



GLEN FALLS

CITY SCHOOL DISTRICT

REQUEST FOR HOME INSTRUCTION APPLICATION

If you believe that your child is unable to attend school due to a health, medical or mental or emotional illness or injury, you may request homebound, or hospital/institutional instruction (e.g., a rehabilitation facility) from the school district. Home instruction (including home tutoring, homebound, hospital or institutional instruction) is an educational service provided by a school district to resident students to ensure students continue to learn and work towards mastery of learning standards when they are unable to attend school for a significant period of time for reasons beyond their control.

If you believe that your child will be unable to attend school for at least 10 days during a three-month period due to temporary or chronic illness or injury as your child may be homebound or in a hospital or other institution for care and treatment, you may submit a written request for tutoring to the District. Any request for home, hospital or institutional instruction must be submitted, in writing, by a parent or legal guardian AND must be accompanied by written medical verification for the request from the student's treating health care provider demonstrating the student's anticipated inability to attend school or to participate in their usual education setting. All requests for home, hospital or institutional instruction will be forwarded to the school's medical director for review and approval. **You must provide consent to permit the school health officer to communicate or consult with your child's health care provider- failure to provide consent will result in an automatic denial of the request for homebound instruction.**

If approved, the district will provide instructional services to the student within five (5) school days after the district receives notification of the student's medical condition and request for home/hospital or institutional instruction parent or guardian's request for home, hospital or institutional instruction accompanied by a written medical verification from a treating health care provider. Plans can be approved for a maximum of 30 school days before the need for updated documentation and approval.

Alternatively, if the request is denied following the school health officers' review, the school district will notify the parent or guardian, in writing, of the school health officer's denial within five (5) school days after receipt of written medical verification from the student's treating health care provider.

A parent or guardian may appeal the school health officers' denial to the school district's board of education within ten (10) school days of the receipt of the notice of denial. During an appeal to the board of education of a denial by the district's school health officer, tutoring or instructional services will be provided, until the appeal of the denial is reviewed and decided by the board of education.

Once a request is approved, the school district, in consultation with the parent or legal guardian (and student, where appropriate) will establish a written home, hospital, or institution instruction delivery plan to continue the student's academic progress and to maintain a record of delivery of instructional services and student progress. The plan will identify the number of hours per week and hours per day the student will receive

instructional services, the method by which the instructional services will be delivered, the location where instructional services will be provided, and an explanation of how the instructional services will enable the student to make academic progress.

A student may receive less than the required amount of instruction per week if requested by their parent(s) or legal guardian(s) and if such request is supported by documentation submitted by the student's treating health care provider. If a plan of instruction will include less than the minimum number of hours required, then the district must ensure that the plan of instruction is reviewed regularly to determine if the instructional hours may be increased.

Student Name:

Name of Parent Parent/ Guardian Submitting this Request:

Based on my child's current medical diagnosis, we are requesting:

- ____ Modified Day
- ____ Tutoring (in person)
- ____ Tutoring (virtual)

Please attach medical documentation that provides:

- ☐ medical diagnosis
- ☐ description of how this impedes school attendance (including if partial days are possible)
- ☐ current treatment plan in place to assist the student's return to school
- ☐ anticipated duration of the students' inability to to attend school (start and estimated end dates)
- ☐ Name, Contact Information and Signature of medical Provider

EXPLANATION OF REQUEST FOR HOME, HOSPITAL OR HOMEBOUND INSTRUCTION

Please provide detailed and specific information relevant to the temporary or chronic physical, mental, emotional illness or injury that you believe supports the request for home, hospital or institutional instruction services for your child (you may submit additional information as attachments) and the anticipated duration of such service need (if known).

Signature of Parent/Guardian: _____

Date: _____

REQUIRED MEDICAL VERIFICATION

Any application or request for home/hospital or institutional instruction due to a temporary or chronic physical, mental, emotional illness or injury must be supported by written medical verification from the students' treating health care provider demonstrating the student's anticipated inability to attend school in person for at least ten days during the next three months and that the student is unable to participate in their usual educational setting due to such condition.

Additionally, you must consent to permit the school's medical director to communicate and consult with the health care provider submitting verification. Failure to provide consent will result in an automatic denial of the request. Please attach any relevant documentation including the treating healthcare provider's medical verification letter.

Complete and Sign the attached Authorization and Release to Communicate with Treating Health Care Provider

FOR OFFICE USE ONLY

Application reviewed by school medical director date: _____

☐ Approved

☐ Denied

Parent notified of decision date: _____

Appeal to BOE deadline (if applicable): _____

Glens Falls City School District

Authorization for Release of Confidential Information

I, _____ do hereby consent to and authorize Glens Falls City School District, to, as indicated below obtain from and/or release to:

Name of Person/Facility/Organization

Address/City/State/Telephone/Fax

The following information pertaining to:

Student _____ DOB _____

The information to be disclosed is:

Obtain

Release

- | | | |
|--------------------------|--------------------------|---|
| ☐ | ☐ | Discharge Plan |
| ☐ | ☐ | Presence in services (including admission and discharge dates). |
| ☐ | ☐ | Medical history and physical examination. |
| ☐ | ☐ | Diagnosis, brief description of progress and prognosis. |
| ☐ | ☐ | Educational records including achievements and assessments. |
| ☐ | ☐ | Psychological tests or projective assessments. |
| ☐ | ☐ | Health records. |
| ☐ | ☐ | Treatment Plan |
| ☐ | ☐ | Educational testing records. |
| ☐ | ☐ | Immunization records. |
| ☐ | ☐ | Other: _____ |

THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSES:

- ☐ To provide ongoing treatment/continuing care.
- ☐ To coordinate treatment efforts with family/concerned person.
- ☐ To coordinate educational planning and re-entry programs with school persons.
- ☐ To enable caseworkers to support treatment goals, including decisions in connection with
Complying with terms and conditions of probation and/or court orders.
- ☐ To coordinate services with authorized school officials and/or community service providers
- ☐ Other: _____

I understand that I have the right to revoke this authorization at any time by submitting a request in writing. The revocation will not apply to information that has already been released in response to this authorization. This authorization will expire in one year from the date of the signature below and may be used until such time for either a one-time release or a periodic release of information. I understand that disclosure of this information is voluntary. I understand that I have a right to receive a copy of this authorization. The duration of this authorization is for no longer than one (1) year unless I specify a date, event or condition upon which it will expire sooner. Redisclosure of this information without written consent is prohibited.

Signature of Client

Date

Signature of Parent or Legal Representative

Date

