



SENSITIVE BUT UNCLASSIFIED

Case Verification Number: 2018095134402XT

Report Prepared: 04/05/2018

Company Information

Company ID: 47429

Company Name: Employer Solutions Staffing Group

Employee Information

Last Name: Rivera Portillo

First Name: Maria

Date of Birth: 04/14/1983

Social Security Number: *** ** 2173

Hire Date: 04/05/2018

Citizenship Status: An alien authorized to work

Document Information

List A Document: Employment Authorization Document (Form I-766)

Alien Number: 208593622

Card Number: LIN1790633194

Document Expiration Date: 09/24/2019

Case Status Information

Final Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 04/05/2018

Case Submitted By: ZZEP3284

Closed On: 04/05/2018

Closed By: ZZEP3284

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

SENSITIVE BUT UNCLASSIFIED



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

▶ **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation (Employee must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)

Last Name (Family Name) Rivera Portillo		First Name (Given Name) Maria		Middle Initial E	Other Last Names Used (if any) N/A	
Address (Street Number and Name) 1343 Western Ave N			Apt. Number	City or Town St. Paul		State MN
Date of Birth (mm/dd/yyyy) 04-14-1983		U.S. Social Security Number 895-25-2173		Employee's E-mail Address		Employee's Telephone Number 651-313-4109

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 boxes):

<input type="checkbox"/> 1. A citizen of the United States
<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions)
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): 22919
<input checked="" type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): 09/24/2019 Some aliens may write "N/A" in the expiration date field. (See Instructions)

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
 An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
 OR
 2. Form I-94 Admission Number: _____
 OR
 3. Foreign Passport Number: _____
 Country of Issuance: _____

OR Code - Section 1
 Do Not Write in This Space

Signature of Employee [Signature]	Today's Date (mm/dd/yyyy) 31/9/2018
---------------------------------------------	-----------------------------------------------

Preparer and/or Translator Certification (check one):

I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
 (Fields below must be completed and signed when preparer and/or translator assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code

Employer Completes Next Page



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification
 (Employer or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "List of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name) <u>Rivera Portillo</u>	First Name (Given Name) <u>Maria</u>	M.I. <u>E</u>	Citizenship/Immigration Status
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List A
OR
List B
AND
List C
 Identity and Employment Authorization Identity Employment Authorization

Document Title	Document Title <u>Employment Authorization</u>	Document Title <u>Social Security Card</u>
Issuing Authority	Issuing Authority <u>U.S. Citizenship & Immigration</u>	Issuing Authority <u>Social Security Adm</u>
Document Number	Document Number <u>208593622</u>	Document Number <u>895-25-2173</u>
Expiration Date (if any)(mm/dd/yyyy)	Expiration Date (if any)(mm/dd/yyyy) <u>09-24-2019</u>	Expiration Date (if any)(mm/dd/yyyy) <u>NIA</u>
Document Title	<div style="border: 1px solid black; padding: 5px;">Additional Information</div>	
Issuing Authority		
Document Number		
Expiration Date (if any)(mm/dd/yyyy)		
Document Title		
Issuing Authority	<div style="border: 1px solid black; padding: 5px;">QR Code - Sections 2 & 3 Do Not Write In This Space</div>	
Document Number		
Expiration Date (if any)(mm/dd/yyyy)		
Document Title		
Issuing Authority		
Document Number		
Expiration Date (if any)(mm/dd/yyyy)		

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): 04/05/2018 (See instructions for exemptions)

Signature of Employer or Authorized Representative <u>[Signature]</u>	Today's Date (mm/dd/yyyy) <u>04/05/2018</u>	Title of Employer or Authorized Representative <u>Recruiter</u>	
Last Name of Employer or Authorized Representative <u>Zepeda</u>	First Name of Employer or Authorized Representative <u>Zhilghean</u>	Employer's Business or Organization Name <u>EMPLOYER SOLUTIONS STAFFING GROUP LLC</u>	
Employer's Business or Organization Address (Street Number and Name) <u>7480 FLYING CLOUD DRIVE SUITE 200</u>	City or Town <u>EDEN PRAIRIE</u>	State <u>MN</u>	ZIP Code <u>55344</u>

Section 3. Reverification and Rehire (To be completed and signed by employer or authorized representative)

A. New Name (if applicable)			B. Date of Rehire (if applicable)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)	

If the employee's previous grant of employment authorization has expired, provide the information for this document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
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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	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
----------------------------------------------------	---------------------------	-----------------------------------------------

UNITED STATES OF AMERICA EMPLOYMENT AUTHORIZATION CARD

RIVERA PORTILLO
Card No. **MARIA E**
HSCSN **20R-593-822 C08** Category Code **LIN1790833194**
Country of Birth **El Salvador**
Issuance Conditions **0019**
Date of Issue **07/29/17**
Expiration Date **09/24/19**
Signature Waived

NOT VALID FOR REENTRY TO U.S.

SOCIAL SECURITY
VALID FOR WORK ONLY
WITH DHS AUTHORIZATION
895-25-2173
THIS NUMBER HAS BEEN ESTABLISHED FOR
MARIA ELENA RIVERA PORTILLO
SIGNATURE **10/11/2017**
USA



employer solutions staffing group.

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Rivera Parliua First Name Maria Elena Middle Initial G
 Street Address 1315 Western Ave N Apt #24 Apt/Ste _____
 City/State/Zip San Paul MN Social Security Last Four XXX-XX-2173
 Phone Number 651 313 4109 Email Address MariaRivera814@gmail.com
 Staffing Agency/Recruitment Partner _____

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.

Maria Elena Rivera
Name (Print or type)

[Signature]
Applicant's Signature

3/20/2018
Date

A copy or facsimile ("fax") will be considered the same as an original signature. Email will ONLY be used for employment correspondence

For ESSG Office Use Only				
DOH _____	NHW _____	LE _____	SSSO _____	W4 _____
Emergency Contact Info _____	Background Release Form _____	Background Results _____	Unemployment Letter (if applicable) _____	ESG Application _____
For ESSG Client Use				
DOH _____	ROP _____	Work Site Loc. _____	WG Code _____	

Form W-4 (2017)

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 indicate it. Your exemption for 2017 expires February 14, 2018. See Pub. 508, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds \$1,050 and includes more than \$500 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- is age 65 or older,
- is blind, or
- Will claim adjustments to income, tax credits, or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than \$1,000,000.

Basic instructions. If you aren't 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-earner/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. 528 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. 526 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. 508 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1398, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 508 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 508, especially if your earnings exceed \$181,000 (single) or \$180,000 (married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we released it) will be posted at www.irs.gov/w4.

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: { • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. }	B	_____
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 \$2,000 of child or dependent care expenses for which you plan to claim a credit	F	_____
(Note: Do not include child support payments. See Pub. 508, 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 \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children. • If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$118,000 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		_____
<p>For accuracy, complete all worksheets that apply.</p> <ul style="list-style-type: none"> • 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 \$20,000 (\$20,000 if married), see the Two-Earner/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 W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074 2017	
1 Your first name and middle initial <i>Maria</i>			2 Your social security number <i>895-25 2173</i>		
Home address (number and street or rural route) <i>1345 Western Ave N</i>			3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.		
City or town, state, and ZIP code <i>San Paul MN 55117</i>			4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1218 for a replacement card. <input type="checkbox"/>		
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)			6 Additional amount, if any, you want withheld from each paycheck		
7 I claim exemption from withholding for 2017, and I certify that I meet both of the following conditions for exemption.			8 <input type="checkbox"/> 3		
• Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and			9 <input type="checkbox"/> 0		
• This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.			10 <input type="checkbox"/> 8		
If you meet both conditions, write "Exempt" here. 7					
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>Maria</i>				Date <i>3/29 2018</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)



employer solutions staffing group.
Direct Deposit/Payroll Debit Card Authorization

Employees have the option of receiving wages by Direct Deposit and/or Payroll Debit Card.
If you do not provide a written election, wages will be paid by Payroll Debit Card.

