



# CECIL COUNTY PUBLIC SCHOOLS HOME AND HOSPITAL EDUCATION & HOME INSTRUCTION

GEORGE WASHINGTON CARVER EDUCATION LEADERSHIP CENTER  
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## HOME AND HOSPITAL TEACHING PROGRAM *Student Referral Process* 2023-2024

The Cecil County Public Schools offers a program of Home and Hospital Teaching for Cecil County public school students who are unable to participate in their school of enrollment due to a physical or emotional condition. According to, COMAR, the Home and Hospital Program is a temporary support service, and not an alternative placement. The need for such services due to a physical condition shall only be submitted by a **licensed medical professional or certified nurse practitioner**. The need for such services due to an emotional condition shall only be submitted by a **licensed psychiatrist, licensed psychologist, certified school psychologist**. The student's illness must be determined to necessitate an absence of at least ten (10) consecutive school days with an expected absence of fifteen (15) or more days in order to be eligible for services or have a chronic health problem which causes absences from school in excess of 20 percent of the time to make this program feasible. Students may receive up to six (6) hours of instruction per week, unless otherwise indicated. Sixty (60) calendar days is the limitation for services. *Please Note:* Home and Hospital Teaching for a student with an emotional condition may not exceed sixty (60) consecutive school days. *Sixty (60) consecutive school days is the limitation for students in Special Education.*

The process for applying to access Home and Hospital Teaching Services is as follows:

1. The student's parent/guardian must complete SECTION A: Parent/Guardian, of the Home and Hospital Teaching Program Referral form (see attachment), and then forward this form to the medical professional, who must complete SECTION B: Medical Professional. The completion of this form authorizes Cecil County Public Schools staff to communicate with your medical professional. Please note that failure to sign this release of information may result in denial of Home and Hospital Teaching Services.
2. If the student's diagnosed illness is emotional or behavioral in nature, a treatment plan **must** also be submitted (see Medical Professional's Recommendation form).
3. If the request for home teaching services is due to pregnancy, services are provided for six (6) weeks post-delivery.
4. Return the completed form to the School Principal. Upon receipt of the form, Cecil County Public Schools staff will determine if Home and Hospital Teaching is appropriate. If the service is determined to be appropriate, the request may be approved.
5. Upon approval, a homebound teacher(s) may be assigned to the case.
6. The home and hospital teacher will contact the parents to begin instruction to the student.
7. Please remember that the maximum amount of time that a student can be assigned to Home and Hospital Teaching is **60 calendar days**. If the student is not able to return to school by that time, a review and re-verification process will determine if services will continue, be modified or ended. In addition, Cecil County Public Schools requires that a responsible adult (21 years of age or older) must be present throughout the duration of the time the home teacher is teaching with the student. Also, parents should be prepared to make arrangements to provide adult supervision if Home and Hospital Teaching is approved for direct teacher home teaching.

**Cecil County Public Schools**  
**Home and Hospital Teaching Program Referral -2023-2024**

**SECTION A - PARENT/GUARDIAN**

Student Name: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male/Female

Home Address: \_\_\_\_\_

Telephones: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Currently, my child is already receiving Home and Hospital Teaching Services: ( ) Yes or ( ) No

( ) Regular Education

\*( ) Special Education

\*( ) 504 Plan

**\*Please attach a copy of the student's current school schedule and/or IEP or 504 Plan, if applicable.**

**NOTICE OF REQUEST:**

First \_\_\_\_\_

Second \_\_\_\_\_

Third \_\_\_\_\_

Home and Hospital Teaching for health impaired or a pregnant student consists of minimum of 6 hours weekly or a minimum of three hours for a partial or half-day school program. I request the services for the above named student.

**I understand that a parent/guardian of this student or another designated responsible adult must be present in the home during the hours that direct home teaching services are scheduled.**

The adult who will be present is: \_\_\_\_\_

Address: \_\_\_\_\_

City

State

Zip

Relationship to student: \_\_\_\_\_ Telephone: \_\_\_\_\_

***The above information is correct to the best of my knowledge. I understand that should the above named adult be unable to be present during any scheduled instruction time, I am to contact the Home Teacher and/or the Office of Home and Hospital Education & Home Instruction immediately.***

***I am applying for Home and Hospital Teaching for my child. I grant permission for the Cecil County Public Schools Student Services staff to contact and confer with the referring and treating Medical Professional(s) to exchange information about my child. This release is valid for one year from the dated signed. Failure to sign this release of information may result in denial of Home and Hospital Teaching Services.***

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

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Cecil County Public Schools  
HOME AND HOSPITAL TEACHING PROGRAM- 2023-2024**

