Rev 2024

To: Mental Health Professional
From: Antoinette Linker, Coordinator of IDEA
RE: Homebound Physican's Letter

To the Treating Psychiatrist

St. Charles Parish Public Schools provides instruction for students, who because of **mental health or the treatment** thereof, are temporarily unable to attend school and are confined to the home for a **minimum of 10 school days**. Homebound is not warranted for a student with chronic mental health illness (long-term depression, school anxiety, social anxiety, autism, ADHD, etc.). For students with chronic mental health illness, exacerbations requiring hospitalization or changes in treatment may warrant temporary homebound placement.

Homebound services are warranted for acute mental illness, treatment, and recovery following an acute episode or hospitalization, or a threat of harm to self or others. If the condition is so severe as to exclude the student from in-school education services, a treatment plan must be specific with the goal of the student returning to school. **The maximum time of exclusion from in-school services for mental illness is 6 weeks.**

Instruction in the home is a temporary arrangement that allows the student under medical care to continue to receive instruction in accordance with SCPPS curriculum so the student can re-engage successfully in the instructional program upon return to school.

Please be aware that homebound instruction cannot replicate the full array of services available at a regular school campus and does not provide social and peer interaction available at the student's school. For instruction provided in the home, the state of Louisiana considers 4 hours of direct instruction to be equivalent to a full week of school. Research has demonstrated that students with mental health illness (especially due to depression and/or anxiety) function better in school. The longer the student is out of school, the more severe these conditions become. ***While the student is receiving homebound services, the student is unable to attend extracurricular activities or have a job.***

Please complete the document and return it to the special education department so that homebound eligibility may be determined. Feel free to contact me with any questions.

Sincerely,

Antoinette C Linker
Coordinator of IDEA
St. Charles Parish Public Schools
985.785.3171

*I have read this document and feel that **temporary homebound services** would be the most appropriate setting for my patient at this time.

_____ _____

Original signature of Psychiatrist Date

****If you feel that an amended day or accommodations for a temporary period would be sufficient for your patient to attend school, please send a letter to the Coordinator of IDEA with your suggestions.**

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St. Charles Parish Public Schools

Application for PSYCHOLOGICAL/EMOTIONAL Homebound Instruction

Completion of this application does not guarantee homebound eligibility. Students must be absent for 10 consecutive days before homebound will be considered. Students are responsible for all makeup work missed during the time homebound is being considered.

Name_____ Sex_____ D.O.B_____Grade_____
Home Address_____ City_____Zip_____
Parent(s) Name_____Phone Number_____
Parent email address_____
School_____
Does this student receive Special Education Services? Yes or No Does the student have a 504 Plan? Yes or No
Last date the student attended school_____ Parent Signature_____

****

PSYCHOLOGICAL CERTIFICATION: This section must be completed by a properly certified PSYCHIATRIST.

1. Specific diagnosed condition which **prohibits school attendance.** (A diagnosis of ADD/ADHD, anxiety/phobia, autism, behavior disorder, depression, etc. is not a qualifying diagnosis for homebound services on its own. Question 2 must explain the acute episode)
   _____

2. How does this acute episode/diagnosis confine the student to the home and limit activities including school, extracurricular activities, driving, social outings with friends, and employment?
   _____
   _____
   _____

3. List medications: _____

4. Plan of action for returning student to in person learning on a school campus (this may be written on your letterhead if you need more space) _____
   _____
   _____
   _____

5. Recommendations for the school setting upon the student's return (this may be adjusted as necessary closer to the student's return via letter). _____
   _____
   _____
   _____

6. Estimated length of time the student will be unable to attend school? A new application is necessary after 6 weeks to determine continued eligibility. Circle one:
   3 weeks 4 weeks 5 weeks 6 weeks

   Psychiatrist Signature_____Date_____
   Printed Name_____ Phone number_____
   Physician's address _____ Fax Number_____

A student will not be considered for homebound instruction if this form is not filled out correctly and fully.

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Consent for Disclosure of Case Information
St. Charles Parish Public Schools

Student name:	Parent(s) Name
DOB	Address:
	City, State, Zip:
Requested by: Antoinette Linker, Coordinator of IDEA St. Charles Parish Public Schools 985.785.3171	Parent phone number:

I, the parent/legal guardian of the above child, am approving the release of his/her records from your agency. I understand that the information contained in his/her record is confidential. However, I give consent for:

Name/Agency_____
Address: _____
To release the following information:

☐ Medical	☐ Diagnostic findings	☐ Treatment/programming
☐ Social	☐ Educational implications	☐ Prescription for treatment
☐ Psychological	☐ Speech	☐ Sensory
☐ Other _____		

The purpose of this release is for SCPPS to evaluate the eligibility for homebound services.

I understand that:

1. I may refuse this authorization, and it is strictly voluntary. I acknowledge receiving a copy of this.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke authorization at any time in writing to the provider authorized to release the protected health information, but if I do, it will not have any effect on any actions taken before receiving the revocation.
4. If the requester or receiver is not a health plan or a healthcare provider, the released information may no longer be protected by Federal Privacy Regulation and may be disclosed.

This authorization will expire on the following date or event:

☐ Date: _____ or
☐ Event: **One (1) Calendar Year from the date of application.**

_____ _____
Signature of parent/legal guardian Date