Sacramento City Unified School District

Home Hospital Instruction (HHI)

Program Information & Application

SCUSD offers Home Hospital Instruction(HHI)as services to meet the educational needs of students residing in our district who incur a temporary, but extended illness or disability which makes attendance at their regular school impossible or inadvisable.

"Temporary disability" (Ed Code 48206.3) is defined as a physical, mental, or emotional disability incurred while a pupil is enrolled in regular day classes or an alternative education program, and after which the pupil can reasonably be expected to return to regular day classes or the alternative education program without special intervention. Ed Code 48207.

Our program requires a minimum expected absence of 4 weeks and a maximum of 9 weeks. Your child's school shall support your student in Short Term Independent Study if less than 4 weeks.

Please review the following program information and include this page when submitting the application for Home Hospital Instruction (HHI):

- Students may be referred to HHI if they are unable to attend school due to a serious injury or illness which will result in school absence for at least 4 weeks.
- School site accommodations such as a 504 or Short-Term Independent Study should be considered BEFORE a referral is made.
- For enrollments exceeding 9 weeks, a new Physician Request (Form C) may be required.
- High School applications must be received 6 weeks prior to the end of the semester.
- Regardless of the physician recommendation, SCUSD will determine the appropriateness of placement on an individual basis. Approval is at the discretion of SCUSD.

For General Education Students, there are two models for delivering instruction:

1. Home Hospital Instruction (HHI) in the home, hospital setting, or virtually-if deemed medically necessary for up to 5 hours of instruction a week.
2. Medical Independent Study (MIS) is a less restrictive setting where a student meets with a teacher at Capital City School for 1 hour a week.

Please submit a completed application to HomeHospital@scusd.edu

For Students With an IEP:

1. Instruction will take place in person or virtually at a time agreed upon by the family and the HHI teacher based on an Amendment IEP Meeting.
2. An addendum meeting will be scheduled to discuss HHI placement and changes to the student's offer of FAPE.

Please submit a completed application to HomeHospital@scusd.edu

For Students Hospitalized:

If your child is at Shriner's Hospital, Sutter Center for Psychiatry, Sutter Medical Center, or UC Davis Children's Hospital, instruction will be provided by a SCUSD teacher in the hospital.

Home Hospital Instruction will not commence until the following forms have been received and approved by the HHI Leadership Team and the parent/guardian agrees to the following:

- ☐ HHI/MIS Program Information and Application Checklist
- ☐ Parent Request (Form A)
- ☐ Authorization for Use or Disclosure of Health Information (Form B)
- ☐ Physician Request (Form C)
- ☐ For all Special Education referrals - Individualized Education Plan (IEP) designating Home Hospital Instruction (Addendum)

If you have any questions, please email HomeHospital@scusd.edu

Sacramento City Unified School District

Home Hospital Instruction (HHI)

Application Parent Request (Form A)

SCUSD offers Home Hospital Instruction (HHI) as services to meet the educational needs of enrolled students, residing in our district, who incur a temporary but extended illness or disability which makes attendance at their regular school impossible or inadvisable. The expected period of absence must be **at least four (4) weeks, but not to exceed 9 weeks.**

Student's Name:_____ Birthdate:_____ Grade:____ Gender:_____

Parent(s)/Guardian(s) Name(s):_____

Home Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

E-mail:_____

Current School:_____ Current Teacher/Counselor:_____

Reason for Home Hospital Instruction (HHI) Request:

Does your child currently have an IEP? ☐Yes ☐No If so, please provide Case Manager or Special Education Teacher name:_____

Please initial all of the following and sign below:

- ☐ I hereby request that my child be reviewed by SCUSD for the Home Hospital Instruction or Medical Independent Study program because he/she is temporarily unable to attend his/her school for medical reasons.
- ☐ I understand that placement in these programs is at the discretion of SCUSD.
- ☐ I agree to attend planning/placement meetings.
- ☐ It is my intent that my child will return to his/her regular class(es) as soon as possible when his/her medical condition improves.

