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 | INFORMATIONAL LETTER |  
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TRANSMITTAL: 90 INF-29

TO: Commissioners of  
 Social Services

DIVISION: Income  
 Maintenance

DATE: May 15, 1990

SUBJECT: Revision of "Employment Verification" Form  
 (DSS-3707)

SUGGESTED

DISTRIBUTION: Income Maintenance Directors  
 Food Stamp Directors  
 Medical Assistance Directors  
 WMS Coordinators  
 Staff Development Coordinators

CONTACT PERSON: Wayne Marquit  
IM/WMS Program Operations  
 1-800-342-3715, extension 6-3413

ATTACHMENTS: DSS-3707: "Employment Verification" -  
 (not available on-line).

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
89 INF-17	89 INF-17			<u>PASB</u>	
88 INF-66				<u>IV-C</u>	
				<u>FSSB</u>	
				<u>V-E</u>	
				<u>MARG pp</u>	
				66, 68 & 70	
				Appendix	
				II p. 10	

The purpose of this release is to introduce the revised "Employment Verification" form (DSS-3707). The form is designed to be mailed directly to an employer at the time of application or recertification.

The revisions to the (12/88) version, which are included in the (4/90) version, are listed below:

FACE PAGE

- 1. To be consistent with other Department forms, the title of the form has been added to the top right-hand corner.
- 2. At the request of the Division of Medical Assistance, in the boxed-in section on the "Abstract of Section 143 of the NY State Social Services Law", fourth line, the word "care" has been changed to "medical assistance".
- 3. In the boxed-in area for wages:
  - In the box "Gross Pay Excluding EITC\*", "EITC\*" was changed to "EIC\*".
  - The box for "EITC\*", was changed to "EIC\*".

REVERSE PAGE

At the request of the Division of Medical Assistance, under question #4, the information on Third Party Health Insurance (TPHI) was reformatted as follows:

- a. Is health insurance available to:
 

The employee?	_____ Yes	_____ No
The employee's family?	_____ Yes	_____ No
- b. Is the employee and/or his/her family enrolled?
 

	_____ Yes	_____ No
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If yes, who is covered? \_\_\_\_\_

\_\_\_\_\_
- c. Name and address of Insurance Carrier \_\_\_\_\_
- Effective date of coverage \_\_\_\_\_
- Policy # \_\_\_\_\_

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Attached is a sample copy of the revised DSS-3707. In order to ensure that usage of the revised form begins within a reasonable amount of time, you may continue to use the existing (12/88) supply until your stock is depleted, or until September 1, 1990, whichever occurs first.

Requests for additional copies of these forms are to be submitted on Form WMS-47 (Rev. 9/89): "WMS Order Form", and should be sent to:

New York State Department of Social Services  
Welfare Management System  
P.O. Box 1990  
Albany, New York 12201  
Attention: Office of Systems Development (OSD)

Questions concerning ordering the forms should be directed to OSD by calling 1-800-342-4100, extension 6-6223.

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Oscar R. Best, Jr.  
Deputy Commissioner  
Division of Income Maintenance