Minnesota Department of **Human Services**

DHS-2146-ENG 4-13

Authorization for Release of Employment Information

Date: 03/11/20

Case number:

To: CMG

Worker name:
Agency name:
Agency address:
City, state, zip code:
Worker phone: (507) 923-4955 Fax:

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

Person name: Molly Bolling
Address: 618 13th St SE
City/state/zip code: Rochester MN 55904

Social Security number: XXX-XX-4760

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 	DATE 03/11/2020	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
Molly Bolling	4760	

Employment period:

DATE BEGAN/EXPECTED TO BEGIN	DATE ENDED/EXPECTED TO END	IF ENDED, DATE LAST PAID
8/22/19	2/21/2020	2/28/2020

REASON ENDED ☐ Voluntary ☒ Involuntary EXPLAIN: Terminated involuntary due to attendance - FT work was available

GROSS AMOUNT $388.50

Pay rate:

☒ $ 10.00 /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? 8/30/2020

EMPLOYMENT IS:	AVERAGE # HOURS PER PAY PERIOD:	HOW OFTEN PAID:		
☐ Part time	40	☒ Each week	☐ Every two weeks	☐ Twice a month
☒ Full time		☐ Once a month	☐ End of job	☐ Other _____

Work Schedule:

SUN	MON	TUES	WED	THUR	FRI	SAT
as needed	230P-1030P				→	as needed

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				N/A				
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? $ 20.91 per week (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	
[signature], ESG Rep.	~~CMG~~ ESG	
FEIN	PHONE NUMBER	DATE
9644843	8079234955	3/11/2020

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກຳກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1-0001 (3-13)

ADA5 (12-12)

This information is available in accessible formats for individuals with disabilities by contacting your county worker. For other information on disability rights and protections to access human services programs, contact the agency's ADA coordinator.