



SUFFOLK COUNTY DEPARTMENT OF SOCIAL SERVICES
CONFIDENTIAL INQUIRY ON EMPLOYMENT

DATE	EMPLOYEE	SSN	CASE #
CASE NAME AND ADDRESS		RETURN FORM TO: <input type="checkbox"/> EMPLOYEE OR <input type="checkbox"/> LISTED ADDRESS	
		ATTN: _____ <input type="checkbox"/> DSS FAX _____	
ATTENTION EMPLOYERS: This form must be completed for any individual who is currently working for you <u>OR</u> Who has worked for you in the last six months.			REQUESTED RETURN DATE: _____

An eligibility requirement for receipt of Public Assistance is verification of employment. Section 143 of the Social Welfare Law states : ***"If requested by an authorized representative...the officials or executives of any corporation or partnership, and all employers of labor of any kind doing business within the State of New York, shall furnish to such representative or authority, information relating to wages, salaries, earnings or other income of any applicant for, or recipient of public assistance or care...or of any relative legally responsible for the support of such applicant or recipient."***

EARNINGS FOR LAST 8 WEEKS OF EMPLOYMENT (TO BE COMPLETED BY EMPLOYER)

PAY PERIOD		GROSS PAY	TIPS	EIC	BONDS, SAVING, IRA	NYS DISAB OR PRIVATE.	OTHER (SPECIFY)
FROM	TO						

Circle the days of the week employee works	M	T	W	T	F	S	S
Indicate time worked each day (i.e. 9am-5pm)							

DATE HIRED:	PAY CYCLE <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> SEMI-MONTHLY <input type="checkbox"/> MONTHLY	DAY PAID M T W T F S S 1 ST 15 TH 30 TH OTHER (SPECIFY) _____
JOB TITLE:	HOURLY WAGE	AVG. HOURS WORKED
IF THE EMPLOYEE NO LONGER WORKS FOR YOU WHY?: <input type="checkbox"/> Left voluntarily <input type="checkbox"/> Temporary worker <input type="checkbox"/> Lay-off <input type="checkbox"/> Discharged State reason _____		DATE OF <input type="checkbox"/> FIRST PAY <input type="checkbox"/> LAST PAY _____ WOULD YOU REHIRE? <input type="checkbox"/> NO <input type="checkbox"/> YES WHEN? _____
Name and Address of Employer PLEASE PRINT CLEARLY		IS THE EMPLOYEE A UNION MEMBER? <input type="checkbox"/> NO <input type="checkbox"/> YES - Union Name and Local # _____ IS THE EMPLOYEE ELIGIBLE FOR DISABILITY BENEFITS COMPENSATION? <input type="checkbox"/> NO <input type="checkbox"/> YES – give name and address of insurance carrier
EMPLOYER'S SIGNATURE		DATE
LOCAL JOB SITE CONTACT PERSON:		TELEPHONE #
<input type="checkbox"/> FORM MUST BE SENT TO OFFSITE PAYROLL FOR COMPLETION. ANTICIPATED RESPONSE DATE: _____		

NOTE: REVERSE SIDE OF THIS FORM MUST BE COMPLETED BY EMPLOYER IF EMPLOYED WITHIN THE PAST 6 MONTHS

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EMPLOYEES NAME	SSN
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To assist in determining the availability of health insurance coverage for the above-named employee, please complete and sign this form.

IS HEALTH INSURANCE AVAILABLE? No
 YES – PLEASE ANSWER THE FOLLOWING QUESTIONS

COVERAGE AVAILABLE FOR	No cost	Cost per _____
<input type="checkbox"/> EMPLOYEE	<input type="checkbox"/>	\$ _____
<input type="checkbox"/> DEPENDENTS	<input type="checkbox"/>	\$ _____
Is this Employee enrolled?		
<input type="checkbox"/> NO	THE EMPLOYEE MAY BE REQUIRED TO ENROLL IN GROUP HEALTH INSURANCE PLAN AFTER AGENCY EVALUATION.)	
<input type="checkbox"/> YES	DATE ENROLLED:	
EMPLOYEE ELIGIBILITY DATE	POLICY/CERTIFICATE NUMBER	
NAME AND ADDRESS OF CARRIER AND ADDRESS WHERE CLAIMS ARE SENT:		

PLEASE INDICATE AVAILABLE COVERAGE UNDER INSURANCE PLAN.	NO	YES	FOR OFFICE USE
Inpatient Hospital			01
Physician's Service			02
Emergency Room			03
Clinic Care			04
Psychiatric Patient (in hospital)			05
Medicare Complimentary			12
Home Health Care			10
Psychiatric Patient (Office)			06
Nursing Home Care			09
Drugs			07
Dental			08
Major Medical			11
DEDUCTIBLE	INDIVIDUAL		FAMILY MAXIMUM
NAME & ADDRESS OF EMPLOYER			
CONTACT PERSON:			TITLE:
TELEPHONE #			DATE

FOR AGENCY USE ONLY

1. Complete DSS 3281 with available data and forward to TPHI unit with a copy of the SCO/IM 206 for research
2. If employee is required to pay premium, note in remarks: "Evaluate for DSS premium payment."