



# APPLICATION FOR 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 ONE APPLICATION <i>IN FULL</i> FOR <i>EACH</i> FACILITY USING BLOCK PRINTING WHERE POSSIBLE AND COMPLETELY FILLING IN THE APPROPRIATE BOXES ■																																										
<b>STATUS</b>	<b>NEW</b> <input type="checkbox"/> FACILITY <input type="checkbox"/> LICENSEE <input type="checkbox"/> LOCATION		<b>AMENDMENT</b> Facility # _____		<input type="checkbox"/> CHANGE IN MANAGER <input type="checkbox"/> OTHER _____																																					
<b>FACILITY Information</b>	FACILITY NAME																																									
	FACILITY LOCATION ADDRESS																																									
	CITY			POSTAL CODE																																						
	TELEPHONE	FAX	EMAIL																																							
	FACILITY MAILING ADDRESS IF DIFFERENT FROM ABOVE:																																									
	<b>WATER SOURCE</b> <input type="checkbox"/> COMMUNITY (SYSTEM NAME) _____ <input type="checkbox"/> WELL <input type="checkbox"/> OTHER _____ SPECIFY _____																																									
	<b>SEWAGE DISPOSAL</b> <input type="checkbox"/> SEWER <input type="checkbox"/> ONSITE SEWAGE DISPOSAL WILL YOUR FACILITY BE PROVIDING FULL MEALS/FOOD SERVICE? <input type="checkbox"/> YES <input type="checkbox"/> NO																																									
<b>LICENSEE Information</b>	LICENSEE NAME				<input type="checkbox"/> SOCIETY  <input type="checkbox"/> SOLE PROPRIETOR  <input type="checkbox"/> PARTNERSHIP  <input type="checkbox"/> INCORPORATED  <input type="checkbox"/> OTHER   SPECIFY _____																																					
	MAILING ADDRESS																																									
	CITY		PROV			POSTAL CODE																																				
	TELEPHONE	FAX	EMAIL																																							
	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: _____																																										
<b>FACILITY MANAGER Information</b>	MANAGER NAME																																									
	MANAGER MAILING ADDRESS																																									
	CITY		PROV		POSTAL CODE																																					
	TELEPHONE	FAX	EMAIL																																							
	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																																									
<b>BUILDING Information</b>	IF THE FACILITY IS PART OF A MALL, NAME OF MALL _____																																									
	BUILDING NAME (IF DIFFERENT FROM FACILITY) _____																																									
	ADDRESS		CITY		POSTAL CODE																																					
	<input type="checkbox"/> BUILDING OWNER information <b>same</b> as Facility Owner <input type="checkbox"/> BUILDING/PROPERTY address information same as Facility address																																									
<b>OWNER OF BUILDING /COMPLEX &amp; CONTACT FOR BUILDING</b>	REGISTERED NAME				<input type="checkbox"/> SOCIETY  <input type="checkbox"/> SOLE PROPRIETOR  <input type="checkbox"/> PARTNERSHIP  <input type="checkbox"/> INCORPORATED  <input type="checkbox"/> OTHER   SPECIFY _____																																					
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	CITY		PROV			POSTAL CODE																																				
	CONTACT/AGENT NAME					POSITION																																				
	TELEPHONE	FAX	EMAIL																																							
<b>PROPOSED SERVICE – Check the applicable service and include the proposed capacity.</b>																																										
<b>CHILD CARE</b> <input type="checkbox"/> 301 – Group Child Care < 36 mos. <input type="checkbox"/> 302 – Group Child Care > 30 mos. <input type="checkbox"/> 303 – Preschool <input type="checkbox"/> 304 – Family Child Care <input type="checkbox"/> 305 – Group Child Care School Age <input type="checkbox"/> 308 – Occasional Child Care <input type="checkbox"/> 309 – Child-minding <input type="checkbox"/> 310 – Multi-Age Child Care <input type="checkbox"/> 311 – In-Home Multi-Age Child Care <input type="checkbox"/> 312 – School Age Care on School Grounds <input type="checkbox"/> 313 – Recreational Care		<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:15%;">Capacity</th> <th style="width:15%;">Room #</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Capacity	Room #																					<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:100%;">Maximum Capacity (except REC Only)</th> </tr> </thead> <tbody> <tr> <td>Months of Operation</td> </tr> <tr> <td>Days and Hours of Operation</td> </tr> <tr> <td>If this is a home-based facility, specify the number of people over the age of 12 living in this home _____</td> </tr> </tbody> </table>	Maximum Capacity (except REC Only)	Months of Operation	Days and Hours of Operation	If this is a home-based facility, specify the number of people over the age of 12 living in this home _____	<b>RESIDENTIAL CARE</b> <input type="checkbox"/> 400 – Long Term Care Funded <input type="checkbox"/> 401 – Long Term Care Non-Funded <input type="checkbox"/> 410 – Community Living <input type="checkbox"/> 420 – Mental Health <input type="checkbox"/> 421 – Substance Use <input type="checkbox"/> 440 – Acquired Injury <input type="checkbox"/> 450 – Hospice <input type="checkbox"/> 430 – Other <input type="checkbox"/> 500 – Child and Youth Residential	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:100%;">Capacity</th> </tr> </thead> <tbody> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </tbody> </table>	Capacity										
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<b>VERIFICATION</b>																																										
I hereby apply for a Community Care Facility Licence and agree to abide by the regulations made under the authority of the <i>Community Care and Assisted Living Act</i> 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.  TITLE (in organization) _____			<b>Funded by Government:</b> <input type="checkbox"/> <b>Funded</b> <input type="checkbox"/> <b>Non-Funded</b> FUNDED BY: _____ SPECIFY _____  The granting of a licence neither constitutes approval of funding by the provincial government nor local government approval of your facility. It is therefore recommended that you contact the appropriate authorities.  PROPOSED OPENING DATE:   DD / MMM / YYYY _____																																							
PRINT NAME			DATE:   DD / MMM / YYYY _____																																							
LICENSEE OR BOARD MEMBER SIGNATURE			FOR OFFICIAL USE ONLY – FACILITY # _____																																							