Michelle Darby, Homebound Coordinator mdarby@ccps.us
804-633-5088 ext.1077 FAX-1- 833-606-1181
16261 Richmond Turnpike, Bowling Green, VA 22427

Homebound Medical Certification of Need Application

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 (8VAC20-131-180). The term "**confined at home or in a healthcare 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 (if applicable).

Medical Homebound Services will be approved for up to 9 weeks. Incomplete Applications will be returned.

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

Student:	DOB
Parent/Guardian Name: School	Grade
Date of examination or diagnosis of this illness:	
Nature and extent of illness:	
Does this student need to be confined at home or in a healthcare facility? ☐ YES ☐ NO	
Is the illness/treatment *intermittent* in nature (e.g., sickle cell anemia, chemotherapy for childhood cancer)? ☐ YES ☐ NO	
Could this child attend school if accommodations are made by the school? ☐ YES ☐ NO Virtual ☐ Face to Face ☐	
If yes, please list the accommodations required. If no, please explain:	
Estimated date of return to school **3-6 weeks, up to 9 weeks.(A new form is needed after nine weeks):**	
Explain ongoing treatment and/or therapy being provided:	
Frequency of treatment	
Signature of Licensed Physician/Clinical Psychologist	Date
Print Name of Licensed Physician/Clinical Psychologist	Phone Number

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Address of Office

The *Code of Virginia* § 54.1-2957.02 states "whenever any law or regulation requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, it shall be deemed to include a signature, certification, stamp, verification, affidavit or endorsement by a nurse practitioner."

************************************This section for CCPS office use only below********************************

Date received by HBD Coordinator:	HBD Coordinator Signature:

Students may receive instruction in the home, a healthcare facility, or any other approved facility as agreed upon by the school division and parent or student who has reached the age of majority (eligible student). If it is necessary for homebound instruction to continue beyond nine weeks, an extension or re-authorization form, including a treatment plan, progress towards treatment goals, and specific plans to transition the student back to the school setting, will be required.

Student		Home Phone
Street Address		Work Phone
City/State	Zip	Cell Phone

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*. 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.
I understand that the local school division has established policies and procedures for homebound instruction that provide more detail than this certificate of need.

By my signature, I authorize the release and exchange of medical information between the health care provider, listed on the reverse side, or his/her designee, and school division personnel. My signature provides the healthcare provider(s) with the authorization necessary to disclose protected health information and records regarding said student as it pertains to the condition for which homebound instructional services are being requested. This authorization may be withdrawn at any time in writing.
Please note: 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

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services. If you have questions about completing this form, please contact Michelle Darby at 804-633-5088 ext.: 1107. Fax to 1-833-606-1181.

Signature of Parent/Guardian or Eligible Student