



Request for Homebound Instruction

Important Information for Parent/Guardian

Purpose of Homebound Instruction.

The purpose of homebound instruction is to provide educational services in the home, to students with temporary illnesses or injuries, to help the students maintain their academic performance during recovery.

Eligibility for Homebound Instruction.

To be considered for homebound instruction, a complete request packet must be submitted. A complete request packet includes parent form; school form; medical provider’s document; and signed authorization for release of medical information (HIPAA/FERPA). This allows the Home/Hospital medical team to communicate with health care providers regarding your child’s ability to participate in school, and accommodations that your child may need.

**Home instruction is not authorized by the doctor, but by San Diego Unified School District.
The doctor’s role is to provide pertinent medical information to SDUSD staff
so a valid placement may be considered.**

Enrollment in Home/Hospital & Transition Supports School. If your child is determined to be eligible for homebound instruction, he or she will be disenrolled from his or her regular school of attendance and be temporarily enrolled in the Home/Hospital & Transition Support School.

Delivery of Homebound Instruction. If a student is eligible for homebound instruction, five hours of instruction per week will be provided, typically scheduled for one hour per day. Parent/guardian or other responsible adult, age 18 years or older, must be present when the homebound teacher is at the home.

Please follow the directions below to submit a request for homebound services.

Completing and Submitting Request for Homebound Instruction Packet

1. Parent/Guardian completes Parent Documentation for Homebound Services (attachment **A**)
2. School personnel completes School Documentation for Homebound Services (attachment **B**)
3. MEDICAL: Treating physician completes Physical Medical Documentation for Homebound Services (attachment **C**)
OR
MENTAL HEALTH: Treating clinical psychologist or psychiatrist completes
Mental Health Documentation for Homebound Services (attachment **D**)
4. Parent/Guardian completes and signs Authorization for Release of Medical Information (attachment **E**)
5. Parent/Guardian submits completed packet (including any requested attachments) to:

ATTN: HOMEBOUND INTAKE COORDINATOR

U.S. Mail: please call 619-344-6439 for information
regarding mailing instructions

Email: hhts@sandi.net
Fax: (619) 344-6447

6. For questions regarding homebound services call the Homebound Intake Coordinator: (619) 344-6439 or visit our website at www.sandi.net/44779. Please call to confirm that your request has been received.

If your child is currently hospitalized, and you desire educational services, please ask for a Hospital Instruction Request form.

Parent Documentation for Homebound Services (attachment A)

This entire page is to be completed by parent or guardian.

San Diego Unified School District procedures require that a licensed California physician or licensed clinical psychologist, currently treating the student for the diagnosis preventing school attendance, submit substantiating documentation. **Chronic conditions** may not qualify. Home instruction is not authorized by the doctor, but by San Diego Unified School District. The doctor's role is to provide pertinent medical information to SDUSD staff so a valid placement may be considered.

STUDENT INFORMATION

Last Name _____ First Name _____ Gender M F
 Date of Birth ____/____/____ Student/Parent Language _____/_____
 Address _____ City _____ Zip _____
 Contact Information: Phone Number (____) _____ Email _____
 Parent/Guardian Name _____ (please print) Is this student currently hospitalized? Yes No

SCHOOL INFORMATION

Current School District _____ Current School _____ Grade _____
 Student's last date of attendance ____/____/____ Teacher / Counselor _____
 Does your child have an IEP? Yes No Does your child have a 504 Plan? Yes No Copy attached
 Class schedule for middle and high school students. Must be filled in:
 Period 1: _____ Period 4: _____
 Period 2: _____ Period 5: _____
 Period 3: _____ Period 6: _____

Implementation of Services

- Home/Hospital and Transition Supports School will provide five (5) hours of instruction per week in a manner consistent with California laws governing home/hospital.
- Instruction is generally offered in two (2) content areas.
- The student will be temporarily disenrolled from his/her regular school of attendance during the period he/she is receiving home/hospital instruction.
- A responsible adult (18 years of age or older) must be present when the teacher is in the home.

