Olmsted County Community Services Department
Family Support and Assistance Division
2117 Campus Dr SE Suite 100
Rochester, MN 55904-4825
Phone: 507-328-6500
Fax: 507-328-7956

Fax

To: HUMAN RESOURCES

Fax: 289-6552

Phone:

Re: employment information for LAUREN SCHROEDER

From: S. GRANT

Pages: 3

Date: 9/19/12

CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

• **Comments:**

THANK YOU!

Schroeder, Lauren E

Minnesota Department of Human Services

DHS-2146-ENG 2-12

Authorization for Release of Employment Information

Date: 8-28-12 **Case number:** 1084263 MN

To: Employer Staffing Solutions / REICHEL FOODS

Worker name: KISSMIN
Agency name: OLMSTED CO COMM SERVICES
Agency address: 2117 CAMPUS DR SE STE 100
City, state, zip code: ROCHESTER, MN 55901
Worker phone: (507) 328-6500 Fax: (507) 328-7956

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

Person name: LAUERN Schroeder Social Security number: XXX-XX-0697
Address: 109 7th st NE Apt 102
City/state/zip code: Byron, MN 55920

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.

REC'D SEP 04 2012

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	Original copy for agency
Lauern E. Schroeder	8-28-12	
SIGNATURE OF SPOUSE/GUARDIAN/AUTHORIZED REPRESENTATIVE	DATE	Provide copy to client

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	SOCIAL SECURITY NUMBER
LaVern Schroeder	XXX-XX-0697

Employment period:

DATE BEGAN/EXPECTED TO BEGIN	DATE ENDED/EXPECTED TO END	IF ENDED, DATE LAST PAID

REASON ENDED ☐ Voluntary ☐ Involuntary EXPLAIN:

GROSS AMOUNT

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 IS:	AVERAGE # HOURS PER PAY PERIOD:	HOW OFTEN PAID:		
☐ Part time		☐ Each week	☐ Every two weeks	☐ Twice a month
☐ Full time	_____	☐ Once a month	☐ End of job	☐ Other _____

Work Schedule:

SUN	MON	TUES	WED	THUR	FRI	SAT

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								
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	PHONE NUMBER	DATE

Employer Stella M. Martinez