Application

Hospital/Homebound Program

4229 EDISON AVENUE
Building 10
Jacksonville, FL 32254
(904) 381-3840 -Main Phone No.
(904) 381-3848-Fax
Hospital/Homebound Application

4229 Edison Avenue, Bldg 10, Jax, FL 32254 Phone 381-3840 FAX 381-3848

**Parent or Guardian Application Section**

Student Name ____________________________________________________________ DOB __________

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Address________________________________________________________________

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<th>Street</th>
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<th>Zip</th>
<th>County</th>
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Parent/Guardian(s) Name__________________________________________________

Phone: Home__________________ Work ____________________ Cell__________________

Race ______ Gender____ Current School____________________________________

Grade _______________ Home Room Teacher________________________________

Do you have a home computer? __________ What type of Internet access? __________

E-mail Address (Parent) ____________________________ (Student) __________________________

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**Eligibility Policies**

1. I understand that eligibility is based on Florida Statutes, State Board Rule 6A-6.03020, and that the physician statement and medical referral forms are part of the information used to determine eligibility;
2. I understand that my child must be enrolled in a public school prior to the submission of the referral for Hospital/Homebound services;
3. I understand that Hospital/Homebound services are for students confined to the home or hospital due to a medical or mental condition, which is acute, catastrophic or chronic in nature;
4. I understand that if my child is eligible for Hospital/Homebound services and circumstances change, my child will be dismissed from the program so that he/she can return to school;
5. I understand that if my child is eligible for Hospital/Homebound services, each of his/her absences must be reported to the Hospital/Homebound office daily.

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**Program Dismissal**

Dismissal from the Hospital Homebound Program may occur for the following reasons:

1. The physician recommends that a student can attend his/her district assigned school;
2. The student is unable to participate in and benefit from instruction;
3. When the Hospital/Homebound office does not receive an updated Physician’s Certification form by the expiration date, the student will be withdrawn to his/her district assigned school;
4. The student fails to follow the DCPS Code of Student Conduct policies.
PARENT/GUARDIAN AGREEMENT

If approved, I understand the following:

☐ I will provide a quiet, clean, well-ventilated setting for student and teacher in my home;

☐ I will ensure that a responsible adult is present;

☐ I will establish a schedule for student study between delivered instructional times;

☐ I will foster my child’s independent work ethic and will assist only as needed;

☐ I will provide Hospital/Homebound an updated medical application prior to expiration date;

☐ If there is a change in physician, I will provide an additional Hospital/Homebound application, completed by the new physician;

☐ I agree to provide the Hospital/Homebound program staff any updated information regarding the physician’s treatment plan for my child;

☐ I give permission for the physician(s) and appropriate school board personnel to exchange information and records regarding my child’s medical condition, diagnosis and instructional program; Parent/Guardian ( ) initials

☐ I agree to cooperate with the DCPS policies including the Code of Student Conduct and those of the Hospital/Homebound Program, during my child’s enrollment in the Hospital/Homebound Program;

☐ I am aware that AP courses and some electives courses are not available through the Hospital/Homebound program;

☐ Upon withdrawal from the Hospital/Homebound program, I understand that I must enroll my child back in his/her district school;

☐ I understand that provision of incomplete information may delay the application and eligibility determination process to the Hospital/Homebound Program.

__________________________  ______________________________
Parent/Guardian Signature  Date

(NOTE: Provision of incomplete information below may delay application process)
PHYSICIAN CERTIFICATION (MUST BE LICENSED BY THE STATE OF FLORIDA)

Physician’s Name___________________________________________________________

Address_______________________________________________________________

Phone Number_______________________ Fax Number___________________________

Office E-Mail ___________________________________________________________

ELIGIBILITY: The FL licensed physician must certify that the student meets criteria for eligibility. If the student is not eligible for the Hospital/Homebound program he/she could be considered for other services.

