St Lucie Public Schools
Homebound/Hospitalized Program
9461 Brandywine Lane
Port St. Lucie, FL 34986
772.429.4568 Fax: 772.429.4589

Physicians/Psychiatrists:

The referral form must be completed in its entirety.

Students that are **confined to the home or hospital** may be eligible to receive educational services through the Homebound/Hospitalized Program. By completing this referral, **in its entirety**, you, as the physician/psychiatrist are indicating that the student is undergoing medical treatment by you for an illness or injury which is acute, catastrophic, or chronic in nature, and is expected to be absent from school due to this described illness or injury. (6A-6.03020)

Please note that referral forms with **omitted fields or fields marked N/A will not be processed**.

For additional **program information**, please contact:

Yvette Reid, Data Specialist – 772.429.4568 or Yvette.Reid@stlucieschools.org

Sandra Larson, Program Specialist at 772-429-4565 or Sandra.Larson@stlucieschools.org

Crystal Keener, Program Specialist at 772-429-7537 or Crystal.Keener@stlucieschools.org

Completed referrals should be faxed to the Exceptional Student Education office at: 772-429-4589 or sent in email to Yvette.Reid@stlucieschools.org

PARENTS: Please review information on page 2 and complete Section 1 on page 3. NOTE: The physician must complete all areas in section 2.

Before submitting the referral to the physician or psychiatrist for the professional to complete section 2, please sign and date section 1. This section must be completed before the referral can be processed.

Additional referral forms are available through the District Exceptional Student Education Office or the Guidance Counselor at the student's assigned school.

**** A NEW HOMEBOUND/HOSPITAL REFERRAL IS REQUIRED EACH SCHOOL YEAR**

Criteria for Eligibility

A student, who is hospitalized or homebound, is eligible for specially designed instruction if ALL the following criteria are met:

1.	Is expected to be absent from school due to a physical or psychiatric condition for at least fifteen (15) consecutive school days or the equivalent on a block schedule, or due to a chronic condition, for at least fifteen (15) school days or the equivalent on a block schedule, which need not run consecutively **and;**
2.	Is **confined to the home or hospital and;**
3.	Will be able to participate in and benefit from an instructional program **and;**
4.	Is under medical care for illness or injury which is acute, catastrophic, or chronic in nature **and;**
5.	Can receive instructional services without endangering the health and safety of the instructor or other students with whom the instructor may come in contact **and;**
6.	The student is enrolled in a public school in kindergarten through twelfth grade (K-12) or a Pre-K exceptional education student **and;**
7.	A parent/guardian or primary care giver signs parental agreement concerning hospitalized or homebound policies and parental cooperation. See page 3 of this packet.

Procedures for Determining Eligibility

A.	The minimum evaluation to determine eligibility shall be an ANNUAL medical report from a licensed physician. This report shall include **ALL** the following:	
	1.	A description of the disabling condition or diagnosis with any medical implications for instruction **and;**
	2.	A statement by the treating doctor that the student is unable to attend school **and;**
	3.	A description by the treating doctor of the plan of treatment **and;**
	4.	Recommendations by the treating doctor regarding school re-entry and other school-related activities **and;**
	5.	An estimated duration of the condition or prognosis made by the treating doctor.
B.	The completed Homebound/Hospitalized referral must be faxed to the Homebound/Hospitalized Office at 772-429-4528.	
C.	An eligibility meeting is scheduled at the student's assigned school.	
D.	An IEP (individual educational plan) or IFSP (individualized family support plan) is developed or revised prior to assignment to the Homebound/Hospitalized Program and to a school-based program due to an acute, chronic, or intermittent condition.	
E.	The parent, guardian, or primary care giver must sign parental agreement concerning Homebound/Hospitalized policies and parental cooperation.	

