Worth County Schools

Hospital/Homebound Services Guidelines

Hospital/Homebound (HHB) Services Guidelines

Table of Contents

Forms

Overview of Services

The Worth County School System provides continual educational services to students who are unable to attend school due to a physical or psychiatric medical need for a minimum of 10 consecutive days or intermittent periods of time for a minimum of 10 school days per year. The student's inability to attend school for medical or psychiatric reasons must be certified by a licensed physician or licensed psychiatrist. These services may be provided at home or in the hospital.

Student Eligibility

Eligibility for Hospital/Homebound (HHB) service is based on the following criteria:

1. The student must be enrolled in the Worth County School System in order to request this service. Private or home school students are **NOT** eligible for HHB services from a Georgia public school.

2. The student must have a medical and/or psychiatric condition that is documented by a physician licensed by the State of Georgia. Only a psychiatrist can submit a medical request form for an emotional or psychiatric disorder. The psychiatric condition presented must be listed in the latest edition of the *Diagnostic and Statistical Manual* (DSM). The referring licensed physician and/or licensed psychiatrist must be the treating physician or psychiatrist for the medical and/or psychiatric condition for which the student is requesting HHB services. Examples include the following:
    - A student with leukemia may not request HHB services with a medical statement from a pediatrician. A statement from the oncologist currently treating the student is required.
    - A student with paranoid delusions may not request HHB services with a medical statement from a psychologist or pediatrician. The medical request must be from the licensed psychiatrist currently treating the student.

3. The physician or psychiatrist must anticipate that the student will be absent from school for a minimum of ten consecutive school days or for intermittent periods of time anticipated to exceed ten school days during the school year.

4. If the school is on an approved block schedule, then the ten day minimum requirement is reduced to five consecutive or five intermittent days during the school year.

5. Students who have any form of influenza or other airborne contagious diseases will not be provided services until the licensed physician certifies that the student is no longer infectious.

6. Students approved for intermittent HHB services must be absent for three consecutive school days on each occurrence before HHB services will be provided.

Application Process

The Worth County School System will work with the parents and licensed physician to provide a clear application process. The school counselor is the initial contact for parents/guardians to provide information regarding policies, procedures, and the application process.

Parent/Guardian Responsibilities

1. Contact the student's school counselor to discuss HHB services and to obtain the HHB application.
2. Carefully read, complete, and sign the document to verify understanding of HHB policies and procedures.
3. Have the licensed physician/psychiatrist treating the student for the diagnosis presented complete all required sections and return the completed HHB application to the school counselor. An incomplete application may cause a delay in services. Only the original paperwork will be accepted as application for hospital/homebound services.
4. Parents/guardians of students who are hospitalized must follow the application process in order for Worth County Schools to provide HHB services in the hospital setting.

School Counselor Responsibilities

After receiving the completed HHB application:

1. Review the application to ensure that the student meets the minimal eligibility requirements. (Make sure it has a beginning and ending date.)
2. Approve or deny services based on the submitted information. Forward the completed HHB application to the principal to be reviewed and signed. **Note:** The application is not considered finalized until the principal has signed the application.
3. Notify the parent/guardian of approval or denial of services within three days of receiving the completed HHB application.

Directions for Approved Applications

1. Fax completed applications to the HHB Coordinator at WCBE (Fax Number: 229-776-8603). **Send an e-mail to the HHB Coordinator before faxing the application.** A HHB teacher will be assigned to the student to begin services when a completed approved application has been received.
2. If the student has an IEP, immediately notify the Special Education Department so that an IEP meeting can be scheduled to develop an Educational Service Plan (ESP). A SPED designee should notify the school counselor of the date for the meeting.
3. Within five school days of receiving the completed Licensed Physician/Psychiatrist Statement and Medical Referral Form, notify the parent/guardian of the time and place of the school team or IEP meeting to discuss HHB services and develop an Educational Service Plan (ESP).
4. The school team (led by the school counselor) **or** IEP team will develop an ESP for each designated HHB student. **Complete all areas of the ESP Form.**

5. If the doctor does not address reentry on the medical referral form, contact the doctor directly. If such information is not provided, the school team can develop the reentry plan without doctor input.

6. The ESP shall identify the number of hours necessary to meet the instructional needs of the student. To comply with the Georgia State Board of Education Rule 160-4-2-.31 Hospital/Homebound (HHB) Services and meet attendance requirements, a minimum of three hours of instruction per week must be provided.

7. The ESP shall identify the appropriate course load for the student during the approved period of HHB instruction. It is noted that HHB instruction is not structured to supplant the regular school day.

Attendance

1. The student shall be counted present for the entire week when he or she is provided instruction on an individual basis or as part of a group by the HHB teacher for a minimum of three hours per week.

2. If the student is unable to receive instruction during the school week due to his/her medical condition, the HHB teacher must schedule a make-up session. Once the session is completed, the student is counted as present for that week.

3. If the student is unable to receive instruction during the school week due to the parent/guardian and/or student cancelling the session due to non-medical reasons, the student shall be counted absent for the week. The HHB teacher is not obligated to make up the session, but may choose to do so at his/her discretion.

4. The HHB teacher will keep a record of attendance.

Scheduling

1. Within five school days of receiving the completed medical referral form, the school counselor shall notify the parent/guardian of the time and place of the school team meeting for regular education students or the IEP meeting for special education students regarding HHB services and the development of the ESP.

2. The time of the instructional session shall be arranged by the HHB teacher in cooperation with the parent/guardian.

3. A parent/guardian or approved adult parent designee must be present at the student's home during the entire instructional period. If an adult is not present at the time of the scheduled sessions or leaves the home at any time during the scheduled session, that session shall be considered cancelled without notice and shall not be rescheduled. The student shall be counted absent for that school week.

Instructional Delivery

1. An individual employed as a HHB teacher must hold Georgia teacher's certification. The HHB teacher must be employed and supervised by the Worth County Schools HHB coordinator. The HHB teacher should have a broad background of professional training and experience so that he or she will be able to adapt instruction to each student's needs. The HHB teacher must also be able to adjust to a variety of home situations and be knowledgeable of cultural diversity existing within Worth County.

2. HHB teachers providing educational services in a hospital must hold Georgia teacher's certification and possess similar characteristics as teachers in a local school system.

3. HHB instruction can be offered on a one-on-one basis, or in a small group, at the home of the student, at the health care facility where the student is confined, or other locations as identified by the ESP. The type of instruction offered is based on the agreement as set forth in the ESP which shall take into consideration the cognitive ability and medical condition of the student.

4. If instruction is provided in the student's home, a table, desk in a work space that is well ventilated, smoke-free, clean, and quiet (e.g., free of radio, TV, pets, and visitors) must be provided. A schedule for student study time between teacher visits should be established, and the student should be prepared for each session with the teacher.

5. HHB teachers shall provide direct delivery of the course materials provided by the student's classroom teacher. The classroom teacher is required to provide to the HHB teacher a course syllabus when appropriate, assignments, tests, and any supplementary materials (i.e., study guides for quizzes/tests, chapter notes, etc.) in a timely manner. **The school counselors shall designate a location for assignments to be turned in. Classroom teachers will place assignments in the designated location by 3:30 PM each Tuesday. Assignments will be returned to the school by 3:30 PM the following Tuesday.**

6. All state mandated tests shall be administered unless the student is approved to take an alternate assessment as stipulated in the ESP. The decision to administer final examinations shall be included in the ESP.

7. All HHB students will be encouraged to take all state mandated assessments at the school if at all possible. If a student **cannot** come to the school for testing, it is the parent's responsibility to submit further documentation to the school. The school counselor shall inform his/her school test coordinator once the documentation has been submitted.

