

HHB PARENT REQUEST FORM (2026-2027)

Upon completion, please provide all required documentation to the Family Services Department via fax or e-mail.

Note: A Medical Referral **MUST** accompany this Parent Request and be sent to Family Services within **5 days**.

Incomplete applications will result in a processing delay/ denial.

Your child must be currently enrolled in a Henry County school to be considered for Hospital/Homebound Services.

Student Information:

Student Name (First, Middle, Last): _____ Student ID: _____

Date of Birth: _____ Age: _____ Grade: _____

Current School: _____

HR Teacher: _____ Counselor: _____

Address: _____

Parent/Guardian's Name: _____ Email: _____

Home: _____ Work: _____ Cell: _____

Does your child receive special education services (under an IEP)? ☐ Yes ☐ No

Do you have a computer with internet access at your home? ☐ Yes ☐ No

Please carefully review the following policies and procedures related to HHB services **PRIOR** to submitting this request.

Eligibility Policies:

1. I understand that my child must be enrolled in the Henry County School System prior to consideration for HHB services and the submission of HHB documentation does not automatically qualify my child for HHB services.
2. I understand that eligibility for services is based on the [Georgia State Board of Education Hospital/Homebound \(HHB\) Rule 160-4-2.31](#), and that a Medical Referral Form issued from the treating doctor (a licensed physician, Nurse Practitioner (NP) working under a licensed physician, or licensed psychiatrist) is required to determine eligibility.
3. I understand that Henry County School's HHB services personnel may contact the licensed physician or licensed psychiatrist to obtain information needed to determine if my child will be eligible for HHB services and to determine appropriate instructional delivery.
4. I understand that HHB services are for students confined to the home or hospital for 10 days or longer due to a medical or psychological condition, which is acute, catastrophic, chronic, or intermittent.
5. **Impact Academy students** - I understand that all HHB requests for Impact Academy students will be evaluated on an individual basis and on their inability to participate in and/or receive instruction. I also understand that HHB services for Impact Academy students will be determined by their HHB Instructional Team.
6. I understand that I will be required to sign an agreement regarding HHB services and policies and procedures.
7. I understand that my child may be dismissed from the HHB program and may be required to return to school due to failure to participate in HHB sessions or if his or her medical or psychological conditions improve as documented by a licensed physician or licensed psychiatrist.
8. 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.
9. I understand that HHB is temporary by design and not intended to replace in-person school services.

I HAVE REVIEWED AND UNDERSTAND THE ELIGIBILITY POLICIES LISTED ABOVE. Initial: _____

Policies and Procedures:

1. A parent, guardian, or an approved adult designee as identified in the Educational Service Plan (ESP) shall be present during the entire HHB instructional session for students under 18 years of age.
2. HHB Services are not equivalent to classroom instructional services. Students are expected to work on their class assignments daily. A schedule for student study time between HHB sessions will be established and the student will be expected to be prepared for each session with their HHB teacher.
3. All instructional materials must be obtained from the school by the parent upon approval of HHB Services (*if applicable*) and **all assignments must be completed and submitted by the set deadline.**
4. 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 canceled. The HHB tutor may, if their schedule permits, reschedule the canceled session the same week or following week. The HHB teacher will notify the parent, guardian, or approved adult parent designee if the teacher needs to cancel a session and the session will be rescheduled.
5. **Psychiatric HHB Referrals** must be completed by the treating psychiatrist and include a **detailed treatment plan. Psychiatric Referrals for full-time services must be submitted for review every 60 days.**
6. HHB teachers will instruct students on work provided by their classroom teacher(s) and may be unable to tutor students on specific topics/subject areas.
7. The parent/guardian, emancipated minor, or student 18 years of age or older should submit a **Medical Release Form** from the licensed physician or licensed psychiatrist upon the student's return to school. Students cannot return to school before their HHB end date without medical clearance.
8. To extend HHB services beyond the originally identified return to school date, the parent/guardian must submit a new Medical Referral Form from the licensed physician or psychiatrist treating the student.

I HAVE REVIEWED AND UNDERSTAND THE POLICIES & PROCEDURES LISTED ABOVE. Initial: _____

Causes for Dismissal:

1. If the licensed physician or licensed psychiatrist 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 full-time HHB student is employed in any capacity, goes on vacation, participates in extracurricular activities (including organized sport activities and/or workouts outside of school), or is no longer confined at home, the student will be removed from the program.**
3. If the parent, guardian, emancipated minor, student of 18 years of age or older, or adult parent designee **cancels three sessions without 24 hours' notice**, the student may be removed from the program.
4. Services may be canceled if the student consistently fails to actively participate in instruction or fails to submit assignments in a timely fashion or the parent/guardian fails to verify weekly HHB services for the HHB tutor.

I HAVE REVIEWED AND UNDERSTAND THE CAUSED FOR DISMISSAL LISTED ABOVE. Initial: _____

Parent Acknowledgement and Agreement for Release of Medical Information

I have read the Hospital-Homebound services policies for program eligibility, and I understand the reasons for possible denial/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/psychiatrist to release medical information to Henry County Schools Hospital-Homebound personnel as needed for my child.**

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Upon completion, please submit all documentation to the following:

Family Services - Hospital Homebound Program

166 Holly Smith Drive McDonough, GA 30253

Phone: 770-957-3945 Fax: 470-483-0551

Email: Hospitalhomebound@henry.k12.ga.us