Home Instruction Application (Mental Health)

PLEASE READ BEFORE SUBMITTING APPLICATION

To: Parents/Guardians Requesting Home Instruction for Student
From: Loracell Hempstead– 216-838-0209 – loracell.hempstead@clevelandmetroschools.org

Please review the following guidelines prior to completing the Home Instruction Application.

1. All required paperwork must be completed and returned to the Home Instruction Office before it is determined whether or not your son/daughter meets the criteria for Home Instruction.

2. **Once Home Instruction is approved, a tutor will be assigned. The instructional service will begin within five (5) school days, but no later than ten (10) school days following receipt of verification of the need for services.**

3. The tutor will contact you directly to schedule a date and time for the initial meeting.

4. Tutoring sessions can be held in person or virtually depending on the preference of all involved.

5. The tutor will contact your child's school to obtain books, assignments and signatures from the appropriate school personnel.

6. The parent/guardian or an approved adult (at least 21 years of age) must be in the home during the **entire** tutoring session.

7. When the tutor visits your home for the first time, he/she will present to you the goals that they have created for each subject they will tutor your child in while they are on Home Instruction.

8. At the completion of each lesson, you must initial the time card for that day **only.** The time card should include each date for each tutoring session, the arrival and departure time, and the total hours for that day. At the end of the two week period or the completion of the total hours required, you must sign the time card verifying that you agree with the time reported. **DO NOT SIGN A BLANK TIME CARD**.
   * If asked to sign a blank time card please contact Loracell Hempstead at the number at the top of this application ASAP.

9. Your child should receive no less than five (5) hours of home instruction per week. One (1) hour of home instruction is given for each day school is in session to start with additional time provided depending on team decision. The tutors may come twice a week for a two and one half hours session. When schools are closed due to breaks, holidays, or inclement weather, there will be no home instruction.

Home Instruction Application (Mental Health)

Physician/Psychiatrist Report

To the Attending Psychologist/Psychiatrist:

Under the Compulsory Education Laws of the State of Ohio (Revised Code Sec. 3321.01 et seq.), children between the ages of 6 and 18 years are required to attend school, public, or private, except under certain conditions. Therefore, any request that a child be excused from school for more than a temporary period must be supported by evidence that can be produced and accepted in a court of law. Physicians certifying that children should be excused from school due to personal illness are required to complete this form. The Cleveland Metropolitan School District (CMSD), Division of Special Education, earnestly requests the cooperation of the medical profession in enforcing the Compulsory Education Law, with due regard for the health of the child.

*The Home Instruction is a program provided by the CMSD for students with orthopedic and/or health handicaps, health impairments, temporary health conditions, severe emotional handicaps or any other severe handicapping condition which prevent them from attending school even with special services or the aid of transportation. Home instruction is one of the most restrictive programs on the continuum of services. Students receiving home instruction do not attend school and receive **5** hours of instruction per week.*

Please complete and return to Loracell Hempstead, Cleveland Metropolitan School District, Division of Special Education, Office of Home Instruction, 1111 Superior Ave., E Suite 1800. Cleveland, OH. 44114
Phone: 216.838.0209 Fax: 216.777.5292 – loracell.hempstead@clevelandmetroschools.org

Name _____ Date of Birth _____ ID No. _____

Do you certify this student's condition will prevent him/her from attending regular school? Yes [ ] **No** [ ]

If yes, please specify reason(s) the student cannot attend a regular class setting. _____

_____

_____

What other options have been considered? _____

_____

Is home instruction recommended? Yes [ ] No [ ]

What is the anticipated period of time this student will be unable to attend school? _____

_____

Psychologist/Psychiatrist Name (**Print**) _____

Signature _____ Date _____

Address _____ Phone _____

Home Instruction Application (Mental Health)

Psychologist/Psychiatrist Report

Name _____ **Date of Birth** _____ M F **Record #** _____

Address _____ Telephone _____
Street City Zip

Mother _____ Father _____ Guardian _____

To comply with State standards, please provide the following information:.

1. What is the student's diagnosis/DMS-IV code? _____

   _____

2. Has the student ever had a mental health hospitalization? Yes [ ] No [ ]

   If yes: Date _____ Reason(s) _____

   _____

3. Student is receiving therapy/counseling from:

   Name _____ Phone _____

   Therapy/Counseling goals/objectives: _____

   _____

   Expected length of treatment/number of sessions: _____

   _____

4. Specific reason(s) why student is unable to attend school: _____

   _____

   _____

5. State the criteria to be used to determine when the student can return to school: _____

   _____

   _____

Additional comments: _____

_____

Psychologist/Psychiatrist Name (**Print)** _____

Signature _____ Date _____

Address _____ Phone _____

Home Instruction Application (Mental Health)

Physician Report

Name _____ **Date of Birth** _____ M F **Record #** _____

Address _____ Telephone _____
Street City Zip

Mother _____ Father _____ Guardian _____

Psychiatric Test (If applicable) By Whom _____ Date _____

Hospital/Agency _____

Date of Last Physical Examination _____ Doctor's Name _____

Height _____ Weight _____

Significant Findings _____

Neurological Findings _____

Diagnosis _____

Seizures ____ Epilepsy ____ Allergies ____ Communicable Diseases ____

Asthma ____ Anemia ____ Sickle Cell ___ Heart Murmur _____

Vision Screen Results O.U. _____ O.D. _____ O.S. _____ Date _____

Corrected Vision O.U. _____ O.D. _____ O.S. _____ Date _____

Referred to _____

Hearing screen results _____ Date _____

Referred to _____

Speech Normal _____ Delayed _____ Brief History _____

Comments _____

Motor development Normal _____ Delayed _____ Describe _____

_____

Medication prescribed by _____

Medication _____ Dosage _____ Frequency _____

Side Effects _____

Significant medical/physical conditions that may affect school performance _____

_____

Explain any significant behavior problems _____

_____

Medical Recommendations (precautions, limitations, special needs, equipment) _____

_____

Physician Name (**Print)** _____

Signature _____ Date _____

Address _____ Phone _____

Division of Special Education

Permission to Enroll Form

Dear Parents:

The school laws of the State of Ohio require that we have your permission to enroll your child in a program of special education.

Please enroll my son/daughter _____
Full Name Birth date
in a program for home/hospital instruction.

I give consent for the Cleveland Metropolitan School District to consult with my child's Physician and/or Psychiatrist/Psychologist to determine his/her eligibility for home/ hospital instruction.

I will provide a suitable place for the Home Instruction teacher and student to work and have an approved adult (at least 21 years of age) in the home during the entire instructional period.

Sign below and return with completed Home Instruction application to Loracell Hempstead, Division of Special Education, Home Instruction Office, 1111 Superior Ave., E, Suite 1800, Cleveland, OH 44114. If you have any questions/concerns please call Loracell at 216.838.0209.

Signature _____ Date _____

(Circle relationship) Father Mother Guardian

_____
Address

Phone Home _____ Cell _____ Work_____