



# FAMILY INDEPENDENCE ADMINISTRATION

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Policy, Procedures, and Training

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Office of Procedures

## POLICY BULLETIN #10-85-OPE

### REVISIONS TO FORMS M-325U, W-34A, W-106E, W-113E, W-145WW, W-145XX, W-208A, W-209B, W-607A, W-608H, W-719E, W-719G, AND W-719R

| <b>Date:</b><br>August 16, 2010  | <b>Subtopic(s):</b><br>Forms  |
|--|---|
| <p> This procedure can now be accessed on the FIAweb.</p> | <p>The purpose of this policy bulletin is to inform all Job Center staff that the following Disbursement and Collection (D&amp;C) forms have been revised:</p> <ul style="list-style-type: none"> <li>• Request for Lift of Stop Payment Order (<b>M-325U</b>)</li> <li>• Referral/Information Form (<b>W-34A</b>)</li> <li>• Notice of Decision on Returned or Released Check (<b>W-106E</b>)</li> <li>• Information and Referral Notice (<b>W-113E</b>)</li> <li>• Daily Log for Personal Care Kits and Supplementary Items (<b>W-145WW</b>)</li> <li>• Weekly Status Report for Personal Care Kits and Supplementary Items (<b>W-145XX</b>)</li> <li>• Home Delivery Sheet of Cash Assistance Checks (<b>W-208A</b>)</li> <li>• Daily Emergency Public Assistance (EPA) Check Log (<b>W-209B</b>)</li> <li>• Request for Identification Card/Temporary Medicaid Authorization/Update Existing CBIC (<b>W-607A</b>)</li> <li>• Travel Directions to the Manhattan/Brooklyn Common Benefit Identification Card (CBIC) Over-The-Counter (OTC) Sites (<b>W-608H</b>)</li> <li>• Monthly Report of Emergency Public Assistance Checks (<b>W-719E</b>)</li> <li>• Carfare Authorization (<b>W-719G</b>)</li> <li>• Summary of Audit of Single Issue Forms (LDSS-3575) (<b>W-719R</b>)</li> </ul> |

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

All forms have been revised as follows:

- The New York City logo has been updated.
- The forms have been formatted in accordance with current Agency software requirements.
- The forms have been updated to reflect current Agency terminology.

Additional revisions to Form **W-208A**:

- The form has been updated to contain one Home Delivery Sheet rather than two.
- The date and check number of the CA check are now recorded in one combined column.
- The delivery date and amount of the CA check are now recorded in one combined column.

Additional revisions to Form **W-608H**:

- The form has been updated to contain current bus and subway directions.

Job Center Directors must ensure that all previous versions of the revised forms, and all multilingual equivalents, are removed from circulation and recycled.

Samples of the revised forms are attached.

*Effective Immediately*

**Attachments:**

|                |  |
|----------------|--|
| <b>M-325U</b>  | Request for Lift of Stop Payment Order (Rev. 8/16/10)                              |
| <b>W-34A</b>   | Referral/Information Form (Rev. 8/16/10)   |
| <b>W-106E</b>  | Notice of Decision on Returned or Released Check (Rev. 8/16/10)                    |
| <b>W-113E</b>  | Information and Referral Notice (Rev. 8/16/10)                                     |
| <b>W-145WW</b> | Daily Log for Personal Care Kits and Supplementary Items (Rev. 8/16/10)            |
| <b>W-145XX</b> | Weekly Status Report for Personal Care Kits and Supplementary Items (Rev. 8/16/10) |
| <b>W-208A</b>  | Home Delivery Sheet of Cash Assistance Checks (Rev. 8/16/10)                       |
| <b>W-209B</b>  | Daily Emergency Public Assistance (EPA) Check Log (Rev. 8/16/10)                   |

☞ Please use Print on Demand to obtain copies of forms.

