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TO: Parents and Students Requesting Home/Hospital Instruction
FROM: Hardin County Schools
SUBJECT: Home/Hospital Instruction

Directions

1. Parents/Guardians must complete all of **Section I**.
2. Appropriate Medical Professional must complete **ALL** of **Section III**.
3. Return the completed Application Form to **Wes Blair, Director of Alternative Programs** or **Lisa Brown, Homebound Coordinator** at the Hardin County Schools Board of Education located at 65 W.A. Jenkins Rd in Elizabethtown.
4. Once received, the Home/Hospital Review Committee will review the applications and complete Section II.
5. Upon approval, you will be contacted by Student Services Department and assigned a Home/Hospital teacher who will set instruction dates and times.

Eligibility and Mandates

1. Students who anticipate absences for **more than five consecutive school days** for medical purposes may apply for Home/Hospital Instruction to help minimize learning disruptions caused by a lengthy school absence due to a medical diagnosis.
2. A student cannot be enrolled in home/hospital instruction until the completed Application Form (Sections I & III) is received and approved by Review Committee at the Board of Education office. The original Application Form can be mailed or submitted to the Hardin County Schools Board of Education, 65 W.A. Jenkins Rd. Elizabethtown, KY 42701 to the attention of Wes Blair or Lisa Brown. If you have any questions, please call Wes Blair at 270-769-8826 or Lisa Brown at 270-769-8851.
3. Section III of the Application Form must provide satisfactory evidence in the form of a signed statement from a licensed physician, advanced practice nurse, physician's assistance, psychologist, or psychiatrist responsible for diagnosing and treating the child, stating that the condition of the student renders inadvisable attendance at school for **more than five (5) consecutive school days**.
4. If the medical condition is mental health related then the signed statement must be completed by a licensed physician, psychiatrist, psychologist, or a physician's assistant with the mental health credentials described in KRS 202A.011 or an advanced practice registered nurse certified in psychiatric-mental health nursing.

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5. Any student who is excused from school attendance for more than six months must have two (2) signed applications from the providers, unless the original signed application indicates the child has a chronic condition that is unlikely to substantially improve within one year.
6. Since pregnancy is not considered a physical or health impairment, the condition itself, barring complications, would not constitute a need for home/hospital instruction.
7. Students must receive one hour of instruction twice a week to be counted in full attendance. The home/hospital teacher will notify the guardian to schedule each instructional session. Students should schedule any personal activities after these hours (excluding doctor appointments).
8. A responsible adult must be in the home and be visible during the home/hospital teacher's visit.
9. Prior to an instructional session, an adequate work area free from distractions must be prepared by the guardian.
10. The student and/or parent is responsible for making arrangements with the student's classroom teachers regarding assignments not completed prior to placement in the Home/Hospital Program.
11. All subject assignments including tests for each grading period must be completed no later than two weeks (10 school days) following the ending date of the grading period.
12. A student cannot be gainfully employed or participate in extra-curricular activities such as sports, during the time that he/she is enrolled in the Home/Hospital Instruction Program.
13. Elementary and Middle School Promotion and Retention: The decision to promote or retain shall be made by the principal after involvement of classroom teachers and the home/hospital teacher and shall be consistent with HCAR 08.22.
14. Exceptional children must meet all of the above criteria. In addition, an admissions and release committee (ARC) shall determine that an exceptional child shall be eligible for home/hospital instruction provided certain criteria are met.
15. Exemptions and status of all children under the provisions above must be reviewed annually with the evidence required being updated.

**Please feel free to contact Mr. Blair/Ms. Lisa Brown if you have any questions regarding this program, its policies and procedures.

Office: 270-769-8826

Fax: 270-769-8865

Email: wes.blair@hardin.kyschools.us

Office: 270-769-8851

Fax: 270-769-8865

Email: lisa.brown@hardin.kyschools.us

Application for Home/Hospital Instruction
(Please Print Neatly)

Section I

To be completed by the Parent/Guardian prior to full completion by the authorized health professional.

School District _____ School _____

Grade _____ County of Residence _____

Last Date Attended _____ Special Education Student ___ Yes ___ No

Name of Student _____ Date of Birth _____

Address of Student _____ 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 you son or daughter may be enrolled: _____

For purposes of KRS 157.360, a student who receives home/hospital instruction for a minimum of two (2) instructional sessions per week, with a minimum of one (1) hour of instruction per session, by a certified teacher provided by the Board, shall equal the student attending five (5) days in school. An instructional session may be delivered in person, electronically, or through other means established in regulation. A parent/guardian or responsible adult must be present in the home/hospital room during the time the home/hospital teacher is present or is otherwise delivering instruction.

In accordance with KRS 159.030(2), for a child to be exempted from compulsory education due to a physical or mental condition, the local board shall require a signed statement from a properly licensed physician, advanced practice nurse, physician's assistant, psychologist, or psychiatrist responsible for diagnosing and treating the child, stating that the child's diagnosed condition requires home/hospital instruction. If the condition is mental health related then the signed statement must be completed by a licensed physician, psychiatrist, psychologist, or a physician's assistant with the mental health credentials described in KRS 202A.011 or an advanced practice registered nurse certified in psychiatric-mental health nursing. For a child excused from school for more than 6 months, requires 2 signed statements from providers, unless the signed statement indicates the child has a chronic condition that is unlikely to substantially improve within 1 year. All exemptions shall be reviewed annually by the Review Committee in addition to any time based on changes in the student's 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

Section II

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

Name of Student _____

Date of Application Received: _____ Approved _____ Denied _____ Incomplete _____

If approved, date of services will 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 Health Personnel _____ Date _____

Comments:

Section III

This section is to be filled out by the authorized health professional.

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 in accordance with KRS 159.030 (2) and 704 KAR 7:120.

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.

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 this section).

____ I do/ ____ 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: _____

If you do support home/hospital at this time, please fill out the rest of Section III.

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 _____

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? _____

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 _____ Phone Number _____

Address _____

Anticipated date of student's return to school _____

What are your recommendations to assist this student in his/her return to school? _____

Remarks/Comments: _____

Signature of Authorized Professional

Title

Date

Please Print Name of Professional _____

Office Address: _____

Phone Number _____

Fax Number _____