



**AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION/RECORDS**

**HSPHD Contact Person**

All Fields/Sections marked with an asterisk (\*) are required

EWS

\* Full Name \_\_\_\_\_ \* Phone Number \_\_\_\_\_

**HSPHD Eligibility and Work Supports** (612) 596-1300

**Client Information**

\* Client Full Name **Shelly A Mcdade** Phone Number \_\_\_\_\_

Maiden, Previous Names or Aliases \_\_\_\_\_ \* Date of Birth **07/10/1974** SMI Number **170767998**

\* Street Address \_\_\_\_\_ \* City \_\_\_\_\_ \* State **MN** \* ZIP Code \_\_\_\_\_

**\* Obtain/Release Statement**

I authorize Hennepin County Human Services and Public Health Department  
To obtain and release information / records on the above named client with:

**Contact Person / Organization**

Organization  Person

Organization Name **EMPLOYER SOLUTIONS STAFFIN**

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State **MN** ZIP Code \_\_\_\_\_

**Record(s) Requested**

\* The record(s) will be used:

To continue evaluation or treatment.  To determine eligibility for assistance/service.

To coordinate services.  For court proceedings

Other: \_\_\_\_\_





### AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION/RECORDS

Release / Obtain the following information / records:

\* Record \_\_\_\_\_

Additional specifics regarding this record

#### Expiration

- This authorization applies to an open HSPHD case and, unless specified below, is valid until case closure.
- This authorization expires:

#### Client Authorization and Signature

The information may be shared unless otherwise indicated, orally, in writing, or electronically.

- I have the right to refuse to sign this authorization. Treatment, payment or operations are not conditioned on my authorization.
- I may cancel this authorization in writing at any time by contacting my worker and requesting form #HC 12025 if the action it allows has not been carried out.
- A copy of this authorization is as valid as the original.
- I may be required to pay the actual costs of making, certifying and/or compiling the copies of information requested.
- This information may be disclosed to other parties who are entitled to it by law and therefore no longer protected under the privacy rule.
- If I have questions about the privacy of my records, I may ask my worker for more information.

If not signed by subject of disclosure, specify basis for authority to sign:

- Parent of Minor       Guardian       Other personal representative

Printed Name of Person Signing

*Sheryl McJade*

Client Signature (Sign name as it appears above)

*S. McJade*

Date Signed

*6/8/17*

The information is available in other forms to people with disabilities. Call the county worker or contact the worker through the Minnesota Relay Service at 1-800-627-3529 - TTY  
Contact Person: HSPHD Eligibility and Work Supports Phone:



**Hennepin County**  
 Human Services and Public Health Department  
 Eligibility and Work Supports  
 PO Box 107  
 Minneapolis, MN 55440-0107



D10 (02/26/2016)

Phone 612-596-1300  
 Fax 612-288-2983  
 www.hennepin.us

This information is available in other forms to people with disabilities by calling the county worker on this form. For TDD users and those with speech difficulties, please contact your county worker through the Minnesota Relay at 711 or 1-800-627-3529 (TDD) or 1-877-627-3848 (Speech-to-Speech Relay).

**EMPLOYMENT VERIFICATION**

**Case Information**

Client Name	Case Number	SMI Person No.	Date
Shelly A Mcdade	1909047	170767998	06/07/2017

CCA     EWS

**Employee Information**

Employee Name	Social Security No.	Date of Birth
Shelly A Mcdade	503-88-7191	07/10/1974
Employer Name	EMPLOYER SOLUTIONS STAFFIN	
Employer Address	Address Line 2	
City	State	ZIP Code

**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 not 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	<i>Shelly A Mcdade</i>	Date	06/08/17
Signature of Spouse/Guardian/Authorized Representative		Date	

**Original copy for agency, provide copy to client**





**Hennepin County**  
Human Services and Public Health Department  
Eligibility and Work Supports  
PO Box 107  
Minneapolis, MN 55440-0107

Phone 612-596-1300  
Fax 612-288-2981  
www.hennepin.us

**EMPLOYMENT VERIFICATION**

Employee Name: Shelly A Mcdade Social Security Number: 503-88-7191

**To be completed by the employer** - The following information is required to determine eligibility for programs offered by Hennepin County and/or its contracted service providers. Please provide all information requested and return to the agency listed above.

Employer Name: EMPLOYER SOLUTIONS STAFFIN  
Employer Address: , ,

If this person never worked at your company, **STOP HERE. CHECK THE BOX**, Sign and date below.

Select reason person no longer employed:

- Leave of Absence (with pay)
- Strike/Lockout
- Layoff
- Voluntary quit
- Involuntary quit
- Leave of Absence (without pay)

Can employee return to work?  Yes  No If Yes, when? \_\_\_\_\_

End date of employment      Date of final check      Gross amount of final check

1. Employment start date      2. Date of first check      Gross amount of first check      3. Gross salary per pay period

4. Date of next check      Gross amount of next check      5. Day of week check received      6. Pay frequency

7. Hourly pay rate      Pay effective date      8. Occupation/Title

9. Approximate date of next raise      Hourly rate of next raise

10. Does this employee work overtime?  Yes  No . If yes, what is the overtime rate? \_\_\_\_\_

How many hours of overtime does this person average? \_\_\_\_\_

- pay period
- week
- month

OR Year to date Total \_\_\_\_\_

11. Check if employee receives:  Tips  Commissions  Bonuses Average tips/commissions/bonuses per pay period \_\_\_\_\_ YTD total \_\_\_\_\_

12. Are there any company-paid flexible benefits available to be taken in cash? OR Are any "in kind" (non-cash) benefits received (e.g., a housing allowance or an apartment)?  Yes  No

If yes, please list the amount here and explain: \_\_\_\_\_

13. List below actual hours worked each day. (Please fill in below\*\*.)

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Start time	_____	_____	_____	_____	_____	_____	_____
End time	_____	_____	_____	_____	_____	_____	_____

\*\*If the schedule varies, attach last 30 days of posted work schedules or completed time sheets. If schedule changed, indicated change effective date: \_\_\_\_\_

14. Number of hours worked per week \_\_\_\_\_



**EMPLOYMENT VERIFICATION**

15. What is the earliest date health/dental/vision benefits are available? \_\_\_\_\_

Is coverage available for: (check all that apply)  Employee  Spouse  Dependents

16. Employee cost per pay period: Employee: \_\_\_\_\_ Spouse: \_\_\_\_\_ Dependents: \_\_\_\_\_

Monthly employee's amount paid toward health/dental/vision insurance premiums: \_\_\_\_\_

17. Name of Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_

18. Health benefits contact person Name: \_\_\_\_\_ Phone: \_\_\_\_\_

19. Is employee paying court-ordered child support?  Yes  No Amount per pay period: \_\_\_\_\_

Please complete the monthly wage income (or attach printout) for Shelly A Mcdade,  
 from start of employment through present

Date Check Received	Hours worked	Gross wages	Tips	FICA & Medicare	Federal Tax	State Tax	Other Deductions
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

**I certify that this information provided on this form is true and correct to the best of my knowledge. I understand that this form is not a contract for services.**

Signature of Employer Representative

Date

Printed Name of Employer Representative and Title

Phone Number

Employer Name

Federal Employer Identification Number