



MONTHLY CALWORKS ACTIVITY TIMESHEET (MCAT)

PARTICIPANT NAME: _____

REPORT MONTH: _____

DHS CASE NUMBER: _____

SOCIAL SERVICE WORKER NAME AND CASELOAD: _____

SOCIAL SERVICE WORKER PHONE NUMBER: _____

HOW TO COMPLETE YOUR MONTHLY CALWORKS ACTIVITY TIMESHEET (MCAT):

Each day you must record the number of hours you attended any of the activities listed on this timesheet. Upon completion, you will sign, date and submit this timesheet to your WTW Social Service Worker (SSW) by the 5th of the following month. Please answer questions #1 & #2 below:

QUESTION #1:

Were you Self-Employed or paid in cash during the report month?

- No – Proceed to Question #2
- Yes – Total monthly hours worked for Self-Employment.
- Yes – Total amount paid in cash for the month. \$

QUESTION #2:

Did you attend Counseling (Mental Health, Substance Abuse, Group Therapy, Parenting Classes etc...), Community Service, Work Release, Vocational Education, Job Skills Training, High School Diploma, GED, Adult Basic Education or English as a Second Language courses during the report month?

- No – Sign, date and return this form to your Social Service Worker
- Yes – Complete the appropriate section below with the corresponding hours for the month

<u>DATE</u>	<u>COUNSELING</u> <i>(Mental Health, Substance Abuse, Group Therapy, Parenting)</i>	<u>COMMUNITY SERVICE</u> <i>(Community Service, Work Release)</i>	<u>SCHOOL HOURS</u> <i>(Vocational Education, Job Skills Training, HSD, GED, ABE, ESL)</i>
1 st			
2 nd			
3 rd			
4 th			
5 th			
6 th			
7 th			
8 th			
9 th			
10 th			
11 th			

12 th			
13 th			
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23 rd			
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25 th			
26 th			
27 th			
28 th			
29 th			
30 th			
31 st			

CONSENT

I understand that as a CalWORKs participant, I am required to participate **at least 87/130/152 hours per month in WTW activities**. I understand that my timesheet must be returned within five **(5) calendar days following the end of each month**; failure to do so could result in my cash aid being lowered. I declare under penalty of perjury that the facts contained in this report are true, correct and complete for the entire month. I understand my Social Worker may request additional written verifications of my statements.

PARTICIPANT PRINT NAME: _____ **DATE:** _____

PARTICIPANT SIGNATURE: _____

PARTICIPANT PHONE NUMBER: _____

AGENCY REPRESENTATIVE

SOCIAL SERVICE WORKER SIGNATURE: _____ **DATE:** _____

SOCIAL SERVICE WORKER CASELOAD #: _____