8. Full credit shall be given for work completed as stipulated in the ESP.

9. Core subjects will be covered with students receiving HHB instruction. The core subjects include reading, language arts, mathematics, science, and social studies. **However, additional courses may be included in HHB instruction for high school students at the discretion of the school administration**.

Instructional Materials

The HHB student shall use instructional materials issued by the student's classroom teacher(s). The student's parents/guardians shall be responsible for obtaining all of the student's books from the school prior to the first session of HHB instruction.

Pregnancy Policy

1. Students are allowed to attend school until they give birth regardless of the physician's projected delivery date.

2. The student's OB-GYN must complete the Licensed Physician/Psychiatrist Statement and Medical Referral Form in order to be approved for HHB services if the student is put on bed rest and/or is hospitalized prior to the delivery of the baby.

3. Students requesting HHB services post-partum shall obtain a Pregnancy and Delivery Physician's Form. The student will be approved for services beginning on the actual date of delivery and ending on the date specified by the physician.

Termination of Services

A student is released from the HHB program for one of the following reasons:

- As of the projected ending date on the Medical Referral Form **and/or** as defined in the ESP **or** if the licensed physician or licensed psychiatrist indicates that the medical condition has changed.
- When the student is employed in any capacity, goes on vacation, regularly participates in extracurricular activities, or is no longer confined to home.
- On the last day of school of the regular school year.
- 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.
- When the parent/guardian cancels three HHB instructional sessions without providing 24 hours notice.
- When 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.

Return to School

The student's attending doctor is **required** to complete the Release to Return to School form once HHB services are no longer needed. The parent/guardian must submit this documentation to the school counselor before the student will be allowed back in school. The school counselor will send a copy of the form to the system HHB coordinator.

Extension of Services

It is the responsibility of the parent/guardian to contact the school counselor if HHB services need to be extended beyond the projected date of return. The attending licensed physician or licensed psychiatrist must complete a new Medical Referral Form. The completed form must be returned to the school **before** HHB services are extended beyond the initial projected date of return. The school counselor will complete the "**For Extension Requests Only**" section on the original HHB application. The school counselor will send a copy of the revised application and a copy of the new Medical Referral Form to the system HHB coordinator. The school counselor will need to schedule a meeting to review/revise the student's ESP.

Note: The school counselor will contact the parent/guardian to check on the medical status of any student who is absent beyond the projected HHB return date without a request for extension. The school counselor will also notify the school's attendance contact.

HOSPITAL/HOMEBOUND (HHB) SERVICES DEFINITIONS

Adult Parent Designee – an individual who is at least 21 years of age and who the parent designates to be present during homebound instruction.

Chronic Health Condition – a medical condition marked by a long duration or frequent recurrence.

Educational Service Plan (ESP) – an individual plan for students receiving HHB service developed by the local school team, to include a school reentry procedure. The plan may include accommodations and modifications from a Section 504 plan, or Individualized Education Program (IEP), as applicable.

Hospital/Homebound (HHB) Services – academic instruction and other services provided to eligible students who are confined at home or in a health care facility for periods of time that would prevent normal school attendance based upon certification of need by the licensed physician or licensed psychiatrist who is treating the student for the presenting diagnosis.

Instruction – the teaching of standards as defined by Georgia Performance Standards (GPS), the Georgia Quality Core Curriculum (QCC), Section 504 plan, IEP, and any local curriculum for the classes in which the HHB student is enrolled and under the direction of the classroom teacher(s).

Intermittent HHB Service – HHB instruction and other services for eligible students who have a medically diagnosed chronic health condition which may cause the student to be absent at least a total of 10 school days for intermittent periods per year or equivalent on a modified calendar or five school days per year on a high school block schedule.

Licensed Physician – a person licensed to practice medicine under state law O.C.G.A. § 43-34-21 and licensed by the appropriate state board to assess the student's physical condition for which the student is referred.

