# *EAST ALLEN COUNTY SCHOOLS*

*Special Services Department*

## HOMEBOUND SERVICE PLAN

Date: _____

Student Name: _____ DOB: _____ Gender: _____

Address: _____ Phone: _____

Parent or Guardian: _____

School: _____ Grade Level: _____

The purpose of this meeting is to coordinate and communicate with the parent and appropriate staff to determine:

1. instructional areas (courses) the student is to take;
2. schedules for instruction;
3. location and/or method instruction will be provided; and
4. how the services can effectively and efficiently deliver instruction to the homebound student.

Based upon the information discussed, the following plan was determined.

Coordinator for assignments: _____

Location/Method for instruction: _____

| *Instructional Areas* | *Student's Teacher(s)* | *Homebound Teacher(s)* | *Schedule* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Other considerations: _____

_____

_____

Homebound instruction will begin on or about ___/___/___ (date) and will conclude on or about ___/___/___ (date).

_____ (Principal/Designee)

_____ (Parent/Guardian)

Copies to: Parent/Guardian Cumulative File Special Services Department

SpBH – 2 (1of2) (2010)

*Questions to be completed if student is experiencing emotional problems and outpatient psychological treatment is being provided.*

Student's Name _____

1. Explain the diagnosis and why this prevents student from attending school (be specific):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

2. Frequency and goals of therapy sessions:

_____
_____

3. If medication is prescribed, please specify dosage and type:

_____
_____

4. Anticipated duration of therapy:

_____
_____

5. Anticipated return to school:

_____
_____

**A request must be submitted every ninety (90) days to continue homebound services.**