

# **GUIDELINES FOR DISTRICT ADMINISTRATION OF THE HOME/HOSPITAL (H/H) INSTRUCTION PROGRAM**

## **Eligibility**

---

1. A student must be enrolled in the district or must be a private school student receiving ancillary services in the school district.
2. A written statement by a qualified medical practitioner (M.D., D.O., D.M.D., D.C., N.D., P.A.), advanced registered nurse practitioner (A.R.N.P.), or licensed mental health therapist indicating that the student is unable to attend school due to physical disability or illness for at least four weeks must be on file.

## **Program Requirements**

---

1. Tutoring is provided for students absent a minimum of four weeks but less than a semester. Tutoring may be intermittent, but the total weeks of tutoring may not exceed 18 weeks.
2. For information on the relationship of H/H instruction to Special Education and 504 see page 3 of the H/H Bulletin.
3. H/H tutoring is not provided during school vacations unless the student is enrolled in a district summer school program.
4. H/H tutoring may not begin if less than four weeks of school remain in the school year.
5. H/H instruction is for the student unable to attend school due to physical disability or illness. It may not be used to tutor a student who is staying at home with an infant or sick relative.

## **Reporting, Auditing, Fiscal Requirements**

---

1. A final enrollment report must be submitted to the Office of Superintendent of Public Instruction (OSPI) in July following the end of each school year.
2. Locally developed request for H/H instruction forms must contain the following:
  - a. Student's name.
  - b. Diagnosis.
  - c. Qualified medical practitioner's signature, date, and anticipated weeks of absence.
  - d. Dates of service.
  - e. Original request or extension.
  - f. Whether or not the student is enrolled in a special education program.

These forms must be available for inspection by OSPI or educational service district staff/monitors.

3. The district must have on file for each student served the actual number of total weeks of instruction.

# Sample

## REQUEST FOR HOME/HOSPITAL INSTRUCTION

SCHOOL DISTRICT NAME		STUDENT NAME: (Last, First, Middle) Please Print	
CONTACT PERSON	TELEPHONE NUMBER	STUDENT GRADE LEVEL	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female

### SECTION 1—THIS SECTION TO BE COMPLETED BY QUALIFIED MEDICAL PRACTITIONER

#### DIAGNOSIS:

- Disease/Injury/Surgery (primary diagnosis): \_\_\_\_\_  
\_\_\_\_\_
- Drug/Alcohol Treatment
- Pregnancy
- Other \* (describe): \_\_\_\_\_  
\_\_\_\_\_

I certify that this student is unable to attend public school for \_\_\_\_\_ weeks.

_____	BUSINESS ADDRESS
TYPE/PRINT NAME OF QUALIFIED MEDICAL PRACTITIONER	
_____	CONTACT TELEPHONE NUMBER
SIGNATURE	DATE

### SECTION 2—THIS SECTION FOR SCHOOL DISTRICT USE

If the student is eligible to receive special education services, does the IEP team need to meet?  Yes  No

CHECK ONE

- Original Request
- Extension

Beginning date of instructional time or extension:

MO	DAY	YEAR

NOTE: Beginning date on extension request must consecutively follow ending date of original request.

_____	_____	_____
SCHOOL DISTRICT AUTHORIZATION	DATE	CONTACT TELEPHONE NUMBER