Licensed Psychiatrist – a person licensed to practice medicine under state law O.C.G.A. § 43-34-21 and trained to practice in the science of treating mental diseases to assess the student's psychiatric and/or emotional condition for which the student is referred.

Long-term HHB Service – HHB instruction and other services for eligible students who have a medically diagnosed chronic health condition which may cause the student to be absent from school for more than nine consecutive weeks per year or equivalent on a modified calendar.

Online Learning Course – a State Board of Education-approved course of instruction directly correlated to the state-approved curriculum that is delivered via the Internet or in any electronic medium.

School Day – a day as specified by the local board of education which is the period between the time students are required to be present and their dismissal (160-5-1-.02 SCHOOL DAY FOR STUDENTS); ten school days on a regular high school schedule (six 50-minute classes per day) is equivalent to five school days on a high school block schedule.

Temporary HHB Service – HHB instruction and other services for eligible students who have a medically diagnosed physical or psychiatric condition, which confines the student to home or hospital and restricts activities for nine weeks or less, but for a minimum of ten consecutive school days or equivalent on a modified calendar or a minimum of five consecutive days on a high school block schedule.

Hospital/Homebound Forms

Worth County Schools

Hospital/Homebound Application

Provide all requested information. Incomplete applications may experience processing delays.

I. Student Information (Please Print)

Student's Name: _____ DOB: _____ Male_____ Female_____
Address: _____
Parent/Guardian: _____ Phone: (H) _____ (W) _____ (C)_____

School: ☐ WCPS ☐ WCES ☐ WCMS ☐ WCHS Grade: _____ Homeroom Teacher: _____

Student Served by: ☐ 504 ☐ IEP ☐ Gifted ☐ ESOL

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 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 Worth County School System 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.

III. Policies and Procedures

1. A parent/guardian or an approved adult parent designee who is at least 21 years of age as identified 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 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, assignments completed and submitted on time.
5. Assignments will be returned to the regular school teacher for grading.
6. A parent/guardian or an approved adult parent designee at least 21 years of age as identified in the ESP must notify the HHB teacher at least 24 hours in advance if an instructional session must be cancelled. The local school system 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 will be rescheduled.
7. The parent/guardian must submit a release form from the licensed physician or licensed psychiatrist upon the student's return to school.
8. To extend HHB services beyond the originally identified return to school date, the licensed physician or licensed psychiatrist must submit an updated Medical Referral Form.

IV. 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.
3. If the parent/guardian or adult parent designee at least 21 years of age as defined in the Educational Service Plan (ESP) 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.

Return all pages of application and additional documentation to the school counselor.

V. Parent/Guardian Agreement – Release of Information

I have read the Hospital/Homebound (HHB) policies for program eligibility and understand the reasons for possible dismissal from the program. I agree to the policies and requirement of the program and request HHB 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/Psychiatrist Statement and Medical Referral Form --- Please attach. *(See pages 3 and 4.)*

For School Use Only

Date HHB Application Received: _____ After reviewing the above information and eligibility criteria,

_____ ☐ ***is approved*** ☐ ***is not approved*** for HHB instruction.
(Student Applicant's Name)

Services Recommended *(check one)***:** ☐ Long-term ☐ Intermittent ☐ Temporary

Estimated Duration of HHB Services: Start Date _____ End Date _____ Number of Weeks _____

School Counselor Signature: _____ **Date:** _____

Principal Signature: _____ **Date:** _____

Date Parent Notified of Approval/Denial: _____ **Date SpEd Notified** *(if applicable)***:** _____

Date of Educational Service Plan (ESP) Meeting: _____ **Location:**

_____ **State Mandated Testing**

Please select the state mandated tests that apply to the student mentioned above that will be administered while he/she is receiving HHB services. Discuss with school test coordinator.