SECTION 1 BASIC INFORMATION
Employee Name: MARIA Elena RIVERA Portin SSN# (last 4 digits) 2173 Effective Date 3/19/18

SECTION 2 PAYROLL ELECTION
Direct Deposit (Please complete Sections 3 and 5 below)
Payroll Debit Card (Please complete Sections 4 and 5 below)
[X] Paper Check (Option available to GA NH and NY residents only)

SECTION 3 DIRECT DEPOSIT
Update Bank Account
Bank Name:
Routing#:
Account#:
Account Type: [] Checking [] Savings [] Other

Note: Direct Deposit accounts may take up to 7 days to be activated.
I understand and acknowledge that if I do not provide a voided check with this direct deposit form, I am responsible for any delays in payroll or extra costs incurred if the account number that I provide is incorrect.
Initial M E R P Date 3/19/2018

- To help us avoid making an error, please attach a copy of a voided check. (a deposit slip will not work)
If you change banks, do not close your old bank account until your direct deposit has started at the new bank, which may take 2 pay periods.

SECTION 4 PAYROLL DEBIT CARD
Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. In order to request a Payroll Debit Card for you, we must provide all of the following information that will enable the financial institution to identify you. If you do not submit a Direct Deposit/Payroll Debit Card Authorization, ESSG will provide the necessary information and issue you a Payroll Debit Card to pay your wages. For your protection, the financial institution may ask you to provide them additional identification information so they can verify your identity.
Except for the routing and account number, ESSG does not have access to any information regarding your Payroll Debit Card account or transactions. On your first payday, you will receive your new Payroll Debit Card, and a packet containing all of the terms and conditions. You will then sign acknowledging that you received the Payroll Debit Card and packet. Your Payroll Debit Card will be reloaded on each payday you receive wages.

CARDHOLDER INFORMATION (as you want your Payroll Debit Card to be issued)
First Name M.I. Last Name Date of Birth
Street Address (PO BOX NOT ACCEPTABLE) Social Security#
City State Zip Cell Phone (mobile)

RECEIPT OF PAYROLL DEBIT CARD (to be completed when you pick up your Payroll Debit Card)
Payroll Debit Card Routing # Payroll Debit Card Account #

I have received my Payroll Debit Card, welcome brochure, program fees, program terms, conditions, and disclosures. By activating my Payroll Debit Card, I am agreeing to the program terms, conditions, and disclosures that are included or made available to me from time to time from the financial institution. I authorize the financial institution to debit my Payroll Debit Card account for the fees described in the fee schedule that is part of the program terms, conditions, and disclosures.

Employee's Signature: _____ Date: _____

SECTION 5 AUTHORIZATION
I authorize ESSG to directly deposit my periodic wages/compensation payments, net of required tax withholdings, other required withholdings or authorized deductions, into my account(s) as designated above and to initiate, if necessary, debit entries and adjustments for any credit entries made in error to my account(s). * E-mail is required for pay stub information.
*E-mail: _____ @ _____
this information will only be used to send your paystubs electronically
Employee's Signature: _____ Date: 3/19/2018

EMPLOYER SOLUTIONS STAFFING GROUP
BACKGROUND CHECK AUTHORIZATION

Employee Name: Maria Elena Rivera
(First) (Middle) (Last)

Former Name(s) and Dates Used: _____

Current Address Since: 1343 Western San Paul MN 55117
(Mo/Yr) (Street) (City) (State/Zip)

Previous Address From: _____
(Mo/Yr) (Street) (City) (State/Zip)

Previous Address From: _____
(Mo/Yr) (Street) (City) (State/Zip)

Social Security Number: 895-25-2173 DOB: _____

Phone Number: 651-313-4109

Driver's License Number/State: _____

The information contained in this application is correct to the best of my knowledge.

I hereby authorize Employer Solutions Staffing Group, LLC and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number; credit reports, current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency to divulge any and all information, verbal or written, pertaining to me, to Employer Solutions Staffing Group, LLC or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources. Employer Solutions Staffing Group, LLC and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicants personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

Signature: [Signature] Date: 3/20/08

Notice to CA, MN, and OK Residents:

Please check the box below if you wish to receive a copy of a consumer report that is requested.

