

FLEMING COUNTY SCHOOLS

Application for Home/Hospital Instruction

2021-2022

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 504 _____ Yes _____ No

Speech Services _____ Yes _____ No Physical Therapy _____ Yes _____ No Occupational Therapy _____ 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 # _____

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: _____

Section II continued →

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: _____