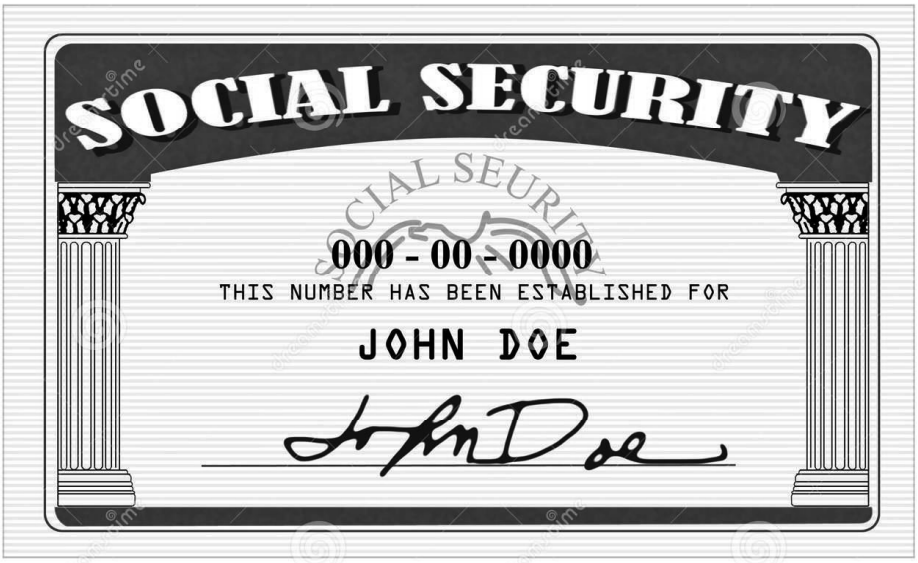
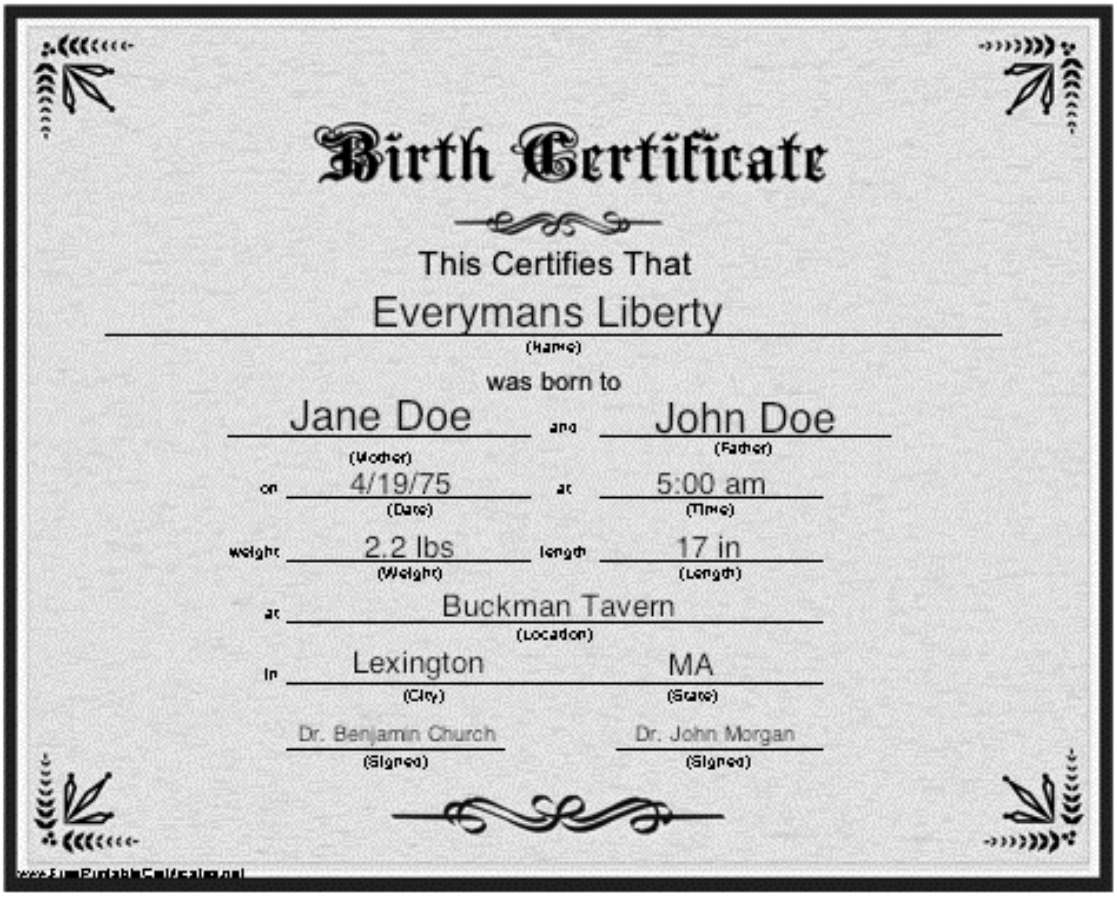

