East Missouri Action Agency, Inc.
Head Start
HOME BOUND VISIT

Child's name _____ Location _____ Date _____

Reason for Home Bound Program:

Approval of Home Bound Services
Head Start Program Director's signature: _____
Approval may be faxed to Program Director at (573) 431-2129.

FOR FIRST VISIT Date initiated: _____
What will occur for child to be able to return to the classroom?

I understand that:
1) The Homebound Program is designed to meet our particular set of circumstances at this time.
2) The program will include:
   a) the Head Start child, unless circumstances prevent this from occurring.
   b) an adult, preferably a family member.
3) Your child and the adult will need to meet with a Head Start staff member on a weekly basis.
4) The time will be: (day of the week) _____ at (time) _____.

Parent's signature: _____

Head Start staff member signature: _____

Area coordinator signature: _____

OUTCOMES AND ACTIVITIES DONE AT HOME BOUND VISIT
Outcome Activities Home theme: _____

_____ _____

_____ _____

Name of book left with Reading Homework sheet _____

Other support provided for the family: _____
Note: Family advocates will provide the home bound visit at least monthly at which time services will be re-evaluated.

For entry: 1) ATTENDANCE N = non-scheduled; P or A = present/absent at home visit
2) MEAL COUNT N = non-scheduled on all classroom days
3) FAMILY SERVICES Home Visit Description: Home Bound Service Area Code: ED
After computer entry, this form goes in the back of the green portfolio.

HOME-BOUND CONCLUSION Date concluded: _____ Site Manager initials: _____

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Outcome Activities Home theme: _____

_____ _____

_____ _____

Name of book left with Reading Homework sheet _____

Other support provided for the family: _____

_____

Parent's signature _____

Head Start staff member signature _____

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Child's name _____ Date _____

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Outcome Activities Home theme: _____

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