

## CAO NAME AND ADDRESS

DEPARTMENT OF HUMAN SERVICES  
530 13TH STREET  
FRANKLIN, PA 16323  
814-437-4342



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES



## CASE IDENTIFICATION

CO	RECORD NUMBER	CAT	CSLD	DIST
61	0112023	MHX	15	0
RECORD NAME <b>William Dolan</b>				DATE 11/21/2025

## Employment Termination Form

TO: William Dolan	SSN: <i>2d-74-8361</i>
----------------------	---------------------------

You have notified this office that you are no longer employed. Please have your employer complete this form and return it to the office no later than : 12/05/2025

A self-addressed return envelope is enclosed or you can fax this form to: 814-437-4441

EMPLOYER'S NAME: <i>EMMAUS HOUSE OF HOUSING</i>	EMPLOYER'S TELEPHONE NUMBER: <i>814 493-8791</i>
EMPLOYER'S ADDRESS: <i>580 Colbert Ave.</i>	
DATE EMPLOYMENT ENDED: <i>11/13/2025</i>	DATE OF FINAL PAY AND GROSS AMOUNT: <i>12/12/25 174.35</i>
MEDICAL COVERAGE (CHECK ONE): <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	IF YES, DATE ENDED:
IS EMPLOYEE ELIGIBLE FOR COBRA BENEFITS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	IF YES, NAME OF INSURANCE CARRIER:
GROUP/CONTRACT POLICY #:	DATE COVERAGE BEGAN:

What was the reason for the employee's termination? *Argument with co-worker*  
*insubordination*

EMPLOYER SIGNATURE <i>[Signature]</i>	DATE <i>1/13/2026</i>
TITLE <i>Director, Supported Housing Programs</i>	TELEPHONE # <i>814 493-8791</i>

