Student Name:       Student ID #:       Date of Birth:

Student Preferred Name:       Gender:  Age:

# Grade:  Native Language:

*The appropriate team is required to meet on both the 30th calendar day and the 50th calendar day after initiation of HHT services to ensure an individualized, structured plan is in place for the student’s full return to school by the 60th school day*

Date of Referral by Professional*(school psychologist, physician, outside professional, etc.):*

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Date of Meeting to determine HHT services: Projected Date of return from HHT:

🞻

Does the student have: 504 Plan [ ]  Yes [ ]  No IEP [ ]  Yes [ ]  No

🞻

🞻

Type of Reentry Plan Meeting: [ ]  Initial Plan development [ ]  30 day Review [ ]  50 day Review

🞻

Date of Today’s Meeting:

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|  |
| --- |
| Names and Titles of Team Members Developing or Reviewing Plan |
|                      | \*Administrator\*School Counselor **or**\*School Psychologist or School Social Worker\*Teacher |                           | Special Educator (required if student has an IEP)\*ParentOther      Other      Other       |

***\*Required***

**SECTION I: Student Information**

*Describe the services the student will receive while on HHT. If appropriate, consider related services such as speech, OT, PT or counseling. Minimum number of hours for classroom instruction is 6 hours.*

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**Services for Emotional Crisis Home and Hospital Teaching:\***

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Service** | **Hours of Service** | **Location of Services** | **Service Provider** |
| Classroom Instruction |       |       |       |
| Speech/Language |       |       |       |
| Occupational Therapy |       |       |       |
| Physical Therapy |       |       |       |
| Counseling |       |       |       |
| Other |       |       |       |
| Other |       |       |       |
| Other |       |       |       |

*\*For students with an IEP or 504 Plan, services are determined by the appropriate team.*

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School Contact:       (*Contact for HHT Teacher*)

Additional Information:

Student Name:       Student ID #:

Date of Meeting:

**SECTION II: Staff Action(s)**

*Identify individualized supports based on the needs of the student.*

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Does the student have a private provider who recommended HHT or who is treating the student? [ ]  Yes [ ]  No

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Staff Action(s)** | **Staff Responsible** | **Due Date** | **30-Day Status** | **50-Day Status** |
| Consultation with Private Provider *(if applicable)*\*\* |       |       |       |       |
| Check in/Check out |       |       |       |       |
| Counseling sessions with appropriate staff member |       |       |       |       |
| Assign a mentor/coach |       |       |       |       |
| Complete assessments for special education eligibility (IEP) |       |       |       |       |
| Complete eligibility determination for Section 504 |       |       |       |       |
| Develop student contract |       |       |       |       |
| Develop IEP, 504 Plan as appropriate |       |       |       |       |
| Regular parent contact |       |       |       |       |
| Revise IEP or 504 Plan, as appropriate |       |       |       |       |
| Other:       |       |       |       |       |
| Other:       |  |  |  |  |
| Other:       |  |  |  |  |
| Other:       |  |  |  |  |

*\*\*Required if there is an outside provider treating the student or placing the student on HHT.*

Additional Information:

Student Name:       Student ID #:

Date of Meeting:

**SECTION III: Student Specific Actions**

*Based on individual needs of the student, identify appropriate actions the student will be required to do when planning to return to school. If a partial day schedule is used, it should start around the 30th* ***calendar*** *day to ensure the student has been fully reintegrated by the 60th* ***school*** *day.*

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Student Specific Action(s)** | **Staff Responsible** | **Due Date** | **30-Day Status** | **50-Day Status** |
| Modified partial day schedule, if appropriate. \* | SEE BELOW |       |       |       |
| Participate in counseling sessions  |       |       |       |       |
| Participate in development of contract (prior to return to school). |       |       |       |       |
| Modify schedule while attending a full day of school (eliminating certain classes) |       |       |       |       |
| Participate in meetings, as appropriate, prior to return to school to develop reentry plan. |       |       |       |       |
| Use identified supports to remain in class or request assistance |       |       |       |       |
| Work with assigned mentor or coach. |       |       |       |       |
| Other       |       |       |       |       |
| Other       |       |       |       |       |
| Other       |       |       |       |       |

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Is a modified partial day schedule required? [ ]  Yes [ ]  No

\*Modified Partial Day Schedule: Full Reentry into school cannot extend beyond the 60th **school** day.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date** | **Increment of Increased Time** | **Duration for Each Step of Incremental Increase** | **Staff Responsible** | **30-Day Status** | **50-Day Status** |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |