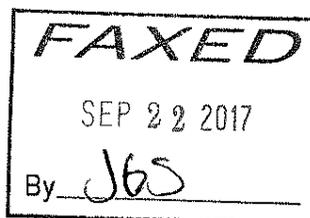


Employer Solutions Group, LLC
PO Box 46270
Minneapolis, MN 55344
Phone: (952) 835-1288

To: Yenviset Xiong Fax: (612) 395-5574
From: Jimena Garcia Salazar Date: 9/22/17
Re: Kayla Gantt Pages: 5

Comments:



Regards,

Nathan Lloyd | Payroll Account Manager
Employer Solutions Group, LLC
PO Box 46270
Minneapolis, MN 55344
Main Phone: (952) 767-8247

Sep. 14. 2017 11:28AM

No. 9886 P. 1



Henepin County
Human Services and Public Health Department

Child Care Assistance
Attn: Case Assignment
PO Box 107
Minneapolis, MN 55440-0107

Return to



D10 (02/26/2016)

→ Yenviset Xiong, GCDF & SP

Phone 612-348-5937
Fax 612-288-2982
www.henepin.us

EAC-RESOURCE, Inc.
5701 Shingle Creek Parkway, Suite 100
Brooklyn Center, MN 55430
Tel: 612-752-8907 Fax: 612-752-8901

10/20/17

EMPLOYMENT VERIFICATION

This information is available in other forms to people with disabilities by calling the county worker on this form. For TDD users and those with speech difficulties, please contact your county worker through the Minnesota Relay at 711 or 1-800-627-3529 (TDD) or 1-877-627-3848 (Speech-to-Speech Relay).

Case Information

CCA EWS

Client Name <i>Kayla Grant</i>	Case Number <i>2000189</i>	SMI Person No.	Date <i>8.14.17</i>
Worker Name	Phone Number		

Employee Information

Employee Name <i>Kayla Grant</i>	Social Security No. <i>478-15-0606</i>	Date of Birth <i>03-13-89</i>
Employer Name <i>D+B Pating</i>		
Employer Address <i>7965 main st NE</i>	Address Line 2	
City <i>Fridley</i>	State <i>MN</i>	ZIP Code <i>55432</i>

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 not 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>Kayla Grant</i>	Date <i>8.14.16</i>
Signature of Spouse/Guardian/Authorized Representative	Date
Original copy for agency, provide copy to client	

From:

09/22/2017 08:18

#402 P.004/010

Sep. 14. 2017 11:29AM

No. 9886 P. 1



Hennepin County
Human Services and Public Health Department

Child Care Assistance
Attn: Case Assignment
PO Box 107
Minneapolis, MN 55446-0107



Return to
Yenviset Xiong, GCDF & SP

EAC-RESOURCE, Inc.
5701 Shingle Creek Parkway, Suite 1009/20/17
Brooklyn Center, MN 55430
Tel: 612-752-8907 Fax: 612-752-8901



D10 (02/26/2016)

Phone 612-348-5937
Fax 612-388-2982
www.hennepin.us

EMPLOYMENT VERIFICATION

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Case Information

CCA EWS

Client Name <i>Kayla Grantt</i>	Case Number <i>2000187</i>	SMI Person No.	Date <i>8.14.17</i>
Worker Name	Phone Number		

Employee Information

Employee Name <i>Kayla Grantt</i>	Social Security No. <i>478-15-0606</i>	Date of Birth <i>07-13-89</i>
Employer Name <i>O+B Pating</i>		
Employer Address <i>7965 main st. NE</i>	Address Line 2	
City <i>Fridley</i>	State <i>mn</i>	ZIP Code <i>55432</i>

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 not 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>Kayla Grantt</i>	Date <i>8.14.16</i>
Signature of Spouse/Guardian/Authorized Representative	Date
Original copy for agency, provide copy to client	

From:

09/22/2017 08:19

#402 P.006/010

Sep. 14. 2017 11:29AM

Fax 612-395-5574 No. 9886 P. 2



Hennepin County Human Services and Public Health Department

D10 (02/26/2016)

Child Care Assistance
Attn: Case Assignment
PO Box 107
Minneapolis, MN 55440-0107

Yenviset Xiong, GCDF & SP
EAC-RESOURCE, Inc.
5701 Shingle Creek Parkway, Suite 100
Brooklyn Center, MN 55430
Tel: 612-752-8907 Fax: 612-752-0901

Phone 612-348-5987
Fax 612-288-2982
www.hennepin.us

EMPLOYMENT VERIFICATION

Employee Name: Kayla Grant Social Security Number: 478-15-0604

To be completed by the employer - The following information is required to determine eligibility for programs offered by Hennepin County and/or its contracted service providers. Please provide all information requested and return to the agency listed above.

Employer Name:
Employer Address: , ,

[X] If this person never worked at your company, STOP HERE. CHECK THE BOX. Sign and date below.

Select reason person no longer employed:

- Leave of Absence (with pay) Strike/Lockout Layoff Voluntary quit Involuntary quit
Leave of Absence (without pay)

Can employee return to work? Yes No If Yes, when?

End date of employment Date of final check Gross amount of final check

1. Employment start date 2. Date of first check 3. Gross amount of first check 4. Gross salary per pay period

4. Date of next check 5. Day of week check received 6. Pay frequency

7. Hourly pay rate 8. Occupation/Title

9. Approximate date of next raise Hourly rate of next raise

10. Does this employee work overtime? Yes No If yes, what is the overtime rate?

How many hours of overtime does this person average? pay period week month OR Year to date Total

11. Check if employee receives: Tips Commissions Bonuses Average tips/commissions/bonuses per pay period YTD total

12. Are there any company-paid flexible benefits available to be taken in cash? OR Are any "in kind" (non-cash) benefits received (e.g., a housing allowance or an apartment)? Yes No
If yes, please list the amount here and explain:

13. List below actual hours worked each day. (Please fill in below**.)

Table with 7 columns: Sun, Mon, Tues, Wed, Thurs, Fri, Sat. Rows: Start time, End time

**If the schedule varies, attach last 30 days of posted work schedules or completed time sheets. If schedule changed, indicated change effective date: 14. Number of hours worked per week

From:

09/22/2017 08:19

#402 P.008/010

Sep. 14. 2017 11:29AM

No. 9886 P. 3



Hennepin County
Human Services and Public Health Department

010 (02/26/2016)

Child Care Assistance
ATTN: Case Assignment
PO Box 107
Minneapolis, MN 55440-0107

Yenviset Xiong, GCDF & SP

Phone 612-348-5937
FAX 612-268-2982
www.hennepin.us

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Brooklyn Center, MN 55430
Tel: 612-752-8907 Fax: 612-752-8907

Kayla Grant

EMPLOYMENT VERIFICATION

15. What is the earliest date health/dental/vision benefits are available? _____

Is coverage available for: (check all that apply) Employee Spouse Dependents

16. Employee cost per pay period: Employee: _____ Spouse: _____ Dependents: _____

Monthly employee's amount paid toward health/dental/vision insurance premiums: _____

17. Name of Insurance Company: _____ Group #: _____

18. Health benefits contact person Name: _____ Phone: _____

19. Is employee paying court-ordered child support? Yes No Amount per pay period: _____

Please complete the monthly wage income (or attach printout) for _____
from start of employment through present.

Date Check Received	Hours worked	Gross wages	Tips	FICA & Medicare	Federal Tax	State Tax	Other Deductions

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

Jimena G. Salazar
Signature of Employer Representative

9/22/17
Date

Jimena Garcia Salazar / payroll Assistant
Printed Name of Employer Representative and Title

(952) 835-1288
Phone Number

Employer Solution Staffing Group
Employer Name

500-26-2726508
Federal Employer Identification Number

Client Name *Kayla Grant* Case Number _____

From:

09/22/2017 08:20

#402 P.010/010