

**CALCASIEU PARISH SCHOOL BOARD
HOSPITAL/HOMEBOUND
1509 ENTERPRISE BLVD., LAKE CHARLES LA 70601
TELEPHONE: 337.217.4980, EXT. 3607 FAX: 337.217.4311**

**THIS FORM TO BE COMPLETED BY THE SCHOOL
COUNSELOR AND FAXED TO THE HOSPITAL/HOMEBOUND
DEPARTMENT**

Title	APPLICATION FORM FOR HOSPITAL/HOMEBOUND SERVICES	Document:	HHB 00
Date:		Revision Date:	9/15
		Page:	1 of 1

STUDENT ID _____

STUDENT NAME _____

BIRTHDATE _____ **AGE:** _____ **SEX** _____

SS# _____

SCHOOL _____ **GRADE** _____

PARENT NAME _____

STREET ADDRESS _____

MAIL ADDRESS _____

HOME PHONE _____ **CELL PHONE** _____

WORK PHONE _____

REASON FOR HOMEBOUND REQUEST
PLEASE CIRCLE ONE
PLEASE SPECIFY

MEDICAL	PSYCHOLOGICAL	PREGNANCY
----------------	----------------------	------------------

IF PREGNANCY, DUE DATE _____

PROBATION OFFICER, if applicable _____

Contact Information _____

School Counselor Name: _____ **School Counselor's Phone#:** _____

Does the student currently have an IEP? _____ Yes _____ No

If yes, attach a copy.

Does the student currently have an IAP? _____ Yes _____ No

If yes, attach a copy.

DATE GIVEN TO PARENT _____

NOTE: This form does not automatically enter a student into the Hospital/Homebound Program. Hospital/Homebound Program placement does not begin for a student until all eligibility criteria have been met, as determined by the Director of Alternative Programs.

Original – School Counselor
Copies: Hospital/Homebound File - fax to 337.217.4311 - Clerk
Parent with Hospital/Homebound Packet

CALCASIEU PARISH SCHOOL BOARD

HOSPITAL/HOMEBOUND

1509 ENTERPRISE BLVD., LAKE CHARLES LA 70601

TELEPHONE: 337.217.4980, EXT. 3607 FAX: 337.217.4311

Title: Hospital/Homebound Parent Letter for
Psychological Condition

Document: HHB 01B

Revision Date: 9/15

Date:

Page: 1 of 1

Parent Name _____

Address _____

City, State, _____

Student Name _____

DOB _____

School _____

Dear Parent(s):

Please have the enclosed forms completed by a licensed psychiatrist, licensed clinical psychologist, or a licensed clinical social worker for psychological reasons if you desire Hospital/Homebound services for your child. The forms must be returned in the self-addressed envelope immediately or hand delivered to Hospital/Homebound Dept., 1509 Enterprise Blvd., Lake Charles, LA 70601.

According to state and parish guidelines, a student is eligible for Hospital/Homebound instruction on the 11th school day following an absence of more than ten (10) consecutive school days for a qualifying illness. Hospital/Homebound placement does not begin for a student until all eligibility criteria have been met, as determined by the Director of Alternative Programs. Hospital/Homebound teachers are only responsible for work missed during Hospital/Homebound placement.

Necessary arrangements will be made upon receipt and a successful review of the following forms:

- (1) the Hospital/Homebound Application Form (Form HHB 00)
- (2) the Hospital/Homebound Psychologist Verification Form (Form HHB 02B)
- (3) the Hospital/Homebound Psychologist Referral Form for Temporary Placement for Psychological Condition (Form HHB 03B)
- (4) the Hospital/Homebound Reciprocal Release of Information Form (Form HHB 04)

The parent/legal guardian is responsible for completing all necessary paperwork as soon as possible to avoid unnecessary absences. All forms must be completed prior to placement in the Hospital/Homebound Program.

Sincerely,
Director of Alternative Programs

cb
Enclosure
Copy: File

**CALCASIEU PARISH SCHOOL BOARD
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TREATMENT PROVIDERS – PLEASE NOTE

The following Hospital/Homebound Referral Form is to be filled out completely. Each item must be completed in order for the student to be considered for placement in the Hospital/Homebound Program.

If any item is not filled out completely, this will result in the student's placement in the Hospital/Homebound Program being denied or delayed.

For questions or further information, please call Connie Briley at (337) 217.4980 ext. 3607.

I appreciate your assistance and cooperation.

