



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. 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.
4. Upon approval, a teacher(s) will be assigned to the case. Some home teaching classes may be provided through an online provider.
5. 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

PARENT/LEGAL GUARDIAN	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
	Home Phone _____ Work Phone(s) _____ 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 _____

MEDICAL PROFESSIONAL	PHYSICIAN, PSYCHIATRIST, LICENSED CLINICAL PSYCHOLOGIST OR CERTIFIED SCHOOL PSYCHOLOGIST STATEMENT FOR HOME & HOSPITAL TEACHING
	(Please note: CRNP, PA signature is not acceptable)
	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? _____
	* 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/Part Time School Attendance (specify number of hours to be spent in school each day _____)
Plan for Return to School _____	
Treating Medical Professional's Name _____ (Please Print) Phone _____ Signature: _____ (Please Print) Fax _____ Date _____	
<input type="checkbox"/> Physician <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Licensed Clinical Psychologist <input type="checkbox"/> Certified School Psychologist	
COMPLETE A TREATMENT PLAN ON PAGE 2 FOR EMOTIONAL/BEHAVIORAL REFERRALS.	

**** 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 clinical 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?

9. What is the anticipated date of return to 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:
 Psychiatrist Licensed Clinical Psychologist Certified School Psychologist

Reviewed by School Psychologist _____

	Name	Signature	Date
Recommended <input type="checkbox"/>	Not Recommended <input type="checkbox"/>	Reason _____	