Maxis Case Number

BENTON COUNTY HUMAN SERVICES

531 Dewey St.
P.O. Box 740
Foley, MN 56329

320-968-5067
1-800-530-6254
Fax: 320-968-5330
TDD# 320-968-884

Fax Transmittal Sheet

From
~~To:~~ Huisken Meats

Attention:

Fax Number: 320-258-4968

Date: 2/9/2015 11:02:45 A

~~From:~~ To: Kris Levanduski Eligibility Specialist

Fax Number: **(320) 968-5330**

Phone Number: **(320) 968-5087** Main Office Line
320 968-5134

Remarks: Addi works at an location through a Staffing Service, CM6, I will give this to them to complete.

Re: Case # 1608631

Minnesota Department of Human Services

DHS-2746-ENG 4-13

Authorization for Release of Employment Information

Date: 2/6/2015 **Case number:** 1608031

To: Hulsken Meats
Fax: (320) 258-4968

Worker name: Kristine M. Levanduski
Agency name: Benton County Human Services
Agency address: P.O. Box 740
City, state, zip code: Foley, MN 56329
Worker phone: 320-968-5134 Fax: 320-968-5330

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

Person name: Addi J Opada Social Security number: 539-49-7052
Address: 240 2nd St Ne Apt 108
City/state/zip code: Saint Cloud MN 56304-0451

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 2/6/15
SIGNATURE OF SPOUSE/GUARDIAN/AUTHORIZED REPRESENTATIVE	DATE

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
Addi J Opada	539-49-7052	1608031

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	_____	☐ 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

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