



Bi-Weekly Timesheet

Activity: ITA Supportive Services Other: _____

Participant Name		State ID #	Funding Source		WIOA Provider	WIOA Provider Contact					
Training Provider		Contact Name			Contract #		Student ID #				
Begin Date This Billing Period	End Date This Billing Period	Total Contract Period			Course Title (ITA only)						
			to								
<p>1. Is the above address your current and correct address? If NO, you must notify your Employment Readiness Specialist immediately for change of address, or your paycheck will be mailed to the address above. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Has your monthly income changed within the last 30 days? (Exclude needs related payment.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>				Hours of attendance should be entered in each space. For absence enter "Ø"; for Holidays enter "HOL".							
					Sat	Sun	Mon	Tue	Wed	Thu	Fri
				Date							
				Hours							
				Date							
Hours											

I certify that the above reported time is in accordance with our records.

TRAINING FACILITY: _____

Authorized Name: _____

Authorized Signature: _____ Date: _____

PARTICIPANT CERTIFICATION: I certify that the above information accurately reflects the actual dates and times I attended class activities. I understand that federal and state laws for willful misrepresentation provide penalties.

Participant Signature: _____ Date: _____

FOR PROVIDER OF SERVICE USE ONLY			
Supportive Service Provided	Rate of Pay	Total Units	Amount Due
Childcare		Hrs.	
Mileage		Days	
Needs Related Payment		Hrs.	
Total			

PROVIDER CERTIFICATION: I have reviewed the information contained in this request and certify that it is in accordance with my records.

Provider Authorized Representative Signature _____ Date: _____