

## SENSITIVE BUT UNCLASSIFIED

Department of Homeland Security  
E-Verify

Report Prepared: 10/16/2012  
Page: 1 of 1

Case Verification Number: 2012290101745MW

**Case Information:**

**Employee Information:**

Last Name:	Shrager	First Name:	Charlene
Middle Initial:		Maiden Name:	
Social Security Number:	*** ** 8069	Date of Birth:	09/16/1953
Citizenship Status:	A citizen of the United States		

**Document Information:**

List B Document:	Driver's license or ID card issued by a U.S. state or outlying possession	List C Document:	Social Security Card
Document Name:	Driver's license	Document State:	Minnesota
Driver's License or ID Card Number:		Document Expiration Date:	09/16/2014
Alien Number:		I-94 Number:	

**Additional Information:**

Hire Date:	10/16/2012	Employer Case ID:	
Three-Day Rule Reason:		Three-Day Rule - Other:	
Submitted By:	ACOR9642	Submitted On:	10/16/2012

**Initial Case Result:**

Case Result: Employment Authorized

**Employee Referred to SSA:**

Referred By: Referred On:

**Case Result from SSA (after SSA Tentative Nonconfirmation):**

Case Result: Response Date:

**Resubmitted to SSA (after Review and Update Employee Data):**

Last Name:		First Name:	
Middle Initial:		Maiden Name:	
Social Security Number:		Date of Birth:	
Resubmitted By:		Resubmitted On:	

**Case Result from SSA (after Resubmission):**

Case Result:

**Request Name Review:**

Comments: Submitted On:  
Submitted By:

**Case Result from DHS (after DHS Verification in Process):**

Case Result: Response Date:

**Employee Referred to DHS:**

Referred By: Referred On:

**Case Result from DHS (after DHS Tentative Nonconfirmation):**

Case Result: Response Date:

**Photo Matching Results:**

Determination:

**Employee Referred to DHS (Additional):**

Referred By:

Referred On:

**Case Result from DHS (after Additional DHS Tentative Nonconfirmation):**

---

Case Result:

Response Date:

**Case Closure:**

---

Closure Statement:

The employee continues to work for the employer after receiving an Employment Authorized result.

Closed By:

ACOR9642

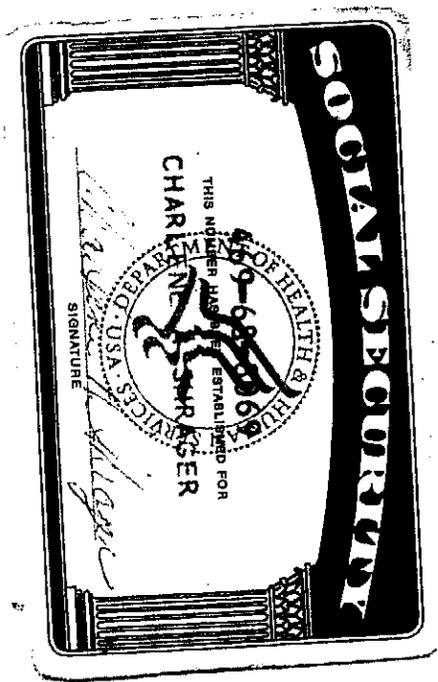
Closed On:

10/16/2012

---

---

**SENSITIVE BUT UNCLASSIFIED**



**MINNESOTA**  
**DRIVER'S LICENSE**

CHARLENE ALICE SHRAGER  
3747 MANOR WOODS DR NW  
ROCHESTER, MN 55901

Date of Birth 09-16-1963  
Sex F Eyes BLU Chas D  
Height 5-7 Weight 307 DDMDR  
ISSUED 05-2011 EXPIRES 08-16-2014

*Charlene Alice Shrager*

V682224162716



## New Hire Application

**Personal Data-- PLEASE PRINT LEGIBLY IN INK**

Last Name Shrager First Name Charlene Middle Initial A  
 Street Address 701 Main St. Apt. \_\_\_\_\_  
 City/State/Zip Kasson MN 55944  
 Home Phone \_\_\_\_\_ Cell/ Message Phone 507-421-7952  
 Company/Employer Shrager

**All offers of employment are conditional upon satisfactory proof of identity and legal ability to work in the U.S.A.**

Are you legally authorized to work in the United States of America?  YES  NO

**Applicant Certification and Authorization**

I authorize Employer Solutions Staffing Group (ESSG) to use the information and statements contained in this application to determine my qualifications for employment. I authorize ESSG to make inquiries of my former employers, except as indicated in this application, regarding my previous duties, responsibilities, performance, compensation and eligibility for rehire.

