Department of Student Services
864 Broad Street
Augusta, GA 30901
(706) 826 – 1129 – Fax: (706) 826 – 4626

Ed Sanderson, Ph.D.
Director

Dear Parents/Guardians:

Georgia State Board of Education Rule 160-4-2-.31 outlines requirements for students enrolled in public schools to receive hospital/homebound (HHB) instruction. In order for a student to receive hospital/homebound services, it must be anticipated by a doctor the student will be absent from school for a minimum of ten consecutive or intermittent school days due to a medical or psychiatric condition. Before services can be provided, the Richmond County School System must have on file a physician's or psychiatrist's statement from the doctor treating the student for the condition stating that services are necessary for a specified period of time. The doctor must also specify that the student is not suffering with a contagious disease and is able to participate in HHB instruction. Only a psychiatrist can submit a medical request form for an emotional or psychiatric disorder. It is your responsibility to complete the parent information on the Medical Form, have the Medical Form completed and signed by your child's physician or psychiatrist, and ensure that it is returned to the Department of Student Services. At times, we may need to contact the physician or psychiatrist to obtain information needed to determine eligibility. Once we have received the signed form, a decision will be made regarding approval of services. Additionally, an Educational Service Plan (ESP) conference will be convened at your child's school to discuss the implementation of HHB services. This meeting may be face-to-face, a phone conference or electronic.

If your child qualifies, services will be arranged and credit will be issued for school attendance after HHB instruction. A student must have a minimum of three hours of instruction to be counted present for a week. However, if an instructional period is scheduled and the child is not prepared to work or does not keep the appointment, attendance credit will not be given for that day. A parent, guardian, or an approved adult parent designee as identified in the ESP must be present during the entire instructional period. Instructional materials will be provided by the school. A workspace that is well-ventilated, smoke-free, clean and quiet should be provided. Services can be terminated services if a student withdraws from school, does not keep appointments with the hospital/homebound teacher, or does not assume responsibility for completion of assignments. If you cannot keep an appointment with the homebound teacher, it is your responsibility to call the teacher and cancel the appointment. 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 no longer receive HHB services. If the homebound teacher does not keep appointments and services are not being rendered, please contact the HHB Contact at your child's school or the Department of Student Services immediately to inform us.

Hospital/homebound services will be terminated on the date specified by the physician. If your child's condition has not improved and services are to be extended, it is your responsibility to have the physician complete another form to extend services. Also, acceptance as a homebound student ***does not*** guarantee credit for courses taken or passing grades for classes in which the student is enrolled. All requirements of classes and courses taken must be met.

We endeavor to provide quality educational services for students through the HHB program. If you have any questions, please contact Wanda Hutcheson, Assistant or Aronica Gloster, Coordinator in the Department of Student Services at (706) 826-1129.

Sincerely,

Ed Sanderson

Director, Student Services Department

Verification of Receipt of Hospital/ Homebound Services Informational Letter and Request for Hospital/Homebound Services

My signature below verifies that I have received an informational letter about Hospital/Homebound (HHB) services and I understand eligibility requirements, the process, and the reasons for possible dismissal from the program. My signature further verifies that I am requesting HHB services for my child.

_____	_____
Student's Name (print)	School
_____	_____
Printed Name of Parent or Guardian	Date
_____	_____
Signature of Parent or Guardian	Date

*Return this form to the HHB Contact at your child's school.

"Learning Today…Leading Tomorrow"

The Mission of the Richmond County School System is building a world-class school system through education, collaboration, and innovation.

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Ed Sanderson, Ph. D.
Director

Dear Parent,

The Health Insurance Portability and Accountability Act (HIPAA) requires written parental consent to speak with your child's doctor. When determining the services that your child may need, it may be necessary for us to contact your child's doctor. Please complete the bottom portion of this and return it with the Hospital/Homebound form.

If you have any questions, please feel free to contact our office at 706-826-1129.

Sincerely,

Ed Sanderson

Director of Student Services

I agree to allow personnel from the Richmond County School System to speak with my child's doctor and/or and/or nurse in regard to a request for Hospital/Homebound services.

_____	_____
Student's Name	School
_____	_____
Signature of Parent of Guardian	Date

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This form should be returned to the Student Services Department

Richmond County School System – Department of Student Services
Hospital/Homebound Services Medical Form

864 Broad Street
Augusta, GA 30901

Phone: (706) 826-1129
FAX: 706-826-4626

To the Parent: ***Complete the section below and then forward this form the attending physician/psychiatrist.***
I request Hospital/Homebound services for my child who is confined to home or the hospital. The disability is not due to contagious disease. I agree to have an adult present each time the hospital/homebound teacher is expected (21 years or older).

Student's Name _____ School _____ D.O.B._____Grade _____

Parent/Guardian: _____ Telephone Number _____

Address _____ Zip Code _____

Parent's Signature _____ Date _____

Does your child receive Special Education Services? YES NO

To the Physician:
The parents/guardians of the above named student have requested Hospital/Homebound services via the Richmond County School System. Georgia Department of Education regulations require that we have information pertinent to the student's health and limitations. Services **will not** be provided to students who have contagious diseases or who will be absent from school less than 10 days.

1. What is the student's exact physical or emotional diagnosis? _____

_____

2. Is the student free from communicable diseases, such as flu or contagious airborne diseases? YES NO
3. Will the student be able to benefit from an instructional program during their time of confinement? YES NO
4. Is the student temporarily confined to the home or hospital and temporary services are recommended? YES NO
   (If yes, complete questions 5 & 6; if no, complete questions 7 – 9)

Temporary Services (*answer questions 8 & 9 if requesting temporary services – student absent for 9 weeks or less; 10 day minimum*):

5. Start date for temporary services:_____
6. What date will the student be able to return to school? ***Please be specific.*** _____

Intermittent Services (*answer questions 7 – 9 if requesting intermittent services – for students with chronic illnesses*)
7. Does the student suffer from a chronic disease or ailment that may cause the student to miss school ***intermittently*** or may require the student to attend school part of a school day? YES NO
8. What is the length of time the student will need ***intermittent*** services? (i. e., 2 weeks, 1 month, etc.) _____
9. Start date for intermittent services:_____End date for intermittent services:_____

**Please note: If intermittent services are required for longer than 3 months, the parent may need to provide additional documentation from the physician in order to continue services.*

Physician Certification *(required)*
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's Name_____PhoneNumber_____
Please Print

Physician's Signature _____ Date _____License #_____

This information must be completed by the physician prior to services being approved. ***A date or tentative date of return to school must be provided. Failure to provide this information may delay the start of services***. **Please send or fax form to Wanda Hutcheson**

For Student Services Dept Only: **Approved** _____ **Not Approved** _____ Temporary_____ Intermittent_____Long-Term_____

Coordinator's Signature _____Date_____ Teacher Assigned:_____