

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

# HOMEBOUND INSTRUCTION – Documentation Form

<b>I. STUDENT INFORMATION</b>			
<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:	Phone Number:		
Home Address:			
<b>II. SCHOOL DISTRICT INFORMATION</b>			
1. Teaching completed by: <input type="checkbox"/> Phone <input type="checkbox"/> Home teaching <input type="checkbox"/> Other: <b>Homebound instruction</b>			
2. Estimated total length of homebound services:			
Name of Teacher	Social Security Number	Area(s) of Certification	
Legal Name of Educational Agency <b>St. Joseph School District</b>	District Contact Person <b>Lisa Reynolds</b>	Telephone <b>(816) 671-4007</b>	Fax <b>(816) 671-4013</b>
Address <b>1415 N 26<sup>th</sup> Street</b>	City <b>St. Joseph</b>	State <b>MO</b>	Zip Code <b>64506</b>
<b>III. EDUCATIONAL INFORMATION (To be completed by Director/Coordinator of Special Services)</b>			
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)			
<b>IV. MEDICAL INFORMATION (To be completed by Physician)</b>			
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			
<b>V. CERTIFICATION (To be completed by the School District)</b>			
<b>I certify that a need for homebound service exists and the provision of homebound instruction is the most appropriate educational alternative at this time.</b>			
Superintendent or Authorized Representative	County/ District Code <b>011-082</b>	Date	
<b><u>MEDICAL PERSONNEL</u></b>		<b><u>DISTRICT PERSONNEL</u></b>	
<p><b>Mail or fax form to the school district where the child is enrolled.</b> 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><b>DESE no longer requires districts to submit this application.</b> 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>	