Hospital Homebound Parent/Student Checklist

- [ ] **Parents/Students Read P-1 through P-6**
- [ ] **Read P-5 through P-7. Complete Student Section on HHB Application (P- 5) Sign Page 7 (Policies & Requirements of HHB**
- [ ] **Sign P-8 HIPPA Form**
- [ ] **Return the HHB Application to School (P-5 through P-7)**
- [ ] **Give the treating Physician the Medical Referral/Recommendation Form (P-9 through p-11)**
- [ ] **The Dr./Dr.'s office can fax P-9 through P-11 (770) 888-1278**

Forsyth County School System
1120 Dahlonega Highway
Cumming, Georgia 30040

Notice to Parents Regarding Hospital/Homebound (HHB) Services

Dear Parent:

The Forsyth County School System provides continuous educational services for students who are unable to attend school due to a diagnosed medical or psychiatric condition for a minimum of ten consecutive school days or for intermittent periods of time for a minimum of ten school days per year. These services may be provided in the hospital or at the child's home or other agreed upon location.
To initiate Hospital/Homebound (HHB) services, obtain a *Hospital/Homebound (HHB) Services Request Form* and *Licensed Physician/Psychiatrist Statement and Medical Referral Form* from your school's HHB contact. Complete the services request form and have the medical form completed by the licensed physician or licensed psychiatrist who is treating your child for the diagnosed condition. Give both completed forms to your HHB contact.

A conference to develop an Educational Service Plan (ESP) for your child will be convened within five school days of receipt of the completed application. The purpose of the conference is to address the impact that the physical and/or psychological condition may have on your child's educational performance. The school team or Individualized Education program (IEP) team will determine the exact amount of instructional time based on the ESP, which takes into consideration the cognitive ability and medical condition of your child. To comply with the Georgia State Board of Education Rule 160-4-2-.31 Hospital/Homebound (HHB) Services, a minimum of three instructional contact hours per week must be provided for your child to be counted present.

Should you have any questions regarding HHB services, please communicate with the school's HHB contact.

Local education agencies (LEAs) are responsible for providing instructional services for students who are eligible for Hospital/Homebound (HHB) services and hospitalized in health care facilities. The LEA may provide the services directly or can arrange with or contract directly with the health care facility, the LEA in which the health care facility is located, or appropriately certified teachers in the geographic area in which the health care facility is located. Below is a sample contract with a hospital for services.

NOTE: Parents/guardians, emancipated minors, or students 18 years of age or older must complete the LEA HHB application forms before services can be provided by the LEA. A contract with the hospital to provide HHB services for a specific student must be in place before the LEA will reimburse the hospital for instructional services.

HOME INSTRUCTION INFORMATION FOR PARENTS

The cooperation of parents is a vital factor in the success of the home instruction program. It is the responsibility of the parents to do the following:

A. Obtain referral forms from the school and have the student's physician fill out this section so that the student can be considered for the home instruction program.

B. Arrange to get assignments for student from the school if he/she is able to work before the instructor can begin teaching (in order to keep up with assignments as much as possible).

C. Arrange to have parents or an Adult Parent Designee present during instruction. An Adult
Parent Designee is an individual who is at least 21 years of age and whom the parent designates to be present during homebound instruction.

D. Prepare a comfortable, quiet, well-lighted place in the home for the teacher and student to work. It should be away from family activity, if possible.

E. Ensure that the student is rested and ready to work when the instructor arrives (if possible). Encourage the student to complete all assignments as directed.

F. Be prepared to work. Assist the student, as necessary, in having materials (books, paper, pencils, etc.) organized and on hand prior to the arrival of the teacher

G. Help the student plan a regular time for daily study.

H. Notify the home instructor in advance of any change in the schedule. Please call your school after 8:00 a.m.

HOME INSTRUCTION INFORMATION FOR THE STUDENT

A homebound student should understand that the home instruction program has been established as a bridge between his class and home during the time that he is physically unable to attend regular school. A homebound student must learn to discipline himself to work in an environment that may be more difficult to control than that in the classroom. He must learn to work more independently.

A. The homebound student should make a satisfactory attempt to complete assignments.

    1. Plan several times during the day when work can be done without interruptions.

    2. Television viewing must be planned and controlled.

B. He/she should study in a well-lighted place.

C. Every effort should be made to independently accomplish as much work as possible since the time of instruction is limited.

D. He should be ready for the instructor.

    1. Be rested.

    2. Have needed materials.

E. It is essential that he/she give undivided attention during the instruction period.

Remember that it is for instruction and not a drill or study period.