I wish to receive a copy of any Background Check Report on me that is requested.

EMERGENCY CONTACT INFORMATION

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

Employee Name: Maria Elena Rivera Borlino
Address: 1345 western Ave # 224 San Paul MD 55117
Home Phone: 651 313 4109

EMERGENCY CONTACTS	
Please list two people (in priority order) who could be contacted in case of an emergency	
Contact #1	Home Phone: <u>651 263 5413</u>
Name: <u>Anner Amilcar</u>	Cell Phone:
Relationship: <u>es POSO</u>	Work Phone:
Contact #2	Home Phone:
Name: <u>Sorgue Rivera</u>	Cell Phone: <u>651 442-6710</u>
Relationship: <u>ermano</u>	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.



employer solutions staffing group, llc

STATEMENT OF CONFIDENTIALITY

This agreement made this 19 day of March, 2018, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Main 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.

Employee Signature

Employer Solutions Staffing Group LLC, Representative



employer solutions staffing group_{inc}

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: *Maria Elena Ruzic*

Printed Name: Maria Elena Ruzic



employer solutions staffing group.

Important/Importante

LOST OR STOLEN PAYCHECKS

If a paycheck is lost (*missing, misplaced, destroyed, lost in the mail, etc.*), you must notify your staffing recruiter that the check cannot be found. If it can be verified that the check has not been cashed, ESSG will stop payment on the check and re-issue the check to you, deducting a fee of between \$25-\$35.

If your paycheck was stolen, you must first file a police report before we can re-issue the check. Once you have done so, you must provide a copy of the police report to your staffing recruiter that the check was stolen. If the check has not been cashed and if the loss of the check was not your fault, ESSG will issue a new check and no fee will be deducted.

CHEQUES DE PAGO PERDIDOS O ROBADOS

Si un cheque de pago se pierde (que falta, fuera de lugar, destruido, perdido en el correo, etc), usted debe notificar a su reclutador de personal que el cheque no se puede encontrar. Si se puede verificar que el cheque no ha sido cobrado, ESSG se detendrá el cheque de pago y reemitir el cheque a usted, descontando un cargo de entre \$ 25 - \$ 35.

Si su cheque de pago fue robado, primero debe denunciar el robo a la policía antes de que podamos volver a emitir el cheque. Una vez hecho esto, usted debe proporcionar una copia de la denuncia a su reclutador de personal que el cheque fue robado. Si el cheque no ha sido cobrado y si la pérdida del cheque no fue su culpa, ESSG emitirá un nuevo cheque y no hay cuota se deducirá.

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde): Maria Elena Rivera Portino

Signature/Firma: [Handwritten Signature]



employer solutions staffing group^{llc}

ESSG WORKPLACE SAFETY POLICY

It is ESSG's policy that all employees should be able to enjoy a hazard free and safe work environment. It is ESSG's duty to:

- (1) Ensure that its clients provide you with a workplace free from serious recognized hazards and comply with standards, rules and regulations issued under the OSH Act.**
- (2) Ensure that its clients perform a job hazard assessment in order to identify and eliminate potential safety and health hazards and to determine necessary training and protections for employees at the facility.**
- (3) Make sure employees have and use safe tools and equipment.**
- (4) Establish or update operating procedures and communicate them so that employees follow safety and health requirements.**
- (5) Provide safety training in a language and vocabulary workers can understand.**

ESSG is committed to vigorously enforcing its OSHA Compliance Policy.

To help ensure a safe workplace, you have certain responsibilities too, which include the following:

- Responsibility to work in compliance with OSHA laws and regulations**
- Responsibility to use personal protective equipment and clothing as directed by the host employer**
- Responsibility to report workplace hazards and dangers**
- Responsibility to work in a manner as required by the employer and use the prescribed safety equipment.**

You have the following basic rights:

- Right to refuse unsafe work**
- Right to know or be informed about actual and potential dangers in the workplace**
- Right to review copies of appropriate standards, rules, regulations and requirements that the host employer is required to have available at the workplace.**



employer solutions staffing group, LLC

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 952.885.1288/1.866.496.7578 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 952.885.1288/1.866.496.7578 in order to obtain assistance in the resolution of such matters.

