Stop Work

DSHS MAILING ADDRESS **DSHS PO BOX 11699 TACOMA, WA 98411-9905**	
DSHS PHONE NUMBER	DSHS FAX NUMBER **888-338-7410**
CASE / CLIENT ID NUMBER	DATE

Section 1: Client, fill out this section before taking it to your job that ended.

By signing here, I give my permission to my employer to complete this form for the Department of Social and Health Services.

CLIENT'S SIGNATURE	DATE	CLIENT: PLEASE PRINT YOUR NAME HERE

NAME OF COMPANY / EX-EMPLOYER			
COMPANY / EX-EMPLOYER STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE**

Section 2: The person in the company who knows the employment and pay information fills out this section.

1. What was the last date that the employee worked? ______________________

2. Amount of final paycheck (before taxes): $ ______________ Date received: ______________

   List the amounts (before taxes) and dates received for other paychecks received in the same month as the final paycheck:

AMOUNT RECEIVED (BEFORE TAXES)	DATE RECEIVED
$____________	____________
$____________	____________
$____________	____________
$____________	____________

3. Why did this job end?

   ☐ Lack of work ☐ Job was temporary/seasonal ☐ Laid off

   ☐ On leave (such as leave of absence or parental leave). Is it: ☐ Paid ☐ Unpaid

   If paid, how much is the employee paid: $______________

   When is the employee expected to return? ______________

   ☐ Other: ______________________

4. Will the employee receive any severance pay? ☐ yes ☐ No

   IF YES: When will it be received? ______________ How much will it be? $______________

5. Can the employee cash out vacation/sick pay? ☐ yes ☐ No

   IF YES: When will it be received? ______________ How much will it be? $______________

6. Can the employee withdraw retirement/pension/401K funds? ☐ yes ☐ No

   IF YES: When will it be received? ______________ How much will it be? $______________

Please provide the following in case we need to contact you:

SIGNATURE	DATE	TELEPHONE NUMBER
PRINT YOUR NAME HERE	**POSITION / TITLE**	