**Hospital/Homebound Placement Procedures**

OVERVIEW: The East Baton Rouge Parish School System (EBRPSS) provides an alternative for all students (regular education, students with disabilities and 504 students) having a permanent or temporary medical illness/condition that substantially limits one or more major life activities.

The Hospital Homebound Program provides an alternative for students with a medical illness/condition that impacts their class work and ability to attend school for a designated period of time, as agreed upon by the Physician or Individual Education Program (IEP) Committee.

**Before the decision to place a student in the Hospital Homebound Program, the following steps must be utilized by the school and family through the attached application process.**
NOTE: This HH1 Screening Form should be completed by the school’s Guidance Counselor.

Questions/Concerns Re: Hospital/Homebound Program

Call (225) 929.8601 or Fax: (225) 929-8775

The purpose of the HH1 is to determine via the School Building Level Committee (SBLC) whether the student should be referred for Hospital Homebound (HH) Services. Completing this form does not guarantee that a student will receive HH Services. If the SBLC determines that the student may qualify for HH Services, then the Application for Hospital/Homebound Program shall be completed by the student’s physician/psychiatrist verifying the medical condition and submitted directly to the student’s school’s Guidance Counseling Department or faxed to (225) 929.8775. Student eligibility will be determined upon review of the application.

Referring School: ___________________________ SBLC Meeting Date: ___________________________
Form Completed By: ___________________________ Contact Information: ___________________________
Student Referred for HH Services: ___________________________
Student Information – Age: _______ Date of Birth: _______ Sex: Male/Female Grade: _______
Regular Education (Y/N): _______ Special Education (Y/N): _______ 504: (Y/N): _______

Reason for Referral: (Indicate below)
_____ Medical _______ Psychological _______ Pregnancy

Additional Information:

Describe the school’s documented interventions that were used prior to referring the student for HH Services: (Examples of Interventions: Work Packets/Modified School Day/etc.)

____________________________________________________

Anticipated duration of HH Services (must include a beginning date of HH Services and an ending date):

____________________________________________________

Does the student have access to a computer with high speed internet service? (Y/N): _______
Email address (must be working and current): ________________________________

Schools should submit this HH1 Screening Form to:

ESS Supervisor for Hospital/Homebound Programs
Goodwood Administrative Center
6550 Sevenoaks Avenue
Baton Rouge, Louisiana 70806
Fax #: (225) 929-8775

EBR Hospital/Homebound Program Developed 11.2021
APPLICATION FOR HOSPITAL/HOMEBOUND PROGRAM
EAST BATON ROUGE PARISH SCHOOL SYSTEM

Name: ___________________________ Student ID: _______ DOB: _______ Race: _____ Sex: ___ Grade: ___

School: __________________________ Is your child in the Special Education Program of EBR? Yes ☐ No ☐

Parent’s Name: _____________________ Home Ph: ____________ Wk.#: __________ Cell# __________

Student’s home address: ________________________________ City: __________________ Zip: __________

Address where student will be instructed (if different): ________________________________________________

Name of responsible adult to be present during instruction: ____________________________________________

Hospital: ___________________________ Doctor: _________________ Hospital Ph #: ____________ Room #: ______

SIGNATURE OF PARENT/ GUARDIAN: _______________________________________________________________

Date: ________________________________

MEDICAL CERTIFICATION- TO BE COMPLETED BY PHYSICIAN

I. Illness, Injury, Hospital Recovery

A. The undersigned certifies that the above-named student is unable to attend school for the following reason(s):
   (GIVE SPECIFIC DIAGNOSIS AND COMPLETE TREATMENT PLAN ATTACHED)

B. Pregnancy- In case of pregnancy complete the following:
   1. The student is experiencing the following complications in her pregnancy which would be detrimental to her
      health or the health of her unborn child. ______________________________________________________________

   The expected delivery date (EDC) is: ____________________________

   2. Actual Date of Delivery: __________________________

   Postpartum recuperation required? (NOT TO EXCEED SIX WEEKS) ☐ YES ☐ NO

II. Communicable Status

A. Is this student contagious at this time? ☐ YES ☐ NO

B. Can this illness be transmitted by the Hospital/Homebound teacher to another homebound student? ☐ YES ☐ NO

III. Duration
   The expected duration of the condition which prevents school attendance is: (A TIME PERIOD MUST BE CHECKED.
   IF MORE THAN TWELVE WEEKS PHYSICIAN UPDATE MUST BE SUBMITTED)

