



EASTERN ILLINOIS AREA OF SPECIAL EDUCATION

5837 Park Drive, Suite 1
Charleston, IL 61920
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REFERRAL FOR HOME AND HOSPITAL INSTRUCTION

Home and Hospital Instruction

In order to provide for home and hospital instruction for students enrolled in member districts of Eastern Illinois Area of Special Education, the following procedures are outlined:

1) Eligibility:

A licensed physician confirms in writing that a student will be absent from school and confined to a home or hospital. This absence will be for more than two consecutive weeks, but not more than six months because of a temporary physical or health impairment.

2) Procedure:

- a. The local district is informed that a student is eligible for home or hospital instruction.
- b. A local district administrator or designee contacts the parents/guardians. If the parents/guardians agree to home/hospital instructions, the parent must provide a licensed medical physician's statement of need. (Form H/HA) and a signed parental/guardian consent form (EIASE F). The district administrator or designee is responsible to see that form H/H is completed.
- c. A local district administrator or designee sends the Application for Home/Hospital Services (Form H/H) to the EIASE director for his/her signature. A copy is made, filed, and the original Form H/H is returned to the local district.
- d. The local school administrator or home/hospital teacher gathers the necessary information on the student's Individual Education Program (Form H/HC). The time schedule for instruction is set with the parents/guardians and/or hospital. If the student already has an IEP, necessary modifications may be made, rather than a new individualized educational program written.

3) Home or Hospital Instruction Terminates

The student's anticipated recuperation time (stated on the physician's medical certification) determines the duration of home or hospital instruction. If an extension is needed, another note from the physician should be added to the application. The home or hospital instructor informs the school at the end of home or hospital instruction. Termination of instruction should be dated B121 on Form H/HC.

FORM H/HA

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MEDICAL CERTIFICATION

For Home or Hospital Instruction Program

The Illinois Rules and Regulations for Special Education for Home and Hospital Instruction state that because of a temporary physical or health impairment, it is the opinion of a licensed medical examiner that a student will be absent from school for more than two consecutive weeks, but not more than six months.

Physician:

This completed form must be returned to the local school district before services can be initiated.

Student's Name	Gender	Birthdate	Grade
Address	School District		

Circle One: HOME INSTRUCTION HOSPITAL INSTRUCTION

Estimated length of time that the home or hospital instruction will be needed:

_____ Weeks

Medical Diagnosis:

Date: _____

Physician's Signature

23IAC 226.535a
23IAC 226.545

This completed form must be kept on file in the local district.

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INDIVIDUALIZED EDUCATION PROGRAM
Home/Hospital Instruction

Student's Name	Birthdate	Grade
Resident District		Date

Date: _____ home _____ hospital instruction is scheduled to begin: _____

Date ended: _____

Medical Certification by: _____
Physician Date

IEP Completed by: _____

This IEP has been discussed with:

NAME

DATE

Student _____

Parent/Guardian _____

HHI Teacher _____

Teacher _____

Teacher _____

Teacher _____

Teacher _____

Principal _____

Describe the student's current educational status.

Is this student identified as a special education student? _____ YES _____ NO

GOALS AND OBJECTIVES

1 Student will maintain current skills and achievement level.

Objective _____

Objective _____

2 _____

Objective _____

Objective _____

3 _____

Objective _____

Objective _____

EASTERN ILLINOIS AREA OF SPECIAL EDUCATION
APPLICATION FOR HOME/HOSPITAL SERVICES

A. To be completed by Parents or Guardians:

My child is unable to go to school and I request _____ home _____ hospital instruction for:

Name	Birthdate	Grade
Address		Telephone
Name of School	Date last attended	
Student's disability		
Date	Signature of Parent or Guardian	

B. To be completed by Physician:

Check one: _____ HOME _____ HOSPITAL Instruction recommended YES _____ NO _____

Estimated length of time that home or hospital services will be needed: _____

Medical Diagnosis _____

Date _____ Signature of Physician _____

C. To be completed by School Official:

Student's Program:

SUBJECT	TEACHER	PERIOD
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current special education placement? YES _____ NO _____

Related services provided? YES _____ NO _____ (If yes, specify type)

Current IEP on file? YES _____ NO _____

Date _____ Signature of School Official _____

D. To be completed by Home Instructor:

Name: _____ Phone: _____

Date Instruction started: _____ Date ended: _____

Date of Team meeting: _____

E. Date filed:

_____ Signature of Director of Special Education