Application for Home/Hospital Instruction

(please type or print neatly)

Parent/Student Information

Section I

To be completed by the parent (s) /guardian (s) prior to full completion by the licensed medical or mental health professional.

School District _____ School _____Grade _____
County of Residence _____ Last Date Attended _____ Special Education Student _____ Yes _____No
Name of Student _____ Date of Birth _____
Address of Student _____ Zip Code _____
Sex _____ Race _____ Social Security # _____ Telephone # _____
Full Name of Father/Guardian _____Work Phone _____
Full Name of Mother/Guardian _____ Work Phone _____
List any Special Education Programs in which your son or daughter may be enrolled:
_____
_____
Directions to Student's Home
_____
_____

Pursuant to KRS 159.030, Section (2), before granting an exemption under paragraph (d) of subsection (1) of this section, the board of education shall require satisfactory evidence, in the form of a signed statement of a licensed physician, advanced registered nurse practitioner, psychologist, psychiatrist, chiropractor or public health officer, that the condition of the child prevents or renders inadvisable attendance at school or application to study. On the basis of such evidence the board may exempt the child from compulsory attendance. Eligibility for home/hospital instruction for students with disabilities shall be determined by the Admissions and Release Committee (ARC) in accordance with their Individual Education Program (IEP), with the services to be in the least restrictive environment. In lieu of this application, the ARC chairperson shall provide written notice of this eligibility to the local Director of Pupil Personnel (DPP) for purposes of program enrollment.

Any child who is excused from school attendance more than six (6) months must have two (2) signed statements from two different local health personnel which can be a combination of the following professional persons: a licensed physician, advanced registered nurse practitioner, psychologist, psychiatrist, chiropractor and health officer. If a medical professional certifies that a student has a chronic physical condition unlikely to substantially improve within one (1) year, then the one signed statement is sufficient for services that extend beyond six (6) months. This exception does not apply to students with mental health conditions.

Exemptions of all children under the provisions of subsection (1) (d) of this section must be reviewed annually with the evidence required being updated, except that children with disabilities certified by a medical professional to have a chronic physical condition unlikely to substantially improve within three (3) years may continue to be eligible for home/hospital instruction services, based on the admissions and release committee's (ARC) annual review of documentation to determine if updated evidence is required. Updated documentation of evidence of need for home/hospital services for children with chronic physical conditions shall be provided as requested by the ARC, or at least every three (3) years.

Pursuant to 704 KAR 7:120, the condition of pregnancy is not to be considered a physical or health impairment in and of itself, and the nature and extent of any complication shall be delineated prior to consideration of home/hospital instruction for this condition.

RELEASE OF INFORMATION

I understand that the Home/Hospital Review Committee may request a review of the information provided on these forms by local health personnel. I hereby authorize this committee to have access to pertinent information regarding this request.

_____ _____
Parent/Guardian Signature Date

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Professional Statement

Section II

This section is to be filled out by the authorized medical or mental health professional.

It shall be determined that a child or youth is to be provided home/hospital instruction if the condition of the child or youth prevents or renders inadvisable attendance at school as verified by signed professional statement in accordance with KRS 159.030 (2) and 704 KAR 7:120.

Please Note: Home Instruction (homebound) is short-term instruction provided in a home or other designated site for a student who is temporarily unable to attend school. According to state guidelines, two hours of home instruction each week is the equivalent to one full week of school attendance. Home instruction is not designed to take the place of a more appropriate school placement.

Name of Student _____

Please check one of the following:

_____ The student can attend school without any type of modifications or special provisions.
Comments:_____

_____ The student can attend school only with modifications or special provisions.
Describe Modifications Needed
_____
_____

_____ The student is unable to attend school at this time due to health concerns, and I do support Home/Hospital instruction (If checked, please complete the rest of this section).

_____ I do / _____ do not support home/hospital instruction for this student. If you do not support home/hospital instruction at this time, please state your concerns and/or recommendations:_____
_____

If you do support home/hospital instruction at this time, please fill out the rest of Section II

Diagnosis _____ Prognosis Good _____ Fair _____ Poor _____

Specific reason (s) why the student is unable to attend school at this time:
_____
_____
_____

How long have you been seeing the patient for the diagnosis listed?
_____

Approximate length of time student will need Home/Hospital Instruction
_____

Please summarize test and all other data collected that supports the need for Home/Hospital Instruction at this time.
_____
_____

What is the treatment plan for the patient?

_____

_____

What is the expected duration of treatment?

_____

_____ Check here if this student has a chronic physical condition that is unlikely to substantially improve within one year.

What ancillary services are involved in treatment?

_____

_____

List consultants/specialist to whom this student has been referred.

Name	Specialty	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Will you be following the patient? _____ Yes _____ No If not, who will?

Name: _____ Phone Number: _____

Address: _____

Anticipated date of student's return to school:

_____

What are your recommendations to assist this student in his/her return to school?

_____

_____

Remarks/Comments:

_____

_____

_____

_____ _____ _____

Signature of Licensed Professional Title Date

Please Print or Type Name of Professional:

_____

Office Address _____ Phone Number _____

_____ Fax Number _____

_____

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Home/Hospital Review Committee

Section III

This section is to be completed by the Home/Hospital Review Committee.

Name of Student
_____

Date Application Received: _____Approved _____Denied _____Incomplete _____

If approved, date services will be from _____until _____
(Review Date)

If eligibility for services denied, reason for denial
_____
_____
_____

If incomplete application, type of additional information requested
_____
_____

Date of Request _____Person Contacted _____

Signatures of Committee Members:

Director of Pupil Personnel _____ _____
Date

Home/Hospital Services Teacher
or Program Director _____ _____

Date

Local Medical or
Mental Health Personnel _____ _____
Date

Comments:
_____
_____
_____
_____