After my child has been approved for HHI and it is determined that instruction will take place in the home or virtually if deemed medically necessary:

- ☐ I agree that my child will be ready for instruction as arranged with the teacher with materials, books, and his/her physical needs met.
- ☐ I agree to be present and visible or have a designated adult (25 years or older) present in the home during HHI.
- ☐ I agree to provide a quiet and appropriate place for instruction
- ☐ I understand that some classes cannot be taught on HHI or MIS (For example, AP, career pathway, and special programs). No schedule is guaranteed. An alternative schedule may be offered.
- ☐ I agree to notify the teacher 4 hours prior to the scheduled appointment if my child is unable to receive instruction for any reason.
- ☐ I understand that if placement is expected to exceed the return date, I may be asked to provide a new Physician Request form and attend an addendum meeting.

Parent/Guardian Signature:_____ Date:_____

Sacramento City Unified School District

Home Hospital Instruction (HHI)

Authorization for the Use or Disclosure of Health Information to School Districts (Form B)

wCompletion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all requested information may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name:_____ Birthdate:_____

I, the undersigned, do hereby authorize (name of agency and/or healthcare providers):

(1)_____ (2)_____

to provide health information from the above-named child's medical record to & from:

Sacramento City Unified School District - 5735 47th Avenue, Sacramento, CA 95824

Home Hospital Coordinator/Credentialed Nurse (916) 643-9412

The disclosure of health information is required for the following purpose: **To evaluate the student and determine the need for services.**

Requested information shall be limited to the following: ☐ All health information;

☐ Mental health information; or ☐ Disease-specific information as described:

DURATION:

This authorization shall become effective immediately & shall remain in effect until _____ (enter date) 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.

YOUR RIGHTS:

I understand that 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, & delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.

RE-DISCLOSURE:

I understand that the Requestor(School District) will protect this information as prescribed by the Family Equal Rights Protection Act (FERPA) and that the information becomes part of the student's permanent 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 a 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.

APPROVAL:

Parent/Guardian Printed Name:_____

Parent/Guardian Signature:_____Date: _____

Relationship to Student:_____ Phone Number: _____

Sacramento City Unified School District

Home Hospital Instruction (HHI)

Physician Request (Form C)

Dear Medical Provider,

SCUSD offers Home Hospital Instruction(HHI) as services to meet the educational need of students with a temporary acute condition that prevents attendance at their regular school.

"Temporary disability" (Ed Code 48206.3) is defined as a physical, mental, or emotional disability incurred while a pupil is enrolled in regular day classes or an alternative education program, and after which the pupil can reasonably be expected to return to regular day classes or the alternative education program without special intervention. A temporary disability shall not include a disability for which a pupil is identified as an individual with exceptional needs pursuant to Ed Code 48207.

Please complete the ENTIRE FORM to assist us in determining how to best meet the academic needs of your patient.

Our programs require a minimum expected absence of four (4) weeks.

Expected duration of Absence: Beginning date:_____ End date:_____

Student's Name:_____ Birthdate:_____

Medical Diagnosis:_____

If emotional, psychological, or behavioral, is this student receiving ongoing medical care? ☐ Yes ☐ No

Prognosis:_____

Date(s) of Medical/Psychiatric Examination:_____

Location and Duration of Hospitalizations:_____

Medications:_____

Physical limitations preventing school attendance:

Psychological or emotional limitations preventing school attendance:

Recommendations for physical/psychological accommodations upon return to school:

TO BE COMPLETED AND SIGNED BY A MEDICAL DOCTOR (MD)

This is to certify that the student named above is in my professional care. This student does not have a contagious disease that will endanger the health & safety of the teacher. I understand that placement of this student in Home Hospital Instruction or Medical Independent Study is at the discretion of SCUSD.

Physician's Signature:_____ Date:_____

Physician's Name:_____ Phone Number:_____

Hospital Affiliation:_____ Fax Number:_____

For questions, please contact HomeHospital@scusd.edu or submit form to Confidential SCUSD Health Services fax# (916) 399-2028