

### Application for Home/Hospital Instruction

**Section I** - To be completed by parent/guardian. Once entire application is complete, parent should submit to school counselor for further processing.  
*Parent or student should check with all teachers for any make up work/books until Home Hospital has been approved and teacher assigned.*

School: \_\_\_\_\_ Student Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

DOB: \_\_\_\_\_ Grade: \_\_\_\_\_ Gender:  M  F School Counselor: \_\_\_\_\_

Student Address: \_\_\_\_\_ Student Cell # \_\_\_\_\_

Name Father/Guardian: \_\_\_\_\_ Cell # \_\_\_\_\_ Email: \_\_\_\_\_

Name Mother/Guardian: \_\_\_\_\_ Cell # \_\_\_\_\_ Email: \_\_\_\_\_

Resides:  Dad  Mom  Both  Guardian(s) Internet at home:  Yes  No Section 504 Plan:  Yes  No

SPED/IEP:  Yes  No Case Manager Name: \_\_\_\_\_ IEP Expires: \_\_\_\_\_

Pursuant to **KRS 158.033(4)**, eligibility for home or hospital instruction for students with disabilities shall be determined by the Admissions and Release Committee (ARC) and shall be provided pursuant to the Individualized Education Program (IEP). The ARC chairperson shall provide written notice of home/hospital placement to the local Director of Pupil Personnel (DPP) for purposes of program enrollment using the form in section IV of this application. **702 KAR 7:150.**

Pursuant to **KRS 159.030(2)**, before granting any student an exemption from compulsory attendance, the board of education of the district in which the student resides shall require submission to the board of satisfactory evidence in the form of a signed statement of a properly licensed physician, advanced practice registered nurse, physician's assistant, psychologist, or psychiatrist responsible for diagnosing and treating the child, stating that the diagnosed condition of the child prevents or renders inadvisable attendance at school and requires home or hospital instruction. If the condition is mental health related, then the signed statement shall be completed by a licensed physician, psychiatrist, psychologist, or physician's assistant described in **KRS 202A.011** or an advanced practice registered nurse defined in **KRS 314.011** and certified in psychiatric-mental health nursing. On the basis of such evidence, the local board of education may exempt the student from compulsory attendance. A student with a *recurring* condition, which results in periods in which the need for home or hospital instruction is intermittent and the student is able to attend school for short periods, may be exited and reentered on home or hospital instruction, and the following shall apply: (a) Initial approval by the Review Committee shall be required; (b) The Review Committee shall review the need for an alternative schedule of services based on verification by the professional statement in the application for home or hospital instruction of the need for intermittent services; (c) If a health professional who completed the initial application for a student to be served on home or hospital determines the student needs additional time for services, the health professional shall submit a written statement, either mailed or faxed, to the Director of Pupil Personnel, requesting additional time up to two (2) weeks for services and provide a brief explanation for the extension; (d) The Review Committee shall meet to review this extension and either approve or deny the request for an extension, prior to provision of any extended services; (e) The Review Committee shall review intermittent placement **every six (6) months**, and at that time a statement from a *second professional*, shall be required by the Review Committee for continued program eligibility; and (f) The parent or guardian shall notify the principal or Director of Pupil Personnel prior to the need for school reentry or to exit to home or hospital instruction.

Pregnancy is not 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 or hospital instruction for this condition as described in **702KAR 7:150.**

For students receiving home or hospital instruction pursuant to a determination by a Home or Hospital Review Committee, eligibility shall cease if the student works, plays sports or participates in extracurricular activities unless work is listed as part of an active 504 plan as described in **702 KAR 7:150.**

**RELEASE OF INFORMATION**

I understand that if the Home/Hospital Review Committee makes the determination of placement for this student, they 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. I understand that if the Admissions and Release Committee makes the determination of placement for this student, they will have access to all pertinent information regarding this request.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

***IN OFFICE USE ONLY:***

HH Teacher Assigned: \_\_\_\_\_ Attendance Clerk: \_\_\_\_\_ FDI: \_\_\_\_\_

App Expires: \_\_\_\_\_ HH tab updated:  Yes  No ATT Group Start: \_\_\_\_\_ End: \_\_\_\_\_ T-Code NT: \_\_\_\_\_

Attendance HH Code Start: \_\_\_\_\_ End: \_\_\_\_\_ New App Required: \_\_\_\_\_ 2 Apps Required  Yes  No

**\*\*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). The ARC chair shall provide written notice of eligibility to the local Director of Pupil Personnel (DPP) for purposes of program enrollment. The form provided in Section IV shall be used to provide this notice. \*\***