1. Make every effort to understand instruction for studying.

2. Remember that it is for instruction and not a drill or study period.

Forsyth County School System

1120 Dahlonega Highway
Cumming, Georgia 30040
Fax: (770) 888-1278

Hospital/Homebound (HHB) Application

(Note: There may be a delay in processing incomplete applications.)

Student Information

Student Name: _____
Last First MI

Address: _____

_____

Date of Birth: _____

Parent/Guardian: _____
Last First MI

Phone: (H) _____ (W) _____ (C) _____

School Name: _____Grade: _____

Counselor/Social Worker: _____

Do you have a computer with DSL, high speed, or wireless connection at the instruction location?

____Yes ____No

Student Email Address: _____

Parent Email Address: _____

Eligibility Policies

1) I understand that eligibility for services is based on the Georgia State Board of Education Rule 160-4-2-.31 Hospital/Homebound (HHB) Services, and that a medical referral form issued from a licensed physician or licensed psychiatrist is required to determine eligibility.

2) I understand that local education agency (LEA) HHB services personnel may contact the licensed physician or licensed psychiatrist to obtain information needed to determine if my child will be eligible for HHB services and provide appropriate instructional delivery.

3) I understand that my child must be enrolled in a public school prior to the referral for HHB services.

4) I understand that the HHB services are for students confined to the home or hospital due to a

medical or psychological condition, which is acute, catastrophic, chronic, or repeated intermittent.

5) I understand that I will be required to sign an agreement regarding HHB services policies and procedures.
6) I understand that if my child is eligible for HHB services, my child may be dismissed from the HHB program and may be required to return to school if his or her medical or psychological conditions improve as documented by a licensed physician or licensed psychiatrist.

7) I understand that if my child is eligible for HHB services, he or she is subject to the same mandatory attendance requirements as other students.

Policies and Procedures

1) A parent, guardian, or an approved adult parent designee as identified in the Educational Service Plan (ESP) shall be present during each entire home instructional period.

2) A table or a desk in a workspace that is well ventilated, smoke-free, clean, and quiet (i.e., free of radio, TV, pets, and visitors) must be provided.

3) A schedule for student study time between teacher visits will be established and the student will be prepared for each session with the teacher.

4) Instructional materials must be obtained from the school, and assignments completed and submitted on time.

5) Assignments will be returned to the regular school teacher for grading if the student is on HHB services for a short period of time.

6) A parent, guardian, emancipated minor, student 18 years of age or older, or an approved adult parent designee as identified in the ESP must notify the HHB teacher at least 24 hours in advance if an instructional session must be cancelled. The LEA may, at its discretion, reschedule the cancelled session. The HHB teacher will notify the parent, guardian, or approved adult parent designee if they need to cancel a session and the session may be rescheduled.

7) For long-term or intermittent HHB students, the HHB teacher, in collaboration with the regular school teacher, shall assign grades for the work completed.

8) The parent/guardian, emancipated minor, or student 18 years of age or older must submit a release form from the licensed physician or licensed psychiatrist upon the student's return to school.

9) To extend HHB services beyond the originally identified return to school date, the licensed physician or licensed psychiatrist must submit an updated medical referral request form.

Cause for Dismissal

1) If the licensed physician or licensed psychiatrist recommends that the student is able to attend school or can no longer participate or benefit from HHB services, the student will be removed from the program.

2) If the student is employed in any capacity, goes on vacation, regularly participates in extracurricular activities, or is no longer confined at home, the student will be removed from the program.

3) If the parent, guardian, emancipated minor, student 18 years of age or older or adult parent designee cancels three sessions without 24 hours notice, the student will be removed from the program.

4) If the conditions of the location where HHB services are provided are not conducive for instruction or threaten the health and welfare of the HHB teacher, the student will be removed from the program.

Parent/Guardian Agreement/Release for Information

I have read the Hospital/Homebound (HHB) services policies for program eligibility and I understand the reasons for possible dismissal from the program. I agree to the policies and requirements of the program and request HHB services for my child.