Sincerely,

Connie Briley, Clerk
Hospital/Homebound Program

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TELEPHONE: 337.217.4980, EXT. 3607 FAX: 337.217.4311**

Title: Hospital/Homebound Psychiatrist/Psychologist/
Social Worker Verification Form

Document: HHB 02B

Revision Date: 9/15

Date: _____

Page: 1 of 1

Physician Name: _____

Address _____

Student Name _____

DOB _____

School _____

Dear Dr. _____

Hospital/Homebound is the most restrictive environment in education. Therefore, it is advantageous for the student to return to the least restrictive environment, which is the regular school setting.

According to state and parish guidelines, a student is eligible for Hospital/Homebound instruction on the 11th school day following an absence of more than ten (10) consecutive school days for a qualifying illness. Hospital/Homebound placement does not begin for a student until all eligibility criteria have been met, as determined by the Director of Alternative Programs. Hospital/Homebound teachers are only responsible for work missed during Hospital/Homebound placement.

A licensed psychiatrist, licensed clinical psychologist, or a licensed clinical social worker's verification that the student is receiving ongoing care and treatment is necessary each six (6) weeks. It will be the responsibility of the parent/guardian to schedule appointments and have the appropriate form completed and signed each six (6) weeks documenting treatment dates for a student to continue being eligible for the Hospital/Homebound Program.

Your cooperation in helping our students is appreciated.

Sincerely,
Director of Alternative Programs

**Please
Sign
Here**



Original Signature of Licensed Psychiatrist,
Licensed Clinical Psychologist, or
Licensed Clinical Social Worker

**Please
Date
Here**



Date

Licensed psychiatrist, licensed clinical psychologist, or a licensed clinical social worker's signature is necessary for student's application to be considered for Hospital/Homebound placement. Please attach to form HHB-03B.

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1509 ENTERPRISE BLVD., LAKE CHARLES LA 70601
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Title:	Hospital/Homebound Referral for Temporary Placement For	Document:	HHB 03B
	Psychological Condition	Revision Date:	9/15
Date:		Page:	1

Student's Name _____ Age _____ DOB _____
 School _____ Grade _____ Sex _____
 Parent Name _____ Telephone _____
 Home Address _____

Psychological Certification: THIS SECTION IS TO BE COMPLETED BY A LICENSED PSYCHIATRIST, LICENSED CLINICAL PSYCHOLOGIST, OR LICENSED CLINICAL SOCIAL WORKER.

The undersigned certifies that the above named student is unable to attend school for the following **PSYCHOLOGICAL** reason. **A SPECIFIC DIAGNOSIS OF THE PSYCHOLOGICAL CONDITION AND HOW THIS CONDITION PREVENTS SCHOOL ATTENDANCE IS NECESSARY IN ORDER FOR THE CALCASIEU PARISH SCHOOL BOARD TO SERVE THE HOSPITAL/HOMEBOUND STUDENT APPROPRIATELY.**

Please explain psychological complication

PSYCHOLOGICAL CONDITION/DIAGNOSIS _____

Medication _____ **Negative effects, if any** _____

IS THE STUDENT ABLE TO ATTEND REGULAR SCHOOL WITH THE ABOVE DIAGNOSIS? ____ YES ____ NO

Please explain

IF NO, HOW DOES THE ABOVE DIAGNOSIS AFFECT THE EDUCATIONAL HOURS? _____

DOES THE STUDENT HAVE AN INFECTIOUS OR COMMUNICABLE DISEASE? ____ YES ____ NO

IF YES, PLEASE LIST NECESSARY PRECAUTIONS: _____

Date of last examination/treatment: _____

The Calcasieu Parish School Board requires a Treatment Plan completed by a licensed psychiatrist, licensed clinical psychologist, or licensed clinical social worker if the student is to qualify for the Hospital/Homebound Program.

What is the treatment plan for above diagnosis?

I certify that the student is receiving a program of care and treatment as prescribed below and I will verify the student's continuing qualification by completing HHB 03B a minimum of every six weeks.

Please Mark

The expected duration of the condition which prevents school attendance is:

____ 3 weeks ____ 4 weeks ____ 5 weeks ____ 6 weeks

Complete

Licensed Psychiatrist, Licensed Clinical Psychologist, Licensed Clinical Social Worker _____

Address _____ Telephone # _____

Original Signature of Treatment Provider _____ **Date** _____

STAMPED SIGNATURE WILL NOT BE ACCEPTABLE***

MAIL THE ORIGINAL TO: 1509 Enterprise Blvd., Lake Charles LA 70601

ATTN: HOMEBOUND FAX #337.217.4311

COPY Student - Teacher - Director of Alternative Programs - Counselor's Office

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1509 ENTERPRISE BLVD., LAKE CHARLES LA 70601
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**Title: Hospital/Homebound Reciprocal Release of
Information**

**Document: HHB 04
Revision Date: 9/15**

Date:

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This release authorizes Calcasieu Parish School Board to release to the physician listed below:

Physician Name

Address

City, State, Zip

Parish/County

any of the following information.

