Office of Home and Hospital Teaching

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8437 Landover Road|Landover, MD 20785

RESET FORM

PSYCHIATRIST/ PSYCHOLOGIST VERIFICATION: Emotional Conditions

Parent/Guardian:
This form is used to obtain the recommendation of a **licensed psychiatrist, licensed psychologist, or licensed psychiatric mental health nurse practitioner** to initiate Home and Hospital Teaching (HHT) services for students who have an emotional condition that renders them unable to attend school. School personnel may need to contact the referring physician for additional information necessary to determine service need. Services may be denied if the referring psychiatrist, licensed psychologist, or licensed psychiatric mental health nurse practitioner cannot be reached within three days of the initial attempt to make contact. Your signature below provides authorization for the physician or clinician to **release information** to PGCPS staff and for PGCPS staff to **release information** to the physician or clinician. HHT is a temporary support for a student experiencing an emotional crisis. It does not replicate daily classroom instruction. Students receive 6 hours of support **per week** compared to 30 hours of instruction provided in school. **Prince George's County Public Schools does not offer online or virtual school instead of regular school attendance.**

Parent Signature: _____ Date: _____

Student Information:

Student Name: _____ Date of Birth: _____

School Name: _____ Student Grade: _____

Student PGCPS ID#: _____

Professional School Counselor/School Administrator:
This student has an IEP and is receiving the following accommodations by the school district (check all that apply).

☐ Dedicated One-on-One Aide	☐ Private Duty Nurse	☐ Extended Time

Medical Information for Home & Hospital Teaching Determination

1. **Diagnosis and DSM-5-TR or ICD-10 code(s) that prevent the student from attending school for 20 or more days.**
If necessary, attach additional information to aid the district in determining why the district would not be able to accommodate the student for 20 or more school days.

Based on this diagnosis above, the student is (CHECK ONE)

- ☐ **UNABLE** to **ATTEND** school for 20 consecutive days or more, but may begin a graduate transition back to a school setting after 20 days.
- ☐ **ABLE** to **ATTEND** school intermittently as health permits. If the student can **ATTEND INTERMITTENTLY AS HEALTH PERMITS,** explain how the student's emotional condition and/or treatment may affect the student's attendance or functioning at school.

2. If the student is **UNABLE TO ATTEND SCHOOL,** explain how the student's emotional condition and/or treatment plan prevents them from being accommodated in a traditional school setting. Include any supporting documentation that will assist the district in determining the necessity for the student to be absent for 20 or more school days.

3. I am the provider who provides medication management for the above-named student.	☐ **NO** ☐ **YES**

Student Name: _____

PGCPS

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4. I am the provider who provides mental health/behavioral therapy for the student named above.	☐ **NO** ☐ **YES**
5. Date of first appointment with the above-named student.	
6. Date of most recent appointment with the above-named student.	
7. Is the student currently taking medication?	☐ **NO** ☐ **YES** Provide the names of the medication and dosage.
8. Has treatment of this emotional condition required hospitalization or time in a residential facility?	☐ **NO** ☐ **YES** If yes, provide names of facilities and dates of stays:
9. I have provided a copy of the treatment plan and therapy goals for this student to be submitted with this form. **A treatment plan with therapy goals must be submitted with this form.**	☐ **NO** ☐ **YES**
10. Date HHT services should BEGIN:	

11. End HHT after: (Check number of weeks): NOTE: HHT is NOT a year-long service. Students are expected to transition back to school. ONLINE SCHOOL IS NOT AVAILABLE unless the student has been accepted to PGCPS Online Campus. The school district can provide accommodations and modifications to assignments, mental health support, check-ins with a professional school counselor, and workload or school day adjustments.

☐ 4 WEEKS (20 school days)
☐ 5 WEEKS (25 school days)
☐ 6 WEEKS (30 school days)
☐ 7 WEEKS (35 school days)
☐ 8 WEEKS (40 school days)
☐ 9 WEEKS (45 school days)
☐ 10 WEEKS (50 school days)
☐ 11 WEEKS (55 school days)
☐ 12 WEEKS (60 school days)

Health Care Provider Verification

Health Care Provider's Name and Title (Print):	
Health Care Provider (check one):	☐ Licensed Psychiatrist ☐ Licensed Psychologist ☐ Licensed Psychiatric Mental Health Nurse Practitioner
License Number:	Contact Phone Number:
Email Address (For School Psychologist Consult):	

This form is valid for 60 days from the date of the physician's signature.

Health Care Provider's Signature: _____ Date: _____