



Administrative Form SSS-F503  
HOME & HOSPITAL (H/H) PROGRAM REFERRAL FORM

**Responsible:** Office of Student Services, Home & Hospital Department  
Telephone: 775-337-7560; Fax: 775-333-5353; Address: 350 Hunter Lake Drive, Reno (Glenn Hare Center)

**I. STUDENT INFORMATION – Please Print**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_ City/Zip Code: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Track: \_\_\_\_\_

Date of Last Attendance: \_\_\_\_\_ Date of IEP Revision for H/H Services: \_\_\_\_\_

IEP Annual Review Date: \_\_\_\_\_ Re-Eval Date: \_\_\_\_\_ Eligibility Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Case Manager: \_\_\_\_\_ School Nurse: \_\_\_\_\_

**II. MEDICAL INFORMATION**

Diagnosis or nature of disability: \_\_\_\_\_

Reason for Recommending H/H: \_\_\_\_\_

Expected Duration of Service: From \_\_\_\_\_ to \_\_\_\_\_

Special Considerations/Comments: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

The following must be submitted to the Home & Hospital secretary. Do not send materials until all documents are complete. The H/H secretary must receive a complete referral packet. Please initial that you have included each:

- \_\_\_\_\_ 1. Home-Hospital Program Referral (SSS-F503)
- \_\_\_\_\_ 2. IEP with revision addressing Home-Hospital services
- \_\_\_\_\_ 3. Physicians Letter
- \_\_\_\_\_ 4. Copy of SES 13 – Parent Consent to Release or Exchange Confidential Information

**TO BE COMPLETED BY Home & Hospital Department:**

H/H Teacher \_\_\_\_\_ Enrollment Date: \_\_\_\_\_ W/D Date: \_\_\_\_\_