Hospital/Homebound Application Process

Step 1: Licensed physician or psychiatrist indicates a medical need for HHB services.

https://nhec.paulding.k12.ga.us/hospital-homebound/hhb-information
Or

1. Paulding County School District website at:
    a. https://www.paulding.k12.ga.us/Domain/4
    b. Our Schools
    c. New Hope Education Center
    d. Hospital Homebound

Step 2: Physician's office or parent sends completed application to the local school including the transitional plan for the student's return to school. Incomplete applications will be denied. Please place N/A when needed.

Step 3: Local school completes the application with required signatures:

Parent's Signature ⟹ Principal's Signature ⟹ Counselor's Signature

Step 4: Counselor sends completed application to:

Dr. Vladimir Labossiere Director of New Hope Education Center vlabossiere@paulding.k12.ga.us

Step 5: Application is reviewed for approval.

Important Notes:

Hospital Homebound (HHB) services are not intended to replace regular school attendance. Because students receive reduced instructional time due to medical needs, HHB placement may negatively impact academic progress. The overarching goal of HHB is always to return the student to a full-time academic setting as soon as medically appropriate.

To support this goal:

- Intermittent HHB students are expected to attend school whenever medically feasible.
- Full-time HHB students are expected to remain home for the first ten consecutive school days and then attend school whenever medically feasible thereafter.

If an intermittent HHB student is spending more than 50% of instructional days at home, updated medical documentation will be required to determine eligibility for full-time HHB services.

PCSD Hospital/Homebound Services

This page is to be completed by the parent/guardian

I. Student Information (Please print)

Provide all requested information; incomplete applications may experience processing delays.

Name: _____ DOB: _____ Student ID: _____

Does the student have an IEP: Yes ( ) No ( ) 504: Yes ( ) No ( )

School: _____ Grade: _____

Address: _____

Parent/Guardian: _____ Phone _____

Do you have a computer? Yes ( ) No ( ) Do you have an internet connection? Yes ( ) No ( )

Student E-mail address: _____

Parent E-mail address: _____

II. Eligibility Policies

1. I understand that eligibility is based upon Georgia Statues, State Board Rule 160-4-2-.31 and the medical referral form completed by the attending licensed physician or licensed psychiatrist is part of the information used to determine eligibility.
2. I understand that Paulding School District Hospital/Homebound personnel may contact the attending licensed physician or licensed psychiatrist to obtain information to determine eligibility for HHB services.
3. I understand that my child must be enrolled in a public school prior to the referral for HHB services.
4. I understand that HHB Instructional Services are for students confined to their home or hospital due to an acute, catastrophic, chronic, or repeated intermittent medical or psychological condition.
5. I understand that I will be required to sign an agreement regarding HHB policies and procedures.
6. I understand improvement of the medical or psychological condition(s) for which HHB services were approved may result in the student's dismissal from the program and his/her returning to school.
7. I understand that if my child is eligible for HHB services, he/she is subject to the same mandatory attendance requirements as students in a regular instructional setting.

III. Policies and Procedures

1. A parent/guardian or a designee of the parent/guardian at least 21 years of age as defined in the Educational Service Plan (ESP) must be present in the home for the entire HHB instructional period.
2. A table or a desk in a well-ventilated, smoke-free, clean, and quiet (i.e., free of radio, TV, pets, and visitors) workspace must be provided.
3. A schedule for student study time between teacher visits must be established and the student well-prepared for each instructional period.
4. Instructional materials are prepared by the home school; students complete and submit work on time.
5. Assignments will be returned to the teacher of record for grading.

Return to the school counselor

PCSD Hospital/Homebound Services

This page is to be completed by the parent/guardian and signed by school personnel

Policies and Procedures (Cont'd)

6. A parent/guardian or a designee of the parent/guardian at least 21 years of age as defined in the Educational Service Plan (ESP) must notify the HHB instructor 24 hours in advance if an instructional session must be canceled. The local school system may, at its discretion, reschedule an instructional session.
7. The parent/guardian must submit a release form from the attending licensed physician or licensed psychiatrist for the student's return to school.
8. To extend HHB services beyond the initial return-to-school date, the attending licensed physician or licensed psychiatrist must submit an updated medical referral form.

