Virtual Hospital/ Homebound Services

Parent/Guardian Acknowledgement and Request for Virtual HHB Services

Please submit all completed forms to either:

Georgia Connections Academy, under State Board Rule 160-4-2-31, is authorized to provide instructional services to eligible students who have a medically diagnosed physical or mental condition that confines the student to home or hospital and whose activities are restricted for an extended period of time. To be eligible for services, students must meet the following criteria:

1. A licensed physician or psychiatrist who is currently treating the condition must certify that the student is expected to be absent from school due to a physical or mental condition, or due to a repeated intermittent chronic condition, for at least 10 consecutive or intermittent school days and will be unable to participate and benefit from a virtual instructional program. Therefore, virtual hospital homebound is required. Medically fragile students who can participate in the regular virtual school day may also qualify with appropriate documentation.

2. The student is under medical care for the illness, which may be acute or chronic in nature.

3. The physician must certify that the student can receive instruction without endangering the health of the instructor or other students with whom the instructor may come in contact. Students are not eligible for Hospital/Homebound instructional services if their absence is due to communicable disease.

4. Re-documentation of a chronic or recurring condition is not required but may be requested by the system coordinator.

Parent/Guardian Agreement Hospital/Homebound Policies

Parents, the success of instruction and progress of the Hospital/Homebound student is contingent upon student cooperation and home planning.

- The parent must ensure that the student completes the minimum required 3 hours of instruction/online coursework per week.
- Consistent times for study should be established between scheduled Hospital/Homebound services.
- The Learning Coach must be present during instructional time and weekly check-ins
- The parent/hospital staff must allow Hospital/Homebound personnel and the treating physician to exchange pertinent information regarding the student's medical condition and the impact on educational programming. (HIPPA Form)
- The parent must work with their "Physician" to have the Physicians portion of the referral completed.
- The Hospital/Homebound student must participate in the recorded live lesson sessions and complete a minimum of 3 hours of instruction/online course work per week in order for their absences to be excused. Excessive absences and tardiness may cause the student to lose Hospital/Homebound services.
- The parent/hospital staff must allow Hospital/Homebound personnel and the treating physician to exchange pertinent information regarding the student's medical condition and the impact on educational programming. (HIPPA Form)
- The parent must work with their "Physician" to have the Physician's portion of the referral completed.
- The Virtual Hospital/Homebound student must participate in the live or recorded Virtual Hospital/Homebound sessions, complete 3+ hours of instruction/online course work per week (as determined by the HHB committee and written into the ESP) and complete a weekly check-in with the HHB coordinator in order to be counted present.
- The parent must sign below indicating understanding of procedures and policies, requirements of the Virtual Hospital/Homebound program and to authorize Georgia Connections Academy to receive information from the treating physician regarding the student's medical condition.

Termination of Hospital/Homebound Services

- A student is released from the Hospital/Homebound program:
    - As of the projected return date on the Application for Hospital/Homebound Services Medical Referral of if the licensed physician or licensed psychiatrist indicates that the medical condition has changed or as defined in the ESP. If the licensed physician, physician's designated advanced practice provider, or licensed psychiatrist recommends that the student is able to attend Virtual school or can no longer participate or benefit from HHB services, the student will be removed from the program.
    - 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.
    - 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.
    - On the last day of school of the regular school year.
    - If the parent, guardian, emancipated minor, student 18 years of age or older or adult parent designee cancels or fails to participate in three HHB check-ins without 24 hours' notice, the student will be removed from the program.
    - When the conditions of the location where the HHB services are provided, are not conducive for instruction, or threaten the health and welfare of the HHB teacher.

Hospital/ Homebound Services

Section I:

I have read the Hospital/Homebound (HHB) services policies for program eligibility and I understand the reasons for possible dismissal from the program. I agree to the policies and eligibility requirements of the program and request Virtual HHB services for my child.

