Jackson County School System

1660 Winder Highway
Jefferson, GA 30549
706-367-5151
www.jacksonschoolsga.org

Dear Parent/Guardian,

The Jackson County School System provides continuous educational services for students who are unable to attend school due to a diagnosed medical or psychiatric condition for a minimum of ten consecutive school days or for intermittent periods of time for a minimum of ten school days per year. These services may be provided in the hospital, Google Meets/Zoom, a child's home or other agreed upon location. In order to comply with the Georgia State Board of Education Rule 160-4-2-.31 Hospital/Homebound (HHB) Services, a minimum of three instructional contact hours per week must be provided for your child to be counted present.

To initiate Hospital/Homebound (HHB) services, please complete the application for Hospital/Homebound (HHB) Services (pages 1-5). Once the completed application is received, the medical forms will be emailed to you from the HHB contact, Hannah McIncrow. The medical form must be completed by the licensed physician who is treating your child for the diagnosed condition. The form should be emailed back to the HBB contact. Should you have any questions regarding HHB services, please communicate with the HHB contact, Hannah McIncrow. The school nurse should be consulted if and when there are some medical questions that need clarification that may be answered on a limited basis by the school nurse.

Local education agencies (LEAs) are responsible for providing instructional services for students who are eligible for Hospital/Homebound (HHB) services and hospitalized in health care facilities. The LEA may provide the services directly or can arrange with or contract directly with the health care facility, the LEA in which the health care facility is located, or appropriately certified teachers in the geographic area in which the health care facility is located. Parents/guardians, emancipated minors, or students 18 years of age or older must complete the LEA HHB application forms before services can be provided by the LEA.

Sincerely,

Hannah McIncrow, LMSW
School Social Worker
Homebound Coordinator/HHB Contact
hmcincrow@jcss.us
706-387-7381

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Hospital/Homebound (HHB) Services Request Form

(Note: There may be a delay in processing incomplete applications.)

School:_____

Student Information

Student Name:_____ DOB_____

Grade:_____Address_____

_____

Parent Information

Parent/Guardian: _____

Phone: (H) _____ (W) _____ (C) _____ Email Address:

_____

Do you have a computer with DSL, high speed, or wireless connection at the instruction location?
Yes___ No_____

Eligibility Policies

1) Eligibility for services is based on the Georgia State Board of Education Rule 160-4-2-.31 Hospital/Homebound (HHB) Services, and that a medical referral form issued from a licensed physician is required to determine eligibility. 2) The Local Education Agency (LEA) HHB services personnel may contact the licensed physician to obtain information needed to determine if my child will be eligible for HHB services and provide appropriate instructional delivery.

3) A child must be enrolled in a public school prior to the referral for HHB services. 4) HHB services are for students confined to the home or hospital due to a medical or psychological condition, which is acute, catastrophic, chronic, or repeated intermittent.

5) Parents will be required to sign an agreement regarding HHB services policies and procedures.

6) A child eligible for HHB services, may be dismissed from the HHB program and may be required to return to school if his or her medical or psychiatric condition(s) improve as documented by a licensed physician.

7) A child who is eligible for HHB services, is subject to the same mandatory attendance requirements as other students.

Policies and Procedures

1) A parent, guardian, or an approved adult parent designee as identified in the Educational Service Plan (ESP) shall be present during each entire home/virtual instructional period.

2) A table or a desk in a workspace that is well ventilated, smoke-free, clean, and quiet (i.e., free of radio, TV, pets, and visitors) must be provided.
3) A schedule for student study time between teacher visits will be established and the student will be prepared for each session with the teacher.
4) Instructional materials must be obtained from the school, and assignments completed and submitted on time.
5) Assignments will be returned to the regular school teacher for grading if the student is on HHB services for a short period of time.
6) A parent, guardian, emancipated minor, student 18 years of age or older, or an approved adult parent designee must notify the HHB teacher at least 24 hours in advance if an instructional session must be cancelled. The LEA may, at its discretion, reschedule the cancelled session. The HHB teacher will notify the parent, guardian, or approved adult parent designee if they need to cancel a session and the session may be rescheduled.
7) For long-term or intermittent HHB students, the HHB teacher, in collaboration with the regular school teacher, shall assign grades for the work completed.
8) The parent/guardian, emancipated minor, or student 18 years of age or older must submit a release form from the licensed physician upon the student's return to school.
9) To extend HHB services beyond the originally identified return to school date, the licensed physician must submit an updated medical referral request form.
10) The student shall be counted present for the entire week when he or she is provided instruction on an individual basis or as part of a group by the HHB teacher for three hours per week.
11) A student shall be counted absent for the week when the HHB teacher's visit is cancelled by the parent/guardian, emancipated minor or student 18 years of age or older. The LEA may, at its discretion, reschedule the cancelled session. Once the schedule is completed, the student is counted in accordance with the Georgia State Board of Education Rule 160-5-1-.10.

Cause for Dismissal

1) If the licensed physician recommends that the student is able to attend school or can no longer participate or benefit from HHB services, the student will be removed from the program.
2) If the student is employed in any capacity, goes on vacation, regularly participates in extracurricular activities, or is no longer confined at home, the student will be removed from the program.
3) If the parent, guardian, emancipated minor, student 18 years of age or older or adult parent designee cancels three sessions without 24 hours notice, the student will be removed from the program
4) If the conditions of the location where HHB services are provided are not conducive for instruction or threaten the health and welfare of the HHB teacher, the student will be removed from the program.

Parent/Guardian Agreement/Release for Information

I have read the Hospital/Homebound (HHB) 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 HHB services for my child.

Parent/Guardian Printed Name_____ Date _____

Parent/Guardian Signature_____ Date _____

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FERPA/HIPAA CONSENT

Student Support Services Phone: 706-387-7381

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN HEALTHCARE PROVIDERS AND JACKSON COUNTY SCHOOL SYSTEM.

Completion of this document allows the disclosure and/or use of individual identified education records and health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name:

_____ Date of Birth _____

I, the undersigned, do hereby authorize (name of agency and contact info and/or health care providers): (1)

_____

(2) _____

to provide health information from the above-named child's medical record to and from:

School District Address _____

Contact Person at School District Telephone Number _____

The disclosure of health information is required for the following purpose:

_____

Description of Information to be Disclosed: I authorize the release and disclosure of any and all medical records, histories, reports, notes, diagnostic films or imaging, and all such other health information pertaining to _____ , a minor, of whatever kind and character, and including but not limited to psychiatric, psychological or mental health records, from_____to the date this release is presented for such records, to the persons/entities identified herein.

DURATION:

This authorization shall become effective immediately and shall remain in effect until for one year from the date of signature, unless sooner revoked by me in writing.

RESTRICTIONS:

Law prohibits the School District from making further or different disclosure of the health information contemplated by this Consent form unless another authorization form is obtained from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/health care agencies/persons listed above. My refusal will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization. I understand that any use or disclosure made prior to the effective revocation under this authorization will not be affected by a revocation.

RE-DISCLOSURE:

I understand that the Jackson County School School will not improperly disclose this information, as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that this information becomes part of the student's educational record upon being transmitted to a public school that receives federal funding. The information will be shared with individuals working at or with Jackson County Schools for the purpose of providing safe, appropriate, and least restrictive educational settings, school health services, or other academic or extracurricular programs.

I have a right to receive a copy of this Authorization. Signing the Authorization may be necessary in order for this student to obtain appropriate services in Jackson County Schools.

APPROVAL:

Printed Name_____

Signature_____ Date_____