

## APPLICATION FOR HOMEBOUND SERVICES

<b>Student Information: This section should be completed by the parent/guardian.</b>		
<b>Student's Name:</b>	<b>Date of Birth:</b>	<b>Sex:</b>
<b>School:</b>		<b>Grade:</b>
<b>Parent/Guardian:</b>		<b>Phone:</b>
<b>Address:</b>		

<b>The section below should be completed by a PHYSICIAN or PSYCHIATRIST.</b>	
<p><b>The student named above is unable to attend school due to:</b></p>	
<b>Physician/Psychiatrist's Name (Printed):</b>	
<b>Physician/Psychiatrist's Signature:</b>	<b>Date:</b>
<p>For homebound students to be exempt from state-required standardized assessments due to a medical emergency, a letter that includes ALL of the following information must be provided with this application:</p> <ul style="list-style-type: none"> <li>● The letter must be on a doctor, medical clinic, or hospital letterhead with the attending physician's signature.</li> <li>● The letter must address the student's limitations in regard to testing.</li> <li>● The letter must state that the student will be absent due to a medical condition on ALL Days of the testing window and the specific dates the student will be absent must be listed on the letter.</li> </ul>	

**By signing below, I am requesting that homebound services be provided for the student named above. (Once signed, this form should be returned to the principal or counselor at the student's school.)**

\_\_\_\_\_  
**Signature of Parent/Guardian Submitting Referral**

\_\_\_\_\_  
**Date**

- Upon approval of this application, a homebound teacher will serve the student for four hours per week for the duration of the student's impairment.

## APPLICATION FOR HOMEBOUND SERVICES

<b>The section below should be completed by representatives from Rogers Public Schools.</b>	
<b>Additional Comments/Special Instructions from Counselor:</b>	
<b>Counselor Name (Printed):</b>	
<b>Counselor Signature:</b>	<b>Date:</b>
<b>Additional Comments/Special Instructions from the Building Administrator:</b>	
<b>Building Administrator Name (Printed):</b>	
<b>Building Administrator Signature:</b>	<b>Date:</b>
<b>Additional Comments/Special Instructions from the District Homebound Director:</b>	
<b>District Homebound Director Name:</b> Sharon Daniels (Gen Ed.) OR Tita DeVore (SPED)	
<b>District Homebound Director Signature:</b>	<b>Date:</b>

<b>For Office Use ONLY</b>	
<b>Circle ALL that apply:</b>	IEP      504      Health Care Plan
<b>Approved:</b>	<b>Homebound Teacher:</b>
<b>Rejected:</b>	<b>Email:</b>
<b>Date Approved or Rejected:</b>	<b>Effective Date:</b>
	<b>Ending Date:</b>

- Upon approval of this application, a copy of this application should be kept on file with the District Homebound Director, kept on file at the student’s boundary school, kept on file with the District Testing Coordinator if the student will miss state-required standardized assessments, shared with the homebound teacher, and sent to the parent/guardian.