I understand that a comprehensive background check may be conducted to determine my eligibility for hire by certain clients of ESSG. This may include but is not limited to, investigations of criminal and/or conviction records, driving records and/or a drug screen test as required by clients, government regulations or by ESSG policies.

I release ESSG and other persons or entities from any claims that might be based on ESSG's decision to conduct a background check.

I certify that all statements made in my application are true and accurate and that I have not omitted any material information or provided false or misleading information. I understand that any material omission or misrepresentation will result in my disqualification from consideration for employment or, if discovered after I begin employment, will result in my termination.

If hired, I agree to abide by the policies and procedures of ESSG.

Charlene Shrager Name (Print or type) Charlene Shrager Applicant's Signature 10/16/2012 Date

A copy or facsimile will be considered the same as an original signature.

**For ESSG Office Use Only**

DOH _____	NHW _____	I-9 _____	8850 _____	W4 _____
Emergency Contact Info _____	Background Release Form _____	Background Results _____	Unemployment Letter (If applicable) _____	ESC Application _____



# employer solutions staffing group<sup>sm</sup>

Leveraging Resources in a Changing Market

**To:** All Employees

**Quien:** Todos Empleados

**From:** Corporate Management Group & Employer Solutions Group

**De:** Corporate Management Group y Employer Solutions Group

**Re:** Stop Payment Check Fee

**Re:** Tarifa de cheque parado

---

Effective immediately, to replace a lost or stolen check, \$50.00 will be deducted from the replacement check for a stop payment fee and for a reprocessing fee. *Efectivo inmediatamente, para reemplazar un cheque de sueldo perdido o robado, \$50.00 de tarifa sera deducido de el cheque reemplazado para parar el cheque original y para procesarlo denuevo.*

If you lose your check, we will first have to verify that it has not been processed through the bank. If it has not, a new check will be issued, minus the \$50.00 fee. *Si usted pierde su cheque, tendremos que verificar que no ha sido procesado en el banco. Si no, un cheque nuevo sera processado, menos las tarifa de \$50.00.*

If your check is stolen, we will first need a copy of the police report before a new check can be reissued. After we receive a copy of the police report, a new check will be issued following the same procedures as listed above. *Si su cheque es robado, necesitaremos una copia de el reporte de policia antes de que un cheque nuevo sera procesado. Despues de obtener una copia del reporte de policia, un cheque nuevo sera procesado usando los mismos procedimientos mencionados arriba.*

If you have any questions regarding this new policy, please contact your On-Site Representative or the Corporate Office (303-920-1425). *Si usted tiene preguntas sobre esta poliza, por favor contacte a su representante de CMG o la oficina corporal al (303-920-1425)*

Thank you for your continued dedication and hard work!

*Gracias por su dedicacion continua!*

By signing below you are confirming that you understand the above policy.  
*Con su firma abajo usted esta confirmando que entiende la poliza descrita.*

Signature/Firma: \_\_\_\_\_

*Charlene Shaper*

Date/Fecha: \_\_\_\_\_

*10/16/2012*

---

Address  
7301 Ohms Lane, Suite 405  
Edina, Minnesota 55439

Telephone 952.835.1288  
Facsimile 952.835.1255

Web [www.ESGStaffingSolutions.com](http://www.ESGStaffingSolutions.com)  
Email [info@ESGStaffingSolutions.com](mailto:info@ESGStaffingSolutions.com)

**EMPLOYER SOLUTIONS STAFFING GROUP  
IN CASE OF AN EMERGENCY - NOTIFICATION INFORMATION**

Employee Name: Charlene Shrager

Address: 701 Main St Kasson MO 55944

Home Phone: Cell 507-421-7952

Person(s) to contact in case of an emergency on the job (in order of preference):

1. **Name:** Margaret Shrager

Phone (work): \_\_\_\_\_

Phone (home): 507-696-4281

2. **Name:** Sue Kern

Phone (work): \_\_\_\_\_

Phone (home): 507-951-4921

Additional information you want Employer Solutions Group and our clients to know in the event of an emergency:

Hospital Preference - OMC

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



employer solutions staffing group<sup>LLC</sup>

---

**STATEMENT OF CONFIDENTIALITY**

This agreement made this 16 day of Oct, 2012, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Charlene Shrager hereafter referred to as "employee".