SOCIAL SECURITY
000 - 00 - 0000
THIS NUMBER HAS BEEN ESTABLISHED FOR
JOHN DOE


Birth Certificate
This Certifies That
Everymans Liberty
(Name)
was born to
Jane Doe
(Mother)
and
John Doe
(Father)
on
4/19/75
(Date)
at
5:00 am
(Time)
weight
2.2 lbs
(Weight)
length
17 in
(Length)
at
Buckman Tavern
(Location)
in
Lexington
(City)
MA
(State)
Dr. Benjamin Church
(Signed)
Dr. John Morgan
(Signed)

123 - John R. Doe	Pay Period 06/02/06 to 06/16/06		
Earnings			
Hours	**Rate**	**This Period**	**YTD**
50	9.00	450.00	900.00
Gross Pay		**450.00**	**900.00**

Required Deductions		
Federal Income Tax	00.00	00.00
FICA - Medicare	06.08	12.16
WI State Income Tax	00.00	00.00
FICA - Social Security	25.92	51.84
Other Deductions		
Health Insurance	00.00	00.00
401k	00.00	00.00
Parking	00.00	00.00
NET PAY	**$418.00**	**$836.00**

Your Employer
1234 Some Street
Milwaukee, WI ZIPCODE

Check Number: XXXXXX
Pay Date: 06/19/06

PAY ***Four hundred eighteen dollars and 00 cents**********$418.00

To the Order of
John R. Doe
555 Some Street
Milwaukee, WI ZIP CODE

LOGO

COMPANY NAME
Street Address
City, State Zip
Phone Number

UTILITY BILLING STATEMENT

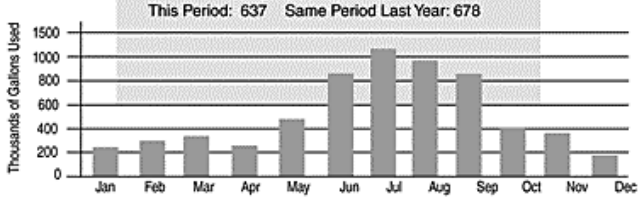
ACCOUNT NO.	CUSTOMER NAME	SERVICE ADDRESS	BILLING DATE	DUE DATE
0000000000	JOHN Q. PUBLIC	1234 ANY STREET	01/29/2009	02/15/2009

METER READ DATE From	To	Days	METER READING Previous	Current	Consumption
12/09/2008	01/10/2009	32	8,544	9,181	637

DESCRIPTION	AMOUNT
Previous Balance	287.03
Adjustments	
Payments	287.03 CR
WATER	146.94
SEWER	115.20
STATE/COUNTY TAX	8.96
CITY TAX	2.94
FUNDING	0.41
BALANCE DUE	**$274.45**

LOGO

WATER CONSUMPTION
This Period: 637 Same Period Last Year: 678



Office Hours: 8:00 a.m. - 5:00 p.m., Monday through Friday. Billing Inquiries: (000) 000-0000

AIS (0/09)

BULLETIN BOARD

MESSAGE AREA

KEEP THIS PORTION FOR YOUR RECORDS

RETURN THIS STUB WITH YOUR PAYMENT

LOGO

COMPANY NAME
Street Address
City, State Zip
Phone Number

SERVICE ADDRESS		
1234 ANY STREET		
ACCOUNT NUMBER	**DUE DATE**	**PAY THIS AMOUNT**
0000000000	2/15/2009	$274.45

AMOUNT ENCLOSED
$

Make checks payable to: COMPANY NAME
PLEASE RETURN THIS PORTION WITH MAILED PAYMENT AND USE ENCLOSED ENVELOPE TO ENSURE PROPER POSTING

❑ **CHECK HERE AND COMPLETE BACK OF STUB FOR SURE PAY.**

ADDRESSEE

*****AUTO**5-DIGIT 00000 1-28
JOHN Q. PUBLIC
1234 ANY STREET
CITY, STATE ZIP

REMIT TO

COMPANY NAME
STREET ADDRESS
CITY, STATE ZIP

Monthly Bank Statement

24 HOUR TELEPHONE TRANSFER LINE - 123-5678
CUSTOMER SERVICE NUMBER - 567-1234 EXT 296

****

DEPOSIT ACCOUNTS

DETAIL CHECKING
REGULAR CHECKING
ACCOUNT:
SOC. SEC.

THIS STATEMENT SHOWS ALL ACCOUNT TRANSACTIONS FROM SEP 14,19?? - THRU OCT 12, 19??

DEPOSITS		CHECKS AND DEDUCTIONS						DAILY BALANCES	
DATE	AMOUNT	NO	DATE	AMOUNT	NO	DATE	AMOUNT	DATE	AMOUNT
9/19	100.00	4882	9/15	32.00				9/15	2533.40
		****						9/16	2503.45
		****						9/19	2603.45
9/28	269.00	4885	9/18	29.95				9/26	2593.45
		4886	9/26	10.00				9/28	2862.45
		****						10/02	2822.45
		4888	10/02	40.00					

2000

**** INDICATES ONE OR MORE MISSING CHECKS

BEGINNING BALANCE 9/14/??	DEPOSITS & CREDITS		CHECKS & DEBITS		ENDING BALANCE 10/12/??
	NO	AMOUNT	NO	AMOUNT	
2565.40	2	369.00	4	111.95	2822.45

2000

ENCLOSURES: 8

STATE OF NEVADA
DEPARTMENT OF MOTOR VEHICLES

CERTIFICATE OF TITLE

VIN	YEAR	MAKE	MODEL	VEHICLE BODY	TITLE NUMBER

DATE ISSUED	ODOMETER MILES	FUEL TYPE	SALES TAX PD.	EMPTY WT.	GROSS WT.	GVWR

VEHICLE COLOR	ODOMETER BRAND	BRANDS

OWNER(S) NAME AND ADDRESS

LIENHOLDER(S) NAME AND ADDRESS

If a lien is listed in this section of the title, you must acquire an original Letter of Lien Release from the bank or lien company showing that the lien has been paid in full before the title can be processed.

LIENHOLDER(S) RELEASE - INTEREST IN THE VEHICLE DESCRIBED ON THIS TITLE IS HEREBY RELEASED:

Do not sign here

SIGNATURE OF AUTHORIZED AGENT — DATE

Printed Name

FEDERAL AND STATE LAW REQUIRES THAT YOU STATE THE MILEAGE IN CONNECTION WITH THE TRANSFER OF OWNERSHIP. FAILURE TO COMPLETE OR PROVIDING A FALSE STATEMENT MAY RESULT IN FINES AND/OR IMPRISONMENT.

The undersigned hereby certifies that the vehicle described in this title has been transferred to the following buyer(s):

Please leave this blank. Thanks! ☐ AND ☐ OR

Printed Name of Buyer(s)

Please leave this blank. Thanks!

Printed Name of Buyer(s)

Please leave this blank. Thanks!

Address — City — State — Zip Code

I certify to the best of my knowledge that the odometer reading is the actual mileage of the vehicle unless one of the following statements is checked:

Odometer Reading | NO TENTHS

ODOMETER READING

☐ The mileage stated is in excess of its mechanical limits. Date of Sale
☐ The odometer reading is not the actual mileage. WARNING: ODOMETER DISCREPANCY.
☐ Exempt - Model year over 9 years old.

Signature of donor(s)

Signature of Seller(s)

I am aware of the above odometer certification made by the seller/agent. ☐

Please leave this blank. Thanks!

Signature of Buyer(s)

Printed name of donor(s)

Printed Name of Seller(s)

Please leave this blank. Thanks!

Printed Name of Buyer(s)

ACCORDING TO THE RECORDS OF THE DEPARTMENT OF MOTOR VEHICLES, THE PERSON NAMED HEREON IS THE OWNER OF THE VEHICLE DESCRIBED ABOVE, SUBJECT TO LIEN(S) AS SHOWN.

CONTROL NO. N000000

RD-2 (Rev. 10/01)

(THIS IS NOT A TITLE NO.)

ALTERATION OR ERASURE VOIDS THIS TITLE

RESIDENTIAL LEASE AGREEMENT

This Residential House Lease Agreement ("Lease") is made and effective this **January 1, 2013** by and between **Joe Sample** ("Landlord") and **Fred Example** and **Wilma Example** ("Tenant," whether one or more). This Lease creates joint and several liability in the case of multiple Tenants.

1. **PREMISES**.

Landlord hereby rents to Tenant and Tenant accepts in its present condition the house at following address: **123 Main Street, Hometown, MN 55555** (the "House").

2. **TERM.**

The term of this Lease shall start on **January 1, 2013**, and end on **December 31, 2013**. In the event that Landlord is unable to provide the House on the exact start date, then Landlord shall provide the House as soon as possible, and Tenant's obligation to pay rent shall abate during such period. Tenant shall not be entitled to any other remedy for any delay in providing the House.

3. **RENT**.

Tenant agrees to pay, without demand, to Landlord as rent for the House the sum of **$750.00** per month in advance on the first day of each calendar month, at **[Address for Rent Payments]**, or at such other place as Landlord may designate. Landlord may impose a late payment charge of **[Late Pay Charge]** per day for any amount that is more than five (5) days late. Rent will be prorated if the term does not start on the first day of the month or for any other partial month of the term.

4. **SECURITY DEPOSIT**.

Upon execution of this Lease, Tenant deposits with Landlord **[Security Deposit Amount]**, as security for the performance by Tenant of the terms of this Lease to be returned to Tenant, **[With or Without Interest]**, following the full and faithful performance by Tenant of this Lease. In the event of damage to the House caused by Tenant or Tenant's family, agents or visitors, Landlord may use funds from the deposit to repair, but is not limited to this fund and Tenant remains liable.

5. **QUIET ENJOYMENT**.

Landlord agrees that if Tenant timely pays the rent and performs the other obligations in this Lease, Landlord will not interfere with Tenant's peaceful use and enjoyment of the House.

6. **USE OF PREMISES**.

A. The House shall be used and occupied by Tenant exclusively as a private single-family residence. Neither the House nor any part of the House or yard shall be used at any time during the term of this Lease for the purpose of carrying on any business, profession, or trade of any kind, or for any purpose other than as a private single-family residence.

Minnesota Department of **Human Services**

Change Report Form

NAME	CASE NUMBER
Dino Flintstone	99999992
ADDRESS	
320 Washington Street , Northfield, MN 55054-1111	
WORKER NAME	WORKER PHONE NUMBER

Purpose: This form is to report changes to your county human services agency which may affect your eligibility or benefit level.
Instructions: Fill out this form only if you have changes to report. If you get cash assistance or health care, **report any change within 10 days.** If you get Supplemental Nutrition Assistance Program (SNAP) benefits, **report changes by the 10th of the month following the month of the change.** For example, if a change happens in March, you must report the change by April 10. You may also call your worker to report a change. If you don't know whether to report a change, call your worker.

Note: Return your completed form to your county human services agency. Remember to sign and date it. Use a separate sheet if you need more room. If you do not know your county agency's address, call your worker. **Do not** return this form to the Minnesota Department of Human Services Issuance Operation Center (IOC) in St. Paul.