|                   |   |
|-------------------|---|
| <b>W-607A</b>     | Request for Identification Card/Temporary Medicaid Authorization/Update Existing CBIC (Rev. 8/16/10)  |
| <b>W-608H</b>     | Travel Directions to the Manhattan/Brooklyn Common Benefit Identification Card (CBIC) Over-The-Counter (OTC) Sites (Rev. 8/16/10)           |
| <b>W-608H (S)</b> | Travel Directions to the Manhattan/Brooklyn Common Benefit Identification Card (CBIC) Over-The-Counter (OTC) Sites (Spanish) (Rev. 8/16/10) |
| <b>W-719E</b>     | Monthly Report of Emergency Public Assistance Checks (Rev. 8/16/10)   |
| <b>W-719G</b>     | Carfare Authorization (Rev. 8/16/10)  |
| <b>W-719R</b>     | Summary of Audit of Single Issue Forms (LDSS-3575) (Rev. 8/16/10)   |

### Request for Lift of Stop Payment Order

Job Center: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_ Case Name

\_\_\_\_\_ Cat./Case Number

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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Check Number

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Date

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Amount

SAMPLE

### Request for Lift of Stop Payment Order

Job Center: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_ Case Name

\_\_\_\_\_ Cat./Case Number

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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Check Number

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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Date

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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Amount

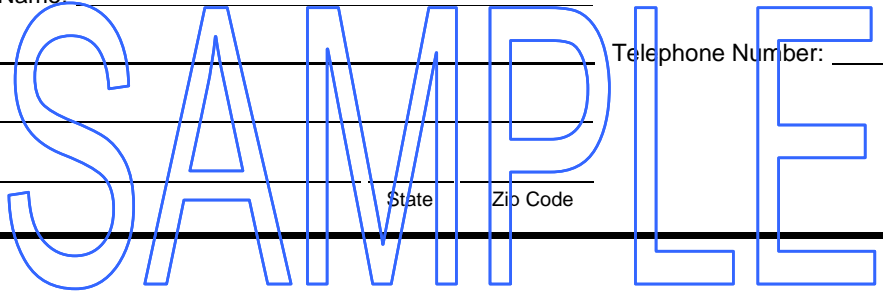
Date: \_\_\_\_\_  
Case Name: \_\_\_\_\_  
Case Number: \_\_\_\_\_

### Referral/Information Form

|                                   |                                  |                                    |                                  |                                 |
|-----------------------------------|----------------------------------|------------------------------------|----------------------------------|---------------------------------|
| <input type="checkbox"/> Referral | <input type="checkbox"/> Message | <input type="checkbox"/> Enclosure | <input type="checkbox"/> Inquiry | <input type="checkbox"/> Report |
|-----------------------------------|----------------------------------|------------------------------------|----------------------------------|---------------------------------|

|  |  |
|--|--|
| To (Agency):   | From (Agency):   |
| <input type="checkbox"/> Job Center <input type="checkbox"/> Other | <input type="checkbox"/> Job Center <input type="checkbox"/> Other |
| Attention (Name of Agency Representative):                         | By (Name of Agency Representative):                                |

Applicant/Participant Name: \_\_\_\_\_  
Present Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
\_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_



Subject: \_\_\_\_\_

Comments:

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|                                     |              |                  |      |  |  |
|-------------------------------------|--------------|------------------|------|--|--|
| <input type="checkbox"/> Job Center |              |                  |      |  |  |
| <input type="checkbox"/> Other      |              |                  |      |  |  |
| Worker Signature                    | Worker Title | Telephone Number | Date |  |  |
| Supervisor Signature                | Section      | Telephone Number | Date |  |  |

