

SENSITIVE BUT UNCLASSIFIED

Department of Homeland Security

Report Prepared: 03/03/2015

E-Verify

Page: 1 of 1

Case Verification Number: 2015062120843KD

Case Information:

Employee Information:

Last Name: Powell

Middle Initial:

Social Security Number: *** ** 7123

Citizenship Status: A citizen of the United States

Document Information:

List B Document: Driver's license or ID card issued by a U.S.

Document Name: Driver's license

Driver's License or ID Card Number:

Alien Number:

Additional Information:

Hire Date: 03/03/2015

Three-Day Rule Reason: JM/IS3269

Submitted By: Submitted On: 03/03/2015

Initial Case Result: Employment Authorized

Employee Referred to SSA:

Referred By:

Referred On:

Case Result from SSA (after SSA Tentative Nonconfirmation):

Case Result:

Response Date:

Resubmitted to SSA (after Review and Update Employee Data):

Last Name:

Middle Initial:

Social Security Number:

Resubmitted By:

First Name: Other Names Used: Date of Birth: Resubmitted On:

Case Result from SSA (after Resubmission):

Case Result:

Request Name Review:

Comments:

Submitted By:

Submitted On:

Case Result from DHS (after DHS Verification in Process):

Case Result:

Response Date:

Employee Referred to DHS:

Referred By:

Referred On:

Case Result from DHS (after DHS Tentative Nonconfirmation):

Case Result:

Response Date:

Photo Matching Results:

Determination:

Employee Referred to DHS (Additional):

Referred By:

Referred On:

Case Result from DHS (after Additional DHS Tentative Nonconfirmation):

Case Result

Response Date:

Case Closure:

Closure Statement:

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

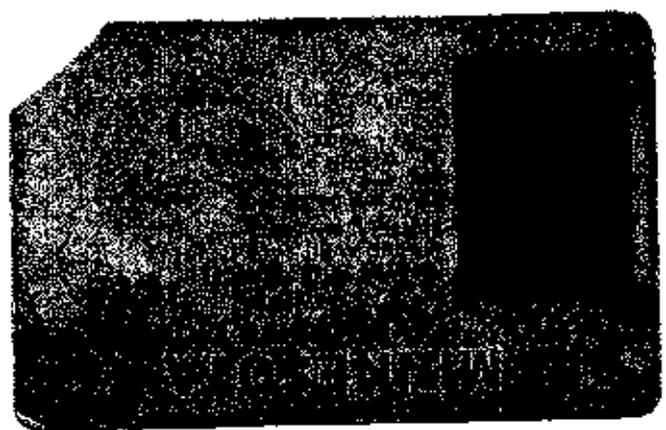
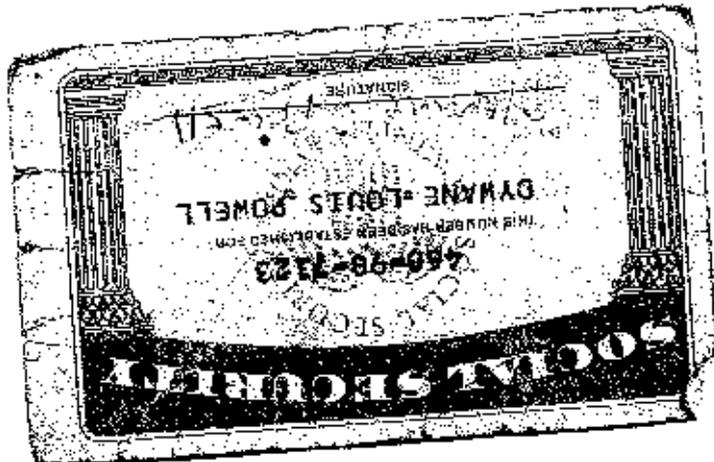
Closed By:

JMIS3269

Closed On:

03/03/2015

SENSITIVE BUT UNCLASSIFIED



New Hire Application

Personal Data - PLEASE PRINT LEGIBLY IN INK

Last Name powell First Name Dwayne Middle Initial L
 Street Address 1043 17th Ave S City/State/zip St Cloud MN 56301
 Phone Number 320-534-8855 Email Address Jenny Missel @
 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.

Name (Print or type) Dwayne Powell
 Applicant's Signature Dwayne Powell
 Date 3-3-15

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

DOH		ESSG - C/MG	
Emergency Contact Info	Background Release Form	Background Results	Unemployment Letter (if applicable)
DOH	MHW	I-9	8850
For ESSG Office Use Only		For ESSG Client Use	
Work Site Loc.	ROP	W/C Code	

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, 4, and 7 and sign the form on line 8. Your exemption for 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim an exemption from withholding if your income exceeds \$1,000 and includes more than \$350 of unearned income (for example, interest and dividends).

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

- is blind, or
- is age 65 or older.

• With claim adjustments to income, tax credits, or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than \$1,000,000.

