ROWAN COUNTY SCHOOL DISTRICT 2023-2024
Application for Home/Hospital Instruction
Return completed form to Denine Sergent, Director of Pupil Personnel
551 Viking Drive; Morehead, KY 40351; FAX: 606.783.1011

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: __Rowan County__ 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 _____ Social Security # _____ 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 of a licensed physician, advanced registered nurse practitioner, psychologist, psychiatrist, chiropractor 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 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.

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

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:_____

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Section II: Medical Professional Statement: *This section is to be filled out by the authorized medical or mental health professional ONLY.*

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:

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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?

_____ 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 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:

Office Address_____ Phone Number _____ Fax Number _____
_____

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Section III: School District Home/Hospital Review Committee: *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 Professional: _____ Date: _____

Local Medical or Mental Health Professional _____ Date: _____

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