NYS Child Support Processing Center
PO Box 15368
Albany NY 12212-5368

Wage and Health Benefits Report

Mail completed form to the address above
Or fax return to: (518) 320-1081

New York Case Identifier:
JCA Worker Code:
Employer/Benefit Administrator Number:
Source Code:
Employer FEIN:

(name of employer/benefit administrator)
(c/o line)
(street address)
(city), (state) (zip code)

Date: ___/___/____ County name: _____

Regarding: _____
Date of birth: _____
Social Security number: _____

For additional information on the form and process visit our website at *childsupport.ny.gov*

Dear Employer/Benefit Administrator:
Please review your records and provide the information requested in this report for the above named individual. This employee/beneficiary is, or may be, legally responsible for a person receiving child support services or public assistance and care. Sections 111-h (9), 111-r and 143 of the New York State Social Services Law (SSL) require that employers furnish the information requested to the Support Collection Unit (SCU). SSL § 111-s authorizes the SCU access to information contained in government and private records, such as benefits information. You must complete and return this report no later than 10 business days from the above date. **If the employee/beneficiary is no longer in your employ or under contract with you, or receiving benefits from you, all information must still be completed and submitted as indicated.** No substitute for this report is acceptable.

Failure to comply may result in a $500 penalty for initial non-compliance and a $700 penalty for later non-compliance (SSL § 111-r).

Is individual employed by you or working as an independent contractor?

☐ **YES**, *go to Section 1* ☐ **NO**

☐ **YES**, independent contractor, *go to Section 1*

☐ Seasonal worker expected return date: _____
Date of separation: _____/_____/_____ Reason for separation: _____
Separation: ☐ Voluntary ☐ Involuntary
Is employee still receiving benefits? ☐ **YES** ☐ **NO**
New employer name/address if known: _____
_____

Section 1 – **Employer**

Employer name (if different from above): _____ Employer FEIN (if different from above): _____
Address for mailing income withholding orders (if different from above): _____
Employer telephone number: _____ Email: _____

Section 2 – Employee Information

Date hired or rehired: _____/_____/_____ Pay rate: $_____ per _____

Work days: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Work hours: _____ AM/PM to _____ AM/PM ☐ Full time ☐ Part time ☐ Seasonal from _____ to _____

Worksite address, if different from employer address: _____

Mailing address: _____

Residential address, if different than mailing: _____

Primary telephone number: (_____) _____ Date of birth (if different from above): _____/_____/_____

Social Security number (if different from above): _____ **or** Individual Taxpayer Identification Number: _____

Union information (name and address): _____

_____

Section 3 – Compensation and Non-Health Insurance Benefit Information

From most recent W2 - tax year: _____ Wages, tips and other compensation: $_____

Current year wages - from: _____ / _____ / _____ to _____ / _____ / _____ Gross earnings: $_____

Medicare wages and tips: $_____ Medicare tax withheld: $_____

Total pre-tax deductions (these are the actual pre-tax deductions/contributions and include retirement contributions): $ _____

Total after-tax deductions (these are the actual after-tax deductions and include union dues, if any): $_____

Benefit type: ☐ Severance/Lump sum ☐ Other: _____ Effective date of benefit: _____

☐ Public/Private retirement benefits – provider name and address: _____

Benefit amount: ☐ Recurring amount: $_____ per _____ ☐ Lump sum amount: $_____

Section 4 - Health Insurance Benefit Information

1. Is the employee/beneficiary currently enrolled in a health care plan?
   ☐ **YES** ___ Family Plan ___ Single Plus One Plan ___ Individual Plan
   ☐ **NO**, *go to question 3*

2. Enrolled dependents (attach additional page(s) if necessary):

	Name	Date of Birth	Start Date
(1)	_____	_____/_____/_____	_____/_____/_____
(2)	_____	_____/_____/_____	_____/_____/_____
(3)	_____	_____/_____/_____	_____/_____/_____

   Health insurance carrier name: _____

   Address: _____

   Group policy number: _____ Employee's/Beneficiary's policy number: _____

3. The employee/beneficiary is not enrolled in a family (dependent) health care plan because:
   ☐ we do not offer health care plans. ☐ they are not eligible for health care coverage.
   ☐ they are not currently eligible to enroll, but will become eligible on _____/_____/_____.
   ☐ they have failed to enroll in the family (dependent) health care plan, and ☐ **ARE** ☐ **ARE NOT** enrolled in individual plan.
   ☐ they are no longer employed/receiving benefit and ☐ **ARE** ☐ **ARE NOT** enrolled in COBRA coverage.

4. **Whether or not the employee/beneficiary is enrolled in a health care plan, provide the cost of the health care plans that are offered to the employee/beneficiary.** Please specify the employee's/beneficiary's cost of each option. If you offer multiple plan options, use additional pages to provide the cost information for each plan.

Cost of Family Plan	Cost of Single Plus One Plan	Cost of Individual Plan
$_____ per _____	$_____ per _____	$_____ per _____
Annual deductible $_____	Annual deductible $_____	Annual deductible $_____

5. If you offer multiple plan options, attach a copy of printed descriptions of covered services available under ALL family (dependent) health care plans offered to this employee/beneficiary.

Section 5 - Certification

I hereby certify that: I am required by the NYS SSL to provide a correct and complete report regarding the employee/beneficiary, based on the records maintained by the employer/benefit administrator; the information in this report was taken from records of the employment, compensation and benefits of this employee/beneficiary; such information is maintained in the regular course of business; it is the regular course of such business to maintain such information; and a memorandum or record of the information was made at the time of the act, transaction, occurrence or event, or within a reasonable time thereafter. I certify that I am the head of this business or entity or an employee designated by such person for the purpose of making this certification.

Authorized Designee: Telephone number: ( )

Signature: _____ Date: _____

Print name and title: _____ Email: _____

New York Case Identifier: