

**CALCASIEU PARISH SCHOOL BOARD**  
**HOSPITAL/HOMEBOUND**  
100 N. PRATER STREET., LAKE CHARLES LA  
TELEPHONE: 337.217.4980, EXT. 3808 FAX:337.217.4311

**THIS FORM TO BE COMPLETED BY THE SCHOOL  
COUNSELOR AND FAXED TO THE HOSPITAL/HOMEBOUND  
DEPARTMENT**

<b>Title</b>	<b>APPLICATION FORM FOR HOSPITAL/HOMEBOUND SERVICES</b>	<b>Document:</b>	<b>HHB 00</b>
<b>Date:</b>		<b>Revision Date:</b>	<b>7/14</b>
		<b>Page:</b>	<b>1 of 1</b>

<b>STUDENT ID</b>	<hr/>		
<b>STUDENT NAME</b>	<hr/>		
<b>BIRTHDATE</b>	<b>AGE:</b>		<b>SEX</b>
<b>SS#</b>	<hr/>	<hr/>	<hr/>
<b>SCHOOL</b>	<hr/>		
<b>PARENT NAME</b>	<hr/>		
<b>STREET ADDRESS</b>	<hr/>		
	<hr/>		
<b>MAIL ADDRESS</b>	<hr/>		
	<hr/>		
<b>HOME PHONE</b>	<hr/>		
	<hr/>		
<b>WORK PHONE</b>	<hr/>		
	<hr/>		

<b>REASON FOR HOMEBOUND REQUEST</b>			
<b>PLEASE CIRCLE ONE</b>	<b>MEDICAL</b>	<b>PSYCHOLOGICAL</b>	<b>PREGNANCY</b>
<b>PLEASE SPECIFY</b>	<hr/>		
<b>IF PREGNANCY, DUE DATE</b>	<hr/>		
	<hr/>		
<b>PROBATION OFFICER, if applicable</b>	<hr/>		
<b>Contact Information</b>	<hr/>		
	<hr/>		

<b>Does the student currently have an IEP?</b>	_____	Yes	_____	No
<b>If yes, attach a copy.</b>				
<b>Does the student currently have an IAP?</b>	_____	Yes	_____	No
<b>If yes, attach a copy.</b>				

<b>School Counselor's Name:</b>	<b>School Counselor's Phone #:</b>
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**DATE GIVEN TO PARENT: NOTE: This form does not automatically enter a student into the Hospital/Homebound. Hospital/Homebound placement does not begin for a student until all eligibility criteria have been met, as determined by the Director of Alternative Programs.**

Original – School Counselor  
Copies: Hospital/Homebound File - fax to 337.217.4311 -Shanice Fowler-Clerk  
Parent with Hospital/Homebound Packet

**CALCASIEU PARISH SCHOOL BOARD**  
**HOSPITAL/HOMEBOUND**  
100 N. PRATER, LAKE CHARLES, LA 70601  
TELEPHONE: 337.217.4980, EXT. 3808 FAX: 337.217.4311

**Title:** Hospital/Homebound Parent Letter  
Physical Injury or Illness

**Document:** HHB 01A

**Revision Date:** 8/14

**Date:** \_\_\_\_\_

**Page:** 1 of 1

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Parent Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_

School: \_\_\_\_\_

Dear Parent(s):

Please have the enclosed forms completed by the attending physician for medical reasons if you desire Hospital/Homebound services for your child. The forms must be returned in the self-addressed envelope immediately or hand delivered to Hospital/Homebound Office., 100 N. Prater., Lake Charles, LA 70601.

According to state and parish guidelines, a student is eligible for Hospital/Homebound instruction on the 11<sup>th</sup> school day following an absence of more than ten (10) consecutive school days for a qualifying illness. Hospital/Homebound placement does not begin for a student until all eligibility criteria have been met, as determined by the Director of Alternative Programs. Hospital/Homebound teachers are only responsible for work missed during Hospital/Homebound placement.

