LANCASTER COUNTY PUBLIC SCHOOLS

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, non-academic activities (such as field trips), or community activities unless these activities are specifically outlined in the students medical plan of care or the Individualized Education Program (if applicable).

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

1. Name of Student: ______________________ DOB:________
2. Name of School: ______________________ Grade:________
3. Nature and extent of illness: ______________________
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/Clinical Psychologist **Date**

______________________ ______________
Print Physician/Psychologist Name **Telephone Number**

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

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 re-authorization form, including treatment plan, progress towards treatment goals, and specific plans to transition the student back to the school setting, will be required.

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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 anytime 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:

____.

______________________________ ____________________
Signature of Parent/Guardian or Eligible Student **Date**

* The *Code of Virginia* § 54.1-2957.02 states "whenever any law or regulation requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, it shall be deemed to include a signature, certification, stamp, verification, affidavit or endorsement by a nurse practitioner."

To be completed by Division Superintendent: I hereby approve homebound instruction for this student and further certify the teacher employed to provide the services will hold a certificate in full force in accordance with the rules and regulations of the State Board of Education.

Date: ________ Superintendent's Signature: ______________________________

Beginning Date of Homebound ______________ Expiration Date of Eligibility (max. 9 wks) __________

Rev. 9/28/11

CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

I, ______________________________, am signing this form for
(Full printed name of consenting person(s))

____
(Full printed name of client)

____
(Client's address) (Client's Birth Date) (Client's SSN optional)

My relationship to the client is: □ Self □ Parent □ Power of Attorney

□ Guardian □ Other Legally Authorized Representative

I want the following confidential information about the client (except drug or alcohol abuse diagnoses or treatment information) to be exchanged:

Yes	No		Yes	No		Yes	No	
		Assessment Information			Medical Diagnosis			Educational records
		Financial Information			Mental Health Diagnosis			Psychiatric Records
		Benefits/Services Needed, Planned, and/or Received			Medical Records			
		Criminal Justice Records			Psychological Records			Employment Records

I want:

____

____
(Name and Address of referring agency and staff contact person)

And the following other agencies to be able to exchange this information:

Are more agencies listed on back? □Yes □No

I want this information to be exchanged ONLY for the following purpose(s):
□ Service Coordination and Treatment Planning □ Eligibility Determination
Other (write in): ______________________________

I want information to be shared: (check all that apply)
□ Written information □ In meetings or By phone □ Computerized Data
This consent is good until: ______________________________
I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn. I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information.
I want all the agencies to accept a copy of this form as a valid consent to share information.
If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need.

Signature(s) ______________________________

Date: ______________

Person Explaining Form : ______________________________
(Name) (Title) (Phone Number)

Witness (If Required): ______________________________
(Signature) (Address) (Phone Number)