Student name
(last, first, middle)_____

Date request received
(office use only) _____

Referral Request for Hospital or Homebound Services

WAKULLA COUNTY SCHOOLS
COMMITTED TO SUCCESS

69 Arran Rd | Crawfordville, FL 32327
Phone: 850-926-0065 | Fax: 850-926-0125

October 2022

Student name _____ Hover fields forinstructions

Student Information

Student number	Grade	Date of birth	Last 4 of SSN	Gender

Race (Select all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other

Street_____ City_____ State_____ ZIP_____

Cell phone_____ Home phone_____ Email_____

Parent/Guardian Information

Parent/guardian name(s)	Cell phone	Work phone	Email

School Information

Current school	Current school district	Contactname	Contact phone

Check if student has one or more of the following current plans

☐ Section 504 ☐ IEP ☐ EP (Gifted only)

ESL program(s) _____

Setting _____

The Hospital/ Homebound staff forms a partnership with the student's assigned school in order to facilitate and support the delivery of educational services.

The public school where the student is currently enrolled will:

- Provide point of contact above for transitioning collaboration & communication
- Provide assignments, grades and maintain the record of attendance until the student is officially enrolled in the Hospital/Homebound program;
- Provide withdrawal grades and student schedule(s) to the Hospital/Homebound program, upon request;
- Provide applicable textbooks;
- Provide a copy of the current IEP, FBA/BIP or 504 plan, if applicable;
- Participate as a member of the Individual Education Plan (IEP) Team, asappropriate.

Information to be considered in the determination of eligibility

I am aware that the student named above is requesting services through Hospital/Homebound.

Principal signature/
date _____

Student name _____

Eligibility Criteria

According to 6A-6.03020 FAC, a student is eligible for educational instruction through homebound or hospitalized services if the following criteria are met:

I. A physician licensed in Florida in accordance with Chapter 458 or 459, F.S., unless a report of medical examination from a physician licensed in another state is permitted in accordance with paragraph 6A-6.0331(3)(e), F.A.C., must certify that the student:

a. Is expected to be absent from school due to a physical or psychiatric condition for at least fifteen (15) consecutive school days, or the equivalent on a block schedule, or due to a chronic condition, for at least fifteen (15) school days, or the equivalent on a block schedule, which need not run consecutively; **and,**

b. Is confined to home or hospital;

c. Will be able to participate in and benefit from an instructional program;

d. Is under medical care for illness or injury that is acute, catastrophic, or chronic in nature; **and,**

e. Can receive instructional services without endangering the health and safety of the instructor or other students with whom the instructor may come in contact.

II. The student is enrolled in a public school in kindergarten through twelfth grade.

III. A parent, guardian or primary caregiver signs a parental agreement concerning homebound or hospitalized policies and parental cooperation.

I have read and understand the Eligibility Criteria as indicated and hereby give consent to Wakulla County Public Schools to:

1. Utilize the Hospital/Homebound Referral as a part of the evaluation procedures in consideration of eligibility;
2. Contact my child's physician(s) to exchange information and records regarding my child's medical condition(s), diagnosis, and instructional program to assist with educational planning.
3. Contact another agency (named below) to exchange information and records regarding my child's medical condition(s), diagnosis, and instructional program to assist with educational planning.

Agency name_____ Agency Phone _____

Physician's name_____ Agency Fax _____

Email _____

_____

Signature of parent, guardian, surrogate, or adult student and date

Student name _____

Parent/Guardian/Adult Student Agreement

Upon determination of eligibility for Hospital/Homebound, I understand and agree to:

- Provide signed consent for placement for services to begin;
- Provide a quiet, clean, well-ventilated setting for student and teacher in my home, as necessary;
- Ensure that a responsible adult is present;
- Establish a schedule for student study between delivered instructional times;
- Report to the Hospital/Homebound office daily any student absences that will prevent the teacher from providing instruction;
- Foster my child's/the student's independent work ethic and will assist only as needed;
- Obtain and provide transfer grades for current quarter or transcripts for course history as appropriate;
- If there is a change in physician, provide an additional Hospital/Homebound medical, completed by the new physician;
- Provide the Hospital/Homebound program staff any updated information regarding the physician's treatment plan for my child/the student;
- Understand that a discontinuation/dismissal from services may be considered through a reevaluation meeting;
- Understand the WCSB policies including the Code of Student Conduct and those of the Hospital/ Homebound Program, during my child's/the student's enrollment in the Hospital/Homebound Program.

Additionally:

- I am aware that accelerated courses and electives courses are not available through the Hospital/ Homebound program;
- Upon the dismissal/discontinuation of Hospital/Homebound services, I agree to enroll my child/the student into school or other instructional program;
- I understand that provision of incomplete information may delay the eligibility determination process into the Hospital/Homebound Program.

_____

Signature of parent, guardian,
surrogate, or adult student and date

Student name _____ Hover fields forinstructions

Physician Certification

Medical Information

(MUST BE COMPLETED BY A LICENSED PHYSICIAN IN FLORIDA, AS DEFINED IN CHAPTERS 458 & 459 F.S.)

Physician name _____ Phone number _____ Fax number _____ Email _____

Street_____ City_____ State_____ ZIP _____

1. Diagnosis

2. Medical implications for instruction

3. Plan of treatment

4. Medications and precautions

Student name _____

Physician Certification (cont'd)

Physician Recommendations

Eligibility: According to 6A.6.03020 FAC, a Florida licensed physician must certify that the student meets ALL of the following criteria for eligibility. If the student is not eligible for the Hospital/Homebound program, he or she could be considered for other services.

☐ Yes ☐ No Is the student under medical care for illness or injury that is acute, catastrophic, or chronic in nature?

☐ Yes ☐ No Is the student expected to be absent from school due to a physical or psychiatric condition for at least fifteen (15) consecutive school days, or due to a chronic condition, for at least fifteen (15) school days which need not run consecutively?

☐ Yes ☐ No Is the student confined to the home, residential facility, or hospital?

☐ Home ☐ Facility or hospital _____ Date confined _____

☐ Yes ☐ No Is the student well enough to participate in and benefit from an instructional program?

☐ Yes ☐ No Can the student receive instructional services without endangering the health and safety of the instructor or other students with whom the instructor may come in contact?

Service Delivery Considerations

The following modes of delivery should be considered to serve students in the least restrictive environment (LRE). The student may be served:

☐ Full-time (Student is UNABLE to attend ANY portion of the school day at his/her district assigned school)

☐ Part-time(Student is ABLE to attend a partial school day/week at his/her district assigned school)

☐ Intermittently (Student will attend district assigned school; upon 3 days of consecutive chronic illness, academic support will be provided for a specified amount of time)

Comments _____

School Re-Entry Considerations

The Hospital/Homebound Program is designed to be a temporary instructional intervention to help children who are unable to attend school for medical or psychiatric reasons and is not intended to replace the classroom experience. The Hospital Homebound service delivery model is considered the most restrictive educational setting because students are not instructed with their non-disabled or disabled peers. In addition, the amount of instruction provided by the Hospital/Homebound Program may be significantly less than that provided by the school-based setting. However, every attempt is made to maintain continuity of curriculum and learning by providing an appropriate instructional program.

Suggested school re-entry date _____

Physician's Certification

I certify that this student is under my care and treatment for the aforementioned illness/condition. The information provided and my recommendations have been made based on the current medical needs of the patient, keeping in mind that the least restrictive educational setting is mandated by federal law. This further certifies that this treatment plan is medically necessary.

_____ _____

Physician signature (MD, ARNP, or PA) and date

IR ARNP or PA, print supervising physician's name