Employee Name (Please Print)

Maria Elena Riquelme Pacheco

Employee's Signature:

~~Maria Elena Riquelme Pacheco~~

Date: 3/20/23

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

OMB No. 1545-1800

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

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

Your name Maria Elena Rivera Portillo Social security number ► 895-252173

Street address where you live 1345 WESTERN AVE N Apt #2

City or town, state, and ZIP code SAN PAUL MN 55117

County _____ Telephone number 651 313 4109

If you are under age 40, enter your date of birth (month, day, year) 04/14/1983

- 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 8-month period during the past 16 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 8 of the past 6 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 ► Maria Elena Rivera Portillo

Date 3/19/2018



EMPLOYER SECTION:

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

EMPLOYEE SECTION:

First Name: Last Name: <i>Maria Elena</i>	Suffix:	Street Address: <i>Weslert</i>	City/State: <i>owl MN</i>	Zip: <i>55117</i>
SSN: <i>895-25-2173</i>	Date of Birth: <i>4-14-1983</i>	Age: <i>34</i>	Have you worked for this company before? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
If yes, location:				

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

Yes No

<p>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.)</p> <p>Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____</p>	□	□
<p>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.)</p> <p>Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____</p>	□	□
<p>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.</p>	□	□
<p>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:</p> <p><input type="checkbox"/> Vocational Rehabilitation Agency <input type="checkbox"/> Dept. of Veterans Affairs <input type="checkbox"/> Employment Network (Ticket to Work Program)</p> <p>Name of Agency: _____ Phone #: _____ City: _____ County: _____ State: _____</p> <p><i>*If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.</i></p>	□	□
<p>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 no, please provide information below. If no, please continue to question #6.)</p> <p>Dates of Service - From: _____ To: _____ Branch of Service: _____</p> <p>Are you entitled to or are you receiving compensation for a service-connected disability?</p>	□	□
<p>6. Have you been unemployed at any time during the last 12 months?</p> <p>If yes, dates of unemployment - From: _____ To: _____</p> <p>Did you receive unemployment compensation at any point during your unemployment? _____</p> <p>If yes, in which state did you receive unemployment compensation? _____</p>	□	□
<p>7. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?</p> <p>Conviction Date: _____ Release Date: _____</p> <p>Was this a <input type="checkbox"/> Federal or <input type="checkbox"/> State conviction? If State - County: _____ State: _____</p>	□	□
Additional Tax Credits		
<p>IEC (Native American): Are you or your spouse a member of a Native American Tribe? <i>If you checked yes please provide a copy of your CDIB card.</i></p> <p>CA Residents: <input type="checkbox"/> Are you the child of foster parents? <input type="checkbox"/> Do you receive CalWorks? <input type="checkbox"/> Workforce Investment Act? <input type="checkbox"/> Are you a migrant or seasonal farm worker? <input type="checkbox"/> Have you ever been convicted of a misdemeanor?</p> <p>SC Residents: <input type="checkbox"/> Do you receive Family Independence Benefits?</p>	□	□

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: *[Signature]*

Date: *3/19/2018*



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: [Signature] Date 3/12/2018

New Hire Name: Maria Elana Rivera Portino

Social Security Number: 895 - 25 - 2173

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 _____
(Enter start date)

Privacy Act Notice

The Internal Revenue Code of 1986, Section 61, 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. 111-6). 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.

Fixed Indemnity Medical Benefits Plan 2

VSI **219301-ESG-1** OFFICE USE ONLY LOCATION _____ Hire Date ____/____/____

ENROLLMENT FORM

ESC CU(UNAC-MN) P1 v18.2

A. REQUIRED EMPLOYEE INFORMATION		PRINT USING BLACK or BLUE INK (Must Be Filled Out)				
Name	Maria E. Rivers	Social Security #	895-25-2173	Home Phone	651-313-4109	
Address	1343 Western Ave N				Sex	<input checked="" type="checkbox"/> M <input type="checkbox"/> F
City	St. Paul	State	MN	Zip	55117	
				Date of Birth	04/14/1983	

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS? Yes No. If Yes, please continue.

