Dear Parent:

Enclosed are the medical forms that will help determine the need for exemption from school and for the provision of Home/Hospital instruction for your child. Please complete the personal identifying information on the top of each form with a pen, writing or printing clearly. In order to process the application, you must sign where indicated. Then mail or take the forms to your child's doctor who must complete, sign and date the Section III – Professional Statement. The entire application, including the signed Professional Statement, must be returned to our office to determine eligibility before instruction can begin. Forms can either be emailed to jackie.ayers@jefferson.kyschools.us or teresa.devenuto@jefferson.kyschools.us, mailed to the address below, or dropped off at the front desk at the VanHoose Education Center.

Requests for school exemptions based on medical reasons must have their application completed by a properly licensed physician, advanced practice registered nurse, or physician's assistant responsible for diagnosing and treating the child. Requests for school exemptions based on mental health reasons must be completed by the licensed physician, psychiatrist, psychologist, physician's assistant, or an advanced practice registered nurse certified in psychiatric-mental health nursing who is treating your child.

Based upon a review of the medical information your doctor provides on this form, it will be determined if your child is eligible for school exemption and if Home/Hospital instruction is appropriate. The final decision for Home/Hospital eligibility rests with the Home/Hospital Committee or Admission and Release Committee, (ARC), not with the physician. However, if your request is denied, we will send you a letter telling you why. Students will only be eligible if it is anticipated that they will miss at least five (5) consecutive days of school. Students who have chronic illnesses can be approved for Intermittent Home/Hospital instruction but must still miss the required five (5) consecutive days each time Home/Hospital is activated. If you know your child will be missing at least five (5) consecutive school days due to a planned surgery or delivery of an infant, you may complete the application prior to the date that services will need to begin. Since the student cannot receive attendance with the Home/Hospital program until the teacher's first visit, attendance for the program cannot be backdated.

If approved via Committee or ARC, we will coordinate with your student's school and teacher. The Home Hospital teacher for your student will call you to schedule a time to work with your child. An adult MUST be present the entire time the teacher is in your home. For school-age children, the teacher will come to work with your child for two (2) one-hour sessions a week, scheduled on different days, which is considered by the state to be equivalent to one full week of student attendance. For preschool children, the teacher will come to work with your child for one (1) one-hour session per week.

If home instruction continues longer than six months, a second application must be submitted and signed by a DIFFERENT licensed professional to verify the continued need for school exemption. Students who have a chronic illness may be approved for Intermittent Home/Hospital instruction for up to one (1) year, provided they attend school the majority of the time and only activate Home/Hospital on an as-needed basis. There must be a review of all documentation for each student exempted from school attendance more than six months. A plan and a timeline should be developed for returning the student to school or else documentation must be maintained to verify why that is not feasible. Any student requesting continuation of home instruction from one school year to the next must submit a new application each year BEFORE instruction can begin.

A student cannot receive attendance until their first visit from a teacher. For general education students, until the first visit, it is the parent's responsibility to request make-up work from the classroom teachers/counselor for all days missed. Make-up work should be returned to the classroom teachers/counselor for grading. For ECE students, the Home Hospital teacher and the teacher of record will collaborate to ensure continuity of curriculum.

Any student identified as having a disability who receives Exceptional Child Education services may have an Admissions and Release Committee meeting to review the IEP and to modify the goals and objectives, if necessary. The meeting summary should also note a change in placement to home instruction. Someone from the Home Instruction office must participate in this meeting.

Kentucky regulations state, "Eligibility for home/hospital instruction shall cease if the student works or participates in athletic activities". The state has interpreted this to mean both school and privately sponsored activities. In addition, if a student accumulates four (4) or more absences while receiving Home/Hospital instruction, they may lose their eligibility and be withdrawn from the program. Doctor appointments, as well as other scheduled appointments, are not considered excused absences from Home/Hospital instruction. Nothing in this letter replaces or substitutes any student rights as guaranteed by the Individuals with Disabilities Education Act (IDEA), Section 504, or state law.

If you have any questions this letter has not answered, please contact the Home/Hospital office at (502) 485-6054. Thank you for your cooperation and your interest in the Home/Hospital program.

Sincerely,

Teresa DeVenuto
Home/Hospital Program
Jefferson County Public Schools
PO Box 34020
Louisville, KY 40232-9987
Phone: (502) 485-6054
Fax: (502)485-6054
teresa.devenuto@jefferson.kyschools.us

Application for Home/Hospital Instruction
(Please type or print neatly)

Section I
To be completed by the parent(s)/guardian(s) prior to full completion by the authorized health professional.

School District_____ School_____ Last Date Attended_____

Name of Student_____ Date of Birth_____ Grade_____

Home Address_____ City_____ State_____ Zip_____

Home Telephone_____ Emergency Telephone_____ County of Residence_____

Sex_____ Race_____ Social Security #_____ Special Education Student _____Yes _____No

List any Special Education programs in which your son or daughter may be enrolled: _____

Full Name of Father/Guardian_____ Work/Cell Phone_____

Full Name of Mother/Guardian_____ Work/Cell Phone_____

Pursuant to KRS 158.033(4), eligibility for home or hospital instruction for students with disabilities shall be determined by the Admissions and Release Committee (ARC) and shall be provided pursuant to the Individualized Education Program (IEP). The ARC chairperson shall provide written notice of home/hospital placement to the local Director of Pupil Personnel (DPP) for purposes of program enrollment using the form in section IV of this application. 702 KAR 7:150. Pursuant to KRS 159.030(2), before granting any student an exemption from compulsory attendance, the board of education of the district in which the student resides shall require submission to the board of satisfactory evidence in the form of a signed statement of a properly licensed physician, advanced practice registered nurse, physician's assistant, psychologist, or psychiatrist responsible for diagnosing and treating the child, stating that the diagnosed condition of the child prevents or renders inadvisable attendance at school and requires home or hospital instruction. If the condition is mental health related, then the signed statement shall be completed by a licensed physician, psychiatrist, psychologist, or physician's assistant described in KRS 202A.011 or an advanced practice registered nurse defined in KRS 314.011 and certified in psychiatric-mental health nursing. On the basis of such evidence, the local board of education may exempt the student from compulsory attendance. A student with a recurring condition, which results in periods in which the need for home or hospital instruction is intermittent and the student is able to attend school for short periods, may be exited and reentered on home or hospital instruction, and the following shall apply: (a) Initial approval by the Review Committee shall be required; (b) The Review Committee shall review the need for an alternative schedule of services based on verification by the professional statement in the application for home or hospital instruction of the need for intermittent services; (c) If a health professional who completed the initial application for a student to be served on home or hospital determines the student needs additional time for services, the health professional shall submit a written statement, either mailed or faxed, to the Director of Pupil Personnel, requesting additional time up to two (2) weeks for services and provide a brief explanation for the extension; (d) The Review Committee shall meet to review this extension and either approve or deny the request for an extension, prior to provision of any extended services; (e) The Review Committee shall review intermittent placement at least every six (6) months, and at that time a statement from a second professional, shall be required by the Review Committee for continued program eligibility; and (f) The parent or guardian shall notify the principal or Director of Pupil Personnel prior to the need for school reentry or to exit to home or hospital instruction. Pregnancy is not considered a physical or health impairment in and of itself, and the nature and extent of any complication shall be delineated prior to consideration of home or hospital instruction for this condition. 702 KAR 7:150. For students receiving home or hospital instruction pursuant to a determination by a Home or Hospital Review Committee, eligibility shall cease if the student works, plays sports or participates in extracurricular activities. 702 KAR 7:150.

RELEASE OF INFORMATION

I understand that if the Home/Hospital Review Committee makes the determination of placement for this student, they 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. I understand that if the Admissions and Release Committee makes the determination of placement for this student, they will have access to all pertinent information regarding this request.

_____ _____
Parent/Guardian Signature Date

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

Date Application Received_____ Approved_____ Denied_____ Incomplete_____

If approved, date of services will be from_____ until_____

If eligibility for services is 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_____

Program Director _____Date_____

Home/Hospital Teacher _____Date_____

Medical or Mental
Health Personnel _____Title_____Date_____

Other Relevant Professional_____Title_____Date_____

Comments: _____
_____
_____

Professional Statement

**Eligibility for home/hospital instruction for students with disabilities shall be determined by the Admissions and Release Committee (ARC) in accordance with their Individual Education Program (IEP). The ARC chair shall provide written notice of eligibility to the local Director of Pupil Personnel (DPP) for purposes of program enrollment. The form provided in Section IV shall be used to provide this notice. **

Section II

This section is to be filled out by a properly licensed physician, advanced practice registered nurse, physician's assistant, psychologist, or psychiatrist responsible for diagnosing and treating the student. If the condition is mental health related, then the signed statement shall be completed by a licensed physician, psychiatrist, psychologist, or physician's assistant described in KRS 202A.011 or an advanced practice registered nurse defined in KRS 314.011 and certified in psychiatric-mental health nursing. In order for a district board of education to exempt a student from compulsory attendance, the student must provide satisfactory evidence in the form of a signed statement from a qualified healthcare professional that the diagnosed condition of the student prevents or renders inadvisable attendance at school and requires home or hospital instruction.

Name of Student_____

_____I do/_____I 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: _____

_____

_____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 Section II.**

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 _____

Recommended start date of 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? _____

_____

Start date of hospital admission, if applicable: _____

_____

Check here if this student has a chronic physical condition that is unlikely to substantially improve within one year. _____
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_____Telephone # _____ Address_____
Anticipated date of student's return to school _____
What are your recommendations to assist this student in their return to school? _____

_____

Remarks/Comments: _____

_____

_____ _____ _____
Signature of Licensed Professional Title Date

Please Print or Type Name of Professional: _____

Office Address_____ Phone Number _____ Fax Number _____