Respite Funds Application Form.

Submit completed Application Forms to the:

IBWU Respite Funds Committee

Email: **board@ibwu.org**

**Eligibility Criteria**

To be eligible, your child/person you care for must:

* live at home
* need intensive care and constant monitoring on a 24-hour basis
* be medically fragile and/or technology dependent, meeting one of the following criteria:
	+ relies on medical and technological equipment, such as mechanical ventilators, apnea monitors, renal dialysis, urinary catheters, colostomy bags
	+ is administered drugs intravenously
	+ relies on tracheotomy tube care, suctioning, oxygen support or tube feeding
	+ Exhibit a functional loss or impairment (social, emotional, behavioral, developmental, and physical impairment) which limits ability on a day to day basis.

# Parents/Guardians Full Names:

Address:

Email address:

Phone Home: Cell

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Child/Persons Details**First Name Last Name | M/F | Age | Birth Date M/D/Y | Livesat home | Applying for respite |
|  |  |  |  |  |  |

Other people living in the family home

# Applicant/Parent Signature

**Qualifying Criteria** Check the **Respite Fund** you are applying to:

 **Autism Spectrum Disorder** Child has a diagnosis of Autism Spectrum Disorder

#  Developmental and/or Physical Disability

 If applying for Developmental and/or Physical Disability check the statements below that apply:

 Child/Person has one or more disability related need resulting from a developmental disability, that requires support for participation in activities of daily living, school and play

 Child/Person has one or more disability related need resulting from a physical disability that requires support for participation in activities of daily living, school and play

 Child/Person is medically fragile/technologically dependent and requires 24 hour observation and/or treatment:

M**andatory supporting documentation** of the diagnosis and/or the professional assessment must be **attached to the application**. List & detail the **diagnosis and/or functional loss or impairment** of the Child/Person

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Personal Care & Activities | Independent | Prompts orreminders required | Some supports required | Full supports required |
| Eating |  |  |  |  |
| Dressing |  |  |  |  |
| Toileting |  |  |  |  |
| Activities |  |  |  |  |
|  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Full capacity | Somewhat limited | Very limited | None |
| Speech/Hearing |  |  |  |  |
| Vision |  |  |  |  |
| Mobility |  |  |  |  |
|  |  |  |  |  |

School attended/grade:

**Formal Supports** Check all that apply **Details required.**

|  |  |  |
| --- | --- | --- |
| ACSD - Assistance For Children with Severe Disabilities |  |  |
| Childcare/Subsidy |  |  |
| Family and Children’s Services |  |  |
| Ontario Autism Program |  |  |
| Ontario Works/Childcare subsidy |  |  |
| Special Services at Home |  |  |
| Other, specify |  |  |

Describe the family’s **informal support** network:

Has the family previously submitted a Respite Application to any Organization? Yes No

If yes, provide date & details of prior funding

# Respite Plan

**Type of respite** requested? (Worker, day program, camp, host family, overnight care, etc)

**Projected cost?** (Hourly/daily rates, number of hours per week or month, number of weeks, etc.)

Does the family have transportation?

What will be the **expected outcome** of respite for the parent(s) and family as a whole?

**Respite Approved:**

|  |  |
| --- | --- |
| Type/Location |  |
| Frequency |  |
| Duration/Cost |  |

**Respite not approved or deferred:**

Signed, on behalf of IBWU Foundation Date