



Building the Future

# Carroll County Public Schools

125 N. Court Street | Westminster, MD 21157

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

Stephen H. Guthrie  
Superintendent

Dear Parent/Legal Guardian:

Carroll County Public Schools' home/hospital teaching program provides instructional continuity to students who are unable to attend their regular school of enrollment due to physical illness/injury, emotional crisis (including substance abuse), pregnancy, or chronic health impairment(s). Home/hospital teaching is a short-term instructional service mandated by state law with specific guidelines for program implementation and delivery. Home/hospital teaching services allow students the opportunity to continue their academic education as they prepare for their eventual return to the school building.

In order to qualify for home/hospital teaching services, the student must be 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 impairment. High school students may qualify for services after an absence of ten (10) consecutive school days, if the absence is anticipated to last for at least fifteen (15) school days.

**Physical illness/injury, pregnancy, or chronic health impairment:** Obtain a Medical Professional's Recommendation for Home/Hospital Teaching (*Physical Only*) form. Complete the parent/legal guardian section and forward the form to the appropriate medical professional. The completion of the form authorizes CCPS staff to communicate with your medical professional. Please note that failure to sign the release of information may result in denial of home/hospital teaching services.

- **Physical Illness/Injury:** A licensed physician or CNP must complete all information in the medical professional section, including the anticipated date the student will return to school.
- **Pregnancy:** Pregnant students are expected to attend school during their pregnancy. The doctor must provide an estimated date of delivery on the home/hospital teaching request form. Home/hospital teaching services are provided for six (6) weeks postpartum.
- **Chronic Health Impairment:** Students diagnosed as having a chronic health impairment (such as cancer, asthma, sickle cell anemia, kidney failure, juvenile diabetes, cystic fibrosis, or cardiac disorders) are eligible for home/hospital teaching services without an anticipated 3-week absence. The physician's statement must indicate that the illness will cause frequent intermittent absences of 20% or more of the school year. Home/hospital teaching services are provided to the student during intermittent absences, due to the specific chronic illness, of at least three (3) consecutive school days.

**Emotional Crisis (including substance abuse):** Obtain a Medical Professional's Recommendation for Home/Hospital Teaching (*Emotional Only*) form. The recommendation for home/hospital teaching must be made by a licensed psychiatrist, licensed psychologist, or CPNP. A treatment plan must also be submitted. The recommendation will be reviewed by the school psychologist assigned to the student's school, as well as other school staff. A transition plan must be developed by the licensed psychiatrist/psychologist to return the student to school. Failure to develop a transition plan may result in denial of services.

The medical professional should return the completed form to the Student Services Department **by faxing it to 410-751-3695, Attention: Home/Hospital Teaching Office**. Upon receipt of the form, CCPS staff will determine if home/hospital teaching services is appropriate. If the service is determined to be appropriate and approved, an instructional plan will be developed with the student's home school. CCPS provides home/hospital teaching through an on-line provider, as well as with individually assigned home/hospital teachers at the student's home. CCPS requires that a responsible adult (18 years of age or older) must be present throughout the duration of the time the home/hospital teacher is with the student. The assigned teacher or on-line provider will contact the parent/legal guardian directly to schedule teaching sessions.

Maryland State Dept. of Education regulations require a review and re-verification of home/hospital teaching services after 60 calendar days of service to determine if home/hospital teaching services will continue. If you have any questions, please contact the Student Services Department at 410-386-1838.

