Volusia County Schools

Parent Information for Hospital/Homebound Services

Phone: (386) 255-6475, ext. 38395; Fax (386) 943-3413

Please read all information below prior to signing consent to exchange information with physician.

1. Hospital/Homebound is intended to be a temporary instructional program through Exceptional Student Education for students with a catastrophic or acute illness and is not designed to replicate a typical school day or school hours.
2. Students must be enrolled at their assigned school in Volusia County prior to initiating the Hospital/Homebound eligibility process.
3. Hospital/Homebound is not a program of choice for parents nor is it designed to provide services to students with attendance issues without a diagnosed catastrophic or acute medical condition. Please contact your child's school counselor for additional information regarding parent programs of choice or attendance concerns.
4. If the student is not attending school**, it is the responsibility of the parent and the zone school to coordinate student assignments up until the decision for Hospital/Homebound eligibility is made**. Hospital/Homebound will not assign make up work. Student withdrawal grades may be impacted by excessive absences without complete student work.
5. If the student can access the school campus, travel outside of the home or access any activities in the community, the student may not be eligible for full time Hospital/Homebound services. Part time eligibility may be considered.
6. Decision of eligibility for Hospital/Homebound services is determined by the IEP committee. Information obtained from the physician will be reviewed when making this determination, and all relevant student information will be considered when making eligibility decisions, including prior history of participation in the Hospital/Homebound program.
7. The Physician's Referral for Hospital/Homebound services must be completed by a medical doctor or osteopathic physician certified in the state of Florida. A chiropractic physician or psychologist **may not** complete the referral.
8. Hospital/Homebound services will not be considered until all required information is obtained from the physician supervising the medical treatment plan related to the referral for Hospital/Homebound.
9. Students who are found eligible for Hospital/Homebound services, based upon their documented medical diagnosis and/or current medical treatment plan, must be able to fully participate and demonstrate benefit from the program. The student must be able to follow the assigned instructional schedule. Failure of the student to attend scheduled instructional lessons, complete assignments, and/or participate in scheduled courses will require an Individual Education Plan (IEP) meeting to discuss further participation in the Hospital/Homebound program.
10. To determine eligibility for the Hospital/Homebound program, the following steps must be followed:
    a) Parent reads and signs ***Parent Information for Hospital/Homebound Services*** and ***Consent for Exchange of Medical Information for Hospital/Homebound Services*** forms.
    b) Parent submits the signed forms to the Hospital/Homebound office via Fax - **386-943-3413**, email - HomeEducation-HospitalHomebound@volusia.k12.fl.us or US Mail – **Tina Sutton, Hospital/Homebound at Atlantic High School, 1250 Reed Canal Rd., Port Orange, FL 32129**
    c) **Parents may not take the Hospital/Homebound referral to the physician or return completed referral to Volusia County Schools.** Hospital/Homebound staff will fax the referral to the physician's office.
    d) Physician faxes or mails back the completed referral to the Hospital/Homebound office. Please note: **Failure of the Physician to return the application in a timely manner and/or receipt of an incomplete referral may delay determination of eligibility for Hospital/Homebound.**
    e) An eligibility IEP meeting is scheduled by Volusia County Schools at the student's school of enrollment.

I have read the above information and understand I am making a request to begin the referral process for Hospital/Homebound.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

Student Name: _____ Student Alpha: _____

Volusia County Schools

Consent for Exchange of Medical Information
for Hospital/Homebound Services

Phone: (386) 255-6475, ext. 38395; Fax (386) 943-3413

Rule 6A-6.03020, Florida Administrative Code (FAC.), identifies a H/H 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 of time.

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.

PARENT SECTION: To be completed by Parent/Guardian.

Student Name: _____**Student ID**: _____ **DOB:** _____ **Grade**: _____

Home Address: _____**City**: _____ **Zip**: _____

School Name: _____

Parent/Guardian's Name: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____

(Hospital/Homebound will communicate with you via email regarding the status of the Hospital/Homebound referral.)

PHYSICIAN'S CONTACT INFORMATION: To be completed by the Parent/Guardian. Please include the physician's fax number.

Physician's Name: _____

Address: _____

Phone Number: _____ **Fax Number**: _____

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

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

Information will be shared between: Volusia County Schools district personnel and the Physician, including medical and/or office staff.

Authorization Statement and Signature:

I authorize the School District of Volusia 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. A copy of this consent form with revocation date indicated will be sent to me upon revocation. Failure to authorize or revocation of consent will impact eligibility for Hospital/Homebound services.

Signed: _____ Date: _____

Parent/Guardian/Educational Surrogate

Office Use: Date Consent Revoked _____ Date Confirmation Copy Sent to Parent _____

Please submit the signed Parent/Guardian Consent for Exchange of Medical Information to:
Hospital/Homebound at Atlantic High School via county mail or by fax (386) 943-3413.