WCPS | Washington County Public Schools

10435 Downsville Pike
Hagerstown MD 21740
301-766-2955 phone
301-766-2938 fax

Department of Student Services

Application for Home/Hospital Teaching (HHT)

PARENT
Completed by Parent/Legal Guardian(s)

Name of Student: _____ Grade:_____

School of Attendance: _____ Date of Birth:_____

Telephone: Home _____ Work _____ Cell _____

Home Address: _____

Special Education services received? □ Yes □ No Do you waive the 10-day notice for IEP Meeting? □ Yes □ No

→ ***Delivery of HHT services will be virtual. Individual exceptions will require review and approval by the Director of Student Services.***

K-8 students receiving full time HHT services will complete **state testing at their school.**
□ I elect to have my student grades 9-12 complete **state testing at their school.**
□ I elect to have my student grades 9-12 complete **state testing at the Center for Educational Services.**

Parent Signature: _____ Date: _____

Parent**: Please note that your signature on this application gives appropriate Washington County Public School personnel permission to contact the licensed physician, psychiatrist, psychologist or certified (psychiatric) nurse practitioner providing treatment to the child concerning the medical or emotional diagnosis and treatment as it applies to the assignment and coordination of HHT services and to utilize this information to provide ongoing educational services. An adult (21 years or older) must be present during instruction. Please note that some courses cannot be taught while the student is at home. (i.e.- AP, world language classes, lab science classes, band, PE, etc.) The Office of Student Services will determine which courses will be offered. If the student is a graduating junior or senior and needs PE to graduate an additional medical form is required for the student to participate in a PE class while on HHT. When both the parent and provider sections are complete, please return this form to the principal of the school that the student attends. ***PLEASE ASK YOUR MEDICAL OR PSYCHIATRIC PROVIDER TO PROVIDE THE REQUIRED INFORMATION ON THE REVERSE OF THIS FORM.

SCHOOL
Completed by the IEP Case Manager or the school-based 504 Plan Coordinator

Does the student have a 504 Plan? □ Yes (If yes, attach a copy) □ No
Does the student have an IEP? □ Yes □ No If Yes, list the date of the IEP meeting: _____

Note: An IEP meeting must be held within ten (10) days of receipt of application in order to reflect the student's placement in the HHT program and to determine the hours of service to be provided in order for instruction to begin.

→ IEP Case Manager or 504 Plan Coordinator Signature: _____Date: _____

If there is an IEP, the IEP Case Manager must forward this to their Supervisor of Special Education for review.

→ Supervisor of Special Education Signature: _____ Date: _____
□ I have reviewed & approve this form, will ensure that an IEP meeting is set, and will follow up with the HHT PPW after the IEP meeting.

□ I have reviewed this form and took the following action (include the date & summary of any contact with the parent or provider):

_____

Completed by the School Principal/Designee
Has all information on this application been completed and verified? □ Yes □ No
Student's Schedule – List all classes the student is currently taking this semester. _____

_____

→ Principal/Designee Signature: _____ Date: _____

Completed by Pupil Personnel Worker
Has all information on this application been completed and verified? □ Yes □ No □ Approved □ Denied

→ Pupil Personnel Worker Signature: _____ Date: _____

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HHT Medical/Emotional Referral - completed by the provider

□ **Medical-** Completed by a Licensed Physician/Nurse Practitioner.

□ **Emotional-** Completed by a Licensed Psychologist/Psychiatrist or Certified Psychiatric Nurse Practitioner.

Name of Student:_____ Date of Birth:_____

□ **Full time student is too ill to attend school-** Unable to attend school, due to a physical or emotional illness, for 15 consecutive school days or longer. Re-verified every 60 days.

OR

□ **Intermittent student with a chronic health issue may miss days of school periodically-** Condition requires student to be absent, intermittently, for 1 or more days in a school week. Re-verified annually.

1. Diagnosis:_____
2. Is the student seen on regularly scheduled visits to your office? □ Yes □ No
   Date of Last Visit: _____
3. Is the student on medication that will affect instructional performance? □ Yes □ No
   Medication (s): _____
4. Describe your treatment plan and how it addresses the student's medical condition. Please feel free to attach additional information as needed.

   _____
5. Are there any modifications or accommodations that could be made by the student's school that would allow the student to return to/remain in school rather than receive HHT?

   _____
6. What is the plan to transition the student back to school?

   _____
7. What is the anticipated length of time HHT will be necessary? (Maximum 60 days for full time students.) End date: _____ (End date cannot be prior to provider's signature date.)
8. If applicable, the student is medically able to participate in graduation practices and ceremony □ Yes □ No

Name and address of Provider (Please Print):

_____

Phone: _____ Fax: _____

Provider Signature: _____ Date:_____

Original signature required; stamped signature is not acceptable.

***Licensed physician, certified (psychiatric) nurse practitioner, psychiatrist, and psychologist: Please be advised that Home/Hospital Teaching is generally considered a short-term or temporary service for a student who is unable to attend school due to a medical or emotional condition. Home/Hospital Teaching is not intended to replace the student's school program for an extended period of time (beyond sixty days). Should the student require additional time receiving HHT, it is necessary for the initiating provider to request an extension of HHT and provide supporting documentation.**