SCHOOL YEAR 2026-2027

Carroll County Public Schools Home & Hospital Application (Emotional Reason) - PAGE 1 of 5

Student Name:_____ Grade:_____School:_____

Instructions: Parent(s)/Legal Guardian(s)/Medical Provider-Please review the information below which describes the CCPS Home & Hospital Program. This information is provided as an overview of Carroll County Public Schools' (CCPS) Home & Hospital Program.

The 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 are provided either virtually or in person. Home & hospital services are not intended to replicate the classroom experience and are not intended to help students make up past work prior to the home & hospital services approval period. Services are intended to keep students academically current until they return to school. Services are provided in core academic subjects only.

To qualify for home & hospital services, the student must be either absent from school for at least 15 consecutive school days or 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.

Service Option	Description	Services Provided	Additional Information
Concurrent Services	Recommended for students with chronic conditions that may cause them to miss 3 or more consecutive days of school during condition flare ups.	Tutoring services to assist the student with making up missed assignments.	Students expected to attend most days. Only one application per school year is necessary. Parent responsible for collecting missed work.
Full-Time Services	Recommended for students who are experiencing a condition that precludes them from being able to attend school.	Maximum of 8 hours of service per week. Classes offered and total hours of services provided weekly are determined by the Supervisor of Student Services-Student Support.	Designed to support students during their healing and transition period back to the school building. Reverification every 60 calendar days.
Part-Time Services	Recommended for students who can attend school part-time. Student attends school either in the morning or in the afternoon for half of the school day.	Maximum of 4 hours of service per week. Classes offered and total hours of services provided weekly are determined by the Supervisor of Student Services-Student Support.	Supports students who can attend school part-time. Reverification every 60 calendar days, if needed.

*Students who receive IEP services: If home and hospital services are approved, the IEP team will schedule an IEP meeting to review and revise the student's IEP. Home and hospital services may not exceed 60 consecutive school days (except in rare cases).

To apply for services:

- Parents complete the parent/legal guardian section of the Recommendation for Home & Hospital Services (Emotional Reason) form and forward the form to the appropriate medical professional.
- The recommendation for home & hospital services for an emotional reason must be made by a licensed psychiatrist, licensed psychologist, licensed mental health psychiatric nurse practitioner or certified school psychologist. A transition plan must also be submitted. Failure to do so may result in denial of services.
- **Submit the completed application and the signed Parent/Student Requirements for CCPS Home & Hospital form to the Student Services Department by faxing it to 410-751-3695, Attention: Home & Hospital Services Office or email to Maria Martin, Supervisor of Student Services – Student Support: MariaMartin@carrollk12.org**
- The Student Services office will notify you regarding the status of the application within 10 school days of submission.

RECOMMENDATION FOR HOME & HOSPITAL SERVICES (Emotional Only) - PAGE 2 of 5

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 Email Address: _____

I have read and understand the overview of home & hospital services presented on page 1. 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 may 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.)

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

Name: _____
(please print)

Address: _____

Phone Number:_____ **Fax Number**: _____ **Email Address:** _____

About the Student:

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 two (2) weeks of recommendation.)

I recommend home & hospital services: Yes ☐ No ☐

Approximate Length of Time (**60-Day Max**.): _____ Expected Date of Return: _____

☐ **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 ½ days on a daily basis)

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

PLEASE COMPLETE A TREATMENT/TRANSITION PLAN ON *PAGES 3 & 4 FOR* EMOTIONAL/BEHAVIORAL REFERRALS. FAILURE TO PROVIDE A TRANSITION PLAN MAY RESULT IN DENIAL OF SERVICES. CONSULTATION WITH TREATING THERAPIST IS RECOMMENDED IN DEVELOPING THE TRANSITION PLAN.

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. Consultation with treating therapist is recommended in completing the information below. Failure to provide a transition plan may result in denial of services.

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: _____

   Email Address: _____

   Best time/days to reach the Therapist: _____

3. Date of most recent therapy appointment: _____How often is student seen for therapy? _____

   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. The plan should detail actions/steps that the student/provider will make in order to progress toward a return.

   _____

   _____

   _____

   _____

   _____

   _____

6. **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.** 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 or remain in the school building?
   If so, please describe below.

   _____

   _____

   _____

   _____

Name of Student: _____ Date of Birth: _____

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 MAY RESULT IN THE DENIAL OF SERVICES.** Please feel free to attach additional information as needed. The plan should detail the actions/steps and timeline that the student/school/parent/provider will take in order for the student to make more progress toward a return to school.

_____

_____

_____

_____

_____

_____

8. If approved, explain any precautions to be taken during home & hospital services: _____

_____

9. 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:_____

Professional Acknowledgement

As the licensed psychologist, licensed psychiatrist, licensed psychiatric mental health nurse practitioner, or MSDE licensed school psychologist treating the student, your collaboration is crucial. Should services be approved, you will communicate with the student's school support team and assigned school-based case manager to develop an appropriate transition plan during the student's emotional crisis or chronic health impairment. **By signing below you are confirming that you have read the overview of home & hospital services presented on page 1. You are confirming that you are recommending home & hospital services for the student, and you are confirming you will be available to speak with CCPS staff to discuss the student and their needs.**

Signature: _____ **Date:** _____

Please return completed forms to the Student Services Department via FAX at 410-751-3695.
Maria Martin, Supervisor of Student Services – Student Support
Phone: 410-386-1822 Email: MariaMartin@carrollk12.org

For Office Use Only

Recommended ☐ **Not Recommended** ☐ **Reason:** _____

Signature of School Psychologist: _____ Date: _____

For Office Use Only

Approved ☐ **Denied** ☐ **Reason:** _____

Signature of Supervisor: _____ Date: _____

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. 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 or emailed to MariaMartin@carrollk12.org
- 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 may 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 or email to MariaMartin@carrollk12.org