Home and Hospital / Health Program
2000 Edgewood Street - Lower Level
Baltimore, MD 21216
410-396-0775 / Fax: 410-233-1367
HOMEANDHOSPITALMEDICAL@bcps.k12.md.us

We Bring the Classroom to the Child!

MEMORANDUM

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.

□ **Initial**

□ **Re-certification**

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.

I. This section is to be completed by Parent/Guardian

Name of Student _____ Date of Birth _____ Gender _____

School Number _____ Grade _____ Is student receiving special education services? Yes _____ No _____

Home Address _____ Zip _____

Telephone: Home _____ Work _____ Cell _____

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.*

Parent/Guardian _____ Parent/Guardian _____ _____
(Please Print) (Signature) (Date)

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:

_____ Medical Diagnosis Date of Examination: _____
_____ Emotional Diagnosis Date of Examination: _____
_____ Emotional Crisis Date of Examination: _____

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.

***Home Teaching** □	***Hospital Teaching** □	**VALID FOR CURRENT SCHOOL YEAR ONLY**	**Transportation** □
Start Date _____	_____ Hospital	**Chronic Health Impaired Program (CHIP)** □	Duration _____
Duration _____	_____ Room Number	Student must experience intermittent absences from school because of chronic illness.	Indicate Medical Necessity _____

Signature _____ Date _____
Print Name _____
(Please circle: Physician Psychiatrist Licensed Psychologist Certified School Psychologist)
Address _____ 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@bcps.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 identify 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.

EXPIRATION DATE: _____ DIAGNOSIS CODE: _____

Authorization Signature: _____ Date _____

Revised 2019-2020 SY

□ **Initial**
□ **Re-certification**

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

□ **Initial**
□ **Re-certification**

BALTIMORE CITY PUBLIC SCHOOLS
APPLICATION FOR HOME & HOSPITAL PROGRAM
PART III

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. ***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 Date

_____ _____
Address Phone Number / Fax #

EXPIRATION DATE: _____ DIAGNOSIS CODE: _____
Authorization Signature: _____ Date _____
Service Denied _____ Reason: _____