ATLANTA PUBLIC SCHOOLS

Department of Student Intervention & Support
Telephone: 404-802-2683 Fax: 404.802.1602

Referral for Hospital Homebound (HHB)

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

STUDENT INFORMATION – to be completed by principal/designee and parent

Student Name: _____ DOB: _____ Grade: _____ ID#: _____

Address: _____ Zip Code: _____ Phone: _____

School: _____ Homeroom Teacher: _____

Email Address: _____ Computer/Internet at Home: _____

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. Also, I am aware that AN ADULT OVER THE AGE OF 21 MUST BE PRESENT IN THE HOME DURING INSTRUCTIONAL SESSIONS. 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 Signature: _____ Date: _____

Student's Signature: _____ Date: _____

Principal's Signature: _____ Date: _____

SST/RTI Specialist Signature: _____ Date: _____

(Note: The school is responsible for providing assignments and grades to the student until the student is officially enrolled in the HHB program. HHB instruction will only occur after school hours.)

~ 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:	

ATLANTA PUBLIC SCHOOLS

Department of Student Intervention & Support
Telephone: 404-802-2630 or 2665 Fax: 404.802.1602

HHB MEDICAL EXAMINATION REPORT

Physician/Psychiatrist _____ Address _____ Phone _____

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

License#: _____ Email Address: _____

Student Information

Student's Name: _____ DOB: _____ Phone: _____
Address: _____ City, State: _____ ZIP: _____

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: ☐
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).*

Yes ☐ No ☐

- 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 home/hospital confinement?

Yes ☐ No ☐

- Could the student attend school with accommodations? If so, describe

Recommendations for Accommodations:

_____

_____

_____

_____

Yes ☐ No ☐

- Can 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, etc?

Yes ☐ No ☐

- Can tutoring or face-to-face instruction be provided to the student without endangering the health of the teacher?

(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 or licensed psychiatrist who is currently treating the student for the diagnosis presented.)*

Daily ☐ Weekly ☐ Monthly ☐

- What is the scheduled frequency of treatment/therapy for this student?

_____

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

Yes ☐ No ☐

- Will the student take medication?

Medications student will take for diagnosis:

Name of medication	Effects on student's ability to comprehend	Effects on student's ability to independently complete assignments	Effects on student's ability to relate to teachers and other students

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?

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

Physician Signature

Date:

GA License#

Phone:

Fax:

ATLANTA PUBLIC SCHOOLS

Department of Student Intervention & Support
Telephone: 404-802-2630 or 2665 Fax: 404.802.1602

HHB PARENT LETTER

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 physically cannot attend school for 10 days or more, to continue their learning process during their time away from school.

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 any 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) improve 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. A parent, guardian, or an approved adult parent designee as identified in the Educational Service Plan (ESP) shall be present during each homebound session.
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 temporarily.
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. 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.

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 or licensed psychiatrist upon the student's return to school.
9. 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.
10. A certified teacher is assigned to provide instruction in core subject's only afterschool hours.

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 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 procedures 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.

Student Name	School
Parent/Guardian Signature	Date

ATLANTA PUBLIC SCHOOLS

Department of Student Intervention & Support
Telephone: 404-802-2683

Homebound Services Minutes

Student Name: _____ DOB: _____ ID#: _____
Address: _____ Zip Code: _____ Phone: _____
School: _____ Grade: _____ Homeroom Teacher: _____

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

Why were all accommodations rejected? _____

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 Meeting? _____
SST Chairperson: _____ Recorder: _____

ATLANTA PUBLIC SCHOOLS

Department of Student Intervention & Support
Telephone: 404-802-2630 or 2665 Fax: 404.802.1602

Educational Service Plan

Conference Date: _____ Location: _____ Conference Call _____
Student: _____ DOB: _____ Grade: _____ ID# _____
School: _____ Grade: _____ Homeroom Teacher: _____

Initial ESP _____ Recurring ESP _____ Full time HHB _____ Intermittent _____

School Counselor: _____ School Social Worker: _____
Test Scores: Reading/LA: _____ Math: _____ # of Days Absent: _____
Parent/Guardian: _____ Home Phone: _____ Cell: _____
HHB Teacher: _____

Current Educational Program

Subject	Current Level	Recent Grade	Text/Materials & Adaptations/Comments	Regular Classroom Teacher Name

Proposed Educational Program

Instruction Begin Date: _____ End Date: _____ Setting: _____

Subject	Text/Materials and/or Assignments	Direct Instruction	Online Hours	Hours Per Week

Medical considerations for instruction: _____

Other accommodations: _____

Procedures for intermittent HHB services: _____

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: _____