

THOMAS COUNTY SCHOOLS

200 N. Pinetree Blvd., Thomasville, GA 31792

Dr. Lisa Williams, Superintendent

229-225-4380 229-225-5012 Fax

Overview of Hospital/Homebound (HH) Services

Georgia State Board of Education Rule 160-4-2-.31 Hospital/Homebound (HH) Services

Hospital/Homebound (HH) services are designed to provide continuity of educational services between the classroom and home or hospital for students in Georgia public schools whose medical needs, either physical or psychiatric, do not allow them to attend school for a limited period of time. HH instruction may be used to supplement the classroom program for students with health impairments whose conditions may interfere with regular school attendance.

HH services are not intended to replace regular school services and are intended to be temporary. The student must anticipate being absent from school for a minimum of ten consecutive or intermittent school days due to a medical or psychiatric condition. The student's inability to attend school for medical or psychiatric reasons must be certified by the licensed physician or licensed psychiatrist who is currently treating the student for the diagnosis presented.

Student Eligibility

Eligibility for HH service is based on the following criteria and the need for services will be evaluated on a case by case basis:

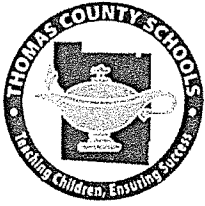
1. The student must be enrolled in the Thomas County School System. Private or home school students are **NOT** eligible for HH services from a Georgia public school.
2. The student must have a medical and/or psychiatric condition that is documented by a licensed physician. Only a psychiatrist can submit a medical request form for an emotional or psychiatric disorder. The referring licensed physician and/or licensed psychiatrist must be the treating physician or psychiatrist for the medical and/or psychiatric condition for which the student is requesting HH services.
3. The student must be anticipated to be absent from school for a minimum of ten consecutive school days or for intermittent periods of time anticipated to exceed ten school days during the school year.
4. Students who have been declared emancipated by a court or are 18 years of age or older are eligible to sign the *Hospital/Homebound (HH) Services Request Form* and the *Compliant Authorization for Exchange of Health and Education Information (The Health Insurance Portability and Accountability Act - HIPAA)*.
5. A parent, guardian, emancipated minor, or student 18 years of age or older must sign the HIPAA release form relating to the reason for the request for HH services and the form must be submitted before services can be provided.

Application Process

1. The parent/guardian, emancipated minor, or student 18 years of age or older should contact the school's HH contact to discuss HH services and to obtain an application for these services.
2. The parent/guardian, emancipated minor, or student 18 years of age or older should read and sign a document to certify his or her understanding of the HH policies, procedures and application process.
3. The parent/guardian, emancipated minor, or student 18 years of age or older should take the HH application to the licensed physician or licensed psychiatrist treating the student for the medical condition. The completed application must be returned to the school HH contact.
4. The appropriate school designee will review the application to ensure that the student meets the minimal eligibility requirements and submit the application to the appropriate system personnel for action.
5. Within five school days of receiving the completed *Licensed Physician/Psychiatrist Statement and Medical Referral Form*, the appropriate school or system personnel shall notify the parent, guardian, emancipated minor or student 18 years of age or older of the application status. A Educational Services Plan (ESP) or IEP meeting may be held to determine the appropriate course load for the student and discuss other aspects of HH services.

Termination of Services

1. A student can be released from the HH program:
 - a. As of the projected return date on the Application for Hospital/Homebound Services Medical Referral or if the licensed physician or licensed psychiatrist indicates that the medical condition has changed or as defined in the ESP.
 - b. When the student is employed in any capacity, goes on vacation, regularly participates in extracurricular activities, or is no longer confined to home.
 - c. On the last day of school of the regular school year.
 - d. When the student returns to school or is able to return to school for any portion of the school day other than to participate in state-mandated standardized testing.
 - e. When the parent/guardian cancels three HH instructional sessions without providing 24 hours notice.
 - f. When the conditions of the location where HH services are provided, are not conducive for instruction, or threaten the health and welfare of the HH teacher.



