Independence Administration

Date: ______________________

Case Number: ______________________

Case Name: ______________________

Notice to Applicants and Participants Regarding Third Party Health Insurance

As a condition of eligibility, Cash Assistance applicants and participants are required to apply for and use any group health insurance available to them. This insurance coverage can be provided by their present or former employer or union plan, coverage provided under a legally responsible relative's plan or any other source.

You are required to provide information concerning health insurance coverage for yourself and other legally responsible relatives who are eligible for group health insurance. Please have the appropriate person (current/former employer, union representative or other party offering group health insurance) complete the reverse of this form and return it to you. If you have been instructed to mail it, send it to the address provided. If you are scheduled for an interview, bring the completed form with you along with any health, dental, optical and/or prescription drug identification cards that have been issued to you.

If you refuse or fail to cooperate in the verification of this information, or refuse to apply for any group health insurance available to you, your Cash Assistance and Medicaid may be denied or terminated in accordance with NYCRR 351.1(b)(2)(iii).

SAMPLE

Include in 'A' Kit/Recert Packet

Applicant's/Participant's Name: ______________________ **Case Number:** ______________

Health Insurance for: ____
(Current/Former Employee)

Date Employment Began : ____________________ **Date Employment Ended:** ______________

Home address while in your employ: ______________________________

____

City: ______________ State: _____ Zip: ______

Social Security number under which payments were made: ______________________________

Does employee have health insurance? ☐ **Yes** ☐ **No**

Through Employer: ____________________ Through Union: ____________________

Name of Carrier: ____________________ Group Number: ____________________

Policy or ID Number: ____________________ Coverage Dates: From __________

To __________

Names of Covered Individuals: ______________________________

Amount Paid by Employee: $__________ per ____________________
(Week/Month)

Types of Coverage
Enter "x" in applicable
coverage code(s):

MJR MED	INP HOS	SENR CARE	OUT PAT	DRG PHM	HOME CARE	DENTAL	NURS HOME	OPTICAL
☐	☐	☐	☐	☐	☐	☐	☐	☐

SAMPLE

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

Can policy be converted to an individual policy? ☐ Yes ☐ No

Cost of conversion to employee: $______________ per ______________________ .
(Week/Month)

Employer Information

Address: ______________________________

____

City: ____________________ State: _____ Zip: ____________

Employer ID No.: ______________________________

Please print your name: ______________________________

Signature: ______________________________

Title: ______________________________

NYC Human Resources Administration
Department of Social Services
Family Independence Administration

Fecha: ______________________________

Número del Caso: ______________________________

Nombre del Caso: ______________________________

Aviso a Solicitantes y Participantes con Respecto a Seguros de Salud de Tercera Persona

Como condición de elegibilidad para asistencia en efectivo, solicitantes y participantes son requeridos de solicitar y usar cualquier seguro de salud disponible a ellos. Esta cobertura de seguro puede ser proveida a través del plan de la union o de su patron actual o anterior, o disponible a través de la cobertura del seguro de salud de un pariente responsable legalmente, o de cualquier otra fuente.

SAMPLE

Se require que usted provea sus datos de cobertura de seguro médico y los de otros familiares legalmente reponsables que sean elegibles para seguro médico en grupo. Por favor asegúrese de que la persona adecuada (empleador actual/anterior, representante sindical u otra parte que brinde seguro médico en grupo) llene la parte posterior de este formulario y de que se lo devuelva a usted. Si usted recibió instrucciones de enviar el formulario por correo, utilice la dirección indicada. Si tiene una cita de entrevista, traiga el formulario lleno con toda tarjeta de seguro médico, dental, optico y/o de identificación para receta de medicamentos que le hayan expedido.

Si usted rehusa o no coopera en la verificación de esta información, o rehusa solicitar para cualquier seguro de salud disponible a usted, su asistencia en efectivo y Medicaid pueden ser negados o terminados de acuerdo con NYCRR 351.1(b)(2)(iii).

Applicant's/Participant's Name: ______________________________ **Case Number:** ____________

Health Insurance for: ____
(Current/Former Employee)

Date Employment Began : ______________________ **Date Employment Ended:** ________________

Home address while in your employ: ______________________________________

____

City: ____________________ State: ______ Zip: ________

Social Security number under which payments were made: ______________________________________

Does employee have health insurance? ☐ **Yes** ☐ **No**

Through Employer: ____________________________ Through Union: ______________________

Name of Carrier: ____________________________ Group Number: ______________________

Policy or ID Number: ____________________________ Coverage Dates: From ____________

To ____________

Names of Covered Individuals: ____

Amount Paid by Employee: $____________ per ________________________________
(Week/Month)

Types of Coverage
Enter "x" in applicable coverage code(s):

MJR MED	INP HOS	SENR CARE	OUT PAT	DRG PHM	HOME CARE	DENTAL	NURS HOME	OPTICAL
☐	☐	☐	☐	☐	☐	☐	☐	☐

SAMPLE

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

Can policy be converted to an individual policy? ☐ Yes ☐ No

Cost of conversion to employee: $______________ per ______________________________ .
(Week/Month)

Employer Information

Address: ____

____

City: ______________________________ State: ______ Zip: ______________

Employer ID No.: ____

Please print your name: ____

Signature: ____

Title: ____