CERTIFICATION STATEMENT

1. The Provider agrees and shall certify under penalty of perjury that all claims for services provided to regional center clients have been provided to the clients by the Provider
2. The services were, to the best of the Provider's knowledge, provided in accordance with the client's written Individual Program Plan.
3. The Provider shall also certify that all information submitted to the regional center is accurate and complete.
4. The Provider understands that payment of these claims will be from federal and/or state funds, and any falsification or concealment of material fact may be prosecuted under Federal and/or state laws.
5. The Provider agrees to keep for a minimum period of **three years** from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client.
6. The provider agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Developmental Services; California Department of Justice; Office of the State Controller, U.S. Department of Health and Human Services, or their duty authorized representative.
7. The Provider also agrees that services are offered and provided without based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

PLEASE USE KEY AS NOTED

P = PRESENT
A = ABSENT
H = HOLIDAY
V = VACATION
C = FACILITY CLOSED
E = EXIT
HOS = HOSPITAL

MONTHLY ATTENDANCE SHEET

FACILITY: _____

ADRESS: _____

_____

_____

MONTH/YEAR

Clients 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	Total