Application for Home/Hospital Instruction December 2023

(please type or print neatly)

Parent/Student Information Section

I

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 _____ Zip Code _____ Address of Student 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 son or daughter may be enrolled: 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). 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

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Application for Home/Hospital Instruction Professional Statement

Section II

This section is to be filled out by an 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:	
	l without any type of modifications or special provisions.
	ol only with modifications or special provisions.
The student is unable to atter instruction (If checked, please comp	and school at this time due to health concerns, and I do support Home/Hospital polete the rest of this section).
	ort home/hospital instruction for this student. If you do not support home/hospital your concerns and/or recommendations:
If you do support home/hospital ins	truction at this time, please fill out the rest of Section II
Diagnosis	Prognosis Good Fair Poor
Specific reason (s) why the student	is unable to attend school at this time:
	patient for the diagnosis listed? will need Home/Hospital Instruction
	her data collected that supports the need for Home/Hospital Instruction at this time

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What is the expected duration of treatment?	
Check here if this student has a chronic physical condition that is unlikely to substantia	ally 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 Phone Number	
Address	
Anticipated date of student's return to school	
What are your recommendations to assist this student in his/her return to school?	
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Remarks/Comments:	
Signature of Licensed Professional Title	Date
Diagon Deint on Tong Manner of Description I	
Please Print or Type Name of Professional:	
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Application for Home/Hospital Instruction Home/Hospital Review Committee

1st Application	
2 nd Application	
3 rd Application	

Section III

This section is to be completed by the Home/Hospital Review Committee. Name of Student					
Date Application Received:ApprovedDeniedIncomplete	This section is to be completed by th	e Home/Hospital l	Review Committee.		
Date Application Received:ApprovedDeniedIncomplete If approved, date of services will be from	Name of Student				
Teacher assigned to provide services:	Date Application Received:	Approved	Denied		
Teacher assigned to provide services:	If approved, date of services will b	until			
If eligibility for services denied, reason for denial				(Review D	Oate)
If eligibility for services denied, reason for denial	Teacher assigned to provide servic	es:	or In Dorgon		
If incomplete application, type of additional information requested	Homeodina Teacher will provide.	virtually	_ or in-reison		
If incomplete application, type of additional information requested	If eligibility for services denied, reas	son for denial			
Date of Request Person Contacted					
Date of Request Person Contacted					
Date of Request Person Contacted	If incomplete application, type of ad-	ditional informatic	on requested		
Signatures of Committee Members: Director of Pupil Personnel	if incomplete application, type of ac-	unional informatic	m requested		
Signatures of Committee Members: Director of Pupil Personnel	D. (CD.)	D C	1		
Director of Pupil Personnel Date Home/Hospital Services Teacher Date or Program Director Date Local Medical or Mental Health Personnel Title Date	Date of Request	Person Con	ntacted		
Director of Pupil Personnel Date Home/Hospital Services Teacher Date or Program Director Date Local Medical or Mental Health Personnel Title Date					
Home/Hospital Services Teacher or Program Director Date Local Medical or Mental Health Personnel Title Date	Signatures of Committee Members:				
Date	Director of Pupil Personnel	Date			
Date					
Local Medical or Mental Health Personnel Title Date	-			Data	
	or Frogram Director			Date	
Comments:	Local Medical or Mental Health Pers	sonnel	Title		_ Date
Comments:					
	Comments:				

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