Student Name: \_\_\_\_\_

**SECTION B – MEDICAL PROFESSIONAL’S RECOMMENDATION (To be completed by Licensed Physician, Certified Nurse Practitioner, Licensed Psychiatrist, Licensed Psychologist, or Certified School Psychologist)**

Description of Presenting Problem: \_\_\_\_\_

Reason student cannot function in the regular school environment: \_\_\_\_\_

Date of Last Appointment: \_\_\_\_\_ Frequency of Appointments: \_\_\_\_\_

Is the student’s health condition contagious?  Yes  No Specify: \_\_\_\_\_

Are there any precautions needed when teaching this student? \_\_\_\_\_

If request is due to pregnancy, what is the estimated date of delivery? \_\_\_\_\_

*Please consider any in-school accommodations that could be made to allow attendance at the home school before making the recommendation for Home and Hospital Teaching.*

I recommend Home/Hospital Teaching  Yes  No **Please Note: \*Approx. length of time (60 Day Max.)** \_\_\_\_\_

I recommend Home/Hospital Teaching to begin on: \_\_\_\_\_

Full Time Home Teaching  Part Time Home Teaching (*hours to be spent in school daily* \_\_\_\_\_)

Intermittent Services (one semester max.) \_\_\_\_\_ Home and Hospital Teaching is provided for students who

suffer from a chronic illness (such as diabetes, lung diseases or migraines) that causes frequent intermittent absences. Concurrent home teaching services assist a student in completing work that was missed when they were absent two or more consecutive days in a week to their chronic illnesses.

Plan for Return to School: \_\_\_\_\_

Treating Medical Professional’s Name: \_\_\_\_\_

*(Please Print)*

Email Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Licensed Physician  Certified Nurse Practitioner  Licensed Psychiatrist  Licensed Psychologist

Certified School Psychologist

***Please complete a Treatment Plan on the next page for emotional/behavioral referrals.***

**SPECIAL NOTE: THIS ABOVE COMPLETED FORM MUST BE RETURNED TO THE STUDENT’S SCHOOL.**

**PRINCIPAL’S REVIEW:** I have reviewed the Home and Hospital Teaching information for the student named above.

\_\_\_\_\_  
**Principal’s Printed Name**

\_\_\_\_\_  
**Principal’s Signature**

\_\_\_\_\_  
**Date**

Please return this referral form to: Office of Home and Hospital Education & Home Instruction, 201 Booth Street, Elkton, Maryland 21921.

**FOR HOME AND HOSPITAL EDUCATION & HOME INSTRUCTION OFFICE USE ONLY**

Date Assigned to HHT: \_\_\_\_\_

Tentative Date of Return to School: \_\_\_\_\_

Date HHT Terminated: \_\_\_\_\_

Instructor/Program: \_\_\_\_\_

HHT Approved/Denied: \_\_\_\_\_ Date

*Joshua Mangold, Manager of Blended Virtual Program, Student Services*

Distribution (*as appropriate*):

Principal	
Counselor	
Pupil Personnel Worker	
Special Education Building Coordinator	
Director of Special Education	
School Nurse	
Guidance Secretary	

**Cecil County Public Schools**  
**Home and Hospital Teaching Program-2023-2024**  
**TREATMENT PLAN FOR EMOTIONAL/BEHAVIORAL REFERRALS\***

*\* Please note that COMAR limits home teaching due to emotional reasons for Special Education students to 60 consecutive school days. A transition plan must be developed with the school.*

**To be completed only by a licensed psychiatrist, licensed psychologist, or certified school psychologist. Please respond to each question.**

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

1. Diagnosis: \_\_\_\_\_

2. Is the student seen on regularly scheduled visits to your office?  Yes  No  
Frequency of Visits: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

3. Is the student currently in therapy?  Yes  No  
Therapist's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Frequency of Visits: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

4. Is the student on medication?  Yes  No  
Medication(s) and Dosages: \_\_\_\_\_

How will the medication(s) affect school performance? \_\_\_\_\_

5. Describe your treatment plan and how it addresses the student's emotional condition. Please attach additional information as needed. \_\_\_\_\_

6. Is Home and Hospital Teaching the preferred academic placement? If so, why? \_\_\_\_\_

7. Are there any modifications or accommodations that could be made by the home school that would allow the student to return to/remain in the home school? \_\_\_\_\_

8. What is the recommended plan to transition the student back to school? A transition plan must be developed to return the student to the school setting. \_\_\_\_\_

**Treating Medical Professional's Name:** \_\_\_\_\_  
*(Please Print Name)*

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

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

**Recommendations for Home Teaching due to emotional reasons can only be made by one of the following:**

Licensed Psychiatrist     Licensed Psychologist     Certified School Psychologist