Application for Home or Hospital Instruction

June 2021

(Please type or print neatly)

Parent/Student Information

**Eligibility for home/hospital instruction for students with disabilities shall be determined by the Admissions and Release Committee (ARC). This form is not required for students placed on Home or Hospital instruction by the ARC. **

Section I

To be completed by the parent(s)/guardian(s)

School District_____School_____Grade_____

County of Residence _____Last Date Attended_____

Name of Student_____Date of Birth _____

Address of Student_____Zip Code _____

Sex_____Race_____Social Security #_____Telephone # _____

Full Name of Father/Guardian_____Telephone# _____

Full Name of Mother/Guardian_____Telephone# _____

Does the student have an Individualized Education Program (IEP)? Yes _____ No_____

Does the student have a Section 504 Plan? Yes_____ No _____

Directions to student's home _____

_____

_____

Pursuant to KRS 159.030(2), before granting any student an exemption from compulsory attendance, the board of education of the district in which the student resides shall require submission to the board of satisfactory evidence in the form of a signed statement of a properly licensed physician, advanced practice registered nurse, physician's assistant, psychologist, or psychiatrist responsible for diagnosing and treating the child, stating that the diagnosed condition of the child prevents or renders inadvisable attendance at school and requires home or hospital instruction. If the condition is mental health related, then the signed statement shall be completed by a licensed physician, psychiatrist, psychologist, or physician's assistant described in KRS 202A.011 or an advanced practice registered nurse defined in KRS 314.011 and certified in psychiatric-mental health nursing. On the basis of such evidence, the local board of education may exempt the student from compulsory attendance.

A student with a recurring condition, which results in periods in which the need for home or hospital instruction is intermittent and the student is able to attend school for short periods, may be exited and reentered on home or hospital instruction, and the following shall apply:

(a) Initial approval by the Home or Hosptial Review Committee (Review Committee) shall be required;
(b) The Review Committee shall review the need for an alternative schedule of services based on verification by the professional statement in the application for home or hospital instruction of the need for intermittent services;

(c) If a health professional who completed the initial application for a student to be served on home or hospital determines the student needs additional time for services, the health professional shall submit a written statement, either mailed or faxed, to the Director of Pupil Personnel, requesting additional time up to two (2) weeks for services and provide a brief explanation for the extension;
(d) The Review Committee shall meet to review this extension and either approve or deny the request for an extension, prior to provision of any extended services;
(e) The Review Committee shall review intermittent placement at least every six (6) months, and at that time a statement from a second professional, shall be required by the Review Committee for continued program eligibility; and
(f) The parent or guardian shall notify the principal or Director of Pupil Personnel prior to the need for school reentry or to exit to home or hospital instruction.

Pregnancy is not 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 or hospital instruction for this condition. 702 KAR 7:150.

For students receiving home or hospital instruction pursuant to a determination by a Home or Hospital Review Committee, eligibility shall cease if the student works, plays sports or participates in extracurricular activities. 702 KAR 7:150.

RELEASE OF INFORMATION

I understand that if the Home or Hospital Review Committee makes the determination of placement for this student, they 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 or Hospital Instruction
Professional Statement

Section II

This section is to be filled out by a properly licensed physician, advanced practice registered nurse, physician's assistant, psychologist, or psychiatrist responsible for diagnosing and treating the student. If the condition is mental health related, then the signed statement shall be completed by a licensed physician, psychiatrist, psychologist, or physician's assistant described in KRS 202A.011 or an advanced practice registered nurse defined in KRS 314.011 and certified in psychiatric-mental health nursing. In order for a district board of education to exempt a student from compulsory attendance, the student must provide satisfactory evidence in the form of a signed statement from a qualified healthcare professional that the diagnosed condition of the student prevents or renders inadvisable attendance at school and requires home or hospital instruction.

Name of Student_____

_____I do/__I do not support home/hospital instruction for this student. If you do not support home/hospital instruction at this time, please state your concerns and/or recommendations: _____

_____

_____

_____

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:_____

_____

_____

_____The student is unable to attend school at this time due to health concerns, and I do support Home/Hospital instruction. **If checked, please complete the rest of Section II.**

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 _____

Recommended start date of Home/Hospital instruction: _____

Please summarize test and all 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? _____

Start date of hospital admission, if applicable: _____

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.

Name	Specialty	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Will you be following the patient?_____Yes___No. If not, who will?_____

Name_____Telephone # _____

Address_____

Anticipated date of student's return to school _____

What are your recommendations to assist this student in their return to school? _____

_____

_____

_____

Remarks/Comments: _____

_____

_____

_____

_____

_____ _____ _____

Signature of Licensed Professional Title Date

Please Print or Type Name of Professional: _____

Office Address_____ Phone Number _____

_____ Fax Number _____

Application for Home or Hospital Instruction
Home or Hospital Review Committee

Section III

Name of Student_____

Date Application Received:_____Approved _____Denied_____Incomplete__ If approved, date of services will be from_____until _____
(Review Date)

If eligibility for services denied, reason for denial _____
_____
_____
_____

If incomplete application, type of additional information requested _____
_____
_____

Date of Request_____Person Contacted _____

Signatures of Committee Members:

Director of Pupil Personnel_____Date_____

Program Director _____Date_____

Home/Hospital Teacher _____Date_____

Medical or Mental
Health Personnel_____Title_____Date_____

Other Relevant Professional_____Title_____Date_____

Comments:
_____
_____
_____
_____
_____