Authorization to Receive/Release Medical and Academic Information for Educational Purposes. As the parent or legal guardian of the above named student and by my signature below, I authorize the current school/district of enrollment, San Diego Unified School District (SDUSD) and the treating physician, and/or licensed clinical psychologist, to release and exchange medical and/or academic information relative to the above named student. The information received will be used only to assist SDUSD in determining eligibility, appropriate services, academic needs, and transitions between educational sites for the above named student.

X _____
 Parent/Guardian's Signature Relationship Date

School Documentation for Homebound Services

(attachment B)

This entire page is to be completed by school personnel.

Student Name _____ **Date of birth** _____

School _____ **SDUSD ID #** _____

Teacher / Case Mgr: _____ phone _____ email _____

School Nurse _____ phone _____ email _____

School Counselor _____ phone _____ email _____

School Psychologist _____ phone _____ email _____

Key school contact with the most knowledge about this student _____
(Name) (Position) (Phone)

Please include copies of the following items:

- IEP (most recent, if applicable)
- 504 plan (most recent, if applicable)
- ISHP (with any health accommodations)
- PowerSchool attendance printout
- PowerSchool transfer information
- PowerSchool transcript (secondary)
- PowerSchool class schedule (secondary)

The following program modifications and/or actions have been implemented. Please check all that apply:

- Participation in a modified day. Describe: _____
- Independent Study Program, Learning Contract/CIS contract, at home, or alternative setting.
Describe current program: _____
- Does the student leave the home for activities other than school? If so, what activities: _____
- Student has been discussed at a multi-disciplinary team meeting such as an SST or RTI.
- SARB referral process has been initiated (including all appropriate parent notifications and SART meetings).
- Developed and implemented a Section 504 Plan to accommodate student needs through program modifications.
- Identified as eligible for special education services and an Individualized Education Program.
- Implemented an Individual Student Health Plan with health related school accommodations.
- The following staff members have been involved in this case: School counselor School nurse School psychologist
- Student's treating medical provider has been contacted by _____

Please check the following items as they relate to a request for homebound services due to a mental health diagnosis:

- This section does not apply.**
- School attendance is being impacted by mental health/socio-emotional issues.
- Consulted with your MHRS therapist.
- Does the student have a mental health diagnosis? Describe: _____
- Student/Family receiving community based therapy services.
- Obtained the Treatment Plan.
- Previously or currently receiving Behavior Support Resources (BSR), Counseling & Guidance, School Psychology services.
Describe: _____
- Symptoms are impacting the student's ability to benefit from their current educational setting/placement.
- Psychiatrically hospitalized in the last 12 months.

Signature of School Administrator: _____

(Printed Name)

(Title)

(Date)



Physical Health Medical Documentation for Homebound Services (attachment C)

DO NOT USE THIS FORM FOR MENTAL HEALTH CONDITIONS. (USE ATTACHMENT D)

Student Name _____ Date of birth _____

PHYSICIAN: A request for temporary Home Instruction has been made for the above-named student. SDUSD procedures require that a licensed California physician, currently treating the student for this condition, file a statement, which includes a medical diagnosis, and the extent that the student is unable to attend classes on any school campus. Chronic conditions may not qualify. Home instruction is not authorized by the doctor, but by the San Diego Unified School District. The doctor's role is to provide pertinent medical information to SDUSD staff so a valid placement may be considered.

