Policy Analysis on United States Homebound Statutes and Regulations for Students with Chronic Health Conditions

RESEARCH

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ABSTRACT

In contemporary U.S. samples, approximately one-fifth to nearly one-half of school-age children have a chronic health condition requiring ongoing medical care. This study examined policies and practices related to homebound instruction for students with chronic health conditions across the United States. Applying qualitative coding to the state statutes and Department of Education regulations to identify elements related to: *Eligibility*, *Policy Provisions, Instruction*, *and Continuity*. Of 51 jurisdictions (including Washington, DC), 40 have active statutes and regulations relevant to homebound instruction. Key findings revealed significant variation in eligibility criteria, instructional time requirements, and implementation timelines, with many policies lacking clear definitions for timely service provision and failing to address assessment considerations. Recommendations include reducing eligibility timeframes, expanding acceptable healthcare providers, establishing clear timelines for eligibility determination and service implementation, increasing minimum instructional time, developing reintegration support guidelines, addressing attendance tracking and curriculum requirements more explicitly, requiring professional development for educators, and merging guidance on chronic health and homebound statutes. By implementing these recommendations, policymakers and educators can ensure students with chronic health conditions receive high-quality education despite health-related challenges.

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KEYWORDS:
chronic medical conditions; state policies; homebound; schools; students; education

TO CITE THIS ARTICLE:
Perfect, M., Tureaud, C., Giroud, G., & Larez, N. (2026). Policy Analysis on United States Homebound Statutes and Regulations for Students with Chronic Health Conditions. *Continuity in Education*, 7(1), pp. 82–95. DOI: https://doi.org/10.5334/cie.345

DOI: 10.5334/cie.345

Between 20% and 45% of school-age children receive ongoing medical care for chronic health conditions (Forrest et al., 2025; Stille et al., 2022). An estimated 13% to 27% of youth have a chronic physical illness or health-related condition (Wijlaars et al., 2016). Chronic illness can prevent children from attending school, leading to missed assignments, academic struggles, social isolation, psychological stress, and significant learning barriers (Perfect & Moore, 2019). Lum et al. (2019) also revealed significant educational disparities for chronically ill students, with these students facing a substantially higher likelihood of grade repetition, parent-reported academic struggles, and illness-related absences compared to students without chronic health conditions. Additionally, nearly 8,000 per 100,000 children are hospitalized annually in the United States (Steinke et al., 2016). Even short-term illnesses or intermittent flares of their condition may result in significant disruptions in school functioning (Schuster et al., 2011). In a seminal publication addressing the educational-medical gap, Thies (1999) articulated:

> Who is responsible for managing the education of an adolescent with [a chronic illness] who misses six weeks of algebra and biology – two to four days at a time? This question highlights the challenges to schools posed by children and adolescents with chronic illness. Unlike other disabilities, the course of illness presents a roller coaster of changing needs, moving between acute and medical crises and long-term management of health. Some move in and out of the special education system depending on their health status, a system whose policies, practices, and expectations are not necessarily a good fit. (p. 396)

Since that publication, the integration of better technologies, improved clinical practices for treatment, and the introduction of new medications have contributed to increased survival rates (Burke & Alverson, 2010). On an international level, all children have a right to education and to non-discriminatory access even when illness disrupts school participation (Flood & Carey, 2025). Holistic legal protections, aligned educational and hospital practices, as well as research-based evidence guiding service delivery are potential avenues for mitigating the risk that students who are hospitalized or homebound will become physically, socially, and academically siloed (Kanter, 2019). In practice, this means that education systems bear a responsibility to ensure that chronic or recurring health needs do not arbitrarily limit students' opportunities to learn, participate, and progress alongside their peers (Todres, 2009). Within the United States, although there are federal educational policies, it is generally expected that each jurisdiction (50 states and the District of Columbia [Washington D.C.]) establishes its own regulations (U.S. Department of Education, 2025). This analysis, therefore, examines ways that U.S. federal and state frameworks translate these broader international norms into policy for students whose participation in school is prolonged or intermittently limited by chronic illness, as well as where important gaps remain. To understand the status of homebound policies across the United States, this article presents findings from a systematic analysis of state statutes and Department of Education regulations that address the provision of instruction and educational services to youth with chronic medical conditions.

POLICIES GOVERNING THE EDUCATION OF STUDENTS WITH CHRONIC MEDICAL CONDITIONS

Policies create a culture of service delivery that upholds expectations of supporting those in need and ensuring access to care. Policies include statutes (laws passed by the legislature) and regulations developed by designated agencies such as the Department of Education, both of which are binding (e.g., Department of Education).

FEDERAL REGULATIONS

At the federal level, students with chronic medical conditions may receive accommodations through Section 504 of the Rehabilitation Act of 1973, as any medical condition is eligible as long as it "causes a substantial limitation on the student's ability to learn or [to complete] another major life activity" (U.S. Department of Labor, 1973). The Americans with Disabilities Act (ADA), enacted in 1990 to forbid discrimination for individuals with disabilities, applies both in and outside the school setting (U.S. Department of Justice Civil Rights Division, 1990). The ADA Amendments Act of 2008 included an amendment to the Rehabilitation Act of 1973,

DOI: 10.5334/cie.345

clarifying the meaning of disability in Section 504, expanding examples of "major life activities" to include "eating, sleeping, standing, lifting, bending, reading, concentrating, thinking, and communicating." Most chronic medical conditions result in difficulties in one or more of these areas (ADA 42 U.S.C. §12101 et seq, 2008).

Enacted in 1975, the Individuals with Disabilities Act provides youth with disabilities with the right to a Free and Appropriate Education (FAPE), requiring all schools to provide access to and instruction for students K-12. Students with medical conditions who need specially designed instruction may be eligible for a special education classification of Other Health Impairment (OHI) under the Individuals with Disabilities Education Improvement Act (IDEIA; U.S. Department of Education, 2017). However, since states often oversee educational practices, it is critical to evaluate the current statutes and regulations that govern the education of students with chronic medical conditions.

The lack of clarity or even the existence of legal mandates has created a domino effect of federal, state, and local education agencies leading to inadequate FAPE provisions to students who cannot attend school due to their chronic health conditions. To understand the status of homebound policies across the United States and their implications for educational continuity, this project analyzed U.S. state laws and regulations, providing up-to-date information and recommendations to the general public, educators, and families.

METHOD

SAMPLE

Researchers conducted an internet search to retrieve U.S. laws, statutes, and regulations related to education for children with chronic health conditions. In conjunction with each state name, the following keywords were searched: special healthcare needs, chronic illness, chronic medical condition, chronic illness, homebound laws/statutes, hospital instruction). The timeframe for extracting the statutes and regulations was from January to May 2024, with coding occurring over the following year. A targeted cross-check for policy updates was conducted in May 2026 for the jurisdictions originally coded. Any changes to jurisdictions that lacked relevant policies during the initial data collection window are not reflected in the updated review.

PROCEDURE

The approach taken was consistent with several previously published educational policy analysis studies (Briesch et al., 2018; Eklund et al., 2018; MacFarlane & Kanaya, 2009; Maki et al., 2015; McNicholas et al., 2017; Pennington et al., 2014; Perfect et al., 2013). The primary goal was to identify and obtain the original law or policy. As another step, we reviewed websites and documents containing U.S. state policies established by the state's Departments of Education. When statutes or regulations were unavailable for retrieval, we contacted representatives from state education departments to determine whether policies regarding youth with special healthcare needs existed, and if relevant, obtain them. Prior to coding the compiled laws, each research team member underwent training on homebound education background and a three-hour coding training session. Supplemental Appendix 1 includes the full list of regulations examined and coded, as not all of these were specifically cited in this article.

Once policies were compiled, researchers developed a multi-stage, inductive coding scheme using Taguette software for qualitative analysis. To reduce coding inaccuracies attributable to coder drift, three coders were randomly assigned 26 jurisdictions, with rotating coder pairings. The initial cycle established 25 evaluation codes followed by a secondary coding cycle that generated 120 subcodes to identify more specific patterns. After the double-coding process was complete, the first author met with each pair of coders to examine, discuss, and resolve discrepancies through consensus judgments (McNicholas et al., 2017). Following review of the final codes, they were conceptually organized into four overarching themes, Eligibility, Policy Provisions, Instruction, and Continuity (see Table 1), which capture the full extent of existing homebound policies. As part of the coding and interpretation process, qualitative indicators of reliability and validity included credibility (e.g., team debriefing, triangulation, dependability, and meticulous documentation; Ahmed, 2024; McKim, 2023; Korstjens & Moser, 2017).

Eligibility *Codes*: Qualifying Conditions, Certification Requirements, Time Until Determination, Time Until Implementation, Time Until Eligible, Renewal Requirements
Policy Provisions *Codes*: Reference to Special Education, Dispute Resolution, Last Updated, Recording of Attendance
Instruction *Codes*: Instructional Time, Instructional Modality, Curriculum Requirements, Educator Qualifications
Continuity *Codes*: Oversight of Implementation, Jurisdiction, Monitoring, Recording of Attendance, Caregiver Involvement, Flexibility Scheduling, Reintegration/Transition

Table 1 Policy Coding Framework.

Note: Primary conceptualized themes are presented in **bold**. The qualitative codes contributing to each theme are listed below under "Codes."

RESULTS

ELIGIBILITY

Only 24 jurisdictions (47% overall; 60% of coded states/Washington, DC) included conditions that meet eligibility criteria for homebound instruction. Some states simply mentioned chronic illness or physical conditions; others listed specific conditions. For example, Maryland, outlined that "These conditions include, but are not limited to, kidney failure, cancer, asthma, cystic fibrosis, sickle cell anemia, depression, and bipolar disorder. including drug and alcohol dependency" (MD Code §13A.03.05.01, 2023). Delaware specified "sudden physical or mental illness; Accident; Episodic flare up of a chronic physical or mental health condition; Injury; or Pregnancy, childbirth or related medical condition" (DE Code §930, 2019).

Thirty-one (61% overall; 78% of coded states/Washington, DC) states addressed certification requirements including enrollment requirements, educational profit, and/or healthcare provider qualifications. Nineteen states required students to be prevented from attending school and/or confined to their homes or hospitals. Nine states referenced documenting the potential to benefit from or potential to make progress. Two states restricted students from receiving homebound instructional services if they were enrolled in a nonpublic or virtual school, whereas three states specified enrollment in a public school as a condition to be eligible for homebound.

Regarding healthcare provider qualifications for eligibility, twenty (39.21% overall; 53% of coded states/Washington, DC) states specified a medical doctor/licensed physician, and six states indicated a nurse practitioner. Seven states allowed a mental health provider to authorize homebound instruction and both Maryland and Pennsylvania both permitted a school psychologist to authorize homebound instruction. Some jurisdictions permitted a broader range of providers; Washington, DC's statute included "licensed physician, licensed nurse practitioner, licensed clinical psychologist, licensed mental health counselor or therapist, or physician assistant" (Washington, DC Code §38-251.01–§38-251.10, 2020). Twenty-three (45% overall; 58% of coded states/Washington, DC) states explicitly provided a timeframe for missed school days to become eligible for homebound services. Michigan, Oregon, and Wyoming stood out for prompt implementation, qualifying students after missing more than five days to a week. Fourteen of these states required 10 to 15 consecutive, cumulative, or intermittent days of absence. Three states established longer eligibility periods ranging from 16 to 29 days, though these were often cumulative or aggregate absences. Illinois, however, clarified not only the total number of days, but also when services were expected if a child were to miss school on an "ongoing intermittent basis." The statute defined this to mean "that the child's medical condition is of such a nature or severity that it is anticipated that the child will be absent from school due to the medical condition for periods of at least 2 days at a time" (IL Stat §14-13.01, 2018). Washington, DC encompasses many avenues for coverage such as,

> students who have been or are anticipated to be absent, on a continuous, partial, or intermittent basis, from their school of enrollment for 10 or more consecutive or cumulative school days during a school year due to a health condition. (Washington, DC Code §38-251.01–§38-251.10, 2020)

Other states introduced variations with short-term and long-term eligibility thresholds. Georgia's temporary homebound service requires fewer than nine weeks of absence and a minimum of 10 consecutive (actual or anticipated) days. Like Illinois, Georgia included intermittent absences caveat, allowing homebound services when a student has an anticipated minimum of 10

days, provided they miss "at least 3 consecutive days for each occurrence" (GA Code §160-4-2-.31, 2009). Long-term homebound service is indicated when the student has a "medically diagnosed chronic health condition which may cause the student to be absent from school for more than nine consecutive weeks per year or equivalent on a modified calendar" (GA Code §160-4-2-.31, 2009). At the far end of the spectrum, Texas and Washington required four weeks or one month of estimated or expected absence. Likewise, Arizona established eligibility for those with an "illness, disease, accident, or other health conditions" as being "unable to attend regular classes for a period not less than three school months" (AZ Stat §15-901(B)(16), 2022). However, that statute also indicated that a doctor may certify students with chronic or acute health problems for homebound if they are "unable to attend regular classes intermittent periods of time totaling three school months during a school year" (AZ Stat §15-901(B)(16), 2022). Figure 1 includes a timeline listing the states based on their Time to Eligibility as well as whether their statute includes terminology for anticipated, consecutive, or intermittent.

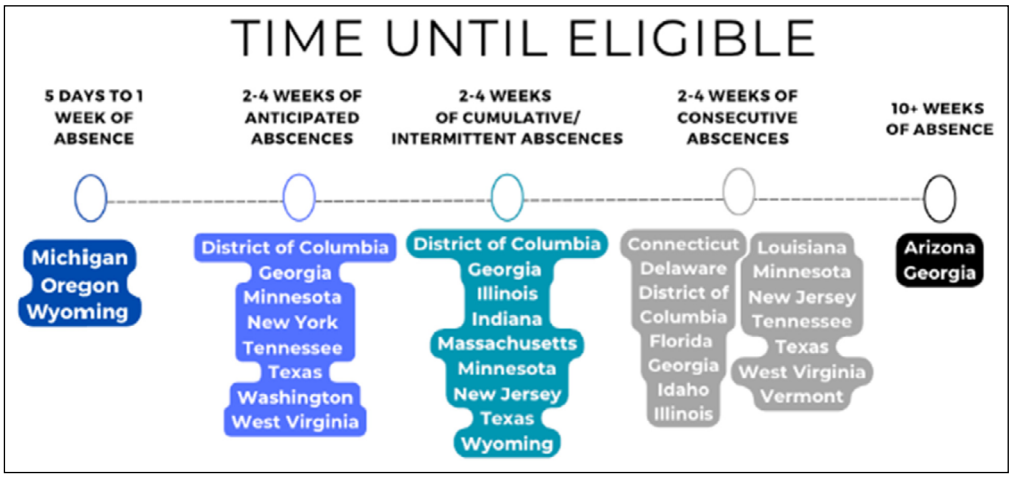


Figure 1 Coded United States Department of Education.

Disclosure: The criteria for eligibility based on time missed can vary between states and may depend on whether the absence is anticipated, consecutive, intermittent, or cumulative. The following map shows where states require a specific duration of absence for eligibility; however, the interpretation can differ based on the terminology used. For example, in Arizona, a student must have three school months of absences, but this can include the cumulative total of intermittent absences.

Nine (18% overall; 23% of coded states/Washington, DC) states' policies referenced a maximum time to determination for rendering a decision regarding approval or denial of homebound instruction. Five states specified a determination within five days. Two states were coded as requiring a determination within 10 to 15 days. Missouri did not specify a determination timeline but required that if homebound services are denied, the principal or designee must notify the requesting party within five school days. Wisconsin had the longest window, requiring a written decision "within 90 days of a request." (WI Stat §118.15(1)(d), 2024)

Nine (18% overall; 23% of coded states/Washington, DC) states were also coded for time until implementation of homebound services as "immediately" or between three and five days, while three states indicated instruction needed to begin within 10 to 15 days. Four states included the added requirement that medical clearance is required in addition to the timeframe. An example of this caveat was Oregon, which only specified parameters around implementation in state-operated hospitals, "educational services in state operated hospitals must commence if a patient's hospital stay is expected to last five schools' days or longer and the hospital staff has determined the patient is medically able to receive educational services" (Oregon Administrative Rule [OAR] §581-015-2580, 2021). Policies related to determination and implementation include phrasing such as *immediately*, *within*, *no later than*, *[number] day of absence*, or *by [number of days]*.

Renewal requirements were coded for 11 (22% overall; 28% of coded states/Washington, DC) states. Three states required reviews for continued eligibility every 30 days, six states mandated reevaluation every 60 days, two required three months or 90 days, and four indicated annual recertification. Without providing a specific review timeline, Iowa's regulation indicated:

> The provision of services in a home or hospital setting shall satisfy the following: a. The service and the location of the service shall be specified in the individual's IEP. b. The status of these individuals shall be periodically reviewed to substantiate the continuing need for and the appropriateness of the service. (IA Code §281-41.410, 2024)

DOI: 10.5334/cie.345

POLICY PROVISIONS

Twenty-nine (57% overall; 73% of coded states/Washington, DC) states made some reference to special education. Eight states specified in their regulations that homebound is available to general education and special education students and require schools to follow the special education plan (IEP or 504) if a student is placed in or is currently in special education. Sixteen additional states explained that homebound instruction for students with disabilities must be delivered in accordance with their IEP or 504 Plan. Five states exclusively referenced homebound in the context of special education.

Nine (18% overall; 23% of coded states) states were coded for dispute resolution. Five states referred to parents' ability to appeal decisions regarding eligibility or delivery parameters for home, hospital instruction. or other placement. Two states were coded as indicating that the school administration's decision regarding placement is final. Three states referenced parental rights for due process as related to special education. Washington, DC stood out for its detailed description of the appeal process for homebound instruction.

Twenty-four (47% overall; 60% of coded states/Washington, DC) unique states were coded for recording of attendance. Thirteen states were coded for mentioning the need to calculate average daily attendance; six of those, along with an additional six, indicated that students receiving homebound instruction or in a hospital could be counted as present. Five states outlined hours to day conversion such that a certain number of hours per week/day of instruction were deemed equivalent to a full school day. For instance, Nevada describes:

> More than 1 day of attendance may be accumulated during a single instructional session of more than 1 hour, but the number of days of attendance reported for the pupil for that school year may not exceed the minimum number of days of free school required. (NV Code §387.286, 2023)

Thirty-one (61% overall; 78% of coded states/Washington, DC) states were coded for listing a date in which at least one aspect of the policies had been last updated. Four states contained at least one update within the past year. One state did not appear to have been updated in nearly 20 years. Six states had evidence of at least one revision from 10 to 19 years ago. The remaining states appeared to have partial updates to their laws from one to nine years ago.

INSTRUCTION

Regarding instructional time (i.e., hours or amount of time a student who is homebound/hospitalized is entitled to), 26 (51% overall; 65% of coded states/Washington, DC) states addressed the requirements. Three states were coded as two or fewer hours per week, and six states mandated 10 to 12 hours per week (one with fewer for elementary, one with more for secondary, and one based on the number of days needing service). Most states required between three and five hours of instruction weekly (12 states, two with more for secondary). States employed different methods to calculate instructional time, including minimum hours per day, average hours per day, or a specific number of hours per week. Several states differentiated instructional time based on grade level, such as Connecticut (five hours versus 10 hours), Delaware (three hours for elementary versus five hours for secondary), New York (10 hours for elementary versus 15 hours for secondary), Rhode Island (five versus six hours), Vermont (six versus two hours for each core course for secondary). Four states did not specify a minimum instructional time, but rather indicated it should be based on students' needs or as indicated in a plan developed by the teacher, school, or the Local Educational Agency (LEA). Eleven states also explicitly deferred the specific hours based on need or students' Individual Educational Plan (IEP). See Figure 2 for a map highlighting instructional time policies.

Thirty-two (63% overall; 80% of coded states/Washington, DC) states included information about requirements or options for instructional modality. Twenty-three states mentioned that instruction could be delivered in the home, whereas 22 states specifically mentioned hospital settings for the provision of instructional services. Twenty jurisdictions were coded for both home and hospital. Twenty-three included other examples such as treatment facility/centers, libraries, rehabilitation centers, healthcare facilities, or other appropriate settings. Fifteen states described online, virtual, remote, or electronic means as acceptable modes of delivering instruction. Three states expected the decision to be made by the IEP team or those responsible for providing homebound instruction.

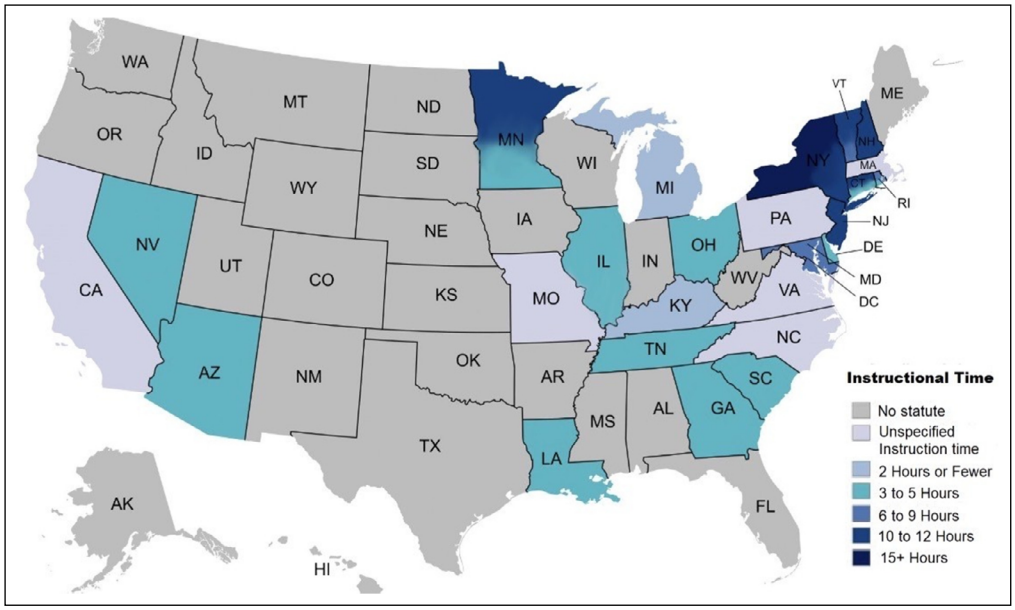


Figure 2 Minimum Instructional Time Requirements for Homebound Students.

Twenty (39% overall; 50% of coded states/Washington, DC) states addressed curriculum requirements. Four states established the expectation that homebound instruction will be coordinated or supervised by the classroom teacher. Five states required a written education plan. Five states included the requirement that the school provides the student with all necessary supplies, textbooks, and/or other instructional materials. Eight states mentioned the requirements of an IEP for students with disability or eligibility under special education. Six states specified curriculum requirements to ensure instruction necessary for progress. Although 37% of states have some reference to curriculum requirements, Connecticut had a statute that was subcoded in nearly every category (e.g., Special Education, Make Progress, Required Material, State-Approved Curriculum).

Twenty-one (41% overall; 53% of coded states/Washington, DC) states specified educator qualifications. Eighteen of those states indicated instruction must be provided by a certified teacher. Additionally, nine states explicitly acknowledged that homebound instruction for students who also qualify as having a disability must be provided by a certified special education teacher. Four states mentioned provisions for contracting with third-party agencies that have qualified staff to provide the instruction. A few states referred specifically to instruction delivered in hospital school programs. For instance, Rhode Island included the requirement, "All teachers employed in hospital programs shall be trained and certified to provide special education in the area of basic disability for which the hospital program is established" (RI Code §200-RICR-20-30-6, 2018).

CONTINUITY

Seventeen (33% overall; 43% of coded states/Washington, DC) states provided information about oversight of implementation. Six states required school districts to be the responsible party for the provision of homebound or instruction services. Four statutes stated school staff (e.g., superintendent, principal, classroom teacher) are responsible. Seven states specified that the special education team is responsible. Massachusetts specifies "the principal shall arrange for provision of educational service" and "The principal shall coordinate such services with the Administrator of Special Education for eligible students" (MA Stat §603 CMR 28.03, 2022). Oregon and Kentucky were coded as their state Department of Education with the authority to oversee the provision of instruction. Oregon and Florida allowed third-party contracting specifically for educational programming in hospital settings.

Twenty-two (43% overall; 55% of coded states/Washington, DC) states were coded for jurisdiction. Only three were coded for allowing schools to contract with third parties to provide homebound instruction. Furthermore, eight states allow schools to establish cooperative agreements or contracts with agencies and hospitals. Seven states specified that the school where the student resides or is hospitalized is responsible for their education. Twelve states were coded for mentioning that the school of origin is responsible for the student's education.

DOI: 10.5334/cie.345

California allowed for dual enrollment, meaning students are entitled to remain enrolled in and return to their school of origin while also attending a hospital school program operated by another jurisdiction. However, regarding jurisdiction, the statute specified,

> either individual instruction at home provided by the school district in which the pupil is deemed to reside, or individual instruction in a hospital or other residential health facility, excluding state hospitals, provided by the school district in which the hospital or other residential health facility is located. (CA Stat §48206.3, 2019)

Eight (17% overall; 20% of coded states/Washington, DC) states included provisions for tracking student progress (monitoring), including grades, competencies, standards, or exam results, as well as timing and type of educational services. However, only five states required that progress reports be submitted. Additionally, six states mandated documentation of instructional activities, such as when and what services were provided, but did not specify reporting timelines. Minnesota was the only state to include a requirement for conducting a needs assessment by stipulating that "A screening must be conducted by education staff to determine the student's academic, social, and behavioral needs" (MN Stat §3525.2325, 2007).

Fourteen (27% overall; 35% of coded states/Washington, DC) states were coded for caregiver involvement. Eleven states specifically mentioned that a caregiver must notify the school and/or provide consent for homebound instruction. For the most part, the eight states that were coded as Caregiver Supervision/Consultation mentioned that an adult 21 years or older, or the legal guardian, must be present during instruction.

Nine (18% overall; 23% of coded states/Washington, DC) states were coded under flexible scheduling. Missouri is one of those states that specified homebound services should only occur during the regular school calendar, whereas Illinois also had the expectation that homebound should only occur during school hours, allowing for the option for all parties involved to agree to an alternative. About 12% (n = 6) of the states permitted instruction during the Summer. South Carolina indicated:

> If the school district delays the start of services for any reason, the student is still entitled to the instructional services, and the school district must make up the missed instructional periods even if the regular school year has ended and services are provided without the benefit of state funding. (SC Code §43-241, 2019)

South Carolina also allowed make-up sessions in the evenings or on weekends. Georgia was the only other state that mentioned make-up sessions, in this case, if the child is unable to receive instruction during a regular school day due to their health. Georgia was the only state coded that students can make up lost instruction, and once a make-up session is completed, it can be counted retroactively towards attendance.

Seven (14% overall; 17% of coded states/Washington, DC) states were coded for reintegration or transition. Three of these states (i.e., California, Delaware, and Florida) allowed for partial return, meaning students were entitled to either a hybrid of homebound and in-school instruction or shortened on-site days. California specified that a student may receive instruction for part of the week by the school where the student is residing when ill as well as at their school of origin when they are well enough to attend school. Additionally, once a student is able to return to school, they are permitted to return to their school of origin.

Tennessee, Georgia, New Hampshire, and Washington, DC required a transition or reintegration plan to support the student's return to school after homebound instruction. For example, New Hampshire regulations mandate that, when an IEP for a child with a disability is implemented at home for more than 45 days, the LEA must,

> develop a written plan for the transition of the child into a less restrictive environment which shall include the following: a. Objective criteria for determining when the student will no longer require a home-based program and will receive special education services in a school-based program; b. Specific activities for each phase of the transition; and c. The specific time frame for each phase of the transition process. (NH Code §Ed 1111.05, 2017)

DOI: 10.5334/cie.345

DISCUSSION

The complex interplay between chronic health conditions and education requires schools to develop comprehensive and flexible systems to support affected students. This includes individualized health planning, improved communication between medical and educational professionals, plus adaptive teaching strategies to ensure these students can achieve their full academic potential despite health-related challenges. Homebound instruction policies vary significantly across the United States, reflecting diverse approaches to supporting students unable to attend traditional school settings. Our analysis identified four essential themes: Eligibility, Policy Provisions, Instruction, and Continuity that form the foundation for effective homebound policy development and maintenance. The acronym EPIC can be derived from these domains to characterize a cohesive framework.

An important difference between state policies was how states outlined the conditions that may warrant homebound instruction and who (i.e., physician, nurse practitioner, psychologist) may determine eligibility. For example, states such as Massachusetts and Maryland expand the scope by providing examples of various conditions. Similarly, Delaware also incorporates unforeseen as well as ongoing conditions and clarifies that emotional-behavioral conditions are health-related. Further, the wording allows for a flexible interpretation by the healthcare provider, whereas a more restrictive set of conditions could be limiting. A more expansive list of suitable providers who may determine eligibility is contained in other states' regulations, such as in Washington, DC's policy (Washington, DC Code §38-251.01–§38-251.10, 2020), as presented in the Results section. This contrasts with states that specify that eligibility can only be determined by a physician.

Regarding timing, although many states also do not address determination and implementation, the most common timeframe for the states that do require a decision, notification, or implementation is within five days, with 10 to 15 days being the second most common timeframe. As shown in Figure 1, time until eligible varied greatly across states. Arizona's eligibility period of three months is a concerning outlier. In addition to omitting how homebound services should be delivered in an intermittent manner for students whose absences are intermittent rather than consecutive, the policy effectively requires providers to predict the total days missed in a single school year, a threshold that is both high and difficult to forecast. For instance, if a student is present for a half-day of school, but absent the rest of the week, the policy does not indicate whether the student would then meet the minimum number of hours and, as a result, absolve the district of the obligation providing additional instructional time. Additionally, it is uncertain what triggers homebound instruction when it is unclear whether a student will attend school during a given week. In contrast, Illinois not only specifies that eligibility occurs after a period of two weeks or more, but also clarifies what intermittent means, "ongoing intermittent basis" (IL Stat §105 5/14-13.01, 2018). Cross-state comparisons of policies, such as the ones described above, are crucial in establishing a precedent and advocating for policies that better meet the needs of students.

A third major area of variation among states was the specificity and clarity of instructional requirements and monitoring. Instructional time requirements ranged from under two hours and up to 15 hours per week. As depicted in Figure 2, the map reflects that Michigan is at the lower end of the minimum (i.e., two 45-minute sessions). New York had one of the most robust statutes, recently updating the number of instructional hours for elementary and middle school students to ten per week and for high school students to 15 per week. Although students with chronic medical conditions may have limitations (e.g., fatigue from treatment) impacting their capacity to participate during instructional time, it is important to optimize policies so that students have the option to engage in as much instructional time as feasible.

In addition to policies specific to homebound education, it is also important to consider other policies that provide guidance on the education of youth with chronic medical conditions who may not qualify for homebound education. For example, another Arizona statute, *Policies and procedures concerning pupils with chronic health problems*, is intended for "Pupils who are *not* homebound, but who are unable to attend regular classes for intermittent periods of one or more consecutive days because of illness, disease, pregnancy complications or accident" and "pupils who suffer from a condition requiring management on a long-term basis" (AZ Stat §15-346, n.d). Moreover, although its protections are limited in scope, this policy specifically requires

DOI: 10.5334/cie.345

homework availability so that students can keep up with assignments and avoid credit loss as well as permits certification by multiple health professionals, such as physician assistant and nurse practitioners. The caveat with this policy is that it directs the governing board (i.e., each school district's governing board) to adopt policies in this regard, which may lead to possible gaps in implementation across local communities and among different school districts.

A major gap in the reviewed policies is the omission of student involvement in guidelines. Involving students throughout the process may have positive implications for their overall well-being and may lead to better academic outcomes despite prolonged absences. Similar benefits have been found when students are involved in research (Anyon et al., 2018). Recent recommendations developed by an international group of experts suggested including students in all aspects of homebound schooling and re-entry, such as curriculum delivery (e.g., virtual, partial curricula, self-paced), privacy and disclosure processes, re-integration plan, and continuity of peer communication (Capurso et al., 2025). Student involvement in implementation of homebound policy is a crucial step in valuing student voice as a core component of access to education for medically vulnerable students and should be treated as such by the multidisciplinary team.

LIMITATIONS

Our research methodology encompasses several critical limitations that require careful consideration. The primary data extraction window was from January to May 2024, with a scan for updates as links to access the policies listed in the supplement were being verified prior to publication. This approach potentially excludes subsequent updates and may affect future access as websites are updated. This temporal constraint suggests potential changes that may have occurred since the review, which may not reflect the current status of homebound instruction in certain states. Policy updates within our research should be carefully distinguished from simple renewals, recognizing there may be no changes even with a recent date or that modifications are not necessarily comprehensive changes, but rather represent non-essential adjustments or renewal.

Information accessibility presented another significant limitation, as not all relevant details were consistently visible across source documents (e.g., states not having publicly available policies or regulations). This variability necessitates a cautious approach to interpretation, acknowledging that some critical contextual elements may have been overlooked in the extraction or coding process. Researchers must remain cognizant of these procedural constraints to ensure accurate and responsible understanding of policies and procedures.

IMPLICATIONS AND POLICY RECOMMENDATIONS

Despite these limitations, we have made various recommendations that may improve the education of students with chronic medical conditions (Table 2). Additionally, the EPIC framework provides structure, offering a practical tool for identifying gaps and advocating for more equitable, comprehensive homebound policy. By implementing the recommended changes and following EPIC, it can be presumed that more students would be served through homebound instruction to reduce significant instructional gaps at the individual and system level. Qualified students would likely receive more targeted and individualized instruction. More specifically, state-mandated instructional time would best be considered minimum, especially if the requirements are on the lower end of the range (e.g., two to four hours). As a result, educational outcomes would likely improve through increased instructional time and more appropriately tailored services. Smoother transitions and fluidity between homebound instruction and regular school attendance would support better continuity of education, while better-informed parents and caregivers would lead to more effective advocacy for their children's educational needs. Developmentally appropriate student involvement throughout the planning of homebound education (e.g., coursework, priorities, reintegration plan) can facilitate agency in their education. Greater consistency in policy implementation across school districts would reduce disparities in service provision, helping to address common barriers faced by students with chronic health conditions or related disabilities. Finally, ongoing program evaluation and research would enable systematic monitoring of the effectiveness of current and revised practices, with findings that could inform future policy and program development.

The following recommendations aim towards improving policy:

1. Ensure that caregivers and students are well-informed about accessing homebound education. Discussions about homebound education options should be developmentally accessible so that students may participate in decision-making.
2. Ensure there are no limits on the health (mental or physical) conditions that are eligible for homebound services
3. Expand acceptable healthcare providers to include nurse practitioners and mental health professionals (e.g., school psychologist)
4. Include an eligibility time frame that ensures timely (e.g., <10 school days, 10 to 15 school days) access
5. Establish clear timelines for time to determination (e.g., within 5 school days) and Implementation (e.g., immediately or after approval), allowing only for exceptions related to the students' health
6. Establish parameters for educational services/instruction for those who may miss school on a partial, ongoing, or intermittent basis
7. Set sufficient instructional time (e.g., >6 hours, 10 hours) with possible differentiation for secondary students (e.g., 3–5 additional hours). A caveat may be needed to adjust according to the needs of the student (i.e., identified learning gaps), the rigor, and/or or number of courses as the inclusion of the word "minimum" typically means that most districts likely impose the minimum even when the courses or curriculum are more intensive or the students themselves require more instructional time.
8. Include mandates regarding make-up sessions or scheduling parameters (e.g., evening, weekend, summer) when districts delay the start of services for any reason or there is a need to accommodate students due to their health condition
9. Develop guidance when involving third-party contractors. School districts should collaborate with the external service provider or nearest hospital school program to develop communication, workflow, and accountability procedures when working with their students in order to achieve successful implementation of homebound services.
10. Develop guidelines for transition and reintegration support when students return to regular school. Reintegration supports or plans should meet the transitional needs of each individual student, incorporate the student's health care plan, and any other necessary accommodations to achieve a successful reentry. Reintegration plans should include students and caregivers as part of the process.
11. As a preventative measure, consider essential auxiliary services such as counseling or behavioral interventions to reduce resistance to returning to school and address mental health challenges
12. Require professional development geared toward chronic health conditions, behavioral supports, and family-school collaborations
13. When not eligible for homebound, yet frequent absences may occur due to a health condition, establish policies to allow for accessibility for graded assignments, assessments at home, real-time grade updates, and flexibility in due dates, so the student's grades are not impacted and transparency in progress is maintained
14. Foster partnerships with local universities that have relevant training programs and research-to-practice initiatives to benefit both institutions and bridge the health-education divide

Table 2 Homebound Policy Recommendations.

Although this study focused on U.S. state policies, educators and policymakers can use these findings to inform their own frameworks globally. Accordingly, research has found persistent gaps between legal recognition and practice (Kanter, 2019; Todres, 2009). Critical review, revision, and/or creation of policies can remove barriers that restrict students' access to inclusive accommodations and undermine their ability to make satisfactory academic progress.

CONCLUSIONS

Our goal in completing this policy analysis, along with recommendations, is to support reform of state statutes and department of education regulations to provide adequate guidance to school staff, medical providers, and mental health professionals. Ultimately, we hope that, as proposed recommendations are incorporated into policies and practices, schools will be equipped with greater flexibility to support medically vulnerable students and thereby reduce instructional gaps. Additionally, although this analysis focused specifically on U.S. statutes and regulations, we encourage all those who support children with special health care needs internationally to review their policies and consider incorporating or adapting these recommendations. Eliminating barriers to access to education is likely to have a positive impact on their social-emotional and academic well-being.

USE OF ARTIFICIAL INTELLIGENCE

An AI-assisted tool was used during manuscript preparation solely for language editing, including grammar correction and improvements to clarity and readability. All content was

reviewed, revised as necessary, and approved by the authors, who take full responsibility for the accuracy, integrity, and originality of the manuscript.

ADDITIONAL FILE

The additional file for this article can be found as follows:

- **Supplementary File 1.** Complete Citation List of State Policies Coded for Analysis. DOI: https://doi.org/10.5334/cie.345.s1

ACKNOWLEDGEMENTS

The authors thank Alexis Nulsen, MEd for contributions to initial project planning and policy extraction, Sara Frye, PhD, for technical assistance with database setup and preliminary background research, and Alli Chavez, BA for coding of state of policies. The editorial team of Continuity in Education would like to express its sincere gratitude to Sarah Klein and Nancy Finelli for their generous contribution of time and expertise in reviewing this article. The editorial processing of this article was overseen by Michele Capurso, with copyediting conducted by Bambi Spicer.

FUNDING INFORMATION

This project was supported by the University of Arizona Eller College of Management Economic and Business Research Center Making Action Possible Grant.

COMPETING INTERESTS

The authors have no competing interests to declare.

AUTHOR CONTRIBUTIONS

MMP: Conceptualization; Data curation; Formal analysis; Funding acquisition; Methodology; Supervision; Writing – review & editing; **CRT:** Conceptualization; Data curation; Formal analysis; Funding acquisition; Supervision; Visualization; Writing – review & editing; **GG:** Formal Analysis; Visualization; Writing – editing; **NL:** Data curation; Writing – editing.

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TO CITE THIS ARTICLE:
Perfect, M., Tureaud, C., Giroud, G., & Larez, N. (2026). Policy Analysis on United States Homebound Statutes and Regulations for Students with Chronic Health Conditions. *Continuity in Education*, 7(1), pp. 82–95. DOI: https://doi.org/10.5334/cie.345

Submitted: 18 December 2025
Accepted: 13 July 2026
Published: 20 November 2026

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