



Children Services Division

Support Services Verification

1. Service Contractor		2. Consultant Name		3. Date of Service	
4. Delegate Agency Name		5. Program Name		6. Program Address	
7. Service Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Mental Health			8. Program Type: <input type="checkbox"/> Head Start – Half Day <input type="checkbox"/> Head Start – Full Day <input type="checkbox"/> Head Start / Child Care - Collaboration <input type="checkbox"/> Head Start – Home Based <input type="checkbox"/> Early Head Start / Family Child Care Homes		
9. Number of Staff Performing Service _____			14. Service Verified By: _____ Signature _____ Title Time In: _____ AM PM Time Out: _____ AM PM		
10. Number of Hours of Service _____					
11. Number of Children Served _____					
12. Number of Staff Served _____					
13. Number of Parents Served _____					

CYS 1388 (Rev. 08/19/04)



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