HENRICO 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 heath 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 **fulltime** homebound instruction may not work or participate in extra-curricular activities, non-academic activities (such as field trips), or community activities.

To be completed by attending licensed physician/licensed clinical psychologist/psychiatrist providing care for the condition in which services are being requested.

1. Name of Student: ____________________ DOB: ____________ Grade: ______ Home School: ______________________________

2. Date of examination or diagnosis of this illness: ____________________ Is the student confined at home or health care facility? Yes ☐ No ☐

3. Nature and extent of illness: ***(If mental/emotional in nature, this form must be signed by a licensed clinical psychologist or psychiatrist)***

____

4. Is the illness/treatment intermittent in nature (e.g., sickle cell anemia, chemotherapy for childhood cancer)? Yes ☐ No ☐

5. Could this child attend school if accommodations are made by the school? Yes ☐ No ☐

If yes, please list the accommodations required. ____

If no, and the student is being placed by a Licensed Clinical Psychologist or Psychiatrist a detailed treatment plan **MUST** be provided with this medical certification of need. The treatment plan must include the frequency and the duration of the treatment and a transition plan for the student's return to school. Treatment Plan: ____

____

____

6. Estimated date of return to school: _______/_______/__________ *(Requests are approved for a maximum of nine calendar weeks.)*

_____________________/_______________________________ ____________________

Print and Signature of Licensed Physician/ Clinical Psychologist/ Psychiatrist Date

____ ____________________

Office Address City, State, Zip Code Telephone Number

____ ____________________

Office/Doctor email address Fax Number

To be completed by the parent/guardian or eligible (18 years or older) student.

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.

Name of Parent/Guardian of Eligible Student: ____

Address/City, State, Zip: ____

Home Phone: ______________________________ Cell Phone: ______________________________

Work Phone: ______________________________ E-mail Address: ______________________________

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 facilitator or contact the facilitator 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 or his/her designee, and school division personnel. My signature provides the heath 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 being requested. This authorization may be withdrawn at any time in writing.*

____ ____________________

Signature of Parent/Guardian or Eligible Student Date

Please note: This form must be completed in full in order for the student to be considered for homebound services. If you have questions about completing this form, please contact the homebound team at (804) 652-3471. Fax completed form to 652-3400.

* 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."