



# Authorization for Release of Employment Information

**Date:** 12/29/15

**Case number:** 2157272

**To:** CGM

Worker name: Amran Muse  
Agency name: EAC  
Agency address: 3333 W. Division, Suite 100  
City, state, zip code: St. Cloud, MN  
Worker phone: (320) 227-1316 Fax: (320) 227-1301

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

Person name: Abdulkadir A Dhucul Social Security number: XXX-XX-9870  
Address: 423 27th Ave  
City/state/zip code: Saint Cloud MN 56303-1822

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.

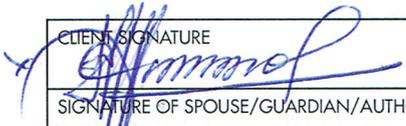
## Authorization for Release of Information

**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 	DATE 12/29/2015	Original copy for agency Provide copy to client
SIGNATURE OF SPOUSE/GUARDIAN/AUTHORIZED REPRESENTATIVE	DATE	

# 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 Abdulkadir A Dhucul	SOCIAL SECURITY NUMBER XXX-XX- 9870
--------------------------------------	--

<b>Employment period:</b>	DATE BEGAN/EXPECTED TO BEGIN	DATE ENDED/EXPECTED TO END	IF ENDED, DATE LAST PAID
REASON ENDED <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary	EXPLAIN:		GROSS AMOUNT

<b>Pay rate:</b> <input type="checkbox"/> \$ _____ /hour <input type="checkbox"/> \$ _____ /day <input type="checkbox"/> \$ _____ /acre <input type="checkbox"/> Other (explain:)	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: _____
---	---

**Income received/expected:** Provide information for these months: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

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

EMPLOYMENT IS: <input type="checkbox"/> Part time <input type="checkbox"/> Full time	AVERAGE # HOURS PER PAY PERIOD: _____	HOW OFTEN PAID: <input type="checkbox"/> Each week <input type="checkbox"/> Every two weeks <input type="checkbox"/> Once a month <input type="checkbox"/> End of job	<input type="checkbox"/> Twice a month <input type="checkbox"/> 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 CGM	PHONE NUMBER	DATE
--------------------	------------------------------	--------------	------