Minnesota Department of Human Services

DHS-2146-ENG 4-1

Authorization for Release of Employment Information

Date: 01/16/2017 **Case number:** 875736

To:

Worker name: Brad Borchers
Agency name: Ramsey County
Agency address: 160 East Kellogg Blvd.
City, state, zip code: St Paul, MN 55101
Worker phone: Fax: (651) 266-3938

We need to verify the employment information for the person listed below:

Person name: June Bennett Social Security number: XXX-XX-7242
Address: 1075 East County Road D. #102
City/state/zip code: Vadnais Heights, MN 55109

Please provide the information requested on the back of this form and sign the form where indicated. On the bottom half of this form is a signed authorization to release information to the human services agency shown below.

Thank you for your cooperation.

Authorization for Release of Information

Giving Permission: I give permission for the person/organization above to release the requested information to the above agency. This information is used to figure my eligibility for public assistance and/or services.

Consequences: State and Federal privacy laws protect my records. I know:

- Why I am being asked to release this information
- I do not have to consent to this authorization, but it may affect my benefits or services if I do not give my consent
- That, generally, I must give my written consent for this person/agency to give out this information, but if I do not consent, the information will not be released unless the law otherwise allows it
- I may stop this authorization with a written notice at any time, but this written notice will not affect information the agency has already requested
- The person or agency who gets my information may be able to pass it on to others
- If my information is passed on to others by DHS, it may no longer be protected by this authorization.

This authorization will end one year from the date I sign it, unless the law allows for a longer period.

CLIENT SIGNATURE June Bennett	DATE 1/11/17	Original copy for agency
SIGNATURE OF SPOUSE/GUARDIAN/AUTHORIZED REPRESENTATIVE	DATE	Provide copy to client

Over

Employment Information

To be completed by employer - return both pages to requesting agency

Mail or fax to agency address/fax number on first page)

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	CASE NUMBER

Employment period:	DATE BEGAN/EXPECTED TO BEGIN	DATE ENDED/EXPECTED TO END	IF ENDED, DATE LAST PAID
REASON ENDED ☐ Voluntary ☐ Involuntary	EXPLAIN:		GROSS AMOUNT

Pay rate:

☐ $_____/hour

☐ $_____/day

☐ $_____/acre

☐ Other (explain:) _____

If per acre, # of acres anticipated? _____

Does this rate depend on the type of work performed? ☐ Yes ☐ No

If yes, explain: _____

Income received/expected: Provide information for these months: _____, _____, _____

What was the date of the first pay check received? _____

EMPLOYMENT IS:	AVERAGE # HOURS PER PAY PERIOD:	HOW OFTEN PAID:		
☐ Part time		☐ Each week	☐ Every two weeks	☐ Twice a month
☐ Full time	_____	☐ Once a month	☐ End of job	☐ Other _____

Work Schedule:	SUN	MON	TUES	WED	THUR	FRI	SAT

Attach verification of income earned, itemized by pay period, or complete the table below.

Note: **For future months,** anticipate income.

	Income received (Record only those wages which you are reasonably certain the employee will be paid.)							
Date received								
Gross earnings								
No. of hours worked								
Advances/Tips/Bonuses								
Child Support withheld								
Medical insurance								

Medical insurance:

Does the employee have medical insurance through you or your company? ☐ Yes ☐ No

Is medical insurance available through you or your company? ☐ Yes ☐ No

If yes, what is the employee cost? $ _____ per _____ (period of coverage)

Signature of employer:

I understand that the information provided on this form is correct to the best of my knowledge. I understand that this form is not a contract for services.

EMPLOYER SIGNATURE	COMPANY/BUSINESS NAME	
FEIN	PHONE NUMBER	DATE

Minnesota Department of Human Services

DHS-29198-ENG 8-12

Verification Request Form - B

CASE NAME		
June Bennett		
ADDRESS		
1075 County Road D E Apt 102		
CITY	STATE	ZIP CODE
Saint Paul	MN	55109

DATE
01/05/17
CASE NUMBER
875736

You will need to show proofs for us to decide if you are eligible. Proofs may be different if you want more than one kind of assistance. Ways you can show proofs are listed next to the item checked. **If you need help getting proofs, call** Brad Borchers at (651) 266-4654

General Information

☑	**Earned income**	**Verification of earnings; for the months of:** 12/01/16 to current **for** (name) June Bennett at Employer Solutions (Check stubs, employer's statement, self-employment records, income tax returns)
☐	**Unearned income**	**Verification of:** For months of: _____ **(Check stubs, benefit statement or check, court order, rental receipts)**
☐	**Educational funds**	Award letter or statement from school, loan agreement
☐	**Educational expenses**	Receipts, statement from school

Miscellaneous

☐	**Illness/incapacity pregnancy/disability**	Medical statement
☐	**Work history**	**Verification of work history from** _____ to _____ (Check stubs, employer's statement, W-2 forms, income tax returns)
☐	**Child or adult care**	Statement from person giving care for (months) _____ for (dependent): _____
☐	**Student status**	Statement from school
☐	**Medical expenses**	Itemized medical bills, health insurance and Medicare payments
☐	**Medical insurance**	Policy or policy number with information, insurance card (for Medicare bring Medicare card), premium notice
☐	**Divorce decree/ child support papers**	
☐	**Federal Employer Identification Number (FEIN)**	
☐	**Other**	

You may be asked to show more proof:

- At the time of your interview
- When your case is reviewed
- When there is new information.

If you don't show proof you may not be able to get the help you asked for.

Return by: 01/16/17

Return to:

NAME		PHONE NUMBER
Ramsey County		(651) 266-4654
ADDRESS		
160 East Kellogg Blvd.		
CITY	STATE	ZIP CODE
Saint Paul	MN	55101

Original - Client *Copy* - Case Record

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໃຫ້ຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກ ຂອງທ່ານຫຼືໂທຣ໌ຫາຕາມເລກໂທຣ໌ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông tin này miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LEZ-0001 (10-09)

ADA5 (3-12)

This information is available in alternative formats to individuals with disabilities by calling your county worker. TTY users can call through Minnesota Relay at 800-627-3529. For Speech-to-Speech, call 877-627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.