Fannin County School District Hospital/Homebound
(HHB) Services Request Form

Part I: Student Information

Student's Name_____
Last First Middle Initial

Address_____

GENDER: M F Date of Birth:_____

School _____ Grade _____

Teacher/Case Manager_____ _Regular Education ___Special Education

Hospital/Homebound Teacher _____

Does the Student have an IEP? _____ 504 Plan? _____

Last date of student's attendance _____

Parent/Guardian _____

Phone: (Home) _____ (Work) _____ (Cell)_____

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

Student Email Address _____

Parent Email Address _____

For questions, please contact the Hospital/Homebound Coordinator, Mrs. Shannon Miller at 706-632-3771 Ext. 227.

PART II MEDICAL REFERAL FORM (PAGES 2-4) MUST BE COMPLETED AND SIGNED BY THE PHYSICIAN.

PART III ELIGIBILITY PROCEDURES AGREEMENT AND RELEASE (PAGES 5-7) ARE TO BE READ AND SIGNED BY THE PARENT/GUARDIAN.

PRINCIPAL MUST SUBMIT THE FULLY COMPLETED REQUEST FORM (PAGES 1-7) TO: MRS. SHANNON MILLER, HOSPITAL/HOMEBOUND COORDINATOR
FANNIN COUNTY SCHOOLS
2290 E. FIRST STREET
BLUE RIDGE, GA 30513 ***FAX: 706-632-7583***

****INCOMPLETE APPLICATIONS MAY RESULT IN A DELAY OR DENIAL OF HOSPITAL/HOMEBOUND SERVICES).***

Principal's Signature_____

NAME OF STUDENT _____

Part II: Medical Referral Form

(NOTE: THIS FORM MUST BE COMPLETED BY A PHYSICIAN OR PSYCHIATRIST LICENSED BY THE STATE OF GEORGIA WHO IS CURRENTLY TREATING THE STUDENT FOR THE DIAGNOSIS PRESENTED. A STATEMENT FROM A TREATING SPECIALIST MAY ALSO BE REQUIRED.)

Physician/Psychiatrist Name:_____

GA License #:_____

Address:_____
_____

Phone Number: _____ Fax: _____

Student Information

Student Name: Last_____First_____MI_____

Date of Birth: _____

Physician/Psychiatrist Statement and Diagnosis

Do you anticipate the student will be absent for a **minimum of ten consecutive school days** per year or the equivalent on a modified calendar or does the student have a chronic health condition causing him or her to be absent for intermittent periods of time anticipated at a minimum of ten school days per year or equivalent on a modified calendar or five school days on a high school block schedule per year?[1] Yes_____ No_____

If so, please identify the patient's diagnosis based upon which he or she requires HHB instruction as described above and the impact of the medical condition on the student's ability to attend school:
_____
_____
_____
_____
_____
_____
_____

Are you the treating physician for the above condition? Yes_____ No

Are there other physicians, psychiatrists, or specialists also treating the student for the above condition? Yes_____ No _____
If so, who? (Please provide contact information, if known) _____
_____
_____

Note: A student with a chronic health condition receiving intermittent HHB services must be anticipated to be absent for at least three consecutive school days for each occurrence before he or she will be eligible for HHB services.

NAME OF STUDENT _____

Estimated Duration of Medical Condition Preventing Student From Attending School:

Starting Date: _____ Ending Date:_____

Date of Initial Medical Evaluation: _____

Date of Next Scheduled Appointment:_____

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, attend, work independently or receive HHB instruction**

Instructional Services:
(Note: Please answer the following questions keeping in mind that the least restrictive environment is preferred.)

Is the student confined to the home or hospital? Yes _____ No_____

Will the student be able to benefit from an instructional program during this time of confinement? Yes____ No _____

Is the student free from communicable diseases, such as flu or contagious airborne diseases? Can the student receive instruction without endangering the health and safety of the instructor or other students with whom the instructor may come in contact? Yes _____ No _____

Could the student attend school regularly and receive HHB services on an intermittent basis as **needed** ***{Note: A student with a chronic health condition receiving intermittent HHB services must be anticipated to be absent for at least three consecutive school days for each occurrence before he or she will be eligible for HHB services.)?*** **Yes ____ No _____**

Could the student attend school with accommodations? If so, describe. Yes_____ No _____
_____
_____
_____
_____

NAME **OF STUDENT**_____

The Educational Service Plan must include a reintegration plan for the student to return to school. What medical issues must be addressed or resolved for the student to be able to re-enter school? What medical accommodations should be included in a re-entry plan?

_____
_____
_____
_____
_____
_____

(Note: You may periodically have to verify that the student remains under your care and continues to qualify for the HHB services program. You may be contacted by District personnel in connection to the student's medical needs with regard to their impact on the student's educational needs. Attached is a signed release.)

PHYSICIAN'S SIGNATURE _____ DATE_____

FORMS MAY BE FAXED TO: 706-632-7583 — OR MAILED TO:

FANNIN COUNTY SCHOOL DISTRICT
2290 EAST FIRST STREET
BLUE RIDGE, GA 30513
ATTN: MRS. SHANNON MILLER
HOSPITAL/HOMEBOUND COORDINATOR

For questions, please contact the Hospital/Homebound Coordinator, Mrs. Shannon Miller at 706-632-3771 Ext. 227.

FOR FANNIN COUNTY SCHOOLS CENTRAL OFFICE USE ONLY:

____ APPROVED

____ NOT APPROVED

REASON_____

_____

_____ _____

HHB COORDINATOR'S SIGNATURE DATE

_____

NAME OF STUDENT_____

Part III: Eligibility Procedures, Agreement and Release
Eligibility Procedures

1) Eligibility for services is based on the Georgia State Board of Education Rule 160-4-2-.31 Hospital/Homebound (HHB) Services. A copy of that Rule is available on the Georgia Department of Education website (www.doe.kl2.ga.us), or from the School District, upon request

2) The local school team or IEP team will make determinations regarding whether a student is in need of HHB services and regarding dismissal from HHB services after considering the medical information available to it.

3) I understand that my child must be enrolled in a public school prior to the referral for HHB services. Private or Home School students are not eligible for HHB services.

4) I understand that the HHB services are for students confined to the home or hospital due to a medical or psychological condition which makes the child unable to attend school.

5) I understand that I will be required to sign this agreement and release regarding HHB services policies and procedures in order for my child (or me if student is an emancipated minor or over 18 years old) to receive HHB services.

6) HHB services personnel may contact the licensed physician or licensed psychiatrist who is treating the student for the diagnosis presented to obtain information needed to determine if my child will be eligible for HHB services and provide appropriate instructional delivery. Additional information from a specialist may also be requested.

7) Within 5 school days of submitting completed HHB paperwork, the appropriate designee will contact the eligible student's family to arrange a conference to develop an Educational Service Plan (ESP) for the student. The conference may be held in person, by telephone, or other electronic means including email.

8) If the student already has an IEP, the ESP may be developed in conjunction with or extension of that document.

9) HHB instruction may be offered individually or in small groups, at the student's home, health care facility through online learning courses, or at other locations as identified in the ESP.

9) The local school team or the IEP team shall determine the number of hours necessary to meet the instructional needs of the student, but the student must be offered a **minimum of three** hours of **HHB instruction per week.**

10) The ESP shall identify the appropriate course load for the student during the approved period of HHB instruction. HHB instruction is not designed to supplant the regular school day and may, therefore, limit the amount and types of instruction offered.

NAME OF STUDENT

Instruction Procedures

1) A parent, guardian, or an adult parent designee (as defined by the Rule, at least 21 years of age or older) as identified in the Educational Service Plan (ESP) shall be present during each home instructional period.

2) The family must make available 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).

3) The District will assign an appropriate HHB instructor.

4) The instruction schedule will be arranged by the HHB teacher in conjunction with the parent, guardian, emancipated minor, or student (if 18 years or older). The time of the instructional sessions may be during the school day or after the school day.

5) A schedule for student study time between teacher visits will be established and the student will be prepared for **each** session with the teacher.

6) The HHB instructor will coordinate with the family to obtain instructional materials from the school and submit completed assignments on time.

7) The HHB teacher will coordinate with the schoolteacher for instructional materials and assignments as well as grading.

8) 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 District may, at its discretion, reschedule the cancelled session.

9) The HHB teacher will notify the parent, guardian, emancipated minor, student 18 years of age or older, or approved adult parent designee if they need to cancel a session and the session may be rescheduled.

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 may be dismissed from HHB services.

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 may be dismissed from HHB services.

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 may be dismissed from HHB services.

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 instructor, the location of the HHB services may be changed or the student may be dismissed from HHB services.

5) Failure to sign the agreement or release may cause a delay or denial of HHB services.

NAME OF STUDENT _____

AGREEMENT

I have read and understand the Hospital/Homebound (HHB) eligibility and instruction procedures. I agree to the procedures.

_____

PRINTED NAME of Parent/Guardian (or student if emancipated minor or over 18) Date

_____

SIGNATURE OF PARENT/GUARDIAN (or student if emancipated minor or over 18) Date

RELEASE

I, _____ , (parent/guardian/emancipated minor/student 18 years or older) give permission for_____ , the attending licensed physician or licensed psychiatrist for the diagnosis presented, to communicate information to the Fannin County School District regarding _____ and his/her

(Student)

medical/emotional condition with regard to its impact on my his/her education and need for hospital/homebound services.

_____

Signature (parent/guardian/emancipated minor/student 18 years or older) Date

For questions, please contact the Hospital/Homebound Coordinator,
Mrs. Shannon Miller at 706-632-3771 Ext. 227.