Change in address

You must send proof of changes

I (we) moved to:	COUNTY MOVED TO	COUNTY MOVED FROM	
ADDRESS			NEW PHONE NUMBER
CITY	STATE	ZIP CODE	DATE MOVED

Have you either moved on to a reservation or left a reservation in the last month? ☐ Yes ☐ No

Change in people in my home

Total number of people now in my home: _____

NAME	RELATIONSHIP TO YOU	Moved	Married	Died	Born	Date of change	Has income?
SSN	BIRTH DATE	In ☐ Out ☐	☐	☐	☐	___ ___ ___	☐ Yes ☐ No
		Source of income? _____				How often paid? _____	
NAME	RELATIONSHIP TO YOU	Moved	Married	Died	Born	Date of change	Has income?
SSN	BIRTH DATE	In ☐ Out ☐	☐	☐	☐	___ ___ ___	☐ Yes ☐ No
		Source of income? _____				How often paid? _____	

Do any of the new people in your home buy, fix or eat meals with you? ☐ Yes ☐ No
If yes, name(s) _____ _____

Change in savings or property

(Cash and health care only) **Types of proof: bank statement, property statement**

☐ Savings/checking, certificates of deposit, IRAs, etc.	☐ open $_____	☐ closed		
☐ Land or buildings	PLACE	☐ Bought ☐ Sold	AMOUNT PAID/RECEIVED	DATE PAID/RECEIVED

Change in vehicles

(Cash and health care only) **Types of proof: bill of sale, title certificate**

Report if you bought, sold, traded, were given or gave away any vehicles (examples-cars, vans, trucks, motorcycles, off-road vehicles, boats).

☐ Bought by or given to someone in your home		☐ Sold, transferred, or given away by someone in your home		
HOUSEHOLD MEMBER		DATE OF TRANSACTION	MONEY RECEIVED IF SOLD	
TYPE OF VEHICLE	MAKE	MODEL	YEAR	VALUE

This information is available in alternative formats to individuals with disabilities by calling your county worker. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.

ADA.5 (5-09)

Over

Minnesota Department of **Human Services**

Minnesota Health Care Programs

Request for Information

Redetermination date: 3/3/2014

Case number: 99999993

Case name: BamBam Rubble

Worker name: _____

Worker phone number: _____

Fax number: _____

Agency name: _____

Agency address: _____

Date: 3/3/2014

To: BamBam Rubble

320 Washington Street

Northfield, MN 55054-1111

Why am I getting this letter?

We need more information to see if you can get or keep your health care coverage.

What do I need to do?

Look at the items marked below. Send the checked information or proofs by _____ (DUE DATE). Write your case number on all papers you send.

☐ **Proof of income received by:**

_____ (NAME) for _____ (DATES) _____ (NAME) for _____ (DATES)

_____ (NAME) for _____ (DATES) _____ (NAME) for _____ (DATES)

Send copies of all pay stubs or a written statement of earnings from the employer. Send copies of checks, award letters, court orders, or other documents as proof of other types of income.

☐ **Copy of _____ Federal Income Tax forms and all W-2 wage statements** for _____. Send all related forms (Schedules C, D, E, F, K-1; Forms 1065, 1120S, 4562, 4797, 4835, 8825, 8829). If taxes have not been filed, send copies of business records or a signed statement of business income and expenses for the past year or since the business started if the business is less than a year old.

☐ **Proof of U.S. citizenship and identity** for _____. Read the enclosed *Citizenship and Identity Proofs* (DHS-6231) list to find out what you need to send.

☐ **Proof of immigration status** for _____. Send a copy of the front and back of all immigration cards and papers. Contact U.S. Citizenship and Immigration Services (USCIS) if you do not have current proof of immigration status at 800-375-5283, or if you are hearing impaired at 800-767-1833.

☐ **Proof of American Indian status** for _____. Send a copy of Tribal membership card or letter from the tribe showing membership, document from Indian Health Services (IHS) showing the person is an American Indian and qualifies for IHS services, or a letter or card from the Bureau of Indian Affairs (BIA) showing tribal membership. *Households with an American Indian enrolled in MinnesotaCare do not pay a monthly premium for coverage.*

☐ These people need to **sign, date and return the Signature Page** included with this letter.

_____

☐ **Complete and return the form(s) included with this letter:** _____

_____

_____

☐ **Other:** _____

_____

_____