Form W-532 (page 1) (LDSS-3707)
Rev. 8/16/11

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 ____________________ (name of employed person), Social Security number ____________________,

Date of Birth ____________________, received for the period from ____________ (date) to ____________ (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					

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