



# Muscogee County School District Hospital/Homebound Application

Hospital/Homebound Services are provided in compliance with Georgia Board of Education Reg. 106-4-2-.31 and related Georgia Department of Education guidelines

## I. Student Information

Please provide all requested information and return the completed application to MCSD Student Services Department. The application process is not finalized until the Director of Student Services receives all parts of the application and signs the application. The school is responsible for providing assignments and grades to the student until the student is officially enrolled in the Hospital/Homebound Services.

Student Name \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_

DOB \_\_\_\_\_ Parent/Guardian \_\_\_\_\_  
Last First MI

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Does student receive special education services YES NO If yes, what eligibility? \_\_\_\_\_ Related Services? \_\_\_\_\_

Is the student presently served by an Individual Health Care Plan? YES NO Does the student presently receive 504 accommodations YES NO

Current School \_\_\_\_\_ Grade \_\_\_\_\_ Does the student have access to a computer? YES NO Internet Connection? YES NO

Parent Email Address \_\_\_\_\_

## II. Eligibility Policies

1. I understand that eligibility is based on Georgia State Board of Education Rule 160-4-2-.31 Hospital/Homebound Service, and that the Medical Referral Form is part of the information used to determine eligibility.
2. I understand that the Medical Referral Form must be signed by a Georgia Board Certified licensed physician (if the medical condition is physical in nature) or psychiatrist (if the medical condition is psychiatric/emotional in nature), a nurse practitioner, or physician assistant who works under the supervision of a Georgia Board Certified licensed physician or psychiatrist.
3. I understand that only a psychiatrist can submit a Medical Referral Form for an emotional or psychiatric disorder.
4. I understand that local school system school personnel and/or Hospital/Homebound personnel may contact the licensed physician, licensed psychiatrist, nurse practitioner, or physician assistant to obtain information needed to determine if my child will be eligible for Hospital/Homebound services and provide appropriate instructional delivery.
5. **I understand that I must complete Online Registration for my child to be enrolled in a Muscogee County Public School prior to the request for Hospital/Homebound Services.**
6. I understand that the Hospital/Homebound Services are for students confined to the home or hospital due to that student's medical or psychological condition which is acute, catastrophic, and/or chronic for temporary, long-term or intermittent periods of time.
7. I understand that I will be required to sign an agreement regarding Hospital/Homebound policies and procedures.
8. I understand that the student must be anticipated to be absent for a minimum of 10 consecutive school days per year or equivalent on a modified calendar or the student has a chronic health condition causing him or her to be absent for intermittent periods of time anticipated at a minimum of 10 school days per year or the equivalent on a modified calendar.
9. I understand that a student with a chronic health condition who is eligible for intermittent Hospital/Homebound service must be anticipated to be absent for at least three consecutive school days for each occurrence to be eligible for a Hospital/Homebound visit.
10. I understand that if my child is eligible for Hospital/Homebound services, he/she is typically subject to mandatory attendance requirements.
11. I understand that if I cancel a HHB in-person or on-line instruction, I must submit a written excuse note to the main education building, Student Services.
12. I understand that I must provide a signed Medical Referral Form. Incomplete forms will not be accepted.
13. I understand that the commencement date of Hospital/Homebound services is the date the Director completes Section VI below and any school days missed before that will be excused upon receipt of a note from the Physician/Psychiatrist who signs the Request Form and I will have to get assignments from the Assigned School Homebound Liaison until the commencement date of services.