**Section II - Professional Statement**

This section is to be filled out by a properly licensed physician, advanced practice registered nurse, physician's assistant, psychologist, or psychiatrist responsible for diagnosing and treating the student. If the condition is mental health related, then the signed statement shall be completed by a licensed physician, psychiatrist, psychologist, or physician's assistant described in **KRS 202A.011** or an advanced practice registered nurse defined in **KRS 314.011** and certified in psychiatric-mental health nursing. In order for a district board of education to exempt a student from compulsory attendance, the student must provide satisfactory evidence in the form of a signed statement from a qualified healthcare professional that the diagnosed condition of the student prevents or renders inadvisable attendance at school and requires home or hospital instruction.

List Full Name of Student \_\_\_\_\_

Please check one of the following:

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

The student can attend school only with modifications or special provisions listed below:

Describe Modifications Needed: \_\_\_\_\_

The student is unable to attend school at this time due to health concerns, and **IDO** support Home/Hospital instruction. (If last selection applies, professional should complete all fields in the remainder of Section II.)

Diagnosis \_\_\_\_\_ Prognosis:  Good  Fair  Poor

Specific reason (s) why the student is unable to attend school at this time: \_\_\_\_\_

How long has student been under your care for the diagnosis listed?  Weeks  Months  Years

Length of time professional requests need Home/Hospital Instruction (application expires in **6** months regardless, unless indicated in IEP)

Weeks  Month(s) Anticipated date student should return to "in-person class setting": \_\_\_\_\_

Recommended start date of Home/Hospital instruction by professional: \_\_\_\_\_

Is this a chronic condition/diagnosis unlikely to substantially improve within one (1) year?  Yes  No

Please summarize test and all other data collected that supports the need for Home/Hospital Instruction at this time.

\_\_\_\_\_

What is the treatment plan for the patient? \_\_\_\_\_

What is the expected duration of treatment? \_\_\_\_\_

Hospital Admission Date: \_\_\_\_\_ Hospital Release Date: \_\_\_\_\_

Facility Name/Location \_\_\_\_\_

List consultants/specialist to whom this student has been referred:

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Will you be following the patient?  Yes  No If not, please indicate provider that will be following patient below.

Name & Title: \_\_\_\_\_ Facility Name: \_\_\_\_\_

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

Please indicate your recommendations to assist this student in their return to school:

Signature of Licensed Professional & Title \_\_\_\_\_ Date \_\_\_\_\_

Please Print Name of Professional: \_\_\_\_\_

Full Office Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**Section III - Home/Hospital Review Committee**

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

Date Application Received: \_\_\_\_\_

Status:  Approved  Denied

Application Expiration/Review Date: \_\_\_\_\_

If eligibility denied state reason: \_\_\_\_\_

**Signatures of Committee Members:**

\_\_\_\_\_  
Director of Pupil Personnel Date Program Director Date

\_\_\_\_\_  
Home/Hospital Teacher Date Medical/Mental Health Personnel Date  
*(Teacher must update PLP area of IC with weekly planned & scheduled visits for specific times of instruction & travel)*

\_\_\_\_\_  
Other Relevant Professional Title Date

Comments: \_\_\_\_\_

**Section IV - Documentation of Admissions and Release Committee (ARC)**

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). The ARC chair shall provide written notice of eligibility to the local Director of Pupil Personnel for purposes of program enrollment. The form provided in this section shall be used to provide this notice.

Name of Student \_\_\_\_\_ Case Manager \_\_\_\_\_

Start date of home/hospital placement: \_\_\_\_\_ Anticipated end date of home/hospital placement: \_\_\_\_\_

Date of ARC meeting for Home/Hospital determined: \_\_\_\_\_ HRS required per Week per IEP: \_\_\_\_\_

IEP Current/Active:  Yes  No IEP Expiration Date: \_\_\_\_\_ Next IEP Mtg Due: \_\_\_\_\_

\_\_\_\_\_  
Signature ARC Chair Date

## Application for Home/Hospital Instruction

**June 2021**

(Please type or print neatly)

### Parent/Student Information

#### **Section I**

To be completed by the parent(s)/guardian(s)

School District \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

County of Residence \_\_\_\_\_ Last Date Attended \_\_\_\_\_

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address of Student \_\_\_\_\_ Zip Code \_\_\_\_\_

Sex \_\_\_\_\_ Race \_\_\_\_\_ Social Security # \_\_\_\_\_ Telephone # \_\_\_\_\_

