

## Stop Work

	Washington State Department of Social & Health Services	Stop Work	DSHS MAILING ADDRESS DSHS PO BOX 11699 TACC DSHS PHONE NUMBER	DMA, WA 98411-9905 DSHS FAX NUMBER 888-338-7410				
	Section 1: Client, fill out this section before taking it to your job that ended.							
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CLI	ENT'S SIGNATURE	DATE	CLIENT: PLEASE PI	RINT YOUR NAME HE	RE		
NAME OF COMPANY / EX-EMPLOYER							
CO	MPANY / 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 rec	eived:			
	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 of	. ,		-			
	If paid, how much is the employee pai	d: \$					
	When is the employee expected to ret	urn?					
	Other:						
4.	Will the employee receive any severance p	pay? 🗌 yes	🗌 No				
	IF YES: When will it be received?		How much will it be	e? \$			
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:							
SIG	NATURE		DATE	TELEPHONE NUMB	ER		
PRI	NT YOUR NAME HERE		POSITION / TITLE	1			