**What is Homebound?**

Homebound instructional services are for students who are **confined** at home or in a health care facility. “**Confined at home or in a health care facility**” means the student is unable to participate in the normal day-to-day activities typically expected during school attendance; and absences from home are infrequent, of relatively short duration, or only to receive health care treatment. These students are medically unable to participate in extracurricular activities or work outside the home.

**Only when ALL portions of the homebound application are complete can this application be submitted to the homebound office. Incomplete applications will not be processed and will be returned to the school.**

**Components of the Homebound Application**

1. Parent/Guardian Section (1 page)
2. Medical Certification (2 pages)
3. School Recommendation (2 pages)

The parent completes components one and two above. Once **Parent and Medical** forms are complete, please return them to your child’s school and the homebound liaison will submit the medical certification of need to the school nurse for review within 48 hours after the application has been submitted by the parent. Once reviewed by the school nurse, the homebound liaison will complete the school’s portion and submit by email within 24 hours.

**Completed homebound applications are to be submitted via email to:** **homeboundapplications@nps.k12.va.us**

The application is **only valid for 30 days from the date of the doctor’s signature.** Applications older than 30 days will be denied, and an updated medical portion will need to be completed.

**Students with a Disability**

If a student with a disability is found eligible for homebound services, you will be notified by the homebound office to schedule the Individualized Education Plan (IEP) meeting. Once notified, the school will consult with the homebound specialist and parent to determine a date, time, and location for the IEP meeting. A representative of the homebound office will attend **ALL** homebound IEP amendment meetings.

**Parent/Guardian Section**

**PART 1**

**ALL sections must be completed, or the application will be considered incomplete and denied.**

This section is to be completed by parent/guardian in its entirety.

|  |
| --- |
| Student Name:  |
| DOB:  | Grade: | Attending School: |
| Address:  | Zip: |
| Parent/Guardian Name:  |
| Email Address (**REQUIRED**): |
| Phone #:  |

**Parent/Guardian Statement and Permission**

|  |
| --- |
|  |
| Parent/Guardian Name |

|  |
| --- |
|  |
| Student Name |

I, certify that **is confined to**

**the home, hospital or a treatment facility and is unable to attend school or participate in regular day-to-day activities.** By my signature, I authorize the release and exchange of medical information between the health care provider and school division personnel. My signature provides the health care provider(s) with the authorization necessary to disclose protected health information and records regarding said student as it pertains to the condition for which homebound instructional services are requested. This authorization may be withdrawn at any time, in writing.

Students receiving homebound instruction **may not** work or participate in extra-curricular activities, non-academic activities (such as field trips), or community activities unless these activities are specifically outlined in the student’s medical plan of care. If approval prior to participation in such activities is not given in writing, this may cause termination of services.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Homebound Instruction – Medical Certification of Need**

**PART 2**

**ALL Questions MUST be answered for application to be processed. Incomplete medical certifications will be denied. Please review medical certification for completion.**

To be completed by the **treating** licensed physician, psychiatrist, or a licensed clinical psychologist providing care to the student for the condition for which services are requested (**2 pages)**.

|  |
| --- |
| **PROVIDER INFORMATION** |
| Provider’s Name: | License #:  |
| Specialty: |
| Email Address (**REQUIRED**):  |
| Practice Name:  |
| Address:  | City:  | Zip: |
| Contact Person: | Phone #: |

|  |
| --- |
| **PATIENT INFORMATION** |
| Patient Name: | DOB:  |
| Date of most recent exam: | Next Exam/Follow-up Date: |
| Is the patient pregnant: YES NO | If YES, EDD: | High-Risk: YES NO |

