



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



D10 (02/22/2019)

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

Submit

EMPLOYMENT VERIFICATION

All fields/sections marked with an asterisk (*) are required.

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).

Case Information

Client Name	Case Number	SMI Person No.	Date
Ragode A Muhammad	1214004	146731527	02/25/2019

Employee Information

Employee Name	Social Security No.	Date of Birth
Ragode A Muhammad		12/21/1981
* Employer Name		
Employer Address	Address Line 2	
City	State	ZIP Code
Employers Phone Number	Employers Fax Number	

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 	Date 2/25/19
Signature of Spouse/Guardian/Authorized Representative	Date
Original copy for agency, provide copy to client	





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Employee Name: Ragode A Muhammad **Social Security Number:**

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 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 OR Year to
 week date Total
 month

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



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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 Ragode A Muhammad,
 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