IV. Cause for Dismissal

1. The student will be removed from HHB Services if the attending licensed physician or licensed psychiatrist determines that the student is able to attend school or is not able to participate or benefit from HHB Services.
2. The student will be removed from HHB Services if employed in any capacity, travels for reasons other than medical, participates in extracurricular activities, or is no longer confined at home.
3. The student will be removed from HHB Services if the parent/guardian or a designee of the parent/guardian at least 21 years of age as defined in the Educational Service Plan (ESP) cancels more than two sessions without appropriate notice.
4. The student will be removed from HHB Services if the conditions or the location of the workspace provided for HHB services are not conducive for instruction or threaten the health and welfare of the HHB instructor.
5. The HHB team, in coordination with the HHB Director, determine HHB services are not conducive to the student's academic progress

V. Parent/Guardian Agreement – Release of Information

I have read the Hospital/Homebound policies for program eligibility and understand the reasons for possible dismissal from the program. I agree to the policies and requirements of the program and request Hospital/Homebound services for my child. I hereby give permission for the attending licensed physician or licensed psychiatrist to communicate information regarding my child's medical/emotional condition for which he/she is referred to HHB personnel.

Parent/Guardian Signature: _____Date: _____

Parent/Guardian Name: _____

(Please print)

Schools are responsible for providing assignments and grades until the student is officially approved for HHB Services.

Principal Signature: _____ Phone Ext: _____

Counselor Signature: _____ Phone Ext: _____

Return to the school counselor

PCSD Hospital/Homebound Services

<u>This page is to be completed by a physician/psychiatrist licensed by the State of Georgia</u>

I. Licensed Physician/Psychiatrist Statement and Medical Referral Form

(Must be completed by a physician/psychiatrist licensed by the State of Georgia)

Student's Name: _____ Student's DOB: _____

Physician's Name (Print): _____ GA License #: _____

Address: _____ PH: _____

II. Physician's/Psychiatrist's Statement and Diagnosis

*Estimated duration of Hospital/Homebound services: **Start Date:** _____**End Date:** _____

Patient's Diagnosis (include a description of the condition): _____

_____

_____

Please select one Hospital Homebound service model.	Full Time	**OR**	Intermittent
Intermittent students attend the normal school schedule when health permit.			
Is the student free from communicable diseases?	Yes		No
Can instruction be provided without endangering the health of the instructor?	Yes		No
Will the student benefit from an instructional program during this time of confinement?	Yes		No
How many full day absences are anticipated throughout the duration of HHB services?	_____ of full days		

III. Treatment

What is the treatment/therapy schedule for this student? ____Daily ____Weekly ____Monthly
What is the expected duration of the treatment/therapy? _____
Date of next scheduled appointment: _____

IV. Recent surgeries

Date	Type	Accommodation required during recuperation

V. Medications with side effects that may affect school performance

Medication	Side Effects

Return to the school counselor

PCSD Hospital/Homebound Services

This page is to be completed by a physician/psychiatrist licensed by the State of Georgia

VI. School Re-Entry Plan

Can the student be in contact/proximity of other students? Yes No

1. What specific criteria or indicators will determine when the student is ready to return to school, either full-time or intermittently?

2. Are there any activity restrictions or environmental considerations (e.g., physical activity, exposure to illness) that the school should consider during the transition back to full-time school?

3. What is the recommended schedule or phased approach for returning to full-time school (e.g., no phased approach needed, half- days, specific classes, gradual increase in attendance)?

4. Will the student require ongoing medical treatments or therapy during school hours, and if so, what accommodations are recommended?

5. Are there any signs or symptoms that staff should monitor that would indicate the student needs to seek medical attention?

Physician's Certification: *I certify that this student is under my care and treatment for the aforementioned medical condition. My recommendation is based on the medical needs of the patient, keeping in mind that the least restrictive environment is preferred.*

Physician's Signature: _____ Date: _____

Physician's Name: _____
(Please print)

Return to the school counselor