Form #12

Monthly Individual Attendance and Service Hour Report

PROGRAM: _____
Name

_____
Address

_____
City State Zip

DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES

Report Period _____
Month Year

Program Type _____

Program ID#: _____

NUMBER OF ATTENDANCE DAYS OR TOTAL SERVICE HOURS* (as applicable):

Last Name, Initial	I.D. #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	T

I CERTIFY THAT THE SERVICE INFORMATION IS CORRECT

Service hours should combine HSAC and DDD hours
For group homes, if applicable, also list any clients on respite status

_____ _____
Signature Title Date

KEY: H - Holiday
T – Day Service - Training
W - Weekend

A - Absent
P - Present

Revised 3/98