



Student Support Services

Rachel Duke, LCSW Phone: 706-387-7391 Fax: 706-367-9768

Hospital/Homebound (HHB) Services Request Form

(Note: There may be a delay in processing incomplete applications.)

School: _____

Phone: _____ Fax: _____

Student Information

Student Name: _____

Student Number: _____ Grade: _____

Student Address: _____

Date of Birth: _____

Parent Information

Parent/Guardian: _____

Phone: (H) _____ (W) _____ (C) _____

Email Address: _____

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

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 is required to determine eligibility.
- 2) The Local Education Agency (LEA) HHB services personnel may contact the licensed physician to obtain 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 psychiatric condition(s) improve as documented by a licensed physician.
- 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 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) 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 services for a short period of time.
- 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. The LEA 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 upon the student's return to school.
- 9) To extend HHB services beyond the originally identified return to school date, the licensed physician must submit an updated medical referral request form.

Cause for Dismissal

- 1) If the licensed physician 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 policies 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.

Parent/Guardian Printed Name

Date

Parent/Guardian Signature

Date



Hospital Homebound Eligibility Policy

- 1) I understand that 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) I understand that local education agency (LEA) HHB services personnel may contact the licensed physician or licensed psychiatrist to obtain information needed to determine if my child will be eligible for HHB services and provide appropriate instructional delivery.
- 3) I understand that my child must be enrolled in a public school prior to the referral 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 is acute, catastrophic, chronic, or repeated intermittent.
- 5) I understand that I will be required to sign an agreement regarding HHB services policies and procedures.
- 6) I understand that if my child is eligible for HHB services, my child may be dismissed from the HHB program and may be required to return to school if his or her medical or psychological conditions improve as documented by a licensed physician or licensed psychiatrist.
- 7) 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.

Policies and Procedures

- 1) A parent, guardian, or an approved adult parent designee 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) 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 services for a short period of time.
- 6) A parent, guardian, emancipated minor, student 18 years of age or older, or an approved adult parent designee must notify the HHB teacher at least 24 hours in advance if an instructional session must be cancelled. The LEA 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.

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.

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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 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 HHB services for my child.

Parent/Guardian Printed Name

Date

Parent/Guardian Signature

Date



FERPA/HIPAA CONSENT
Student Support Services
Phone: 706-387-7390/7391/7392 Fax: 706-367-9768

**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN
HEALTHCARE PROVIDERS AND JACKSON COUNTY SCHOOL DISTRICT.**

Completion of this document allows the disclosure and/or use of individual identified education records and health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name:

Last	First	MI	Date of Birth
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I, the undersigned, do hereby authorize (name of agency and contact info and/or health care providers):

(1) _____

(2) _____

to provide health information from the above-named child's medical record to and from:

_____	_____
School District	Address

_____	_____
Contact Person at School District	Telephone Number

The disclosure of health information is required for the following purpose:

Description of Information to be Disclosed: I authorize the release and disclosure of any and all medical records, histories, reports, notes, diagnostic films or imaging, and all such other health information pertaining to _____, a minor, of whatever kind and character, and including but not limited to psychiatric, psychological or mental health records, from _____ to the date this release is presented for such records, to the persons/entities identified herein.

DURATION:

This authorization shall become effective immediately and shall remain in effect until for one year from the date of signature, unless sooner revoked by me in writing.

RESTRICTIONS:

Law prohibits the School District from making further or different disclosure of the health information contemplated by this Consent form unless another authorization form is obtained from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at anytime. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/health care agencies/persons listed above. My refusal will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization. I understand that any use or disclosure made prior to the effective revocation under this authorization will not be affected by a revocation.

RE-DISCLOSURE:

I understand that the Jackson County School District will not improperly disclose this information, as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that this information becomes part of the student's educational record upon being transmitted to a public school that receives federal funding. The information will be shared with individuals working at or with Jackson County Schools for the purpose of providing safe, appropriate, and least restrictive educational settings, school health services, or other academic or extracurricular programs.

I have a right to receive a copy of this Authorization. Signing the Authorization may be necessary in order for this student to obtain appropriate services in Jackson County Schools.

APPROVAL:

Printed Name

Signature

Date