# APPLICATION FOR HOME/HOSPITAL INSTRUCTION

## SECTION 1: PARENT/STUDENT INFORMATION

**PLEASE PRINT**

(To be completed by parent/guardian. Please submit entire application, once completed by doctor, to school counselor)

**COUNTY: _____ SCHOOL OF ENROLLMENT: _____ GRADE LEVEL: _____**

**SCHOOL COUNSELOR: _____ LAST DATE ATTENDED: _____ GENDER: ☐ M ☐ F**

**STUDENT FULL NAME: _____ DOB: ☐☐ / ☐☐ / ☐☐☐☐**

**SPECIAL EDUCATION: ☐ Y ☐ N SE DISABILITY: _____ 504 PLAN: ☐ Y ☐ N**

**STUDENT ADDRESS: _____ LIVES WITH: ☐ F ☐ M ☐ BOTH**

**FATHER/GUARDIAN NAME: _____ CELL:_____ EMAIL: _____**

**MOTHER/GUARDIAN NAME: _____ CELL: _____ EMAIL: _____**

**HOME INTERNET ACCESS: ☐ Y ☐ N STUDENT EMAIL: _____ STUDENT CELL: _____**

Pursuant to KY Dept. of Education, Pupil Attendance Manual, students who are unable to attend school due to illness or injury may continue education services through the provision of instruction in a home or hospital setting, Home Hospital is intended to be a short-term instruction in the home or other designated site for a student who is temporarily unable to attend school. Home instruction is not designed to take the place of a more appropriate school service. Students receiving home instruction may participate in virtual courses as part of their educational program. They must still receive two (2) 1-hour visits every five (5) consecutive instructional days from the assigned home/hospital teacher.

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 the child's 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.

Pursuant to 704 KAR 7:120, An application for home/hospital instruction shall be accepted only for a student for whom there is an expectation of an inability to attend regular school for more than (5) consecutive school days. If a health professional who completed the initial application for a student to be served on home/hospital determines the student needs additional time for services, the health professional shall submit a written statement, to the DPP requesting additional time up to (2) weeks for services and provide a brief explanation of the request for extension.

For a child or youth who is exempted from school attendance more than six (6) months, the board shall require evidence in accordance with the provisions of KRS 159.030(2). 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. A mental health condition shall not be regarded as a chronic physical condition and shall require two (2) signed statements for exemptions beyond six (6) months.

Exemptions of all children under the provisions of subsection (1)(d) of KRS 159.030 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 lease every three (3) years.

Eligibility for home/hospital instruction shall cease if the student works or participates in athletic activities. The condition of pregnancy shall not 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. In addition to the teacher and student, an adult shall be present in the home/hospital room during the time the home/hospital instruction teacher is present.

The parent or student shall notify the principal or DPP prior to the need for school reentry or to exit home/hospital instruction. Failure to provide this notice to school staff may terminate the student's eligibility for home/hospital instruction and the student shall return to regular school attendance.

**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: _____

# APPLICATION FOR HOME/HOSPITAL INSTRUCTION

**SECTION 2: PROFESSIONAL STATEMENT**

(To be completed 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 (2) hours of home instruction each five (5) consecutive instructional days, equivalent to one full week of school attendance. Home instruction is not designed to take the place of a more appropriate school placement.*

**Student Full Name: _____ DOB: ☐☐ / ☐☐ / ☐☐☐☐**

**Please check one of the following:**

- ☐ **The student CAN attend school without any type of modifications or special provision.**
- ☐ **The student CAN attend ONLY w modifications or special provision. Explain: _____**
- ☐ **The student CAN NOT attend school at this time due to health concerns, and I support Home/Hospital instruction.**
- ☐ **I DO NOT support home/hospital instruction for this student at this time. Please state concerns or recommendations.**

_____

_____

**<u>If you currently DO support home/hospital instruction, please fill out the remainder of Section 2</u>**

**DIAGNOSIS: _____ PROGNOSIS: ☐ Good ☐ Fair ☐ Poor**

**REASON STUDENT IS UNABLE TO ATTEND CLASSROOM INSTRUCTION AT THIS TIME:**

_____

How long has patient been under your care for the diagnosis listed: _____

Approximate length of time student will need Home/Hospital instruction: _____

Please summarize test(s) and all other data collected that supports the need for Home/Hospital instruction at this time:

_____

_____

What is the treatment plan for the patient?

_____

Expected duration of treatment for this diagnosis? _____

Does this student have a chronic physical condition that is unlikely to substantially improve within one year? ☐ Y ☐ N

What ancillary services are currently involved in patient's treatment:

_____

List consultants/specialists to who this patient has been referred:

Name _____ Specialty _____ Phone _____

Name _____ Specialty _____ Phone _____

Will you be following the patient? ☐ YES ☐ NO If not, please list provider below.

Name: _____ Facility: _____

Address: _____ Phone: _____

Anticipated date of student's return to classroom instruction: ☐☐ / ☐☐ / ☐☐☐☐

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

_____

_____

Remarks/Comments:

_____

_____

_____ _____ _____

**Signature of Licensed Professional** **Title** **Date**

**PLEASE PRNT:**

**Name of Licensed Professional: _____**

**Office Address: _____**

**_____**

**_____**

**Phone Number: _____**

**Fax Number: _____**

# APPLICATION FOR HOME/HOSPITAL INSTRUCTION

**SECTION 3: HOME/HOSPITAL REVIEW COMMITTEE**

(To be completed by the Home/Hospital Review Committee after parent/licensed professional completion)

**STUDENT FULL NAME: _____ DOB: ☐☐ / ☐☐ / ☐☐☐☐**

**DATE COMPLETED APPLICATION RECEIVED: ☐☐ / ☐☐ / ☐☐☐☐**

**STATUS OF APPLICATION: ☐ APPROVED ☐ DENIED ☐ INCOMPLETE ☐ EXTENDED TO: _____**

**PLEASE STATE REASON IF DENIED:**

_____

_____ _____

**SIGNATURE OF DEPT OF PUPIL PERSONNEL** **DATE**

_____ _____

**SIGNATURE OF HOME/HOSPITAL TEACHER** **DATE**

_____ _____

**LOCAL MEDICAL/MENTAL HEALTH PERSONNEL** **DATE**

**COMMENTS:**

_____

_____

_____