Hospital/Homebound Application Process

Step 1: Licensed physician or psychiatrist indicates a medical need for HHB services (10+ consecutive absences or intermittent) and completes medical portion of the HHB application which is located at:

www.paulding.k12.ga.us

- Parent Dashboard
- Find it Fast: Nurse/Homebound
- Medical Information Forms: Homebound Form

Step 2: Physician's Office sends completed application to the local school including the transitional plan for student's return to school.

Step 3: Local school completes the application with required signatures:

- Principal's Signature
- Parent's Signature
- Counselor's Signature

Step 4: Counselor sends completed application to:

Dr. Vladimir Labossiere
Director of New Hope Education Center
Email: vlabossiere@paulding.k12.ga.us

Step 5: Application is reviewed for approval.

NOTES: Hospital Homebound (HHB) services are not intended to supplant regular school services and are by design temporary services.

- Verification that the student remains under the physician's care and continues to qualify for HHB services must be provided every nine weeks.
- Social/Emotional Conditions – A Licensed Psychiatrist is required.
- Students receive three hours per week of HHB instruction.
- HHB students may not be employed, participate in extracurricular activities or travel in any capacity for reasons beyond medical services.

Paulding School District
Hospital/Homebound Application

I. Student Information (Please Print)

Provide all requested information; incomplete applications may experience processing delays.

Student's Name:_____ DOB:_____ Student ID#_____ Special Ed_____ Yes/No

Address: _____

Parent/Guardian:_____ Home Phone: _____ Alternate Phone:_____

School:_____ Grade: _____ Homeroom Teacher: _____

Principal Signature_____ Counselor Signature_____

Schools are responsible for providing assignments and grades to the student until the student is officially approved for HHB Services.

Do you have a computer? Yes ( ) No ( ) Do you have an internet connection? Yes ( ) No ( )

Student E-mail address:_____ Parent e mail address: _____

II. Eligibility Policies

1. I understand that eligibility is based upon Georgia Statues, State Board Rule 160-4-2-.31 and the medical referral form completed by the attending licensed physician or licensed psychiatrist is part of the information used to determine eligibility.
2. I understand that Paulding School District Hospital/Homebound personnel may contact the attending licensed physician or licensed psychiatrist to obtain information to determine eligibility for HHB services.
3. I understand that my child must be enrolled in a public school prior to the referral for HHB services.
4. I understand that HHB Instructional Services are for students confined to their home or hospital due to an acute, catastrophic, chronic, or repeated intermittent medical or psychological condition.
5. I understand that I will be required to sign an agreement regarding HHB policies and procedures.
6. I understand improvement of the medical or psychological condition(s) for which HHB services were approved may result in the student's dismissal from the program and his/her returning to school.
7. I understand that if my child is eligible for HHB services, he/she is subject to the same mandatory attendance requirements as students in a regular instructional setting.

III. Policies and Procedures

1. A parent/guardian or a designee of the parent/guardian at least 21 years of age as defined in the Educational Service Plan (ESP) must be present in the home for the entire HHB instructional period.
2. A table or a desk in a well-ventilated, smoke-free, clean and quiet (i.e. free of radio, TV, pets and visitors) workspace must be provided.
3. A schedule for student study time between teacher visits must be established and the student well-prepared for each instructional period.
4. Instructional materials must be obtained from the school, assignments completed and submitted on time.
5. Assignments will be returned to the regular school teacher for grading.
6. A parent/guardian or a designee of the parent/guardian at least 21 years of age as defined in the Educational Service Plan (ESP) must notify the HHB instructor 24 hours in advance if an instructional session must be canceled. The local school system may, at its discretion, reschedule an instructional session.
7. The parent/guardian must submit a release form from the attending licensed physician or licensed psychiatrist for the student's return to school.
8. To extend HHB services beyond the initial return-to-school date, the attending licensed physician or licensed psychiatrist must submit an updated medical referral form.

