Application for Home/Hospital Instruction

(please type or print neatly)

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 __LaRue County______ School ______________________________ Grade __________
County of Residence __________________ Last Date Attended ______________________________
Special Education Student _____ Yes _____No

Name of Student ____________________________ Date of Birth ______________________________
Address of Student ____________________________ City________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 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

Application for Home/Hospital Instruction - Section II - Professional Statement

to be filled out by a licensed medical or mental health professional. (please type or print neatly)

Per KRS 159.030 (2) and 704 KAR 7:120: 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.** 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.**

_____ **The student can attend school with modifications or special provisions as described below:**

____

____

_____ **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 remainder of this form below).

Diagnosis ____________________ Prognosis Good _______ Fair _______ Poor _______

How long have you been seeing the patient for the diagnosis listed?____________________

Specific reason(s) why the student is unable to attend school at this time - please summarize test and other data collected: ____

____

____

What is the treatment plan for the patient and expected duration of treatment? ____________________

____

What ancillary services are involved in treatment? ____________________

____

_____ Check here if this student has a chronic physical condition that is unlikely to substantially improve within one year.

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:____________________(need a specific date)

Remarks/Comments: ____

____

____________________	____________	____________
Signature of Licensed Professional	**Title**	**Date**

Please Print Name of Professional:____________________

Office Address ____________________ Phone Number ____________________

____________________ Fax Number ____________________

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Home/Hospital Review Committee

Section III

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

Name of Student

____

Date Application Received: ______________ Approved _____ Denied _____ Incomplete _____

If approved, date 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

Home/Hospital Services Teacher
or Program Director ______________________ ______________
Date

Local Medical or
Mental Health Personnel ______________________ ______________
Date

Comments:

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