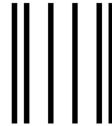
STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DIVISION OF CHILD SUPPORT

EMPLOYMENT TERMINATION NOTICE

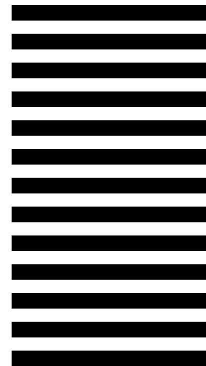
Use this form to report termination of employees for whom you had a requirement to withhold child support or enroll the employee's children in a health insurance plan. **Be sure to print your return address on the reverse side.**

YOUR BUSINESS OR COMPANY NAME	**YOUR TELEPHONE NUMBER**
EMPLOYEE'S NAME	DCS CASE NUMBER
EMPLOYEE'S LAST-KNOWN PO BOX OR STREET ADDRESS	TELEPHONE NUMBER
EMPLOYEE'S LAST-KNOWN CITY STATE ZIP CODE	SUBJECT TO REHIRE? ☐ YES ☐ NO
NEW EMPLOYER'S NAME/ADDRESS/TELEPHONE NUMBER	DATE EMPLOYMENT TERMINATED
	DATE HEALTH INSURANCE TERMINATED

EMPLOYMENT TERMINATION NOTICE
DSHS 18-560(X) (REV. 04/2006) (AC 04/2010)



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 256 OLYMPIA WA

POSTAGE WILL BE PAID BY ADDRESSEE

DEPARTMENT OF SOCIAL & HEALTH SVCS
DIVISION OF CHILD SUPPORT
PO BOX 11520
TACOMA WA 98411-9902