MEDICAL/DENTAL COVERAGE:

Is medical insurance available through your company? ☐ Yes ☐ No

Name of Insurer: _____ Group # _____

Employer # _____

What part of the monthly premium does the employee pay? $ _____

Coverage is for (please circle): Employee Spouse Dependents Coverage Start Date: _____

TERMINATION OR LEAVE OF ABSENCE DETAILS:

Termination:
Date Employment Ended: _____ Date Last Check Rcvd: _____ Amount: $ _____

Reason: _____

Is this employee eligible for re-employment? ☐ Yes ☐ No If yes, when? _____

Leave of Absence:
Date leave began: _____ Expected return date: _____

Reason for leave: _____

Any Disability Benefits available while on leave? _____

INCOME VERIFICATION: please list the dates and amounts of all pay checks issued to this employee (or attach a print-out) for the following period: _____ through _____ .

Date Actually Paid	Pay Period Ending Date	Gross Wages	Tips	Other

Check here if printout or separate sheet attached: ☐

Printed Name of Employer Representative: _____

Title _____ Phone Number _____

Signature _____

REQUESTING AGENCY: Please send the completed form to:

Worker	Phone #	Fax #
CHA ZONG XIONG	(651) 266-4644	(651) 266-3704

Agency
RAMSEY COUNTY Human Services

Address	City	State	Zip
160 Kellogg BLVD E.	ST. Paul	MN.	55101-1420

Authorization for Release of Information

Giving Permission: I give permission for the above employer to release the requested information to the requesting agency. This information is used to figure my eligibility for services from this agency.
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 that gets my information may be able to pass it on to others.
- If my information is passed on to others, 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.

Employee Signature	Joey R. Shapley	Date 12/4/09
Signature of Spouse/Guardian or Authorized Representative		Date

See other side