CARROLL COUNTY PUBLIC SCHOOLS

APPLICATION FOR HOSPITAL/HOMEBOUND INSTRUCTION

164 INDEPENDENCE DR.
CARROLLTON, GA 30116
770-832-3568 FAX 770-834-6399

I. Student Information: (Please Print)

Provide all requested information. There may be a delay in processing incomplete applications.

Student's Name:_____ **DOB:**_____ **Student ID #**_____

Address:_____

Parent/Guardian_____ **Home Phone** _____ **Work/Cell Phone** _____

School_____ **Grade**_____ **Homeroom Teacher**_____

The school is responsible for providing assignments and grades to the student until the student is officially in the HHB program.

Do you have a computer? Yes___ No___ **Do you have Internet connection? Yes___ No___**

Student Email Address _____ **Parent Email Address** _____

II. Eligibility Policies

1. I understand that eligibility is based upon Georgia Statutes, State Board Rule 160-4-2-.31 and that the licensed physician or licensed psychiatrist and medical referral form is part of the information used to determine eligibility.
2. I understand that Carroll County Schools Hospital/Homebound personnel may contact the licensed treating physician or licensed psychiatrist to obtain information needed to determine if the student will be eligible for Hospital/Homebound services and provide appropriate instructional delivery.
3. I understand that my child must be enrolled in a public school prior to the referral for Hospital Homebound services.
4. I understand that Hospital/Homebound Instructional Services are for students confined to the home or hospital due to a diagnosed medical or psychological condition, which is acute, catastrophic, chronic, or repeated intermittent.
5. I understand that I will be required to sign an agreement regarding Hospital/Homebound policies and procedures.
6. I understand that if my child is eligible for HHB services and the medical or psychological conditions improve, my child may be dismissed from the program and may be required to return to school.
7. I understand that if my child is eligible for HHB services, he/she is subject to the same mandatory attendance requirements as other students.
8. I understand an individual who is at least 21 years of age and who the parent designates must be present in the home during HHB instruction.
9. I understand that during development of the Educational Service Plan a decision may be made to limit the instruction to core subjects only. The core subjects include reading, language arts, mathematics, science, and social studies.

III. Policies and Procedures

1. A parent, guardian, or an appointed adult parent designee as defined in the Educational Service Plan (ESP) shall be present during each entire home instructional period.
2. A table or a desk in a workspace that is well ventilated, smoke-free, clean and quiet (i.e., free of radio, TV, pets, and visitors) must be provided.
3. A schedule for student study time between teacher visits will be established and the student will be prepared for each session with the instructor.
4. Instructional materials must be obtained from the school, assignments completed and submitted on time.
5. Assignments will be returned to the regular school teacher for grading unless stipulated differently in the ESP.
6. A parent, guardian, or an approved adult parent designee as defined in the Educational Service Plan (ESP) must notify the Hospital/Homebound teacher 24 hours in advance if an instructional session must be canceled. The local school system may, at its discretion, reschedule the canceled session. The HHB teacher will notify the parent, guardian, or approved adult parent designee if they need to cancel a session and the session will be rescheduled.
7. For long-term or intermittent HHB students, the HHB teacher, in collaboration with the regular school teacher, may assign grades for the work completed.
8. The parent/guardian must submit a release form from the licensed physician upon the student's return to school.
9. To extend HHB services beyond the originally identified return to school date, the licensed physician or licensed psychiatrist must submit an updated medical referral form.

Return Completed Form to:
LaNelle Holland
Hospital-Homebound Instruction
164 Independence Dr.
Carrollton, GA 30116

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Student Name: _____ **DOB** _____ **Student ID#** _____

IV. Cause 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 student is employed in any capacity, goes on vacation, regularly participates in extracurricular activities, or is no longer confined at home, the student will be removed from the program.
3. If the parent, guardian, or adult parent designee cancels two sessions without the appropriate notice, the student will be removed from the program.
4. If the condition or the location where HHB services are provided are not conducive for instruction or threaten the health and welfare of the HHB teacher the student will be removed from the program.

V. Parent/Guardian Agreement/Release for Information

I have read the Hospital/Homebound policies for program eligibility and I understand the reasons for possible dismissal from the program. I agree to the policies and requirements of the program and request Hospital/Homebound services for my child. I hereby give permission for the attending licensed physician or licensed psychiatrist for the diagnosis presented to communicate information regarding my child's medical/emotional condition for which he/she is referred.