   ☐ 3 weeks ☐ 4 weeks ☐ 5 weeks ☐ 6 weeks ☐ 7 weeks ☐ 8 weeks

   ☐ 9 weeks ☐ 10 weeks ☐ 11 weeks ☐ 12 weeks

IV. Physician’s Name: ___________________________ Phone#: __________________________

Address: __________________________________________ City: __________________ State: ____________ Zip# __________

Physician’s Signature ______________________________________ Date: ______________

Print Legibly or Type Required

Stamped signatures are not acceptable

Hospital/Homebound Application
HH Form 1A Medical

Revised 11.2021

Issue Copy to- School Cum Folder Homebound Office School Nurse Parent CW&A
V. **Treatment Plan**

**Name of Patient:** ________________________________

**Patient Data**

<table>
<thead>
<tr>
<th>Address:</th>
<th>Birthdate:</th>
<th>Age:</th>
<th>Patient Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>Gender</th>
<th>Race:</th>
<th>Previously Treated?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State:</th>
<th>Zip:</th>
<th>Marital Status:</th>
<th>Treatment Setting:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Phone:</th>
<th>Admission Date:</th>
<th>PCP:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work Phone:</th>
<th>Cell Phone:</th>
<th>Discharge Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student ID:</th>
<th>Last Review:</th>
<th>Employer:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Guardian:</th>
<th>Referral Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Treatment Modalities**

The following treatment modalities are being utilized:

<table>
<thead>
<tr>
<th>Type of Therapy</th>
<th>Frequency</th>
<th>Weekly, Biweekly, Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Treatment Approaches**

The following treatment approaches are being implemented:

- 
- 
- 

**Medication**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Start Date</th>
<th>End Date</th>
<th>Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Provider Credentials/Information**

Name of Service: ____________________________ Phone #: ______________

Address: ____________________________

Physician’s Signature: ____________________________ Date: ______________

Print Name: ____________________________

**Medical Provider**

**Medical provider should fax this form to the hospital/homebound program at 225.929.8775.**

**This form should not be returned to the student’s school.**

**Attention:** Dr. Janet A. Harris, ESS Supervisor for Homebound Programs

Goodwood Administrative Center 6550 Sevenoaks Avenue, Baton Rouge, Louisiana 70806

Hospital/Homebound Application
HH Form 1A Medical

_Revised 11.2021_
APPLICATION FOR HOSPITAL/HOMEBOUND PROGRAM
EAST BATON ROUGE PARISH SCHOOL SYSTEM

Name: ____________________ Student ID: _______ DOB: _______ Race: _____ Sex: ____ Grade: ____

School: ____________________ Is your child in the Special Education Program of EBR? Yes ☐ No ☐

Parent’s Name: ____________________ Home Phone: __________ Wk.#: __________ Cell#: __________

Student’s home address: __________________________________ City: __________________ Zip: __________

Address where student will be instructed (if different): _____________________________________________

Name of responsible adult to be present during instruction: __________________________________________

Hospital: ____________________ Doctor: _________________ Hospital Ph #: __________ Room #: ______

SIGNATURE OF PARENT/GUARDIAN: ___________________________ Date: __________________

MEDICAL CERTIFICATION- TO BE COMPLETED BY A PSYCHIATRIST/PSYCHOLOGIST

I. Psychological Condition or Diagnosis

The undersigned certifies that the above-named student is unable to attend school for the following reason(s): (GIVE SPECIFIC DIAGNOSIS AND COMPLETE TREATMENT PLAN ATTACHED)

_____________________________________________________________________________________

_____________________________________________________________________________________

Please explain in detail why the student cannot function for any period of time in a classroom setting.

_____________________________________________________________________________________

_____________________________________________________________________________________

What length of time is the student able to attend school at this time (hours/minutes)? ________________
What accommodations and/or modifications does the student need to remain in/or return to the classroom setting?

