Application for Home/Hospital Instruction 2026-2027
KDE updated June 2021
(Please type or print neatly)
Parent/Student Information

Section I

To be completed by the parent(s)/guardians(s)

School District_____ School _____ Grade _____

County of Residence _____ Last Date Attended _____

Name of Student _____ Date of Birth _____

Address of Student_____ Zip Code_____

Sex_____ Race_____ Social Security #_____ Telephone #_____

Full Name of Father/Guardian_____ Telephone #_____

Full Name of Mother/Guardian_____ Telephone #_____

Does the student have an Individualized Education Program (IEP)? Yes_____ No _____

Does the student have a Section 504 Plan? Yes_____ No_____

Directions to student's home _____

_____

Pursuant to KRS 158.033(4), eligibility for home or hospital instruction for students with disabilities shall be determined by the Admissions and Release Committee (ARC) and shall be provided pursuant to the Individualized Education Program (IEP). The ARC chairperson shall provide written notice of home/hospital placement to the local Director of Pupil Personnel (DPP) for purposes of program enrollment using the form in section IV of this application. 702 KAR 7:150.

Pursuant to KRS 159.030(2), before granting any student an exemption from compulsory attendance, the board of education of the district in which the student resides shall require submission to the board of satisfactory evidence in the form of a signed statement of a properly licensed physician, advanced practice registered nurse, physician's assistant, psychologist, or psychiatrist responsible for diagnosing and treating the child, stating that the diagnosed condition of the child prevents or renders inadvisable attendance at school and requires home or hospital instruction. If the condition is mental health related, then the signed statement shall be completed by a licensed physician, psychiatrist, psychologist, or physician's assistant described in KRS 202A.011 or an advanced practice registered nurse defined in KRS 314.011 and certified in psychiatric-mental health nursing. On the basis of such evidence, the local board of education may exempt the student from compulsory attendance.

A student with a recurring condition, which results in periods in which the need for home or hospital instruction is intermittent and the student is able to attend school for short periods, may be exited and reentered on home or hospital instruction, and the following shall apply:

(a) Initial approval by the Review Committee shall be required;
(b)The Review Committee shall review the need for an alternative schedule of services based on verification by the professional statement in the application for home or hospital instruction of the need for intermittent services;
(c)If a health professional who completed the initial application for a student to be served on home or hospital determines the student needs additional time for services, the health professional shall submit a written statement, either mailed or faxed, to the Director of Pupil Personnel, requesting additional time up to two (2) weeks for services and provide a brief explanation for the extension;
(d)The Review Committee shall meet to review this extension and either approve or deny the request for an extension, prior to provision of any extended services;
(e)The Review Committee shall review intermittent placement at least every six (6) months, and at that time a statement from a second professional, shall be required by the Review Committee for continued program eligibility; and
(f)The parent or guardian shall notify the principal or Director of Pupil Personnel prior to the need for school reentry or to exit to home or hospital instruction.

Pregnancy is not considered a physical or health impairment in and of itself, and the nature and extent of any complication shall be delineated prior to consideration of home or hospital instruction for this condition. 702 KAR 7:150.

For students receiving home or hospital instruction pursuant to a determination by a Home or Hospital Review Committee, eligibility shall cease if the student works, plays sports or participates in extracurricular activities. 702 KAR 7:150.

RELEASE OF INFORMATION

I understand that if the Home/Hospital Review Committee makes the determination of placement for this student, they may request a review of the information provided on these forms by local health personnel. I hereby authorize this committee to have access to pertinent information regarding this request. I understand that if the Admissions and Release Committee makes the determination of placement for this student, they will have access to all pertinent information regarding this request.

_____ _____
Parent/Guardian Signature Date

Application for Home/Hospital Instruction
Professional Statement

**Eligibility for home/hospital instruction for students with disabilities shall be determined by the Admissions and Release Committee (ARC) in accordance with their Individual Education Program (IEP). The ARC chair shall provide written notice of eligibility to the local Director of Pupil Personnel (DPP) for purposes of program enrollment. The form provided in Section IV shall be used to provide this notice. **

Section II

This section is to be filled out by a properly licensed physician, advanced practice registered nurse, physician's assistant, psychologist, or psychiatrist responsible for diagnosing and treating the student. If the condition is mental health related, then the signed statement shall be completed by a licensed physician, psychiatrist, psychologist, or physician's assistant described in KRS 202A.011 or an advanced practice registered nurse defined in KRS 314.011 and certified in psychiatric-mental health nursing. In order for a district board of education to exempt a student from compulsory attendance, the student must provide satisfactory evidence in the form of a signed statement from a qualified healthcare professional that the diagnosed condition of the student prevents or renders inadvisable attendance at school and requires home or hospital instruction.

Name of Student _____

_____I do/_____ I do not support home/hospital instruction for this student. If you do not support home/hospital instruction at this time, please state your concerns and/or recommendations: _____

_____

_____

_____

Please check one of the following:

_____The student can attend school without any type of modifications or special provisions.

Comments: _____

_____The student can attend school only with modifications or special provisions.

Describe Modifications Needed: _____

_____

_____

_____The student is unable to attend school at this time due to health concerns, and I do support Home/Hospital instruction. **If checked, please complete the rest of Section II.**

Diagnosis_____ Prognosis: Good _____ Fair _____ Poor _____

Specific reason (s) why the student is unable to attend school at this time: _____

_____

_____

How long have you been seeing the patient for the diagnosis listed? _____

Approximate length of time student will need Home/Hospital Instruction _____

Recommended start date of Home/Hospital instruction: _____

Please summarize test and all other data collected that supports the need for Home/Hospital Instruction at this time.

_____

_____

What is the treatment plan for the patient? _____

_____

What is the expected duration of treatment? _____

Start date of hospital admission, if applicable: _____

Check here if this student has a chronic physical condition that is unlikely to substantially improve within one year. _____

What ancillary services are involved in treatment? _____

_____

_____

_____

List consultants/specialist to whom this student has been referred.

Name	Specialty	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Will you be following the patient? _____ Yes _____ No. If not, who will? _____

Name _____ Telephone # _____

Address _____

Anticipated date of student's return to school _____

What are your recommendations to assist this student in their return to school? _____

_____

_____

_____

Remarks/Comments: _____

_____

_____

_____

_____

_____ _____ _____

Signature of Licensed Professional Title Date

Please Print or Type Name of Professional: _____

Office Address _____ Phone Number _____

_____ Fax Number _____

PLEASE COMPLETE AND RETURN TO:

Russell Co Board of Education
ATTN: Jessica Gossage
Email: jessica.gossage@russell.kyschools.us
Address: 404 S Main St
Jamestown, KY 42629
Phone: (270)343-3191
Fax (270) 343-3072

Application for Home/Hospital Instruction
Home/Hospital Review Committee

Section III

Name of Student_____

Date Application Received:_____ Approved _____ Denied _____ Incomplete_____

If approved, date of services will be from_____ until _____ Review Date _____

If eligibility for services denied, reason for denial_____

_____

_____

_____

If incomplete application, type of additional information requested_____

_____

_____

Date of Request_____ Person Contacted_____

Signatures of Committee Members:

Director of Pupil Personnel Program Director_____ Date_____

Home/Hospital Teacher_____ Date_____

Medical or Mental Health Personnel_____ Title_____ Date_____

Other Relevant Professional _____ Title_____ Date_____

Comments:

_____

_____

_____

_____

Application for Home/Hospital Instruction
Documentation of Admissions and Release Committee (ARC)

Section IV

Eligibility for home/hospital instruction for students with disabilities shall be determined by the Admissions and Release Committee (ARC) in accordance with their Individual Education Program (IEP). The ARC chair shall provide written notice of eligibility to the local Director of Pupil Personnel (DPP) for purposes of program enrollment. The form provided in this section shall be used to provide this notice. **

Name of Student _____

Does the student have a current/active Individualized Education Program (IEP)? ☐ Yes ☐ No

Start date of home/hospital placement: _____

Anticipated end date of home/hospital placement: _____

Date of the most recent ARC meeting where Home/Hospital placement was decided: _____

Total number of hours of Home/Hospital instruction per week: _____

ARC Chair: _____

_____ _____

Signature of ARC Chair Date