Department of Education

HOME INSTRUCTION SCHOOLS
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出於醫療原因的必要教學：學生申請表

如果您要求獲得出於醫療原因的必要教學服務，家長/監護人必須通知學校的輔導員，並找所屬學校（「本身的學校」）幫忙完成以下材料並提交。（高中學生必須也提交他們的永久學生檔案、課程、成績單。）

申請出於醫療原因的必要教學的完整申請表必須包括以下的表格：

1. 出於醫療原因的必要教學轉介表（由學生本身的學校完成）
2. 出於醫療原因的必要教學醫療轉介表（由一名醫生完成）
3. 披露醫療檔案授權書（*HIPAA* 表格）（由家長/學生完成）
    a. 填寫這份表格頂端的部分，包括病人（學生）姓名、地址、出生日期（DOB）。
    b. 第 7 和第 8 方框不要填寫，除非您想限制提供給教育局的醫療資訊。請注意，限制授權可能會造成審核和/或批准申請表的延遲。
    c. 如果適用，請填寫第 10 和第 11 方框。
    d. 在表上簽名並註明日期。如果學生滿 18 歲並有能力，學生**必須**自己在表格上簽名。
4. 出於醫療原因的必要面授教學服務家庭申請表（由一名家長完成）

提交申請材料不等於確保批准獲得服務。

- 關於申請程序和資格方面的更多資訊，請造訪schools.nyc.gov/learning/programs/medically-necessary-instruction
- 爲了避免申請程序延誤，請確保已填妥所有相關的資訊。
- 請確保填妥申請表的所有頁面。
- 所有出於精神方面理由的轉介必須由一名**精神病學家**提出。
- 把這個填妥的資料集發送到hiapply@schools.nyc.gov，或者傳真到(718) 472-6113。

註：無法到學校上學的學生不能選擇出於醫療原因的必要教學，因爲他們沒有完成免疫要求。家庭應該聯絡家庭教學辦公室了解詳情，號碼是917-339-1793，或者發電郵到homeschool@schools.nyc.gov。

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.

關於出於醫療原因的必要面授教學家長申請表

由於新冠疫情仍然持續，出於醫療原因的必要教學主要是在網路平台提供。在為數不多的情況下，如果學生只能以這種方式學習（例如，學生無法在沒有援助的情況下使用科技），出於醫療原因的必要教學可以以面授方式進行。

如果您考慮讓子女接受出於醫療原因的必要教學，請在下方註明。

我們將審核您這一要求和您子女的教育檔案，並通知您，您的出於醫療原因的必要教學將以什麼形式提供。請注意，對於在學生家裏提供的教學，一名成年陪同人員必須在所有教學課節全程在場。

學生姓名（必須填寫）：

學生 OSIS 號碼（必須填寫）：

您是否希望您的子女接受面授的家庭教學？（必須填寫）
☐ 是　　☐ 否

如果是，除了申請表裏所分享的，您的子女是否還有其他健康問題或教育需求，使您子女必須接受面授教學（可不填）

您是否能夠使用以下方法確保教學環境空氣流通：（必須填寫）

1. 開窗
2. 在老師到達前開電風扇或抽氣系統

☐ 是　　☐ 否

一名指定的住戶必須填妥紐約市教育局每天健康篩查表，並在老師到達時，將篩查表結果與老師分享。請確保在家中的所有成員（在醫療情況可能下）在面授教學期間都戴上口罩。家長可以透過子女的「家庭教學」老師要求一部空氣淨化器。學生家庭將向副校長報告家中任何陽性的新冠病例。

遵循以上所述的安全規程旨在加強教學期間的環境安全。