Month/Year:

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES Division of Family Assistance Participant Time Sheet

Participant's Name:				Site Supervisor's Name:
PIN No.:				Site Supervisor's Phone No.:
Work/Training Site:				WP Activity Code: Contract No.:
Month/Day	Work/Training Miles/ Hours/Minutes Day		Reason for Absence	TO BE COMPLETED BY THE PARTICIPANT'S SUPERVISOR
				Work/Study Habits: Good Satisfactory Needs Improvement
				Supervisor's Comments:
				TO BE COMPLETED BY THE PARTICIPANT
				□ I agree □ I disagree with the evaluation of my performance.
				Participant's Comments:
				Certification: I certify that the information on this form is correct to the best
				of my knowledge and the statements are made in good faith. I know that
				federal funds are involved and penalties are prescribed by law for willful
				misrepresentation of facts in order to obtain payments or services.
				Participant's Signature:
				Site Supervisor's Signature:
				DHHR STAFF USE ONLY
				I. Actual Attendance Hours:
				+ Homework Hours Excused Absence Hours:
				Federal Holiday Hours:
				= Total Monthly Hours:
				II. Excused Absence Hours for the past 12 months
				III. Transportation Payment : # Days X \$ Per Day = \$
				IV. Additional Notes: $V = V = V = V = V = V = V = V = V = V $
TOTAL				

This time sheet must be submitted to the local DHHR office by the 5th day of the next month.