Sincerely,

*Steven C. Shoup*

Steven C. Shoup  
Pupil Personnel Worker  
Home/Hospital Teaching Program

**MEDICAL PROFESSIONAL'S RECOMMENDATION FOR HOME/HOSPITAL TEACHING (*Emotional Only*)**

<b>PARENT/LEGAL GUARDIAN</b>	Date: _____ Student: _____ Sex: M <input type="checkbox"/> F <input type="checkbox"/> Date of Birth: _____
	Address: _____ (Street) (City) (State) (Zip)
	School: _____ Grade: _____
	Does the student have a current IEP? Yes <input type="checkbox"/> No <input type="checkbox"/> Does the student have a 504 plan? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Primary Phone: _____ Phone #2: _____ Phone #3: _____
	E-Mail Address: _____
	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 (1) year from the date signed. Failure to sign this release of information may result in denial of home/hospital teaching services.
	Parent or Legal Guardian Name (please print): _____
	Parent or Legal Guardian Signature: _____

<b>MEDICAL PROFESSIONAL</b>	<b>LICENSED PSYCHIATRIST, LICENSED PSYCHOLOGIST, OR CPNP STATEMENT FOR HOME/HOSPITAL TEACHING DUE TO EMOTIONAL / BEHAVIORIAL REASON</b> <i>(Please note: PA, LCSW, or Counselor signatures are not permitted by COMAR.)</i>
	Description of Presenting Problem: _____
	Reason student cannot function in the regular school environment and requires home/hospital teaching: _____
	Date of Last Appointment: _____ Frequency of Appointments: _____ <b>(Student must have been seen by a licensed psychiatrist, licensed psychologist, or CPNP within one (1) week of recommendation.)</b>
	Are there any precautions needed when teaching this student? _____
	<b>Please seriously consider any in-school accommodations or modifications, including partial-day attendance and/or alternative programs, before making the recommendation for home/hospital teaching.</b>
	I recommend home/hospital teaching. Yes <input type="checkbox"/> No <input type="checkbox"/> Approximate Length of Time (60-Day Max.): _____
	<input type="checkbox"/> Full-Time Home/Hospital Teaching = <b>6 – 8 HOURS OF INSTRUCTION PER WEEK</b> (student will <u>NOT</u> attend school)
	<input type="checkbox"/> Part-Time Home/Hospital Teaching = <b>3 – 4 HOURS OF INSTRUCTION PER WEEK</b> (student will attend on a <u>daily basis</u> )
	<input type="checkbox"/> Concurrent / Intermittent Home/Hospital Teaching as needed
Anticipated Date of Return: _____	
Treating <i>Licensed Psychiatrist, Licensed Psychologist, or CPNP</i> : _____ <div align="right"><i>(Please Print)</i></div>	
Address: _____	
Phone Number: _____ Fax Number: _____	
Email Address: _____	
Signature: _____ Date: _____	
Licensed Psychiatrist <input type="checkbox"/> Licensed Psychologist <input type="checkbox"/> CPNP <input type="checkbox"/> <b>PLEASE COMPLETE A TREATMENT/TRANSITION PLAN ON PAGE 2 FOR EMOTIONAL/BEHAVIORIAL REFERRALS. FAILURE TO PROVIDE A TRANSITIONAL PLAN MAY RESULT IN DENIAL OF SERVICES.</b>	

**Please return completed forms to the Student Services Department via FAX at 410-751-3695.**  
**ATTN: Steven C. Shoup, Pupil Personnel Worker of Home & Hospital Teaching**  
**Phone: 410-386-1838 Email: [scshoup@carrollk12.org](mailto:scshoup@carrollk12.org)**

*For Office Use Only*

Approved <input type="checkbox"/> Denied <input type="checkbox"/> Reason: _____
Signature: _____ Date: _____

**TREATMENT PLAN – Page 2**  
**FOR EMOTIONAL / BEHAVIORAL REFERRAL FOR HOME/HOSPITAL TEACHING**

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

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

1. What is the nature of the emotional crisis: \_\_\_\_\_  
\_\_\_\_\_ 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  Or substance abuse treatment? Yes  No   
Therapist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Frequency of Visits: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_
4. Is the student on medication? Yes  No   
Medication(s): \_\_\_\_\_ Dosage: \_\_\_\_\_  
\_\_\_\_\_ 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/ hospital teaching the recommended placement? Would the student benefit from in-school accommodations or modifications, including partial-day attendance and/or alternative programs? If so, why?  
\_\_\_\_\_  
\_\_\_\_\_
7. 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/remain in the school building?  
\_\_\_\_\_  
\_\_\_\_\_
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 THE DENIAL OF SERVICES.  
\_\_\_\_\_  
\_\_\_\_\_
9. What is the **anticipated date of return to school** (Maryland State allows 60 days maximum of HHT service)? \_\_\_\_\_
10. 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 times to reach you:  
Times: \_\_\_\_\_ Preferred phone number: \_\_\_\_\_

