



Building the Future  
Cynthia McCabe, Ed.D.  
Superintendent

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# Carroll County Public Schools

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125 N. Court Street | Westminster, MD 21157

410-751-3000  
410-751-3034 TTY  
410-751-3003 FAX

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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](mailto: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.

**SCHOOL YEAR 2023-2024**

**MEDICAL PROFESSIONAL'S RECOMMENDATION FOR CCPS HOME & HOSPITAL SERVICES (Emotional Only)**

**PARENT/LEGAL GUARDIAN**

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

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: \_\_\_\_\_

**MEDICAL PROFESSIONAL**

**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: \_\_\_\_\_  
**(Student 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 – Student Support**

**Phone: 410-386-1822**

**E-mail: [MariaMartin@carrollk12.org](mailto:MariaMartin@carrollk12.org)**

**For Office Use Only**

Approved  Denied  Reason: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SCHOOL YEAR 2023-2024**  
**TREATMENT PLAN – Page 2**  
**FOR EMOTIONAL REFERRAL FOR HOME & HOSPITAL SERVICES**

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: \_\_\_\_\_

**PARENT/STUDENT REQUIREMENTS FOR CCPS HOME & HOSPITAL SERVICES**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Home & Hospital Provider: \_\_\_\_\_ Date: \_\_\_\_\_

The following guidelines have been developed to provide the best experience for your child during his/her participation in the program.

**Parent/Legal Guardian Requirements:**

- Obtain your child’s textbooks, materials, and laptop from the school. If your child completed schoolwork before starting home & hospital services, please submit that work to the school.
- Provide a quiet work environment and proper supervision during home & hospital sessions.
- Confirm service dates/times with the home & hospital provider. Notify the provider before the scheduled class time if your child is unable to participate in the day's session. Excused absences include illness, a doctor's visit, or a death in the family. All absences will be recorded at the school. Try to schedule personal appointments that do not conflict with scheduled sessions.
- Cooperate with the home & hospital provider and provide assistance in helping your child progress academically.
- Keep the home & hospital services office informed of any changes to your child’s medical condition.
- Notify the home & hospital services office at 410-386-1822 as soon as you know your child will be released to return to school. Please provide us with a medical release and/or relevant restrictions. This information can be faxed to 410-751-3695.
- In all situations where a home & hospital provider is assigned to come to the home (In person or virtually), you must ensure that a responsible adult 18 years of age or older is present during all sessions.

**Student Requirements:**

- Attend all classes as scheduled, on time, and participate through the duration of the class.
- Be prepared for class and participate in class discussions/activities.
- Complete independent work to progress through the courses, as expected.
- Cooperate with the home & hospital provider, at all times.

**Procedures for Missed Services:**

- Home & hospital services are made available to students on the days that school is in session. If school is closed one (1) or more days during the school week, the number of hours is prorated based on the number of days school is open. If school is closed for an entire week, no services are provided. Examples of non-school days include Election Day, Thanksgiving break, winter break, spring break, holidays, and snow days.
- If scheduled services are cancelled by the home & hospital provider, an effort will be made to make up the time missed within a week.
- If the student is unavailable for instruction due to illness, services may be made up within a week of the absence.

**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.**