_____ _____

Parent/Guardian Printed Name Date

_____

Parent/Guardian Signature

Section II:

Student Name: _____ Grade: _____

Address: _____

_____

Date of Birth: _____

Parent/Guardian: _____

Parent/Guardian Email Address: _____

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

Learning Coach (if different from Parent/Guardian): _____

Student receives the following services: ☐ 504 ☐ IEP ☐ Regular Education

(Note: The school is responsible for providing assignments and grades to the student until the student is officially enrolled in the HHB program. Parent signs indicating that they understand the requirements of the reduced classroom assignments request and provide Georgia Connections Academy information from the treating physician regarding the student's medical condition and the impact on educational programming.)

Hospital/ Homebound Services

Section III:

Licensed Physician/Psychiatrist Statement and Medical (Please print unless otherwise stated).

(Note: This form must be completed by a licensed physician, psychiatrist, or advanced provider.)

Please submit all completed forms to either:

Physician/Psychiatrist/Advanced Practice Provider Information :

Name: _____

Address: _____

_____

Phone Number: _____

Fax: _____

Student Information:

Name: _____

Address: _____

_____

Date of Birth: _____

Parent/Guardian: _____

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

Hospital/Homebound Services

Physician/Psychiatrist Statement and Diagnosis:

Patient's Diagnosis: (Note: Please include a description of the condition.)

Is student able to attend virtual classes from home and complete 6 hours of work on a daily basis?

Yes No

If checked "Yes", please include how virtual instruction will require the following limitations:

If checked "No", please include how illness will impact the student's ability to receive and/or participate in virtual instruction.

Hospital/Homebound Services

Approximate number of days student will require hospital/homebound services. Please include how illness will impact the student's ability to receive and/or participate in virtual instruction.

Estimated Duration of Hospital/Homebound Services:

Starting Date:

Ending Date:

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 virtual school (complete 6 hours of online work) for a minimum of ten consecutive school days?
Yes No

Will the student be able to benefit from a virtual instructional program during this time of confinement?
Yes No

Could the student attend virtual school with accommodations? If yes, describe.
Yes No

Recommendations for Accommodations:

Could the student attend virtual school regularly and receive hospital/homebound services on an intermittent basis as needed?
Yes No

Is the student confined to the home or hospital and full-time hospital/homebound 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 who the teacher may contact?
Yes No

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

Treatment and School Reentry Plan
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 scheduled frequency of treatment/therapy for this student?
Daily Weekly Monthly

What is the expected duration of the treatment/therapy?

Will the student take medication? Yes No

Student Diagnosis	Medications student will take for each diagnosis	Name of medication effects on student's ability to comprehend	Effects on student's ability to complete independent assignments

Could this student return to school on an intermittent basis after his or her medication and condition is stabilized? Yes No

Can this student come into contact with other students? Yes No

The HHB services program is designed to be a temporary educational program to help students who are unable to attend school for medical or psychiatric reasons. Please describe your time frame and transitional plan for the student's reentry 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. I also certify that I understand the student is enrolled in a virtual school and is requesting virtual hospital/homebound services indicating they will have the inability to comply with the attendance requirements at Georgia Connections Academy. My recommendation has been based on the medical needs to the patient, keeping in mind that the least restrictive environment is preferred.

Physician Printed Name_____

Physician Signature_____ Date: _____

**Advanced Practice Provider:_____
(on behalf of licensed physician)

Please submit all completed forms to either:

*Note: The Georgia Composite Medical Board provided information on the following statute: O.C.G.A. 43-34-25, regarding Advanced Practice Providers signing health forms for educational purposes. The law states:
(e.1) Except for death certificates and assigning a percentage of a disability rating, an advanced practice registered nurse may be delegated the authority to sign, certify, and endorse all documents relating to health care provided to a patient within his or her score of authorized practice, including, but not limited to documents relating to physical examination forms of all state agencies and verification and evaluation forms of the Department of Human Services, the State Board of Education, local boards of education, the Department of Community Health, and the Department of Corrections.

**The Advanced Practice Provider may only provide this service if the Physician delegates these duties and is in agreement with the diagnosis.