ATLANTA PUBLIC SCHOOLS | Office of Student Services
www.atlantapublicschools.us

REFERRAL FOR HOMEBOUND SERVICES

(In order for referral to be processed, this entire packet must be completed in full)

STUDENT INFORMATION – To be completed by MTSS Contact/SELT and signed by parent.

General Ed Student: ☐ Yes **OR** Special Ed Student: ☐ Yes **GAA** ☐ Yes ☐ No

Student Name: _____ DOB: _____ AGE: _____ ID# _____

Parent Name: _____ Email Address: _____

Address: _____ Zip Code: _____ Phone: _____

School: _____ Grade: _____ Homeroom Teacher: _____

504 Plan? ☐ Yes ☐ No Is student employed? ☐ Yes ☐ No Computer/Internet at home? ☐ Yes ☐ No

I understand that Hospital Homebound (HHB) services are for students enrolled in Atlanta Public Schools. The student must be diagnosed with a medical or psychiatric condition which is acute or catastrophic in nature, or a chronic illness, or a repeated intermittent illness due to a persisting medical problem which confines the student to a hospital or home and restricts activities for an anticipated ten consecutive days or for intermittent periods of times anticipated to exceed ten school days during the school year.

If found eligible for HHB services, I agree for my child to receive Homebound Services. I am aware that I can participate in which educational plans are made for him/her and only regular core academic subjects/courses are covered under HHB. I understand that an ADULT OVER THE AGE OF 21 MUST BE PRESENT IN THE HOME DURING INSTRUCTIONAL SESSIONS.

I understand the APS District HHB liaison may contact the licensed physician or licensed psychiatrist to obtain additional information needed to determine eligibility for HHB services. My signature authorizes APS HHB personnel to obtain needed medical information from student's treating physician and approval for student to receive hospital/homebound services.

Parent's Signature_____ Date_____

Student's Signature (18 yrs. old)_____ Date_____

☐ Student is 18 years old (Parent signature not required)

Principal's signature _____ Date _____

MTSS Contact/SELT Signature _____ Date _____

~~OSPS USE ONLY~~

APPROVED_____ DENIED BECAUSE _____

Type of Homebound Services Approved:

☐ Temporary ☐ Long Term ☐ Intermittent

Start Date_____ End Date_____ HHB Teacher Assigned: _____

Approved by: _____ Date_____

Rev. 07/2024

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LETTER TO PHYSICIAN/PSYCHIATRIST

Dear Physician or Psychiatrist,

The parent of this student has requested a referral for Hospital Homebound services, which requires information from you regarding the student's medical condition. This letter and the attached Hospital Homebound Physician Report is to provide you the information regarding the Hospital Homebound Program as you consider this option for your patient (our student).

Hospital Homebound (HHB) instruction is academic support provided to students who are confined at home or in a health care facility for periods of time that would prevent normal school attendance based upon medical certification. The Georgia Department of Education (GADOE) defines a Hospital Homebound student as a student who has a diagnosis, physical or psychiatric, that has been certified by a Georgia licensed physician or psychiatrist as acute, catastrophic, chronic in nature, due to a persisting medical problem, or due to an injury. The Georgia attending physician/ psychiatrist or licensed designee must anticipate that the certified diagnosis will confine the student to home, hospital, or medical/treatment facility and restrict activities for an extended period of time. The GADOE defines that length of time as ten or more consecutive school days or intermittent days. (HHB rule 160-4-2-.31)

Your completion of the attached referral represents evaluation data to be reviewed by the SST/504 or IEP team.

Important Information to consider:

- The Hospital Homebound service is the most restrictive educational placement. It is designed to be temporary while the student is recovering from illness/injury/surgery or condition.
- Hospital Homebound instruction is offered as a **support** service for 3 hours a week and is not intended to replace regular classroom instruction. (The student does not receive regular direct instruction).
- Hospital Homebound is **NOT** a virtual school. The student will be assigned one teacher who will provide support in all 4 core courses only after school hours. Electives (specials), AP/IB, and foreign language courses/subjects are not covered.
- All APS schools accommodate students at school who require wheelchair and/or crutches to access their education.
- A request for HHB that extends for an entire semester or school year (and student is not hospitalized) must consist of a reasonable explanation as to why student is confined to the home as this may jeopardize the student remaining on track to complete matriculation and/or graduation requirements.
- Hospital Homebound is not retroactive. It will not excuse absences, provide instruction for missed assignments, or change failing grades accumulated prior to the eligibility for services.
- Hospital Homebound will exclude the student from campus activities (unless on intermittent HHB).

