# Ogden City School District
## Home and Hospital Plan

Student: _____

Expected length of absence (physician's statement must be attached): _____

Goal(s)/Objective(s)/Benchmark(s) from the existing IEP to be addressed during the absence:

_____

_____

_____

_____

_____

_____

_____

Comments:

_____

_____

_____

Type of service to be provided:

- ☐ Consultation — Amount of Time: _____ min/hr ☐ daily ☐ weekly
- ☐ Direct Service — Amount of Time: _____ min/hr ☐ daily ☐ weekly
- ☐ Other _____ — Amount of Time: _____ min/hr ☐ daily ☐ weekly

Service Provider(s): _____ _____

_____ _____

| Initiation of H/H Service | Termination of H/H Service |
|---|---|
| Date: | Date: |
| _____ Parent | _____ Parent |
| _____ LEA | _____ LEA |
| _____ Sp. Ed. Teacher | _____ Sp. Ed. Teacher |
| _____ Reg. Ed. Teacher | _____ Reg. Ed. Teacher |
| _____ Other | _____ Other |
| _____ Other | _____ Other |
| ☐ Change of Placement form completed | ☐ Change of Placement form completed |
| ☐ SCRAM sheet adjusted | ☐ SCRAM sheet adjusted |

**Copy to Parent/ Guardian /Student (if I8 or older) and Special Education Director**

**Parent/Student (if 18 or older) signature indicates receipt of copy**