



AMENDMENT EXISTING COMMUNITY CARE FACILITY LICENCE

The personal information collected relates directly to and is necessary for program operation as outlined in the *Community Care and Assisted Living Act*. Information that appears on a licence may be disclosed per Section 22(4)(i) of the *Freedom of Information and Protection of Privacy Act*, as it is not considered an unreasonable invasion of personal privacy. If you have any questions about the collection and use of this information, contact the Island Health, Information and Privacy Office, at 250.370.8323.

COMPLETE SECTION OF FORM THAT APPLIES TO THE AMENDMENT REQUESTED. THE VERIFICATION SECTION MUST BE COMPLETED FOR ALL REQUESTS. THIS FORM IS ONLY TO BE USED FOR CURRENT LICENCE HOLDERS. COMPLETE FORM USING BLOCK PRINTING WHERE POSSIBLE AND COMPLETELY FILLING IN THE APPROPRIATE BOXES.

PLEASE NOTE – CHANGE IN LICENSEE OR FACILITY RELOCATION TO A NEW PHYSICAL LOCATION ARE NEW APPLICATIONS AND REQUIRE A NEW APPLICATION PACKAGE TO BE SUBMITTED.

CHOOSE APPROPRIATE SECTIONS

Type of Amendment <small>[tick all that apply and complete corresponding section]</small>	AMENDMENT: Facility Name and Licence Number:		
	<input type="checkbox"/> Change of Manager [Section 3] <input type="checkbox"/> Days/Hours/Months of Operation [Section 5] <input type="checkbox"/> Capacity Change [Section 5] <input type="checkbox"/> Other	<input type="checkbox"/> Facility Name [Section 1] <input type="checkbox"/> Existing Licensee Name Change Only [Section 2] <input type="checkbox"/> Amend or Addition of Service Type [Section 5]	<input type="checkbox"/> Facility Mailing Address [Section 1] <input type="checkbox"/> Relocation within existing site [Section 5] <input type="checkbox"/> Licensee Mailing Address [Section 2]

FACILITY Information [Section 1]	FACILITY NAME		
	FACILITY LOCATION ADDRESS		
	CITY		POSTAL CODE
	TELEPHONE	FAX	EMAIL
	FACILITY MAILING ADDRESS IF DIFFERENT FROM ABOVE:		
	WATER SOURCE: <input type="checkbox"/> COMMUNITY (SYSTEM NAME) <input type="checkbox"/> WELL <input type="checkbox"/> OTHER: (specify) _____ SEWAGE DISPOSAL: <input type="checkbox"/> SEWER <input type="checkbox"/> ONSITE SEWAGE DISPOSAL		

LICENSEE Information [Section 2]	LICENSEE NAME		
	MAILING ADDRESS		
	CITY		PROV
	TELEPHONE		FAX
	LICENSEE CONTACT		PHONE
	Is the Licensee or a Board Member at least 19 Years Old? <input type="checkbox"/> YES <input type="checkbox"/> NO Has The Licensee Previously Applied To Be A Licensee or Manager of a Community Care Facility? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	Is the Organization Registered? <input type="checkbox"/> YES <input type="checkbox"/> NO If "yes", Registration Number: _____		

FACILITY MANAGER Information [Section 3]	MANAGER NAME		
	MANAGER MAILING ADDRESS		
	CITY		PROV
	TELEPHONE		FAX
	Is the Manager at least 19 Years Old? <input type="checkbox"/> YES <input type="checkbox"/> NO Is this Manager Currently the Manager of Any Other Community Care Facility? <input type="checkbox"/> YES <input type="checkbox"/> NO Has the Manager Previously Applied to be a Licensee or Manager of a Community Care Facility? <input type="checkbox"/> YES <input type="checkbox"/> NO		

OWNER OF BUILDING/ COMPLEX & CONTACT FOR BUILDING [Section 4]	REGISTERED NAME		
	MAILING ADDRESS		
	CITY		PROV
	CONTACT/AGENT NAME		POSITION
	TELEPHONE		FAX

SECTION 5: PROPOSED SERVICE – Check the applicable service and include the capacity

CHILD CARE	Capacity	Room #	Maximum Capacity (except REC Only)	RESIDENTIAL CARE	Capacity
<input type="checkbox"/> 301 – Group Child Care < 36 mos.			Months of Operation	<input type="checkbox"/> 400 – Long Term Care Funded	
<input type="checkbox"/> 302 – Group Child Care > 30 mos.				<input type="checkbox"/> 401 – Long Term Care Non-Funded	
<input type="checkbox"/> 303 – Preschool			Days and Hours of Operation	<input type="checkbox"/> 410 – Community Living	
<input type="checkbox"/> 304 – Family Child Care				<input type="checkbox"/> 420 – Mental Health	
<input type="checkbox"/> 305 – Group Child Care School Age				<input type="checkbox"/> 421 – Substance Use	
<input type="checkbox"/> 308 – Occasional Child Care			If this is a home-based facility, specify the number of people over the age of 12 living in this home.	<input type="checkbox"/> 440 – Acquired Injury	
<input type="checkbox"/> 309 – Child-minding				<input type="checkbox"/> 450 – Hospice	
<input type="checkbox"/> 310 – Multi-Age Child Care				<input type="checkbox"/> 430 – Other	
<input type="checkbox"/> 311 – In-Home Multi-Age Child Care				<input type="checkbox"/> 500 – Child and Youth Residential	
<input type="checkbox"/> 312 – School Age Care on School Grounds					
<input type="checkbox"/> 313 – Recreational Care					

VERIFICATION: MUST BE COMPLETED FOR ALL AMENDMENT REQUESTS

I hereby apply to amend an existing Community Care Facility Licence and agree to abide by the regulations made under the authority of the *Community Care and Assisted Living Act* and certify that the information I have provided is correct to the best of my knowledge.
 I hereby certify that the information set out by me in this application is true and correct to the best of my knowledge and belief. I acknowledge that it is an offence to supply false or inaccurate information on this application.

LICENSEE OR BOARD MEMBER SIGNATURE:

PRINT NAME:

DATE:

TITLE (in organization):