employer solutions staffing group

STATEMENT OF CONFIDENTIALITY

This agreement made this_____day of_____, 201__, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and _____ 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.

Keelan King (Oct 2, 2017)

Employee Signature

Employer Solutions Staffing Group LLC, Representative

EMERGENCY CONTACT INFORMATION

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

Employee Name: Keelan king

Address: 3945 Fremont Ave n Minneapolis MN 55413 55413

Home Phone: 7634347347

EMERGENCY CONTACTS Please list two people (in priority order) who could be contacted in case of an emergency	
Contact #1 **Name:** Maxine **Relationship:** Mom	**Home Phone:** **Cell Phone:** 6122053945 **Work Phone:**
Contact #2 **Name:** Starr **Relationship:** Lee	**Home Phone:** **Cell Phone:** 6127351237 **Work Phone:**

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

This information will remain confidential and will only be used in the case of an emergency.

DRUG AND ALCOHOL
TESTING CONSENT FORM

1. I have been allowed to read and inspect a written copy of ESSG policy on drugs and alcohol.

2. I have read the entire contents of this policy and I am aware and fully understand: (a) the policy and its contents; (b) what conduct the policy prohibits and the consequences of such conduct; (c) my rights under the policy and the consequences if I exercise certain rights; and (d) that certain events as described in the policy may result in adverse personnel action, including my termination from employment with ESSG. I understand that this policy in any form, and any employee handbook including this policy, are not a unilateral employment contract or offer thereof.

3. I hereby voluntarily consent to ESSG, or its health service providers, or other persons or entities acting for or with them, to collect a body component (blood, urine, breath, or any combination thereof) from me for testing for alcohol and/or drugs. I understand that the laboratory selected by ESSG may conduct testing and other analysis on the sample provided by me. I further voluntarily consent to the laboratory's disclosure to ESSG of the results of my drug and/or alcohol test and other information related to the test.

Keelanking (Oct 2, 2017)

Individual's Name

Oct 2, 2017

Date

SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6

Form **8850** (Rev. March 2016)
Department of the Treasury
Internal Revenue Service

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

▶ Information about Form 8850 and its separate instructions is at www.irs.gov/form8850.

OMB No. 1545-1500

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

Your name Keelan king

Social security number ▶ 473175602

Street address where you live 3945 Fremont Ave n

City or town, state, and ZIP code Minneapolis MN 55413 55413

County Hin

Telephone number 7634347347

If you are under age 40, enter your date of birth (month, day, year) 11/16/1988

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.

7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

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 ▶ Keelan king (Oct 2, 2017)

Date Oct 2, 2017

U.S. Department Labor
Employment and Training Administration

OMB Control No. 1205-0371
Expiration Date: January 31, 2020

LONG-TERM UNEMPLOYMENT RECIPIENT SELF-ATTESTATION FORM
Work Opportunity Tax Credit (WOTC) Program

Instructions: This Self-Attestation Form (SAF) is to be completed, signed, and dated by the new hire only. Employers or consultants submit this SAF to the State Workforce Agency with IRS Form 8850 or if filed separately, with ETA Form 9061 (or ETA Form 9062) for each certification request filed for the new target group.

Under penalties of perjury, I declare that this information is true and correct to the best of my knowledge.

New Hire's Signature: Keelan King Oct 2, 2017 Date Oct 2, 2017

New Hire Name: Keelan king

Social Security Number: -5602 (Enter last four digits)

Employer Name:

Please check the statements below if they apply to you.

☐ I declare that I was in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period I received unemployment compensation.

☑ I declare that I have been in a period of unemployment since 9-26-17. (Enter start date)

Privacy Act Notice:
The Internal Revenue Code of 1986, Section 51, as amended and its enacting legislation, P.L. 104-188, specify that the State Workforce Agencies are the "designated" agencies responsible for administering the WOTC certification procedures of this program. The information you have provided completing this form will be disclosed by your employer to the State Workforce Agency. Provision of this information is voluntary; however the information is required to determine your employer's eligibility for the federal tax credit.

Public Burden Statement:
Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. Respondents' obligation to complete this form is required to obtain or retain benefits (P.L. 111-5). Public reporting burden is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate to the U.S. Department of Labor, Division of National Programs Tools Technical Assistance, Room C-4510, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.

employer solutions staffing group

Leveraging Resources in a Changing Market

Notification of Minnesota Law Requirement – Unemployment Acknowledgement

According to Minnesota Statute section 268.095, subdivision 2, paragraph (d), an applicant who, within five calendar days after completion of a suitable job assignment from a staffing service, (1) fails without good cause to affirmatively request an additional suitable job assignment, (2) refuses without good cause an additional suitable job assignment offered, or (3) accepts employment with the client of the staffing service, is considered to have quit employment. This paragraph applies only if, at the time of beginning of employment with the staffing service, the applicant signed and was provided a copy of a separate document written in clear and concise language that informed the applicant of this paragraph and that unemployment benefits may be affected.