### Notice of Decision on Returned/Released Check

**To:** Disbursement and Collections Unit

**From:** Staff/Unit \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Case Number/Suffix \_\_\_\_\_

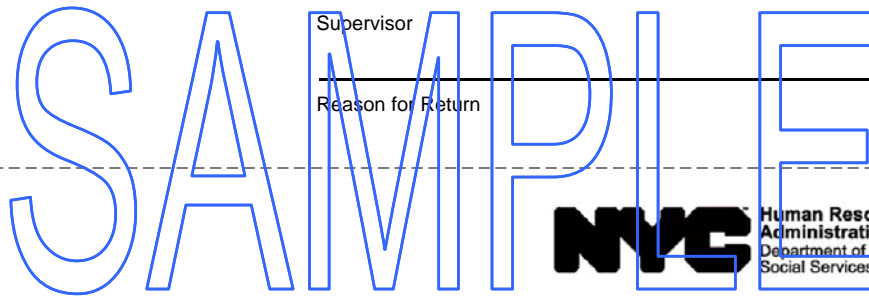
Address \_\_\_\_\_

Amt. of Check \$ \_\_\_\_\_ Date of Check \_\_\_\_\_ Check No. \_\_\_\_\_

RELEASED ABOVE CHECK \_\_\_\_\_  
Supervisor

RETURNED ABOVE CHECK \_\_\_\_\_  
Supervisor

Reason for Return \_\_\_\_\_



### Notice of Decision on Returned/Released Check

**To:** Disbursement and Collections Unit

**From:** Staff/Unit \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Case Number/Suffix \_\_\_\_\_

Address \_\_\_\_\_

Amt. of Check \$ \_\_\_\_\_ Date of Check \_\_\_\_\_ Check No. \_\_\_\_\_

RELEASED ABOVE CHECK \_\_\_\_\_  
Supervisor \_\_\_\_\_ Date \_\_\_\_\_

RETURNED ABOVE CHECK \_\_\_\_\_  
Supervisor \_\_\_\_\_ Date \_\_\_\_\_

Reason for Return \_\_\_\_\_



### Information and Referral Notice

Job Center/Other \_\_\_\_\_ Address \_\_\_\_\_ Date \_\_\_\_\_

|      |                                    |                     |             |          |                       |                          |
|------|------------------------------------|---------------------|-------------|----------|-----------------------|--------------------------|
| To   | Group or Section/Job Center/Agency |                     | Floor       | Room No. | For: Information Only | <input type="checkbox"/> |
| From | Group/Section                      | Signature of Worker | Tel. Number |          | Reply                 | <input type="checkbox"/> |
|      |                                    |                     |             |          | Referral              | <input type="checkbox"/> |

|                               |                         |
|-------------------------------|-------------------------|
| Name of Applicant/Participant | Case Type/Number/Suffix |
|-------------------------------|-------------------------|

Address

Message/Reply (if referral to another Job Center or agency, give reason)

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SAMPLE



### Information and Referral Notice

Job Center/Other \_\_\_\_\_ Address \_\_\_\_\_ Date \_\_\_\_\_

|      |                                    |                     |             |          |                       |                          |
|------|------------------------------------|---------------------|-------------|----------|-----------------------|--------------------------|
| To   | Group or Section/Job Center/Agency |                     | Floor       | Room No. | For: Information Only | <input type="checkbox"/> |
| From | Group/Section                      | Signature of Worker | Tel. Number |          | Reply                 | <input type="checkbox"/> |
|      |                                    |                     |             |          | Referral              | <input type="checkbox"/> |

|                               |                         |
|-------------------------------|-------------------------|
| Name of Applicant/Participant | Case Type/Number/Suffix |
|-------------------------------|-------------------------|

Address

Message/Reply (if referral to another Job Center or agency, give reason)

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| <b>Daily Log for Personal Care Kits and Supplementary Items</b><br><b>Registro Diario de Paquetes para el Cuidado Personal y Artículos Suplementarios</b> |                                       |   |   |                             |   |
|---|---------------------------------------|---|---|-----------------------------|---|
| Case Name<br><i>Nombre del Caso</i>   | Case Number<br><i>Número del Caso</i> | Number of Kits Issued<br><i>Número de Paquetes Emitidos</i> | Description of Supplementary Items Issued (Please Specify)<br><i>Descripción de Artículos Suplementarios Emitidos (Por Favor Especifique)</i> | Quantity<br><i>Cantidad</i> | Applicant Signature<br><i>Firma del Solicitante</i> |
|   |                                       |   |   |                             |   |
|   |                                       |   |   |                             |   |
|   |                                       |   |   |                             |   |
|   |                                       |   |   |                             |   |
|   |                                       |   |   |                             |   |
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|   |                                       |   |   |                             |   |
|   |                                       |   |   |                             |   |
|   |                                       |   |   |                             |   |

