



Minnesota Department of Human Services



DHS-2146-ENG

4-1

Authorization for Release of Employment Information

Date: 7-18-17

Case number: 1027902

MAILED

JUL 27 2017

To: 160 East Kellogg Boulevard
St. Paul, MN 55101

Worker name: Mai Vang
Agency name: Ramsey County Human Services Dpt
Agency address: 160 East Kellogg Boulevard
City, state, zip code: St. Paul, MN 55101
Worker phone: (651) 266 4644 Fax: (651) 266 3926

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

Person name: Kokou Doeh
Address: 535 Asbury St Apt 1
City/state/zip code: St. Paul, MN 55104

Social Security number: XXX-XX-2761

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 7/18/17	Original copy for agency
SIGNATURE OF SPOUSE/GUARDIAN/AUTHORIZED REPRESENTATIVE	DATE	Provide copy to client

Over

1885 University Ave.
St. Paul, MN 55104
Suite 365
651 528-8008
651 330-2310
www.UjamaaPlace.org



Fax

To: Shelby From: Kokou Doeh
 Fax: 651-612-395574 Pages: 3 w/cover
 Phone: _____ Date: 7-18-17
 Re: _____ Cc: _____

- Urgent For Review Please Comment Please Reply Please Recycle

Confidential Documents

*please fill out
and fax back.*

*to
651-330-2310*

(re fax)

Employment Information

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

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

01027902 - MALDEN V. 5200

EMPLOYEE NAME Kokou Doeh	SOCIAL SECURITY NUMBER 476-23-2761	CASE NUMBER
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Employment period:	DATE BEGAN/EXPECTED TO BEGIN 6-12-2017	DATE ENDED/EXPECTED TO END 6-16-2017	IF ENDED, DATE LAST PAID 6-23-2017
REASON ENDED	EXPLAIN: Temp Assignment		GROSS AMOUNT \$97.35
<input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary			

Pay rate: <input checked="" type="checkbox"/> \$ <u>11</u> /hour	If per acre, # of acres anticipated? _____
<input type="checkbox"/> \$ _____ /day	Does this rate depend on the type of work performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> \$ _____ /acre	If yes, explain: _____
<input type="checkbox"/> Other (explain): _____	

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

What was the date of the first pay check received? **6-23-2017**

EMPLOYMENT IS:	AVERAGE # HOURS PER PAY PERIOD:	HOW OFTEN PAID:			
<input checked="" type="checkbox"/> Part time <input type="checkbox"/> Full time	<u>9</u>	<input checked="" type="checkbox"/> Each week <input type="checkbox"/> Once a month	<input type="checkbox"/> Every two weeks <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
N/A						

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	6-23-17						
Gross earnings	\$97.35						
No. of hours worked	8.85						
Advances/Tips/Bonuses	0						
Child Support withheld	0						
Medical insurance	0						

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: *medical is only available if they are currently an employee.*

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 500-26-2726508	PHONE NUMBER 952-835-1288
	DATE 7/27/17

