In-Home (License Exempt) Attendance Calendar

Provider: _____ **Prepared by:** _____ **Date Prepared:** _____

Address: _____ **Phone:** _____ **Mo/Year:** _____

Attendance by Days, the 1st through the 15th – indicate AM or PM after in and out times, or use military time (1300, 1400, etc)

Child's Name		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	TOTAL
1.	IN																HOURS
	OUT																
	IN																
	OUT																
Total hours per day																	
Hour (HR) Units Billed																	

Parent Signature: _____ Date: _____

Provider Signature: _____ Date: _____

You must only report the time that a child is scheduled to be in attendance and record the actual number of hours of care provided each day, which may include up to 5 absent days per month. Providers are required to retain attendance calendars for four years. DHHS may request these records for auditing purposes.

WARNING TO PARENTS: Do not sign blank calendars. By signing, you agree that the times recorded on this attendance sheet accurately reflect the attendance of your child(ren) with this care provider. If you sign a blank calendar or a calendar with inaccurate time and attendance, you may be billed for any improper charges. You will also be expected to pay for care that was not for an activity authorized by DHHS.

WARNING TO PROVIDERS: Do not ask a parent to sign a blank calendar. Make sure you have completed the form before the parent signs it. If the time entered on this document is incorrect, you may be assessed an overpayment.

In-Home (License Exempt) Attendance Calendar

Provider: _____ **Prepared by:** _____ **Date Prepared:** _____

Address: _____ **Phone:** _____ **Mo/Year:** _____

Attendance by Days, the 16th through the 31st – indicate AM or PM after in and out times, or use military time (1300, 1400, etc)

Child's Name		16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL
1.	IN																	HOURS
	OUT																	
	IN																	
	OUT																	
Total hours per day																		
Hour (HR) Units Billed																		

Parent Signature: _____ Date: _____

Provider Signature: _____ Date: _____

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