DHS-2146-ENG 3-0

Minnesota Department of Human Services
Authorization for Release of Employment Information

This information is available in other forms to people with disabilities by calling your county worker. For TTY/TDD users, contact your county worker through the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

DATE 12-12-07

To:

EMPLOYER CMG

ADDRESS

CITY Pipestone STATE ZIP CODE

1-507-562-6800 fax 1-507-562-6771

CASE NUMBER 15 14948

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

EMPLOYEE NAME Joshua DeWolf SOCIAL SECURITY NUMBER 475-15-5472

ADDRESS 105 Church St. S, CITY Hills STATE Mn ZIP 56138

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.

COUNTY WORKERS SIGNATURE Ellen Hauer PHONE NUMBER (507) 283-5070

AGENCY [illegible] FAMILY SERVICE AGENCY

ADDRESS PO BOX 715 LUVERNE, MN 56156-0715 (507) 283-5070 FAX (507) 283-5074 CITY STATE ZIP CODE

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 12-12-07

SIGNATURE OF SPOUSE/GUARDIAN/AUTHORIZED REPRESENTATIVE DATE

Original copy for agency
Provide copy to client

RECEIVED DEC 12 2007

Over

To Be Completed By Employer

(Return to requesting agency)

EMPLOYEE NAME	SOCIAL SECURITY NUMBER
Joshua DeWolf	475-15-5472

Employment period:

DATE BEGAN/EXPECTED TO BEGIN	DATE ENDED/EXPECTED TO END	REASON ENDED
11/05/07	11/30/07	Job Abandonment

Pay rate: ☒ $ 10 /hour ☐ $ _____ /day ☐ $ _____ /acre

If per acre
- # of acres anticipated
- Does this rate depend on the type of work performed? ☐ Yes ☐ No

If yes, explain _____

☒ Other (explain): Date last paycheck received: 11/30/07

Income received/expected: Provide income information for these months: Nov, Dec, _____

Employment is: ☐ Part time ☒ Full time

How often paid: ☐ Each week ☒ Every two weeks ☐ Twice a month ☐ Once a month ☐ End of job ☐ Other _____

Note: For future months, anticipate income. Record only those wages which you are reasonably certain the employee will be paid.

• Date pay received	Nov 2	11/30	12/14					
• Gross earnings	400	960	390					
• Additional payments (Advances/tips/bonuses)	—	—	—					
• # Hours worked	40	96.45	39.0					
• Deductions: FICA								
Federal								
State								

- Does the above income include reimbursement for travel? ☐ Yes ☒ No
  If yes, is there a written contract? ☐ Yes ☒ No
- Does the above income also cover services provided by people other than the listed employee? ☐ Yes ☒ No
  If yes, list other people _____ _____

Medical insurance:

Is medical insurance available through you or your company? ☐ Yes ☒ No

If yes, what is the employee cost? $ _____ Per _____ (period of coverage)

Does the employee have medical insurance through you or your company? ☐ Yes ☒ No

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	PHONE NUMBER	DATE
[signature]	501-562-6807	12/12/07

Employee declaration: *(Complete if your benefits are based on anticipated income.)*

- I am reasonably certain that I will get the anticipated amount of income and I will get it in the time period listed above.
- I believe all of the information above is true and correct. I permit the county to use this information to determine if I am eligible for public assistance benefits.

☐ I agree ☐ I do not agree (contact your county financial worker for help)

SIGNATURE OF EMPLOYEE	DATE

P.O. Box 715 Luverne, MN 56156
Phone (507) 283-5070
Fax (507) 283-5074

Rock County Family Service Agency

Fax

To: CMG From: Jean Hovin

Fax: 507-562-6800 Pages: 3 (including this cover sheet)

Phone: 1-507-562-6071 Date: 12-12-07

Re: Joshua DeWolf CC:

☐ Urgent ☐ For Review ☐ Please Comment ☒ Please Reply ☐ As Requested

• Comments:

DATA PRIVACY