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).* ***NOTE: If the student is receiving special education, homebound instruction must be stipulated in the IEP.***

To Be Completed by LICENSED PHYSICIAN / PSYCHIATRIST or LICENSED CLINICAL PSYCHOLOGIST
*** providing care to the student for the condition for which services are requested.**

1. Name of Student: _____
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/Psychiatrist/Clinical Psychologist **Date**

_____ _____
Printed Name of Physician/Psychiatrist, or Clinical Psychologist **Telephone Number**

_____
Office Address **City, State and Zip Code** **(OVER)**

* 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."

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 (HB 1A), progress towards treatment goals, and specific plans to transition the student back to the school setting, will be required.

To Be Completed by 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 heath 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.
*****For a pregnancy referral, BOTH the parent and the student must sign.***

_____ _____ _____

Signature of Parent/Guardian **Signature of Eligible Student** **Date**

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: **Dr. Pamela Joyner, Director of Special Education/Coordinator for Homebound Instruction. Phone:(804) 469-4389 Fax: (804) 469-4499 Email: pjoyner@dcpsnet.org**

This Section To Be Completed By Dinwiddie County School Division ONLY:

I hereby approve homebound instruction from: _____ to _____.

I certify that the teacher to be employed will hold a certificate in full force issued in accordance with the rules and regulations of the Virginia State Board of Education.

_____ _____

Date **Signature of Director of Exceptional Education/Coordinator for Homebound Instruction**