Dismissal from the Homebound/Hospitalized Program

Prior to returning to school the following **MUST** occur:	
1.	A doctor's permission to return to school (Doctor's Release Form) must be completed by the doctor. This form is available from the Homebound/Hospitalized Office or school guidance counselor.
2.	Parents must fax a copy of the Doctor's release to the student's assigned school.
3.	A dismissal or staffing will be scheduled with the student's assigned school.
A student **MAY** also be dismissed from the Homebound/ Hospitalized Program for the following reasons;	
1.	Medical eligibility expires.
2.	The student is no longer confined to the hospital or home.
3.	Failure to keep scheduled appointments in which case an IEP meeting will be scheduled to include a Program Specialist from the Homebound/ Hospitalized Program, teachers, parents, and student to discuss excessive absences or other matters that occur.

Attendance

Due to strictly enforced attendance policies, credit for courses may only be awarded when minimal contact hours have been met. If your child misses a class due to a medical appointment, it is your responsibility to obtain a doctor's note verifying your child was seen in the doctor's office that day. This note should be given to the Homebound/Hospitalized contact. Students enrolled in the Homebound/Hospitalized Program are expected to be in class. Unreported absences will result in an unexcused absence for the class. Absences must be reported by the parent/guardian to the Homebound/Hospitalized teacher in advance.

Incomplete forms will NOT be processed-all fields must be completed

St. Lucie Public Schools - Exceptional Student Education

REQUEST FOR CONSIDERATION FOR HOMEBOUND/HOSPITALIZED SERVICES

SECTION 1 – COMPLETED BY THE PARENT/GUARDIAN

Rule 6A-6.03020, Florida Administrative Code (FAC.), identifies a Hospital/Homebound student as a student who has a medically diagnosed physical or psychiatric condition that is acute or catastrophic in nature, or a chronic illness, or a repeated intermittent illness due to a persisting medical problem. **The condition or illness must confine the student to home or hospital and restrict activities for an extended period.**

Please note: It is the responsibility of the parent and the school to coordinate make-up work until the decision for Eligibility of Hospital/Homebound Services is determined at an Individual Education Plan (IEP) meeting.

Student Name	ID: 56
Date of Birth:	Grade:
Parent/Guardian/Adult Student Name:	
Home Address:	
Cell phone:	Home Phone:
Email Address	Work Phone:
School Name:	

PHYSICIAN'S CONTACT INFORMATION: To be completed by the Parent/Guardian/Adult Student**.**

Please include ALL Information

Physician's Name:			
Address:			
Phone Number:		Fax Number:	

CONSENT FOR MUTUAL EXCHANGE OF INFORMATON: To be completed by the Parent/Guardian/Adult Student

Your consent to this mutual exchange of information is needed to provide coordination of services. The information to exchange will include: **Educationally Relevant Medical Information related to Hospital/Homebound eligibility.**

Information will be shared between St. Lucie Public Schools personnel and the Physician, including medical and/or office staff.

Authorization Statement and Signature:

I authorize the School District of St. Lucie County, Florida to exchange information with my child's physician. This includes information required to complete an application for the Hospital/Homebound program. In addition, I understand that the doctor may be contacted as needed to obtain updated medical information relevant to Hospital/Homebound services. I understand that I have the right to revoke this consent at any time by giving written notice to the Hospital/Homebound office. Failure to authorize or revocation of consent will impact eligibility for Hospital/Homebound services.

_____ _____

Parent/Guardian/Adult Student Signature Date

SECTION 2 – COMPLETED BY THE PHYSICIAN/PSYCHIATRIST

Incomplete forms will not be processed-ALL fields must be completed

Physician/Psychiatrist Name:_____

Specialty:_____

Complete Address: _____
Street City State Zip Code

Telephone:_____ Fax Number:_____

Date of Referral:_____/_____/_____ Last Visit Date:_____/_____/_____

Expected School Return Date (MANDATORY):_____/_____/_____
If an **undetermined** date is indicated, the form will be **returned** to the physician and/or psychiatrist for an expected date of return.

