Hospital Homebound Department
The School District of Polk County Schools
900 Lowry Avenue
Lakeland, FL 33801
The mission of Polk County Public Schools is to provide a high quality education for all students.

REQUEST FOR CONSIDERATION FOR HOSPITAL/HOMEBOUND SERVICES

Office: 863-668-3032 Fax: 863-665-5383

HOSPITAL/HOMEBOUND PROGRAM CRITERIA AND INSTRUCTIONS

Certification by a licensed physician that:

1. Student will require Hospital/Homebound services for 15 school days or longer. (*either* consecutively or intermittently)
2. Student can participate in and benefit from an academic instructional program.
3. Student's medical/emotional condition prohibits attendance in a school-based program.
4. Certification is required by a licensed physician that the student can receive an instructional program without endangering the health of the instructor or other students with whom the instructor may come in contact.
5. A diagnosis must be accompanied with a plan for the student's re-entry into a school-based program before service will be considered.

Form Completion

Parent Responsibilities – Information page to be given to the parent.
Section A – to be completed by the parent
Section B – to be completed by the current school
Medical Information – Release of Information to be signed by the parent prior to being completed by a licensed Physician or Psychiatrist. (*only these 2 pages are sent to the Physician/Psychiatrist)
Checklist of Responsibilities of Parent/Guardian – completed and signed by the parent/guardian.

ENTIRE COMPLETED FORM (4 pages) SHOULD BE FAXED TO THE HOSPITAL/HOMEBOUND OFFICE: 863-665-5383

NOTE: Incomplete information may result in a delay in initiating Hospital/Homebound services.

POLK COUNTY SCHOOLS REQUEST FOR CONSIDERATION OF HOSPITAL/HOMEBOUND SERVICES:
Hospital/Homebound Office: Phone, FAX - 863-665-5383

PARENT RESPONSIBILITIES

The following factors are included in the process to determine eligibility as listed by the Department of Education of the State of Florida:

1. Receipt by the Hospital/Homebound office of a signed "Authorization for Release" which is included in the Medical Information pages (2) of the "Request for Hospital/Homebound Services" form.
2. The Medical Information pages (2) must be completed recommending Hospital/Homebound instruction and signed by a physician.
3. The diagnosis must meet eligibility criteria.
4. The medical portion of the referral must state that your child is expected to be absent from school for at least 15 consecutive school days (or the equivalent on a block schedule) due to a physical or psychiatric condition, or for at least 15 school days (or the equivalent on a block schedule), which need not run consecutively, due to a chronic condition.
5. The medical portion of the referral must state the estimated number of weeks that your child should be provided services by the Hospital/Homeboud program.
6. Your child must be free from transmission of infectious or communicable diseases.
7. Your child must be able to participate in and benefit from an academic instructional program.
8. The parent, guardian or primary caretaker signs an agreement concerning parental cooperation with Hospital/Homebound procedures.
9. Your child must be enrolled in a Polk County Public School.
10. The IEP team determines Hospital/Homebound program eligibility.

The following are the parent's responsibility PRIOR to the eligibility meeting:

1. Check with your child's doctor to confirm that the medical portion of the referral has been faxed to the Hospital/Homebound office. (863-665-5383)
2. Check with the Hospital/Homebound office to confirm that the medical form has been received.
3. If not already enrolled in a Polk County Public School, the parent must enroll the child and ask the school to notify the Hospital/Homebound office with the referral form.
4. Continue requesting and submitting completed assignments/makeup work from the school.

The following are the parent's responsibilities AFTER ENROLLMENT in the Hospital/Homebound Program:

1. Report absences to the Hospital/Homebound teacher prior to the scheduled class time. The teacher will provide contact information.
2. A doctor's note may be requested for excusing frequent absences. Excessive, unexcused absences may be addressed as a truancy issue.
3. Make all graduation arrangements (senior pictures, ordering graduation items, etc.) with the assigned school, if the student is a graduating senior.
4. Sign "Attendance/Contact Log" when required.

***IMPORTANT INFORMATION YOU SHOULD KNOW:

1. **The Hospital/Homebound Program is a temporary medical setting, NOT intended to address NON-MEDICAL attendance concerns.**
2. **The Hospital/Homebound Program can neither duplicate the classroom experience, nor the amount of academic instruction provided at a school site.**

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SECTION A: COMPLETED BY THE PARENT/GUARDIAN

Please provide all requested information. There may be a delay in processing incomplete applications.

Student Name: _____ DOB: _____ ID# _____
Last First Middle

Address: _____
Street City Zip Code

Parent/Guardian(s) Name: _____ Phone: Home _____
Last, First, Middle
Work _____
Parent email: _____ Cell _____

School: _____Grade: _____

SECTION B: COMPLETED BY CURRENT SCHOOL

Please attach a copy of student's current grades and schedule. If the student has a 504, it is imperative that a copy accompanies the application.

The completion of a Hospital/Homebound referral does NOT guarantee placement in the program. Please make sure the student is supplied with books, make-up work, and tests while awaiting approval and placement into Hospital/Homebound.

Is the student presently staffed into an Exceptional Student Education Program? ____Yes ____No
ESE Program _____ Service Model _____

Last day the student was in class_____

Name of contact person at school _____ Phone _____

MEDICAL INFORMATION

POLK COUNTY SCHOOLS REQUEST FOR CONSIDERATION OF HOSPITAL/HOMEBOUND SERVICES:
Hospital/Homebound Office: 863-668-3032 Phone-, FAX - 863-665-5383

I hereby authorize the physician to release all information concerning diagnosis, treatment and any medical implications for instruction to the School District of Polk County. This communication may be written or verbal. This release will remain in effect until the student has been dismissed from the Hospital/Homebound Program.

