

APPLICATION FOR HOME/HOSPITAL TEACHING SERVICES (H/HTS)

(When sections I and II are completed, return to Home and Hospital Coordinators Office, P.O. Box 1538, Salisbury, MD 21802-1538 or Wicomico County Board of Education Annex 2)

I. (To be completed by parent.)

Name of student _____ Date of Birth _____ Race _____ Sex _____

Does student receive special education services? Yes No

School _____ Grade _____

Home Address _____

Telephone: Home _____ Work _____

I grant permission for Wicomico County Public Schools to provide home and hospital teaching services to my child. I understand that it may be necessary for Pupil Services staff to confer with the referring physician/psychologist for additional data on my child and grant them permission to do this.

Parent/Guardian _____ Parent/Guardian Signature _____

(Please Print)

Date _____

II. Statement by Physician (Physical Condition) or Psychiatrist/Licensed Psychologist/Certified School Psychologist (emotional condition)

Application based on: Physical Condition Emotional Condition Date of Examination: _____

Fully describe the physical/emotional condition that is present for this student that will not allow the student to access his/her current education program:

Special program/accommodations requested for the student based on current physical/emotional description:

How long will the student's condition keep the student out of school _____?
(If more than 60 days, re-verification documentation must be attached to the original H/HTS application.)

For students in Partial Hospital Plan (PHP) a copy of the students proposed treatment plan and a transition meeting must be scheduled with the appropriate people at the student's school one week prior to discharge.

Signature _____ Date _____

Print Name _____

(Please Circle: *Physician, Psychiatrist, Licensed Psychologist, or Certified School Psychologist*)

Address _____ Telephone _____

PROGRAM ELIGIBILITY-COMAR 13A.03.05

- Home and hospital instruction is designed to provide short-term itinerant instructional services to students who are unable to participate in their school of enrollment due to a physical or emotional condition.
- Instructional services are available to all eligible students during convalescence or treatment time in a medical institution, therapeutic treatment center, the student's place of residence, or all of these.
- Initial service need is determined by :
 - Verification of a physical condition, including drug and alcohol dependency, by a licensed physician, or verification of an emotional condition by a certified school, or licensed psychologist or a licensed psychiatrist: and
 - A statement by the physician or psychiatrist/psychologist verifying that the current physical or emotional condition prevents the student from participating in the student's school of enrollment.
- Service need is subject to review 60 calendar days after the initial determination of eligibility or sooner at the request of either the parent, guardian, or local school system.
- Continuation of service need beyond 60 calendar days requires re-verification of service need.

III. (To be completed by school designee)

SUBJECTS TO BE TAUGHT

GRADE TO DATE

1.		
2.		
3.		
4.		

HIGH SCHOOL ASSESSMENT TESTS STATUS:

	Pass	Fail
English	<input type="checkbox"/>	<input type="checkbox"/>
Algebra	<input type="checkbox"/>	<input type="checkbox"/>
Biology	<input type="checkbox"/>	<input type="checkbox"/>
Government	<input type="checkbox"/>	<input type="checkbox"/>

The aforementioned plan has been reviewed and accepted by me.

Principal or Designee _____ Date _____

IV. FOR STUDENT SERVICES OFFICE USE:

Does this application meet the criteria to authorize H/HTS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does student have an Individualized Education Program (IEP)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If this request is approved, date of the IEP team meeting to reflect H/HTS _____		
Has a copy of the IEP been given to the home teacher?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Date Received by Student Services _____

Teacher assigned _____ Phone _____

Date Teacher Assigned _____ Date Instruction Started _____ Date Instruction Terminated _____

Approved: _____ Date _____

Home and Hospital Coordinators Office

**WICOMICO COUNTY PUBLIC SCHOOLS
HOME/HOSPITAL**

Name of Student: _____

School: _____

The above named student has been referred to our Home and Hospital program. By state law, students may not exceed sixty (60) calendar days in this program without proper re-verification. It is anticipated that with the proper treatment a student will return to school at the end of the initial sixty-day period. Re-eligibility is granted only if a student's condition precludes regular school attendance. Please provide the following information.

MEDICAL TREATMENT PLAN
(TO BE COMPLETED BY REFERRING PHYSICIAN)

1. Please describe (*in detail*) the student's current medical condition.

2. How does this condition prevent the student from attending school on a regular or modified basis?

3. Is the student seen on regularly scheduled visits to your office? *yes* *no*
Frequency of visits _____ Date of last visit _____

4. Is the student currently in therapy? *yes* *no*
Therapist's Name: _____
Frequency of visits _____ Date of last visit _____

5. Is the student currently on medication? *yes* *no*
Medication(s): _____

Dosage(s): _____

How will the medication effect school performance?

6. How will home and hospital instruction support or advance the student's progress?

7. How does the medical treatment plan address the student's physical condition and facilitate and eventual return to school?

8. What is the anticipated date of return to school: _____

9. Additional comments:

Signature of Physician

Date

Address: _____

Phone #: _____

Contact Persons:

Phone Number:

**WICOMICO COUNTY PUBLIC SCHOOLS
HOME/HOSPITAL**

Name of Student: _____

School: _____

The above named student has been referred to our Home and Hospital program. By state law, students may not exceed sixty (60) calendar days in this program without proper re-verification. It is anticipated that with the proper treatment a student will return to school at the end of the initial sixty-day period. Re-eligibility is granted only if a student's condition precludes regular school attendance. Please provide the following information.

Please note: State Special Education bylaw mandates that a student with an education disability may not receive Home/Hospital Teaching for more than sixty (60) consecutive school days based on an emotional condition.

TREATMENT PLAN
(TO BE COMPLETED BY REFERRING PSYCHIATRIST/PSYCHOLOGIST)

3. Please describe (*in detail*) the student's current medical condition.

4. How does this condition prevent the student from attending school on a regular or modified basis?

3. Is the student seen on regularly scheduled visits to your office?

yes *no*

Frequency of visits _____ Date of last visit _____

4. Is the student currently in therapy?

yes *no*

Therapist's Name: _____

Frequency of visits _____ Date of last visit _____

5. Is the student currently on medication?

yes *no*

Medication(s): _____

Dosage(s): _____

How will the medication effect school performance?

6. How will home and hospital instruction support or advance the student's progress?

7. How does the medical treatment plan address the student's physical condition and facilitate and eventual return to school?

8. What is the anticipated date of return to school: _____

9. Additional comments:

Signature of Psychiatrist/Psychologist/Certified School Psychologist

Date

Address: _____

Phone #: _____

Contact Persons:

Phone Number: