State of Georgia

ABAWD VOLUNTEER WORK VERIFICATION FORM

_____County Department of Family and Children Services

Client Name
Client ID #

Case Manager Name _____
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