



# RESPONSIBILITY AND SERVICES PLAN ATTENDANCE AND ACTIVITY REPORT

Attendance Record for Week Ending (Friday): \_\_\_\_\_

Customer First Name: \_\_\_\_\_ Customer Last Name: \_\_\_\_\_

Provider: \_\_\_\_\_  20 Hours  30 Hours  Deem

DHS Case Number: \_\_\_\_\_ IDHS FCRC: \_\_\_\_\_ LO # \_\_\_\_\_

**Primary Core Activities:** Job Search/Job Readiness-200 Work First-211 Subsidized Employment-282 Community Service-346  
Vocational Education Training-350 Teen Parent High School/GED-355 Work Experience-530 Self-Employment-801 Employment-802

**Secondary Non-Core Activities:** Job Skills Training - 222 Education Related to Employment - 356

Non-Countable:\* Bachelor Degree - 342 Voc. Rehabilitation - 611 Alcohol/Substance Abuse - 783 Mental Health - 788 Medical-616 Domestic Violence-784

Hours Assigned = Time customer is expected to perform activity in a week Regular = Actual time spent in activity Absent = time missed due to absence

Location:																
Activity 1 Code	Activity 2 Code				Activity 3 Code				Activity 4 Code							
Hours Assigned:	Hours Assigned:				Hours Assigned:				Hours Assigned:							
Regular Hours	Min	Absent Hours	Min	Regular Hours	Min	Absent Hours	Min	Regular Hours	Min	Absent Hours	Min	Regular Hours	Min	Absent Hours	Min	
Reported																
Countable	Activity 1				Activity 2:				Activity 3:				Activity 4:			

Total Reported Hours: \_\_\_\_\_ Minutes: \_\_\_\_\_ Total Countable Hours: \_\_\_\_\_ Minutes: \_\_\_\_\_

\*SHADED ITEMS MAY BE COUNTABLE

Reconciliation Date: \_\_\_\_\_  Sanction/SWAP Recommended SWAP Effective: \_\_\_\_\_ Sanction Effective: \_\_\_\_\_

I have approved these activities. The information on this form is correct to the best of my knowledge.

Certifying Name: \_\_\_\_\_ Date: \_\_\_\_\_ Telephone: \_\_\_\_\_

Comments regarding absences, reconciliation, student progress, and employment

I have reviewed the information submitted on this report and have correctly entered all countable and reportable hours.

Caseworker Signature: \_\_\_\_\_ Date: \_\_\_\_\_

New Employment: Providers are required to report new employment information to DHS within 48 hours.

Employer Name: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Start Date: \_\_\_\_\_ First Pay Date: \_\_\_\_\_

Job Title: \_\_\_\_\_

Hourly Wage: \_\_\_\_\_ Hours/Week: \_\_\_\_\_ Pay Frequency: \_\_\_\_\_ Health Insurance:  Yes  No