Parent(s)/Legal Guardian(s):

Carroll County Public Schools’ (CCPS) home & hospital program provides instructional continuity to students who are unable to attend their regular school of enrollment due to physical illness/injury, an emotional condition, pregnancy, or a chronic health impairment. Home & hospital is a short-term instructional service mandated by state law with specific guidelines for program implementation and delivery. Services will be provided either virtually or in person.

In order to qualify for home & hospital services, the student must be expected to be absent from school for a projected period of fifteen (15) consecutive school days or more as a result of physical or emotional problems or has a history of intermittent absences due to a chronic health impairment.

*Students will receive a maximum of eight (8) hours of services per week.* The classes offered and total hours of services provided weekly will be determined by the Supervisor of Student Services-Student Support (some classes will not be offered).

**EMOTIONAL CONDITION**

Obtain a Medical Professional’s Recommendation for Home & Hospital Services *(Emotional Only)* form. Complete the parent/legal guardian section and forward the form to the appropriate medical professional. The completion of the form authorizes CCPS staff to communicate with your medical professional. Please note that failure to sign the release of information will result in denial of home & hospital services. The recommendation for home & hospital services must be made by a licensed psychiatrist, licensed psychologist, licensed mental health psychiatric nurse practitioner or certified school psychologist. A treatment plan must also be submitted. The recommendation will be reviewed by the school psychologist assigned to the student’s school, as well as other school staff. A transition plan must be provided by the medical professional and approved by CCPS for the student’s return to school. Failure to develop a transition plan will result in denial of services.

The medical professional should return the completed form to the Student Services Department by faxing it to 410-751-3695, Attention: Home & Hospital Services Office. Upon receipt of the form, CCPS staff will determine if home & hospital services are appropriate. If the service is approved, an instructional plan will be developed in consultation with the student’s home school. The assigned provider(s) will contact the parent/legal guardian directly to schedule services.

Maryland State Department of Education regulations require a review and re-verification of home & hospital services after 60 calendar days of service to determine if home & hospital services will continue.

If you have any questions, please feel free to contact Ms. Maria Martin, Supervisor of Student Services - Student Support, at 410-386-1822 or MariaMartin@carrollk12.org

**Note:** Please be aware that home & hospital services do not replicate the classroom experience and are not intended to help students make up past work prior to the home & hospital services approval period.
**MEDICAL PROFESSIONAL’S RECOMMENDATION FOR CCPS HOME & HOSPITAL SERVICES (Emotional Only)**

<table>
<thead>
<tr>
<th><strong>Date:</strong></th>
<th><strong>Student:</strong></th>
<th><strong>Date of Birth:</strong></th>
</tr>
</thead>
</table>

**Address:**

(Street) (City) (State) (Zip)

**School:**

Grade:

Does the student have a current IEP? Yes ☐ No ☐

Does the student have a 504 plan? Yes ☐ No ☐

Primary Phone: ___________________ Phone #2: ___________________ Phone #3: ___________________

Parent E-mail Address: ___________________

I am applying for home & hospital services for my child. I grant permission for CCPS Student Services staff or their designee to contact and confer with the referring and treating mental health professional(s) to exchange information about my child. This release is valid for one (1) year from the date signed. Failure to sign this release of information will result in denial of home & hospital services.

Parent or Legal Guardian Name (please print): __________________________

Parent or Legal Guardian Signature: __________________________

**LICENSED PSYCHIATRIST, LICENSED PSYCHOLOGIST, LICENSED PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONER OR CERTIFIED SCHOOL PSYCHOLOGIST STATEMENT FOR HOME & HOSPITAL SERVICES DUE TO EMOTIONAL CONDITION**

(please note: PA, LCSW, LCPC, or Counselor signatures are not permitted by COMAR.)

Description of Presenting Problem: __________________________

Reason student cannot function in the regular school environment and requires home & hospital services: __________________________

Date of Last Appointment: _______________ Frequency of Appointments: _______________

(Students must have been seen by a licensed psychiatrist, licensed psychologist, licensed psychiatric mental health nurse practitioner or certified school psychologist within one (1) week of recommendation.)

Are there any precautions needed when working with this student? __________________________

Please seriously consider any in-school accommodations or modifications, including partial-day attendance and/or alternative programs, before making the recommendation for home & hospital services.

I recommend home & hospital services: Yes ☐ No ☐

Approximate Length of Time (60-Day Max.): ___________________

☐ Full-Time Home & Hospital Services = MAXIMUM OF 8 HOURS OF SERVICES PER WEEK (student will NOT attend school)

☐ Part-Time Home & Hospital Services = MAXIMUM OF 4 HOURS OF SERVICES PER WEEK (student will attend school 1/2 days daily)

Anticipated Date of Return for Full or Part-Time Students: ___________________

☐ Concurrent Home & Hospital Services = STUDENT ELIGIBLE FOR TUTORING AFTER 3-DAY CONSECUTIVE ABSENCE DUE TO CHRONIC CONDITION (anticipated 20% absence for school year)

Licensed Psychiatrist ☐ Licensed Psychologist ☐ Licensed Psychiatric NP ☐ Certified School Psychologist ☐

**Name:** __________________________

(Please Print)

**Address:** __________________________

**Phone Number:** ___________________ **Fax Number:** ___________________ **E-mail Address:** ___________________

**Signature:** ___________________ **Date:** ___________________

**PLEASE COMPLETE A TREATMENT/TRANSITION PLAN ON PAGE 2 FOR EMOTIONAL/BEHAVIORAL REFERRALS. FAILURE TO PROVIDE A TRANSITION PLAN WILL RESULT IN DENIAL OF SERVICES.**

Please return completed forms to the Student Services Department via FAX at 410-751-3695.

ATTN: Maria Martin, Supervisor of Student Services – Support

Phone: 410-386-1822 E-mail: MariaMartin@carrollk12.org

**For Office Use Only**

Approved ☐ Denied ☐

Reason: __________________________

Signature: ___________________ **Date:** ___________________
Name of Student: ___________________________ Date of Birth: ___________________________

To be completed by a licensed psychiatrist, licensed psychologist, licensed psychiatric mental health nurse practitioner or certified school psychologist. Please respond to each question.

1. What is the diagnosis/emotional condition? __________________________________________

2. Is the student currently in therapy? Yes ☐ No ☐ If no, student may not be eligible for home & hospital services.
   Therapist’s Name: ___________________________ Phone: ___________________________
   E-mail Address: ___________________________

3. Date of most recent appointment: ________________ How often is student seen in your office? ________________
   Has the student kept regular appointments during the last two months? Yes ☐ No ☐
   Is the student compliant with scheduled therapy sessions? Yes ☐ No ☐

4. Is the student on medication? Yes ☐ No ☐ Medication(s)/Dosage(s) ___________________________

5. Describe your treatment plan, how it addresses the student’s emotional condition, and facilitates their return to school. Please feel free to attach additional information as needed.
   __________________________________________

6. Are there any modifications or accommodations (e.g., modified day and/or class schedule, alternative educational setting, counseling services, etc.) that could be offered by the school that would allow the student to return to/remain in the school building?
   __________________________________________

7. What supports are anticipated for the student to transition back to school? A transition plan must be developed collaboratively with school staff to plan for the student’s return to school. FAILURE TO DEVELOP A TRANSITION PLAN WILL RESULT IN THE DENIAL OF SERVICES. Please feel free to attach additional information as needed.
   __________________________________________

8. If approved, explain any precautions to be taken during H&H services: ___________________________

9. What is the anticipated date of return to school? (COMAR allows a maximum 60 calendar days of H&H services) ________________

10. The school psychologist, as well as other staff assigned to the student’s school, will review the request and contact you or the treating therapist to discuss the referral and transition plan. Please indicate the best day(s)/time(s) to reach you:
    Day(s)Time(s): ___________________________ Preferred phone number: ___________________________

*Please note that COMAR limits home & hospital services for students with an IEP for an emotional disability to 60 consecutive school days. A transition plan must be developed with the school. An IEP meeting must be held to determine a transition plan.

Recommendations for home & hospital services due to emotional reasons can only be made by one of the following:
Licensed Psychiatrist ☐ Licensed Psychologist ☐ Licensed Psychiatric NP ☐ Certified School Psychologist ☐

Name: ___________________________
Address: ___________________________
Phone: ___________________________ Fax: ___________________________
Signature: ___________________________ Date: ___________________________

For Office Use Only
Recommended ☐ Not Recommended ☐ Reason: ___________________________
Reviewed by School Psychologist: (Please Print): ___________________________
Signature of School Psychologist: ___________________________ Date: ___________________________

Rev. 7/23
Carroll County Public Schools' guidelines on home & hospital services states that:
"The presumption of the home & hospital program is that students are truly home or hospital bound. Therefore, the expectation is that students are not to be involved in such activities as employment, extended travel/vacations, and/or involvement with school social and extracurricular activities. If such issues arise, the Supervisor of Student Services-Student Support shall be informed immediately. In such cases, home & hospital services may be terminated."

*In the event that the above conditions are not met, home & hospital services will be discontinued until the Supervisor of Student Services - Student Support determines the next course of action.

My signature indicates that I have read and understand the above responsibilities. Failure to accept and sign the Parent/Student Requirements form will result in the denial of services.

Parent/Legal Guardian Name (Please Print)  Parent/Legal Guardian Signature  Date

Student Name (Please Print)  Student Signature  Date

Please return this signed form to the Home & Hospital Services office via FAX to 410-751-3695. Thank you.

Rev. 7/23