Application for Home and Hospital Teaching, with Qualified Mental Health Condition ONLY

MONTGOMERY COUNTY PUBLIC SCHOOLS Maryland

CLEAR FORM

Home and Hospital Teaching
MONTGOMERY COUNTY PUBLIC SCHOOLS (MCPS)
CESC, Room 248, Rockville, Maryland

Note: This form is used by the Home and Hospital Teaching (HHT) Office to obtain a psychiatrist's, psychologist's, or certified mental health nurse practitioner's recommendation and parent/guardian permission to initiate instruction for students with a mental health condition. **Return completed application to student's school counselor or principal/designee.** For more information, see MCPS Regulation IOE-RB, *Home and Hospital Teaching*.

A new completed application, with updated information from the practitioner regarding diagnosis and treatment is required for continuation of service beyond 60 calendar days.

In order for this application to be considered, ALL components of this application must be completed and submitted:

I. Parent portion including signature
II. School portion
III. Practitioner verification including specific steps the school can take to support the student returning to instruction
IV. Return to school plan: The conversation regarding the return to school plan should happen with all stakeholders prior to the submission of the application. It is preferable that the plan be submitted with the application, but it must be submitted no later than 30 days after the application submission.

The school must send the form electronically, when completed, to HHTOffice@mcpsmd.org.

Delivery of HHT will be virtual. Individual exceptions will require review and approval by the Supervisor of HHT.

I. TO BE COMPLETED BY PARENT/GUARDIAN. PLEASE PRINT OR TYPE.

Student Name (Last, First, MI) _____ MCPS ID#_____

MCPS School -- Choose One -- _____ Grade_____ Last day of school attendance _____

The student's home address on file with MCPS is accurate: ❑ Yes ❑ No *(If no, you must update your address with the student's home school)*

Is the student in a Residential Treatment Center (RTC), Partial Hospitalization Program (PHP), or Intensive Outpatient Program (IOP)?
❑ Yes ❑ No?

If Yes, Name of Program _____

Address_____

Facility Contact Name: _____

Contact email _____ Contact Phone _____-_____-_____

Parent/Guardian Name (please print) _____

Parent/Guardian Telephone Number Home _____-_____-_____ Work_____-_____-_____ ext._____ Cell _____-_____-_____

Parent/Guardian Email Address _____

Relationship ❑ Mother ❑ Father ❑ Guardian ❑ Other (specify) _____

Parent/Guardian Name (please print) _____

Parent/Guardian Telephone Number Home _____-_____-_____ Work_____-_____-_____ ext._____ Cell _____-_____-_____

Parent/Guardian Email Address _____

Relationship ❑ Mother ❑ Father ❑ Guardian ❑ Other (specify) _____

I authorize Montgomery County Public Schools (MCPS) to consult with the physician/certified nurse practitioner treating my child to confirm the diagnosis and/or clarify the medical notations. I am aware MCPS has the right to withhold service until the need for Home and Hospital Teachiing has been confirmed.

Signature of Parent/Guardian _____ Date ____/____/_____

(see back)

II. TO BE COMPLETED BY COUNSELOR/PRINCIPAL/DESIGNEE. PLEASE PRINT OR TYPE.

For students with an IEP or 504 Plans

❑ This student has an Individualized Education Program (IEP). IEP Case Manager: _____

❑ This student is in a discreet special education program: _____

❑ This student has a 504 plan.

❑ Most recent IEP or 504 plan attached to application (required for application approval). _____

School teams must conduct an IEP/504 review meeting within ten (10) days of the approval of the application.

For All Students

Accommodations attempted at the school to support student attendance (Please includes dates and results of any EMT meeting and/or parent conferences related to this application): _____

_____

_____

_____

_____ _____

Date application given to parent/guardian____/____/_____ Date application returned from parent/guardian ____/____/_____

By signing, the principal/principal designee understands that developing and submitting a return to school plan is required for every application. Approval of subsequent applications are partially contingent upon implementation of the aforementioned plan. If this is not the initial application for the student, please attach documentation of the results of the previous return to school plan with this application.

Date school submitted application to HHT Office ____/____/_____

Counselor/Principal/Designee Signature _____Date ____/____/_____

COUNSELOR/PRINCIPAL/DESIGNEE SHOULD SCAN AND EMAIL THE COMPLETED APPLICATION TO HHTOFFICE@MCPSMD.ORG

III. TO BE COMPLETED BY PHYSICIAN OR CERTIFIED NURSE PRACTITIONER ONLY. PLEASE PRINT OR TYPE.

PSYCHIATRIST/PSYCHOLOGIST/CERTIFIED MENTAL HEALTH NURSE PRACTITIONER VERIFICATION

For Mental Health Conditions Only

To be completed by a

licensed psychiatrist, licensed psychologist, certified mental health nurse practitioner, or certified school psychologist

Dear Mental Health Professional:

Before processing a request for Home and Hospital Teaching (HHT), a verification made within **30 days** of this application of the student's emotional condition from a licensed psychiatrist, psychologist, or certified mental health nurse practitioner is required. Student need for HHT must be reviewed every **60 calendar days** after the initial date of verification by the practitioner, or sooner at the request of the parent/guardian or MCPS.