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet below. The worksheet on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multi-job situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances 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 individual. 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. 505 for information on converting your other credits into withholding allowances.

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

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax liability. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4.

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.

Married or single. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Enter "1" if:

- You are single and have only one job, or
- You are married, have only one job, and your spouse does not work, or
- Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.

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.)

Enter number of dependents (other than your spouse or yourself) you will claim on your tax return.

Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above).

Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit. (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

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 \$65,000 (\$95,000 if married), enter "2" for each eligible child; then less "1" if you have three to six eligible children or less "2" if you have seven or more eligible children.

If your total income will be between \$5,000 and \$19,000 if married), enter "1" for each eligible child.

Add lines A through G and enter total here. (Note. This may be different from the number of exemptions your claim on your tax return.)

If you plan to renounce 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 \$50,000 (\$20,000 if married), see the Two-Earners/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.

For accuracy, complete all worksheets that apply.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

Department of the Treasury Internal Revenue Service

Form W-4

Employee's Withholding Allowance Certificate

OMB No. 1545-0074 2014

1 Your first name and middle initial

2 Your social security number

3 Single Married Married, but withheld at higher Single rate.

4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.

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 2014, and I certify that I meet both of the following conditions for exemption. Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.

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)

Date: 3-3-15

Employee's signature: Dwayne Powell

This form is not valid unless you sign it.

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.

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Form W-4 (2014)



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

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

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.)

Signature of Employee: <i>Dwayne Powell</i>	Date (mm/dd/yyyy): 3-3-15
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Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

Country of Issuance: _____

Foreign Passport Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

2. Form I-94 Admission Number: _____

OR

1. Alien Registration Number/USCIS Number: _____

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number.

Do Not Write in This Space

- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____ . Some aliens may write "N/A" in this field. (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- A noncitizen national of the United States (See instructions)
- A citizen of the United States

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):

Date of Birth (mm/dd/yyyy): 04-06-1982		U.S. Social Security Number: 468-98-7123		E-mail Address: 320-534-8855	
Address (Street Number and Name): 1043 17th Ave S		City or Town: St Cloud		State: MN	
Apt Number: 5		Zip Code: 56301		Telephone Number: 320-534-8855	
Last Name (Family Name): Powell		First Name (Given Name): Dwayne		Middle Initial: Louis	
Other Names Used (if any):					

Section 1. Employee Information and Attestation: Employees 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.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.



Signature of Employer or Authorized Representative:	Date (mm/dd/yyyy):	Print Name of Employer or Authorized Representative:
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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.

Document Title:	Document Number:	Expiration Date (if any) (mm/dd/yyyy):
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C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

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

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

Last Name (Family Name) Missell		First Name (Given Name) Jennifer		City or Town EDINA		State MIN	Zip Code 55439
Employer's Business or Organization Name EMPLOYER SOLUTIONS STAFFING GROUP LLC				Employer's Business or Organization Address (Street Number and Name) 7301 OHMS LANE SUITE 405			
Signature of Employer or Authorized Representative		Date (mm/dd/yyyy) 03-03-2015	Title of Employer or Authorized Representative Office Staff				

The employee's first day of employment (mm/dd/yyyy): 03-05-2015 (See instructions for exemptions.)

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.

Certification

Document Title: Drivers License	Issuing Authority: State of Minnesota	Document Number: 2335049106611	Expiration Date (if any) (mm/dd/yyyy): 4-26-2017
Document Title: Social Security Card	Issuing Authority: Social Security Administration	Document Number: 468-98-7123	Expiration Date (if any) (mm/dd/yyyy):

Employee Last Name, First Name and Middle Initial from Section 1: Powell, Dwayne, L

List A OR List B AND List C

Section 2. Employer or Authorized Representative Review and Verification

(Employers 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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

3-D Barcode
Do Not Write in This Space

DISCLOSURE AND AUTHORIZATION [IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Employer Solutions Staffing Group LLC (ESSG) may obtain information about you for employment purposes from a third party consumer reporting agency. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" that may include information about your character, general reputation, personal characteristics, and/or mode of living, and that can involve personal interviews with sources, such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security number validation, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. Credit history will only be requested where such information is substantially related to the duties and responsibilities of the position for which you are applying. You have the right, upon written request made within a reasonable time, to request whether a consumer report has been requested and completed about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by Orange Tree Employment Screening, 7275 Chms Lane, Minneapolis, MN 55439. Tel.: 800-886-4777 or 952-941-9040. Fax: 800-886-0774 or 952-941-9041. ORANGE TREE EMPLOYMENT SCREENING'S website is at www.orange-tree-screening.com, or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing ESSG to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

