

CALDWELL COUNTY DSS DAY CARE ATTENDANCE SHEET-BACK DAY CARE PAYMENTS WILL BE LIMITED TO A MAXIMUM OF 30 DAYS

Day Care Center: _____
 Address: _____

Month/Year: _____
 Telephone # _____
 # of Private Paying Children _____

Facility ID# _____

*****Please list children in alphabetical order

| | Name of Child | Age | Name of Parent | PLAN of Care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Office Use Only | | Shift |
|----|----------------------------|-----|-----------------|--------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----------------|-----------|-------|
| | | | | | 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 | Full Days | Part time | |
| | July ex. Appleseed, Johnny | 8 | Appleseed, Mary | B/A | \ | \ | \ | | | C | C | C | C | C | | \ | \ | \ | \ | U | | \ | \ | A | \ | A | | | A | A | T | | | | | | | |
| 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

***LEAVE weekend dates blank or black out blocks

Plan of Care Codes

Hours =

Dates 1-31 Codes

Shift Codes

F =Full time
 3/4 = 3/4 time care
 1/2 = 1/2 time care
 B/S =Before School
 A/S =After School
 B/A =Before/After School
 J= Joint custody

6 1/2 - 11 hours
 3 1/2 -6 1/4 hours
 less than 3 1/2 hours
 Morning only
 After school only
 Before and after school
 M=mom D=Dad

E=Enrolled= 1st day present
 A=Absent
 \ if Present
 C=Closed
 T=termination date on notice
 U=Unscheduled Closing (List reason, do parents pay=_____)

List if plan of care is 2nd or 3rd shift (you do have to list 1st shift)

**DSS will pay 10 closed days requested= Holiday/Vacation Requests

As a Day Care Provider, I understand that I cannot keep more than my total capacity shown on my State Approval Notice or I am operating illegally and DSS will terminate all children and my agreement for the remainder of the current fiscal year. Total capacity means private and subsidized children. Family Day Care Homes cannot keep more than 5 preschool age children (this includes private) at any time. Non-registered providers cannot keep more than 2 non-related children without being registered by the State. **Please Note: DSS can pay for 10 absences only during the month.**

TO ASSURE PAYMENT, ATTENDANCE SHEETS MUST BE SUBMITTED BY 5:00 pm ON THE 2nd OF THE MONTH TO P.O. BOX 200, LENOIR, NC 28645.

FAX: 828-426-8189

I declare under penalties of perjury that the information provided, as reflected on this form, is accurate and complete to the best of my knowledge. *(Each submitted sheet must be signed.)*

Provider Signature/Authorized Representative _____ Date _____

