Appendix A

Hospital/Homebound (HHB) Services Request Form

(Note: There may be a delay in processing incomplete applications.)

System Name: _____

Address: _____

_____

Phone: _____Fax: _____

Student Information

Student Name: _____
Last First MI

Address: _____

_____

M ☐ F ☐ Date of Birth: _____

Parent/Guardian: _____
Last First MI

Phone: (H) _____ (W) _____ (C) _____

School Name: _____Grade: _____

Counselor/Social Worker: _____

Student Testing (ID) Number: _____

(Note: The school is responsible for providing assignments and grades to the student until the student is officially enrolled in the HHB program.)

Do you have a computer with DSL, high speed, or wireless connection at the instruction location?
Yes ☐ No ☐

Student Email Address: _____

Parent Email Address: _____

Eligibility Policies

1) Eligibility for services is based on the Georgia State Board of Education Rule 160-4-2-.31 Hospital/Homebound (HHB) Services, and that a medical referral form issued from a licensed physician is required to determine eligibility.
2) The Local Education Agency (LEA) HHB services personnel may contact the licensed physician to obtain information needed to determine if my child will be eligible for HHB services and provide appropriate instructional delivery.
3) A child must be enrolled in a public school prior to the referral for HHB services.
4) HHB services are for students confined to the home or hospital due to a medical or psychological condition, which is acute, catastrophic, chronic, or repeated intermittent.
5) Parents will be required to sign an agreement regarding HHB services policies and procedures.
6) A child eligible for HHB services, may be dismissed from the HHB program and may be required to return to school if his or her medical or psychiatric condition(s) improve as documented by a licensed physician.
7) A child who is eligible for HHB services, is subject to the same mandatory attendance requirements as other students.

Policies and Procedures

1) A parent, guardian, or an approved adult parent designee as identified 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 teacher.
4) Instructional materials must be obtained from the school, and assignments completed and submitted on time.
5) Assignments will be returned to the regular school teacher for grading if the student is on HHB services for a short period of time.
6) A parent, guardian, emancipated minor, student 18 years of age or older, or an approved adult parent designee as identified in the ESP must notify the HHB teacher at least 24 hours in advance if an instructional session must be cancelled. The LEA may, at its discretion, reschedule the cancelled session. The HHB teacher will notify the parent, guardian, or approved adult parent designee if they need to cancel a session and the session may be rescheduled.
7) For long-term or intermittent HHB students, the HHB teacher, in collaboration with the regular school teacher, shall assign grades for the work completed.
8) The parent/guardian, emancipated minor, or student 18 years of age or older 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 must submit an updated medical referral request form.

Cause for Dismissal

1) If the licensed physician 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, emancipated minor, student 18 years of age or older or adult parent designee cancels three sessions without 24 hours notice, the student will be removed from the program.
4) If the conditions of 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.

Parent/Guardian Agreement/Release for Information

I have read the Hospital/Homebound (HHB) services policies for program eligibility and I understand the reasons for possible dismissal from the program. I agree to the policies and eligibility requirements of the program and request HHB services for my child.

_____

Parent/Guardian Printed Name Date

_____

Parent/Guardian Signature Date

Appendix B

Licensed PhysicianStatement and Medical Referral Form

(Note: This form must be completed by a licensed physician, or advanced practice provider)

*Physician/Advanced Practice Provider Name:_____

Physician/Advanced Practice Provider License #:_____

Address: _____

_____

Phone Number: _____ Fax: _____

Student Information

Student Name: _____
Last First MI

Address: _____

_____

M ☐ F ☐ Date of Birth: _____

Parent/Guardian: _____
Last First MI

Phone: (H) _____ (W) _____ (C) _____

Physician Statement and Diagnosis

Patient's Diagnosis: *(Note: Please include a description of the condition.*)

_____
_____
_____
_____
_____
_____
_____

Estimated Duration of HHB Services:

Starting Date: _____

Ending Date: _____

Date of Initial Evaluation: _____

Date of Next Scheduled Appointment: _____

Physician's Statement: *(Note: 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 ten 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 the home or hospital and full-time HHB services are recommended?

  Yes ☐ No ☐
- Is the student free from communicable diseases, such as flu or contagious airborne diseases?

  Yes ☐ No ☐
- Can instruction be provided to the student without endangering the health of the teacher or other students whom the teacher 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 services program.)*

Treatment and School Reentry Plan ***(Note**: The following information is required to determine eligibility for HHB services and must be completed by the licensed physician who is currently treating the student for the diagnosis presented.*)

- What is the scheduled frequency of treatment/therapy for this student?
  ☐ Daily
  ☐ Weekly
  ☐ Monthly

- What is the expected duration of the treatment/therapy? _____

- Will the student take medication?
  Yes ☐ No ☐

Medications student will take for diagnosis:

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

- Could this student return to school on an intermittent basis after his or her medication and condition is stabilized?
  Yes ☐ No ☐

- Can this student come into contact with other students?
  Yes ☐ No ☐

The HHB services program is designed to be a temporary educational program to help students 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 pages 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 Printed Name Date

_____

*Physician Signature Date

_____

Advanced Practice Provider (on behalf of licensed physician) Date

***Note:** The Georgia Composite Medical Board provided information on the following statute: O. C. G. A. 43-34-25, regarding Advanced Practice Providers signing health forms for educational purposes. The law states:

(e.1) Except for death certificates and assigning a percentage of a disability rating, an advanced practice registered nurse may be delegated the authority to sign, certify, and endorse all documents relating to health care provided to a patient within his or her scope of authorized practice, including, but not limited to, documents relating to physical examination forms of all state agencies and verification and evaluation forms of the Department of Human Services, the State Board of Education, local boards of education, the Department of Community Health, and the Department of Corrections.

Please update any Hospital/Homebound forms and policies your system is currently using to allow for compliance with this law. **Note:** The Advanced Practice Provider may only provide this service if the Physician delegates these duties and is in agreement with the diagnosis.