EXIT INTERVIEW FORMS

Instructions for Supervisor:

1. At a minimum all departing employees will complete pages 3-5 Explain to the employee that the information contained in these pages is vital in enabling us to provide them:
   a) timely final check, and
   b) timely W-2.

2. If possible, try to conduct an exit interview following the format on pages 6-8. Do not force the departing employee to participate; it would be helpful to the Organization only if the employee is cooperative.

3. If the departing employee is a current participant in the **Cafeteria Plan**, give them pages 9-10.

4. If the departing employee is a participant in the employer funded **profit-sharing program,** give them the following contact information:

MUTUAL OF AMERICA
303-694-6102

ALL COMPLETED PAGES 3 -8 ARE FORWARDED TO

THE SoCoCAA HUMAN RESOURCE COORDINATOR

PAGES 9 & 10 ARE GIVEN TO THE EXITING EMPLOYEE

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EXIT INTERVIEW FORM

Employee Name ____________________ Date ____________________

Interviewer Name ____________________ Department ____________________

EMPLOYEE COMPLETES THIS SECTION:

Please provide the following information so we may mail your W-2 form or any other important documents to the correct address or contact you if necessary.

Address ____________________ Phone ____________________

City State ____________________ Zip Code ____________________

I, ____hereby certify that all occupational illnesses and injuries have been reported to Southern Colorado Community Action Agency, Inc.

Employee's Signature Date ____________________

If all occupational illness and injuries have not been reported, please discuss this with your supervisor and/or the Human Resource Coorindator.

INTERVIEWER, PLEASE REVIEW THE FOLLOWING WITH THE EMPLOYEE:

1. SoCoCAA policy on references:

Employees will refer all requests from outside the Organization for personnel information concerning applicants, employees and past employees to the Human Resource Coordinator. If proper authorization to release information is in place, the inquiry may be referred to the Division Director with direction as to what can be released. The Human Resource Coordinator or the Executive/Development Director may verifiy wage and salary information and release the following without first obtaining the consent of the individual involved:

a) Employment dates;

b) Position held; and

c) Location of job site.

________________ Interviewer Initials

________________ Employee Initials

2. Duty to not disclose confidential information and/or compete:

It is the policy of the Organization that the general internal affairs of the Organization should not be discussed with anyone outside the Organization except as may be required in the normal course of business. Information designated as confidential is not to be discussed with anyone outside the Organization and only discussed within the Organization on a "need to know" basis. If you have had access to confidential information you may have been required to sign a confidentiality agreement and/or a covenant not to compete. <u>It is your continuing duty to honor these agreements.</u>

________________ Interviewer Initials

________________ Employee Initials

3. **SoCoCAA Property Inventory**

The employee and the interviewer have verified that all Southern Colorado Community Action Agency, Inc. property has been returned including keys and Personnel Policy & Procedures books (the latter should be verified with the Human Resource Coordinator.) If any property owned by the Organization and issued to the employee has been lost or damaged due to negligence or improper use, the cost of replacing such property shall be deducted from the employee's paycheck without reducing the employee's earnings for the final pay period below the current minimum wage.

________________ Interviewer Initials

________________ Employee Initials

4. **Benefits:**

Your benefit coverage ends on the effective date of your termination.

If you were enrolled in the Organization's health care plan, you will be contacted by an Organization representative with an explanation of your options for continuation of that benefit through COBRA. If you decide to continue through COBRA, all premiums will be 100% your responsibility.

________________ Interviewer Initials

________________ Employee Initials

INTERVIEWER'S COMMENTS:

INTERVIEWER – PLEASE ASK THE EMPLOYEE TO COMPLETE THE FOLLOWING QUESTIONNAIRE IN PRIVACY, THEN RETURN IT TO ________________________________FOR DISCUSSION.