Treating Physician Statement:

Is student physically capable of attending classes on his/her school campus, at this time, with accommodations to meet their physical or other needs? [] Yes [] No

If yes, please list accommodations: _____

Would the patient's condition prevent/prohibit participation in an alternative, independent study program, meeting individually with a teacher at a school site? [] Yes [] No ([] 1-2 hrs/wk [] 2-3 hrs/wk [] 3-4 hrs/wk)

Is the patient able to leave the home for reasons other than medical appointments? [] Yes [] No

Diagnosis (with ICD code): _____

Summary of Therapeutic Plan to enable the student to return to school (required): _____

Is student's condition contagious? [] Yes [] No

Limitations, restrictions, or precautions school staff should take when interacting with this student: _____

I estimate this student will be homebound until (Specific date required): _____ (Not to exceed 60 days from date of request *)

(*Cancer patients: Requests submitted with physician-signed documentation of treatment schedule may be considered for date beyond 60 days)

I am managing the student's care for this condition. [] Yes [] No

Physician's Signature _____ M.D. Date _____

Physician's Name (Print) _____ M.D. License # _____

Phone: _____ Fax: _____ Email: _____

Address _____ City _____ Zip _____



Mental Health Documentation for Homebound Services (attachment D)

DO NOT USE THIS FORM FOR PHYSICAL HEALTH / MEDICAL CONDITIONS. (USE ATTACHMENT C)

Student Name _____ Date of birth _____

Psychiatrist / Clinical Psychologist: A request for temporary Home Instruction has been made for the above-named student. San Diego Unified School District procedures require that a psychiatrist or licensed clinical psychologist, currently treating the student for the mental health diagnosis preventing school attendance, submit substantiating documentation. Chronic conditions may not qualify. Home instruction is not authorized by the doctor, but by San Diego Unified School District. The doctor's role is to provide pertinent medical information to SDUSD staff so a valid placement may be considered.

Treating Psychiatrist / Clinical Psychologist Statement:

Is the student capable of attending classes on his/her school campus now, with accommodations to meet their emotional needs?

Yes No If yes, please list accommodations: _____

Is the patient able to leave the home for reasons other than medical appointments? Yes No

If yes, why is the student unable to attend school? : _____

Would the patient's condition prevent/prohibit participation in an alternative, independent study program, meeting individually with a teacher at a school site? Yes No (1-2 hrs/wk 2-3 hrs/wk 3-4 hrs/wk)

DSM V Diagnosis and ICD/DSM Code: _____

What medication(s) is/are the student currently prescribed? _____

Is the student a danger to self or others: Yes No Explain: _____

Plan for Student's Return to School (required for student to be considered for Homebound Instruction)

Describe Therapeutic Plan (as implemented by you or therapist): _____ (please attach)

Therapist's Name _____ Phone _____

Estimated date student may return to school: ___/___/___ Not to exceed 60 days from date of request.

I am managing the care for this student's current condition. Yes No

I understand that I will be contacted by a member of the school district's health team.

X _____ Date signed _____

Signature of Psychiatrist or Licensed Clinical Psychologist

Physician's Name (Print) _____ License # _____

Phone: _____ Fax: _____ Email: _____

Address _____ City _____ Zip _____



AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO AND FROM SCHOOLS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal laws (e.g., HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____
Last First MI Date of Birth

X _____ X _____
Health Care Provider/Agency Health Care Provider/Agency

School to which disclosure is made:
SDUSD Home Hospital and Transition Supports 5465 El Cajon Blvd., Annex B4 San Diego 92115

Contact person(s) at the school:
SDUSD nurse, physician, school psychologist, teacher, mental health clinician, and related service providers

Disclosure is required for the following purpose: EDUCATIONAL PLANNING

Requested information shall be limited to:

All minimum necessary information; or Disease specific information as described: _____

DURATION: Effective immediately and shall remain in effect until _____, or for one year from the date of signature, if no date entered.

RESTRICTIONS: California law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

PARENT/GUARDIAN RIGHTS: I understand I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.

STUDENT RIGHTS: Students between the ages of 12 and 18 years must sign this form in order to approve the disclosure of information relating to mental health and family planning issues.

RE-DISCLOSURE: I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have the right to receive a copy of this Authorization.

Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

I, the undersigned, do hereby authorize the above named health care providers to exchange information with the above listed school.

APPROVAL: _____
Parent Printed Name Parent Signature Date

Relationship to Patient/Student Area Code and Telephone Number

Student Printed Name Student Signature Date