THE HOSPITAL SCHOOLS PROGRAM
Mary Maher, Principal
www.hospitalschools.com

Hospital Instruction Application Form:

For Students in Certain Hospital Settings

Dear Parent/Legal Guardian:

We understand that because of your child's medical needs, your child is now in a hospital setting (which include hospitals, day treatment centers, and long-term nursing facilities) that is not affiliated with New York City Public Schools (NYCPS). If you are a resident of New York City, your child is eligible to receive hospital instruction when your child is medically cleared by the hospital physician to receive instruction. There may be differences in how your child's instruction will be provided, depending on whether your child's hospital setting is in or out of New York City.

Also, depending on your child's needs, you may make an initial referral for a special education evaluation to determine if your child needs special education services. If your child already has an individualized education program (IEP), then you may request a reevaluation to consider the impact of your child's medical needs.

To request hospital instruction, your child must be affiliated with a school. If your child is enrolled in a NYCPS school, that school is your affiliated school. If your child is not enrolled in school, then you must first enroll your child in an NYCPS school. By submitting this request, you will be contacted about enrolling your child in an NYCPS school which may be assigned to your child. You must provide proof of New York City residency to enroll in NYCPS and receive hospital instruction.

Please work with your school and the hospital setting to submit the following documents:

- *Hospital Instruction Request Form* (to be completed by the Parent / Student and student's school)
  - High school students must also submit their permanent record, program, and transcript.
- *Proof of New York City residency* (if not currently enrolled in an NYCPS school)
- *Medically Necessary Hospital Instruction Medical Referral Form* (to be completed by student's physician)
- *Authorization for release of medical records (HIPAA Form)* (to be completed by Parent / Student)
  - Complete the top portion of the form with patient (student) name, address, and date of birth.
  - Leave blank box numbers 7 and 8, unless you wish to limit the medical information provided to NYCPS. Please note that narrowing the authorization could lead to delays in reviewing and/or approving the application.
  - Complete Box Numbers 10 and 11 if appropriate.
  - Sign and date the form. If the student is 18 years of age or older and able, they MUST sign the form themselves.
- *Authorization for release of educational records (FERPA Consent Form)* (to be completed by Parent / Student)
- *Statement of Parent in Support of Tuition Claim for NYC Resident Child Temporarily Hospitalized Out-of-City*
  - To be completed only if the hospital setting is outside of New York City, and by the Parent/Student, student's physician, and hospital instruction provider/school affiliated with the hospital setting

Send this completed package to Hospitalschoolsnonnyc@schools.nyc.gov. Once NYCPS has received your request packet, an NYCPS staff member will contact you about next steps. Submitting application materials does not ensure approval for services.

- For additional information about the application process and eligibility, please visit [schools.nyc.gov/learning/programs/medically-necessary-instruction].
- To avoid delays in the application process, please make sure that all applicable information is completed.
- Be sure you complete ALL pages in the application.
- All referrals for psychiatric reasons must be made by a PSYCHIATRIST.

NOTE: Hospital Instruction is not available for students who cannot attend school because they have not met immunization requirements. Families should contact the Office of Home Schooling for additional information at 917-339-1793 or homeschool@schools.nyc.gov.

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Hospital Instruction Referral Form

Medically Necessary Hospital Instruction applications **MUST** also include:

1. A Medically Necessary Hospital Instruction *Medical Referral Form* completed by treating physician or psychiatrist.
2. A completed and signed *HIPAA* form (NYC Dept of Health and Mental Hygeine.)
3. A completed and signed *FERPA Consent Form*.
4. *Statement of Parent in Support of Tuition Claim for NYC Resident Child Temporarily Hospitalized Out-of-City*

Send all COMPLETE forms for the application to Hospitalschoolsnonnyc@schools.nyc.gov.

Student Information

Student Name: _____ OSIS#: _____ Date:_____

Date of Birth: _____ Home District: _____

Grade:_____ IEP: ☐ Yes ☐ No

Address: _____ Apt: _____

Borough: _____

Parent / Guardian: _____ Email_____

Home Phone: _____ Cell Phone:_____

Special Alerts or additional information: _____

ATS Immunization Code:_____

Is your child enrolled in an NYCPS School? ☐ Yes ☐ No

- **If "No," you will be contacted about enrolling your child in an NYCPS School.**

Student's School: _____ Principal: _____

School Contact:_____ Phone: _____ Ext:_____

Email: _____ Room: _____ Fax:_____

Guidance Counselor: _____ Phone: _____ Ext:_____

Email: _____ Room: _____ Fax:_____

HS Students Only (HS Students receiving one-to-one instruction are eligible to receive up to 4 credits)
To be completed by your current principal, guidance counselor, or school administrator.

Course Title: _____ Regent: ☐ Yes ☐ NO Month: _____

Course Title: _____ Regent: ☐ Yes ☐ NO Month: _____

Course Title: _____ Regent: ☐ Yes ☐ NO Month: _____

Course Title: _____ Regent: ☐ Yes ☐ NO Month: _____

Course Title: _____ Regent: ☐ Yes ☐ NO Month: _____

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Special Circumstances (e.g. ACS, legal, advocate)

Agency _____ Contact:_____
Phone: _____Ext:_____
Email: _____

Agency _____ Contact:_____
Phone: _____Ext:_____
Email: _____

NYC Public Schools

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MEDICAL REFERRAL FOR MEDICALLY NECESSARY HOSPITAL INSTRUCTION
(To be completed by the Student's Treating Physician and/or Psychiatrist)

Student's name (Last, First)	DOB

Is under my care for the following (Diagnosis):

Please provide detailed and specific information defining the limitations that the student has in order to inform the Department of Education about the necessity of Medically Necessary Hospital Instruction services. Attach additional documentation as needed.

