Rocklin Unified School District

Health Services

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Educational Excellence

Request for Home/Hospital Instruction/Home Instruction (HHI/HI)

Important Information for Parent/Guardian

Purpose of HHI/HI

The purpose of HHI/HI is to provide educational services in the home or hospital for students with:

1) **HHI:** Temporary medical or psychiatric illnesses or injuries, to help the students maintain their educational functional performance during recovery;
2) **HI:** A student with an IEP or 504 who is unable to be educated in the public school setting for a period of time due to significant health or behavioral needs.

Eligibility for HHI/HI

To be considered for HHI/HI, a complete request packet must be submitted. A complete request packet includes parent form; school form; medical provider's document; and signed authorization for release of medical information (HIPAA/FERPA). This allows the HHI/HI team to communicate with health care providers regarding your child's ability to participate in school, and accommodations that your child may need.

HHI/HI is not authorized by the doctor, but by Rocklin Unified School District (RUSD). The doctor's role is to provide pertinent medical information to RUSD staff so a determination for HHI can be made.

Delivery of HHI

If a student is eligible for HHI, 1 hour of instruction per RUSD student calendar day will be provided, typically scheduled for one hour per school day. Parent/guardian or other responsible adult, age 18 years or older, must be present when the HHI teacher is at the home.

Delivery of HI

Services for students eligible for HI will be determined the IEP/504 teams. Parent/guardian or other responsible adult, age 18 years or older, must be present when the HI teacher is at the home.

Please follow the directions below to submit a request for HHI/HI

Completing and Submitting Request for HHI/HI Packet

1. Parent/Guardian completes Parent Documentation for HHI/HI (Attachment **A**)
2. Parent/Guardian completes and signs Authorization for Release of Medical Information (Attachment **B**)
3. **MEDICAL:** Treating physician completes Physical Medical Documentation for HHI/HI (Attachment **C**)
   OR
   MENTAL HEALTH: Treating clinical psychologist or psychiatrist completes Mental Health Documentation for HHI/HI (Attachment **D**)
4. Parent/Guardian submits completed packet (including any requested attachments) to either:
   ➢ Their student's school
5. If an extension is needed, please notify the school and have the doctor complete either Attachment C or D and turn into your students school.
6. When the student returns to campus there may be a re-entry/SST Meeting to help student transition back on campus.

For questions regarding HHI/HI contact your student's school site Administrator

Rocklin Unified School District

Health Services

www.RocklinUSD.org/Health

Educational Excellence

Parent Documentation for Home/Hospital Instruction (HHI/HI) (Attachment A)

This entire page is to be completed by parent or guardian

Rocklin Unified School District (RUSD) procedures require that a licensed California physician or licensed clinical psychologist, currently treating the student for the diagnosis preventing school attendance, submit substantiating documentation. **Chronic conditions** may not qualify. HHI/HI is not authorized by the doctor, but by RUSD. The doctor's role is to provide pertinent medical information to RUSD staff so determination for HHI/HI can be made.

STUDENT INFORMATION

Last Name _____ First Name _____ Gender ☐ M ☐ F

Date of Birth ____ /____ /____ Student/Parent Language _____ /_____

Address_____ City_____ Zip_____

Parent/Guardian Name _____ Relationship _____

Phone Number (_____) _____ Email _____

Days and times the student will be available for instruction. ***Please note that an adult must be present with student and HHI/HI Instructor.*** ☐ Monday _____ ☐ Tuesday _____

☐ Wednesday _____ ☐ Thursday _____ ☐ Friday _____

Is this student currently hospitalized? ☐ Yes ☐ No If so, where? _____

SCHOOL INFORMATION

Current School _____ Grade _____

Student's last date of attendance ____/____/___ Teacher / Counselor _____ Does your student have an IEP? ☐ Yes ☐ No Does your student have a 504 Plan? ☐ Yes ☐No

Class schedule for middle and high school students.

Period 1: _____ Period 4: _____

Period 2: _____ Period 5: _____

Period 3: _____ Period 6: _____

Period 7: _____ Period 8: _____

Implementation of Services

- Pursuant to Education Code Section 42238.5: Each clock hour of teaching time devoted to individual instruction shall count as one day of attendance. Pursuant to Education Code Section 48206.3: No pupil shall be credited with more than five days of attendance per calendar week, or more than the total number of calendar days that regular classes are maintained by the district in any fiscal year.
- Instruction is generally offered in two (2) content areas.
- The student will be temporarily disenrolled from his/her regular school of attendance during the period he/she is receiving home/hospital instruction.
- A responsible adult (18 years of age or older) must be present when the teacher is in the home.

Authorization to Receive/Release Medical and Academic Information for Educational Purposes As the parent or legal guardian of the above named student and by my signature below, I authorize the current school/district of enrollment, RUSD and the treating physician, and/or licensed clinical psychologist, to release and exchange medical and/or academic information relative to the above named student. The information received will be used only to assist RUSD in determining eligibility, appropriate services, academic needs, and transitions between educational sites for the above named student.

Parent/Guardian Signature _____ Date _____

Rocklin Unified School District

Health Services

www.RocklinUSD.org/Health

Educational Excellence

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO AND FROM SCHOOLS

(Attachment B)

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal laws (e.g., HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization. **USE AND DISCLOSURE INFORMATION:**

Patient/Student Name: _____

Last First MI Date of Birth

X _____ X _____ _____

Health Care Provider/Agency **Health Care Provider/Agency** **Medical Record Number**

School to which disclosure is made:
Rocklin Unified School District Home Hospital/Home Instruction 2615 Sierra Meadows Dr Rocklin, CA 95677
Contact person(s) at the school: RUSD nurse, physician, school psychologist, teacher, mental health clinician, and related service providers
Disclosure is required for the following purpose: planning for educational and physical accommodations at school

Requested information shall be limited to:
X All minimum necessary information; **or** □ Disease specific information as described: _____

DURATION: Effective immediately and shall remain in effect until _____, or for one year from the date of signature, if no date entered.