**Necessary arrangements will be made upon receipt and a successful review of the following forms:**

- (1) the Hospital/Homebound Application Form (Form HHB 00)**
- (2) the Hospital/Homebound Physician's Verification Form, (Form HHB 02A)**
- (3) the Hospital/Homebound Physician's Referral Form for Temporary Placement for Physical Illness or Injury (Form HHB 03A)**
- (4) the Hospital/Homebound Reciprocal Release of Information Form (Form HHB 04)**

The parent/legal guardian is responsible for completing all necessary paperwork as soon as possible to avoid unnecessary absences. All forms must be completed prior to placement in the Hospital/Homebound.

Sincerely,  
Director of Alternative Programs  
Ronnie Harvey

Enclosure  
Copy: File

## **TREATMENT PROVIDERS – PLEASE NOTE**

The following *Hospital/Homebound Referral Form* is to be filled out completely. Each item must be completed in order for the student to be considered for placement in Hospital/Homebound.

If any item is not filled out completely, this will result in the student's placement in Hospital/Homebound being denied or delayed.

For questions or further information, please call Shanice Fowler at (337) 217.4300 ext. 3808. I appreciate your assistance and cooperation.

Sincerely,

Shanice Fowler, Clerk  
Hospital/Homebound

**CALCASIEU PARISH SCHOOL BOARD**  
**HOSPITAL/HOMEBOUND**  
**100 N. PRATER., LAKE CHARLES LA 70601**  
**TELEPHONE: 337.217.4980, EXT. 3808    FAX: 337.217.4311**

**Title:** Hospital/Homebound Physician Verification Form  
**Physical Illness or Injury**

**Document:** HHB 02A

**Revision Date:** 8/14

**Date:** \_\_\_\_\_

**Page:** 1 of 1

Physician Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Student Name \_\_\_\_\_

DOB \_\_\_\_\_

School \_\_\_\_\_

Dear Dr. \_\_\_\_\_

Hospital/Homebound is the most restrictive environment in education. Therefore, it is advantageous for the student to return to the least restrictive environment, which is the regular school setting.

According to state and parish guidelines, a student is eligible for Hospital/Homebound instruction on the 11<sup>th</sup> school day following an absence of more than ten (10) consecutive school days for a qualifying illness. Hospital/Homebound placement does not begin for a student until all eligibility criteria have been met, as determined by the Director of Alternative Programs. Hospital/Homebound teachers are only responsible for work missed during Hospital/Homebound placement.

A physician's verification that the student is receiving ongoing care and treatment is necessary each six (6) weeks. It will be the responsibility of the parent/guardian to schedule appointments and have the appropriate form completed and signed each six (6) weeks documenting treatment dates for a student to continue being eligible for the Hospital/Homebound .

Your cooperation in helping our students is appreciated.

Sincerely,  
Director of Alternative Programs  
Ronnie Harvey

**PLEASE  
SIGN  
HERE**



\_\_\_\_\_  
Physician's Signature

**PLEASE  
DATE  
HERE**



\_\_\_\_\_  
Date

Physician's signature is necessary for student's application to be considered for Hospital/Homebound placement. Please attach to form HHB-03A.

**CALCASIEU PARISH SCHOOL BOARD  
HOSPITAL/HOMEBOUND  
100 N. PRATER., LAKE CHARLES LA 70601  
TELEPHONE: 337.217.4980, EXT. 3808 FAX: 337-217-4311**

<b>Title:</b>	<b>Hospital/Homebound Referral For Temporary Placement for</b>	<b>Document:</b>	<b>HHB 03A</b>
	<b>Physical Illness or Injury</b>	<b>Revision Date:</b>	<b>8/14</b>
<b>Date:</b>		<b>Page:</b>	<b>1</b>

Student's Name _____	Age _____	DOB _____	
School _____	Grade _____	Sex _____	
Parent Name _____	Telephone _____		
Home Address _____			