\*Please note that COMAR limits home/hospital teaching due to emotional reasons for special education students to **60 calendar days**. A transition plan must be developed with the school. An IEP meeting must be held to determine transition plan.

**Treating Licensed Psychiatrist / Licensed Psychologist / CPNP Name & Title:** \_\_\_\_\_  
*(Please Print)*

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Recommendations for home/hospital teaching due to emotional reasons can only be made by one of the following: LCSW or Counselor not permitted.  
Licensed Psychiatrist  Licensed Psychologist  CPNP

<b>For Office Use Only</b>	
Recommended <input type="checkbox"/>	Not Recommended <input type="checkbox"/> Reason: _____
Reviewed by School Psychologist: <i>(Please Print)</i> : _____	
Signature of School Psychologist: _____	

**CARROLL COUNTY PUBLIC SCHOOLS**  
**PARENT/STUDENT RESPONSIBILITIES IN HOME/HOSPITAL TEACHING**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Home/Hospital Teacher: \_\_\_\_\_ Date: \_\_\_\_\_

If your child is approved for CCPS home/hospital teaching services, the following guidelines have been developed in order to provide the best experience for your child during his/her participation in home/hospital teaching.

**Parent/Legal Guardian Responsibilities:**

- Obtain all books and materials from school for your child. If your child completed school work before starting home/hospital teaching, please submit that work to the school.
- Provide a quiet atmosphere, appropriate setting, and proper supervision during home/hospital teaching sessions. Designate an area free from distractions for the teacher and the student to work.
- Ensure that a responsible adult over age 18 is present during all sessions.
- Coordinate teaching dates/times with the home/hospital teacher. Notify the home/hospital teacher before the scheduled class time if your child is unable to participate in the day's lesson. Excused absences include sickness, a doctor's visit, or a death in the family. All absences will be reported to the school. Try to schedule appointments that do not conflict with scheduled class times.
- Cooperate with the home/hospital teacher and provide assistance in helping your child progress academically.
- Notify the home/hospital teacher and the home/hospital teaching office at 410-386-1838 as soon as you know your child will be released to return to school. Obtain a medical release and fax a copy to the home/hospital teaching office at 410-751-3695.
- Keep the home/hospital teaching office informed of any changes to your child's medical condition.

**Student Responsibilities:**

- Be present and on time for all home/hospital teaching appointments.
- Be prepared and complete all assignments.
- Present a positive attitude.
- Cooperate with the home/hospital teacher at all times.

**Home/Hospital Teaching Hours Policy**

- Home/hospital teaching 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 teacher, an effort will be made to make up the time missed within a week.
- **If the student is unavailable for instruction due to illness or any other reason, the student is considered absent and hours will not be made up.**

**Carroll County Public Schools' policy on home & hospital teaching states that:**

"The presumption of the home and hospital teaching program is that students in such a status are truly home-bound 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 emerge in the course of a home teaching case, the Pupil Personnel Worker of Home & Hospital Teaching shall be informed immediately. In such cases home teaching services may be terminated."

**\*In the event that the above conditions are not met, home & hospital teaching will be discontinued until the Pupil Personnel Worker of Home & Hospital Teaching 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 responsibilities form may 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 completed form to the Student Services Department via FAX at 410-751-3695.**

**Attention: Steven C. Shoup, Pupil Personnel Worker of Home & Hospital Teaching**

**Phone: 410-386-1838      Email: [scshoup@carrollk12.org](mailto:scshoup@carrollk12.org)**