

FAX

To: Huskin Meats
Company: 320-740-0654
Fax: 320-740-0654
Phone:

From: Stearns County
Fax:
Phone:
E-mail: Deanna.Kampa@co.stearns.mn.us

NOTES:

Second Request
Please complete the attached form for Angelina Hodge case #1302409;
once completed please fax back to Stearns County at 320-656-6447.

Thank you.
Stearns County - Family Financial Services
320-656-6000 phone
320-656-6447 fax

To whom it may concern:

Angelina Hodge reached here through a staffing
agency, CMG/ESG, she was met on our payroll.
I have forwarded them your request again.

Thank you,

Nichol Weyck

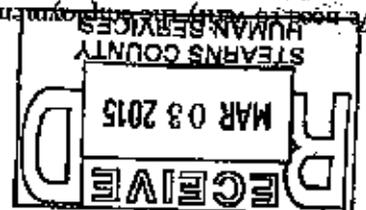


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Authorization for Release of Employment Information

Date: 2/23/2015 Case number: 1302409

To: Huskin Meats



Worker name: Family B
 Agency name: Stearns County Human Services
 Agency address: Box 1107
 City, state, zip code: St. Cloud, MN 56302
 Worker phone: 320-656-6000
 Fax: 320-656-6447

We need your employment information for the person listed below:

Social Security number: XXX-XX-7671

Person name: Angelina Hodge
 Address: 1516 4th St N
 City/state/zip code: Saint Cloud, MN 56303-3915

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 03-21-15	Provide copy to client
SIGNATURE OF SPOUSE/CHILD/AN AUTHORIZED REPRESENTATIVE	DATE 03-21-15	Original copy for agency

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 Angelina Hodge	SOCIAL SECURITY NUMBER 7671	CASE NUMBER 1302409
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Employment period: 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		GROSS AMOUNT
EXPLAIN:		

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: <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
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Work Schedule:	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.

Income received: (Award 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 Huskin Meats
FEN	PHONE NUMBER
	DATE