Please review the following in order to prevent delay in processing requests:

**SECTION I OF PART I** must be **COMPLETED, SIGNED AND DATED** by the Parent/Guardian before the Application can be considered.

Only **PART I** of the Application is to be filled out for students who are requesting CHIP and/or TRANSPORTATION services.

**PARTS I AND II** must be completed for MEDICAL Home Teaching or Hospital Teaching requests. This applies to the initial request as well as to all recertification.

**PARTS I AND III** must be completed for students with EMOTIONAL CONDITIONS who are being referred to the Home & Hospital Program either initially or for recertification. Only a psychiatrist, licensed psychologist or school psychologist may make this type of request.

Please call the Program Nurse, at 410-396-0775 / 410-525-6850 or the Program’s School Psychologist, Dr. Andrea Hogarth at 410-396-0775 / 410-525-6865 with any questions regarding the forms.
**Baltimore City Public Schools**  
**Application for Home & Hospital Program**

**PART I**

**Baltimore City Public Schools Pupil ID Number**

Completed form should be returned to Home & Hospital / Health Program, 2000 Edgewood Street, Baltimore, MD 21216 or FAX 410-233-1367 - Telephone: 410-396-0775.

<table>
<thead>
<tr>
<th>I. This section is to be completed by Parent/Guardian</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Student</strong></td>
</tr>
<tr>
<td><strong>School Number</strong></td>
</tr>
<tr>
<td><strong>Home Address</strong></td>
</tr>
<tr>
<td><strong>Telephone: Home</strong></td>
</tr>
</tbody>
</table>

I grant permission for Baltimore City Public Schools to provide home and hospital teaching services for my child. In addition, I give my consent for the Health Department and/or Home and Hospital staff to confer with the referring physician/psychologist for additional information regarding my child's current condition. This authorization will remain in effect for one year from today's date unless revoked in writing. I understand that I may revoke my consent in writing at any time during the home and hospital teaching process by sending a letter to the director of Home and Hospital Program.

<table>
<thead>
<tr>
<th>II. This section is to be completed by a Physician for Medical Diagnosis - or - Psychiatrist/Licensed Psychologist/Certified School Psychologist for Emotional Diagnosis. This application is based on:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Diagnosis</strong></td>
</tr>
</tbody>
</table>

**Diagnosis:**

| Is this disease communicable? | [Yes] [No] |
|-----------------------------|

If yes, explain

Select a program based on the student's current medical/emotional diagnosis. *In addition to Part I, Part II or Part III of this application must also be completed based on your program choice.*

<table>
<thead>
<tr>
<th><em>Home Teaching</em></th>
<th><em>Hospital Teaching</em></th>
<th><strong>VALID FOR CURRENT SCHOOL YEAR ONLY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Start Date</strong></td>
<td><strong>Hospital</strong></td>
<td>Chronic Health Impaired Program (CHIP)*</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td><strong>Room Number</strong></td>
<td>Student must experience intermittent absences from school because of chronic illness.</td>
</tr>
</tbody>
</table>

**Transportation**

<table>
<thead>
<tr>
<th><strong>Transportation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration</strong></td>
</tr>
<tr>
<td><strong>Indicate Medical Necessity</strong></td>
</tr>
</tbody>
</table>

**Signature**

**Print Name**

**Address**

(Please circle: **Physician**  **Psychiatrist**  **Licensed Psychologist**  **Certified School Psychologist**)

**Telephone**  **Fax**

Approved for: [CHIP] [Hospital Teaching] [Extension] [Transportation]

**Notice of Nondiscrimination**

Baltimore City Public Schools does not discriminate on the basis of race, color, ancestry or national origin, religion, sex, sexual orientation, gender identity, gender expression, marital status, disability, veteran status, genetic information, or age in its programs and activities and provides equal access to the Boy Scouts of America and other designated youth groups.

For inquiries regarding the nondiscrimination policies, please contact

**Equal Opportunity Manager, Title IX Coordinator - Equal Employment Opportunity and Title IX Compliance**

200 E. North Avenue - Room 208 - Baltimore, MD 21202

Phone 410-396-8542 - Fax 410-396-2955

Or

Coordinator - Section 504 - Special Education and Student Supports

200 E. North Avenue - Room 210 - Baltimore, MD 21202

Phone: 443-462-4247 - Email: 504support@bcpms.k12.md.us

If you believe you have been treated differently because of your race or color, national origin or ethnicity, religion of creed, sex or gender, age, physical or mental disability, genetic information, marital status, sexual orientation, or gender identity or expression, you have the right to file a complaint with the Equal Employment Opportunity department. You must file a complaint within 90 days of the most recent act(s) of discrimination or harassment.

**Expiry Date:**

**Diagnosis Code:**

Authorization Signature: ____________________________ Date: ___________________________

Revised 2019-2020 SY

200 East North Avenue • Baltimore, Maryland 21202 • www.baltimorecityschools.org
BALTIMORE CITY PUBLIC SCHOOLS
APPLICATION FOR HOME & HOSPITAL PROGRAM
PART II

Name of Student ____________________________ Date of Birth __________ Gender ________
School Name ____________________________ School Number ______________

The above named student has been referred to our Home and Hospital Program. Enrollment is granted only if a student’s diagnosis precludes regular school attendance. (By State law, students may not exceed (60) calendar days in this program without proper re-certification.)

Please provide the following information.

MEDICAL TREATMENT PLAN
(TO BE COMPLETED BY REFERRING PHYSICIAN)

1. Please describe in detail the student’s current medical diagnosis.

________________________________________________________________________
________________________________________________________________________

2. How does this medical diagnosis prevent the student from attending school on a regular or modified basis? Please be specific.

________________________________________________________________________
________________________________________________________________________

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 on medication? _____ Yes _____ No

Medication(s): __________________________
Dosage(s): __________________________

How will the medication affect school performance?

________________________________________________________________________

Additional Comments:

________________________________________________________________________
________________________________________________________________________

Signature of Physician __________________________ Date ________________
The above named student has been referred to our Home and Hospital Program. Enrollment is granted only if a student’s diagnosis precludes regular school attendance. The State Special Education bylaw mandates that a student, in emotional crisis, receiving special education services may not receive Home/Hospital teaching for more than (60) consecutive school days. Re-certification is needed after 60 calendar days. Please provide the following information.

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

1. Please describe in detail the student’s current emotional diagnosis.

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

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 affect school performance?
   _____________________________________

6. How will the treatment plan address the student’s emotional diagnosis and facilitate the student’s return to school? 
   *(If a student is in emotional crisis a referral to the SST or an IEP is required to facilitate re-entry)*

7. What is the anticipated date of return to school? ______________________

Signature of Psychiatrist/Psychologist

Address

Date

Phone Number / Fax #

EXPIRATION DATE: ________________________

DIAGNOSIS CODE: ________________________

Authorization Signature: ________________________ Date

Service Denied ________________________ Reason: ________________________

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