DEPARTMENT FOR SELF RELIANCE
DIVISION OF SOCIAL SERVICES
Work Participation Time Sheet

Name:_____ **CIF:**_____ **Case Type:**_____ **Month/Yr:**_____

Authorized Work Activities Week ending: _____	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Worksite Verification

Authorized Work Activities Week ending: _____	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Worksite Verification

Authorized Work Activities Week ending: _____	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Worksite Verification

Authorized Work Activities Week ending: _____	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Worksite Verification

Authorized Work Activities Week ending: _____	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Worksite Verification

I certify the information provided is accurate and true. I understand this information is subject to verification by the Department for Self Reliance and, if I do not meet the minimum work participation hours requirement, my monthly assistance amount may be reduced or my case may be closed.

Customer Signature: _____ Date:_____

Date Received: _____ Hours Entered By/Date_____

Reviewed By: _____ Total WP Hours:_____ Weekly Average: _____ WP Code: _____