MFTD Respite Referral Form

All fields are required unless marked "optional"

Please note that payment for all requested sessions are due on booking. This cost to families represents 7% of the total cost of providing respite care, with the rest subsidized by donations. Fees are necessary to secure the resources and commit to staffing. Assistance is available for families in need, please see our Resources page for more information.

GENERAL CONSENT

This request is being submitted with the knowledge and consent of names parents/legal guardians.
Have parents provided implied consent to information collection as per ErinoakKids Privacy Policy available at: https://erinoakkids.ca/about-us/about-erinoakkids/accountability/policies/privacy-and-confidentiality

Consent Received: ☐ Yes ☐ No If No, ErinoakKids will not process this referral

ERINOAKKIDS' RESPITE SERVICES STREAMS

Please access the ErinoakKids website for descriptions and eligibility criteria for each respite service stream https://www.erinoakkids.ca/all-services/family-supports/respite-services

Medically Fragile Technologically Dependent (MFTD)

Please fill out the following four questions to determine eligibility for MFTD Respite Services:

Is your family member under the age of 18 years?

- ☐ Yes
- ☐ No *(if no, please fill out 18+ form)*

Does your family member reside in the Province of Ontario?

- ☐ Yes
- ☐ No *(If no, family member is not eligible for ErinoakKids Respite Services)*

Does your family member qualify for enhanced respite funding identified by Home and Care Community Support Services (HCCSS)? For additional information, please refer to https://www.healthcareathome.ca/

- ☐ I do not qualify *(family member is not eligible, please refer to Non-MFTD referral form)*
- ☐ I do qualify
- ☐ Unsure

Does your family member reside at home with their parent/caregiver?

- ☐ Yes
- ☐ No *(if no, family member is not eligible for ErinoakKids Respite Services)*

CLIENT INFORMATION

Date of Birth (dd-mmm-yyyy) _____

Gender ☐Male ☐Female ☐Other

Child's Name
Last Name _____
First Name _____ Middle Name (optional) _____
Health Card # (optional) _____ Version Code _____

Address
Unit#_____ Street# _____ Street Name _____
City _____ Postal Code _____

Parent / Legal Guardian Names

1. Person to Notify *(primary contact - will be the only person notified for services)*

Last name _____ First Name _____
Relationship _____
Phone #1 _____ Phone Type Choose from below: _____
Phone #2 _____ Phone Type Choose from below: _____
Email _____
Address ☐Same as client ☐Different from Client *If different from client, please fill out below*
Unit#_____ Street#_____ Street name _____
City _____ Postal Code _____

2. Next of Kin *(secondary contact - optional)*

Last name _____ First Name _____
Relationship _____
Phone #1 _____ Phone Type Choose from below:
Phone #2 _____ Phone Type Choose from below:
Email _____
Address ☐ Same as client ☐ Different from Client *If different from client, please fill out below*
Unit#_____ Street#_____ Street name _____
City _____ Postal Code _____

Who your family member lives with:

☐ Both parents ☐ One parent ☐ Foster Parent
☐ Other (specify) _____

Primary Language spoken in the home _____

Are Interpreter Services required? ☐Yes ☐ No ☐ Unsure If yes, state language/ASL _____

SPECIAL NEEDS INFORMATION

Children's Protective Services, Agency Name: (optional) _____

Caseworker's Name (optional)_____ Phone Number (optional) _____

Diagnosis ☐Yes ☐No If yes, identify diagnosis _____

Identify area of concern: _____

Allergies ☐Yes ☐No If yes, specify allergy(s) _____

Epipen required? ☐Yes ☐No If yes, specify Epipen allergy _____

DATE SELECTION

Please select your top 3 choices per quarter (three month period)

Medically Fragile Technologically Dependent (MFTD)

2025 Dates:

Quarter 4 (January - March 2025)

First choice: Choose from below:

Second choice: Choose from below:

Quarter 1 (April -June 2025)

First choice: Choose from below:

Second choice: Choose from below:

Third choice: Choose from below:

Thank for outlining your priority dates. We will work diligently to accommodate your dates as requested.

MEDICAL NEEDS

Does your family member use equipment or require respiratory support to help with their breathing in the day? Examples include tracheostomy, BiPap, CPAP, oral or trach suctioning, cough assist or oxygen.

☐ Yes ☐ No If Yes, describe: _____

_____

Which type of bed does your family member use?

☐ safety-enclosed bed (twin bed with 1-3 ft rails)

☐ standard bed (twin bed with 6 inch rails)

BEHAVIOURAL NEEDS

Does your family member demonstrate any of the following

Does your family member demonstrate aggression towards others?

- ☐ 1 to 3 times/day
- ☐ 1 to 3 times/week
- ☐ 1 to 3 times/month
- ☐ None of the above

Does your family member demonstrate aggression towards themselves?

- ☐ requires medical treatment
- ☐ requires first aid-treatment
- ☐ does not require treatment
- ☐ None of the above

Does your family member try to leave the house on their own?

- ☐ 1 to 3 times/day
- ☐ 1 to 3 times/week
- ☐ 1 to 3 times/month
- ☐ None of the above

FUNDING

How will you be paying for your Respite stay?

☐ Special Services at Home (SSAH) where ErinoakKids is your Transfer Payment Agency (TPA)
☐ Parent Funded – self pay

REFERRAL SOURCE

☐ Parent / Guardian ☐ Medical ☐ Community Agency ☐ Other

Referral Source Name and Contact Information

_____

_____

_____

If you have any questions regarding your family member's eligibility, please contact our respite administration at (905) 855-2690 x2273

Thank you. Please submit the completed form.