LDSS-5040 (Rev. 3/15)

NYS OTDA State Supplement Program

Income Verification Form

SSP Recipient Last Name	First Name	Middle Initial	Person ID Number
Designated Representative Name (if applicable)			

Who is filling out this form?

☐ SSP Recipient ☐ Designated Representative ☐ Other_____

ANSWER ALL FURTHER QUESTIONS AS THEY APPLY TO THE SSP RECIPIENT. Please attach a separate piece of paper if you need more space.

Section 1: Earned Income

Is anyone in your family (you, your spouse and/or your children) currently working or seasonally employed?

☐ Yes, fill out this section. ☐ No, go to section 2.

Include your parent(s) income if you are under 18 or if you are under 22, not married, and are a full-time student.

Name of the person who is employed:_____

Employer #1: Name_____

Type of Work (check all that apply): ☐full time ☐part-time ☐self-employed ☐day labor

☐seasonal yearly wage $_____ ☐sheltered workshop yearly wage $_____

Number of hours worked per week_____ Weekly pay before deductions $_____

Date work began _____ Date work ended _____ (if still employed, enter N/A).

Name of the person who is employed:_____

Employer #2: Name_____

Type of Work (check all that apply): ☐full time ☐part-time ☐self-employed ☐day labor

☐seasonal yearly wage $_____ ☐sheltered workshop yearly wage $_____

Number of hours worked per week_____ Weekly pay before deductions $_____

Date work began _____ Date work ended _____ (if still employed, enter N/A).

If you have more employers, please attach a separate sheet of paper.

If you are blind or disabled and have expenses that you pay so that you can work, please list the type of expense and the monthly amount:

Section 2: Unearned Income

Does anyone in your family (you, your spouse and/or your children) have any other income, **including rental income**?

☐Yes, fill out this section. ☐No, go to section 3.

Include your parent(s) income if you are under 18 or if you are under 22, not married and are a full-time student.

Unearned Income Types– Include but are not limited to:	
* Supplemental Security Income (SSI) Social Security Disability or Retirement (monthly amount you receive plus the Medicare premium) * Social Security Survivor's Benefits * State Disability Benefits * Veteran's benefits * Military Allotments * Pensions, retirements or 401K income * Rental Income * Self-employment income	* Child support and alimony received * Unemployment insurance * Worker's Compensation * Interest, dividend or CD income * Royalties or leases (mineral, grazing, etc.) * Temporary Assistance * Railroad retirement or disability * Other (please describe below)

Who receives this Income?	Relationship	Type of Income (from list above)	Source of income	Dates income received (mm/yy to mm/yy)	Monthly amount received

Section 3: In-Kind Income

1. Does anyone not listed in Section 4 give you or your spouse any money, food, a free place to live or help in paying your bills?

   ☐Yes, fill out this section. ☐No, go to section 4.

Type of Help	How often is help received	Amount of Help

2. What is the average total monthly amount of the following household expenses: mortgage/rent, property insurance, property taxes, heating fuel, electricity, gas, water, sewer, and garbage removal?

   $ _____

3. What is your average total monthly cash contribution towards the household expenses?

   $ _____

Section 4: Household Information

Please list family members living in your household (including your spouse, parent(s), children and sponsor, if applicable).

Name First, Middle Initial, Last	What is this person's relationship to you?	Date of Birth (Mo./Day/Year)	Social Security Number	Is this person in school, grades K-12?	Is this person attending college?
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No

Section 5: Certification

I attest that the information I have given is correct and true.

Signature of Applicant/Recipient/Designated Representative	**Date**
Signature of Spouse	**Date**

*Designated representative must be on file with New York SSP in order to sign for recipient.

If you do not return the completed form(s) within 30 days of the date of this letter, your SSP benefits may be affected.

If you need help completing the form(s), or have questions, please call us toll free at 1-(855)-488-0541.

Please return the requested information:

by mail to: NYS OTDA
State Supplement Program
PO Box 1740
Albany, New York 12201

by email to: otda.sm.ssp@otda.ny.gov

OR by fax to: 518-486-3459