Department of Education

HOME INSTRUCTION SCHOOLS
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의료적 필수 교육: 학생 지원서

의료적 필수 수업 서비스를 요청하려면 학부모/보호자는 반드시 학교의 가이던스 카운슬러에게 통지하고 소속 학교("홈 스쿨")에 다음 자료를 제출해야 합니다. (고등학교 학생들은 반드시 영구 기록, 프로그램, 성적 증명서도 제출해야 합니다.)

의료적 필수 수업 지원서는 반드시 다음 양식을 포함해야 합니다:

1. *의료적 필수 수업 의뢰 양식*(학생의 홈 스쿨이 작성)
2. *의료적 필수 수업 의료 의뢰 양식*(주치의가 작성)
3. *의료 기록 공개 동의(HIPAA 양식)* (학부모/학생이 작성)
    a. 양식 상단에 환자(학생)의 이름, 주소, 생년월일(DOB)을 가입하십시오.
    b. DOE 에 제공되는 의료 정보를 제한하기를 원하는 경우를 제외하고 7 번 및 8 번 박스는 비워 두십시오. 동의 범위를 좁힌다면 지원서 검토 및/또는 승인이 늦어질 수 있습니다.
    c. 적절한 경우 10 번 및 11 번 박스를 작성하십시오.
    d. 양식에 서명하시고 날짜를 적으십시오 18 세 이상의 학생으로 가능한 경우 반드시 학생이 직접 서명해야 합니다.
4. *의료적 필수 수업 대면 서비스를 위한 가정 요청 양식*(학부모가 작성)

지원서 자료 제출이 서비스 승인을 보장하지 않습니다.

- 지원서 절차 및 자격 관련 추가 정보: schools.nyc.gov/learning/programs/medically-necessary-instruction
- 지원서 처리 절차가 지연되는 것을 방지하기 위해 반드시 모든 지원서 정보를 작성하시기 바랍니다.
- 지원서의 모든 페이지가 작성되었는지 반드시 확인하십시오.
- 정신 의학적 이유의 모든 의뢰는 반드시 **정신과 의사**에게 받아야 합니다.
- 작성한 패키지는 반드시 이메일 hiapply@schools.nyc.gov 또는 팩스 (718) 472-6113로 보내야 합니다.

알림: 의료적 필수 수업은 접종 요건을 충족하지 못해 학교에 출석할 수 없는 학생에게는 제공되지 않습니다. 추가 정보는 홈 스쿨링 담당실에 917-339-1793 또는 homeschool@schools.nyc.gov로 문의하십시오.

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.

의료적 필수 수업 대면 서비스를 위한 가정 요청 양식

계속되는 COVID-19 팬데믹으로 인하여 의료적 필수 수업은 주로 온라인 플랫폼에서 제공될 것입니다. 제한적인 경우 학생이 학습하기 위해 필요하다면 의료적 필수 수업이 대면으로 제공될 수 있습니다(예를 들어 학생이 도움 없이 테크놀로지 사용이 불가한 경우).

대면 의료적 필수 수업에 자녀가 고려되기를 원하신다면 아래 표시하십시오.

저희는 요청과 자녀분의 교육 기록을 검토하여 어떻게 의료적 필수 대면 수업이 제공될지 알려드리겠습니다. 학생의 가정에서 대면으로 수업이 제공되는 동안, 성인 보호자가 반드시 전체 가정 방문 교육 시간 동안 함께 해야함을 주의하십시오.

학생 성명 (필수):

학생 OSIS (필수):

가정에서 대면 수업에 고려되기를 원하십니까? (필수)
☐ 예 ☐ 아니요

예라고 답했다면 자녀분이 대면 학습을 받아야 하는 지원서에 공유한 내용 이상의 의료적 질환이나 교육적 필요가 있나요? (선택 사항)

내용 입력을 위해 여기를 클릭하거나 탭하십시오.

다음의 방법으로 학습 환경에 적절한 환기가 가능한가요? (필수)

1. 창문 열기
2. 교사가 도착하기 전 선풍기나 공기 배출 유닛 사용

☐ 예 ☐ 아니요

지정된 가족이 반드시 뉴욕시 교육청 일일 보건 스크리닝을 작성하고 도착 시 교사에게 결과를 공유해야 합니다. 대면 학습 중 집에 있는 모든 가족은 의료적으로 가능하다면 마스크를 착용해야 합니다. 부모님은 가정 학습 교사에게 공기 청정기를 요청하실 수 있습니다. 가족 중 COVID-19 양성 확진이 발생하면 교감에게 알리십시오.

위에 안내된 안전 프로토콜 준수는 학습 시간 중 환경적 안전을 향상시키기 위해 계획되었습니다.