

# 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 \_\_\_\_\_

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)**

**2025 Dates:**

**Quarter 4** (January - March 2025)

First choice: \_\_\_\_\_

Second choice: \_\_\_\_\_

**Quarter 1** (April -June 2025)

First choice: \_\_\_\_\_

Second choice: \_\_\_\_\_

Third choice: \_\_\_\_\_

**Thank for sharing your priority dates. We cannot guarantee availability, but we will do our best to accommodate your choices.**

**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.