

Date Received

For office use only

SNCS-Grass Valley
Service Month _____
 Must be received by the 5th of the following month.

Mail To:
 256 Buena Vista, Suite 110
 Grass Valley CA 95945
 (530) 272-8866

Parent:	Child:	Age:	Child ID:
Provider:	Address:		Phone:
Program:	Specialist:		Family ID:
Provider APID:	Provider Type:		Provider ID:

	SUN	MON	TUES	WED	THU	FRI	SAT
Regular Schedule							
Vacation Schedule							

PARENT SIGN IN THIS COLUMN ONLY			PROVIDER MUST INITIAL IF CHILD HAS A SPLIT SCHEDULE				PARENT SIGN IN THIS COLUMN ONLY			OFFICE USE
DAY OF MONTH	TIME IN	PARENT'S SIGNATURE	TIME OUT	PROVIDER INITIALS	TIME IN	PROVIDER INITIALS	TIME OUT	PARENT'S SIGNATURE	ABSENCE REASON	TOTAL HOURS
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
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31										

OFFICE USE ONLY				
TOTAL HOURS OF CARE	_____	x	HOURLY PAY	\$ _____ = \$ _____
TOTAL DAYS OF CARE	_____	x	DAILY PAY	\$ _____ = \$ _____
TOTAL WEEKS OF CARE	_____	x	WEEKLY PAY	\$ _____ = \$ _____
TOTAL MONTHS OF CARE	_____	x	MONTHLY PAY	\$ _____ = \$ _____

COUNSELOR

I verify under penalty of perjury that by signing this attendance sheet for services provided in the above named month, that the hours and days of child care provided for this child are true and correct. This is the same rate charged to non-subsidized families. I understand that I will be paid only for hours authorized on the current Child Care Certificate. I certify the accuracy of the hours on this attendance sheet.

Child ID

Provider ID

SIGNATURE OF PROVIDER

SIGNATURE OF PARENT