New York and Maine applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by ESSG by contacting the consumer reporting agency identified above directly. You may also contact ESSG to request the name, address and telephone number of the nearest unit of the consumer reporting agency designated to handle inquiries, which ESSG shall provide within 5 days.
New York applicants or employees only: Upon request, you will be informed whether or not a consumer report was requested by ESSG, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.
Oregon applicants or employees only: Information describing your rights under Federal and Oregon law regarding consumer identity theft protection, the storage and disposal of your credit information, and remedies available should you suspect or find that ESSG has not maintained secured records is available to you upon request.
Washington State applicants or employees only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of these documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by ESSG at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, company, or insurance company to furnish any and all background information requested by Orange Tree Employment Screening, 7275 Chms Lane, Minneapolis, MN 55439. Tel.: 800-886-4777 or 952-941-9040. ORANGE TREE EMPLOYMENT SCREENING'S website is at: www.orange-tree-screening.com, another outside organization acting on behalf of the company, and/or the company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants or employees only: By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law. **Minnesota and Oklahoma applicants or employees only:** Please check this box if you would like to receive a copy of a consumer report if one is obtained by ESSG. (Must include email address: _____)

Signature: Dwayne Powell Date: 3-3-15

Other Names/Aliases: _____

Social Security #: 468-98-7123

Driver's License #: E335049106611

Present Address: 1043 17th Ave S

City/State/Zip: St Cloud MN 56301

Telephone # (Primary): 320-534-8855

State of Driver's License: Minnesota

Date of Birth (mm/dd/yyyy): 4-26-82

First: Dwayne Middle: Louis Last Name: Powell

This information will be used for background screening purposes only and will not be used as hiring criteria.

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: Dwaine Powell SSN (last 4 digits): 468-98-7133 Effective Date: 3-3-15

SECTION 2 PAYROLL ELECTION

Direct Deposit (Please complete Sections 3 and 5 below)
 Payroll Debit Card (Please complete Sections 4 and 5 below)

SECTION 3 DIRECT DEPOSIT

Update Bank Account

Bank Name: _____

Routing#: _____

Account#: _____

Account Type: Checking Savings Other

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 _____

Date _____

SECTION 4 PAYROLL DEBIT CARD (GLOBAL CASTLE 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. (In 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: Dwaine M.I.: Louis Last Name: Powell
 Street Address (no box not acceptable): 1043 St Cloud Ave
 City: St Cloud State: MA Zip: 56301
 Cell Phone (mobile): _____
 Social Security #: 468-98-7133
 Date of Birth: 4-9-82

GET TEXT ALERTS, when your paycheck is deposited on your card!
 All we need to know your cell phone service provider and mobile number above!
 Yes, sign me up, for text alerts 320
 My mobile service provider is: 534-8855

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

Payroll Debit Card Routing #: 073972181
 Payroll Debit Card Account #: 4853-4001-4357-1604

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.

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: kkritina@yahoo.com

this information will only be used to send your pay stubs electronically

Employee's Signature: Dwaine Powell

Date: 3-3-15

ENROLLMENT FORM

ESC NAV*SAD P2M *15.0

**OPTION 1
FIXED INDEMNITY PLAN**

Weekly Rates
You MUST enroll in the Indemnity Medical Insurance Plan before adding any additional Indemnity benefits, except Dental. Your coverage level for the Term Life will be identical to your medical plan selection.

FIXED INDEMNITY MEDICAL
 \$20.91 Employee Only
 \$42.44 Employee + 1
 \$56.67 Employee + Family
 NO to all Indemnity benefits.

This coverage is not available to residents of New Hampshire, Hawaii, or Puerto Rico.

DENTAL

\$5.99 Employee Only
 \$11.98 Employee + 1
 \$19.77 Employee + Family
 NO

TERM LIFE

YES
 NO
 \$0.60 Employee Only
 \$0.90 Employee + 1
 \$1.80 Employee + Family

Short-Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

**OPTION 2
MEC WELLNESS/PREVENTIVE PLAN**

Monthly Rates
 \$58.87 Employee Only
 \$87.73 Employee + 1
 \$186.99 Employee + Family
 NO to MEC Wellness/Preventive Plan

REQUIRED EMPLOYEE INFORMATION

(Must Be Filled Out)
 Social Security Number 468-98-2123
 Date of Birth 04/26/1982 Sex M F

Name Dwayne Powell

Street Address 1043 17th Ave. S
 City St Cloud State WA Zip 546301
 Home Phone 320-534-8855

Do you or any dependents have Medicare?
 Yes No If Yes:
 Medicare Health Insurance Claim Number (HICN)
 Medicare Effective Date

1. Names of Covered Person(s)
 2.
 3.

REQUIRED DEPENDENT INFORMATION

Name _____
 Social Security Number _____
 Date of Birth _____ Sex M F
 Relationship: Spouse Child Domestic Partner

Name _____
 Social Security Number _____
 Date of Birth _____ Sex M F
 Relationship: Spouse Child Domestic Partner

BENEFICIARY INFORMATION

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information.

NAME OF BENEFICIARY

RELATIONSHIP

Accidental Death & Dismemberment is part of the Term Life Benefit.

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 declaration of coverage.
 Signature Dwayne Powell
 Date 03/03/2015