



## CARROLL COUNTY PUBLIC SCHOOLS

125 N. Court Street • Westminster, MD 21157

CHARLES I. ECKER  
*Superintendent*

Dear Parent/Guardian,

Carroll County Public Schools provides a program of Home & Hospital Teaching for Carroll County students who cannot attend school for physical or emotional reasons. The need for these services due to a physical condition shall only be certified by a **licensed physician**. The need for such services due to an emotional condition shall only be certified by a **licensed psychiatrist, licensed psychologist or a certified school psychologist**. The student's illness must be determined to necessitate an absence of at least ten (10) school days at the high school level with an expected absence of fifteen(15) or more days or fifteen (15) school days at the elementary/middle school level in order to be eligible for the service. Elementary and middle school students may receive up to six hours of instruction per week while high school students may receive up to eight hours per week of instruction.

The process for applying to access this service is as follows:

1. The student's parent/guardian must obtain a Medical Professional's Recommendation for Home & Hospital Teaching form (attached to this letter). The parent/guardian must complete the "Parent/Legal Guardian" section, and then forward this form to the medical professional, who must complete the "Medical Professional" section. The completion of this form authorizes Carroll 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 & Hospital Teaching Services.
2. If the student's diagnosed illness is emotional or behavioral in nature, a treatment plan must also be submitted (see page 2 of the Medical Professional's Recommendation form).
3. If the request for home teaching services is due to pregnancy, services are provided for 6 weeks post delivery.
4. Return the form(s) to the Student Services Department by faxing to **(410) 751-3695**. Upon receipt of the form, Carroll County Public Schools staff will determine if Home & Hospital Teaching is appropriate. (For behavior/emotional illness referrals, a CCPS School Psychologist must review the treatment plan and make a recommendation as to the appropriateness of Home & Hospital Teaching). If the service is determined to be appropriate, the request will be approved.
5. Upon approval, a teacher(s) will be assigned to the case. Some home teaching classes may be provided through an online provider.
6. The home and hospital teacher will contact the family to begin providing instruction to the student.

**Please be aware that the maximum amount of time that a student can be assigned to Home & 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, Carroll County Public Schools requires that a **responsible adult (18 years of age or older) must be present throughout the duration of the time the home teacher is with the student.** Please be prepared to make arrangements to provide adult supervision if Home & Hospital Teaching is approved.

If you have any questions, please feel free to contact the Assistant Supervisor of Student Records and Home and Hospital Teaching at (410) 386-1838.

Sincerely,

Barbara J. Bankard, Assistant Supervisor  
Student Records and Home and Hospital Teaching

**MEDICAL PROFESSIONAL'S RECOMMENDATION FOR HOME & HOSPITAL TEACHING**

<b>PARENT/LEGAL GUARDIAN</b>	Date _____ Student _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: _____
	Address _____ (Street) (City) (State) (Zip)
	School _____ Grade _____
	Name of Parent(s)/Guardian(s) _____
	Does the student have a current IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the student have a 504 plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Primary Phone _____ Alt Phone _____ Other Phone _____
	E-Mail _____
	I am applying for Home & Hospital Teaching for my child. I grant permission for the CCPS 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 date signed. Failure to sign this release of information may result in denial of Home & Hospital Teaching Services.
	Parent or Guardian Name (please print) _____
	Parent or Guardian Signature _____

<b>MEDICAL PROFESSIONAL</b>	<p><b>LICENSED PHYSICIAN, LICENSED PSYCHIATRIST, LICENSED PSYCHOLOGIST OR CERTIFIED SCHOOL PSYCHOLOGIST STATEMENT FOR HOME &amp; HOSPITAL TEACHING</b></p> <p>(Please note: CRNP, PA signature is not permitted by COMAR)</p>
	Description of Presenting Problem _____
	Reason student cannot function in the regular school environment: _____
	_____
	Date of Last Appointment _____ Frequency of Appointments _____
	Is the student contagious? <input type="checkbox"/> Yes <input type="checkbox"/> 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 seriously consider any in-school accommodations that could be made to allow attendance at the home school before making the recommendation for Home & Hospital Teaching.
	I recommend Home/Hospital Teaching <input type="checkbox"/> Yes <input type="checkbox"/> No Approx. Length of Time (60-Day Max.) _____
	<input type="checkbox"/> Full Time Home Teaching <input type="checkbox"/> Part Time Home Teaching (# hrs to be spent in school daily _____)
	Plan for Return to School _____
	Treating Medical Professional's Name _____ (Please Print) Phone _____
	Email Address _____ Fax _____
	Signature: _____ Date _____
<input type="checkbox"/> Licensed Physician <input type="checkbox"/> Licensed Psychiatrist <input type="checkbox"/> Licensed Psychologist <input type="checkbox"/> Certified School Psychologist	
<b>COMPLETE A TREATMENT PLAN ON PAGE 2 FOR EMOTIONAL/BEHAVIORAL REFERRALS.</b>	

**\*\* Return completed form to the Student Services Department via FAX at 410-751-3695**

For Office Use Only: Approved <input type="checkbox"/> Denied <input type="checkbox"/> Reason _____
Signature _____ Date _____

**TREATMENT PLAN  
FOR EMOTIONAL / BEHAVIORAL REFERRALS**

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

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

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: \_\_\_\_\_  
Frequency of Visits: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

4. Is the student on Medication?  Yes  No  
Medication(s): \_\_\_\_\_ Dosage: \_\_\_\_\_  
How will the medication(s) affect school performance? \_\_\_\_\_

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

6. Is Home & 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 plan to transition the student back to school? A transition plan must be developed to return the student to the school setting.  
\_\_\_\_\_  
\_\_\_\_\_

9. What is the anticipated date of return to school? \_\_\_\_\_

\*\*\* 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.

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

**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

Reviewed by School Psychologist

\_\_\_\_\_  
Name Signature Date  
Recommended  Not Recommended  Reason \_\_\_\_\_