This release authorizes: **(Physician's Name)** _____
To release to:

Calcasieu Parish School Board
Hospital/Homebound
1509 Enterprise Blvd.
Lake Charles, LA 70601
Phone: 337-217-4300, ext. 3607
Fax: 337-217.4311

Attention: Director of Alternative Programs

Information as described below pertaining to:

_____ Student Name	_____ Date of Birth
Any of the following information:	
_____ Medical	_____ Social
_____ IEP	_____ IHCP
_____ IAP	_____ Psychological
	_____ Educational Evaluation
	_____ Other _____

This information is requested to assist in determining eligibility for Special Education services or Hospital/Homebound services, and will not be released to any other source or used for any purpose other than the one stated above.

This authorization is effective from the date of the appended signature and will remain in effect for one (1) calendar year. Authorization is subject to written revocation at any time except to the extent that action has already been taken in reliance upon this document.

Signature of Parent or Guardian

Date of Signature

Signature of Witness

Date of Witness Signature

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Responsibilities of the Parent

Parents of a student requiring hospital/homebound instruction are responsible for:

- registering the student in a Calcasieu Parish School Board prior to applying for hospital/homebound services;
- notifying the school counselor if the student has an injury or illness that would require an absence of ten (10) consecutive school days or more;
- submitting the completed Hospital/Homebound Packet Forms for hospital/homebound services to the Hospital/Homebound Department which include the following:
 - Hospital/Homebound Referral for Temporary Placement for Physical Illness or Injury (Form HHB 03A), or Hospital/Homebound for Temporary Placement for Psychological Condition (Form HHB 03B), or School Age Mothers (SAM) Program for Temporary Placement for Pregnancy with Complication (Form HHB 03C),
 - The appropriate Hospital/Homebound Physician/Psychologist Verification Form (Form HHB 02A, HHB 02B, or HHB 02C), and
 - Hospital/Homebound Reciprocal Release of Information Form (Form HHB 04)
- ensuring that hospital/homebound student's textbooks and workbooks are picked up from the school prior to first class;
- attending IEP/504 conference with Hospital/Homebound IEP/IAP Teacher on the agreed time and date;
- reading, signing, and adhering to Hospital/Homebound Rules and Regulations for Parents, Students, and Teachers (Form HHB 13);
- cooperating with the hospital/homebound teacher in scheduling days, time, and location of hospital/homebound class sessions;
- transporting the hospital/homebound student in a prompt manner to and from hospital/homebound classes, when held at a location other than home;
- scheduling of required treatment plan and providing updated medical form and documentation of plan to the hospital/homebound teacher each six weeks) every six weeks;
- ensuring that all prior school work (assignments and incompletes ("I"s) prior to hospital/homebound placement, will be completed by the student independent of the hospital/homebound teacher;
- ensuring that all previous classroom absences, prior to hospital/homebound placement, are addressed with the school;
- ensuring that a medical release is given to the hospital/homebound teacher and to the home based school prior to release date of hospital/homebound services;
- ensuring the student attends his/her school on the release date;
- ensuring that any or all textbooks, library books, etc. used exclusively while on hospital/homebound are returned to the school upon reentry to a regular school setting; and
- ensuring that the hospital/homebound student is prepared for class and ready to receive instruction during the scheduled time.

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Responsibilities of the Hospital/Homebound Student

A **student** placed on the Hospital/Homebound Program is responsible for:

- adhering to Hospital/Homebound Rules and Regulations for Parents, Students and Teachers;
- securing textbooks, workbooks, and supplies obtained prior to first hospital/ homebound class;
- attending scheduled classes;
- completing all assigned lessons;
- scheduling all appointments at times other than those set aside for instruction;
- cooperating in establishing an appropriate learning environment. The following **are not allowed** in the home during instructional time: pets, smoking, consuming alcoholic beverages or illegal substances, playing television or radio, or using inappropriate language;
- following the school's Visitation Policy when desiring to visit his/her home based school;
- working with his/her home based school to fulfill all attendance, assignments, class requirements, and graduation procedures prior to placement into the Hospital/Homebound Program;
- completing all assignments and tests within the next nine weeks period to clear incompletes ("I"s) assigned while on the Hospital/Homebound Program the previous nine weeks. Assignments and tests not completed within the next nine weeks period will receive a grade of zero; and
- providing the appropriate updated medical referral form to the Hospital/Homebound Department if the probable period of confinement requires an extension of service.

NOTE:

Senior students are responsible for knowing and fulfilling graduation procedures and requirements mandated by their home based school.