BALTIMORE COUNTY PUBLIC SCHOOLS

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COVID-19 School Closure Statement

To All Medical Doctors, Psychiatrists, and Psychologists

The Home and Hospital Program of Baltimore County Public Schools traditionally provides an educational alternative for students who are unable to participate in the comprehensive school's programming due to medical and or emotional needs. Their illness prevents them from attending a full day of regular school programming.

In the wake of the COVID-19 Pandemic, Baltimore County Public Schools is offering remote learning for ALL BCPS students. There will be no face to face instruction for all students until after January 29, 2021. Students will be able to engage in online learning with their classmates and teachers in their regular school community.

The Home and Hospital Program is encouraging families and schools to allow students to begin their initial instruction with their peers and classroom teachers in order to provide access to their school community. If medical and/or emotional conditions are severe or continue to be a barrier to their educational access, students can still be referred to the Home and Hospital Program for online instruction with modifications and reduced time.

We appreciate your cooperation and are here to support and collaborate with you.

The Home and Hospital Program
Baltimore County Public Schools

Date Received by Enrollment School: _____

APPLICATION FOR INSTRUCTIONAL PROGRAM
FOR HOMEBOUND OR HOSPITALIZED STUDENTS
HOME AND HOSPITAL PROGRAM
Baltimore County Public Schools
6229 Falls Road Baltimore, MD 21209
Telephone (410) 887-3222
Email hhreferrals@bcps.org

EMOTIONAL CONDITION- SY 2020-2021

PLEASE REVIEW THE ATTACHED COVID-19 SCHOOL CLOSURE STATEMENT BEFORE COMPLETING THIS FORM

NOTE: All portions of this professional statement must be completed for Home and Hospital instructional services to be considered. All signatures are required for processing.

Student Information

Name of Student: _____

Sex: Male ☐ Female ☐

Date of Birth: _____

Address: _____

Zip Code: _____

School: _____Grade: _____

Professional Credentials and Contact Information

Please indicate credentials: (<u>ONLY THE</u> medical or mental health providers may certify an emotional condition)

☐ School Psychologist ☐ Private Licensed Psychologist ☐ Private Licensed Psychiatrist

<u>*A Nurse Practitioner, LCSW, LCPC or any other therapist(s) must have form co-signed by above mentioned medical/mental health professionals. *</u>

Psychologist/Psychiatrist's Name: _____

License # _____ (Please Print) (*For Private Providers Only)

Office Telephone Number: _____ Office Fax #: _____

Office Address: _____

_____

Professional Statement

Is the student seen on regularly scheduled visits to your office? Yes ☐ No ☐

If Yes, Frequency of visits: _____ Date of last visit: _____

Is the student currently on medication? Yes ☐ No ☐

If Yes, Medication(s): _____

Dosages: _____

How does the medication affect school performance?

_____

Is the student currently in therapy with someone other than you? Yes ☐ No ☐

If Yes, Therapist Name: _____ Office Telephone: _____

Frequency of visits: _____

Date of last visit: _____

I. **Diagnosis/Emotional Condition:** Describe in detail the student's current emotional condition. (*Behavior problems alone do not qualify as an emotional condition: i.e., oppositional defiance, physical aggression)

_____

_____

II. **Explanation (Specifically explain impact):** How does the emotional condition of the student manifest acutely in the current school setting such that it prevents the student from attending school. (*COMAR mandates that The Home and Hospital Program may not utilized for students awaiting nonpublic placement, nor for students who have been, or are being, disciplinarily removed*) _____

_____

_____

_____

III. **Recommended type of program for student:**

☐ **Full Time Emotional** – (**For a student anticipated to be **continuously** absent for 20 or more school days**) ***Must also complete Part IV***

☐ **Chronic/Intermittent- SERVICES TO BEGIN WHEN SCHOOLS RE-OPEN FOR IN-PERSON INSTRUCTION** (**For a student anticipated to be **intermittently** absent due to a verified emotional condition throughout the school year**) ***Do not complete Part IV***

IV. **Anticipated Length of Absence from School:** _____ (request must not exceed 60 calendar days) **for a period of absence in excess of 60 calendar days, re-verification is required prior to the 60th calendar day. **

a. *For a **General Education** student, a new **Re-verification** statement must be completed by the **expiration date*** and *be accompanied by SST notes and an updated Action Plan for Re-Entry in order for the student to receive an extension of the Home and Hospital Program services.*
b. *For a **Special Education** student, a **Re-verification** statement must be completed by the psychologist/psychiatrist by the **expiration date and** be accompanied by IEP team notes and an updated Action Plan for Re-Entry, in order for the student to receive an extension of the Home and Hospital Program services through the 60th consecutive school day, if required.*
   Note: *A **Special Education** student, with a verified emotional condition, **may not exceed 60 consecutive school days of instruction** through the Home and Hospital Program during one school year.*

RETURN to SCHOOL

How will time on home teaching and treatment address the student's emotional condition and facilitate the student's return to school?

_____

_____

Please indicate by checking:

☐ **Psychiatrist/Licensed Psychologist - I am currently treating the above-named student.**

☐ **School Psychologist - I have met/consulted with the above-named student/family and/or provider.**

☐ **Nurse Practitioner, LCSW, LCPC, etc. - I am currently treating the above-named student (*Form must be co-signed by Psychiatrist/Licensed Psychologist*).**

NOTE: By signing this statement, I certify that:

- **This student is not able to attend the regular day-school program with modifications because of his/her emotional condition.**
- **I understand that students approved for <u>full-time</u> Home and Hospital Program instructional services with a tutor typically receive 6 hours of instruction per week and that these services are the students' sole source of instruction—not a supplemental tutoring service.**
- **I have reviewed the COVID-19 Statement.**
- Psychologist/Psychiatrist's Signature: _____
- Date: _____

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As the parent/guardian of the above student, I give my permission for my son/daughter to be referred to the Home and Hospital Program and when necessary, for the administrator, or his/her designee, to contact the psychologist/psychiatrist/therapist above in reference to the emotional condition(s) necessitating this referral. I am aware additional medical information may be required, as needed.

Signature of Parent or Guardian: _____ **Date**: _____

E-mail Address: _____

Phone Numbers: (H) _____ (W) _____ (C) _____

For Home and Hospital Use Only

Date Received:_____

Date Assigned:_____

Program(s): e-LC

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