I hereby request that this child receive Medically Necessary Hospital Instruction because of the above limitations due to this/ these diagnosis/es which preclude this child's attending school.

This request is based on: ☐ parental request ☐ my professional opinion

☐ other (*please specify*):_____

I request that Medically Necessary Hospital Instruction be provided for _____ weeks (no less than 4 weeks)

Practitioner's Name (print)	Degree
Practitioner's Original Signature / Date of Signature	License

CONTACT INFORMATION

Telephone#	Extension	Email
Cell phone#	Pager#	

Times/hours I can be reached: Mon_____Tues_____Wed_____Thurs_____Friday _____

	Attending Physician or fellow		Other	PRACTITIONER'S STAMP
	Psychiatrist			
	Nurse Practitioner			
	Oral Surgeon			
	Podiatrist			

NOTE: Residents are not allowed to complete this form.

All referrals should be sent to Hospitalschoolsnonnyc@schools.nyc.gov

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name | Date of Birth | Patient Identification Number

Patient Address

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and Privacy Rule of the Health Insurance Portability and Accountability of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of Information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except· psychotherapy notes, and CONFIDENTIAL HIV/AIDS• RELATED INFORMATION only if l place my initials on the appropriate line in Item 7. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 7, I specifically authorize release of such information to the New York City Department of Health and Mental Hygiene ("DOHMH"),
2. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, DOHMH is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of the people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care providers listed below. l understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by DOHMH (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **I AUTHORIZE ALL MY HEALTH CARE PROVIDERS TO RELEASE THIS INFORMATION TO, AND DISCUSS THIS INFORMATION WITH THE OFFICE OF SCHOOL HEALTH, A JOINT PROGRAM OF THE NEW YORK CITY DEPARTMENT OF EDUCATION AND THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE.**

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

7. Specific information to be released and discussed:
Entire Medical Record (written and oral) including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records send to my health care providers by other health care providers.

☐ If this box is checked, release and discuss only my Medical Record from the range of dates starting from (insert date) _____ and ending on (insert date) _____.

☐ Other:

Include: (indicate by Initialing)
____ Alcohol/Drug Treatment Information
____ Mental Health Information
____ HIV/AIDS-Related Information

8. Reason for release of information: this information is released at request of the patient or representative unless otherwise specified here:

9. This authorization expires on the date that the patient is no longer enrolled in a school or program operated by the New York City Department of Education or serviced by the Office of School Health unless otherwise specified here**.

10. If not the patient, name of person signing form:

11. The person signing this form is authorized by law to sign on behalf of the patient as the parent or legal guardian of the patient, or as specified here:

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW | DATE

*Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV Symptoms or infection and information regarding a person's contacts.
**If an expiration date is specified in item 9 above, the form will expire on that date and a new form must be submitted by the parent or legal guardian of the patient, or other persons authorized by law

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PARENT CONSENT TO RELEASE EDUCATION RECORDS

I, _____, am the parent/guardian of the student below. The student is under the age of 18. I give consent to the New York City Public Schools to release the records identified below to the individual or organization indicated below.

Student's Information

Student Name: _____

Student's Date of Birth: _____

Student ID/OSIS Number (9-digits) _____

School Information (Current or Last NYCPS School Attended)

School Name: _____

School District/Borough/Number: _____

Years of Attendance: _____

Records to be Released: _____

Purpose of Disclosure: _____

Records to be Released To:

Individual/Organization Name: _____

Individual/Organization Address: _____

Individual/Organization Phone Number: _____

Individual/Organization Email Address: _____

Signature

Parent/Guardian Signature: _____Date: _____

NYC
Department of Education

Notice of Tuition Request -NYC Resident Child Admitted to an Out of City Hospital

Claiming School District Information

School District Claiming Tuition:					
Mailing Address:					
City:		State:		Zip code:	

Student & Parent Information

Student Name:		Age:		Date of Birth:	
Student Current Address:					
Committing Authority:				Date of Admission:	
Name of Parent or Guardian:				Telephone #	
Parent / Guardian Current Address:					
NYC School Last Attended:		Date of Discharge:		Telephone #	
Dates patient is expected to remain hospitalized:	To:		Days:		Grade:
District Contact:		Title:		Telephone #	

Certification

Certification as to need for hospitalization by physician (use AMA classification)

Medical Doctor Signature

Date

Mail to: New York City Department Of Eduction
Division of Financial Operations
Non Public School Payables
65 Court Street , Room 1001
Brooklyn, NY 11201
Attention: Non-Resident Tuition Unit

Department of Education

Statement of Parent in Support of Tuition Claim For NYC Resident Child Temporarily Hospitalized Out-Of-City

Name of Claiming School District: _____

Address: _____

NY State School District Code: _____ School Year: _____

I, _____ parent of _____ who was hospitalized in _____, located at _____

herby affirm that the undersigned resides in New York City at: _____

_____

In the event of a change of address to a location outside of New York City, notice of such change will be furnished to the Department of Education, Non Public School Payables at the address listed below:

Affirmed: _____ Date: _____ Telephone #: _____

Signature of Parent

Please complete and return to:

NYC Department of Education
65 Court Street, Room 1001
Brooklyn, NY 11201
Attention: Tuition Unit

Social Worker: _____ Date: _____

Include Credentials & Signature

Name of Group Home / Agency: _____

Address: _____