



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. Please ask your doctor to complete them quickly and to fax them to (502) 485-6317, then mail the original to the address listed below.

Requests for school exemptions based on medical reasons must be completed by your child's licensed physician. Requests for school exemptions based on mental health reasons must be completed by the licensed psychologist or psychiatrist 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, 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 be enrolled in the Home/Hospital program until the teacher's first visit, enrollment for the program cannot be backdated.

If your request is approved we will contact your child's school so that a teacher can be assigned. The teacher 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 is not enrolled in the Home/Hospital program until their first visit from a teacher. 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.

Any student identified as having a disability who receives Exceptional Child Education services must 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.

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,

Tonya Groves  
Home/Hospital Program  
Jefferson County Public Schools  
PO Box 34020  
Louisville, KY 40232-9987  
(502) 485-6054 phone  
(502) 485-6317 fax

**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 159.030, Section (2), before granting an exemption under paragraph (d) of subsection (1) of this section, the board of education shall require satisfactory evidence, in the form of a signed statement of a licensed physician, advanced registered nurse practitioner, psychologist, psychiatrist, chiropractor or public health officer, that the condition of the child prevents or renders inadvisable attendance at school or application to study. On the basis of such evidence the board may exempt the child from compulsory attendance. 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). In lieu of this application, the ARC chairperson shall provide written notice of this eligibility to the local Director of Pupil Personnel (DPP) for purposes of program enrollment. Any child who is excused from school attendance more than six (6) months must have two (2) signed statements from two different local health personnel which can be a combination of the following professional persons: A licensed physician, advanced registered nurse practitioner, psychologist, psychiatrist, chiropractor and health officer. If a medical professional certifies that a student has a chronic physical condition unlikely to substantially improve within one (1) year, then the one signed statement is sufficient for services that extend beyond six (6) months. This exemption does not apply to students with mental health conditions. Exemptions of all children under the provisions of subsection (1)(d) of this section must be reviewed annually with the evidence required being updated, except that children with disabilities certified by a medical professional to have a chronic physical condition unlikely to substantially improve within three (3) years may continue to be eligible for home/hospital instruction services, based on the admissions and release committee's (ARC) annual review of documentation to determine if updated evidence is required. Updated documentation of evidence of need for home/hospital services for children with chronic physical condition shall be provided as requested by the ARC, or at least every three (3) years. Pursuant to 704 KAR 7:120, the condition of pregnancy is not to be 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/hospital instruction for this condition.

**RELEASE OF INFORMATION**

I understand that the Home/Hospital Review Committee 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.

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

**Section II**

**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 \_\_\_\_\_

Home/Hospital Program Director \_\_\_\_\_ Date \_\_\_\_\_

Local Health Personnel \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Comments \_\_\_\_\_

**Professional Statement**

**Section III**

**This section is to be completed by the authorized and appropriate health professional.**

It shall be determined that a child or youth is to be provided home/hospital instruction if the condition of the child or youth prevents or renders inadvisable attendance at school as verified by a signed professional statement in accordance with KRS 159.030 (2) and 704 KAR 7:120. **Please Note: Home Instruction (homebound) is short-term instruction provided in a home or other designated site for a student who is temporarily unable to attend school. According to state guidelines, two hours of home instruction each week is equivalent to one full week of school attendance. Home instruction is not designed to take the place of a more appropriate school placement.**

1. Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

2. Please check one of the following:

\_\_\_\_\_ The student can attend school without any type of modifications or special provisions. (If checked, please skip to #3)

\_\_\_\_\_ The student can attend school only with modifications or special provisions. (If checked, please skip to #3)

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 skip to #4)

3. \_\_\_\_\_ 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 \_\_\_\_\_

4. \_\_\_\_\_ I do support home/hospital instruction for this student. **If you do support home/hospital instruction at this time, please complete all of the following information:**

Diagnosis \_\_\_\_\_ DSMV Code \_\_\_\_\_ Prognosis: Good \_\_\_ Fair \_\_\_ Poor \_\_\_

Specific reason(s) the student is unable to attend school at this time: \_\_\_\_\_

Approximate length of time student will need Home/Hospital instruction \_\_\_\_\_

How long have you been seeing the student for the diagnosis listed? \_\_\_\_\_

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 student? \_\_\_\_\_

Expected duration of treatment/date of delivery \_\_\_\_\_ **OR** \_\_\_\_\_ Check here if the student has a chronic physical condition that is unlikely to substantially improve within one (1) year.

List consultants/specialists to whom this student has been referred

Name	Specialty	Phone
_____	_____	_____
_____	_____	_____

Will you be following the patient? \_\_\_ Yes \_\_\_ No- If not, please list who will be following the patient below:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Anticipated date of student's return to school \_\_\_\_\_

What are your recommendations to assist this student in his/her return to school? \_\_\_\_\_

Signature of Licensed Professional \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Please print the name of the professional: \_\_\_\_\_

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

\_\_\_\_\_ Fax Number \_\_\_\_\_