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TO: Parents and Students Requesting Home/Hospital Instruction
FROM: Hardin County Schools
SUBJECT: Home/Hospital Instruction

Directions

1. Parents/Guardians must complete all of **Section I**.
2. Appropriate Medical Professional must complete **ALL** of **Section III**.
3. Return the completed Application Form to **Wes Blair, Director of Alternative Programs or Lisa Brown, Homebound Coordinator** at the Hardin County Schools Board of Education located at 65 W.A. Jenkins Rd in Elizabethtown.
4. Once received, the Home/Hospital Review Committee will review the applications and complete Section II.
5. Upon approval, you will be contacted by Student Services Department and assigned a Home/Hospital teacher who will set instruction dates and times.

Eligibility and Mandates

1. Students who anticipate absences for **more than five consecutive school days** for medical purposes may apply for Home/Hospital Instruction to help minimize learning disruptions caused by a lengthy school absence due to a medical diagnosis.

2. A student cannot be enrolled in home/hospital instruction until the completed Application Form (Sections I & III) is received and approved by Review Committee at the Board of Education office. The original Application Form can be mailed or submitted to the Hardin County Schools Board of Education, 65 W.A. Jenkins Rd. Elizabethtown, KY 42701 to the attention of Wes Blair or Lisa Brown. If you have any questions, please call Wes Blair at 270-769-8826 or Lisa Brown at 270-769-8851.

3. Section III of the Application Form must provide satisfactory evidence in the form of a signed statement from a licensed physician, advanced practice nurse, physician's assistance, psychologist, or psychiatrist responsible for diagnosing and treating the child, stating that the condition of the student renders inadvisable attendance at school for **more than five (5) consecutive school days**.

4. If the medical condition is mental health related then the signed statement must be completed by a licensed physician, psychiatrist, psychologist, or a physician's assistant with the mental health credentials described in KRS 202A.011 or an advanced practice registered nurse certified in psychiatric-mental health nursing.

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5. Any student who is excused from school attendance for more than six months must have two (2) signed applications from the providers, unless the original signed application indicates the child has a chronic condition that is unlikely to substantially improve within one year.

6. Since pregnancy is not considered a physical or health impairment, the condition itself, barring complications, would not constitute a need for home/hospital instruction.

7. Students must receive one hour of instruction twice a week to be counted in full attendance. The home/hospital teacher will notify the guardian to schedule each instructional session. Students should schedule any personal activities after these hours (excluding doctor appointments).

8. A responsible adult must be in the home and be visible during the home/hospital teacher's visit.

9. Prior to an instructional session, an adequate work area free from distractions must be prepared by the guardian.

10. The student and/or parent is responsible for making arrangements with the student's classroom teachers regarding assignments not completed prior to placement in the Home/Hospital Program.

11. All subject assignments including tests for each grading period must be completed no later than two weeks (10 school days) following the ending date of the grading period.

12. A student cannot be gainfully employed or participate in extra-curricular activities such as sports, during the time that he/she is enrolled in the Home/Hospital Instruction Program.

13. Elementary and Middle School Promotion and Retention: The decision to promote or retain shall be made by the principal after involvement of classroom teachers and the home/hospital teacher and shall be consistent with HCAR 08.22.

14. Exceptional children must meet all of the above criteria. In addition, an admissions and release committee (ARC) shall determine that an exceptional child shall be eligible for home/hospital instruction provided certain criteria are met.

15. Exemptions and status of all children under the provisions above must be reviewed annually with the evidence required being updated.

**Please feel free to contact Mr. Blair/Ms. Lisa Brown if you have any questions regarding this program, its policies and procedures.

Office: 270-769-8826
Fax: 270-769-8865
Email: wes.blair@hardin.kyschools.us

Office: 270-769-8851
Fax: 270-769-8865
Email: lisa.brown@hardin.kyschools.us

Application for Home/Hospital Instruction

(Please Print Neatly)

Section I

To be completed by the Parent/Guardian prior to full completion by the authorized health professional.

School District________________________________ 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 you son or daughter may be enrolled: __________________

____

For purposes of KRS 157.360, a student who receives home/hospital instruction for a minimum of two (2) instructional sessions per week, with a minimum of one (1) hour of instruction per session, by a certified teacher provided by the Board, shall equal the student attending five (5) days in school. An instructional session may be delivered in person, electronically, or through other means established in regulation. A parent/guardian or responsible adult must be present in the home/hospital room during the time the home/hospital teacher is present or is otherwise delivering instruction.

In accordance with KRS 159.030(2), for a child to be exempted from compulsory education due to a physical or mental condition, the local board shall require a signed statement from a properly licensed physician, advanced practice nurse, physician's assistant, psychologist, or psychiatrist responsible for diagnosing and treating the child, stating that the child's diagnosed condition requires home/hospital instruction. If the condition is mental health related then the signed statement must be completed by a licensed physician, psychiatrist, psychologist, or a physician's assistant with the mental health credentials described in KRS 202A.011 or an advanced practice registered nurse certified in psychiatric-mental health nursing. For a child excused from school for more than 6 months, requires 2 signed statements from providers, unless the signed statement indicates the child has a chronic condition that is unlikely to substantially improve within 1 year. All exemptions shall be reviewed annually by the Review Committee in addition to any time based on changes in the student's condition.

<u>RELEASE OF INFORMATION</u>

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

Section II

This section is to be completed by the Home/Hospital Review Committee.

Name of Student____

Date of Application Received:_______ Approved_____ Denied_____ Incomplete_____

If approved, date of services will 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_____________

Home/Hospital Services Teacher
Or Program Director _______________________________________ Date_____________

Local Health Personnel _____________________________________ Date_____________

Comments:

____

____

____

____

Section III

This section is to be filled out by the authorized health professional.

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 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/Hosptial instruction (If checked, please complete the rest of this section).

____I do/____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: ____________________________
____
____

If you do support home/hospital at this time, please fill out the rest of Section III.

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____________________________

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?____

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 ______________________________ 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?_________________

____

____

Remarks/Comments: ____

____

____

______________________________ ______________________________ ______________

Signature of Authorized Professional Title Date

Please Print Name of Professional ____

Office Address:___________________________ Phone Number ________________________

___________________________ Fax Number __________________________

____