SAMPLE

Center: \_\_\_\_\_

Date: \_\_\_\_\_



## Weekly Status Report for Personal Care Kits and Supplementary Items

Today's Date: \_\_\_\_\_

**From:**

Center Director/Designee: \_\_\_\_\_

Center Location/Number: \_\_\_\_\_

**To:**

Regional Manager: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Submitted here is a weekly report confirming the number of Personal Care kits as well as Supplementary Items issued at our center for the week ending: \_\_\_\_\_

Number of Personal Care kits issued: \_\_\_\_\_

Supplementary Items issued: \_\_\_\_\_ Quantity: \_\_\_\_\_

(please specify)

Quantity: \_\_\_\_\_

(please specify)

Quantity: \_\_\_\_\_

(please specify)

Quantity: \_\_\_\_\_

(please specify)

Quantity: \_\_\_\_\_

(please specify)

Quantity: \_\_\_\_\_

(please specify)

Quantity: \_\_\_\_\_

(please specify)

Quantity: \_\_\_\_\_

(please specify)

Quantity: \_\_\_\_\_

(please specify)

Quantity: \_\_\_\_\_

(please specify)

\_\_\_\_\_  
D&C Supervisor

\_\_\_\_\_  
Date

## Home Delivery Sheet of Cash Assistance Checks

(Prepare in Triplicate)

Center/Division: \_\_\_\_\_ Date to Center/Div: \_\_\_\_\_

| Case # | Name & Address of Participant<br>(Last name first) | Date & Number of Check | Date Delivered & Amount | Signature | Remarks |
|--------|--|------------------------|-------------------------|-----------|---------|
| 1.     |  |                        |                         |           |         |
|        |  |                        | \$                      |           |         |
| 2.     |  |                        |                         |           |         |
|        |  |                        | \$                      |           |         |
| 3.     |  |                        |                         |           |         |
|        |  |                        | \$                      |           |         |
| 4.     |  |                        |                         |           |         |
|        |  |                        | \$                      |           |         |
| 5.     |  |                        |                         |           |         |
|        |  |                        | \$                      |           |         |
| 6.     |  |                        |                         |           |         |
|        |  |                        | \$                      |           |         |
| 7.     |  |                        |                         |           |         |
|        |  |                        | \$                      |           |         |
| 8.     |  |                        |                         |           |         |
|        |  |                        | \$                      |           |         |
| 9.     |  |                        |                         |           |         |
|        |  |                        | \$                      |           |         |
| 10.    |  |                        |                         |           |         |
|        |  |                        | \$                      |           |         |

SAMPLE

## Daily Emergency Public Assistance (EPA) Check Log

### Section A

This Section is to be completed by D&C Unit

### Section B

#### Batch Transmittal

This Section is to be completed by Control Unit

Job Center: \_\_\_\_\_ Date: \_\_\_\_\_

| EPA Check No. | Name on LDSS-3575 | Case No./Suffix | Amount of Check |
|---------------|-------------------|-----------------|-----------------|
| 1.            |                   |                 |                 |
| 2.            |                   |                 |                 |
| 3.            |                   |                 |                 |
| 4.            |                   |                 |                 |
| 5.            |                   |                 |                 |
| 6.            |                   |                 |                 |
| 7.            |                   |                 |                 |
| 8.            |                   |                 |                 |
| 9.            |                   |                 |                 |
| 10.           |                   |                 |                 |
| 11.           |                   |                 |                 |
| 12.           |                   |                 |                 |
| 13.           |                   |                 |                 |
| 14.           |                   |                 |                 |
| 15.           |                   |                 |                 |

| Rejected by Screen | Individual LDSS-3575 Rejections | Authorization Number | Reason for Rejection | Date of Resubmission | Date of Detail Report |
|--------------------|---------------------------------|----------------------|----------------------|----------------------|-----------------------|
|                    |                                 |                      |                      |                      |                       |
|                    |                                 |                      |                      |                      |                       |
|                    |                                 |                      |                      |                      |                       |
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|                    |                                 |                      |                      |                      |                       |
|                    |                                 |                      |                      |                      |                       |
|                    |                                 |                      |                      |                      |                       |
|                    |                                 |                      |                      |                      |                       |

SAMPLE

No. of EPA Checks: \_\_\_\_\_

PA Check Total: \_\_\_\_\_

Attach adding machine tape.

