State of Illinois

Department of Human Services

RESPONSIBILITY AND SERVICES PLAN ATTENDANCE AND ACTIVITY RECORD

ATTENDANCE RECORD FOR WEEK ENDING (FRIDAY): _____

CUSTOMER NAME: _____ PROVIDER: PROJECT CHOICE

DHS CASE NUMBER: _____ DHS FCRC: _____

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

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

Non-Countable Other Activities: Bachelor Degree Program-342 Vocational Rehabilitation Services-611 Medical/Family Care Barrier-616 Domestic Violence-784 Mental Health-788 Alcohol/Substance Abuse-783 Child Support-612 Child Safety-615 Basic Needs-614 Health-613

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_____ **Hours Assigned:**_____				**Activity 2 code**_____ **Hours Assigned:**_____				**Activity 3 code**_____ **Hours Assigned:**_____				**Activity 4 code**_____ **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
Saturday / /																
Sunday / /																
Monday / /																
Tuesday / /																
Wednesday / /																
Thursday / /																
Friday / /																
TOTAL:																

I agree that I spent the amount of time in the above activities as reported on this form. I understand that if I do not follow through with this plan, including the steps I need to be successful; it could result in denial of my application, loss/reduction of my TANF benefits, and/or prosecution for fraud, if I falsify information. If I do not agree with any decision made by the Department of Human Services I may appeal this decision.

Customer Signature: _____ **Date:** _____

I have approved these activities. The information on this form is correct. _____

Provider/Casework Manager Signature **Date** **Phone**

Comments re: customer absences, reconciliation (attach reconciliation forms), employment hours: _____

_____

NEW EMPLOYMENT: Providers are required to report new employment information to DHW within 48 hours.

Employer name: _____ Contact person: _____

Employer address: _____ Phone:_____ Fax#: _____

Job title: _____ Start date: _____ First pay date: _____

Wages/hr: _____ Hours/wk: _____ Pay frequency: _____ Health Insurance: ( ) YES ( ) NO