Department of Education

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 Hygeine.)
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 Distrcit: _____ 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.e. 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
Practitioners 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 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 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 l 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 ttyg1ene ("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 JOIN PROGRAM OF THE NEW YORK CITY DEPARTMENT OF EDUCATION AND THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE.**

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.

   ☐ f 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:

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.