

Program Description: Enhanced Home Transition Support (EHTS)

Things it might be helpful to know about this program:

- EHTS is a 90-day program designed to provide home supports and personal care to people returning home from being admitted to hospital. Services can include things like help with bathing and other personal care needs, as well as light housekeeping and light meal preparation.
- To be eligible for service clients must:
 - Be referred by the hospital.
 - Be age 55, have a place to live after hospitalization and have any necessary equipment in the home they need to live safely.
 - Be able to feed themselves and be able to take their own medication with supervision.
 - Be able to manage their own care or with supports through Ontario Health@Home services after the 90 days of service has ended.
 - Live between Yonge and the Humber River, and between Lawrence Ave and Lake Ontario
- Eligibility for service will not be denied on the basis of language or disability. Supports will be arranged for as needed.
- Clients on LTC and LTC Crisis waitlists are eligible for service.
- Clients requiring 24/7 care are NOT eligible. However, those needing 24/7 care for up to a month may be considered on a case-by-case basis if it can be shown that the high level of service will not be needed beyond the specified timeframe.

Once in service you can expect the following:

- You will participate in an initial assessment with Reconnect staff to determine which services are needed.
- Hours of service are available mornings, afternoons and evenings, seven days a week.
- Service will be provided by trained Personal Support Workers. Depending on scheduling limitations, clients should expect to be visited by different PSWs over the course of their service.
- To be informed of changes to the schedule as far in advance as possible
- You will be expected to inform the program manager of any changes to your health, so that services can be adjusted to meet needs, as much as possible.
- A Caseworker will contact the client/family weekly for the first 4 weeks to provide updates and check on progress.
- After the first 4 weeks, the caseworker will contact client/family biweekly for the remainder of the program.
- At the start of the final 30 days of service, the client/family will be sent a reminder about the impending service end date and provide the transition plan.

- The client/family will be sent weekly reminders until the service end date to ensure the client/family is prepared for the transition.
- You will be provided with the name and contact information for the program manager
- You will be made aware of the agency's complaint process and how to access it.
- You will be made aware of your right to privacy, how your personal health information is being kept secure, and how and under what circumstances the agency will collect, use or disclose your personal health information.