CECIL COUNTY PUBLIC SCHOOLS
HOME AND HOSPITAL EDUCATION
ADMINISTRATIVE SERVICES CENTER
900 NORTH EAST ROAD • NORTH EAST, MD 21901

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HOME AND HOSPITAL TEACHING PROGRAM
SY26-27
Student Application

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 mental health 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 physician or certified nurse practitioner**. The need for such services due to a **mental health condition** shall only be submitted by a **licensed psychiatrist, licensed psychologist, psychiatric mental health nurse practitioner, or 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 ongoing intermittent absences from school 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. Intermittent applications may be approved for up to 180 school days or less as determined by the Manager of Home and Hospital and based on the provider's recommendation and prior student academic and attendance history. *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 discussed/developed/reviewed for returning the student to a school-based program as soon as possible.*

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

1. The student's parent/guardian must complete and sign page 2 - *SECTION A: Parent/Guardian*, of the Home and Hospital Teaching Program Application and then forward the application to the medical professional, who must complete page 3/4 - *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 **a mental health condition, page 5 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 5 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 discuss/develop/review 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 SY26-27

SECTION A - PARENT/GUARDIAN

Student Name: _____

School: _____ Grade: _____

Date of Birth: _____ Age: _____ Gender: _____

Home Address: _____

Telephones: Home: _____ Work: _____

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 the home and hospital teaching for my child. I grant permission for The Manager of Home and Hospital Services 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 date 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

SECTION B - MEDICAL/LICENSED PROFESSIONAL'S RECOMMENDATION

Physical Health Conditions - Only to be completed by: A Licensed Physician or Certified Nurse Practitioner

Mental Health Condition - Only to be completed by: A Licensed Psychiatrist, Licensed Psychologist, Certified School Psychologist, or Psychiatric Mental Health Nurse/Practitioner

Student Name: _____

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 the request is due to pregnancy, what is the estimated date of delivery? _____

I recommend Home/Hospital Teaching ☐ Yes ☐ No ***Approx. Length of time (60 Calendar Day Max.)** _____

I recommend Home/Hospital Teaching to begin on: _____

I recommend the following home and hospital placement **(Check the appropriate box below)**:

☐ Full Time Home Teaching (Student is not in physical school for the duration of the home and hospital placement)

☐ Part Time Home Teaching (Student is in physical school for part of the day and home for part of the day. *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.

Specific Milestones for Return:

What clinical or functional markers must be met before the student can safely return to school?

_____

_____

_____

_____

Treating Medical Professional's Name: _____

(Please Print)

☐ Licensed Physician ☐ Nurse Practitioner ☐ Certified Mental Health Nurse Practitioner ☐ Licensed Psychiatrist

☐ Licensed Psychologist ☐ Certified School Psychologist

Email Address: _____ Phone: _____ Fax: _____

Signature: _____ Date: _____

Please complete transition planning recommendations on the next page for emotional/behavioral referrals.

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 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: _____ Date: _____

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

Cecil County Public Schools
HOME AND HOSPITAL TEACHING PROGRAM
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. 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? _____
   _____
7. 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:** _____