



CARROLL COUNTY PUBLIC SCHOOLS

125 N. Court Street • Westminster, MD 21157

410-751-3000
TTY 410-751-3034
FAX 410-751-3003

STEPHEN H. GUTHRIE
Superintendent

Dear Parent/Guardian,

The Carroll County Public Schools Home and Hospital Teaching Program is designed to provide instructional continuity to students who are unable to attend their regular school of enrollment due to: **physical illness or disability, emotional crisis** (including substance abuse), **pregnancy** or **chronic health impairment**. Home teaching is a short-term instructional service mandated by State law with specific guidelines for program implementation and delivery. These educational services enable students to continue their academic work and to remain current with their peers as they prepare for their eventual return to their home schools.

In order to qualify for home and hospital teaching services, the student must be expected to be absent from school for a projected period of 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 condition. High school students may qualify for services after an absence of 10 school days, if the absence is anticipated to last for at least 15 school days.

- Obtain a **Medical Professional's Recommendation for Home & Hospital Teaching** form (attached to this letter). Complete the parent/legal guardian section and forward the form to the appropriate medical professional. 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.
- **Physical Illness** – A **Licensed Physician** must complete all information in the Medical Professional section, including the anticipated date the student will return to school.
- **Emotional Crisis** - If the student's diagnosed illness is emotional or behavioral in nature, the recommendation for home teaching must be made by a **Licensed Psychiatrist or Licensed Psychologist**. A treatment plan must also be submitted (see page 2 of the Medical Professional's Recommendation form). The recommendation will be reviewed by the school psychologist assigned to the student's school and a transition plan developed to return the student to school. Failure to develop a transition plan may result in denial of services.
- **Pregnancy** – Pregnant students are expected to attend school during their pregnancy. The doctor must provide an estimated date of delivery on the home teaching request. Home teaching services are provided for 6 – 8 weeks post delivery.
- **Chronic Health Impairment** - Students diagnosed as having chronic illnesses (such as asthma, cancer, sickle cell anemia, kidney failure, juvenile diabetes, cystic fibrosis, or cardiac disorders) are eligible for home teaching services without an anticipated three-week absence. The physician's statement needs to indicate that the illness will cause frequent intermittent absences. Home teaching services are provided to support the student during intermittent absences and help the student keep pace with classmates.
- The medical professional should return the form 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. If the service is determined to be appropriate, the request will be approved.

Once home teaching services are approved, an instructional plan will be developed in conjunction with the student's home school. CCPS provides home teaching through an online provider, as well as with individually assigned home teachers who come to the home. The assigned teacher or online provider will contact the parent/guardian directly to schedule teaching sessions.

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.

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. For students identified with a Chronic Health Impairment, a review and re-verification will be done once each semester or earlier if appropriate.

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,

A handwritten signature in black ink that reads "Barbara J. Bankard". The signature is written in a cursive style with a large, prominent initial "B".

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

MEDICAL PROFESSIONAL'S RECOMMENDATION FOR HOME & HOSPITAL TEACHING

PARENT/LEGAL GUARDIAN

Date: _____ Student: _____ Sex: M F 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: _____

E-Mail: _____

I am applying for Home & Hospital Teaching for my child. I grant permission for the CCPS Student Services staff or their designee to contact and confer with the referring and treating Medical Professional(s) to exchange information about my child, including medical and /or therapy notes. 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 _____

MEDICAL PROFESSIONAL

**LICENSED PHYSICIAN, LICENSED PSYCHIATRIST, LICENSED PSYCHOLOGIST OR
CERTIFIED SCHOOL PSYCHOLOGIST STATEMENT FOR HOME & HOSPITAL TEACHING**
(Please note: CRNP, PA, LCSW or Counselor signature is not permitted by COMAR)

Description of Presenting Problem: _____

Reason student cannot function in the regular school environment: _____

Date of Last Appointment: _____ Frequency of Appointments: _____

Is the student contagious? Yes No Specify _____

Are there any precautions needed when teaching this student? _____

If student is pregnant, what is the estimated date of delivery? _____ Home teaching is provided for 6 weeks post partum.

* 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 Yes No Approx. Length of Time (60-Day Max.) _____

Full Time Home Teaching (student will NOT attend school) Part Time Home Teaching (student will attend school part-time)

Chronic Health Impaired Full Time (student will NOT attend school) Intermittent/Concurrent (intermittent absences)

Plan for Return to School: _____ Anticipated Date of Return: _____

Treating Medical Professional's Name & Title: _____
(Please Print)

Phone: _____ Fax: _____

Email Address: _____

Signature: _____ Date: _____

Licensed Physician Licensed Psychiatrist Licensed Psychologist Certified School Psychologist

**COMPLETE A TREATMENT/TRANSITION PLAN ON PAGE 2 FOR EMOTIONAL/BEHAVIORAL REFERRALS.
FAILURE TO PROVIDE A TRANSITION PLAN MAY RESULT IN DENIAL OF SERVICES.**

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

For Office Use Only:

Approved Denied Reason _____

Signature: _____ Date: _____

Revised 11/11

TREATMENT PLAN – Page 2
FOR EMOTIONAL / BEHAVIORAL REFERRALS

Name of Student: _____ Date of Birth: _____

To be completed by a **licensed psychiatrist, licensed psychologist** or **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. Why is home teaching the recommended placement? Would the student benefit from an alternative 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. FAILURE TO DEVELOP A TRANSITION PLAN MAY RESULT IN DENIAL OF SERVICES.

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 & Title: _____
(Please Print)

Address: _____

Phone: _____ **Fax:** _____

Signature: _____ **Date:** _____

Recommendations for Home Teaching due to emotional reasons can only be made by one of the following: LCSW not permitted.
Licensed Psychiatrist Licensed Psychologist Certified School Psychologist

Reviewed by School Psychologist: _____ Name

Signature: _____ Date: _____

Recommended Not Recommended Reason: _____