Application for Hospital Homebound Instruction

216 S. Sixth Street
Griffin, Ga. 30224
Student Services: 770-229-3710 ext. 349, 350 or 335 Fax: 770-227-1932
Special Education Services: 770-229-3710 ext. 328 or 333 Fax: 770-227-0358

Parent Section ***(Please complete pages 1-2)***

I. Student Information (Please print)

Provide all requested information; incomplete applications may experience processing delays.

Student Name: ____ DOB: _______________ Student ID#_______________________

Address ____ City _____________ State GA Zip __________________

Parent/Guardian: _______________________________Home Phone: ___________________ Alternate Phone: _________________

School _______________ Grade ______ Age ______ Sex ( ) M ( ) F Counselor __________ Homeroom Teacher _____________

Does your child receive Special Education Services? YES ☐ NO ☐
If yes, please specify the area of disability: ____

Principal's Signature: ____ Date: ____________________________________

Schools are responsible for providing assignments and grades to the student until the student is officially approved for HHB Services

Planning Purposes:
Do you have a computer? Yes ☐ No ☐ Do you have an internet connection? Yes ☐ No ☐

Student Email Address: ___________________________________ Parent Email Address: __________________________________

II. 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 the Griffin-Spalding County Schools' 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 the Griffin-Spalding County School System 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 and the medical or psychological condition improves, as documented by the physician, my child will be dismissed from the HHB program and will be required to return to school.
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**.**

III. Policies and Procedures

1. A parent, guardian, or an approved adult parent designee (who is at least 21 yrs old) and who is 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 Griffin-Spalding County Schools 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.

IV. Termination of Services

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.

V. Parent/Guardian Agreement/Release for Information

I have read the Hospital/Homebound policies for program eligibility and understand the reasons for possible dismissal from the program. I agree to the policies and requirements of the program and request Hospital/Homebound services for my child. I hereby give permission for the attending licensed physician or licensed psychiatrist to communicate information regarding my child's medical/emotional condition for which he/she is referred to HHB personnel.

Parent/Guardian Signature: ____**Date:** __________________________

Parent/Guardian Name: ____
(Please print)

Once page 1 & 2 is completed by the parent, send the entire packet to the treating physician. The physician MUST supply a beginning and ending date on page 3 as well as information on page 4 to help school personnel facilitate hospital homebound instruction and reentry to school.

Return completed packet to the office of:
Student Services
210 South Sixth Street
Griffin, GA 30224
770-229-3710, ext. 349, 350 or 335 Fax: 770-227-1932

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PHYSICIAN SECTION *(Please complete pages 3-4)*

Student Name: ___________________________________ DOB:___________________________

VI. 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)

Print Physician/Psychiatrist Name: __________________________________ GA License #______________

Address: ___________________________________ City ______________, GA, Zip ________________

Phone Number ________________________________ Fax Number _____________________________

Section A. Physician/Psychiatrist Statement and Diagnosis

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

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Estimated Duration of Hospital/Homebound Services: **Starting Date:** _______ **Ending Date**: _______ **Number of weeks**______

Date of Initial Evaluation: _________________ Date of Next Scheduled Appointment: ___________________

Physician's Statement*: 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 with whom the teacher may be in contact? YES ☐ NO ☐

Note: Verification that the student remains under your care and continues to qualify for the HHB services may be requested periodically.

Student Name:_______________________________________ **DOB:**_______________________

Section B. Treatment and School Reentry Plan

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 in Section A.

- What is the treatment/therapy schedule for this student? Daily ☐ Weekly ☐ Monthly ☐
- What is the expected duration of the treatment/ therapy? _________________________________
- Will the student take medication: YES ☐ NO ☐

Medication	*Effects on student's ability to comprehend*	*Effects on student's ability to complete assignments independently*	*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/or condition is stabilized?

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).

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

_______________________________________ _________________________
Physician's Signature Date

____
Physician's Name *(Please print)*

Student Name:_______________________________________ DOB:__________________________________

VI. Griffin-Spalding County Schools Hospital/Homebound Approved / Not Approved

After reviewing the above information and eligibility criteria, ____
(Student)

☐ *Is Approved for HHB Instruction* ☐ *Is Not Approved for HHB Instruction*

HHB Starting Date:______________ HHB Ending Date:______________ Number of Weeks:_________

Student Services Director/Special Education Director or Designee Signature:_________________________ Date:_______

HHB Instructor Assigned: _________________________ Phone#: _________________________ Date:_____________