

DESE no longer requires districts to submit this application. For District use only.

HOMEBOUND INSTRUCTION – Documentation Form

I. STUDENT INFORMATION			
<input type="checkbox"/> Student with an IEP		<input type="checkbox"/> Nondisabled	
Date of Application:	<input type="checkbox"/> Initial	<input type="checkbox"/> Extension (Circle One)	1 2 3
Type of Application:	<input type="checkbox"/> Medical	<input type="checkbox"/> Reevaluation	<input type="checkbox"/> Suspension/Expulsion <input type="checkbox"/> Other:
Name of Student:	DOB:	Grade:	
Name of Parent/Guardian:			
Home Address:			
II. SCHOOL DISTRICT INFORMATION			
1. Teaching completed by: <input type="checkbox"/> Phone <input type="checkbox"/> Home teaching <input type="checkbox"/> Other: Homebound instruction			
2. Estimated total length of homebound services:			
Name of Teacher	Social Security Number	Area(s) of Certification	
Legal Name of Educational Agency St. Joseph School District	District Contact Person Amanda Bowen	Telephone (816) 671-4007	Fax (816) 671-4013
Address 1415 N 26th Street	City St. Joseph	State MO	Zip Code 64506
III. EDUCATIONAL INFORMATION (To be completed by Director/Coordinator of Special Services)			
1. Are you requesting a reevaluation? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, enclose copy of Notice of Reevaluation)			
2. Has the IEP Team met? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, date: _____)			
3. Has this student been suspended or expelled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, enclose copy of Change of Placement and Manifestation Determination)			
4. Is this student not attending due to a court injunction? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, attach copy of court order)			
IV. MEDICAL INFORMATION (To be completed by Physician)			
1. Does condition prevent student from maintaining school schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Medical or Psychological Diagnosis: If pregnant, please indicate due date: _____			
3. Number of weeks student will require homebound:		Date of hospitalization:	
4. Recommendations and explanations of diagnosis: (NOTE: In the case of emotional disorders, a treatment plan should be designed to encourage the re-entry of the student into regular school environment as soon as possible.)			
Signature of Physician	Date	Print Physician's Name	
Address of Physician	State	Zip	Phone
Indicate Area of Licensed Specialty: <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist			
V. CERTIFICATION (To be completed by the School District)			
I certify that a need for homebound service exists and the provision of homebound instruction is the most appropriate educational alternative at this time.			
Superintendent or Authorized Representative		County/ District Code 011-082	Date
<u>MEDICAL PERSONNEL</u>		<u>DISTRICT PERSONNEL</u>	
<p>Mail or fax form to the school district where the child is enrolled. NOTE: In the case of emotional disorders, a treatment plan should be designed to encourage the re-entry of the student into regular school environment as soon as possible</p>		<p>DESE no longer requires districts to submit this application. Districts may choose to use this form as documentation in the child's file. If you have questions, please contact your local school district.</p>	