Should you decide the referral for Hospital Homebound services is appropriate for your patient (our student), **all** portions of the attached Medical Report must be completed by the medical professional. Items left blank or incomplete forms will cause a delay in HHB services being approved. When determining the length of time for student to be confined to home, we ask that you keep in mind the least amount of time medically possible to prevent the student from the loss of direct instruction as much as possible.

Please remember to include your signature, printed name, address, telephone, license number, and the date of form completion. You may return the completed original form directly to the student's school (Attn: MTSS Contact/SELT) or to the parent/guardian.

You may be contacted by the APS District HHB Liaison to confirm, share, or request additional information regarding the student once your referral is submitted. If so, you will receive a copy of a signed release form signed by the student's parent or guardian.

The school system makes the final determination of a student's eligibility and approval for HHB instructional support services. Full consideration will be given to the signed medical documentation submitted by the attending physician/psychiatrist. However, a recommendation for HHB by a treating physician/psychiatrist does NOT guarantee Hospital Homebound approval.

HHB MEDICAL PHYSICIAN REPORT

*(Note: **This form must be completed by a licensed physician or psychiatrist).***

Please PRINT:

Physician/Psychiatrist	Address	Phone
_____	_____	_____

License #: _____ Email Address: _____

Student Information

Student's Name _____ DOB _____ Phone _____

Address _____

Date of Initial Evaluation _____ Date of Next Scheduled Appointment _____

Physician/Psychiatrist Statement and Diagnosis

Patient's Diagnosis of Physical Illness or Diagnosis of Psychiatric/Emotional Disorder:
(*Please include a description of the condition. Attach additional pages as needed*)

_____

_____

_____

_____

_____

Diagnostic code number in Diagnostic and Statistical Manual (DSM) _____

Estimated Duration of HHB Services:

Starting Date _____ Ending Date _____ **(undetermined or indefinite will NOT be accepted)**

Type of Homebound Services Recommended: ☐ Temporary ☐ Intermittent ☐ Long Term

*Please note, no more than eight weeks of HHB support will be approved for students with psychiatric diagnoses. A request for extension can be made if student has not been released from psychiatric/medical facility.

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 ☐
- Is the student confined to the home or hospital or psychiatric facility?
  Yes ☐ No ☐
- Will the student be able to benefit from an instructional program during this time of confinement?
  Yes ☐ No ☐
- Are full-time HHB services being recommended?
  Yes ☐ No ☐
- Could the student attend school with accommodations? If so, describe.
  Yes ☐ No ☐

Recommendations for Accommodations:

_____

_____

_____

_____

- The student who has a chronic or long-term illness and who will be absent from school ten days in the year may receive intermittent HHB services rather than full-time HHB services. Can the student attend school regularly and receive HHB services on an intermittent basis as needed?
  Yes ☐ No ☐

- Is the student free from communicable diseases, such as flu or contagious airborne diseases, etc?
  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/psychiatrist who is currently treating the student for the diagnosis presented.)*

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

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

- Will the student take medication? Yes ☐ No ☐

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

- Can this student come into contact with other students?
  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

Hospital Homebound (HHB) instruction is offered as a support service and only covers core academic subjects. It is NOT virtual school. The HHB services program is designed to be a temporary educational program to help students who are confined to home for medical or psychiatric reasons. HHB is not intended to replace regular classroom instruction. All students are encouraged to return to school as soon as possible. Please describe your time frame and transitional plan for the student's reentry to school (attach additional pages as needed).

_____

_____

_____

_____

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_____

_____

Physician/Psychiatrist Certification: With the understanding that the Hospital Homebound program is the most restrictive educational environment, (see attached letter), I certify that this student is under my care and treatment for the aforementioned medical or psychiatric condition. In my professional opinion, it is my recommendation that it is medically necessary to place this child in this very restrictive educational environment.