_____ _____

Parent/Guardian Signature Date

Once Page 1 & 2 is completed by the parent send the entire packet to the treating physician. The physician MUST supply beginning and ending dates on Page 3, as well as information on Page 4 to help school personnel facilitate hospital-homebound instruction and reentry to school. All may be FAXED to LaNelle Holland – 770-834-6399.

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VI. Licensed Physician/Psychiatrist Statement and Medical Referral Form (Must be completed by a physician/psychiatrist licensed by the State of Georgia)**PLEASE PRINT ALL EXCEPT SIGNATURE**

Print Physician/Psychiatrist's Name _____GA License #_____

Address_____Phone Number_____

Section A. Physician/Psychiatrist Statement and Diagnosis
Patient's Diagnosis _____

If HHB is recommended for pregnancy/post-partum or complicated please give the Estimated Date of Delivery: _____

Physician's Statement of Condition: _____

Estimated Duration of Hospital/Homebound Services: **Starting Date**_____**Ending Date**_____Number of Weeks_____

Date of initial evaluation _____Date of Injury/Illness_____ Date of Next Appointment _____

Physician's Statement: Please answer the following questions keeping in mind that the least restrictive environment is preferred.

- Is the student unable to attend school for a minimum of 10 consecutive school days? Yes ___ No ___
- Will the student be able to benefit from an instructional program during this time of confinement? Yes ___ No ___
- Could the student attend school with accommodations? If so, describe. Yes ___ No ___

Recommendations for accommodations: _____

- Could the student attend school regularly and receive HHB services on an intermittent basis, as needed? Yes ___ No ___
- Is the student confined to home or hospital and full time HHB services are recommended? Yes ___ No ___
- Is the student free from communicable disease? Yes ___ No ___
- Can instruction be provided to the student without endangering the health of the instructor or Other students whom the instructor may contact? Yes ___ No ___

NOTE: You may periodically have to verify that the student remains under your care and continues to qualify for the HHB program.

Section B. Treatment and School Reentry Plan
The following information is required to determine eligibility for Hospital/Homebound service and must be completed by the licensed physician or licensed psychiatrist who is currently treating the student for the diagnosis presented.

- *What is the treatment/therapy schedule for this student?* *Daily* _____ *Weekly* _____ *Monthly* _____
- *What is the expected duration of the treatment/therapy?* _____
- *Will the student take medication?* *Yes* ___ *No*___
- *Please complete the following information for each medication that the student will take*

Name of Medication	*Effects on student's ability to comprehend*	*Effects on student's ability to complete independent assignments*	*Effects on student's ability to relate to teachers and other students.*

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Student Name: _____ ***DOB*** _____ ***Student ID #*** _____

- *Could this student return to school on an intermittent basis after his/her medication and/or condition is stabilized? Yes___ No ___*
- *Can this student come into contact with other students? Yes ___ No ___*

The Hospital/Homebound program is designed to be a temporary program to help children who are unable to attend school for medical or psychiatric reasons. Please describe your time frame and transitional plan for the student's reentry to school: (Attach additional sheets as needed)

Physician's Certification: *I certify that this student is under my care and treatment for the aforementioned medical condition. My recommendation has been based on the medical needs of the patient, keeping in mind that the least restrictive environment is preferred.*

_____ _____
Physician's Signature *Date*

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Student Name: _____ **DOB** _____ **School** _____ **Student ID#** _____

VII. Carroll County Schools Hospital-Homebound Approval

After reviewing the above information and the eligibility criteria _____
(Student's Name)

Has Been Approved _____ Has Not Been Approved _____ for HHB Instruction.

_____ _____
Signature of HHB Personnel Date

The teacher assigned to provide instruction is _____. Phone #_____

There will be a meeting held to develop and Educational Service Plan for this student on _____
Date

At _____ in room _____ at the school this student attends. Your presence is requested.
Time Number

Please call _____ at _____ to confirm your attendance.
Name Phone

*****If this student has not been approved you may appeal this decision by a written statement to the Carroll County Schools, Hospital-Homebound Instruction, 164 Independence Dr., Carrollton, GA 30116. A committee will contact you for a meeting to review all eligibility criteria and come to consensus as to the eligibility of the student to receive Hospital-Homebound Instruction.******

Entire Application (pages 1-5) may be FAXED to LaNelle Holland – 770-834-6399