Solano County Health & Social Services Department
Employment and Eligibility Services

CalWORKs Monthly Attendance/Transportation Sheet

Workers's Name/Workers's Number: _____

Participant's Name: _____

Address: _____

_____

Telephone: _____

Case Number: _____

WTW ☐ Cal-Learn ☐

Employed ☐ Attending School ☐

Other approved WTW Activity ☐

Request for Transportation Payment – **Yes** ☐ **No** ☐

Month/Year

Please complete the following information. Attach proof of attendance and activity participation; pay stubs, time sheets, grades, etc., by the 10th of the month. When proof is not attached, your transportation reimbursement may go down or stop.

Date	Day of Week	Total Miles	Tolls	Public Transportation	Activities	Activity Locations
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
	Totals:					

If requesting mileage reimbursement, I certify that I have a valid driver's license, current vehicle registration, and auto insurance as required by California State law. I certify under penalty of perjury that the statement above is true and correct and that incorrect information may result in an overpayment.

➡ Participant Signature: _____ Date: _____

➡ Worker Signature: _____ Date: _____

Worker's Name/Number: _____ **Month/Year:** _____

Case Name: _____ **Case Number:** _____

Activity 1 _____				Activity 2 _____				Activity 3 _____			
Date	Start Time	End Time	Total Time	Date	Start Time	End Time	Total Time	Date	Start Time	End Time	Total Time
1				1				1			
2				2				2			
3				3				3			
4				4				4			
5				5				5			
6				6				6			
7				7				7			
8				8				8			
9				9				9			
10				10				10			
11				11				11			
12				12				12			
13				13				13			
14				14				14			
15				15				15			
16				16				16			
17				17				17			
18				18				18			
19				19				19			
20				20				20			
21				21				21			
22				22				22			
23				23				23			
24				24				24			
25				25				25			
26				26				26			
27				27				27			
28				28				28			
29				29				29			
30				30				30			
31				31				31			
Total Hours				**Total Hours**				**Total Hours**			
Provider Stamp & Signature				Provider Stamp & Signature				Provider Stamp & Signature			

I Certify under penalty of perjury that the above information is a true and accurate record.

_____ Participant Signature/Date

_____ Worker Signature/Date