**Medical Certification: THIS SECTION IS TO BE COMPLETED BY A PROPERLY CERTIFIED PHYSICIAN.**  
The undersigned certifies that the above named student is unable to attend school for the following **MEDICAL** reason. **A SPECIFIC DIAGNOSIS OF THE MEDICAL COMPLICATION AND HOW THIS COMPLICATION PREVENTS SCHOOL ATTENDANCE IS NECESSARY IN ORDER FOR THE CALCASIEU PARISH SCHOOL BOARD TO SERVE THE HOSPITAL/HOMEBOUND STUDENT APPROPRIATELY.**

Please  
explain  
medical  
complication

→ **PHYSICAL ILLNESS/DIAGNOSIS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Explain

→ **Medication** \_\_\_\_\_ **Negative effects, if any** \_\_\_\_\_

Explain

**IS THE STUDENT ABLE TO ATTEND REGULAR SCHOOL WITH THE ABOVE DIAGNOSIS?** \_\_\_\_YES \_\_\_\_NO  
**IF NO, HOW DOES THE ABOVE DIAGNOSIS AFFECT THE EDUCATIONAL HOURS?** \_\_\_\_\_

→ **DOES THE STUDENT HAVE AN INFECTIOUS OR COMMUNICABLE DISEASE?** \_\_\_\_YES \_\_\_\_NO  
**IF YES, PLEASE LIST NECESSARY PRECAUTIONS:** \_\_\_\_\_

→ **Date of last examination/treatment:** \_\_\_\_\_

The Calcasieu Parish School Board requires a Treatment Plan completed by a physician if the student is to qualify for the Hospital/Homebound.

I certify that the student is receiving a **program of care and treatment** as prescribed below and I will verify the student's continuing qualification by completing HHB 03A a minimum of every six weeks.

What is  
the treatment  
plan for  
above  
diagnosis?

→ \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The expected duration of the condition which prevents school attendance is:

Please  
Mark

→ \_\_\_\_3 weeks \_\_\_\_4 weeks \_\_\_\_5 weeks \_\_\_\_6 weeks

Complete

→ **Physician's Name (Type or Print)** \_\_\_\_\_

→ **Address** \_\_\_\_\_ **Telephone #** \_\_\_\_\_

→ **Physician's Original Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**STAMPED SIGNATURE WILL NOT BE ACCEPTABLE\*\*\***

**MAIL THE ORIGINAL TO: 100 N. Prater., Lake Charles, LA 70601  
ATTN: HOMEBOUND FAX #337.217.4311**

COPY   Student   -   Teacher   -   Director of Alternative Programs   -   Counselor's Office

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TELEPHONE: 337.217.4980, EXT. 3808    FAX: 337.217.4311

**Title: Hospital/Homebound Reciprocal Release of  
Information**

**Document: HHB 04**

**Revision Date: 7/13**

**Date:**

**Page: 1 of 1**

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This release authorizes Calcasieu Parish School Board to release to the physician listed below:

\_\_\_\_\_  
**Physician Name**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**City, State, Zip**

\_\_\_\_\_  
**Parish/County**

any of the following information.

This release authorizes: **(Physician's Name)** \_\_\_\_\_  
To release to:

Calcasieu Parish School Board  
Hospital/Homebound  
100 N. Prater Street  
Lake Charles, LA 70601  
Phone: 337-217.4300, ext. 3808  
Fax: 337-217.4311  
**Attention: Hospital/Homebound Dept.**

Information as described below pertaining to:

\_\_\_\_\_  
**Student Name**

\_\_\_\_\_  
**Date of Birth**

Any of the following information:

\_\_\_\_\_  
Medical

\_\_\_\_\_  
Social

\_\_\_\_\_  
Psychological

\_\_\_\_\_  
IEP

\_\_\_\_\_  
IHCP

\_\_\_\_\_  
Educational Evaluation

\_\_\_\_\_  
IAP

\_\_\_\_\_  
Other \_\_\_\_\_

This information is requested to assist in determining eligibility for Special Education services or Hospital/Homebound services, and will not be released to any other source or used for any purpose other than the one stated above.