Must be signed by parent/guardian or
student at the age of majority (18 years or older) _____
SIGNATURE OF PARENT/GUARDIAN OR STUDENT AT THE AGE OF MAJORITY

Student Name: _____ Date of Birth: _____

COMPLETED BY THE PHYSICIAN/PSYCHIATRIST (required)

Incomplete forms will be returned.

ELIGIBILITY: The licensed physician must certify that the student meets all of the following criteria for eligibility. Students who do not meet all of the minimum eligibility criteria listed below will not be eligible for Hospital/Homebound Services. **All questions must be answered by the physician. Please be as specific as possible. Hospital/Homebound instruction cannot be considered until the completed medical form is received. Thank you for your prompt reply.**

Diagnosis **(REQUIRED- PLEASE BE SPECIFIC):**

_____

_____

_____

1. Pregnancy in and of itself does not constitute eligibility for Hospital/Homebound services. The Physician must indicate the specific medical condition that necessitates a request for Hospital/Homebound services. (Due Date) _____
2. Is this condition contagious to the teacher or to other students seen by the same teacher? Yes _____ No _____
3. Will the student be able to participate in and benefit from an instructional program? Yes _____ No _____
4. The student may participate in extracurricular activities? Yes _____ No _____

   Please list any restrictions to extracurricular activities: _____
5. Further comments as to restrictions, limitations, etc. related to Hospital/Homebound services:_____

   _____

Only required for SOCIAL/EMOTIONAL DIAGNOSES

1. Does your examination of this student satisfy you that he/she is unable to attend a school based program, due to a social/emotional diagnosis? Yes_____ No_____
2. Is this student a danger to self or others? Yes_____ No_____
   If yes, please provide explanation:

   _____

PHYSICIAN'S RECOMMENDATION (REQUIRED):

****Students entering the Hospital/Homebound Program will be placed in the most restrictive educational and social environment where the student will NOT have physical contact with their peers during the school day.****

1. **PLEASE INDICATE IF HOSPITAL/HOMEBOUND SERVICES ARE NEEDED FOR A MINIMUM OF 3 CALENDAR WEEKS:**

   CHECK ONLY ONE:

   a.___ Homebound not needed-- able to attend school full time
   b. ___ Requires full time Homebound services
   c. ___ Requires PRN Homebound services (after absent 3 days)
   d. ___ Requires partial- day Homebound services (attends school)

2. **LENGTH OF TIME HOSPITAL/HOMEBOUND SERVICES ARE NEEDED:**

   a. **___One calendar year (this option should also be used if the student needs PRN services or partial day services)**
   b. _____ Months (Indicate the number of months)
   c. _____ Weeks (Indicate the number of weeks with 3 as the minimum)

   EXPECTED SCHOOL RETURN DATE: _____

3. ****FEDERAL DIRECTIVES REQUIRE COMPLETION OF THE FOLLOWING INFORMATION **:**

   a. The patient was last seen by the physician on _____ (date).

   b. Medical plan for the patient to re-enter a school-based program: _____

   _____

   c. List medications **and** effects on student performance: _____

   _____

   _____

Physician's Certification: With the understanding that the Hospital/Homebound Program is the most restrictive educational environment, **I certify that, in my professional opinion, it is medically necessary to place this child in this very restrictive educational environment.**

_____ _____
Physician's Signature and Title* *Date*

_____
Please Print Name ▶ Legibly ◀

Please make sure information is legible so that we can contact the office for needed information.

Physician/Psychiatrist Name: _____ Specialty: _____
Physician/Psychiatrist Address: _____
City, State: _____ Zip code: _____
Phone Number: _____ Fax Number: _____

*PLEASE NOTE: **If an ARNP or PA signs above,** the **name, signature, and phone number** of the supervising physician is required below:
*Please Print Supervising Physician and Title*_____ *Phone number* _____

*Supervising Physician's Signature*_____

CHECKLIST OF RESPONSIBILITIES OF PARENT/GUARDIAN OF HOSPITAL/HOMEBOUND APPLICANT:

PLEASE INDICATE BY CHECK MARKS AND YOUR DATED SIGNATURE THAT YOU HAVE READ THE FOLLOWING REGARDING PARENTAL RESPONSIBILITIES IN THE HOSPITAL/HOMEBOUND REFERRAL PROCESS:

☐ I understand that before Hospital/Homebound services can be provided, my child must be enrolled in a Polk County Public School; it is my responsibility to request enrollment.

☐ I understand that it is my responsibility to **first** follow-up with the doctor's office to confirm their completion and submission of the Hospital/Homebound Medical Information form, and **second** to call the Hospital/Homebound office to confirm that the completed form has been received.

☐ I understand that it is my responsibility to continue requesting and submitting completed assignments/makeup work, until the child is withdrawn from the school as grades will transfer with the student.

☐ I understand that if my child is too ill to attend school, I must continue to report absences to the school, per district policy, until an eligibility meeting **and** I give official written permission for instruction to the Hospital/Homebound Program.

☐ I understand that state eligibility criteria for Hospital/Homebound services require that the child be confined to the home or hospital. The only exception is if the student is co-enrolled with a school site.

☐ **I understand the Hospital/Homebound Program CANNOT duplicate the hours or all courses provided at a school site.**

☐ **I have read and understand the Hospital Homebound Program Criteria and Instructions form included with this packet.**

My child has access to a computer at home. ___ Y ___ N
My child has access to the internet at home. ___ Y ___ N

_____
Student Name

_____ _____
Parent/Guardian Signature Date

(PARENT SHOULD BE GIVEN A COPY OF COMPLETED FORM)