Batch No.: \_\_\_\_\_

Batch Accepted

Corrected No. of Forms LDSS-3575: \_\_\_\_\_

Batch Rejected

PA Grant Batch Total Amount: \_\_\_\_\_

Control Clerk: \_\_\_\_\_ Date: \_\_\_\_\_

State Reason and Disposition:

Head Control Clerk: \_\_\_\_\_ Date: \_\_\_\_\_

Corrected No. of Forms LDSS-3575: \_\_\_\_\_

CRT Operator: \_\_\_\_\_ Date: \_\_\_\_\_

Head Control Clerk: \_\_\_\_\_

Head Control Clerk: \_\_\_\_\_ Date: \_\_\_\_\_

Initials/Date

\_\_\_\_\_  
D&C Supervisor

\_\_\_\_\_  
Date

## Request for Identification Card/ Temporary Medicaid Authorization/Update Existing CBIC

**Prepare in the following situations:**

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li>Replacement of CBIC or Medicaid card</li> <li>Update CBIC</li> </ul> | <ul style="list-style-type: none"> <li>Undomiciled applicant/participant</li> <li>Issuance of Immediate Needs/ Expedited Food Stamp Grant</li> </ul> | <ul style="list-style-type: none"> <li>Authorized representative (payee) case</li> <li>Temporary Medicaid Authorization for applicant before case is on WMS</li> </ul> |
|---|--|--|

**Section I: (To be completed by JOS/Worker)**

| To: Reception/Disbursement and Collections Unit   | From: Job Center/Food Stamp Office:      Caseload:  |          |           |  |  |  |  |
|---|---|----------|-----------|--|--|--|--|
| Case Name:  | Applicant/Participant's Signature:  |          |           |  |  |  |  |
| Authorized Representative (Payee) Name (print):   | Authorized Representative (Payee) Signature:  |          |           |  |  |  |  |
| Finger Imaging/Photo/Signature Completed <input type="checkbox"/>   | Applicant/Participant CIN: <input type="checkbox"/>   |          |           |  |  |  |  |
| SAMPLE  |   |          |           |  |  |  |  |
| <p><b>Check Reason for Action:</b></p> <input type="checkbox"/> 01 Lost card <input type="checkbox"/> 06 Surrendered<br><input type="checkbox"/> 02 Stolen <input type="checkbox"/> 09 First card/never received<br><input type="checkbox"/> 03 Defective <input type="checkbox"/> CBIC update (no CBIC referral required)<br><input type="checkbox"/> 04 Mutilated | <p>Applicant/Participant Case Type/Case No./ Registry No./Suffix:</p> <p>Identification documents witnessed for applicant/participant or authorized representative; the same two pieces must be presented to the Disbursement and Collections (D&amp;C) Unit.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Document</th> <th style="width: 30%;">ID Number</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </tbody> </table> | Document | ID Number |  |  |  |  |
| Document  | ID Number   |          |           |  |  |  |  |
|   |   |          |           |  |  |  |  |
|   |   |          |           |  |  |  |  |

