INTERIM ASSISTANCE REPORTING FORM

CLIENT: ______________________ SSI# ______________________MUNICIPALITY: __________________

RETRO. PERIOD of SSI AWARD FROM: ___________________TO:_________________________________

DATE FIRST RECEIVED ASSISTANCE: ____

Assistance Authorized Workfare Y/N Month/Year_______________ Hours_____________ Total Assistance ___________ Hr. Rate___________ Total Paid_________________Amt.______________ Reimb. Rate____%	Assistance Authorized Workfare Y/N Month/Year_______________ Hours_____________ Total Assistance ___________ Hr. Rate___________ Total Paid_________________Amt.______________ Reimb. Rate____%
Assistance Authorized Workfare Y/N Month/Year_______________ Hours_____________ Total Assistance ___________ Hr. Rate___________ Total Paid_________________Amt.______________ Reimb. Rate____%	Assistance Authorized Workfare Y/N Month/Year_______________ Hours_____________ Total Assistance ___________ Hr. Rate___________ Total Paid_________________Amt.______________ Reimb. Rate____%
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Total Assistance Authorized $_______________ **Total Assistance Paid** $_______________________

Municipal Share $_________________________ State Share $ ______________________________

Signature of Preparer: ____________________ Date:___________________________________