ALLEGHANY HIGHLANDS PUBLIC SCHOOLS

CERTIFICATION OF NEED FOR HOMEBOUND INSTRUCTION
Role of Physician or Clinical Psychologist Providing Certification

Homebound instruction is designed to provide continuity of educational services between the classroom and home or health care facility for students whose medical needs, both physical and psychiatric, do not allow school attendance for a **limited** period of time. At the time of the initial request, the physician or clinical psychologist providing medical certification of need for homebound instruction must provide in writing to the school division the following:

1. Name of the student
2. Certification that the student is "confined at home or in a health care facility"
3. Nature and extent of the illness, including whether the condition(s) prohibit attendance for a full day or a portion of the day
4. Date of examination or diagnosis
5. Whether the illness is chronic or intermittent
6. Accommodations the school could make that would allow the student to attend
7. Any particular aspects of the illness that may impact the way in which instruction is delivered (e.g., the student will be unable to write or type)
8. Estimated date of return to school (the parent and health care provider should be informed that if this date is beyond nine calendar weeks, additional steps must be taken as outlined below.)
9. Ongoing treatment and/or therapy being provided
10. Frequency of treatment and/or therapy
11. Specific plans to transition the student back to the school setting
12. Signature, date, office address, and phone number

Since homebound instruction is not intended to supplant school services, if it is necessary to extend homebound instruction beyond the initial time frame or longer than nine calendar weeks, a transition plan is required outlining the following:

1. Name of the student
2. Justification for the extension of homebound instruction
3. Additional time homebound instruction is anticipated
4. Specific steps planned to return the student to classroom instruction
5. Changes in amount and kind of activity for the student during extended homebound instruction
6. Signature, date, office address, and phone number

Plan for Student to Return to School

Please be advised that homebound instruction is necessary for

_____, effective _____
(Student Name) (Date)

The following plan outlines the student's treatment during confinement and return from this short-term confinement:

_____ _____
(Signature of physician, physician assistant, nurse practitioner, or clinical psychologist) (Date)

Note: A student's IEP must stipulate homebound instruction as appropriate.

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HOMEBOUND INSTRUCTION
MEDICAL CERTIFICATION OF NEED

Homebound instruction shall be made available to students who are **confined** at home or in a health care facility for periods 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. Students receiving homebound instruction may not work or participate in extra-curricular activities, nonacademic activities (such as field trips), or community activities unless these activities are specifically outlined in the student's medical plan of care or the Individualized Education Program (if applicable.)

To be completed by the licensed physician, physician assistant, nurse practitioner, or licensed clinical psychologist providing care to the student for the condition for which the services are requested.

1. Name of Student: _____
2. Name of School: _____
3. Nature and extent of illness: _____Grade:_____
   _____
   _____
4. Date of examination or diagnosis of this illness: _____
5. Is the student confined at home or in a health care facility? YES NO
6. Is the illness/treatment intermittent in nature? (e.g., sickle cell anemia, chemotherapy for childhood cancer)
   YES NO
7. Could this child attend school if accommodations are made by the school? YES NO
   If yes, please list the accommodations required. If no, please
   explain:_____
   _____

8. Estimated date of return to school:_____
9. Explain ongoing treatment and/or therapy being provided: _____
   _____
   _____
   _____
10. Frequency of treatment:_____

_____ _____
Signature of Licensed Physician/Physician Assistant/Nurse Practitioner/Clinical Psychologist **Date**

_____ _____
Print Physician/Physician Asst./Nurse Practitioner/Clinical Psychologist Name **Telephone Number**

_____

Office Address **City, State, and Zip Code**

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Students may receive instruction in the home, a health care facility, or any other approved facility as agreed upon by the school division and parent or student who has reached the age of majority (eligible student). If it is necessary for homebound instruction to continue beyond **nine** weeks, an extension or reauthorization form, including treatment plan, progress towards treatment goals, and specific plans to transition the student back to the school setting, will be required.

To be completed by the parent/guardian or eligible student.

Name of Parent/Guardian or Eligible Student: _____

Home Phone:_____ Work Phone:_____

Cell Phone:_____

Street Address:_____

City:_____ State:_____ ZIP Code:_____

Acknowledgement/Release: I acknowledge this request and agree with the need for homebound services. I further acknowledge that the requested homebound services for students receiving special education services shall be subject to review by the student's IEP team pursuant to the Individuals with Disabilities Education Act. I will provide an environment conducive to learning, ensure that a responsible adult is in the home for the duration of instruction, or provide transportation to another agreed upon facility. I will keep appointments with the homebound teacher or contact the teacher or homebound coordinator if an appointment must be missed.

I understand that the local school division has established policies and procedures for homebound instruction that provide more detail than this certificate of need.

By my signature, I authorize the release and exchange of medical information between the health care provider, listed on the reverse side, or his/her designee, 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. This authorization may be withdrawn at any time in writing.

Please note: This form, including parental permission to contact the treating physician or psychologist, must be fully completed in order for the student to be considered for homebound services. If you have questions about completing this form, please contact the Alleghany Highlands School Board Office at 540-863-1810.

_____ _____

Parent/Guardian Signature **Date**

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