Please provide the information requested below. You may attach this information to this signed document in lieu of responding on the form itself. Please note that missing information will result in a delay in processing the application.

1. Student Name _____
2. Have you completed an application for this student previously? ❑ Yes ❑ No
   If yes, how many applications have you completed this school year? ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6
3. Diagnosis of mental health conditions which prevent school attendance (Include DSM-V code):

   _____

   _____

   _____

   _____
4. Specify why the mental health condition prevents the student from attending their school of enrollment.

   _____

   _____

   _____

   _____
5. Date of most recent appointment ***(must be within 30 calendar days of the submission of this form to HHT Office)*** ____/____/_____
6. How often is the student seen in your office: _____
7. Is the student currently in therapy? ❑ Yes ❑ No

   Therapist's name _____

   Therapist's contact _____

   Frequency of visits _____
8. Is the student currently taking any medication? ❑ Yes ❑ No

   Medicine/Dosage _____

   _____
9. Requested duration of services ***(no more than 60 days)*** _____
10. Recommendations for school attendance:
    ❑ Student is unable to attend school
    ❑ Student is able to attend regular day program and student's school of enrollment with modifications. Please list necessary modifications below.
    ❑ Student is able to attend school part-time ❑ Yes ❑ No

    _____

    _____

    _____

    _____

11. Regimen of Treatment to be Prescribed: (Indicate number of previous visits, general nature and duration of treatment, including referral to other provider of health services. Include a schedule of future visits or treatment since you are deeming it medically necessary for the student to be out of school for an extended period of time. You may attach documentation to this application:

    _____

    _____

    _____

    _____

12. Please list actionable steps the school can take, in your estimation, to support the student in returning to school by the end of the requested duration of services:

    _____

    _____

    _____

    _____

I certify that:

❑ I am a licensed psychiatrist, psychologist, or certified mental health nurse practitioner and am currently treating this student; or

❑ I am a certified school psychologist and am working with the student and the student's family to identify community resources that can assist with the student's treatment.

AND

❑ This student IS NOT able to attend the regular day program at their school of enrollment because of their mental health condition.

❑ I understand that I am part of the support team for this student and I will communicate with the school to assist in ensuring the student's return to school as quickly as is reasonably possible.

❑ I understand that by signing this application, the parent/guardian/caregiver of the named student has given authorization for me to discuss and clarify any of the information I have provided with Montgomery County Public Schools.

Signature of Certifying Professional_____Date ____/____/_____

Printed Psychiatrist, Psychologist/CMHNP Name_____

License Number _____

Address_____Phone _____-_____-_____

Email address_____

IV. RETURN TO SCHOOL PLAN

The return to school plan should be created through a collaboration among the school (Suggested members of school team to include: School Counselor, School Psychologist, Pupil Personnel Worker, Administrator, Team Leader, other school staff as appropriate), student (when possible), parent, and practitioner to outline the steps each will take in facilitating the student's return to the school by the end of the requested duration of services. The school should document the success or challenge of each component of the plan. In the event that services need to be continued at the end of the requested duration of services on this application, schools will need to submit evidence of the implementation of the return to school plan, along with an updated plan taking into account any new information.

Please note that the return to school plan can be implemented as soon as is practical, and should not be delayed until the full requested duration of services has elapsed.

The return to school plan should consider the following:

1. What supports will the school put in place to ease the student's transition back into the school building? Some items to consider:
   - Identify the trusted adult who will meet the student upon their return and the steps school staff will take during the first day/week/month/etc. to support the student's transition back into the school building.
   - Identify a lunch/check-in buddy for the student
   - Schedule a time for the student to come to the school outside of school hours to acclimate to the building, view their schedule, etc.
   - Schedule regular check-ins with the counselor or other, trusted, school-based staff.
2. If a student has a 504 plan or an IEP, when will the team meet to determine whether modified or additional accommodations may be necessary (renewal applications should contain notes from this meeting)?
3. If the student does not currently have a 504 plan or an IEP, is an EMT meeting necessary to determine whether codified accommodations are necessary for this student upon their return?
4. What steps will parents take to ensure that the student is present at school for the transition back into the building?
5. What specific steps can the practitioner take to support student attendance at school, and how and when will the school communicate with the practitioner to gather this information?
6. How will the school scaffold the student's return to the building?

This is not an exhaustive list, and schools, students, parents, and practitioners should include anything that will be necessary to ensure a welcoming, safe environment for students returning to school. Below, you will find return to school plan exemplars to support you in creating a successful plan for this student:

Elementary School

Middle School

High School