_____

Physician/Psychiatrist Printed Name

_____

Physician/Psychiatrist Signature Date

_____ _____ _____

GA License # Phone Fax

PLEASE NOTE: If form is completed by an **ARNP**, the name, signature, and phone number of the supervising physician/psychiatrist is <u>required</u> below:

Supervising Physician/Psychiatrist Name (Printed) _____

Phone Number of Supervising Physician/Psychiatrist: _____ GA License#: _____

Specialty: _____, _____, _____

Physician/Psychiatrist Designee Name (Printed) _____

Physician/Psychiatrist Designee Title: _____

Signature of Supervising Physician/Psychiatrist _____ Date: _____

Signature of Physician's/Psychiatrist's Designee _____ Date: _____

Revised 7/2024

Department of Student Services
Fax: 404.802.1602

Dear Parents or Guardian,

Please read the following information and sign at the bottom. It is important that you and your child understand the purpose and the rules of the Hospital/Homebound Program.

Purpose
The purpose of the Hospital/Homebound Program is to help students, who are confined to the home, hospital or psychiatric facility and physically cannot attend school for 10 days or more, to continue their learning process during their time away from school. It is important to understand that HHB services are not the same as direct instruction at school. Your student will be assigned one teacher to support him/her in all core subjects only.

Goal
Our goal is to educate the student during the time he/she is unable to attend school and to assist with the transition back to school once he/she has been released from the doctor.

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 or licensed psychiatrist is required to determine eligibility.
2) HHB services personnel may contact the licensed physician or licensed psychiatrist to obtain additional 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 psychological condition(s) improves as documented by a licensed physician or licensed psychiatrist.
7) A child who is eligible for HHB services is subject to the same mandatory attendance requirements as other students.

Policies and Procedures

1) During the home instructional sessions, a parent, guardian, or parent designee 21 years or older must be present during the entire visit.
2) HHB instruction does not include elective (specials) courses/classes. It is the parent's responsibility to work with teachers to obtain assignments in those classes. If HHB is long term, during the SST/504 or IEP meeting, alternatives will be discussed that may impact the child's schedule.
3) The student shall be counted present for the entire week when he/she is provided instruction by the HHB teacher for a minimum of 3 hours per week.
4) To foster a productive learning environment, parents/guardians are requested to provide a workspace free from distractions. 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.
5) A schedule for student study time between teacher visits must be established and the student will be prepared for each session with the teacher.
6) Instructional materials must be obtained from the school, and assignments completed and submitted on time.
7) Assignments will be returned to the regular school teacher for grading if the student is on HHB temporarily.
8) A parent, guardian, emancipated minor, student 18 years of age or older, or an approved adult parent designee as identified in the ESP or IEP must notify the HHB teacher **at least 24 hours** in advance if an instructional session must be cancelled. HHB Personnel 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.
9) For long-term or intermittent HHB students, the HHB teacher, in collaboration with the regular school teacher, shall assign grades for the work completed.
10) The parent/guardian, emancipated minor, or student 18 years of age or older must submit a release form from the licensed physician or licensed psychiatrist upon the student's return to school.
11) To extend HHB services beyond the originally identified return to school date, the licensed physician or licensed psychiatrist must submit an updated medical referral request form before the expiration date of services.

(Continued on the next page)

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 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 student is approved for intermittent homebound, but is absent from school daily/weekly, an updated medical form will be needed changing the type of HHB to continue services.
5) If the student has excessive unexcused absences, then he/she is withdrawn from HHB services
6) 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.
7) When the school year ends, the student is withdrawn and must re-apply for HHB services for the following year, if warranted.

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 understand that if my child is eligible for HHB services, he or she is subject to the same mandatory attendance requirements as other students. I agree to the policies and eligibility requirements of the program and request HHB services to be considered for my child.