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Request for Hospital/Homebound (HH) Services

Parent/Guardian Agreement

I have read the Hospital/Homebound (HH) services policies for program eligibility and I understand the reasons for possible dismissal from the program. I agree to the policies and eligibility requirements of the program and request HH services for my child _____

(Print Student's Name)

Parent/Guardian Printed Name

Phone Number

Parent/Guardian Signature

Date

Application Checklist

An application will not be processed until all forms listed below are given to the school and the completed application is forwarded to the appropriate department at the Board of Education.

The completed application includes:

- Signed Parent/Guardian Agreement
- Signed Release of Medical Information
- Completed Physician/Psychiatrist Referral

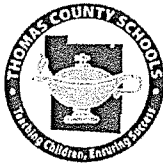
For District Office Use Only

___ HH Approved ___ HH Intermittent Approved ___ HH Not Approved

HH Begins _____ HH Ends/Recertification Required _____

HH Instructor: _____

Comments:



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Physician/Psychiatrist Statement and Medical Referral Form

To the Physician/Psychiatrist:

The parents/guardians of _____ have requested Hospital/Homebound (HH) services through the Thomas County School System. HH services are not intended to replace regular school services and are intended to be temporary.

Student Information

Printed Student Name: _____ Date of Birth: _____
Last First MI

The remainder of this form must be completed by the treating physician or psychiatrist.

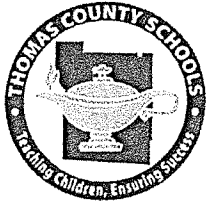
<p>Brief Description of Patient's Diagnosis: <i>(Note: Any diagnosis of mental illness must be made by a psychiatrist)</i></p> <hr/> <hr/>	
<p>Starting and ending dates are required. Estimated Need for HH Services: Starting Date: _____ Ending Date: _____</p>	
<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Could the student attend school regularly and receive HH services on an intermittent basis as needed?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Can instruction be provided to the student without endangering the health of the HH student, the HH teacher or other students whom the teacher may contact?</p>	
<p>Physician's Certification: I certify that this student is under my care and treatment for the aforementioned medical condition. My recommendation has been based on the medical needs of the patient and keeping in mind that the least restrictive environment is preferred.</p>	
<p>Physician/Psychiatrist Printed Name _____</p>	<p>Medical License Number _____</p>
<p>Physician/Psychiatrist Signature _____</p>	<p>Date _____</p>
<p>Phone Number: _____ Fax: _____</p>	

Questions about Thomas County School System HH services can be directed to Mr. Clay Stanaland by calling 229-584-9159 or by emailing: cstanaland@tcjackets.net

Schools should return completed forms to:

Student Services
Thomas County Schools
200 N. Pinetree Blvd.
Thomasville, GA 31792
Fax: 229-225-4376

Revised June 30, 2021



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Authorization for Release of Information

Student's name: _____ Date of Birth: _____

Treating Physician/Psychiatrist Name: _____

Name of Clinic or Medical Office _____

Address: _____ City: _____ State: _____

Phone _____ Fax: _____

Treating Physician/Psychiatrist Name: _____

Name of Clinic or Medical Office _____

Address: _____ City: _____ State: _____

Phone _____ Fax: _____

I authorize verbal and/or written information to be released to:

Thomas County Schools
200 North Pinetree Blvd.
Thomasville, GA 31792
Phone: 229-225-4380 ext. 159 Fax: 229-225-4376
Or to email: cstanaland@tcjackets.net

The following information may be exchanged for purposes of consultation and educational planning:

- Eligibility Report Psychological Testing Social Reports
- Psychological Report(s) Educational Reports Psychiatric Reports
- Medical Reports Recent Redetermination tied to previous eligibility report
- ____ Other _____

The above information will be used for the following purposes:

- Hosp/Homebound Placement Hosp/Homebound Re-Evaluation _____ Other: _____

I understand that I may revoke this consent at any time by providing written notice and will hold all agencies harmless for information released prior to written revocation. After one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Parent/guardian signature: _____ Date: _____

Person informing parent of rights: _____ Date: _____