

**Fax Cover**

**From: Corporate Management Group**

**Phone: 507-923-7956**

**Fax: 507-216-4904**

**To: Olmsted Co. Family Support**

**Fax 507-328-7956**

**Re: Scott Lathrop**

**Case number 344046**

**1 of 3 pages**



# Authorization for Release of Employment Information

Date: 3-31-11

Case number: 344046

To: OLMSTED CO. FAMILY  
FAX 507-328-7956 SUPPORT  
SALVATION ARMY  
c/o TAM I  
FAX - 507-281-8348

Worker name:  
Agency name:  
Agency address:  
City, state, zip code:  
Worker phone: Fax:

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

Person name: SCOTT LATHROP  
Address: 863 21ST AVE. S.E. #106E  
City/state/zip code: ROCHESTER, MN. 55904

Social Security number: XXX-XX-0653

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. PLEASE FAX ALL THIS TO ABOVE:

## 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 3-31-11	Original copy for agency
SIGNATURE OF SPOUSE/GUARDIAN/AUTHORIZED REPRESENTATIVE	DATE	Provide copy to client

**To be completed by employer -  
return both pages to requesting agency**

(Mail or fax to agency address/fax number on first page)

EMPLOYEE NAME <b>SCOTT RICHARD LATHROP</b>	SOCIAL SECURITY NUMBER <b>XXX-XX-0653</b>
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<b>Employment period:</b>	DATE BEGAN/EXPECTED TO BEGIN <b>4/19/11</b>	DATE ENDED/EXPECTED TO END	REASON ENDED <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary
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<b>Pay rate:</b> <input checked="" type="checkbox"/> \$ <b>15.00</b> /hour <input type="checkbox"/> \$ _____ /day <input type="checkbox"/> \$ _____ /acre <input type="checkbox"/> Other (explain: _____)	If per acre, # of acres anticipated? _____ Does this rate depend on the type of work performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____
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**Income received/expected:** Provide income information for these months: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

What was the date of the first pay check received? 4/29/11

EMPLOYMENT IS / AVERAGE #HOURS <input type="checkbox"/> Part time _____ <input checked="" type="checkbox"/> Full time _____	HOW OFTEN PAID: <input checked="" type="checkbox"/> Each week <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month <input type="checkbox"/> End of job <input type="checkbox"/> Other _____
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	SUN	MON	TUES	WED	THUR	FRI	SAT
Work schedule	as needed	9p-5a	9p-5a	9p-5a	→		as needed

Attach verification of income earned, *itemized by pay period*, or complete the table below.

**Note:** For future months, anticipate income.

Record only those wages which you are reasonably certain the employee will be paid.

	Income received						
Date received							
Gross earnings							
No. of hours worked			N/A				
Advances/Tips/Bonuses		1st check on		4/29/11			
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 <i>Emily Sage</i>	EMPLOYER NAME (Print) <b>Emily Sage</b>	PHONE NUMBER <b>(507) 923-4955</b>	DATE <b>4/18/11</b>
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