1. What is your major reason for leaving?

[ ] A. Other Employment

- [ ] Southern Ute Indian Tribe
- [ ] Tribal related program
- [ ] Another local employer
- [ ] Self-employment
- [ ] A Durango employer
- [ ] Other (describe)

[ ] B. Personal

- [ ] Health
- [ ] Child care
- [ ] Pregnancy/child birth
- [ ] Transportation problems
- [ ] Marriage/spouse relocation
- [ ] Full-time student
- [ ] Leaving the area
- [ ] Other (describe)

[ ] C. Job related

- [ ] Retirement
- [ ] Discharge
- [ ] Layoff
- [ ] Job stress/pressures (describe)
- [ ] Relationship with Supervisor
- [ ] Relationship with co-workers
- [ ] Working conditions (describe)
- [ ] Work load
- [ ] Little opportunity to advance
- [ ] Job not challenging to you
- [ ] Lack of training
- [ ] Benefits
- [ ] Salary
- [ ] Other (describe)

2. What did you like most about your job?

3. **What did you like least about your job?**

5. **What could the Southern Colorado Community Action Program, Inc. do to prevent you from leaving your job?**

6. **How is your new job better than the one you are leaving?**

6. **Any other comments/suggestions you would like to make?**

NOTICE TO EXITING EMPLOYEES WHO PARTICIPATED IN CAFETERIA PLAN

Employee's Name____

Our records indicate that you were a participant in the Southern Colorado Community Action Agency, Inc. Flexible Spending Account prior to your termination. When you terminate employment, you are entitled to receive the balance of the contributions you have made. However, the IRS requires that you follow specific rules. The rules are different for both the Dependent Care Assistance Program and the Health Care Reimbursement Plan.

Health Care Reimbursement Plan (HCRP)

If you still have a balance in the HCRP, you can elect to continue your participation in the HCRP for the remainder of the Plan year, subject to the following conditions.

1. You may continue to participate in HCRP if you have contributed more money than you have been reimbursed in claims. If you incurred a health claim prior to your termination date, but have not submitted the claim to Discovery Benefits, and the claim is equal to or greater than your current balance, you may receive reimbursement for your balance without electing FSA-COBRA.

2. If you continue to have a balance after submitting all receipts for services received prior to your termination date and you wish to receive the balance in your account, you must elect FSA-COBRA and you must continue to pay for the coverage throughout the current plan year just as if money has been taken out of your paycheck, but on an after-tax basis. If you do not elect FSA-COBRA, you balance will be forfeited.

3. If you wish to elect FSA-COBRA, you must complete the attached *Section 125 Cafeteria Plan Health Flexible Spending Account COBRA Notice/Election* form, and return it to Discovery Benefits along with your contribution no later than 60 days from the date the form was mailed to you.

Dependent Care Assistance Program

If you still have a balance in the Dependent Care Assistance Program, you may continue to send Discovery Benefits qualified receipts until you have been reimbursed the entire amount of your balance. All plan rules apply.

You do not have to elect FSA-COBRA to receive your balance for the Dependent Care Assistance Program and no further salary reduction contributions may be made.

Under all circumstances, your claims for the current plan year must be submitted to Discovery Benefits within 60 days of the end of the current plan year.

Termination Date________________________Date Notice Mailed________________________

SoCoCAA

Section 125 Cafeteria Plan Medical Reimbursement Account

COBRA Notice/Election

Name: ____ SSN: _____________

Street Address: ____

City: ______________________ State: ____________ Zip: _____________

Termination Date: _____________ Day Time Phone Number: _____________

This is to inform you that you may have a balance in your Section 125 Cafeteria/Flexible Spending Account. All expenses you claim must be incurred during your period of coverage. If you still have a balance in your account, you may elect COBRA and extend your period of coverage. To keep your plan active under COBRA, you must continue to contribute your current election through the end of the current plan year.

Please note that your monthly contribution, along with this form, must be mailed to:

Discovery Benefits
P. O. Box 869
Fargo, ND 58107

Discovery Benefits must receive your contribution with this form. If any subsequent monthly contribution(s) are not received on time (the first day of each month), you will lose your option to continue coverage. You may submit your total contributions for the balance of the year at one time. You have 60 days from the date you receive this notice to elect to continue coverage. Please call Discovery Benefits with any questions, at 1-866-451-3399.

I wish to continue participation in my Medical Reimbursement Account. [ ] Yes [ ] No

____ ________________

Signature **Date**

Enclosed is my contribution of $_________for one month, or $_________ for _______months.