VendorFiscal/Employer Agenct (VF/EA)
Financial Management Services (FMS)

DIRECT CARE WORKER TERMINATION NOTICE FORM

Use this form to notify _____ (Name of the Vendor Fiscal/Employer Agent [VF/EA] Financial Management Services [FMS]) when a direct care worker will no longer be working for you. Submit this form to _____ (Name of VF/EA FMS) within 24 hours of termination. List the date and reason why the direct care worker is no longer employed. The information provided on this form will help determine whether the direct care worker is eligible for unemployment benefits.

Please Check One: □ Voluntary Termination □ Involuntary Termination

Participant Information

Name:_____ **VF/EA FMS ID:** _____

Address: _____

Home Phone Number: ____/ ____/ _____ **Cell Phone Number:** ____/ ____/ _____

E-mail Address: _____

Direct Care Worker Information

Name:_____ **VF/EA FMS ID:** _____

Address: _____

Home Phone Number: ____/ ____/ _____ **Cell Phone Number:** ____/ ____/ _____

E-mail Address: _____

Last Date of Employment: _____/ _____/ _____

Employment Status: Part Time _____ Full Time _____
Number of Hours Usually Worked: Per Day _____ Per Week _____

Reason for Separation from Employment:
_____ Employee failed to report for work for _____ consecutive days
_____ Employee quit with verbal notice
_____ Employee quit with written notice
_____ Employer no longer had work available for employee at time of separation (lay-off)
_____ Employee dismissed (fired) for the following reasons: _____
_____
_____

Common Law Employer Name: (Please print or type): _____

Common Law Employer's Signature: _____ Date: _____

MAIL FORM TO:
CURRENT VENDOR