_____ _____

Student Name School

_____ _____

Parent/Guardian Signature Date

ATLANTA PUBLIC SCHOOLS
Authorization for Exchange of Health Information for Hospital Homebound

TO: _____ DATE: _____

_____

_____

_____

RE: _____ _____

Last Name First Name Middle D.O. B

_____

School attended in Atlanta Public Schools

To assist in the educational/health planning and placement of the student named above, you are hereby authorized to exchange health and education information/records for the purpose(s) listed below.

Description:

The health information to be disclosed consists of the following:

Information related to the medical or psychiatric condition of student necessitating hospital homebound instruction.

These records should be sent to: Atlanta Public Schools

Attn: Hospital Homebound Liaison

Fax: 404.802.1602

- This authorization expires as of the last day of this school year, including the summer/extended year session, if applicable.
- This information is requested to assist in determining eligibility for Hospital Homebound services and will not be released to any other source or used for any purpose other than the one stated above.
- I understand that effective, April 14, 2023, under the Health Insurance Portability and Accountability Act ("HIPPA"), disclosure of certain medical information is limited. However, I herein authorize disclosure of pertinent medical information for the provision of services for my child while in attendance in the Atlanta Public School District.
- I understand that I may revoke this authorization at any time by submitting a written notice of the withdrawal of my consent. I recognize that health records, once received by the local education agency (LEA), may no longer be protected by HIPAA, but they will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

_____ _____ _____

Parent/Guardian Signature Relationship to Student Date

ATLANTA PUBLIC SCHOOLS

Department of Student Services
Student Support Team/504 Team

Educational Service Plan (ESP)
(Must accompany the Referral for Homebound Services)
*Note: IEP will replace ESP for special ed students

Conference Date: _____ Conference Location:_____ Conference Call: Yes ☐ No ☐

Student: _____DOB:_____Grade:_____Student ID: _____

_____Full time HHB _____Intermittent HHB _____ Number of Days Absent

School Counselor: _____School Social Worker: _____

Parent/Guardian: _____Phone: Home_____Cell_____

Current Educational Program
Please attach a copy of the student's current schedule and most recent grade report (progress and/or report card).

Proposed Educational Plan
*The proposed educational plan must address plans for elective (specials) courses/subjects not covered under HHB. Additionally, if student is in Middles/High school and taking AP and/IB courses, a plan must be addressed if student is on long-term HHB. Please be sure to invite the counselor and graduation coach as schedule adjustments may be needed.

Instruction: Begin Date: _____End Date: _____Setting: Home_____Hospital: _____

Subject	Text/Materials and/or Assignments (indicate plan to retrieve work)	Direct Instruction	Online Hours	Hours Per Week

Plan for Elective Courses (and IB/AP courses, if applicable):

_____

_____

_____

_____

_____

_____

_____

_____

Medical considerations for instruction: _____

_____

School Re-entry Plan
For Hospital–Homebound Students

Anticipated date of return to school: _____

Strategies to facilitate the student's reentry to school:

_____

_____

_____

_____

_____

_____

_____

_____

_____
Parent/Guardian Signature Date

_____
MTSS/504 Contact Signature Date

_____
Principal or Designee Date

If the above-mentioned parent/guardian is not at home at the time of the scheduled instructional session, the following 21-year-old or older adult designee is authorized to monitor the session.

Adult Parent Designee: _____ Phone: _____

Department of Student Services
Student Support Team/504 Team

Homebound ESP Minutes (Gen Ed)
(Must accompany the Referral for Homebound Services)

Student _____ DOB _____ ID# _____

Address _____ Zip Code _____ Phone _____

School _____ Grade/Section _____ Homeroom _____

Medical Information

Diagnosis _____

What are the student's specific limitations/restrictions because of illness: _____

_____

_____

Because of this student's illness, he/she is unable to perform the following activities related to his/her instruction:

_____

_____

Accommodations

List the 504 accommodations explored that might enable the student to continue in his/her school environment:

_____

_____

_____

_____

Does this student have special instructional needs that must be addressed while he/she is homebound?

_____

_____

Length of Service

Approximately how long will the student need homebound instruction?

From _____ To _____ Physician's Name _____

Address _____ Phone _____

Was parent present at the SST/504 Meeting? _____

SST/504 Contact _____ Recorder _____