



Child Care Assistance Program (CCAP)  
One College Drive, East Peoria IL 61635-0001  
**309/690-7300 800/301-3304 Fax 309-690-7320**  
Hours of Operation: Monday through Friday, 8:00 a.m. – 4:30 p.m.

**MONTHLY WORK HOUR VERIFICATION**  
**(To be completed by the employer.)**

Name of Employee: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_

**SPECIAL INSTRUCTIONS TO EMPLOYER:**

Please indicate which days and hours the employee worked for the month. Be certain to list the from and to times with a.m. or p.m. indicated. If the employee did not work that day, enter “0”.

\_\_\_\_\_: 1 \_\_\_\_\_, 2 \_\_\_\_\_, 3 \_\_\_\_\_, 4 \_\_\_\_\_, 5 \_\_\_\_\_,  
Month/Year 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 \_\_\_\_\_

\*\*\*\*Photo copies of employee’s work schedule would also be accepted as long as employer completes and signs the following . . .

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_

Phone: \_\_\_\_\_

Supervisor’s Name: \_\_\_\_\_

Supervisor’s Signature: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

**SPECIAL INSTRUCTIONS TO EMPLOYEE/CLIENT:**

You **must** attach your check stubs for the entire pay period listed above. This form will not be accepted with out them.