



Mohave District Annex
8505 E. Valley View Road
Scottsdale, AZ 85250-6768

Telephone: 480-484-5065
FAX: 480-484-5108
Web site: www.susd.org

Application Form for the Homebound Program

Dear Parent or Guardian,

Please complete and sign the referral information below. Have your child's physician complete the physician's portion on the reverse side.

Return the form to Tiffany Maxwell/Calli Greenbaum, Homebound Specialists, at the above address.

A decision will be made regarding your child's placement in the program.

If you have any questions regarding homebound services, please call: 480.484.5065

Student: _____ Date of Birth: _____ Sex: _____
 Last First MI

Student #: _____ School: _____ Grade: _____

Parents/Guardians: _____

Address: _____, _____ AZ 85_____

E-mail Address _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

I confirm that the information above is correct and that I give my consent for the homebound department to contact my child's doctor to verify the information contained in this application.

Parent Signature: _____ Date: _____

Student Name: _____

Student ID#: _____

Physician signature certifies that it is his/her opinion that this student will not be able to attend school for a period of at least 3 months (see *definitions below**) due to the following condition (*described below*). The patient, if eligible, will be able to receive academic instruction in the home or hospital setting while services are necessary.

Physician Information (MUST BE SIGNED BY A MEDICAL DOCTOR)

Please Attach Your Business Card

Physician's Name (please print): _____

Address: _____, AZ 85 _____

Telephone: _____

Diagnosis limiting student from attending school for more than 60 school days:

How does this diagnosis prevent the student from attending school full time?
Please specify:

Limits of academic instruction due to condition:

___ No Limits

___ Other: Please specify:

Could this student attend school part time? Y N

Could this student take their coursework on-line? Y N

Is condition due to an illness (chronic)? Yes No If yes, please explain

The last time I treated this patient was on _____.

The anticipated date of return to the regular classroom is _____
Please note specific date)

Physician Signature: _____ **Date:** _____

(Definition: "Homebound" or "Hospitalized" means a pupil who is capable of profiting from academic instruction but is unable to attend school due to illness, disease, accident or other health conditions, who has been examined by a competent medical doctor and who is certified by that doctor as being unable to attend regular classes for a period of not less than three school months or a pupil who is capable of profiting from academic instruction but is unable to attend school regularly due to chronic or acute health problems, who has been examined by a competent medical doctor and who is certified by that doctor as being unable to attend regular classes for intermittent periods of time totaling three school months during a school year. The medical certification shall state the general medical condition, such as illness, disease or chronic health condition that is the reason that the pupil is unable to attend school. ARS 15-901(B) (13)

Placement Decision

Accepted Rejected Reason: _____

Homebound Administrator signature

Date