Alameda County
Social Services Agency

Department of Adult, Aging and Medi-Cal Services
In-Home Supportive Services
6955 Foothill Blvd., Suite 300
Oakland, CA 94605

PROVIDER LEAVE OR DISCONTINUANCE

Provider Name (Last, First)	
Address	City, State and Zip code
Telephone Number	Social Security Number

This form will serve as written request to:

☐ **Discontinue the provider's employment with the following recipient:**
☐ **Place the provider in Leave status (suspend my employment) for the following recipient:**

Recipient Information	
Name (Last, First)	
Case Number or Social Security Number	Telephone Number
Last day the provider worked	Total number of hours authorized from the first day of the month to the last day worked.

Reason(s) for discontinuance or Leave request:

☐ Quit/ Fired	☐ Recipient is in the hospital.
☐ Disability/Workers' Compensation injury	☐ Recipient is deceased.
☐ Recipient is no longer eligible for services.	
☐ Recipient is on vacation/out of County/State/Country. Anticipated Return Date .	
☐ Other reasons	

Person Completing Form: ☐ Recipient ☐ Provider ☐ Recipient's Authorized Representative	
Print Name	Date
Signature	

County Use Section