_____________________________________________________________________________________

II. Communicable Status

A. Is this student contagious at this time? ☐ YES ☐ NO

B. Can this illness be transmitted by the Hospital/Homebound teacher to another homebound student? ☐ YES ☐ NO

III. Duration

The expected duration of the condition which prevents school attendance is: (A TIME PERIOD MUST BE CHECKED. IF MORE THAN EIGHT WEEKS A NEW REFERRAL MUST BE SUBMITTED PRIOR TO THE END DATE)

☐ 3 weeks ☐ 4 weeks ☐ 5 weeks ☐ 6 weeks ☐ 7 weeks ☐ 8 weeks

IV. PSYCHIATRIST/LICENSED PSYCHOLOGIST’S Name: __________________________ Phone#: __________

Address: __________________________ City: _________________ State: ________ Zip#: __________

PSYCHIATRIST/LICENSED PSYCHOLOGIST’S Original Signature __________________________ Date: __________

Stamp signatures are not acceptable

Revised 11.2021

Hospital/Homebound Application
HH Form 1B Psychological

Issue Copy to- School Cum Folder Homebound Office School Nurse Parent CW&A
V. Treatment Plan

Name of Patient: ________________________________________________

Patient Data

<table>
<thead>
<tr>
<th>Address:</th>
<th>Birthdate:</th>
<th>Age:</th>
<th>Patient Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>City:</td>
<td>Gender</td>
<td>Race:</td>
<td>Previously Treated?</td>
</tr>
<tr>
<td>State:</td>
<td>Zip:</td>
<td>Marital Status:</td>
<td>Treatment Setting:</td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Admission Date:</td>
<td>PCP:</td>
<td></td>
</tr>
<tr>
<td>Work Phone:</td>
<td>Cell Phone:</td>
<td>Discharge Date:</td>
<td></td>
</tr>
<tr>
<td>Student ID:</td>
<td>Last Review:</td>
<td>Employer:</td>
<td></td>
</tr>
<tr>
<td>Guardian:</td>
<td>Referral Source:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Treatment Modalities

The patient is actively participating in the following treatment modalities:

<table>
<thead>
<tr>
<th>Type of Therapy Sessions</th>
<th>Frequency</th>
<th>Weekly, Biweekly, Monthly</th>
</tr>
</thead>
</table>

Treatment Approaches

The following treatment approaches are being implemented:

Medication | Dosage | Frequency | Start Date | End Date | Prescriber |

Provider Credentials/Information

Name of Service: ____________________________________________ Phone #: ______________________

Address: ____________________________________________________

PSYCHIATRIST/LICENSED PSYCHOLOGIST’S Original Signature: ____________________________ Date: ______________________

Print Name: __________________________________________________________ Date: ______________________

MEDICAL PROVIDER SHOULD FAX THIS FORM TO THE HOSPITAL/HOMEBOUND PROGRAM AT 225.929.8775
THIS FORM SHOULD NOT BE RETURNED TO THE STUDENT’S SCHOOL.

ATTENTION: Dr. Janet A. Harris, ESS Supervisor for Homebound Programs
Goodwood Administrative Center 6550 Sevenoaks Avenue, Baton Rouge, Louisiana 70806

Hospital/Homebound Application
HH Form 1B Psychological

Issue Copy to- School CumFolder Homebound Office School Nurse Parent CW&A

Revised 11.2021
Parent and Student Rules for Homebound

(The Please keep a signed copy for future reference)

The parents and student must observe the following rules once a homebound teacher has been assigned. Failure to observe these regulations could result in the withdrawal of this special service.

1. One of the student’s parents or a responsible adult over 18 yrs. old must be present in the home or assigned location for the duration of a homebound session. The homebound teacher will not remain in the home if uncomfortable with the adult left in charge.

2. A parent/guardian of the homebound student is responsible for picking up textbooks from school. Supplies are also the responsibility of the parent. At no time will the homebound teacher be required to transport books to and from schools. The homebound teacher provides the assignments and instruction.

3. Student and teacher are not to be interrupted during the instructional period.
   - Members of family must remain out of the room during the class period to minimize distractions unless stipulations have been made by the parent that will hinder adequate service delivery (refer to disclosure form).
   - A quiet setting without TV or radio will enhance the learning experience for your child. Please provide a quiet and clean environment. Frequent interruptions due to visitors, phone calls, etc. interfere with instruction and should be limited.
   - In order to maintain a healthy environment for the student and teacher, please refrain from smoking in the house during homebound sessions. A parent should notify the teacher if animals are in or around the home.

