FLEMING COUNTY SCHOOLS

Application for Home/Hospital Instruction

2020-2021

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. Please print neatly.

School District________________________ School____________________________ County of Residence_____________________

Last Date Attended______________________ Grade ________ Special Education ____Yes ____No or 504 ____Yes ____No

Name of Student____ Date of Birth_________________ Sex ______ Race ______

Address of Student ____ Home phone # ___________________

Full Name of Father/Guardian ____ Work/Cell phone #___________________

Full Name of Mother/Guardian ____ Work/Cell 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 practice nurse, physician's assistant, psychologist, psychiatrist, 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 practice nurse, physician's assistant, psychologist, psychiatrist, and/or 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.

Pursuant to 704 KAR 7:120, an application for mental health reasons may be considered **IF** completed by a licensed physician, psychiatrist, psychologist or a physician's assistant with mental health credentials described in KRS202A.011 or an advanced practice registered nurse certified in psychiatric mental health nursing.

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 or Student if 18 yrs. old or older **Date**

Application for Home/Hospital Instruction

Professional Statement

Section II: This section is to be filled out by the authorized medical or mental health professional. An application for mental health reasons must be completed by a licensed psychologist , psychiatrist, licensed physician, physician's assistant with mental health credentials described in KRS202A.011, or an advanced practice registered nurse certified in psychiatric mental health nursing..

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 modification or special provisions.
Comments:____
____

____The student **can attend school only with modifications or special provisions**.
Describe the modifications/special provisions needed:____
____
____

____I **do not** support home/hospital instruction for this student. Please state your concerns and/or recommendations:______________
____
____

____ I **do support** home/hospital instruction and the student is **unable to attend school** at this time due to health concerns.

If you do 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: ____________________________________

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

Professional Statement

Section II continued:

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/specialists to whom this student has been referred:

Name	Specialty	Phone
______________________________	______________________________	______________
______________________________	______________________________	______________
______________________________	______________________________	______________

Will you be following the patient: _____Yes _____No If not, who will:

Name ____ Phone ___________________________

Address ____

Anticipated date of student's return to school: Please be specific….. month/day/year ________________________

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

____

Remarks/Comments: ____

____

____ ____________________________ ______________

Signature of Licensed Professional **Title** **Date**

***An application for mental health reasons may be considered *if* completed by a licensed psychologist, psychiatrist, license physician, physician's assistant with mental health credentials or an advanced practice registered nurse certified in psychiatric mental health nursing.**

Please print or type name of professional: ____

Office Address: ____ **Phone #** ___________________________

____ **Fax #** ______________________________

PLEASE COMPLETE AND RETURN AS SOON AS POSSIBLE TO:

Patsy Adams, Home/Hospital Instructor
Fleming County Schools
211 W. Water St.
Flemingsburg, KY 41041
Phone: 606-845-5851
Fax: 606-845-9900 or 606-849-3158

Application for Home/Hospital Instruction

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 approve, date of services will be from ___________________ until ___________________ Return date ________________________
(Start Date) (End Date)

Date of 6 month review if student is still receiving services after that time: ____

If eligibility for services is *denied*, list reason for denial ____

____

If *incomplete* application, list the type of additional information requested ____

____

Date of request ____________________________ Person contacted ____

Signature of Committee Members:

Director of Pupil Personnel ____ Date ______________________

Home/Hospital Instructor or Program Director ____ Date ______________________

Local Medical or Mental Health Personnel ____ Date ______________________

☐ This is an ARC or 504 committee decision

ARC/504 requested with Facilitator/Counselor, ____ on ____________________

Special education director, ____ notified on ___________________________

Results of ARC/504 committee received on ______________________________

Teacher, ____ assigned on ______________________________

Special education director, ____ notified on ______________________________

Related services provider, ____ notified on _______________________________

Comments: ____

____