It is your responsibility to contact ESSG through Corporate Management Group (for instance, by calling 303-920-1425 or using any other form of contact) for additional assignments. If you fail to do so, it may affect your unemployment benefits.

I understand by signing this form that I am responsible to contact ESSG within 5 calendar days once an assignment ends. I also acknowledge that I have received a separate copy of this form. King (Initial)

Keelanking (Oct 2, 2017)

Employee Signature: _____ Date: Oct 2, 2017

Keelanking

Employee (please print your name here)

Telephone: 303-920-1425
12000 N. Washington Street Suite 350
Thornton, CO 80241

_MN_02.2013

MINNESOTA · REVENUE

2016 Minnesota Employee Withholding Allowance/ Exemption CertiÀcate

W-4MN

Employees

You must complete and give this form to your employer if you:

- claim fewer Minnesota withholding allowances than your federal allowances;
- claim more than 10 Minnesota withholding allowances;
- want additional Minnesota tax withheld from your pay each pay period; or
- claim to be exempt from federal withholding or claim to be exempt from Minnesota withholding.

Do not complete this form if you are claiming the same number of Minnesota allowances as federal and the number claimed is 10 or less.

Employee Information

Employee's first name and initial	Last name	Employee's Social Security number
Keelanking		473175602

Permanent address: 3945 Fremont Ave n

City: Minneapolis. State: MN. ZIP code: 55412

Marital status (check one box)
- ◉ Single; Married, but legally separated; or Spouse is a nonresident alien
- ○ Married
- ○ Married, but withhold at higher Single rate

Minnesota Allowances

Employees: Read instructions on back, complete Section 1 OR Section 2, sign and give the completed form to your employer. (Do not complete both Section 1 and Section 2. Completing both sections will make the form invalid.)

☑ Section 1 —Determining Minnesota allowances

Complete Section 1 if you claim fewer Minnesota allowances than your federal allowances, AND/ OR if you want additional Minnesota withholding deducted each pay period.

1 Total number of federal allowances claimed on federal Form W-4 ..... 1 **1**

2 Total number of Minnesota allowances (line 2 cannot be more than line 1) 2 **1**

3 Additional Minnesota withholding you want deducted each pay period ..... 3 $ **0**

Exempt from Minnesota Withholding

☐ Section 2 —Exemption from Minnesota withholding

Complete Section 2 if you claim to be exempt from Minnesota income tax withholding (see Section 2 instructions for qualiÀcations). If applicable, check one box below to indicate the reason why you believe you are exempt:

☐ I meet the requirements and claim exempt from both federal and Minnesota income tax withholding.

☐ Even though I did not claim exempt from federal withholding, I claim exempt from Minnesota withholding because I had no Minnesota income tax liability last year, I received a refund of all Minnesota income tax withheld, AND I expect to have no Minnesota income tax liability this year.

☐ My spouse is a military service member assigned to a military location in Minnesota, my domicile (legal residence) is in another state, AND I am in Minnesota solely to be with my spouse. My state of domicile is _____.

☐ I am an American Indian living and working on a reservation.

☐ I am a member of the Minnesota National Guard or an active duty U.S. military member and claim exempt from Minnesota withholding on my military pay.

Sign Here

I certify that all information provided in Section 1 OR Section 2 is correct. I understand there is a $500 penalty for Àling a false withholding allowance/ exemption certiÀcate.

Employee's signature: Keelanking (Oct 2, 2017) Date: Oct 2, 2017 Daytime phone: 7634347437

Employees: Give the completed form to your employer.

Employers

If you are required to send a copy of this form to the Department of Revenue (see instructions), you must enter the employer information below and mail this form to: Minnesota Revenue, Mail Station 6501, St. Paul, MN 55146-6501. (Incomplete forms are considered invalid.) A $50 penalty may be assessed for each required Form W-4MN not Àled with the department.

Keep a copy for your records.

Employer Information

Name of employer | Federal employer ID number (FEIN) | Minnesota tax ID number

Address | City | State | ZIP code

ESSG

employer solutions staffing group

Acknowledgement of Receipt of Workplace Safety Policy

I certify that I have received a copy of Employer Solutions Staffing Group's ESSG WORKPLACE SAFETY POLICY. I understand that it is my responsibility to read this policy and ask my supervisor, a member of management or to telephone Employer Solutions Group (ESSG) at **952.835.1288/1.866.496.7573** with any questions I may have about this policy. I agree to comply with ESSG's policy on ESSG WORKPLACE SAFETY POLICY and I understand failure to comply is grounds for disciplinary action, up to and including termination.

I also agree that if at any time during my employment I am believe that I am working in an unsafe or dangerous work environment, I will immediately contact my supervisor, manager, director or ESSG's Safety Director at **952.835.1288/1.866.496.7573** in order to obtain assistance in the resolution of such matters.

Employee Name (Please Print)

Keelan king

Employee's Signature:

Keelan King (Oct 2, 2017)

Date: Oct 2, 2017

- Right to request information about safety and health hazards in the workplace, appropriate precautions to take, and procedures to follow if involved in an accident or exposed to hazardous substances
- Right to gain access to relevant personal exposure and medical records.

