

MFTD Respite Referral Form

All fields are required unless marked "optional"

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/respice-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*)

Do you reside in one of the following regions? (*If none of below, family member is not eligible for ErinoakKids Respite Services*)

- ☐ Halton
- ☐ Peel
- ☐ Dufferin

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 _____

Phone #2 _____ Phone Type _____

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 _____

Phone #2 _____ Phone Type _____

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)

Quarter 3 (October - December 2023)

First choice: _____

Second choice: _____

Third choice: _____

2024 Dates:

Quarter 4 (January - March 2024)

First choice: _____

Second choice: _____

Third choice: _____

Quarter 1 (April - June 2024)

First choice: _____

Second choice: _____

Third choice: _____

Quarter 2 (July - September 2024)

First choice: _____

Second choice: _____

Third choice: _____

Quarter 3 (October - December 2024)

First choice: _____

Second choice: _____

Third choice: _____

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.