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 FAX (410) 887-4137

EMOTIONAL CONDITION - SY 2019-2020

NOTE: All portions of this professional statement must be completed in order 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: (NO other medical or mental health providers may certify an emotional condition)
□ School Psychologist □ Private Licensed Psychologist □ Private Licensed Psychiatrist
*A Nurse Practitioner, LCSW, LCPC or any other therapist(s) may not be the sole signature on this Professional statement.*

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): ________________________________________________________________

Date Received by Enrollment School: __________
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. (*The Home and Hospital Program is not appropriate for students awaiting nonpublic placement, nor is it appropriate 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- (*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 full-time 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.
- Psychologist/Psychiatrist’s Signature: _____________________________
- Date: ______________________________

***********************************************************************************************
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__________

Rev. 07/2019