Return all pages of Application and additional documentation to:

Dr. Vladimir Labossiere
Director of New Hope Education Center
4555 Dallas Acworth Highway
Dallas, GA 30132
Phone: 770-445-2656 Fax: 770-443-7006

Hospital/Homebound Application

IV. Cause for Dismissal

1. The student will be removed from HHB Services if the attending licensed physician or licensed psychiatrist determines that the student is able to attend school, or is not able to participate or benefit from HHB Services.
2. The student will be removed from HHB Services if employed in any capacity, travels for reasons other than medical, regularly participates in extracurricular activities, or is no longer confined at home.
3. The student will be removed from HHB Services if the parent/guardian or a designee of the parent/guardian at least 21 years of age as defined in the Educational Service Plan (ESP) cancels two sessions without appropriate notice.
4. The student will be removed from HHB Services if the conditions or the location of the workspace provided for HHB services are not conducive for instruction, or threatens the health and welfare of the HHB instructor.

V. Parent/Guardian Agreement – Release of Information

I have read the Hospital/Homebound policies for program eligibility and understand the reasons for possible dismissal from the program. I agree to the policies and requirements of the program and request Hospital/Homebound services for my child. I hereby give permission for the attending licensed physician or licensed psychiatrist to communicate information regarding my child's medical/emotional condition for which he/she is referred to HHB personnel.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Name: _____
(Please print)

VI: Physician Statement/Medical Referral Form—Please attach.

(Please see pages 3 and 4.)

VII. Paulding School District Hospital-Homebound Approval

After reviewing the above information and eligibility criteria, _____
(Student Applicant's Name)

(_____) ***is approved*** (_____) ***is not approved*** for HHB Instruction.

HHB Personnel Signature: _____ **Date:** _____

HHB Instructor Assigned: _____ **Phone:** _____

Educational Service Plan Meeting: _____ **Location:** _____
(Date) *(School)* *(Room #)*

Please call your assigned instructor to confirm your attendance.

Decision Appeals: *Submit a written statement appealing a denial for HHB Services to Paulding School District; Attn: Hospital-Homebound Services; 3236 Atlanta Highway, Dallas, GA 30132.*

Paulding School District

Hospital/Homebound Application

VI. Licensed Physician/Psychiatrist Statement and Medical Referral Form

(Must be completed by a physician/psychiatrist licensed by the State of Georgia)

Student's Name_____ Date of Birth_____

Print Physician/Psychiatrist's Name_____ GA License #_____

Address_____ Phone Number_____

Section A. Physician/Psychiatrist Statement and Diagnosis

Patient's Diagnosis (Include a description of the condition) _____

_____

_____

Estimated Duration of Hospital/Homebound Services: Starting Date_____ Ending Date_____ Number of Weeks_____

Date of initial evaluation_____ Date of next scheduled appointment _____

Physician's Statement: 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 10 consecutive school days? Yes____ No ____
- Will the student benefit from an instructional program during this time of confinement? Yes____ No ____

Recommendations for accommodations: _____

- Is the student confined to home or hospital and full time HHB services recommended? Yes_____ No _____
- Could the student attend school regularly and receive HHB services on an intermittent basis, as needed? Yes_____ No _____
- Is the student free from communicable disease? Yes_____ No _____
- Can instruction be provided to the student without endangering the health of the instructor or other students with whom the instructor may be in contact? Yes_____ No _____

NOTE: Verification that the student remains under your care and continues to qualify for the HHB services may be requested periodically.

Section B. Treatment and School Re-Entry Plan

The following information is required to determine eligibility for Hospital/Homebound service and must be completed by the licensed physician or licensed psychiatrist who is currently treating the student for the diagnosis in Section A.

- What is the 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 _____

Please complete the following information for each medication prescribed for the student:

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

Paulding School District
Hospital/Homebound Application

Section B. Treatment and School Re-Entry Plan (Continued)

• Could this student return to school on an intermittent basis after his/her medication and/or condition is stabilized? Yes_____No _____

• Can this student come into contact with other students? Yes_____No _____

The Hospital/Homebound program is designed to be a temporary program to help students who are unable to attend school due to medical or psychiatric reasons. Please describe a transitional plan complete with dates for the student's re-entry 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 is based on the medical needs of the patient, keeping in mind that the least restrictive environment is preferred.*

Physician's Signature: _____ **Date:** _____

Physician's Name: _____

(Please print)