



## Parent Request for Hospital/Homebound (HHB) Services (must accompany the Medical Referral Form)

PLEASE NOTE: This form, including parental permission to contact the treating medical provider, must be fully completed in order for the student to be considered for homebound services. Completed forms should be submitted to the school counselor who will be responsible for forwarding to the Homebound Coordinator. If you have questions about completing this form, please contact the school counselor.

Grade: \_\_\_\_\_ School: \_\_\_\_\_

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Phone: (C) \_\_\_\_\_ Parent Email Address: \_\_\_\_\_

Does your child receive Special Education Services? Yes  No

If yes, please specify the area of disability for Special Education services: \_\_\_\_\_

**Note: The school is responsible for providing assignments and grades to the student until the student is officially enrolled in the HHB program.**

Does the student have a computer or electronic device for instruction, not including cell phones? Yes  No

Does the student have Internet access for instruction? Yes  No

### Eligibility Policies

1. I understand that 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 medical provider is required to determine eligibility.
2. I understand that Lee County School System's HHB services personnel may contact the licensed medical provider to obtain information needed to determine if my child will be eligible for HHB services and provide appropriate instructional delivery.
3. I understand that my child must be enrolled in the Lee County School System prior to the referral for HHB Services.
4. I understand that the HHB services are for students confined to the home or hospital due to a medical or psychological condition : *academic instruction and other services provided to eligible students who are **confined at home or in a health care facility for periods of time that would prevent normal school attendance***
5. I understand that I will be required to sign an agreement regarding HHB services policies and procedures.
6. I understand that if my child is eligible for HHB services, my child may be dismissed from the HHB program and

may be required to return to school if his or her medical or psychological conditions improve as documented by a licensed medical provider.

7. I understand that if my child is eligible for HHB services, he or she is subject to the same mandatory attendance requirements as other students.
8. I understand that if my child does not complete his/her assignments he/she may not receive credit and may be at risk for failing that class.

### **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 face-to-face 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. I understand that if my child does not complete his/her assignments, he/she may not receive credit and may be at risk for failing that class.
6. A parent, guardian, emancipated minor, student 18 years of age or older, or an approved adult parent designee as identified in the ESP 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. The parent/guardian, emancipated minor, or student 18 years of age or older must submit a release form from the licensed physician or licensed psychiatrist upon the student's return to school.
8. To extend HHB services beyond the originally identified return to school date, the licensed medical provider must submit an updated medical referral request form or HHB Extension form.

### **Cause for Dismissal**

1. If the licensed medical provider 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 requirements of the program and request HHB services for my child. **I authorize the attending physician to release medical and/or psychiatric information to Hospital/Homebound personnel as needed.**

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Parent/Guardian Signature

Date



## Medical Referral Form

**(Parent Request Form must be attached)**

*(Note: This form must be completed by a licensed medical provider in the State of Georgia.)*

\*\*\*\*If the initial request for services is for a DSM-V diagnosis, a treatment plan, progress towards treatment goals, and specific plans to transition the student back to the school setting, will be required OR if it is necessary for homebound instruction to continue beyond a period of current nine weeks, an extension for reauthorization form, along with this same information will need to be provided to assess continued services-see attached treatment plan addendum.

Licensed Medical Provider Name: \_\_\_\_\_ GA License #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_, GA Zip \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

### **Student Information**

Student Name: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone-Cell \_\_\_\_\_

### **Section A. Licensed Medical Provider Statement and Diagnosis**

*Students diagnosed with a contagious disease will not be served while contagious.*

### **Patient's Diagnosis and description of chronic health condition:**

\_\_\_\_\_  
\_\_\_\_\_

Is the student free from communicable diseases? Yes No

### **Estimated Duration of HHB Services:**

*HHB students receive a total of 3 hours of instruction per week from a designated teacher. HHB is not intended to replace the instruction received in a traditional setting. Please ensure that HHB services are necessary for the student's health, as these services are not designed to be the best academic option for students that can be accommodated in a traditional setting.*

**HHB Start Date:** \_\_\_\_\_ **HHB End Date:** \_\_\_\_\_

*Pregnant students will not be approved for HHB services, unless there are medical complications which prevent school attendance.*

Pregnancy Expected Due Date \_\_\_\_\_ Complication of Pregnancy \_\_\_\_\_

**Physician's Statement:**

Is the student unable to attend school for a **minimum of ten consecutive school days**? Yes No

Will the student be able to engage in instruction during this time of confinement? Yes No

***"Bound to home" (confined) is part of eligibility language***

Georgia's rule for Hospital/Homebound Services (Rule **160-4-2-.31**) defines the program as instructional services for students who are **confined at home or in a health care facility** for periods that prevent normal school attendance, based on medical certification.

Is the student confined to the home or hospital? Yes No

Would intermittent services be more appropriate? Yes No

**Anticipated Return to School**

The student is **not able** to return to school at this time

The student **may be able** to return to school on a **limited or gradual basis** once the condition and/or medication is stabilized

**Licensed Medical Provider'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, keeping in mind that the least restrictive environment is preferred.

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Licensed Medical Provider Printed Name

Date

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Licensed Medical Provider Signature

Date



# Required Treatment Plan Addendum

(For DSM-V Diagnosis or HHB Extension Beyond Nine Weeks)

Student Name: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Provider Name & Credentials: \_\_\_\_\_ Georgia License #: \_\_\_\_\_  
Diagnosis (DSM-V): \_\_\_\_\_

## 1. Treatment Plan Overview

The student is currently receiving treatment for the above DSM-V diagnosis. The treatment plan is designed to stabilize symptoms, improve functional capacity, and support the student’s safe return to the least restrictive educational environment as medically appropriate.

### Primary Treatment Modalities (check all that apply):

- Individual therapy (frequency: \_\_\_\_\_)
- Family therapy (frequency: \_\_\_\_\_)
- Medication management (provider: \_\_\_\_\_)
- Psychiatric services
- Other (specify): \_\_\_\_\_

## 2. Treatment Goals (Educationally Relevant)

The following goals directly impact the student’s ability to participate in a school setting:

Goal 1:

Goal 2:

Goal 3:

## 3. Educational Impact & Need for HHB

Due to the student’s current medical/psychological condition, the student is **temporarily unable** to attend school in a traditional setting without significant risk to health or treatment progress.

- Student is currently confined to home or hospital
- Student cannot safely or consistently attend school at this time
- HHB services are medically necessary to prevent educational disruption

## 4. Transition Plan Back to School (Required)

\_\_\_\_\_  
\_\_\_\_\_

**Anticipated Readiness for Transition:**

- 1–2 weeks    3–4 weeks    4–6 weeks    More than 6 weeks

**Recommended Transition Supports (check all that apply):**

- Partial school days  
 Reduced course load  
 Gradual increase in attendance  
 Modified schedule  
 Continued therapeutic supports during transition  
 Other: \_\_\_\_\_

*Only Complete if this is a HHB Extension situation beyond current Nine Weeks is requested:*

**1. Progress Toward Treatment Goals**

- Student is making **adequate progress** toward treatment goals  
 Student is making **partial progress** toward treatment goals  
 Student has made **limited progress** and continues to require intensive supports

**Brief Progress Summary:**

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**2. Transition Plan Back to School (Required)**

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**Anticipated Readiness for Transition:**

- 1–2 weeks    3–4 weeks    4–6 weeks    More than 6 weeks

**Recommended Transition Supports (check all that apply):**

- Partial school days  
 Reduced course load  
 Gradual increase in attendance  
 Modified schedule  
 Continued therapeutic supports during transition  
 Other: \_\_\_\_\_