_____

Parent/Guardian Printed Name Date

_____

Parent/Guardian Signature Date

_____

Principal or Designee Signature

HEALTH CARE RECORDS RELEASE REQUEST

HIPPA/FERPA Form

Forsyth County Schools

Last Name	*First Name*	*Middle Name*	*Grade*	*Date of Birth*	*Last 4 Digits of SSN*

Address	*City*	*State*	*Zip*

Parent/Guardian	*Telephone*

SCHOOL/AGENCY REQUESTING INFORMATION

Forsyth County School System
Department of Exceptional Children
Hospital/Homebound Coordinator
Jinger M. Davison E.d.S

Phone No. ***678-243-9695***

Fax No. ***770-888-1278***

DR./AGENCY RELEASING INFORMATION

Phone No. _____

Fax No. _____

Type of Material:

_____	Verbal	_____	Discharge Summary
_____	Release of photocopies of report	_____	Medical records relevant to instructional needs and limitations
_____	Diagnosis	_____	Medication / Treatment Plan
_____	Care Plans	_____	Treatment progress updates
_____	Psychological History	_____	Current medication(s) and dosage
_____	Other _____	_____	Other _____

I hereby authorize the Forsyth County School System to release/obtain pertinent information concerning the above-named student for educational planning/medical treatment or (please specify):

_____

_____

I understand that I may revoke this authorization at any time by submitting written notice of withdrawal of my consent. I recognize that health records once received by local education agency (LEA) may no longer be protected by HIPPA, but they will become educational records protected by the Family Educational Rights and Privacy Act (FERPA).

_____ _____

Authorizing Signature *Date*

Dates Records Requested: _____ *Dates Records Received:* _____

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Fax:770-888-1278

Medical Referral/Recommendation Form
Licensed Physician/Psychiatrist Statement and Medical Referral Form

(Note: This form must be completed by a physician or psychiatrist licensed by the State of Georgia.)

Physician/Psychiatrist Name: _____

GA License #: _____

Address: _____

Phone Number: _____ Fax: _____

Student Information

Student Name: _____
Last First MI

Address: _____

_____

Date of Birth: _____

Parent/Guardian: _____
Last First MI

Phone: (H) _____ (W) _____ (C) _____

Physician/Psychiatrist Statement and Diagnosis

Patient's Diagnosis: *(Note: Please include a description of the condition.*)

_____
_____
_____
_____
_____
_____

Estimated Duration of HHB Services:

Starting Date: _____

Ending Date: _____

(Uncertain, Undetermined, Unknown or Indefinite will not be accepted)

Date of Initial Evaluation: _____

Date of Next Scheduled Appointment: _____

Physician's Statement: *(Note: Please answer the following questions keeping in mind that the least restrictive environment is preferred.)*

Is the student unable to attend school for a minimum of ten consecutive school days? ___ Yes

___No

Will the student be able to benefit from an instructional program during this time of confinement? ____Yes ____No

Could the student attend school with accommodations? If so, describe. ___Yes ___No

Recommendations for Accommodations:

Could the student attend school regularly and receive HHB services on an intermittent basis as needed?
____Yes ____ No

Is the student confined to the home or hospital and full-time HHB services are recommended?
___Yes ___No

Is the student free from communicable diseases, such as flu or contagious airborne diseases?
___Yes ___No

Can instruction be provided to the student without endangering the health of the teacher or other students whom the teacher may contact? ___Yes ___No

(NOTE: You may periodically have to verify that the student remains under your care and continues to qualify for the HHB services program.)

Treatment and School Reentry Plan *(Note: The following information is required to determine eligibility for HHB services and must be completed by the licensed physician or licensed psychiatrist who is currently treating the student for the diagnosis presented*.)

What is the scheduled frequency of treatment/therapy for this student? *(Circle one)*

Daily Weekly Monthly

What is the expected duration of the treatment/therapy? _____

Will the student take medication? ____Yes ____No

Medications student will take for diagnosis:

Name of medication	Effects on student's ability to comprehend	Effects on student's ability to complete independent assignments	Effects on student's ability to relate to teachers and other students

Could this student return to school on an intermittent basis after his or her medication and condition is stabilized? ____Yes ____No

Can this student come into contact with other students? ____Yes ____ No

The HHB services program is designed to be a temporary educational program to help students who are unable to attend school for medical or psychiatric reasons. Please describe your time frame and transitional plan for the student's reentry to school (attach additional pages as needed).

Physician's Certification: I certify that this student is under my care and treatment for the aforementioned medical condition. My recommendation has been based on the medical needs of the patient, keeping in mind that the least restrictive environment is preferred.

Physician Printed Name Date

Physician Signature Date

******For Forsyth County School System Central Office Staff *******

Hospital/Homebound Services:

____ Approved

Services to begin _____ through _____

____ Not Approved (reason) _____

Hospital/Homebound Coordinator's Signature_____ Date _____

Special Education Director's Signature _____ Date _____