**WITNESSETH:**

For the duration of my employment and after resignation or termination of this employment with employer, for any reason whatsoever, the employee shall not use or disclose to any other person or company, and confidential or proprietary information or know-how related to the business of the employer.

In view of the difficulty of determining the amount of damages which may result to the employer from a violation of any of the provisions hereof, the employee agrees to pay to the employer the sum of \$10,000 as liquidated damages for every such violation; provided, however, that the payment of such amount as liquidated damages shall not be construed as a release or waiver by the employer of the right to prevent any such violation in equity or otherwise.

Charlene Shrager  
Employee Signature

Kelsey A. Schil  
Employer Solutions Staffing Group LLC, Representative



employer solutions staffing group<sup>sm</sup>  
Leveraging Resources in a Changing Market

## **INJURY MANAGEMENT PROGRAM**

### **Injured Worker's Responsibilities**

As your employer, we are concerned about your full recovery. Reasonable and necessary medical care will be paid for any compensable work injury. Medically authorized time away from work will be reimbursed in accordance with the **State of Minnesota workers' compensation laws**. Wherever possible light duty restrictions imposed as a result of your injury will be accommodated.

#### **RESPONSIBILITIES OF THE INJURED WORKER:**

Minnesota Rule Sec. 5221.0430, Subp. 1 requires that you choose one primary health care provider. Subpart 2 places limitations on your right to change primary health care providers. Discuss with your employer any change in health care provider.

Attend all scheduled appointments. While on physical limitations, visits should be a minimum of once every two weeks. Failure to have current medical support for disability may result in termination of benefits. Schedule your next appointment immediately after your doctor visit, before you leave the clinic if possible.

Obtain a Report of Workability from your physician at every appointment, a minimum of once every two weeks. M.R. 5221.0420 requires that your physician cooperate with return to work planning and that you be released to return to work at the earliest appropriate time.

Immediately following your appointment, provide a copy of the report to the designated employer representative. You should deliver this in person so that changes in work restrictions may be addressed and any questions answered.

Follow all physical restrictions at home and at work.

Report to work and perform physically suitable tasks as assigned. These may or may not be in your regular department. The work may or may not be on your usual shift.

Maintain regular, weekly, communication with your employer if you are unable to return to work. Contact your employer a minimum of after every visit with your primary health care provider. Keep the claims representative advised of your status.

Notify your employer immediately of any new injuries or conditions that impact your physical condition.

If it is necessary to miss scheduled work due to a work injury, you must be seen by your primary health care provider the same day in order to receive compensation for the time away from work. The physician must complete a Report of Workability.

**I have read my responsibilities and agree to abide by these guidelines.**

Signed: Charlene Shrager

Printed Name: Charlene Shrager

# Form W-4 (2012)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

**Exemption from withholding.** If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2012 expires February 18, 2013. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

**Head of household.** Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity

income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners or multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

**Nonresident alien.** If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2012. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

**Future developments.** The IRS has created a page on [IRS.gov](http://IRS.gov) for information about Form W-4, at [www.irs.gov/w4](http://www.irs.gov/w4). Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted on that page.

## Personal Allowances Worksheet (Keep for your records.)

**A** Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** \_\_\_\_\_

**B** Enter "1" if: } **B** \_\_\_\_\_

- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.

**C** Enter "1" for your **spouse**. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** \_\_\_\_\_

**D** Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . **D** \_\_\_\_\_

**E** Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . . . . . **E** \_\_\_\_\_

**F** Enter "1" if you have at least \$1,900 of **child or dependent care expenses** for which you plan to claim a credit . . . . . **F** \_\_\_\_\_

**(Note.** Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

**G** **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.

- If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to seven eligible children or **less** "2" if you have eight or more eligible children.
- If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child . . . . . **G** \_\_\_\_\_

**H** Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) **H** \_\_\_\_\_

For accuracy, complete all worksheets that apply. }

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

----- Separate here and give Form W-4 to your employer. Keep the top part for your records. -----

