ATTENDANCE VERIFICATION

SIDE I – CLIENT COMPLETES THIS SECTION Month & Year: _____
DUE by the 5th of the following month Case Number: _____

1. **Please complete SIDE II of this Attendance Verification form with the total hours of your CalWORKs Welfare-to-Work (WTW) activities. You must sign and date SIDE II of this form.**

2. Client's Name (First, Middle, Last): _____ SSN (last 4 digits): _____
   Address: _____
   Case Name: _____ Client's Email Address: _____
   Worker Name: _____ Worker ID: _____ Worker Phone # _____
   Office Address: _____ Worker Email: _____

3. You are required to participate in your assigned CalWORKs WTW activity(ies) and/or work.
   Since your last Attendance Verification report, have there been any changes to the following?
   (If yes, check the box and briefly explain the change.)

☐ Address: _____ ☐ Email: _____
☐ Home Phone: _____ ☐ Cell Phone: _____ ☐ Child Care Provider: _____
☐ Other Changes: _____ ☐ Employment: _____

4. **If employed, copies of paycheck stubs should be included.**
   - Forms are available at the Employment Connection website https://ecstaffing.santaclaracounty.gov/home
   - Completed forms may be returned to our office by uploading them to https://benefitscal.com

I UNDERSTAND THAT:

- I am certifying I worked or participated in my CWES activity(ies) on the days and for the number of hours listed on Side II.
- If I do not send in a completed "Attendance Verification" (SCD 1755A), my supportive services, such as transportation or work/education and training-related payments may be delayed, changed, denied, or stopped.
- I have the right to choose the child care provider who is best for me and my child(ren), but I must contact my worker prior to requesting any changes.
- The provider must have a license or be exempt from having a license in order for me to get child care payment approved by CalWORKs.
- If I choose a license-exempt child care provider, (s)he must apply for or be TrustLine registered and meet Health & Safety Certification criteria unless (s)he is an aunt, uncle, grandparent, exempt school, or recreation program providing care.
- The information on this form may be shared with other state and local agencies, Resource and Referral Programs, Alternative Payment Programs (APPs) and federal agencies, including the Internal Revenue Service (IRS) and the Franchise Tax Board (FTB).
- I must pay back any child care and transportation or other supportive service payments that I am not entitled to receive.
- The County is not the child care provider's employer, and does not have a business relationship with the provider when a child care payment is paid.
- **If I choose child care in my home, I am the employer. I am responsible for the Social Security tax. I understand that if I have the child care provider work 20 hours a week or more in my home, I must pay at least minimum wage and be responsible for state disability, and federal and state unemployment taxes according to the Fair Labor Standards Act (FLSA). Pursuant to the Healthy Workplaces, Healthy Families Act of 2014, I must provide at least one hour of paid sick leave after every 30 hours worked, available to the employee on the 90th day of employment.** I am authorizing the County to get any verification necessary to process this request and that statements made on this form are subject to investigation.

5. My travel time from home/childcare provider site to my activity each way is: _____. In the Lunch field of the table on SIDE II, enter lunch time in numbers.

6. • List the activity name, number of hours worked and/or participated each day in the report month. Complete the form on a daily basis. If you are participating in more than 3 activities, use an additional form. **If absent, indicate the date(s) and reason(s) such as Sick, Medical, Jury Duty, or Holiday:**

- **Provider sign-off is required for non-paid activities.** (Do not include your travel time or lunch time in the total hours.)

SIDE II – CLIENT COMPLETES THIS SECTION Month & Year: _____

Client Name: _____ SSN (last 4 digits): _____ Case Number: _____

Activity 1:_____ **Activity 2:** _____ **Activity 3:**_____

Date	Participation Time	Lunch	Total Hrs.	Participation Time	Lunch	Total Hrs.	Participation Time	Lunch	Total Hrs.	Total Hours Per Day
Example	*8:00am to 3:00pm*	*60*	*6*	*4:00pm to 6:00pm*	*0*	*2*	*7:00pm to 8:00pm*	*0*	*1*	*9*
1	**to**			**to**			**to**			
2	**to**			**to**			**to**			
3	**to**			**to**			**to**			
4	**to**			**to**			**to**			
5	**to**			**to**			**to**			
6	**to**			**to**			**to**			
7	**to**			**to**			**to**			
8	**to**			**to**			**to**			
9	**to**			**to**			**to**			
10	**to**			**to**			**to**			
11	**to**			**to**			**to**			
12	**to**			**to**			**to**			
13	**to**			**to**			**to**			
14	**to**			**to**			**to**			
15	**to**			**to**			**to**			
16	**to**			**to**			**to**			
17	**to**			**to**			**to**			
18	**to**			**to**			**to**			
19	**to**			**to**			**to**			
20	**to**			**to**			**to**			
21	**to**			**to**			**to**			
22	**to**			**to**			**to**			
23	**to**			**to**			**to**			
24	**to**			**to**			**to**			
25	**to**			**to**			**to**			
26	**to**			**to**			**to**			
27	**to**			**to**			**to**			
28	**to**			**to**			**to**			
29	**to**			**to**			**to**			
30	**to**			**to**			**to**			
31	**to**			**to**			**to**			
Total:	**Activity 1:**			**Activity 2:**			**Activity 3:**			
Provider's Signature										

CERTIFICATION: I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained on SIDE I and SIDE II on this Attendance report is true and correct.

Client's Signature: _____ **Phone No:** _____ **Date:** _____

Worker Name & ID: _____ Total Actual Monthly Hrs: _____ Date: _____