You can have your name withheld from the host employer and any other entity, by request, if you sign and file a written complaint. You can request to be advised of OSHA actions regarding a complaint, and request an informal review of any decision not to inspect the site or issue a citation. And, you can file a complaint if you are punished or discriminated against for acting as a "whistleblower" under the OSH Act or 13 other federal statutes for which OSHA has jurisdiction, or for refusing to work when faced with imminent danger of death or serious injury and there is insufficient time for OSHA to inspect. Retaliation or reprisal taken against anyone who has expressed concern about workplace safety is illegal.

If you believe that your right to a safe workplace has been violated, you can make a report to a manager of the host worksite employer and/or ESSG (by telephoning **952.835.1288/1.866.496.7573**) and asking for the ESSG Safety Director. You can also contact OSHA directly with any concern. ESSG recognizes the serious nature of ensuring workplace safety will endeavor to protect any employee who may have been subjected to unsafe or hazardous worksite conditions.

Employee Keeps This Form

Healthcare Notice of Exchange

As your employer, we are required to provide you with the following information under Section 1512 of the Affordable Care Act:

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

*****The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov, for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area*****

If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information:

Employer Name: Employer Solutions Staffing Group, LLC				Employer FEIN: 20-8084369	
Employer Address: 7301 Ohms Lane Suite 405 Edina, MN 55439				Phone Number for Health Benefits Team: 952-767-9519	
Insurance Plans Available:	**Who is Eligible?**	**Meets Minimum Value Standard?**	**Meets Minimum Essential Coverage?**	**When is it effective?**	**Will I be penalized if I only have this plan?**
Fixed Indemnity Plan	Everyone	No	No	Available immediately – offered upon hire	Yes
MEC Plan	Everyone	No	Yes	Available immediately – offered upon hire	No
Major Medical Plan	Full time employees after 120 hours are met in 30 days	Yes	Yes	Within 60 days of being determined eligible	No

For more information about ESSG's insurance options, contact:

The Health Benefits Team
Employer Solutions Staffing Group
952-767-9519 | health@employersolutionsgroup.com

Form A (rev. 03/2017)

TAX CREDIT QUESTIONNAIRE

RETROTAX
Specialists in Tax Credit Administration

EMPLOYER SECTION:

Client:		
Location:	**Company:**	
	Position:	**Starting Wage: $**

EMPLOYEE SECTION:

First Name:	Last Name:	Suffix:	Street Address:	City/State:	Zip:
Keelan	king		3945 Fremont Ave n	Minneapolis MN 55413	55413

SS#:	Date of Birth:	Age:	Have you worked for this company before?	If yes, location:
473175602	11/16/1988	28	Yes ☐ No ☒	

Please complete all questions, and sign and date the form.

	Yes	No
1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997? (If yes, please provide information below.) Name of the person receiving benefits: ____ Relationship to you: ____ City: ____ County: ____ State: ____	☐	☐
2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months? (If yes, please provide information below.) Name of the person receiving benefits: Keelan king Relationship to you: ____ City: Mpls County: Hln State: Mn	☐	☐
3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months? Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits. **If you checked yes please provide a copy of your SSI documentation.*	☐	☐
4. Have you received any type of vocational rehabilitation services within the past two years? If yes, please indicate which type of agency you worked with and provide their location information below: ☐ Vocational Rehabilitation Agency ☐ Dept. of Veterans Affairs ☐ Employment Network (Ticket to Work Program) Name of Agency: ____ Phone #: ____ City: ____ County: ____ State: ____ **If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.*	☐	☐
5. Are you a Veteran of the U.S. Military? **If yes, please provide a copy of your DD-214 and letter of separation.* (If yes, please provide information below. If no, please continue to question #6.) Dates of Service - From: ____ To: ____ Branch of Service: ____ **Are you entitled to or are you receiving compensation for a service-connected disability?**	☐	☐
6. 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, in which state did you receive unemployment compensation? __	☐	☐
7. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months? Conviction Date: Release Date: Was this a ☐ Federal or ☐ State conviction? If State - County: ____ State: ____	☐	☐
Additional Tax Credits		
IEC (Native American): Are you or your spouse a member of a Native American Tribe? *If you checked yes please provide a copy of your CDIB card.* **CA Residents:** ☐ Are you the child of foster parents? ☐ Do you receive CalWorks? ☐ Workforce Investment Act? ☐ Are you a migrant or seasonal farm worker? **SC Residents:** ☐ Do you receive Family Independence Benefits? ☐ Have you ever been convicted of a misdemeanor?	☐	☐

PLEASE READ, SIGN, AND DATE:

Under penalties of perjury, I declare the information above to be true and accurate to the best of my knowledge, and 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 (Associated Consultants, Inc. dba Retrotax), or the Department of Labor.

New Employee Signature: Keelan king (Oct 2, 2017) **Date:** Oct 2, 2017