This authorization is effective from the date of the appended signature and will remain in effect for one (1) calendar year. Authorization is subject to written revocation at any time except to the extent that action has already been taken in reliance upon this document.

\_\_\_\_\_  
**Signature of Parent or Guardian**

\_\_\_\_\_  
**Date of Signature**

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Date of Witness Signature**

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**Responsibilities of the Parent**

**Parents of a student requiring hospital/homebound instruction are responsible for:**

- registering the student in a Calcasieu Parish School Board prior to applying for hospital/homebound services;
- notifying the school counselor if the student has an injury or illness that would require an absence of ten (10) consecutive school days or more;
- submitting the completed Hospital/Homebound Packet Forms for hospital/homebound services to the Hospital/Homebound Department which include the following:
  - Hospital/Homebound Referral for Temporary Placement for Physical Illness or Injury (Form HHB 03A), or Hospital/Homebound for Temporary Placement for Psychological Condition (Form HHB 03B), or School Age Mothers (SAM) Program for Temporary Placement for Pregnancy with Complication (Form HHB 03C),
  - The appropriate Hospital/Homebound Physician/Psychologist Verification Form (Form HHB 02A, HHB 02B, or HHB 02C), and
  - Hospital/Homebound Reciprocal Release of Information Form (Form HHB 04)
- ensuring that hospital/homebound student's textbooks and workbooks are picked up from the school prior to first class;
- attending IEP/504 conference with Hospital/Homebound IEP/IAP Teacher on the agreed time and date;
- reading, signing, and adhering to Hospital/Homebound Rules and Regulations for Parents, Students, and Teachers (Form HHB 13);
- cooperating with the hospital/homebound teacher in scheduling days, time, and location of hospital/homebound class sessions;
- transporting the hospital/homebound student in a prompt manner to and from hospital/homebound classes, when held at a location other than home;
- scheduling of required treatment plan and providing updated medical form and documentation of plan to the hospital/homebound teacher each six weeks) every six weeks;
- ensuring that all prior school work (assignments and incompletes ("I"s) prior to hospital/homebound placement, will be completed by the student independent of the hospital/homebound teacher;
- ensuring that all previous classroom absences, prior to hospital/homebound placement, are addressed with the school;
- ensuring that a medical release is given to the hospital/homebound teacher and to the home based school prior to release date of hospital/homebound services;
- ensuring the student attends his/her school on the release date;
- ensuring that any or all textbooks, library books, etc. used exclusively while on hospital/homebound are returned to the school upon reentry to a regular school setting; and
- ensuring that the hospital/homebound student is prepared for class and ready to receive instruction during the scheduled time.

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**Responsibilities of the Hospital/Homebound Student**

A **student** placed on the Hospital/Homebound is responsible for:

- adhering to Hospital/Homebound Rules and Regulations for Parents, Students and Teachers;
- securing textbooks, workbooks, and supplies obtained prior to first hospital/ homebound class;
- attending scheduled classes;
- completing all assigned lessons;
- scheduling all appointments at times other than those set aside for instruction;
- cooperating in establishing an appropriate learning environment. The following **are not allowed** in the home during instructional time: pets, smoking, consuming alcoholic beverages or illegal substances, playing television or radio, or using inappropriate language;
- following the school's Visitation Policy when desiring to visit his/her home based school;
- working with his/her home based school to fulfill all attendance, assignments, class requirements, and graduation procedures prior to placement into the Hospital/Homebound;
- completing all assignments and tests within the next nine weeks period to clear incompletes ("I"s) assigned while on the Hospital/Homebound the previous nine weeks. Assignments and tests not completed within the next nine weeks period will receive a grade of zero; and
- providing the appropriate updated medical referral form to the Hospital/Homebound Department if the probable period of confinement requires an extension of service.

**NOTE:**

**Senior students are responsible for knowing and fulfilling graduation procedures and requirements mandated by their home based school.**