**Section II: Reason for Request (To be completed by JOS/Worker)**

|  |  |  |
|--|--|--|
| <input type="checkbox"/> Photo card?<br><input type="checkbox"/> No<br><input type="checkbox"/> Yes  | <input type="checkbox"/> Is the mailing address different than that on WMS?<br><input type="checkbox"/> No <input type="checkbox"/> Yes<br>If yes, complete below.<br><br><hr/> Care of Name<br><br><hr/> Street <span style="float: right;">Apt. No.</span><br><br><hr/> City <span style="float: right;">State</span> <span style="float: right;">Zip</span> | <input type="checkbox"/> Is applicant receiving expedited FS benefits and/or an immediate needs grant?<br><input type="checkbox"/> No <input type="checkbox"/> Yes<br>Is the payee correctly established?<br><input type="checkbox"/> No <input type="checkbox"/> Yes<br>If No:<br><input type="checkbox"/> Delete current payee<br><br><hr/> CIN<br><br><input type="checkbox"/> Add new payee<br><br><hr/> CIN |
| <input type="checkbox"/> Mail Permanent Card and Temporary Medicaid Card ( <b>LDSS-4113-2</b> ) (CBIC menu function 1)<br><input type="checkbox"/> Over-the-Counter Permanent Card Request ( <b>LDSS-4113-2</b> ) (CBIC menu function 2) |  |  |

**Section II: Reason for Request** (To be completed by JOS/Worker)

Authorized Representative Card (CBIC menu function 3)  
Be sure to send authorized representative to the AFIS Unit for photo and signature only.  
Check one:  Agency pickup (at OTC Site)  Mail

Authorized Representative: \_\_\_\_\_  
First Name M.I. Last Name

Temporary Medicaid Authorization (**LDSS-2831-A**) **Complete Section IV.**

|                        |      |                        |      |
|------------------------|------|------------------------|------|
| JOS/Worker's Signature | Date | Supervisor's Signature | Date |
|------------------------|------|------------------------|------|

**Section III: Signature Verification** (To be completed by D&C or FS Reception)

Temporary card (Vault) referral issued  Permanent card mail request processed (to be decided by D&C or FS Reception)

|                                   |      |   |      |
|-----------------------------------|------|---|------|
| Applicant/Participant's Signature | Date | Authorized Representative (Payee) Signature | Date |
|-----------------------------------|------|---|------|

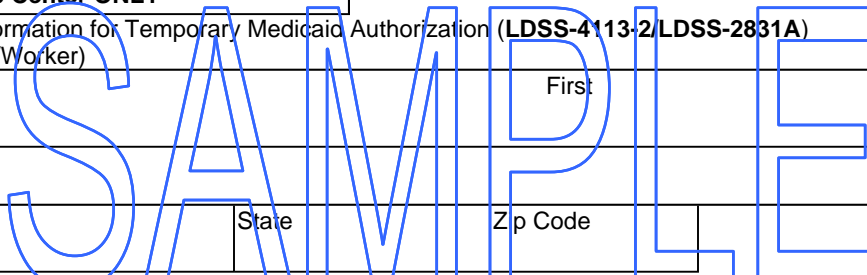
**Signature(s) verified and documents listed in Section I seen.**

FS Reception/D&C or Card Producer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**To be Completed by Job Center ONLY**

**Section IV: Additional information for Temporary Medicaid Authorization (LDSS-4113-2/LDSS-2831A)**  
(To be completed by JOS/Worker)

|         |        |                |
|---------|--------|----------------|
| Name    | Last   | First          |
| Address | Street |                |
|         | City   | State Zip Code |



|  |             |   |
|--|-------------|---|
| Enter 7-digit case number and 1-digit suffix | Leave blank | If enrolled in HIP or HMO plan, enter "P." For all others, enter "A." |
| ↓  | ↓           | ↓   |
| Case Number                                  |             | Enter insurance code if available. If not available leave blank.      |
|  | Category    | ↓ ↓   |

| CIN | Last Name | First Name | Sex | Date of Birth | Ins. Code | Cov. Code | SSN |
|-----|-----------|------------|-----|---------------|-----------|-----------|-----|
|     |           |            |     |               |           |           |     |
|     |           |            |     |               |           |           |     |
|     |           |            |     |               |           |           |     |
|     |           |            |     |               |           |           |     |
|     |           |            |     |               |           |           |     |
|     |           |            |     |               |           |           |     |

**D&C:**

If temporary Medicaid card (**LDSS-2831A**) is issued, please also give the Applicant/Participant \_\_\_\_\_  
Form \_\_\_\_\_.

