

**CARING CONNECTIONS
VISIT CONFIRMATION FORM**

OTTER TAIL COUNTY FAMILY
SERVICES COLLABORATIVE
UNIVERSAL HOME VISITING PROGRAM

Client ID # _____ FOR USE BY PUBLIC HEALTH ONLY
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Child's Name: _____

Child's Address: _____

Child's Date of Birth: _____

Date of Transition Visit: _____

Assigned On-going Home Visitor: _____

Employing Agency of On-going Home Visitor: _____
(Please specify ECFE or HS Center location)

Public Health Nurse: _____

Approximate dates for scheduled visit (please include dates for each) _____ 5 mo. _____ 12 mo.
_____ 18 mo. _____ 24-30 mo. _____ 36-40 mo. _____ 4 - 4½ yrs.
_____ Pre-K _____ K

Other Notes/Comments/Concerns: _____

Date: _____
Signature of On-Going Home Visitor

FOR COMPLETION BY ASSIGNED HOME VISITOR: Please complete and return within 10 days of visit.	
Time spent preparing for visit: _____	Return completed form to:
Travel time to visit: _____	Jane Patrick, Coordinator
Mileage incurred to/from visit: _____	Caring Connections
Time spent at visit: _____	P.O. Box 394
Next visit scheduled: _____	Fergus Falls, MN 56538

FOR COMPLETION BY COORDINATOR ONLY:		
Agency: _____	Date Submitted _____	Request NO. _____