



STOP WORK

CSO/WORKER NAME	TELEPHONE NUMBER
CLIENT IDENTIFICATION NUMBER	DATE

Section 1: Fill out this section before taking it to your job that has ended.

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

SIGNATURE	DATE	PLEASE PRINT YOUR NAME HERE
NAME OF COMPANY		
COMPANY ADDRESS: STREET ADDRESS	CITY	STATE ZIP CODE

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

- What was the last date that the employee worked? _____
- 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
\$ _____	_____
\$ _____	_____
\$ _____	_____
\$ _____	_____
- Why did this job end?
☐ Lack of work ☐ Job was temporary/seasonal ☐ Laid off
☐ On leave (such as leave of absence or maternity leave). Is it: ☐ Paid ☐ Unpaid
 If paid, how much is the employee paid: \$ _____
 When is the employee expected to return? _____
☐ Other: _____
- Will the employee receive any severance pay? ☐ yes ☐ No
 IF YES: When will it be received? _____ How much will it be? \$ _____
- Can the employee cash out vacation/sick pay? ☐ yes ☐ No
 IF YES: When will it be received? _____ How much will it be? \$ _____
- 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	