## III. Policies and Procedures (Georgia State Board of Education Rule 160-4-2-.31)



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Student Name: \_\_\_\_\_

1. A parent, guardian, or an approved adult parent designee as defined in the Educational Service Plan (ESP) shall be present during each entire home visit 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. The parent/guardian and student will schedule study time between teacher visits, and the student will be prepared for each home visit. It is the student and parent's responsibility to stay current with assignments. Students who regularly fail to complete assignments in a timely manner may be referred back to the local school for reconsideration of HHB eligibility.
4. Instructional materials must be obtained from the school and assignments completed and submitted on time.
5. Assignments will be returned to the teacher of record for grading.
6. If a student is receiving in-person visits, a parent, guardian, or an approved adult parent designee as defined in the Educational Service Plan (ESP) must notify the Hospital/Homebound teacher 24 hours in advance if an instructional session must be canceled.
7. The Hospital/Homebound teacher will notify the parent, guardian, or approved adult parent designee to cancel a session and the session will be rescheduled.
8. The parent/guardian must submit a release form from the licensed physician, licensed psychiatrist, nurse practitioner, or physician assistant if the student's return to school is prior to the date indicated on the Medical Referral Form.
9. To extend Hospital/Homebound services beyond the originally identified return to school date, the licensed physician, licensed psychiatrist, nurse practitioner, or physician assistant must submit the request for the extension in writing by the last day of the original end date.

#### IV. Cause for Dismissal

A student is released from the Hospital/Homebound Services:

1. as of the projected return date listed on the Hospital/Homebound application Section VIII, **Medical Referral Form**, Part A, *Physician/Psychiatrist Statement and Diagnosis*;
2. when the licensed physician, licensed psychiatrist, nurse practitioner, or physician assistant recommends that the student is able to attend school or can no longer participate or benefit from Hospital/Homebound services;
3. when the student is employed in any capacity, regularly participates in extracurricular activities, or is no longer confined at home;
4. when the parent, guardian or adult parent designee cancels two sessions without the appropriate notice;
5. when the conditions of the location where Hospital/Homebound Services are provided are not conducive for instruction or threaten the health and welfare of the Hospital/Homebound teacher;
6. when the student returns to school or is able to return to school for any portion of the school day other than to participate in state-mandated standardized testing; and/or
7. As of the last day of school of the regular school year.

#### V. Parent/Guardian Agreement/Release for Medical Information

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

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

#### VI. Student Services Signature

\_\_\_\_ Student Information Received Signed and Appropriately Marked

\_\_\_\_ Student is eligible for HHB

\_\_\_\_ Records Release Form Received Signed and Appropriately Marked

\_\_\_\_ Student is eligible for HHB Online Instruction

\_\_\_\_ Medical Referral Form Received Signed and Appropriately Marked

\_\_\_\_ Student is not eligible for HHB

\_\_\_\_\_  
Director of Student Services Signature

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Scott.Kevin.C@muscogee.k12.ga.us

\_\_\_\_\_  
(706) 748-3217  
Phone Number



## Muscogee County School District Hospital/Homebound Application

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Student Name: \_\_\_\_\_

### VII. Letter to Physician

Dear Physician/Psychiatrist,

The parent of the student listed on the adjoining Hospital/Homebound application has requested services from the Muscogee County School District Hospital/Homebound Service. The Muscogee County School District sends this letter to ensure that the medical community understands the educational implications of serving students through the Hospital/Homebound Services.

The Georgia State Board of Education established Hospital/Homebound services for students who are able to participate in educational instruction but who are medically unable to participate in the school environment. The State Board rule (160-4-2-.31) requires only three hours of instruction per week for students enrolled in the Hospital/ Homebound Services. The School District provides instruction through the traditional method of the Hospital/Homebound instructor taking classwork to the student, reviews the materials and instructional content with the student, and takes the completed work back to the school or through an assigned Hospital/Homebound on-line teacher of record.

In keeping with relevant state laws, all students, including those receiving Hospital/Homebound Services, are required to participate in standardized tests associated with particular grade levels, classes, or subject areas. In many cases, the students must pass the standardized tests to be promoted to the next grade or to be eligible for graduation. Further, students seeking a high school diploma are required to earn a significant number of credits in specific courses. The limited Hospital/Homebound Services cannot substitute for the comprehensive nature of academic studies that the student would receive in school.