### Travel Directions to the Manhattan/Brooklyn Common Benefit Identification Card (CBIC) Over-The-Counter (OTC) Sites

You will need a CBIC in order to get your cash assistance and/or Food Stamp benefits. Form **DSS-4113-2**, Referral to the CBIC OTC Site, is stapled to the bottom portion of this page. **You will NOT get a CBIC unless you have Form DSS-4113-2.** Bring your referral to either the Manhattan or Brooklyn OTC site listed below.

Both CBIC OTC sites are open Monday through Friday, except on holidays.

| Manhattan CBIC OTC Site   | Brooklyn CBIC OTC Site  |
|---|---|
| <p>39A Walker Street<br/>Ground Floor<br/>(between Church Street and Broadway)<br/>New York, NY 10013</p> <p><b>Open: 9:00 AM to 8:45 PM</b></p> <p><b>Travel Directions</b></p> <p><u>By Bus:</u><br/>M5, M20 to Canal Street</p> <p><u>By Train:</u><br/>A, C, E, J, N, Q, R, Z or 6 to Canal Street<br/>1 to Franklin Street<br/>2, 3 to Chambers Street</p> | <p>100A Livingston Street<br/>Ground Floor<br/>(between Court Street and Boerum Place)<br/>Brooklyn, NY 11201</p> <p><b>Open: 8:30 AM to 5:45 PM</b></p> <p><b>Travel Directions</b></p> <p><u>By Bus:</u><br/>B57 to Court &amp; Schermerhorn Streets<br/>B25, B26, B38, B41, B45, B52 to Court &amp; Joralemon Streets<br/>B67 to Livingston &amp; Smith Streets</p> <p><u>By Train:</u><br/>2, 3, 4, 5 to Borough Hall<br/>A, C, F to Jay Street &amp; Borough Hall<br/>N or R to Court Street<br/>B, D, Q to Dekalb Avenue<br/>G to Hoyt &amp; Schermerhorn Streets</p> |

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**

### Indicaciones de Viaje a los Locales de Expedición Inmediata (Over-The-Counter [OTC] Sites) de Tarjeta de Identificación para Beneficios Comunes (Common Benefit Identification Card [CBIC]) de Manhattan/Brooklyn

Usted necesitará una CBIC para poder obtener sus beneficios de asistencia en efectivo y/o Cupones para Alimentos. El Formulario **DSS-4113-2**, Envío al Local de CBIC OTC (Referral to the CBIC OTC Site), se encuentra grapado a la parte inferior de la presente página. **Usted NO obtendrá una CBIC a menos que tenga un Formulario DSS-4113-2.** Traiga su envío al local de OTC de Manhattan o de Brooklyn listado más abajo.

Ambos locales de CBIC OTC están abiertos de lunes a viernes, salvo los días feriados.

| Local de CBIC OTC de Manhattan   | Local de CBIC OTC de Brooklyn  |
|--|--|
| <p>39A Walker Street<br/>Planta Baja<br/>(entre Church Street y Broadway)<br/>New York, NY 10013<br/><b>Abierto: 9:00 AM a 8:45 PM</b></p> <p><b>Indicaciones de Viaje</b></p> <p><u>Por Autobús:</u></p> <p>M5, M20 a Canal Street</p> <p><u>Por Metro:</u></p> <p>A, C, E, J, N, Q, R, Z o 6 a Canal Street<br/>1 a Franklin Street<br/>2, 3 a Chambers Street</p> | <p>100A Livingston Street<br/>Planta Baja<br/>(entre Court Street y Boerum Place)<br/>Brooklyn, NY 11201<br/><b>Abierto: 8:30 AM a 5:45 PM</b></p> <p><b>Indicaciones de Viaje</b></p> <p><u>Por Autobús:</u></p> <p>B57 a las calles Court y Schermerhorn<br/>B25, B26, B38, B41, B45, B52 a las calles Court y Joralemon<br/>B67 a las calles Livingston y Smith</p> <p><u>Por Metro:</u></p> <p>2, 3, 4, 5 a Borough Hall<br/>A, C, F a Jay Street y Borough Hall<br/>N o R a Court Street<br/>B, D, Q a Dekalb Avenue<br/>G a las calles Hoyt y Schermerhorn</p> |

Por ser el espacio limitado, favor de no traer a nadie más con usted a menos que sea absolutamente necesario.

