Complete\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hospital/Homebound (HHB) Application Incomplete\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **2019-20 Student Referral & Information Form** Missing:

Hall County Schools

**711 Green Street Gainesville, GA 30501 (770) 534.1080 Fax (770) 533.4015**

 Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_

***Please provide all requested information and return the completed application to your child’s school counselor. The application process is not finalized until the school counselor receives all parts of the application and signs the application. The school is responsible for providing assignments and grades to the student until the student is officially enrolled in the Hospital/Homebound program.***

Student Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M\_\_\_\_\_\_\_ F\_\_\_\_\_\_\_\_

 Last First MI

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First MI

Phone: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the student have access to a computer? YES/ NO Internet Connection? YES/ NO

Student Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **I. Eligibility Policies** |

1. I understand that eligibility is based on Georgia State Board of Education Rule 160-4-2-.31 Hospital/Homebound Service, 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 local school system personnel and/or Hospital/Homebound personnel may contact the licensed physician or licensed psychiatrist to obtain information needed to determine if my child will be eligible for Hospital/Homebound services and to enable provision of appropriate instructional delivery.

3. I understand that my child must be enrolled in a public school prior to the request for Hospital/Homebound services.

4. I understand that the Hospital/Homebound services are for students confined to the home or hospital due to a medical or psychological condition which is acute, catastrophic, chronic, long-term or intermittent periods of time.

5. I understand that I will be required to sign an agreement regarding Hospital/Homebound policies and procedures.

6. I understand that the student must be anticipated to be absent for a minimum of ten consecutive school days per year or, if the student has a chronic health condition causing him or her to be absent for intermittent periods of time, anticipate at a minimum of ten school days per year (3 or more days at a time).

7. I understand that a student with a chronic health condition who is eligible for intermittent Hospital/Homebound service must be anticipated to be absent for at least three consecutive school days for each occurrence to be eligible for a Hospital/Homebound visit. The parent, guardian, or approved adult must notify the Hospital/Homebound instructor at least five school days prior to the expected three or more absences to arrange the Hospital/Homebound visit.

8. I understand that if my child is eligible for Hospital/Homebound services, he/she is subject to the same mandatory attendance requirements as other students.

9. I understand that I must provide a signed medical release form

10. I understand that Hospital Homebound services request for 8 weeks or greater require an in person meeting with the Hospital Homebound team to determine the Educational Service Plan (ESP).

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| **II. Policies and Procedures**  |

1. A parent, guardian, or an approved 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. The parent/guardian and student will schedule study time between teacher visits, and the student will be prepared for each home visit.

4. Instructional materials must be obtained from the school by the parent or guardian prior to the first session. Assignments need to be completed and submitted on time.

5. Assignments will be returned to the regular schoolteacher for grading.

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.

7. The Hospital/Homebound teacher will notify the parent, guardian, or approved adult parent designee to cancel a session and the session will be rescheduled.

8. The parent/guardian must submit a release form from the licensed physician if the student’s return to school is prior to the date indicated by the physician on the Hospital/Homebound application.

9. To extend Hospital/Homebound services beyond the originally identified return to school date, the licensed physician or licensed psychiatrist must submit an updated medical referral form.

**Student Information & Referral Form (PAGE 2**)

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_ School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*\*\*GEN ED:\_\_\_\_\_\_\_ \*\*\*\*\*\*\*SPED:\_\_\_\_\_\_\_\_\_

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| **III. Cause for Dismissal of Services** |

A student is released from the Hospital/Homebound program:

1. As of the projected return date listed on the Hospital/Homebound application Section VIII, **Medical Referral Form**, Part A, *Physician/Psychiatrist Statement and Diagnosis;*

2. When the licensed physician or licensed psychiatrist recommends that the student is able to attend school or can no longer participate or benefit from Hospital/Homebound services;

3. When the student is employed in any capacity, goes on vacation, regularly participates in extracurricular activities (*prior* approval by the Hospital Homebound Team required), or is no longer confined at home;

4. When the parent, guardian or adult parent designee cancels three sessions without the appropriate notice;

5. When the conditions of the location where Hospital/Homebound services are provided are not conducive for instruction or threaten the health and welfare of the Hospital/Homebound teacher;

6. When the student returns to school or is able to return to school for any portion of the school day other than to participate in state-mandated standardized testing;

7. As of the last day of school of the regular school year.

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| **IV. Parent/Guardian Agreement/Release for Medical 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.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

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| **V. School Counselor/Principal/Administrator** |

\_\_\_\_\_Student Referral Received \_\_\_\_\_ Medical Referral Form Received (**DO NOT** forward until BOTH forms are received and complete)

\*\*\*\*Does student receive SPECIAL EDUCATION services? YES/NO Speech only? YES/NO 504 Plan? YES/NO

IF SPED name of Lead Teacher:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date forwarded to HHB Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Both signatures below are required for approval).

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Counselor /School Level HHB Coordinator Signature Date

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Principal/Administrator Date

**VI. Hall County Schools Hospital-Homebound Approval (to be completed by System HHB Coordinator when ALL information is received and reviewed).**

Approved \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Not Approved \_\_\_\_\_\_\_\_\_\_\_\_\_\_ reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Regular HHB \_\_\_\_\_\_\_\_\_\_\_\_Intermittent HHB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beginning Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ending Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Central Office HHB Coordinator Date Approved

School level contact notified of approval by email on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Revised 8/18)

Please have the parent sign the Student Information/ Referral Form and the Medical Certification Form. Once the referral form is completed and signed by the school and parent, send the Medical Certification Form to the treating physician. The physician MUST supply beginning and ending dates and complete the Medical Certification Form to help school personnel facilitate hospital-homebound instruction and reentry to school. When received, please FAX both COMPLETED Student Information/ Referral Form and Medical Certification Form to Mamie Coker at 770.533.4015 or scan and email to mamie.coker@hallco.org