



Authorization for Release of Employment Information

Date:

Case number: 1788434-MA

To:

Worker name: **NA Vang**
Agency name:
Agency address:
City, state, zip code:
Worker phone: 651- Fax:
266-4657

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

Person name:

Social Security number: XXX-XX-____

Address:

City/state/zip code: _____

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 Permissions: 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 <i>Ma Vang</i>	DATE 11-17	Original copy for agency Provide copy to client
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 MAWAY	SOCIAL SECURITY NUMBER 079-96-6211	CASE NUMBER 1788434
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Employment period:	DATE BEGAN/EXPECTED TO BEGIN 1/5/17	DATE ENDED/EXPECTED TO END 1/18/17	IF ENDED, DATE LAST PAID 1/25/17
REASON ENDED <input checked="" type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary	EXPLAIN: N/A		GROSS AMOUNT \$47.31

Pay rates: <input checked="" type="checkbox"/> \$ ^{9.50-} 10.50 /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 information for these months: _____, _____, _____

What was the date of the first pay check received? 1/18/17

EMPLOYMENT IS:	AVERAGE # HOURS PER PAY PERIOD:	HOW OFTEN PAID:
<input checked="" type="checkbox"/> Part time <input type="checkbox"/> Full time	<u>11.4</u>	<input checked="" type="checkbox"/> Each week <input type="checkbox"/> Every two weeks <input type="checkbox"/> Once a month <input type="checkbox"/> End of job <input type="checkbox"/> Twice a month <input type="checkbox"/> Other

Work Schedule:

SUN	MON	TUES	WED	THUR	FRI	SAT
—	Varies	—	—	—	—	—

Attach verification of income earned, itemized by pay period, or complete the table below.
Note: For future months, anticipate income.

Date received	Income received (Record only those wages which you are reasonably certain the employee will be paid.)					
	<u>1/18/17</u>	<u>1/25/17</u>				
Gross earnings	<u>172.28</u>	<u>47.31</u>				
No. of hours worked	<u>17.75</u>	<u>4.98</u>				
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? \$ 90.61 per month (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 Employer Solutions Staffing Group
FED 26-2726508	PHONE NUMBER 952-835-1258
	DATE 4/13/17