State of Georgia

ABAWD VOLUNTEER WORK VERIFICATION FORM

 County Department of Family and Children Services

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| --- | --- |
| Client Name  | Case Manager Name \_\_\_\_\_  |
|  Client ID #  |  Case # \_\_\_ \_\_\_ \_\_\_\_\_ |
|  Case Manager Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Case Manager Fax# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

PART I: To be completed by case manager to assign number of work activity hours required.

*Work Activity Type*

Comparable Workfare:

Required hours per month:

Participation Month:

 /

|  |
| --- |
| **PART II: To be completed by local organization staff after completion of work activity hours.** |
| **Organization Name** |  |
| **Organization Address** |  |
| **Organization Phone#** |  |
| **Volunteer Supervisor Name** |  |

The person named above is participating in a satisfactory manner *Yes\_\_\_\_\_ No\_\_\_\_(select one)*

and completed\_\_\_\_\_\_ hours in the month of \_\_\_\_\_\_/\_\_\_\_\_\_(month/year).

Printed Name of Volunteer Supervisor

Signature of Volunteer Supervisor/Date

Form 805 (11/18) *ABAWD Comparable Workfare*