 **PROGRAM HOURS\***

(FAMILY &/OR CHILD PRESENT)

|  |  |  |  |
| --- | --- | --- | --- |
| **FAMILY NAME:** |  | **MONTH / YEAR:** |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DATE** | **LEAD STAFF (NAME / TITLE)** | **PROGRAM HRS** | **LEAD INITIAL** |  | **DATE** | **LEAD STAFF (NAME / TITLE)** | **PROGRAM HRS** | **LEAD INITIAL** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

I verify that the above-noted program hours were designated to my child this month:

|  |  |  |
| --- | --- | --- |
| ***Parent / Guardian Signature*** |  | ***Date*** |

\*Does not include Essential Supporting Activities; this indirect time may include travel, planning, documentation, report writing, scheduling, team meetings and other indirect activities related to your family’s program.

For Specialized Services programs, Clinical Coordinator time will be accounted for at a minimum of 4 hours/month to assure high program quality.