



Work First Referral & Attendance Record

I. Client Identification

Client Name: _____
 Client Address: _____
 Client Social Security Number: _____
 TANF Case Number: _____
 Client Telephone Number: _____

Work First Activity Identification

Contact Name: _____
 Company: _____
 Street Address: _____
 City, State and Zip: _____
 Contact Telephone Number: _____

II. Referral

Report to: _____
 on: _____ at: _____ Telephone: _____
 Maximum monthly pay after performance hours: _____
 Total activity hours, if different: _____
 Referring Organization Work First Caseworker: _____
 Address: _____

III. Schedule for pay after Performance and other Work First activities.

Subsidized Employer: Client may not work more than 40 hours per week. If over 8 hours per day, Provider Manager approval is needed.

Date	In Time	Lunch Start Time	Lunch End Time	Time Out	Total Hours	Client Signature (sign daily)	Date	In Time	Lunch Start Time	Lunch End Time	Time Out	Total Hours	Client Signature (sign daily)

Total Hours Worked: _____ Is lunch paid? Yes No
 Should client be reassigned to this employer/location? Yes No

Note: This form must be returned by Work First Pay After Performance Activity Organization directly to the referring Work First Provider/Caseworker no later than the 5th calendar day of the subsequent month. Forms will not be accept from Work First Clients.

IV. Payment Calculation (to be completed by Caseworker/Provider)

a ___ x b ___ = c ___ d ___ - c ___ = e ___
 a=pay after performance hours; b=hourly reduction rate as on 4044; c=amount of grant reduction; d=cash benefit listed on 4044; e=amount issued to client

Date amount issued to client: _____ Work First Signator: _____