☐ GKIDS ☐ EOG ☐ EOC ☐ Alternate GAA ☐ GAA
☐ S R I ☐ SLO ☐ _____ ☐ ACCESS for ELLs

For Extension Request Only

New Medical Referral Form Received: ☐ Yes ☐ No **Date Received:** _____

Extension ☐ ***is approved*** ☐ ***is not approved*** for HHB instruction. **New Start Date** _____ **New End Date** _____

School Counselor Signature: _____ **Date:** _____

Principal Signature: _____ **Date:** _____

Date Parent Notified of Approval/Denial: _____ **Date SpEd Notified** *(if applicable)***:** _____

ESP Review Meeting: _____ **Location:** _____

State Mandated Testing

Please select the state mandated tests that apply to the student mentioned above that will be administered while he/she is receiving HHB services. Discuss with school test coordinator.

☐ GKIDS ☐ EOG ☐ EOC ☐ ACCESS for ELLs ☐ GAA
☐ G A A Altern ☐ SLO ☐ SRI ☐ _____

HHB Coordinator's Use Only

Date Received: _____ HHB Teacher Assigned: _____

Worth County Schools

Hospital/Homebound Application

VI. Licensed Physician/Psychiatrist/Advanced Practice Provider Statement and Medical Referral Form

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

Student's Name: _____ DOB: _____ Male ☐ Female ☐

Address: _____

Parent/Guardian: _____ Phone: (Home) _____ (Work)_____(Cell)_____

Print Physician/Psychiatrist's Name: _____ GA License #: _____

Address:_____Phone Number: _____

Section A. Physician/Psychiatrist /Advanced Practice Provider(APP) Statement and Diagnosis

Patient's Diagnosis (Include a description of the condition. Include due date if medical condition is related to pregnancy.):

_____

_____

_____

_____

_____

_____

Estimated Duration of Hospital/Homebound Services: Starting Date: _____ Ending Date: _____ No. of Weeks: _____

Date of initial evaluation: _____ Date of next scheduled appointment: _____

Physician's Statement: *(Note: 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 ten consecutive school days? ☐ Yes ☐ No
- Will the student benefit from an instructional program during this time of confinement? ☐ Yes ☐ No
- Could the student attend school with accommodations? If so, describe. ☐ Yes ☐ No

Recommendations for accommodations: _____

_____

_____

_____

_____

_____

- Could the student attend school regularly and receive HHB services on an intermittent basis as needed? ☐ Yes ☐ No
- Is the student confined to the home or hospital and full-time HHB services are recommended? ☐ Yes ☐No
- Is the student free from communicable diseases, such as flu or contagious airborne diseases? ☐ Yes ☐ No
- Can instruction be provided to the student without endangering the health of the teacher or other students whom the teacher may contact? ☐ Yes ☐ No

Note: You may periodically have to verify that the student remains under your care and continues to qualify for HHB services.

Section B. Treatment and School Re-Entry Plan

Note: The following information is required to determine eligibility for HHB services and must be completed by the licensed physician or licensed psychiatrist who is currently treating the student for the diagnosis presented.

- 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

Section B. Treatment and School Re-Entry Plan Continued

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 independent assignments	Effects on student's ability to relate to teachers and other students

- Could this student return to school on an intermittent basis after his/her medication and 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 your time frame (using dates) and transitional plan for the student's re-entry to school (attach additional pages as needed).

Physician/Psychiatrist/Advanced Practice Provider's 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, keeping in mind that the least restrictive environment is preferred.*

Physician/Psychiatrist/APP's Signature:_____ Date:_____

Physician/Psychiatrist/APP's Name:

(Please Print)

Worth County Schools

Hospital/Homebound Services

Pregnancy and Delivery

Physician Verification Form

Student's Name: _____ DOB: Grade/School: _____

Address: _____

Parent/Guardian: _____ Phone: (Home) _____ (Work)_____(Cell)_____

Print Obstetrician's Name: _____ GA License #: _____

Address:_____Phone Number: _____

Note: The student may attend school up until the actual delivery date. The attending physician must complete the Hospital/Homebound Services Medical Referral Form if the student is put on bed rest or is hospitalized prior to giving birth.

