HOME/HOSPITAL APPLICATION
Instructions for Completion

Parent(s)/Guardian(s):

1. Read the Parent Agreement Letter for Home/Hospital Instruction. If accepted for Home/Hospital instruction, you will be asked to sign the letter at the first lesson.
2. Complete Section I of the Home/Hospital application BEFORE you take the entire application to your health professional.
3. When completed, return the application to:

   Franklin County Public Schools
   C/O Director of Student Services
   190 King's Daughters Drive Bldg. #300
   Frankfort, KY 40601

   (502)695-6000 – Office
   (502)352-2255– Fax

4. You will be contacted as soon as the Home/Hospital Committee reviews that application for eligibility.

Health Professionals:

1. Home/Hospital instruction may be considered only if a student cannot attend school for more than five (5) consecutive school days.
2. Section II of the Home/Hospital application should be completed and signed by the health professional requesting Home/Hospital instruction.
3. For a child to be exempted from compulsory education due to a physical or mental condition, the local board shall require a signed statement from a properly licensed physician, advanced practice nurse, physician's assistant, psychologist, or psychiatrist responsible for diagnosing and treating the child, stating that the child's diagnosed condition requires home/hospital instruction.
4. If the condition is mental health related then the signed statement must be completed by a licensed physician, psychiatrist, psychologist, or a physician's assistant with the mental health credentials described in KRS 202A.011 or an advanced practice registered nurse certified in psychiatric-mental health nursing.
5. Home/Hospital instruction is short-term instruction provided in a home or other designated site for a student who is temporarily unable to attend school.

Application for Home/Hospital Instruction Rev 8/9/21

PARENT AGREEMENT LETTER FOR HOME/HOSPITAL INSTRUCTION

____
Date

Dear Parent/Guardian:

__________________________________ a student at _________________________________
Student's Name Name of School

has met the requirements for the Home/Hospital Instruction Program. There are several ways in which you can assist us in continuing the education of your child during his/her illness.

1. Complete the Home/Hospital application, including release of medical information to school officials.
2. There must be a responsible adult present in the home at all times during the Home/Hospital Instruction teacher's visit.
3. The Home/Hospital teacher will visit at least twice a week, more often if the teacher's schedule permits.
4. Notification to the teacher **must** be made in advance, if there is any reason why it would not be possible to have a lesson. Please call the Franklin County Board of Education at (502) 695-6700, Student Services Division. Absences are unexcused unless pre-arranged and the time rescheduled with the Home/Hospital teacher during the same week.
5. Please check with your child regarding the completion of the required daily assignments in order to be ready for instruction at the next designated time.
6. Please provide a suitable work-study are where student and teacher can work with no interruptions (i.e., music and TV must be turned off in study area). The area should be clean, neat, and free from household traffic.
7. Other children, visitors, or pets should be kept out of the room so that the teacher will the students full concentration.
8. Arrange for the child to have sufficient rest and to be ready for work when the teacher arrives at the home.
9. In additional to the scheduled weekly Home/Hospital instruction, student will work independently to complete assignments.
10. Eligibility for Home/Hospital Instruction shall cease if the students works or participates in athletic activities.

I agree to abide by the above requirements and grant permission for my child to receive Home/Hospital Instruction.

_______________________________________ _______________________________
Parent/Guardian Signature **Date**

Application for Home/Hospital Instruction Rev 8/9/21

Section I: Parent/Student Information

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 _______ Telephone # _______________
Full Name of Father/Guardian _________________________Work Phone _________________
Full Name of Mother/Guardian ________________________ Work Phone _________________

List any special education programs in which your student may be enrolled:

List 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 from a properly licensed physician, advanced practice nurse, physician's assistant, psychologist, or psychiatrist responsible for diagnosing and treating the child, stating that the child's diagnosed condition requires home/hospital instruction.. 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

Application for Home/Hospital Instruction

Rev 8/9/21

Section II: Medical Professional Statement

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:

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

Δ The student can attend school only with modifications or special provisions. Describe modifications needed:

Δ I **do not** support home/hospital instruction at this time. Concerns and/or recommendations:

Δ The student is unable to attend school at this time due to health concerns and **I do** support Home/Hospital instruction If you support home/hospital instruction at this time, please provide the following information:

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:

Application for Home/Hospital Instruction Rev 8/9/21

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?

Additional Remarks/Comments:

____

Signature of Licensed Professional Title Date

Please Print or Type Name of Professional:

---

*An application for mental health reasons may be considered if completed by a licensed psychologist or psychiatrist.

Office Address____________________

Phone Number ___________________

Fax Number _____________________

Application for Home/Hospital Instruction Rev 8/9/21

Section III: <u>School District Home/Hospital Review Committee</u>

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 _________________
(Start Date) (End Date)

Date of 6 month review if the child is still receiving services after that time: _______________

If eligibility for services is denied, list the reason for denial:

If the application is incomplete, list the 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 Professional ____
Date

Date for 6 month review of the Home/Hospital application: ______________________