|  |
| --- |
| **MEDICAL CONDITION(S): PHYSICAL OR MENTAL HEALTH** |
| Is this student **unable** to attend school regularly due to illness, surgery, **mental health diagnosis** or other **physical medical condition(s**)?  | YES NO |
| ***IF YES***, what is the specific nature **and** extent of the illness or condition? What specific symptoms/characteristics of this illness/condition confines the student to the home and makes them unable to attend school for any length of time? Please be thorough and provide as much detail as possible.  |
| Please **specify** the treatment plan including frequency and duration of treatments (attach additional sheets if necessary): |
| List the names and practices of any other counselors, therapists, or related practitioners providing treatment for the listed condition(s), if applicable:1.2. |
| **ADDITIONAL MANDATORY QUESTIONS** |
| Is this illness/condition intermittent? | YES NO |
| Is this illness/condition continuous? | YES NO |
| Are the parent/guardians and student complying with all aspects of the treatment plan? | YES NO |
| If NO, please explain:  |
| Could the student attend school (even part time) if accommodations are made? | YES NO |
| If YES, what accommodations are needed: |
| If NO, please explain specifically why not: |
| Can this student attend school part-time? | YES NO |
| If YES, maximum number of hours per school day: |
| Date homebound instruction should begin: | Estimated date of return: |
| \**Anything beyond 9 weeks/45 days from the start date will require a Medical Need Extension Request Form* |

**Homebound instruction shall be made available to students who are confined at home or in a health care facility for period that would prevent normal school attendance (8VAC20-131-180). The term “confined at home or in a health care facility” means the student is unable to participate in the normal day-to-day activities typically expected during school attendance; and absences from home are infrequent, for periods of relatively short duration, or to receive health care treatment.**

**By signing below, as the licensed practitioner, you certify the above statement applies to the patient on this form:**

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Signature of licensed physician, psychiatrist, or licensed psychologist)**

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Printed name of licensed physician or licensed psychologist/psychiatrist)**

**School Recommendation**

**PART 3**

**ALL questions/sections must be completed in full, or the application will be considered incomplete and will be denied.**

The School Recommendation must be signed and submitted by the building *homebound liaison* (assigned administrator identified by the building principal).

|  |  |
| --- | --- |
| Student Name:  | Student #: |
| DOB:  | Grade: | Attending School: |
| Student has an IEP/504: | YES NO | If yes, attach and submit a copy of the IEP or 504 plan. |
| Student Data Specialist (SDS) Name:  | Email: |
| School Counselor Name: | Email: |
| Homebound Liaison (administrator) Name: | Email: |
| IEP/504 Case Manager Name (if applicable): | Email: |
| Date parent submitted completed referral(part 1 and 2): | Date: |

|  |
| --- |
| **SCHOOL NURSE REVIEW OF MEDICAL CERTIFICATION OF NEED** |
| School Nurse Name: |
| Signature of Nurse certifying completion of the medical portion: |
| 1st Attempt to contact physician | Date |
| 2nd Attempt to contact physician | Date |
| 3rd Attempt to contact physician | Date |

**SCHOOL STATEMENT**

*The school team has reviewed the attached form, Part I (Parental/Guardian Request) and Part II (Medical Certification of Need) for homebound instructional services and recommends the following:*

|  |
| --- |
| The student [should or should not] receive homebound instructional services as requested.If SHOULD NOT, please explain: |
| Homebound services **should not** be considered because the student’s needs can possibly be met with a 504 plan? | YES NO |
| Has the student ever been referred for attendance/truancy?If YES, please list dates and outcomes of the case. | YES NO |
| Number of days of unexcused absences for 24-25 SY |  |
| Number of days of excused absences for 24-25 SY |  |

**Current courses/classes for which the student is eligible for homebound instruction.**

|  |  |
| --- | --- |
| **Teacher Name:**  | Email:  |
| Subject:  | Check all that apply: [ ] SOL [ ] VAAP [ ] PALS |
| Current Grade:  |  |
|  |  |
| **Teacher Name:**  | Email:  |
| Subject:  | Check all that apply: [ ] SOL [ ] VAAP [ ] PALS |
| Current Grade:  |  |
|  |  |
| **Teacher Name:**  | Email:  |
| Subject:  | Check all that apply: [ ] SOL [ ] VAAP [ ] PALS |
| Current Grade:  |  |
|  |  |
| **Teacher Name:**  | Email:  |
| Subject:  | Check all that apply: [ ] SOL [ ] VAAP [ ] PALS |
| Current Grade:  |  |
|  |  |
| **Teacher Name:**  | Email:  |
| Subject:  | Check all that apply: [ ] SOL [ ] VAAP [ ] PALS |
| Current Grade:  |  |
|  |  |

**Homebound Liaison (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Homebound Liaison (signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_**