Serving Learners, Families, and the Community

CECIL COUNTY PUBLIC SCHOOLS
HOME AND HOSPITAL EDUCATION

GEORGE WASHINGTON CARVER EDUCATION LEADERSHIP CENTER
201 BOOTH STREET • ELKTON, MD 21921
phone: 410.996.5660 • fax: 410.996.5454 • www.ccps.org

Jeffrey A. Lawson, Ed.D.
Superintendent of Schools

Diana B. Hawley
President, Board of Education

HOME AND HOSPITAL TEACHING PROGRAM
Student Application
2024-2025

Cecil County Public Schools offer a program of home and hospital teaching for Cecil County Public Schools' 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, psychiatric mental health nurse practitioner, or CCPS approved provider.** 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. All approved home and hospital applications will be in place for 60 calendar days or less based on the medical professional's recommendation. Home and hospital placements may not exceed 60 calendar days without a written extension request from the treating medical professional being submitted and approved. ***All approved home and hospital applications and extensions will result in a student support team (SST) or IEP team meeting at the student's home school. During this meeting, a transition plan will be developed for returning the student to a school-based program as soon as possible.***

The process for applying to access home and hospital teaching services is as follows:

1. The student's parent/guardian must complete and sign *SECTION A: Parent/Guardian*, of the Home and Hospital Teaching Program Application form and then forward this form to the medical professional, who must complete *SECTION B: Medical or Licensed Professional.* The completion of this form authorizes Cecil County Public Schools' staff to communicate with your medical/licensed 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 condition is **emotional or behavioral in nature, page 4 of this application must also be completed in order for the application to be processed.** The information provided by the medical/licensed professional on page 4 will be utilized by the student support/IEP team to create a transition plan during the home school's SST/IEP meeting following application approval.
3. Return the completed form to the school principal. Upon receipt of the form, the school principal will review the application, sign it, and send it to the Manager of Home and Hospital Programming. The Manager of Home and Hospital Programming will determine if home and hospital teaching is appropriate.
4. The Manager of Home and Hospital Programming will contact the parent/guardian to discuss the application and make final approval. **The placement of first consideration for students on home and hospital will be virtual programming.** When appropriate, a home and hospital teacher may be assigned to individual students. This decision will be made by the Manager of Home and Hospital Programming after reviewing all relevant information provided through the application, home school, and parent/guardian interview.
5. Once a home and hospital educational placement is established, the home school will contact the parent/guardian to participate in a SST/IEP meeting to develop a transition plan for returning the student to a school-based program.
6. Please remember that the maximum amount of time 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.

Cecil County Public Schools

Home and Hospital Teaching Program Application 2024-2025

SECTION A - PARENT/GUARDIAN

Student Name: _____

School:_____Grade:_____

Date of Birth:_____ Age:_____ Gender:_____

Home Address: _____

Telephones: Home:_____Work: _____

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

( ) General Education *( ) Special Education *( ) 504 Plan

Please list the names of any staff members that may be considered as points of contact for your student's transition plan. These staff members may be an administrator, counselor, teacher, or anyone that is an employee within the building that your student has a connection with. This information will be reviewed when you meet with the school based team to develop your student's transition plan.

Staff Member 1:_____

Staff Member 2:_____

Staff Member 3:_____

The placement of first consideration in home and hospital will be virtual programming. If an in home tutor is assigned by the Manager of Home and Hospital Programming, 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.

I am applying for home and hospital teaching for my child. I grant permission for 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 (Print):_____Date: _____

Parent/Guardian Signature:_____Date: _____

Cecil County Public Schools
HOME AND HOSPITAL TEACHING PROGRAM 2024-2025

Student Name: _____

SECTION B – MEDICAL/LICENSED PROFESSIONAL'S RECOMMENDATION (To be completed by Licensed Physician, Certified Nurse Practitioner, Licensed Psychiatrist, Licensed Psychologist, Certified School Psychologist, Psychiatric Mental Health Nurse Practitioner, or CCPS Approved Provider)

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 ***Approx. length of time (60 Calendar 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 – These services are provided for students who suffer from a chronic illness (such as diabetes, lung diseases or migraines) that causes frequent intermittent absences.

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 ☐ Other _____

Please complete transition planning recommendations 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, 900 North East Rd. North East, MD 21901

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: _____ _____

Joshua Mangold - Manager of Blended Virtual & Home Hospital Programming, Student Services ***Date***

Cecil County Public Schools
Home and Hospital Teaching Program 2024-2025
TRANSITION PLANNING RECOMMENDATIONS FOR EMOTIONAL/BEHAVIORAL REFERRALS

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/Licensed Professional's Name: _____
(Please Print Name)

Address:_____

Phone:_____ **Fax:**_____

Signature:_____ **Date:**_____