Full Name of Father/Guardian \_\_\_\_\_ Telephone# \_\_\_\_\_

Full Name of Mother/Guardian \_\_\_\_\_ Telephone# \_\_\_\_\_

Does the student have an Individualized Education Program (IEP)? Yes \_\_\_\_\_ No \_\_\_\_\_

Does the student have a Section 504 Plan? Yes \_\_\_\_\_ No \_\_\_\_\_

Directions to student's home \_\_\_\_\_

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A student with a recurring condition, which results in periods in which the need for home or hospital instruction is intermittent and the student is able to attend school for short periods, may be exited and reentered on home or hospital instruction, and the following shall apply:

(a) Initial approval by the Review Committee shall be required;

(b) The Review Committee shall review the need for an alternative schedule of services based on verification by the professional statement in the application for home or hospital instruction of the need for intermittent services;

- (c) If a health professional who completed the initial application for a student to be served on home or hospital determines the student needs additional time for services, the health professional shall submit a written statement, either mailed or faxed, to the Director of Pupil Personnel, requesting additional time up to two (2) weeks for services and provide a brief explanation for the extension;
- (d) The Review Committee shall meet to review this extension and either approve or deny the request for an extension, prior to provision of any extended services;
- (e) The Review Committee shall review intermittent placement at least every six (6) months, and at that time a statement from a second professional, shall be required by the Review Committee for continued program eligibility; and
- (f) The parent or guardian shall notify the principal or Director of Pupil Personnel prior to the need for school reentry or to exit to home or hospital instruction.

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\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Application for Home/Hospital Instruction  
Professional Statement**

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**Section II**

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

\_\_\_\_\_ I do/ \_\_\_ I do not support home/hospital instruction for this student. If you do not support home/hospital instruction at this time, please state your concerns and/or recommendations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please check one of the following:

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

\_\_\_\_\_ The student can attend school only with modifications or special provisions.  
Describe Modifications Needed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ The student is unable to attend school at this time due to health concerns, and I do support Home/Hospital instruction. **If checked, please complete the rest of Section II.**

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 \_\_\_\_\_

Recommended start date of Home/Hospital instruction: \_\_\_\_\_

Please summarize test and all other data collected that supports the need for Home/Hospital Instruction at this time.

\_\_\_\_\_

What is the treatment plan for the patient? \_\_\_\_\_

What is the expected duration of treatment? \_\_\_\_\_

Start date of hospital admission, if applicable: \_\_\_\_\_

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 \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_

Anticipated date of student's return to school \_\_\_\_\_

What are your recommendations to assist this student in their return to school? \_\_\_\_\_

Remarks/Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Licensed Professional

Title

Date

Please Print or Type Name of Professional: \_\_\_\_\_

Office Address \_\_\_\_\_ Phone Number \_\_\_\_\_

\_\_\_\_\_ Fax Number \_\_\_\_\_

**Application for Home/Hospital Instruction  
Home/Hospital Review Committee**

**Section III**

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

Date Application Received: \_\_\_\_\_ Approved \_\_\_\_\_ Denied \_\_\_\_\_ Incomplete\_ If  
approved, date of services will be from \_\_\_\_\_ until \_\_\_\_\_  
(Review Date)

If eligibility for services denied, reason for denial \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If incomplete application, type of additional information requested \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Request \_\_\_\_\_ Person Contacted \_\_\_\_\_

**Signatures of Committee Members:**

Director of Pupil Personnel \_\_\_\_\_ Date \_\_\_\_\_

Program Director \_\_\_\_\_ Date \_\_\_\_\_

Home/Hospital Teacher \_\_\_\_\_ Date \_\_\_\_\_

Medical or Mental  
Health Personnel \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Other Relevant Professional \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Application for Home/Hospital Instruction  
Documentation of Admissions and Release Committee (ARC)**

**Section IV**

**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). The ARC chair shall provide written notice of eligibility to the local Director of Pupil Personnel (DPP) for purposes of program enrollment. The form provided in this section shall be used to provide this notice. \*\***

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

Does the student have a current/active Individualized Education Program (IEP)?  Yes  No

Start date of home/hospital placement: \_\_\_\_\_

Anticipated end date of home/hospital placement: \_\_\_\_\_

Date of the most recent ARC meeting where Home/Hospital placement was decided: \_\_\_\_\_

Total number of hours of Home/Hospital instruction per week: \_\_\_\_\_

ARC Chair: \_\_\_\_\_

\_\_\_\_\_  
Signature of ARC Chair

\_\_\_\_\_  
Date