411 SOUTH 5TH AVENUE, VIRGINIA, MN 55792 | 218.749.5437 | FAX: 218.741.8522 | WWW.RRPS.ORG

HOMEBOUND INSTRUCTION

MEDICAL CERTIFICATION OF NEED

As defined by the Minnesota Department of Education, homebound instruction shall be made available to students who are **confined** at home or in a health care facility for periods that would prevent normal school attendance. The term "**confined at home or in a health care facility**" means the student is unable to participate in the normal day-to-day activities typically expected during school attendance; and, absences from home are infrequent, for periods of relatively short duration, or to receive health care treatment. Students receiving homebound instruction may not work or participate in extracurricular activities, non-academic activities (such as field trips), or community activities unless these activities are specifically outlined in the student's medical plan of care or the Individualized Education Program. Students that do not meet this definition may be eligible for home-based instruction as defined by the Minnesota Department of Education.

While the medical needs of a student always take precedence, it is important to note that it is often difficult to keep students up to date on their schooling if they are not enrolled full time.

- Homebound instruction typically generates 1 hour of instruction per school day to remain full time.
- Home based instruction typically generates 1 hour of instruction per class period to remain full time.

This form, including parental permission to contact the treating physician or psychologist, must be fully completed in order for the student to be considered for homebound or home-based services. If you have questions about completing this form, please contact Mark Winter at (218) 749-5437 ext. 1916.

To be completed by the parent/guardian or eligible student.

Name of student: _____

Name of Parent/Guardian: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Acknowledgement/Release: I acknowledge this request and agree with the need for homebound services. I further acknowledge that the requested homebound services for students receiving special education services shall be subject to review by the student's IEP team pursuant to the Individuals with Disabilities Education Act, if applicable. I will provide an environment conducive to learning, ensure that a responsible adult is in the home for the duration of instruction, or provide transportation to another agreed upon facility. I will keep appointments with the homebound teacher or contact the teacher or homebound coordinator if an appointment must be missed. If it is necessary for homebound instruction to continue beyond nine weeks, an extension or re-authorization form, including treatment plan, progress towards treatment goals, and specific plans to transition the student back to the school setting, will be required.

_____ _____

Signature of Parent/Guardian or Eligible Student Date

To be completed by the licensed physician or licensed clinical psychologist providing <u>ongoing</u> care to the student for the condition for which services are requested.

If it is necessary for homebound instruction to continue beyond nine weeks, an extension or re-authorization form, including treatment plan, progress towards goals, and specific plans to transition the student back to the school setting, will be required.

1. Name of student: _____
2. Name of School: _____ Grade: _____
3. Nature and extent of illness: _____
4. Date of examination or diagnosis of this illness: _____
5. Is the student confined at home or in a health care facility? _____ YES _____ NO
   If no, the student does not qualify for homebound. However, they may qualify for home-based instruction.
6. Is the illness/treatment intermittent in nature? ____YES ____NO
7. Could this child attend school if the school makes accommodations? ____YES ____NO

   If yes, please list the accommodations required. If no, please explain. _____

   _____

   _____

8. Estimated date of return to school: _____
9. Explain ongoing treatment and/or therapy being provided: _____

   _____

   _____

10. Frequency of treatment: _____

_____ _____
Signature of Licensed Physician/Clinical Psychologist **Date**

_____ _____
Print Physician/Psychologist Name **Telephone Number**

_____ _____
Office Address **City, State and Zip Code**

To be completed by school administration.

_____ Initial here when homebound/home based instruction plan is confirmed and attach to form.

Homebound/Home Based Instructor: _____

_____ Date Received _____ Date Homebound Begins _____ Date Homebound Ends/Renews

Other Pertinent Information: