Bakersfield City School District

Statement to Request Home and Hospital Instruction

Student Name: **Nombre del estudiante:**	**Date of Birth:** **Fecha de nacimiento:**
School: **Escuela:**	**School Year:** **Año escolar:**

THIS SECTION TO BE REVIEWED AND COMPLETED BY A HEALTHCARE PROVIDER

Home and Hospital Instruction Program

Home and Hospital Instruction (HHI) is individual instruction provided to a student with a temporary disability in the student's home or in a hospital or other residential health facility, excluding state hospitals. A temporary disability is defined as a physical, mental, or emotional disability incurred while a student is enrolled in regular day classes or an alternative education program, and after which the student can reasonably be expected to return to regular day classes or the alternative education program. The purpose of HHI is to help a student maintain continuity of instruction and maintain the former level of performance when a temporary disability makes attendance in regular classes or an alternative educational program **impossible or inadvisable**. Education Code 48206.3.

Please note: The student will only be provided with one hour of instruction for every day of instruction that is offered by the District in the regular education program. Enrollment in the HHI Program is temporary. **HHI is not a "home-school" or "independent study" program. If reasonable accommodations can be made that would allow the student to participate in the regular education program, do not complete this form.**

Diagnosis/Disability:	
HHI Start Date: **(Minimum of 3 weeks)**	**HHI End Date:** **(Maximum of 12 weeks)**
Health Care Provider Name:	**National Provider Identification (NPI) Number:**
Address:	**Phone:**

I certify that the student listed above has a temporary disability that makes attendance in regular classes or an alternative educational program **impossible or inadvisable** and that the student is expected to return to regular day classes or the alternative education program.

Health Care Provider Signature:	**Date:**

FOR DISTRICT USE ONLY

Received By:	**Date:**
Reviewed By:	**Date:** **Approved** **Denied**
HHI Agreement Completed By:	**Date:**