Actual Delivery Date: _____

_____is not able to attend school beginning_____and ending
Student's Name

_____.

Physician/APP's Comments:

_____

_____

_____

_____

Physician/APP's Signature: _____ **Date:** _____ **Phone:** _____

For School Use Only

Date HHB Application Received: _____ After reviewing the above information and eligibility criteria,

_____ ☐ ***is approved*** ☐ ***is not approved*** for HHB instruction.
(Student Applicant's Name)

Services Recommended *(check one)***:** ☐ Long-term ☐ Intermittent ☐ Temporary

Estimated Duration of HHB Services: Start Date _____ End Date _____ Number of Weeks _____

School Counselor Signature: _____ **Date:** _____

Principal Signature: _____ **Date:** _____

Date Parent Notified of Approval/Denial: _____ **Date SpEd Notified** *(if applicable)***:** _____

Date of Educational Service Plan (ESP) Meeting: _____ **Location:** _____

State Mandated Testing

Please select the state mandated tests that apply to the student mentioned above that will be administered while he/she is receiving HHB services. Discuss with school test coordinator.

☐ GKIDS ☐ EOG ☐ EOC ☐ Alternate GAA ☐ GAA

☐ SRI ☐ SLO ☐ _____ ☐ ACCESS for ELLs

Worth County Schools

Hospital/Homebound Services

Physician Certification
Release to Return to School

Student's Name: _____ Grade/School: _____

Address: _____

Parent/Guardian: _____

The above named student has been under my care from_____to_____.

I hereby release the student from Hospital/Homebound confinement as follows:

- ☐ Return to school on_____with no restrictions.
- ☐ Return to school on_____with the following restrictions.

_____

_____

_____

_____

Physician's Name (Please Print)**:** _____

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

Address: _____ **Phone:** _____

Note to School:

This form must be signed by the attending physician before the student is permitted to return to school. Send a copy of this completed form to the system HHB coordinator.

Worth County Schools

Hospital/Homebound Services

HHB Adult Designee Permission Form

I,_____, give permission to _____
Parent's Name Adult's Name (age 21 or older)

to serve as the **approved adult parent designee** who will be present during the entire HHB instructional period in which my child,_____, will receive
Student's Name

HHB services. I also give permission for the adult mentioned above to sign HHB logs in my absence to verify instructional services were delivered to my child.

The address where my child will receive HHB services is _____

_____.

Parent/Guardian Signature:_____ Date: _____

Adult Designee's Signature: _____ Date: _____

Worth County Schools

Hospital/Homebound Services

Educational Service Plan

Conference Date:_____ Conference Location:_____ Conference Call? ☐ Yes ☐ No

Student's Name: _____ DOB: Male ☐ Female ☐

Parent/Guardian: _____ Phone: (H) _____ (W)_____(C) _____

School: ☐ WCPS ☐ WCES ☐ WCMS ☐ WCHS Grade: _____ Number of Days Absent (current year): _____

Student Served by: ☐ 504 ☐ IEP ☐ Gifted ☐ ESOL HHB Service: ☐ Temporary ☐ Intermittent ☐ Long-Term

Current Educational Program

Subject	Current Level (Below, On, or Above)	Recent Grade	Text/Materials & Adaptations/Comments	Teacher

Proposed Educational Plan

Instruction: Begin Date: _____ End Date: _____

Location: Home: ☐ Yes ☐ No Hospital: ☐ Yes ☐ No

Subject	Text/Materials and/or Assignments	Direct Instruction	Online	Day(s) of Instruction	Time of Service
		☐ Yes No	☐ Yes No		
		☐ Yes No	☐ Yes No		
		☐ Yes No	☐ Yes No		
		☐ Yes No	☐ Yes No		
		☐ Yes No	☐ Yes No		
		☐ Yes No	☐ Yes No		
		☐ Yes No	☐ Yes No		

* Only academic subjects will be offered through HHB services.

Medical considerations for instruction: _____

Other accommodations: _____

_____

_____

_____

_____

_____

If the above mentioned parent/guardian is not at home at the time of the scheduled instructional session, the following adult designee is authorized to monitor the session. I certify that this person is 21 years of age.

Adult Parent Designee: _____

Phone: _____

Parent/Guardian Printed Name: _____

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

Re-Entry Plan

Anticipated date of return to school: _____

Strategies to facilitate the student's re-entry to school: _____

_____

_____

_____

_____

_____

_____

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

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

School Counselor Signature: _____ **Date:** _____

IEP Designee Signature: _____ **Date:** _____

Principal or Designee Signature: _____ **Date:** _____

HHB Teacher Signature: _____ **Date:** _____

Worth County Schools

Hospital/Homebound Services

Weekly Instruction Documentation Form

HHB Teacher: _____ Employee #: _____

Student Name: _____ Grade: _____ School: ☐ WCPS ☐ WCES ☐ WCMS ☐ WCHS

HHB Scheduled Days & Time: _____

Date of Service	Start Time	Stop Time	Total Time	Signature of Parent/Guardian or Parent Designee
Total Contact Hours for Week				**Note to Parent: It is your responsibility to verify the times entered by the teacher are correct. Please do not sign if the line is left blank. Signatures only. Please do not initial.**

I certify that the time listed above is an accurate statement of total student contact hours only.

HHB Teacher Signature:_____ (Return completed form to your school bookkeeper.)

For Office Use Only

Account #/Bookkeeper's Initial: _

Principal Signature: _____ Date: _____

Director/Asst. Director Signature: _____ Date: _____

Worth County Schools

Hospital/Homebound Services

Status Check Documentation Form

Student Name: _____ Grade: _____ School Year: _____

Parent/Guardian: _____ Phone: (Home) _____ (Work)_____(Cell)_____

HHB Services: Start Date _____ End Date _____ ☐ Long-term ☐ Intermittent ☐ Temporary

Classroom Teacher(s):_____ HHB Teacher:_____

Contact	Date Contacted	Method of Contact	Comments
Parent		Phone Call ☐ E-mail	
HHB Teacher		Phone Call ☐ E-mail	
Classroom Teacher(s)		Phone Call ☐ E-mail	
Parent		Phone Call ☐ E-mail	
HHB Teacher		Phone Call ☐ E-mail	
Classroom Teacher(s)		Phone Call ☐ E-mail	
Parent		Phone Call ☐ E-mail	
HHB Teacher		Phone Call ☐ E-mail	
Classroom Teacher(s)		Phone Call ☐ E-mail	
Parent		Phone Call ☐ E-mail	
HHB Teacher		Phone Call ☐ E-mail	
Classroom Teacher(s)		☐ Phone Call ☐ E-mail	

Worth County Schools

Hospital/Homebound Services

Status Check Documentation Form

Contact	Date Contacted	Method of Contact	Comments
Parent		Phone Call ☐ E-mail	
HHB Teacher		Phone Call ☐ E-mail	
Classroom Teacher(s)		Phone Call ☐ E-mail	
Parent		Phone Call ☐ E-mail	
HHB Teacher		Phone Call ☐ E-mail	
Classroom Teacher(s)		Phone Call ☐ E-mail	
Parent		Phone Call ☐ E-mail	
HHB Teacher		Phone Call ☐ E-mail	
Classroom Teacher(s)		Phone Call ☐ E-mail	
Parent		Phone Call ☐ E-mail	
HHB Teacher		Phone Call ☐ E-mail	
Classroom Teacher(s)		Phone Call ☐ E-mail	
Parent		Phone Call ☐ E-mail	
HHB Teacher		Phone Call ☐ E-mail	
Classroom Teacher(s)		☐ Phone Call ☐ E-mail	