EL DORADO COUNTY HEALTH AND HUMAN SERVICES AGENCY

MONTHLY ATTENDANCE REPORT

PLEASE SUBMIT BY THE 5TH OF THE FOLLOWING MONTH

Month and Year: _____ Case Number: _____

Client Name: _____ Case Manager: _____

Codes for Missing Time: AB – Absent**, S –** Sick**, H –** Holiday (Attach verification of sick time if available)

My lunch time is ☐ ½ hour ☐ 1 hour - Do not include travel time

Activity #1: I certify that this information is correct and the person listed above is making good progress in this activity.

_____
Verifier's Name (Please Print)

_____
Signature

_____
Title

_____
Phone

_____
Date

Activity #2: I certify that this information is correct and the person listed above is making good progress in this activity.

_____
Verifier's Name (Please Print)

_____
Signature

_____
Title

_____
Phone

_____
Date

	Activity #1		Activity #2		County Use Only
1	TO	1	TO	1	
2	TO	2	TO	2	
3	TO	3	TO	3	
4	TO	4	TO	4	
5	TO	5	TO	5	
6	TO	6	TO	6	
7	TO	7	TO	7	
8	TO	8	TO	8	
9	TO	9	TO	9	
10	TO	10	TO	10	
11	TO	11	TO	11	
12	TO	12	TO	12	
13	TO	13	TO	13	
14	TO	14	TO	14	
15	TO	15	TO	15	
16	TO	16	TO	16	
17	TO	17	TO	17	
18	TO	18	TO	18	
19	TO	19	TO	19	
20	TO	20	TO	20	
21	TO	21	TO	21	
22	TO	22	TO	22	
23	TO	23	TO	23	
24	TO	24	TO	24	
25	TO	25	TO	25	
26	TO	26	TO	26	
27	TO	27	TO	27	
28	TO	28	TO	28	
29	TO	29	TO	29	
30	TO	30	TO	30	
31	TO	31	TO	31	

I declare under penalty of perjury the facts contained in this report are true and correct to the best of my knowledge.
I understand that supportive services such as Child Care and Mileage Reimbursement may be delayed, changed, denied or stopped and my cash aid may be reduced without verification of attendance.

Participant Signature: _____ Date: _____

Case Manager Signature: _____ Date: _____

EL DORADO COUNTY HEALTH AND HUMAN SERVICES AGENCY

INFORME MENSUAL DE ASISTENCIA

POR FAVOR DE ENVIAR ANTES DEL DIA 5 DEL MES SIGUIENTE.

Mes Y Año: _____ Numero del Caso: _____

Nombre del Cliente: _____ Nombre del Trabajador/a:_____

Codigos para Tiempo Perdido: AB – Ausente**, S –** Enfermo**, H –** Vacaciones (Adjuntar verificación del tiempo de enfermedad)

Tiempo del almuerzo ☐ ½ hora ☐ 1 hora – No incluya el tiempo de viaje

Activity #1: I certify that this information is correct and the person listed above is making good progress in this activity.

_____
Verifier's Name (Please Print)

_____
Signature

_____
Title

_____
Phone

_____
Date

Activity #2: I certify that this information is correct and the person listed above is making good progress in this activity.

_____
Verifier's Name (Please Print)

_____
Signature

_____
Title

_____
Phone

_____
Date

	Actividad #1		Actividad #2		Uso del Condado Solamente
1	DE	A	DE	A	
2	DE	A	DE	A	
3	DE	A	DE	A	
4	DE	A	DE	A	
5	DE	A	DE	A	
6	DE	A	DE	A	
7	DE	A	DE	A	
8	DE	A	DE	A	
9	DE	A	DE	A	
10	DE	A	DE	A	
11	DE	A	DE	A	
12	DE	A	DE	A	
13	DE	A	DE	A	
14	DE	A	DE	A	
15	DE	A	DE	A	
16	DE	A	DE	A	
17	DE	A	DE	A	
18	DE	A	DE	A	
19	DE	A	DE	A	
20	DE	A	DE	A	
21	DE	A	DE	A	
22	DE	A	DE	A	
23	DE	A	DE	A	
24	DE	A	DE	A	
25	DE	A	DE	A	
26	DE	A	DE	A	
27	DE	A	DE	A	
28	DE	A	DE	A	
29	DE	A	DE	A	
30	DE	A	DE	A	
31	DE	A	DE	A	

Declaro bajo pena de perjurio que los hechos contenidos en este informe son verdaderos y correctos a lo mejor de mi conocimiento. Yo entiendo que servicios de apoyo tales como cuidado de niños y el reembolso de kilometraje pueden ser retrasados, cambiados, negados o parados y mi asistencia monetaria puede ser reducida sin la verificación de asistencia.

Firma del Participante: _____ Fecha: _____

Firma del Trabajador/a: _____ Fecha: _____