Office of Pupil Placement Services
119 W. Leigh Street, 3rd Floor
Richmond, VA 23220
Telephone: (804) 780-7811

2021-2022 Request for Homebound Services

To be completed by the parent/guardian or eligible student

Student Name: _____
Student's RPS ID# _____
Student's School and Grade: _____
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 if necessary for homebound to continue beyond nine weeks, an extension to include a new application along with the medical certification of need and treatment plan will be required.

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 signing this document, 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 This authorization may be withdrawn at any time in writing.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 Office of Pupil Placement Services at (804) 780-7811

_____ _____

HOMEBOUND INSTRUCTION
MEDICAL CERTIFICATION OF NEED

Please Note: This Medical Certification of Need must be filled out by a medical provider. All diagnosis of a psychological nature will require the "Medical Certification of Need" and the "Treatment Plan" pages be completed with the signature of a licensed clinical psychologist or a psychiatrist. The diagnosis by a family physician or primary care physician will not be accepted.

Diagnosis of a psychological nature will also be accepted by a psychiatric nurse practitioner or a psychiatric physician's assistant.

This form must be completed in full. Incomplete forms will not be accepted.

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).

1. Name of Student: _____
2. Name of School: _____ Grade: _____
3. Nature and extent of illness: _____

_____

_____

3a. If the condition is pregnancy, what is the expected date of delivery:_____

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 _____

_____

_____

7a. Are there environmental conditions that triggers the child's illness? If yes, please list the triggers:

_____

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

_____

_____

10. Frequency of treatment: _____

_____ _____

Signature of Medical Provider Listed Above **Date**

Office Address: _____
City, State, Zip Code _____
Telephone Number _____

TREATMENT PLAN

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Date_____

Name of Student_____
School_____ **Date of Birth** _____ **Age** _____
Parent's Name_____
Student's Address_____ **Phone** _____

ICD9/DSM V Diagnosis_____

To what extent does the psychological condition affect everyday life. Please add information about how this condition affects the student's capacity to learn. (Please attach separate narrative if more space is needed to explain.) _____

_____

_____

TREATMENT PLAN RECOMMENDATIONS_____
_____
_____

PSYCHOTHERAPY_____
_____
_____

MEDICATION MANAGEMENT_____
_____
_____

ONGOING ASSESSMENT AS TO READINESS TO RETURN TO SCHOOL_____
_____
EXPECTED DATE OF RETURN TO SCHOOL_____
ADAPTATIONS IF NECESSARY: **1.** _____
2. _____
3. _____
Are you referring to the student to the Child Study Committee upon Return to School: _____

MEDICAL PROVIDERS AUTHORIZATION

Type or print medical providers name_____

Address_____ **Zip Code**_____

Business phone_____ **Business Fax**_____

_____ _____
Medical Provider's Signature **Dat**

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Homebound/Home-based Instruction Student Information Sheet

Directions: This information sheet is to be completed by a school counselor or Homebound Site Coordinator and sent to the Office of Pupil Placement Services no later than two 2 school days after the receipt of the Request for Homebound Services Forms and Medical Referral Forms from the parent(s).

Student Name: _____ DOB: _____ RPS ID#: _____
School: _____ School Year: _____ Grade: _____
School contact / title: _____ Phone: _____
Does this student have an IEP or 504? YES / NO Date of current IEP/504: _____
(If "yes", attach IEP)
Date of last Eligibility: _____

Please attach a copy of student's schedule and most recent grades

Indicate how student will be tested in each content area by completing the attached testing form: (SOL, VGLA, VAAP, or N/A):

Reading	Mathematics	Science	History/Social Science

	YES	NO
Medical Referral Forms Given to Parent	☐	☐
All Information Above Has Been Verified	☐	☐
School Concurs With Need	☐	☐
Student has an IEP	☐	☐
Student has a 504 Plan	☐	☐

Form Completed by (school counselor): _____ Date: _____

Home School Site Coordinator Signature _____ Date: _____

School Administrator's Acknowledgment of Request: _____ Date: _____
(signature required)

Please forward completed forms to the Homebound Program Coordinator at the address below.

Incomplete forms will be returned without being processed.

To be completed by Homebound Coordinator (Manager of Pupil Placement Services):
Request for Homebound Services is approved: ☐ YES ☐ NO
Homebound Coordinator: _____ Date: _____