4. Independent home study is essential for the student to maintain his/her class standing. It then becomes the student’s responsibility, under the supervision of the parent/guardian, to complete the work which has been assigned. An assigned lesson not completed is a loss of valuable time for the student and a loss of limited time the homebound teacher has to spend with your child. Therefore, the parent/guardian is also responsible for:
   - assuring the student will be available and appropriately dressed and ready to participate with the homebound teacher;
   - helping a younger student set up a daily schedule that provides a specific time and place in the home where the student can work on his/her assignments; and
   - checking that assignments are completed. This will demonstrate to your child that you are genuinely interested in his/her performance and future academic success.

5. The parent(s) shall be notified in a timely fashion if the teacher is unable to keep the child’s homebound appointment. If your child is unable to receive a lesson at the scheduled time, the parent should inform the homebound teacher as soon as possible. Each unexcused absence will count for two and one half (2½) days absent and reported to Child Welfare and Attendance.

6. Emergency evacuation procedures: In case there is an emergency in your home, please develop an evacuation procedure to exit safely from your home or location of homebound instruction. Please inform the homebound teacher of this evacuation plan.

7. Observations and evaluations of teachers are necessary and will be conducted during regularly scheduled homebound sessions with or without prior notification.

Failure to observe these regulations can result in the withdrawal of this special service.

My signature indicates that I have received and read a copy of these homebound rules.

________________________________________  __________________________________________  ____________
Student Name                                      Parent or Guardian Signature                          Date

The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records.

ESS
Revised 8/2019
APPLICATION FOR HOSPITAL/HOMEBOUND INSTRUCTION
EAST BATON ROUGE PARISH SCHOOLS
EXCEPTIONAL STUDENT SERVICES DEPARTMENT
6550 Sevenoaks Avenue, Baton Rouge, LA 70806

Students’ Schedules retrieved from JCampus must be attached to this form.

STUDENT DEMOGRAPHIC INFORMATION:

Student: ___________________________ Student ID: ___________________________
DOB: ___________________ Race: ______________ Sex: ______ Grade: ______________

Parent(s) Name: ___________________________
Telephone Numbers: __________(work); __________ (cell); __________ (home)
Home Address: _____________________________________________________________

SCHOOL INFORMATION:

School: ___________________________
School Contact Person: ___________________________
School Contact’s Email/Telephone: ___________________________________________

STUDENT ACADEMIC INFORMATION:

ESS STUDENT
Current IEP Date: ___________________________
Current Eval.Date: ___________________________
Primary Exceptionality: ___________________________

DIRECT and/or RELATED SERVICES
(Check those that the student receives)
APE ___ Speech ___ OT
PT ___ VI ___ HI
Other

ASSESSMENT INFORMATION:
(Check those assessments that the student will take)
_____ LEAP 2025: English I _____ LEAP 2025: English II
_____ LEAP 2025: Algebra I _____ LEAP 2025: Geometry
_____ LEAP 2025: U.S. History _____ LEAP 2025: Biology
_____ ACT _____ WorkKeys
_____ ELPT

REGULAR EDUCATION STUDENT
NOTE: Regular education students’ IAPs must accompany this Homebound Application.

ASSESSMENT INFORMATION:
(Check those assessments that the student will take)

Please do not write below this line.
APPLICATION FOR HOSPITAL/HOMEBOUND INSTRUCTION
EAST BATON ROUGE PARISH SCHOOLS
EXCEPTIONAL STUDENT SERVICES DEPARTMENT
6550 Sevenoaks Avenue, Baton Rouge, LA 70806

Students’ Schedules retrieved from JCampus must be attached to this form.

**********************************************************************************************************************************************************************************************************

DURATION OF HOMEBOUND SERVICES:
H/H Beginning Date: ____________
H/H Ending Date: ______________

Dr. Janet A. Harris, ESS Supervisor for HH
Goodwood Administrative Center
6550 Sevenoaks Avenue, Baton Rouge, LA 70806
Phone: (225) 771.8878; FAX: (225) 929.8775

APPROVAL/DENIAL of Services:
Homebound Services are: _____ APPROVED _____ DENIED

________________________________________________________________________________________________________________________________________________________

ESS Supervisor for Homebound (signature) Date of Decision

Homebound Teacher Assigned: __________________________ Contact #: ______________

ADDITIONAL INFORMATION:
________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________

Special Instructions for ESS students (if applicable):
________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________

EBR Homebound Program
Form HH3
2

Revised 11.2021