

Home Instruction Program Overview

Bethlehem Central School District

1. All home instruction inquiries will be directed to the health office.
 - a. The health office will email, fax, or give the application to the parent/guardian.
 - The parent and doctor/mental health professional are responsible for completing the application.
 - Application must list medical and/or mental health diagnosis in detail.
 - The parent should sign the release on the bottom of section 1 to give the school nurse permission to contact the doctor if an extension is needed.
 - b. The application will be returned to the health office once completed and scanned into a shared folder.
 - c. For any unique situation, the nurse will reach out to the counselor, school physician, and home instruction coordinator (the home instruction team) to discuss.
2. The nurse will forward all completed applications to the assistant superintendent's office for approval/denial and also notify designated clerical staff, counselors, and supervisors.
3. The assistant superintendent will review the application and forward the approval or rejection letters to the school nurse, designated clerical staff, counselors, and supervisors:
 - a. If approved, the counselor will be the point person for the home instruction.
 - b. If denied, the home instruction coordinator will reach out to the parent/guardian.
4. If home instruction is granted, the **counselor** will complete the following tasks:
 - a. Contact the parent/guardian to inform them of home instruction approval.
 - b. E-mail the teachers to inform them that the student will be out on home instruction.
 - c. Ensure that teachers submit curriculum materials to designated clerical staff within 5 calendar days.
 - d. Ensure that completed materials are returned to the teacher in a timely manner.
 - e. Send teachers the tutor's weekly progress report.
5. If home instruction is granted, the **designated clerical staff** will complete the following tasks:
 - a. Complete the Student Information Sheet and e-mail it to the counselor, tutor, and home instruction coordinator.
 - b. Schedule a tutor to work with the home instruction student.
 - c. Connect the tutor and the parents; solidify the tutoring schedule.
 - d. Collect work submitted by the teachers; distribute work to the tutor.
 - e. Collect completed work from the tutor; the counselor will distribute back to the teachers.
 - f. Ensure that the tutor is submitting weekly progress reports. Forward them to the counselor.
 - g. Forward time/mileage sheets to the home instruction coordinator for approval (including the tutor and parent signatures).
6. If home instruction is granted, the **teachers** will complete the following tasks:
 - a. Provide work to the designated clerical staff for distribution to the tutor within 5 calendar days.
 - b. Assess the completed work and review the weekly progress report from the tutor.
 - c. Communicate with the parents weekly regarding academic progress.
 - d. Work with the department supervisor for long term planning.
7. If home instruction is granted, the **tutor** will complete the following tasks:
 - a. Collect work for home instruction students from designated clerical staff.
 - b. Return completed work to the designated clerical staff **on a weekly basis**.
 - c. Submit time sheets to the designated clerical staff weekly; mileage sheets are submitted monthly.
 - d. Submit weekly progress reports to the designated clerical staff.

8. If home instruction is granted, the home instruction coordinator will complete the following tasks:
 - a. Contact the parent/guardian if home instruction is denied.
 - b. Monitor approved tutoring hours to ensure accuracy.
 - c. Submit time/mileage sheets to the business office.

9. In the event an extension is needed, the parent will contact the counselor and the following will take place:
 - a. The counselor will inform the school nurse to obtain an update from the student's doctor.
 - b. The counselor will set up a meeting with the subject area supervisors/teachers to monitor student progress and ensure curriculum standards are being met.

10. Any issues or problems should be reported to the home instruction coordinator immediately so they can be addressed.

11. Return to School Meeting/Plan

- a. Parents will be provided an opportunity for a re-entry meeting with the counselor and any other individual that would facilitate a transition back into school.
 - The school counselor will review any work that still needs to be completed and outline a timeframe for completion.
 - Any adjustments/modifications that need to be made to a student's schedule/program will be completed at this meeting.

Section I
Parent/Student Information

To be completed by the parent(s)/guardian(s) prior to completion of Section II by a licensed medical professional.

Name of Student: _____ Date: _____

Address: _____ DOB: _____

School _____ Grade: _____

Full Name of Father/Guardian _____ Work Phone: _____

Full Name of Mother/Guardian _____ Work Phone: _____

Name of Attending Physician: _____ Phone: _____

Address of Physician: _____

Name of Psychiatrist/Psychologist: _____ Phone: _____

Address of Psychiatrist/Psychologist: _____

Reason for Request of Home/Hospital Instruction: _____

Does the student have an Individualized Education Plan (IEP) or 504 Plan: _____ Yes _____ No

RELEASE OF INFORMATION

Release of information from the student's medical provider(s) is necessary in the event additional information is required to approve the application for Home/Hospital Instruction.

I hereby authorize the Home/Hospital Review Committee, to contact, consult with and obtain any further information in relation to this request that they may deem appropriate relating to my child's medical condition and/or treatment, from any medical or mental health care provider and/or pharmacist that has provided medical or health services to my child.

Parent/Guardian Signature

Date

Section II
Professional Statement

To be completed by a licensed medical professional.

Name of Student _____

Date: _____

Please check one of the following:

_____ The student is unable to attend school at this time due to health concerns, and I do support Home/Hospital instruction (***If checked, please complete the rest of this Section II.***)

_____ The student can attend school without any type of modifications or special provisions.

_____ The student can attend school only with modifications or special provisions.

Describe Modifications Needed: _____

_____ I do / _____ do not support home/hospital instruction for this student

Explain: _____

Diagnosis: _____

_____ Check here if this student has a chronic physical condition that is unlikely to substantially improve within one year.

Please provide specific reason(s)/limitation(s) as to why the student is unable to attend school at this time:

How long have you been seeing the patient for the diagnosis listed?: _____ Will you be following the patient? _____
Yes _____ No _____

Date you anticipate student may return to school: _____

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 patient?: _____

Is there a return to school plan for this student?(If so, please attach): _____

What are your recommendations to assist this student in his/her return to school?: _____

Signature of Licensed Professional

Please Print the Name of Professional

Office Address: _____

Phone Number: _____

Fax Number: _____

Section III
Home/Hospital Review Committee
To be completed by the Home/Hospital Instruction Team.

Name of Student: _____

Date Application Received: _____ Approved _____ Denied _____ Incomplete _____

If approved, date services will be provided from _____ until _____
(Review Date)

If eligibility for services denied, reason for denial:

If incomplete application, type of additional information requested

Date of Decision _____ Person Contacted: _____

Signatures of Home/Hospital Instruction Team:

Assistant Superintendent: _____ Date _____

Home/Hospital Services
Program Director: _____ Date _____
(Building Principal)

Local Medical or
Mental Health Personnel: _____ Date _____
(School Nurse or Doctor)

Comments:

