PUYALLUP
SCHOOL DISTRICT
A Tradition of Excellence

Directions to Health Care Provider Requesting Home/Hospital Instruction

The enclosed form is a request for Home or Hospital Instruction. This is a tutoring service provided to students who are medically unable to attend school for a **minimum of 4 weeks and a maximum of 18 weeks** because of a disability or illness.

Please complete the attached form as follows:

1. The number of weeks the student is medically unable to attend school.
   PLEASE NOTE: The dates for Home Hospital tutoring cannot be back-dated and there must be a minimum of 4 weeks remaining on the medical orders to begin arranging services.
2. The appropriate diagnostic code and description.
3. Sign and date the form.
4. Submit the following information to the Home/Hospital coordinator via fax to (253) 841-8655:
   a. HIPAA authorization signed by parent/guardian
   b. Request for Home/Hospital Instruction Form
   c. Diagnoses which are manifested by severe behavioral problems will require an accompanying letter consisting of the diagnosis, a brief plan of care, prognosis, etc.

<u>Please Note:</u>

H/H tutoring *may* be provided for intermittent absences **under the following conditions**:

- Absences lasting one week or more at a time;
- Intermittent absences will total at least four weeks, but;
- No more than a semester during a school year;
- The student is expected to resume regular classroom instruction after the absence;
- All other eligibility criteria for H/H have been met.

If it is foreseeable that a student's illness would require them to be home on an intermittent or long-term basis that does not meet the guidelines for H/H services (e.g. partial days; several days a week; unpredictable days based on student condition or treatment plan; beyond 18 weeks), all documentation received will be forwarded to the 504 coordinator at the student's school.

Thank you for your assistance.

HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Puyallup School District
Special Services
1501 39th Ave SW, Puyallup, WA 98373
Phone: (253) 841-8700 Fax: (253) 841-8655

Patient Information:

______________________________ BD: ______________
(PRINT name of patient)

Information to be released from: ______________________________
Name of designated Facility or Provider

____
Address

______________________ ______________
City, State, Zip Code Phone Number

Information to be sent to:

PUYALLUP SCHOOL DISTRICT
1501 39th Ave SW
PUYALLUP, WA 98373

Requestor: ______________________

Information to be released:

- ☐ The most recent 2 years of pertinent information (Chart notes, labs, x-rays and special tests)
- ☐ All medical records
- ☐ Specific information (Please specify): ______________________________

____

The disclosure of this medical information is for educational evaluation and planning.

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (please initial):

___ Drug/Alcohol abuse/treatment & diagnosis ___ Sexually Transmitted Disease
___ HIV/AIDS diagnosis/treatment/testing ___ Mental Illness or Psychiatric diagnosis/treatment

I understand that the information used or disclosed may be subject to redisclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying Puyallup School District Schools in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition my treatment of me on whether or not I sign the authorization.

SIGNATURE: ______________________________ DATE: ______________
(Patient, Guardian*, or Authorized Representative*)
*Please provide documents to prove authority to sign on behalf of the patient.
This authorization will expire 90 days from the date signed.

REQUEST FOR
HOME / HOSPITAL INSTRUCTION

SCHOOL DISTRICT NAME Puyallup School District		STUDENT NAME (Last, First Middle) Please Print	
HOME HOSPITAL SUPERVISOR Director of Special Education	DISTRICT TELEPHONE (253) 841-8700 DISTRICT FAX (253) 841-8655	STUDENT DOB STUDENT GRADE LEVEL	GENDER ☐ Male ☐ Female ☐ Other: ______________

Please send completed request form and any supporting documents by fax to the
Puyallup School District Home/Hospital coordinator at (253) 841-8655

SECTION 1 – THIS SECTION TO BE COMPLETED BY A QUALIFIED MEDICAL PRACTITIONER

DIAGNOSIS:

☐ Disease/Injury/Surgery (primary diagnosis): ______________________________

☐ Drug/Alcohol Treatment

☐ Pregnancy

☐ Other* (describe): ______________________________

*Diagnosis such as "mental illness," "anxiety neurosis," and certain other illnesses which are manifested by severe behavioral problems will require an accompanying letter consisting of the diagnosis, a brief plan of care, prognosis, etc.

I certify that this student is unable to attend public school for ______ weeks ☐ continuously ☐ intermittently**

____
TYPE / PRINT NAME OF QUALIFIED MEDICAL PRACTITIONER

____
____
____
BUSINESS ADDRESS

____
SIGNATURE DATE

____
CONTACT TELEPHONE NUMBER

SECTION 2 – THIS SECTION FOR SCHOOL DISTRICT USE

Is the student eligible to receive special education services? ☐ Yes ☐ No

If the student is eligible to receive special education services, does the IEP team need to meet? ☐ Yes ☐ No

CHECK ONE:

☐ Original Request ☐ Extension

____
BEGINNING DATE OF INSTRUCTIONAL TIME OR EXTENSION

NOTE: Beginning date on extension request must consecutively follow ending date of original

______________________________ ______________ ______________________
SCHOOL DISTRICT AUTHORIZATION DATE CONTACT TELEPHONE NUMBER

** If it is foreseeable that a student's illness would require them to be home on an intermittent or long-term basis that does not meet the guidelines for Home/Hospital services (e.g. partial days; several days a week; unpredictable days based on student condition or treatment plan; beyond 18 weeks), all documentation received will be forwarded to the 504 coordinator at the student's school.