Form <b>W-4</b> Department of the Treasury Internal Revenue Service	<h2>Employee's Withholding Allowance Certificate</h2> <p>► <b>Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</b></p>	OMB No. 1545-0074 <span style="font-size: 2em; font-weight: bold;">2012</span>
1 Your first name and middle initial <i>Charlene</i>		2 Your social security number <i>469-68-8069</i>
Last name <i>Shrager</i>		3 <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note.</b> If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
Home address (number and street or rural route) <i>701 Main St.</i>		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. <input type="checkbox"/>
City or town, state, and ZIP code <i>Kasson MN 55944</i>		5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) <b>5</b> <i>5</i>
6 Additional amount, if any, you want withheld from each paycheck		6 \$
7 I claim exemption from withholding for 2012, and I certify that I meet <b>both</b> of the following conditions for exemption. <ul style="list-style-type: none"> <li>• Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability, <b>and</b></li> <li>• This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability.</li> </ul> If you meet both conditions, write "Exempt" here . . . . . <b>7</b>		
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (This form is not valid unless you sign it.) <i>Charlene Shrager</i>		Date <i>10/16/2012</i>
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)
10 Employer identification number (EIN)		

**Form I-9, Employment Eligibility Verification**

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Verification** (To be completed and signed by employee at the time employment begins.)

Print Name: Last <u>Shrager</u>	First <u>Charlene</u>	Middle Initial <u>A</u>	Maiden Name <u>Watson</u>
Address (Street Name and Number) <u>701 Main St.</u>		Apt. #	Date of Birth (month/day/year) <u>09/16/1953</u>
City <u>Kasson</u>	State <u>MN</u>	Zip Code <u>55944</u>	Social Security # <u>469-68-8069</u>

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- A citizen of the United States
- A noncitizen national of the United States (see instructions)
- A lawful permanent resident (Alien #) \_\_\_\_\_
- An alien authorized to work (Alien # or Admission #) \_\_\_\_\_ until (expiration date, if applicable - month/day/year)

Employee's Signature Charlene Shrager Date (month/day/year) 10/16/2012

**Preparer and/or Translator Certification** (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	Date (month/day/year)

**Section 2. Employer Review and Verification** (To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)

List A	OR	List B	AND	List C
Document title: _____	OR	<u>Driver's License</u>	AND	<u>Social Sec. Card</u>
Issuing authority: _____		<u>State of Minnesota</u>		<u>Social Security Adm.</u>
Document #: _____		<u>168 2024402716</u>		<u>469-68-8069</u>
Expiration Date (if any): _____		<u>09/16/2014</u>		
Document #: _____				
Expiration Date (if any): _____				

**CERTIFICATION:** I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) \_\_\_\_\_ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative <u>Anna C. Cordova</u>	Print Name <u>Anna C. Cordova</u>	Title <u>Administrative Asst.</u>
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code) <u>EMPLOYER SOLUTIONS STAFFING GROUP 7301 OHMS LANE, STE 405 EDINA, MN 55439</u>		Date (month/day/year) <u>10/16/2012</u>

**Section 3. Updating and Reverification** (To be completed and signed by employer.)

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.	
Document Title: _____	Document #: _____
Expiration Date (if any): _____	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.	
Signature of Employer or Authorized Representative	Date (month/day/year)

# Background Investigation Information Release Form

Please read this form carefully and be aware that by allowing Employer Solutions Staffing Group LLC to investigate your background with state and federal agencies, you will be waiving and releasing all claims for damages you might sustain arising out of the criminal and driving record background check and review.

I understand that a successful criminal and driving record background investigation is a condition of my employment by Employer Solutions Staffing Group LLC to work at facilities of:

I / Union

and, further, that Employer Solutions Staffing Group may, at its discretion, conduct periodic criminal and driving record background investigations on me during the course of my employment with Employer Solutions Staffing Group.

I agree to waive and relinquish all claims I may have against Employer Solutions Staffing Group LLC and its officers, agents, servants and employees as a result of my participation in any criminal and driving record background investigation.

I do hereby fully release and discharge Employer Solutions Staffing Group LLC, its respective officers, agents, servants, and employees from any and all claims from damages that I may have or that may accrue to me on account of the results of any aspect of any criminal and driving record background investigation.

I further agree to indemnify and hold harmless and defend Employer Solutions Staffing Group LLC, its respective officers, agents, servants, and employees from any and all claims resulting from damages sustained by me or arising out of, connected with, or in any way associated with, any of the activities of any criminal and driving record background investigation and review.

## I have read and fully understand this Waiver and Release of All Claims.

<u>469-68-8069</u> Social Security Number	<u>V682224162716</u> Driver's License No:	<u>MW</u> State
<u>Shrager</u> Last Name	<u>Charlene</u> First Name	<u>A</u> M.I
<u>Watson, Shannahan, Webb</u> Maiden and/or Other Last Names Used		
<u>701 Main St.</u> Current Address	<u>Kasson / Dodge</u> City and County	<u>MW 55944</u> State and Zip Code
<u>09/16/1953</u> Date of Birth	Circle One: Male / Female	

Signature: Charlene Shrager Date: 10/16/2016

# Pre-Screening Notice and Certification Request for the Work Opportunity Credit

OMB No. 1545-1500

▶ See separate instructions.

**Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.**

Your name Charlene Shrager Social security number ▶ 469-68-8069

Street address where you live 701 Main St

City or town, state, and ZIP code Kasson MN 55944

County Dodge Telephone number 507-421-7952

If you are under age 40, enter your date of birth (month, day, year) \_\_\_\_\_

- 1  Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
  
- 2  Check here if **any** of the following statements apply to you.
  - I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
  - I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
  - I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
  - I am at least age 18 but **not** age 40 or older and I am a member of a family that:
    - a Received SNAP benefits (food stamps) for the past 6 months, **or**
    - b Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
  - During the past year, I was convicted of a felony or released from prison for a felony.
  - I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
  - I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.
  
- 3  Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.
  
- 4  Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.
  
- 5  Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.
  
- 6  Check here if you are a member of a family that:
  - Received TANF payments for at least the past 18 months, **or**
  - Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years, **or**
  - Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

**Signature – All Applicants Must Sign**

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ▶ Charlene Shrager

Date 10/16/2012

PLEASE CHECK "YES" OR "NO" AND ANSWER ALL QUESTIONS

Name Charlene Shrager
Address 701 Main St
City Kasson State MW Zip 55944 Social Security # 469-68-8069
Date of Birth 09/16/2012 Age 59

Please CHECK ONE ANSWER for each of the following questions, and complete question #5:

- 1. Have you or any family member living with you received Temporary Assistance to Needy Families (TANF) or Aid to Families with Dependent Children (AFDC) during the past 24 months?
2. Have you or any family member living with you received Supplemental Nutritional Assistance Program (SNAP) (Food Stamps) at any time during the past fifteen (15) months?
3. Have you received Supplemental Security Income (SSI) benefits in the past sixty (60) days?
4. Are you part of the Ticket to Work program?

5. Name of person who received benefits Charlene Shrager
Relationship Self City & State where benefits received Rochester MN

6. Are you a veteran? and Disabled due to service?
Service Dates: From: To: Branch:

7. Have you been unemployed at any time during the last 12 months?
If yes, dates of unemployment: From: To:
Did you receive unemployment compensation at any point during your unemployment?
If yes, dates received compensation: From: To:

8. Have you been convicted of a felony or released from prison in the last 12 months?
Date of Conviction: Date of Release:
Parole Officer's Name: Parole Officer's Phone #

9. Have you received rehabilitation services from a State approved or Department of Veterans Affairs approved Vocational rehabilitation agency?
Name of Agency Phone #
Address of Agency Counselor's Name

10. Have you attended High School, College or Technical School for more than an average of 10 hours per week at any time during the last 6 months?

11. Did you receive a high school diploma or GED? If yes, date received:
Have you been employed or been admitted to technical school or college since then?

12. How much in gross wages have you earned TOTAL in the past six months? \$

I hereby authorize any agency, organization, or individuals to supply such verification or information that may be needed to determine tax credit eligibility to my employer, employer representative, or the Department of Labor.
NEW HIRE SIGNATURE DATE

Questions below to be completed by manager
Starting Wage Position
Has employee worked for this company before? If yes, date and location

## NOTICE OF WAIVER FROM ANNUAL LIMIT REQUIREMENT

The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least \$750,000.

Your health insurance coverage, offered by BCS Insurance Company does not meet the minimum standards required by the Affordable Care Act describe above. Instead, it puts an annual limit on the following plans offered:

Annual Limit	Plan
Both inpatient & outpatient benefits	\$10,000
Outpatient benefits only	\$1,500
Prescription drugs	Subject to outpatient maximum of \$1,500

In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least \$750,000 in 2011. That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing \$750,000 in coverage for key benefits in 2011 would result in a significant increase in premiums or a significant decrease in access to benefits. This waiver is valid for one year.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to [www.HealthCare.gov](http://www.HealthCare.gov)

If you have any questions or concerns about this notice, contact the Essential StaffCARE Customer Service at [866-798-0803](tel:866-798-0803).

In addition, you can contact:

Minnesota Department of Commerce

Consumer Concerns

Toll-free- (800) 657-3602 / Main – (651) 296-2488