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Prince George's County Public Schools – Office of Home and Hospital Teaching

TRANSITION PLAN

Student Name: **Grade:** **Student ID #:** **School:**

School Psychologist: **School Counselor:**

Home and Hospital Teaching is a temporary support service and not an alternative placement. From the time a referral is made, emphasis should be placed on returning the student to school. The transition plan should be developed by the IEP, SIT, or SST team to assist with returning the student to school. Student transition plans should follow a continuum designed to increase school engagement and consider a variety of factors, including the student's stamina, capacity for academic engagement, and support needs while transitioning or at school. **A completed transition plan must accompany all requests for Home and Hospital Teaching (HHT) services for students unable to attend school due to an emotional condition. The plan must be created by the school team. The plan has specific sections for the Professional School Counselor and School Psychologist.**

PART I: School Implemented Interventions/ Strategies Before HHT Referral
(Professional School Counselor or Administrator should complete this section.)

Intervention	Description
☐ IEP/504/SIT meeting convened (Date:)	
☐ Revised IEP/504/ BIP	
☐ Schedule change	
☐ Morning check-in with school staff	
☐ In-school counseling services	
☐ Modified day	
☐ PPW referral (current # of days absent: _____)	
☐ Consult with the treating psychiatrist/ psychologist	
☐ Other :	

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Part II: School Psychologist Transition Plan Recommendations:

(School Psychologists should complete this section.)

Modifications & Supports	Description
☐ School Attendance/Scheduling (e.g., school day, time in class, class schedule)	
☐ Academic Workload (e.g., amount of work, time spent working, level of difficulty)	
☐ Accommodations (e.g., extended time, reduced distractions, brain breaks, etc.)	
☐ Mental or Behavioral Health Support (e.g., check-in/out, counselor check-ins, flash pass, consult w/ referring clinician, etc.)	
☐ Other:	

Part III: Plan to Return to School

(SIT, SST, or IEP team should complete this section.)

Week	Instructor (Select or or both)	# of Hours	# of Days	Indicate Location (School, Home, Hospital, Treatment Center)	Subjects
1	HHT				
2	HHT and/or Classroom				
3	HHT and/or Classroom				
4	HHT and/or Classroom				
5	HHT and/or Classroom				
6	Classroom				

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Part III. Plan to Return to School

List all modifications and supports that will occur during the transition period or when the student has returned to school.

Modification & Support	Description
☐ School Attendance/Scheduling (e.g., school day, time in class, class schedule)	
☐ Academic Workload (e.g., amount of work, time spent working, level of difficulty)	
☐ Accommodations (e.g., extended time, reduced distractions, brain breaks, etc.)	
☐ Mental or Behavioral Health Support (e.g., check-in/out, counselor check-ins, flash pass, consult w/ referring clinician, etc.)	
☐ Other:	

PART IV: Review by Office of Home and Hospital Teaching

Transition Plan has been: ○ Denied ○ Approved

☐ Approved with revisions(indicate revisions):

HHT Case Manager **Date**

NOTE: Participants in the development of this plan should be documented on the appropriate IEP, SIT, or SST sign-in sheet and attached to the transition plan. It is recommended that the IEP Case Manager or SIT/SST chair monitor and provide the updates to the Home and Hospital Case Manager.

Name of Transition Plan Monitor/Title **Date**

Parent Signature/Date: **Student Signature/Date:**