Shasta Head Start
CHILD DEVELOPMENT, INC.

ALTERNATE LOCATION FOR HOME VISIT PLAN

Family Name: _____ Date: _____

Summary of Family Situation (Reasons the family prefers to meet at an alternate location):
Existing Condition (Circumstances or factors that prevent weekly home visits from occurring in the family's home):
Action Taken (Is there a plan to transition visits back to the home setting?):
Alternate Location (Address of alternate location):
Time Frame (What is the anticipated duration for conducting visits at the alternate location?):

Parent/Guardian Signature: _____

Home Visitor Signature:_____

Family Services Manager Signature: _____

Revised 2/18/2026