McCreary County School System

Application
for
Home/Hospital Placement
with Procedural Forms

Student’s Name:_______________________ School:_________________________________ Grade:_______

Homebound instruction is intended for students who have short-term (acute) illnesses and are temporarily unable to attend school. Students on Home/Hospital (homebound) instruction will receive 2 hours of instruction per week by the homebound teacher. If a child on Home/Hospital received less than this amount of instructional time, the parent should notify the Director of Pupil Personnel @ (606) 376-2591.

Applications for Home/Hospital (Homebound) instruction are to be obtained at the office of the Director of Pupil Personnel, located at the McCreary County Board of Education.

Home/Hospital (Homebound) instruction forms must be completed in its entirety before consideration for approval by the Home/Hospital (Homebound) Review Committee. Applications submitted by secondary students must also include the completed High School Credit Recommendation for the Home/Hospital Instruction Form.

Approval by the (Homebound) Review Committee must be obtained before a student is enrolled in the Homebound Instruction Program.

State Regulation does not accept the condition of pregnancy (uncomplicated) as a health impairment necessitating homebound instruction.

Applications for mental health reasons will only be considered if completed by a licensed psychologist or psychiatrist.

Parents may be asked to provide the committee with updates from the referring physician on a monthly basis.

The number of high school credits received for homebound instruction will be determined by the Home/Hospital (Homebound) Review Committee, the High School Principal, or his/her designee, and the appropriate teachers.

Parent’s Signature:______________________________________ Date:______________________

___________________________________________________________________________________________

For Office Use Only: Date Returned:_______________ Person Receiving Application:_____________

Circle One: Application Complete or Incomplete
If incomplete, please list what is still needed to complete application:__________________________________

____________________________________________________________________________________________
Section I: Parent/Student Information

To be completed by the parent(s)/guardian(s) prior to full completion by the licensed medical or mental health professional.

School District _____________________ School _____________________ Grade ___________
County of Residence ________________ Last Date Attended ___________________________
Special Education Student _____ Yes _____No

Name of Student _____________________________ Date of Birth ______________________
Address of Student _________________________________ Zip Code ____________________
Sex ______ Race _______ Social Security # _______________ Telephone # _______________
Full Name of Father/Guardian _________________________ Work Phone _________________
Full Name of Mother/Guardian ________________________ Work Phone _________________

List any special education programs in which your student may be enrolled:

List directions to student’s home:

Pursuant to KRS 159.030, Section (2), before granting an exemption under paragraph (d) of subsection (1) of this section, the board of education shall require satisfactory evidence, in the form of a signed statement of a licensed physician, advanced registered nurse practitioner, psychologist, psychiatrist, chiropractor or public health officer, that the condition of the child prevents or renders inadvisable attendance at school or application to study. On the basis of such evidence the board may exempt the child from compulsory attendance. 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), with the services to be in the least restrictive environment. In lieu of this application, the ARC chairperson shall provide written notice of this eligibility to the local Director of Pupil Personnel (DPP) for purposes of program enrollment.

Any child who is excused from school attendance more than six (6) months must have two (2) signed statements from two different local health personnel which can be a combination of the following professional persons: a licensed physician, advanced registered nurse practitioner, psychologist, psychiatrist, chiropractor and health officer. If a medical professional certifies that a student has a chronic physical condition unlikely to substantially improve within one (1) year, then the one signed statement is sufficient for services that extend beyond six (6) months. This exception does not apply to students with mental health conditions.

Exemptions of all children under the provisions of subsection (1) (d) of this section must be reviewed annually with the evidence required being updated, except that children with disabilities certified by a medical professional to have a chronic physical condition unlikely to substantially improve within three (3) years may continue to be eligible for home/hospital instruction services, based on the admissions and release committee’s (ARC) annual review of documentation to determine if updated evidence is required. Updated documentation of evidence of need for home/hospital services for children with chronic physical conditions shall be provided as requested by the ARC, or at least every three (3) years.

Pursuant to 704 KAR 7:120, the condition of pregnancy is not to be 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/hospital instruction for this condition.

RELEASE OF INFORMATION

I understand that the Home/Hospital Review Committee 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.

______________________________                                                 _______________
Parent/Guardian Signature                                                              Date
Section II: Medical Professional Statement

This section is to be filled out by the authorized medical or mental health professional.

It shall be determined that a child or youth is to be provided home/hospital instruction if the condition of the child or youth prevents or renders inadvisable attendance at school as verified by signed professional statement in accordance with KRS 159.030 (2) and 704 KAR 7:120.

Please Note: Home Instruction (homebound) is short-term instruction provided in a home or other designated site for a student who is temporarily unable to attend school. According to state guidelines, two hours of home instruction each week is the equivalent to one full week of school attendance. Home instruction is not designed to take the place of a more appropriate school placement.

Name of Student ______________________________________________________________________

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:

△ I DO NOT support home/hospital instruction at this time. Concerns and/or recommendations:

△ The student is unable to attend school at this time due to health concerns and I do support Home/Hospital instruction
If you support home/hospital instruction at this time, please provide the following information:

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:

Please summarize test and 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?

_____ 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.

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

Name: __________________________  Phone Number: __________________________

Address: __________________________________________________________________

What are your recommendations to assist this student in his/her return to school?

Additional Remarks/Comments:

IMPORTANT: Anticipated date of student’s return to school: (Month/Day/Year ___/___/____)

Signature of Licensed Professional: __________________________  Title: __________________________  Date: __________________________

Please Print or Type Name of Professional: __________________________

Office Address: __________________________

Phone Number: __________________________  Fax Number: __________________________

*An application for mental health reasons may be considered if completed by a licensed psychologist or psychiatrist.
Section III: School District Home/Hospital Review Committee

This section is to be completed by the Home/Hospital Review Committee.

Name of Student ___________________ School: ___________________________ Grade: ________

Date Application Received: ☐ Approved ☐ Denied ☐ Incomplete

If approved, date services will be from _______________until _________________
(Start Date) (End Date)

Date of Request: ___________________________ Person Contacted: ___________________________

Date of 6 month review if the child is still receiving services after that time: ______________________

If eligibility for services is denied, list the reason for denial:

_______________________________________________________________________________________

If the application is incomplete, list the type of additional information requested:

_______________________________________________________________________________________

Additional Information Regarding Home/Hospital:

_______________________________________________________________________________________

Signatures of Committee Members:

Director of Pupil Personnel Date

Home/Hospital Services Teacher or Program Director Date

Local Medical or Mental Health Professional Date

Date for 6 month review of the Home/Hospital application: ________________________