

Metro Support Services ATTENDANCE RECORD



Provider: _____ Month/Year: _____
Trade Name _____

Resident Name	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	Days Billed

Back-Up Provider Services: No Yes, Date(s): _____ Location: _____
Date(s): _____ Location: _____

Pay Check: No Yes, Number of Pay Stubs: _____ **Pay Stubs MUST be Attached!**

Resident Name	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	Days Billed

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Back-Up Provider Services: No Yes, Date(s): _____ Location: _____
Date(s): _____ Location: _____

Pay Check: No Yes, Number of Pay Stubs: _____ **Pay Stubs MUST be Attached!**

Code: E=Enrollment Date B=Back-up Provider Services (BPS) H=Hospital C=Camp I=Incarceration	Blank=Client in Residence V=Vacation with Provider F=Family Visit VO=Vacation with Other T=Termination
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Resident Name	Days Billed	Daily Rate	Amount Due
Total Due:			

Signature/Title of Person Certifying Attendance: _____ Date: _____
TRADE NAME _____