RESTRICTIONS: *California law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.*

PARENT/GUARDIAN RIGHTS: *I understand I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt but it will not affect information disclosed before the receipt of the written revocation.*

STUDENT RIGHTS: *Students between the ages of 12 and 18 years must sign this form in order to approve the disclosure of information relating to mental health and family planning issues.*

RE-DISCLOSURE: I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have the right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

I, the undersigned, do hereby authorize the above named health care providers to exchange information with the above listed school.

APPROVAL: _____ _____ _____

Parent/Guardian Printed Name Parent/ Parent Signature Date

Mental Health/Family Planning: _____ _____ _____

Student Printed Name Student Signature Date

_____ _____ _____

Medical Record Number Relationship to Patient/Student Area Code and Telephone Number

Rocklin Unified School District

Health Services

www.RocklinUSD.org/Health

Educational Excellence

Physical Health Medical Documentation for Home/Hospital Instruction (Attachment C)

DO NOT USE THIS FORM FOR MENTAL HEALTH CONDITIONS. (USE ATTACHMENT D)

Student Name _____ **Date of birth** _____

PHYSICIAN: A request for Home/Hospital Instruction (HHI/HI) has been made for the above-named student. Rocklin Unified School District (RUSD) procedures require that a **licensed California physician,** currently treating the student for this condition, file a statement, which includes a medical diagnosis, and the extent that the student is unable to attend classes on any school campus**. Chronic conditions** may not qualify. HHI/HI is not authorized by the doctor, but by RUSD. The doctor's role is to provide pertinent medical information to RUSD staff so a determination for HHI/HI can be made.

Treating Physician Statement:

Is student physically capable of attending classes on his/her school campus with accommodations to meet their physical or other needs? ☐ **Yes** ☐ **No** **If yes**, please list recommended accommodations **If no,** please state why _____

_____

Would the student's condition prevent/prohibit participation in an alternative, independent study program, meeting individually with a teacher at a school site? ☐ **Yes** ☐ **No**

Is the student able to leave the home for reasons other than medical appointments? ☐ **Yes** ☐ **No**
If yes, why is the student unable to attend school? : _____

_____

Diagnosis (with ICD code): _____

Reason for student's absence from school: ☐ medically unstable ☐ medication trial
☐ physically unable to sit at a desk ☐ communicable illness ☐ other: _____

_____

Summary of Therapeutic Plan to enable the student to return to school (required) Describe or attach your Therapeutic Plan (medication management, physical therapy, inpatient services, etc):

_____

_____

Limitations, restrictions, or precautions school staff should take when interacting with this student:

_____

_____

I estimate this student will be homebound until: ____/_____/_____ Specific date required.

I am managing the student's care for this condition. ☐ Yes ☐ No

Physician's Signature _____ Date _____
Physician's Name (Print) _____ License # _____
Phone:_____ Fax:_____ Email: _____
Address_____ City_____ Zip _____

Physician Stamp:

Rocklin Unified School District

Health Services

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Educational Excellence

Mental Health Documentation for Home/Hospital Instruction (Attachment D)

DO NOT USE THIS FORM FOR PHYSICAL HEALTH / MEDICAL CONDITIONS. (USE ATTACHMENT C)

Student Name _____ **Date of birth** _____

Psychiatrist / Clinical Psychologist: A request for Home/Hospital Instruction (HHI/HI) has been made for the above-named student. Rocklin Unified School District (RUSD) procedures require that a psychiatrist or licensed clinical psychologist, currently treating the student for the mental health diagnosis preventing school attendance, submit substantiating documentation. Chronic conditions may not qualify. HHI/HI is not authorized by the doctor, but by RUSD. The doctor's role is to provide pertinent medical information to RUSD staff so a determination for HHI/HI can be made.

Treating Psychiatrist / Clinical Psychologist Statement:

DSM V Diagnosis and ICD/DSM Code: _____

What medication(s) is/are the student currently prescribed? _____

Is the student a danger to self or others: ☐ Yes ☐ No Explain: _____

Has the student been hospitalized in the past 12 months: ☐ Yes ☐ No

Is the student capable of attending classes on his/her school campus, with accommodations to meet their emotional needs? ☐ Yes ☐ No If yes, please list recommended accommodations:

_____

_____

Is the student able to leave the home for reasons other than medical appointments? ☐ Yes ☐ No
If yes, why is the student unable to attend school? _____

_____

Would the student's condition prevent/prohibit participation in an alternative, independent study program, meeting individually with a teacher at a school site? ☐ Yes ☐ No

Summary of Therapeutic Plan to enable the student to return to school (***required***). Describe or attach your Therapeutic Plan (medication management, psychotherapy, behavioral services, etc…) and/or safety plan.

_____

_____

I estimate this student will be homebound until: ____/_____/_____ Specific date required.

I am managing the care for this student's current condition. ☐ Yes ☐ No

I understand that I may be contacted by a member of the school district's health team. ☐ Yes ☐ No

Signature of Psychiatrist or Licensed Clinical Psychologist

Physician's Signature _____ Date _____
Physician's Name (Print) _____ License # _____
Phone:_____ Fax:_____ Email: _____
Address_____ City_____ Zip _____

Psychiatrist or Licensed Clinical Psychologist Stamp: