

COUNTY OF LOS ANGELES  
DEPARTMENT OF PUBLIC SOCIAL SERVICES

Monthly Attendance Report Form

Date: \_\_\_\_\_  
 Case Name: \_\_\_\_\_  
 Case Number: \_\_\_\_\_  
 Worker Name: \_\_\_\_\_  
 Worker ID: \_\_\_\_\_  
 Worker Phone Number: \_\_\_\_\_  
 Customer ID: \_\_\_\_\_

\_\_\_\_\_  
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Report for the Month of \_\_\_\_\_ 20\_\_

In order to make sure that we provide you with transportation and other services, we need you to record your monthly attendance in each of your Welfare-to-Work Activities. In the boxes below, tell us about your Welfare-to-Work Activities listed below for the month of \_\_\_\_\_ Year \_\_\_\_\_. Please give this form to your service provider listed so they can verify your hours. Return this form to your GAIN Services Worker/REP Case Manager (GSW/RCM) on or before the **10th** of the month following the Report Month. Failure to provide this form by the due date may affect your eligibility to receive transportation and other services. If you have any questions, please contact your GSW/RCM.

GSW/RCM Name: _____	Worker ID: _____	GSW/RCM Phone: _____	Fax: _____
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**Please record hours of attendance and excused absences. If absent please write reason for absence and attach verification.**

Activity: _____													Scheduled Hours:			
Provider #1:																
Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Hours																
Day	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
Hours																

\* Colleges verify enrollment only Provider #1 Stamp:

Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- I still need  transportation  child care and/or  other services  
 I am requesting to begin receiving  transportation  child care and/or  other services

One Stamp  
per Provider

**Absence Reporting**

Date(s)	Hours absent	Reason(s) you did not Attend	County use only: Number of hours GSW validates and lists source

Activity: _____													Scheduled Hours:			
Provider #2:																
Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Hours																
Day	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
Hours																

\* Colleges verify enrollment only Provider #2 Stamp:

Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- I still need  transportation  child care and/or  other services  
 I am requesting to begin receiving  transportation  child care and/or  other services

One Stamp  
per Provider

**Absence Reporting**

Date(s)	Hours absent	Reason(s) you did not Attend	County use only: Number of hours GSW validates and lists source

I hereby certify the information listed above is true and correct. In addition, I authorize the release of information to DPSS/State/Federal agencies for purposes of auditing, monitoring and verifying information.

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_