

# Employment Information

To be completed by employer - return both pages to requesting agency  
(Mail or fax to agency address/tax number on first page)

FARMER NAME Victor R Colon	SOCIAL SECURITY NUMBER 355-82-4310	CASE NUMBER 1399392
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<b>Employment period:</b> DATE BEGAN/EXPECTED TO BEGIN	DATE ENDED/EXPECTED TO END	GROSS AMOUNT
REASON ENDED <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary		EXPLAIN

<b>Pay rate:</b> \$ _____ /hour \$ _____ /day \$ _____ /acre	If per acre, # of acres anticipated? _____ Does this rate depend on the type of work performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____ (Other (explain): <input type="checkbox"/>
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**Income received/expected:** Provide information for these months: \_\_\_\_\_

What was the date of the first pay check received? \_\_\_\_\_

EMPLOYMENT IS: <input type="checkbox"/> Full time <input type="checkbox"/> Part time	AVERAGE # HOURS PER PAY PERIOD	HOW/OFTEN PAID: <input type="checkbox"/> Each week <input type="checkbox"/> Once a month <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____	Work Schedule: SUN MON TUES WED THUR FRI SAT
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SUN	MON	TUES	WED	THUR	FRI	SAT
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Attach verification of income earned, itemized by pay period, or complete the table below.  
Note: For future months, anticipate income.

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

**Medical insurance:**

Does the employer 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	PHONE NUMBER	DATE
COMPANY/BUSINESS NAME		





7-11

Minnesota Department of Human Services



# Authorization for Release of Employment Information

Date: 10/01/2014

Case number: 1399392

To:

Worker name: Shawn R. K.  
 Agency name: Benton County Human Services  
 Agency address: P.O. Box 740  
 City, state, zip code: Foley, MN 56329  
 Worker phone: 320-968-5137 Fax: 320-968-5330

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

Social Security number: 355-82-4310

Person name: Victor R Colon

Address: 520 15th Ave Se Apt 202

City/state/zip code: Saint Cloud MN 56304-1264

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.

**Consent:** 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 <i>Victor R Colon</i>	DATE 2/13/14	SIGNATURE OF SPOUSE/GUARDIAN/AUTHORIZED REPRESENTATIVE
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