If during treatment the physician/psychiatrist needs to extend the expected date of return to school, the physician/psychiatrist may do so by sending the following information on letterhead: Extended return to school date and the specific reason why the student must remain enrolled in the HH Program. Letters of extension may be emailed to Yvette.Reid@stlucieschools.org **or** Faxed to the Exceptional Student Education office at: 772-429-4589. **The extension request MUST be received prior to the original expected return date. If received after the expected return date, a new HH referral MUST be completed.**

Please review the eligibility criteria on the page 2 prior to completing the referral.

Condition: Describe the disabling condition(s) or diagnosis to support the need for Homebound Hospitalized Services (attach additional sheets if necessary):

_____
_____
_____
_____
_____

ELIGIBILITY: The licensed physician/psychiatrist must certify that the student meets all the following criteria for eligibility. Students who do not meet all of the minimum eligibility criteria listed below will not be eligible for Homebound/Hospitalized Services. **All questions must be answered by the physician/psychiatrist.**

	Enter checkmark in box and initial 1-9	YES	NO	INITIAL
1.	Could the student attend school with accommodations? If so, please describe. (e.g. second set of books at home or a wheelchair, etc.)			
2.	Could the student attend school regularly and receive Homebound/Hospitalized services on an intermittent basis as needed? (attend school when able and receive HH when ill)			
3.	Could the student attend partial days at school?			
4.	Is the student expected to be absent from school due to a physical or psychiatric condition for at least fifteen (15) school days or the equivalent on a block schedule?			
5.	Is the student **confined** to the home or hospital?			
6.	Will the student be able to participate in and benefit from an instructional program?			
7.	Is the student under medical care for illness or injury which is acute, catastrophic, or chronic in nature?			
8.	Can the student receive instructional services without endangering the health and safety of the instructor or other students the instructor may come in contact?			
9.	Do you recommend the student be placed in this most restrictive environment? See Note Below…			
NOTE: Students entering the Homebound/Hospitalized 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.				

Treatment Plan

Treatment and School Reentry Plan: The following information is required to determine eligibility for Homebound Hospitalized services and must be completed by the treating physician/psychiatrist.

1. What is the therapy schedule for this student?
   Daily _____ Weekly _____ Monthly _____

2. Expected duration of treatment/therapy? _____

3. Will the student be taking medication? Yes _____ No _____

4. Name(s) of medication _____

- Specify effects on student's ability to comprehend instruction. _____
  _____
- Specify effects on student's ability to complete independent assignments. _____
  _____
- Specify effects on student's ability to relate to teachers and other students. _____
  _____

5. Can this student return to school on an intermittent basis after his or her medication and conditions are stabilized? Yes _____ No _____

6. Can this student come into contact with other students? Yes _____ No _____

7. The Homebound/Hospitalized program is designed to be a temporary educational program to help children who are unable to attend school due to medical or psychiatric reasons. Please describe your time frame and transitional plan for the student's reentry to school: _____

_____

_____

Duration of absence from regular school is expected to be: _____ weeks or _____ months
(specify the number of weeks or months 1 school year maximum.)

Confinement Level (Placement): the physician/psychiatrist must certify that the student is unable to attend school. Based on your examination, which level of confinement do you recommend for consideration? Check one.

_____ Full-time Hospital/Homebound - Student is **unable** to attend any portion of the school day.
_____ Part-time Hospital/Homebound – Student is able to attend school part day for _____ hours a day.
_____ Intermittent Hospital/Homebound – Student is able to attend school; however, it is expected that they will experience intermittent days of hospitalization or home confinement.

Physician's/Psychiatrist's Certification: I certify that this student is under my care and treatment for the aforementioned illness. The information provided and my recommendation have been made based on the current medical needs of the patient, keeping in mind that the least restrict educational setting is mandated by federal law. This further certifies that this treatment plan is necessary.

_____ _____ _____
Physician's/Psychiatrist's Signature Title Date
If ARNP or PA signature above,
print supervising physician's/psychiatrist's name/title: _____

Medical Provider Signature MUST be original. Reproduction such as a stamp, will not be accepted.