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|  |  DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA) **Service Verification / Attendance Record for Alternative Living Providers** |
| **Service Verification / Attendance Record for Alternative Living Providers** |
| CLIENT’S NAME | SERVICE PROVIDER’S NAME | CASE RESOURCE MANAGER’S NAME | SERVICE MONTH | YEAR |
|  |
| DAY OF MONTH | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| **A** | **TIME SERVICE BEGAN** | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM |
| **B** | **TIME SERVICE ENDED** | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM |
| **C** | **TOTAL HOURS EACH DAY** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **D** | **PROVIDER MILEAGE** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |
| DAY OF MONTH | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | MONTHTOTALS |
| **A** | **TIME SERVICE BEGAN** | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM |
| **B** | **TIME SERVICE ENDED** | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM | **:**[ ]  AM[ ]  PM |
| **C** | **TOTAL HOURS EACH DAY** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **D** | **PROVIDER MILEAGE** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |
| CLIENT / PARENT / GUARDIAN’S SIGNATURE DATE | SERVICE PROVIDER’S SIGNATURE DATE |
| **Instructions**A. Enter time service began: Indicate AM or PM as appropriate.B. Enter time service ended: Indicate AM or PM as appropriate.C. Provider Mileage: If authorized in the client’s PCSP, enter miles traveled with the client in the car for the purpose of providing service.D. Maintain completed verification forms in your records for six (6) years. Copies must be submitted monthly to the client’s case manager. Copies may also be requested by DDA / DSHS at any time.This form is available on the DSHS forms internet site at: <https://www.dshs.wa.gov/fsa/forms>.  |