



HOME INSTRUCTION SCHOOLS

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Medically Necessary Instruction: Student Application

In order to request Medically Necessary Instruction Services, the parent/guardian must notify the school's guidance counselor and work with the school of affiliation ("home school") to submit the following documents. (High school students must also submit their permanent record, program, and transcript.)

A complete application to Medically Necessary Instruction must include the following forms:

1. *Medically Necessary Instruction Referral Form* (to be completed by the student's home school)
2. *Medically Necessary Instruction Medical Referral Form* (to be completed by a physician)
3. *Authorization for release of medical records (HIPAA Form)* (to be completed by Parent / Student)
 - a. Complete the top portion of the form with patient (student) name, address, and date of birth (DOB).
 - b. Leave blank box numbers 7 and 8, unless you wish to limit the medical information provided to the DOE. Please note that narrowing the authorization could lead to delays in reviewing and/or approving the application.
 - c. Complete Box Numbers 10 and 11 if appropriate.
 - d. Sign and date the form. If the student is 18 years of age or older and able, they MUST sign the form themselves.

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.
- Send this completed package to hiapply@schools.nyc.gov or fax them to (718) 472-6113.

NOTE: Medically Necessary 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.

Medically necessary instruction is typically conducted in-person at the student's home with an adult chaperone present. Remote instruction may be provided at the discretion of the Principal of Home Instruction Schools based on student needs and program capacity.

Medically Necessary Instruction Referral Form

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

1. A Medically Necessary Instruction *Medical Referral Form* completed by treating physician or psychiatrist.
2. A completed and signed *HIPPA* form (NYC Dept of Health and Mental Hygiene.)
3. A *Family Request Form for In-Person Services in Medically Necessary Instruction* completed by a parent.

Send all COMPLETE forms for the application to hiapply@schools.nyc.gov or faxed to (718) 472-6113.

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: _____

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)

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

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

Agency _____ Contact: _____
 Phone: _____ Ext: _____ Email: _____
 Agency _____ Contact: _____
 Phone: _____ Ext: _____ Email: _____

MEDICAL REFERRAL FOR MEDICALLY NECESSARY 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 Instruction services. Attach additional documentation as needed.

I hereby request that this child receive Medically Necessary 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

I request that Medically Necessary 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

☐

Psychiatrist

☐

Nurse Practitioner

☐

Oral Surgeon

☐

Podiatrist

PRACTITIONER'S STAMP

NOTE: Residents are not allowed to complete this form.

All referrals should be sent to hiapply@schools.nyc.gov or faxed to (718) 472-6113

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 Act 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 I 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") and the New York City Department of Education ("DOE"), which jointly operate the Office of School Health.

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 I have authorized to release my information. I 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 may be redisclosed by DOHMH or DOE (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 NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND THE NEW YORK CITY DEPARTMENT OF EDUCATION.

7. Specific information to be released and discussed:

All health information (written and oral) including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to my health care providers by other health care providers.

☐ If this box is checked, release and discuss only health information specified here: _____

(Use this box if you do not want the entire record released or disclosed. Use box 9 below to set how long you want this form to last)

Include: (Indicate by Initialing)

_____ Alcohol/Drug Treatment Information. *Specify records to be released and releasing organization:* _____

_____ 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 PATIENT IS NO LONGER ENROLLED IN A SCHOOL OR PROGRAM OPERATED BY DOE OR SERVICED BY THE OFFICE OF SCHOOL HEALTH, UNLESS OTHERWISE SPECIFIED HERE**:
10. IF NOT THE PATIENT, NAME OF PERSON SIGNING FORM: (PARENT/GUARDIAN MUST COMPLETE)	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:

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.

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.