Accordingly, in the Muscogee County School District, we generally find that such services are appropriate only for those students whose condition is such that attending school is detrimental to that student's health or well-being. For students receiving Hospital/Homebound services, the School District requests information from the authorizing physician information that will allow the School District to develop a plan to transition the student back to the school setting as quickly as possible.

Once you have fully completed the following two page Medical Referral Form, please return it to the parent. The parent has the responsibility to return the completed form to the Director of Student Services at the Muscogee County School District offices.

I appreciate your time and consideration of this information. The Muscogee County School District looks forward to working with you in the best interests of our students.

Sincerely,

*Mr. Kevin C. Scott*

Mr. Kevin C. Scott  
Director of Student Services  
Hospital Homebound  
706.748.3217



# Muscogee County School District Hospital/Homebound Application

Student Name: \_\_\_\_\_

### VIII. Medical Referral Form

**Must be legibly completed by a licensed physician, licensed psychiatrist, nurse practitioner, or physician assistant**

Print Physician's/Psychiatrist's Name \_\_\_\_\_ GA License # \_\_\_\_\_

Print Nurse Practitioner or Physician Assistant's Name (if applicable) \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

### Part A. Physician/Psychiatrist Statement and Diagnosis

Patient's Diagnosis/Prognosis (Include a description of the condition) \_\_\_\_\_  
\_\_\_\_\_

Date student will be medically able to return to school this current school year (provide a specific date) \_\_\_\_\_  
Month, Date, Year

If the medical condition extends into next school year, a new application must be submitted.

Date of initial evaluation \_\_\_\_\_ Date of next scheduled appointment \_\_\_\_\_

#### Physician's Statement: Please answer the following questions.

- Is the student unable to attend school for a minimum of 10 consecutive school days on a traditional schedule? Yes \_\_\_\_\_ No \_\_\_\_\_
- Will the student be able to benefit from an instructional services during this time of confinement? Yes \_\_\_\_\_ No \_\_\_\_\_
- Is the student confined to home or hospital and full time Hospital/Homebound services are recommended? Yes \_\_\_\_\_ No \_\_\_\_\_
- Is the student free from communicable disease? Yes \_\_\_\_\_ No \_\_\_\_\_
- Can instruction be provided to the student without endangering the health or safety of the instructor or other students whom the instructor may contact? Yes \_\_\_\_\_ No \_\_\_\_\_

I have read and understand the information concerning the Muscogee County School District Hospital/Homebound Services as provided in Section VII, Letter to the Physician (physician initial) \_\_\_\_\_.

**NOTE: You may periodically be asked to verify that the student remains under your care and continues to qualify for the Hospital/Homebound Services. This verification is important and can impact the student's eligibility.**

### Part B. Treatment and School Re-entry Plan

*The following information is required to determine eligibility for Hospital/Homebound Services and must be completed by the licensed physician, licensed psychiatrist, nurse practitioner, or physician assistant who is currently treating the student for the diagnosis presented.*

- Will the student take medication? Yes \_\_\_\_\_ No \_\_\_\_\_
- Please complete the following information for each medication that the student will take (attach additional pages if necessary)

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



## Muscogee County School District Hospital/Homebound Application

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Student Name: \_\_\_\_\_

### Treatment and Re-entry Plan

- Could this student return to school after his or her medication and condition are stabilized?
Yes \_\_\_ No \_\_\_
- Can this student come into contact with other students?
Yes \_\_\_ No \_\_\_

The Hospital/Homebound Service is designed to be a *temporary educational service* to help children who are unable to attend school for medical or psychiatric reasons. Please describe the expected time frame of the student's need for Hospital/Homebound services and include any information the school district and/or the Hospital/Homebound teacher needs to know: (Attach additional sheets as needed)

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**Physician/Psychiatrist 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.

\_\_\_\_\_  
Physician/Psychiatrist Signature

\_\_\_\_\_  
Date