JAYNOLAN community services

Status Change

Employee Name: _____

Department No._____ Effective date of change: _____

New Hire: ✓☐New Employee ✓☐Rehire

Shift hours: _____ **Consumer's Name:** _____

✓☐Full Time (30 hrs. per week minimum)_____ **RFP No.:** _____

✓☐Part Time / Days & # of regularly scheduled hours per week: _____

✓☐Per Diem ✓☐Temporary/Duration of assignment: _____

Internal /Existing Employee: ✓☐New Dept. #:_____; ✓☐New Position: _____

Shift hours: _____ **Consumer's Name:** _____

✓☐Full Time (minimum 30 hrs. per week) _____ **RFP No.:** _____

✓☐Part Time / Days & # of regularly scheduled hours per week: _____

✓☐Per Diem ✓☐Temporary/Duration of assignment: _____

Classification: ✓☐New Employee ✓☐Rehire ✓☐Existing Employee/New position

New Job Title: _____ From: _____

New Shift Status: _____ From: _____

New Status: ✓☐Full Time ✓☐Part Time ✓☐Per-Diem ✓☐Temporary

Salary: From: $_____ Per_____ To: $_____ Per_____

Reason: ✓☐New Employee ✓☐Merit ✓☐Promotion ✓☐Demotion ✓☐Special Adjustment

Percentage Increase: _____% ***All salary changes require Executive Director approval.***

Termination:

✓☐Voluntary ✓☐Agency Wide ✓☐From Department No._____Only

✓☐Involuntary ***(If involuntary, termination must be reviewed with HR department prior to termination).***

Reason: _____

_____

Eligible for rehire in dept: ✓☐Yes ✓☐No

Supervisor: _____ Date: _____

Department Director: _____ Date: _____

Executive Director: _____ Date: _____

Payroll Department: _____ Date: _____

IHSS
CHANGE OF STATUS FORM

Date: _____ **Department No.:**_____

Consumer Name: _____

CHANGE IN STAFF

Terminated staff: Name: _____ Effective Date: _____

Terminated staff: Name: _____ Effective Date:_____

New Staff: Name: _____ Effective Date: _____

Monthly Hours: _____ Monthly Deduction Amount: _____

Pay period Hours: _____ Pay period Deduction Amount: _____

New Staff: Name: _____ Effective Date: _____

Monthly Hours: _____ Monthly Deduction Amount: _____

Pay period Hours: _____ Pay period Deduction Amount: _____

NEW IHSS PACKET INFORMATION

Date Requested: _____ Send packet(s) to: _____

_____

_____ Date: _____
Director's Signature

_____ Date: _____
IHSS Coordinator's Signature

_____ Date: _____
Payroll Signature

Updated: 02/25/2020 Xdrive/HR Employment/Forms