Yes  No

☐ ☐  Is the student under medical care for illness or injury which is acute, catastrophic, or chronic in nature?

☐ ☐  Is the student expected to be absent from school due to a physical or psychiatric condition for at least 15 consecutive school days, or due to a chronic condition, for at least fifteen (15) school days which need not run consecutively?

☐ ☐  Is the student confined to the home or hospital (facility)?

☐ ☐  Is the student well enough to participate in and benefit from an instructional program?

☐ ☐  Can the student receive instructional services without endangering the health and safety of the instructor or other students with whom the instructor may come in contact?

☐ ☐  It is my recommendation that this student may (YES) or may not (NO) participate in physical education at this time.

RECOMMENDED SERVICE DELIVERY MODE (please select one below):

_____ Full-time Hospital/Homebound - Student is UNABLE to attend ANY portion of the school day

_____ Part-time Hospital/Homebound - Student is ABLE to attend a partial school day/week

_____ Attend school part-day for _____ hours

_____ Attend school on non-consecutive days based on chronic condition
PHYSICIAN TREATMENT PLAN

FLORIDA STATE BOARD RULE 6A-6.03020 REQUIRES THE FLORIDA LICENSED PHYSICIAN(S) TO DESCRIBE THE PLAN OF TREATMENT AND PROVIDE RECOMMENDATIONS FOR SCHOOL RE-ENTRY. PLEASE COMPLETE THE FOLLOWING:

1. Please indicate the student’s diagnosis:

2. Explain in detail how the physical or psychiatric condition you have diagnosed will significantly limit the child’s ability to receive educational benefit in the regular school setting. In what way(s) would the child’s ability to function in the school setting be jeopardized?

2. Describe your treatment plan for the child (include the frequency and duration of the treatment for psychiatric conditions.)

3. List any medication(s) the child is taking and explain the effects, if any, the medication(s) may have on the child’s ability to achieve educational benefit in the school setting?

4. The Hospital/Homebound Program is designed to be a temporary educational program to help children who are unable to attend school for medical or psychiatric reasons. The amount of instruction provided by the Hospital/Homebound Program is significantly less than that provided by the regular school setting. Given this, indicate below the date this student will reenter his/her district assigned school:

   RE-ENTRY DATE: ________________________

   (NOTE: Provision of incomplete information below may delay application process)

Physician’s Certification: I certify that this student is under my care and treatment for the aforementioned illness. My recommendation has been made on the medical needs of the patient, keeping in mind that the least restrictive setting is mandated by federal law.

This certifies that this treatment plan is medically necessary. Date: ______________________

_________________________________  _____________________________
(Print) Physician’s Name            Physician’s Signature

(If an ARNP or PA signs above, the name/phone number of the supervising physician is required below.)

_________________________________  _____________________________
Supervising Physician Name        Supervising Physician Phone

5 | Page    Student Name ___________________
The Hospital/Homebound staff forms a partnership with the student’s assigned school in order to facilitate and support the delivery of educational services. THE PUBLIC SCHOOL WHERE THE STUDENT IS CURRENTLY ENROLLED WILL:

- Provide assignments, grades and maintain the record of attendance until the student is officially enrolled in the Hospital/Homebound program;
- Provide withdrawal grades and student schedule(s) to the Hospital/Homebound program, upon request;
- Provide applicable textbooks;
- Participate as a member of the Individual Education Plan (IEP) Team, as appropriate.

TO BE COMPLETED BY PUBLIC SCHOOL WHERE STUDENT IS CURRENTLY ENROLLED:

Student Name: ___________________________ Student #: ___________________________

Last Day of School Attendance__________ Current ESE Program(s): ________________

I am aware that this student is applying for the Hospital/Homebound Program. The following information should be considered in the determination of eligibility for the Hospital/Homebound program.

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Principal’s Signature ___________________________ Date ________________

(NOTE: Provision of incomplete information below may delay application process)