#### FORMULARIO DSS-4113-2

STAPLE FORM DSS-4113-2 HERE

## Monthly Report of Emergency Public Assistance Checks

(Prepare in Triplicate)

|  |  |                    |
|--|--|--------------------|
| <b>To:</b> Division of Check Reconciliation, BORAC<br>180 Water Street, 9th Floor  | <b>Month/Year:</b> _____   | <b>Date:</b> _____ |
| <b>From: Name</b> _____  |  | <b>Title</b> _____ |
| <b>Job Center</b> _____  |  |                    |
| <input type="checkbox"/> <b>1. Emergency PA Checks Disbursed</b><br>Month of: _____<br><br>Total Amount Disbursed: \$ _____<br><br><b>Check Range: Series Number</b><br>From: _____ To _____<br>From: _____ To _____ | <input type="checkbox"/> <b>3. Numbers of Missing Blank Checks</b> (List in Individual Check No. Order and attach copies of Stop Payment Orders)<br><br><br><input type="checkbox"/> <b>4.</b> I hereby certify that the checks in the amounts entered and stated were given by me or my authorized representative and the authorizations for these payments were properly prepared and executed, and all checks accounted for:<br><br>Signed: _____<br><div style="text-align: right;">(D &amp; C Supervisor)</div> |                    |
| <input type="checkbox"/> <b>2. Emergency Checks Voided</b> (List in Individual Check No. Order) (Enclose Original and Triplicate)  |  |                    |

SAMPLE



Serial No.: \_\_\_\_\_

### Carfare Authorization

|   |          |   |
|---|----------|---|
| Case Name:  |          | Case No. or Soc. Sec. No.:  |
| Address:  |          |   |
| Purpose of Visit to Center:                                   |          |   |
| No. of Persons Requesting Carfare                             | _____    | If double fare, substantiate (e.g. bus line and bus no.)  |
| Cost Per Person (round trip)                                  | _____    | If other than public transportation, document (Staple receipt to this form; receipt must include date of trip, amount of fare, driver's signature and Hack License No.) |
| Total Cost of Transportation                                  | \$ _____ |   |
| Applicant/Participant's Signature                             |          | D&C Actions:  |
|   |          | Amount Issued _____   |
| Worker's Signature  | Title    | Date  |
|   |          | Date Issued _____   |
| Supervisor's Signature (for other than public transportation) |          | Applicant/Participant's Signature _____   |
|   |          | D&C Worker's Signature  |
|   |          | Title   |
|   |          | Date  |

SAMPLE

### Summary of Audit of Single Issue Forms (LDSS-3575)

Job Center: \_\_\_\_\_

Week Ending: \_\_\_\_\_

| Operator Name | Number of Transactions Input | Number of Transactions Audited | Percentage of Transactions Audited | Number of Transactions Properly Authorized | Number of Transactions Incorrect/Discrepancies |
|---------------|------------------------------|--------------------------------|------------------------------------|--|--|
|               |                              |                                |                                    |  |  |
|               |                              |                                |                                    |  |  |
|               |                              |                                |                                    |  |  |
|               |                              |                                |                                    |  |  |
|               |                              |                                |                                    |  |  |
|               |                              |                                |                                    |  |  |
|               |                              |                                |                                    |  |  |
|               |                              |                                |                                    |  |  |
|               |                              |                                |                                    |  |  |

SAMPLE

Total Number of LDSS-3575 Issuances: \_\_\_\_\_

Total Number of Transactions Audited: \_\_\_\_\_

Number Correct: \_\_\_\_\_

Number Incorrect or with Discrepancies: \_\_\_\_\_

Explanation/Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Deputy Director Signature: \_\_\_\_\_

Center Director Signature: \_\_\_\_\_