Medicare Health Insurance Claim Number (HICN) _____ Medicare Effective Date _____

Name of Covered Person (s):

1.	2.	3.
----	----	----

C. LIMITED BENEFITS PLAN SELECTION Payroll Deducted Weekly Rates

You **MUST** select a coverage level before any benefits in Section C. Your coverage level for the all benefits in Section C will be identical. The Fixed Indemnity Medical Plan, Dental Plan, Term Life Plan, and Short-Term Disability plans are underwritten by BCS Insurance Company. The Vision plan is underwritten by Companion Life Insurance Company.

SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL ¹	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY ²
Employee Only <input type="checkbox"/>	\$20.25 <input checked="" type="checkbox"/>	\$6.17 <input type="checkbox"/>	\$2.42 <input type="checkbox"/>	\$0.60 <input type="checkbox"/>	\$4.20 <input type="checkbox"/>
Employee + 1 <input type="checkbox"/>	\$41.10	\$12.34	\$4.92	\$0.90	
Employee + Family <input type="checkbox"/>	\$54.88	\$20.36	\$6.56	\$1.80	
NO to ALL Benefits <input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No				

¹ This coverage is not available to residents of NH, HI, or PR. ² STD is not available to persons who work in CA, HI, NJ, NY, or RI.

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.

Name _____ Relationship _____

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth	Sex	Relationship
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

E. REQUIRED SIGNATURE **YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE**

I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no benefit selection is a declination of coverage.

DATE 3/19/2016 SIGNATURE [Signature]

This Plan DOES NOT Alleviate the Individual Mandate Penalty

This is an Essential StaffCARE Enrollment Form.



Enhanced MEC_Plan 1



Benefits Enrollment Form New Employee Rehire Rehire Date

EMPLOYEE INFORMATION

Name (First and Last) Maria E Rivero Portillo			Social Security Number	
Address 1343 Western Ave N		City St. Paul	State MN	Zip Code 55117
Gender <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Divorced	Date of Birth		Date of Hire
Phone Number		Email Address		

Please Select Desired Coverage:

Employee Only - \$24.00/Week
 Employee+Spouse - \$38.00/Week
 Employee+Child(ren) - \$38.00/Week
 Family - \$63.00/Week

DEPENDENT

First Name NLL	Last Name NLL	Social Security #	Birth Date	Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
First Name NLL	Last Name NLL	Social Security #	Birth Date	Sex <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
First Name NLL	Last Name NLL	Social Security #	Birth Date	Sex <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

OTHER COVERAGE INFORMATION (If any, Please Indicate)

NAME OF PERSON COVERED (FIRST, LAST)	EFF. DATE
	EFF. DATE
	EFF. DATE

Employee Acknowledgment and Authorization - I hereby apply for the group benefit(s) as indicated. I acknowledge that all entries are true and complete and that any misstatements or failure to report information may be used as the basis for cancellation of coverage for me and my dependent(s), if any, from the original effective date. Further, I authorize my employer to make the necessary payroll deduction of premiums for coverages I have elected.

IF ENROLLING - YOU MUST SIGN HERE

Employee Signature _____ Date _____

EMPLOYEE DECLINING I am DECLINING coverage

I understand that I and/or my dependent(s), if any, waive any coverage and desire to participate in the plan at a later date. I may be considered a late enrollee and must meet the requirements defined in the Certificate of Coverage for the company's medical or dental plans. If I decline enrollment for myself or my dependent(s) (including my spouse) because of other coverage, I may, in future be able to enroll myself or my dependent(s) in this plan, provided I request enrollment within 31 days after the other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, placement for adoption of parenting unit of adoption, I may be able to enroll myself or my dependent, provided I request enrollment within 31 days of the event.

IF DECLINING- YOU MUST SIGN HERE

Employee Signature *[Signature]* Date **3/19/218**

Employer Solutions Staffing Group Health Benefits Team
 PO Box 48270
 Minneapolis, MN 55244
 Phone: 952-767-8810 Fax: 952-767-8815
 Email: Health@employersolutionsgroup.com