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

HOMEBOUND INSTRUCTION – Documentation Form

I. STUDENT INFORMATION ☐ Student with an IEP ☐ Nondisabled

Date of Application: ☐ Initial ☐ Extension (Circle One) 1 2 3

Type of Application: ☐ Medical ☐ Reevaluation ☐ Suspension/Expulsion ☐ Other:

Name of Student: DOB: Grade:

Name of Parent/Guardian:

Home Address:

II. SCHOOL DISTRICT INFORMATION

1. Teaching completed by: ☐ Phone ☐ Home teaching ☐ 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 **Lisa Reynolds**	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? ☐ Yes ☐ No (If yes, enclose copy of Notice of Reevaluation)

2. Has the IEP Team met? ☐ Yes ☐ No (If yes, date:)

3. Has this student been suspended or expelled? ☐ Yes ☐ No (If yes, enclose copy of Change of Placement and Manifestation Determination)

4. Is this student not attending due to a court injunction? ☐ Yes ☐ 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? ☐ Yes ☐ 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: ☐ M.D. ☐ D.O. ☐ Psychiatrist ☐ 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

MEDICAL PERSONNEL

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

DISTRICT PERSONNEL

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.