FROM

Name: Paw Hae Soe

Phone: Fax: 6122941405

E-mail: pawhaes@hmong.org

TO

6123955574@fax.consolidated.com

6123955574

Sent: 5/3/17 at: 3:11:08 PM 4 page(s) (including cover)

Subject: Abdikadir Karshe Employment Verification Form

Comments:

Paw Haesoe Say
Employment Counselor
Direct: 651-495-1548
Email: pawhaes@hmong.org

HAP

1075 Arcade St
Saint Paul, MN 55106
Main Phone: 651.495.9160
Fax: 651-495-1699

Minnesota Department of **Human Services**

DHS-2146-ENG 4-13

Authorization for Release of Employment Information

Date: 05/03/17

Case number: 2154163

To:

Worker name: Paw Haesoe Say
Agency name: Hmong American Partnership
Agency address: 1075 Arcade Street
City, state, zip code: Saint Paul, MN 55106
Worker phone: (651) 495-1548 Fax: (651) 495-1699

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

Person name: Abdikadir Karshe
Address: 1255 White Bear Ave N
City/state/zip code: Saint Paul, MN 55106

Social Security number: XXX-XX-5440

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 ABDIKADIR Karshe	DATE 05/03/2017	Original copy for agency
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	CASE NUMBER
Abdikadir Karshe		2154163

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 ☐ Full time	_____	☐ Each week ☐ Once a month	☐ Every two weeks ☐ End of job	☐ Twice a month ☐ 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	
FEIN	PHONE NUMBER	DATE