



APPLICATION FOR COMMUNITY CARE FACILITY LICENCE

COMPLETE ONE APPLICATION **IN FULL** FOR **EACH** FACILITY USING BLOCK PRINTING WHERE POSSIBLE AND COMPLETELY FILLING IN THE APPROPRIATE BOXES ■

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 Vancouver Island Health Authority, Information and Privacy Office, at 250.370.8323.

STATUS	NEW <input type="checkbox"/> FACILITY <input type="checkbox"/> LOCATION <input type="checkbox"/> LICENSEE	AMENDMENT	Facility # _____ <input type="checkbox"/> CHANGE OF MANAGER <input type="checkbox"/> OTHER _____ <small>SPECIFY</small>	
FACILITY Information	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 _____ <small>SPECIFY</small>	
	SEWAGE DISPOSAL <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				
LICENSEE Information	LICENSEE NAME			<input type="checkbox"/> SOCIETY <input type="checkbox"/> SOLE PROPRIETOR <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> INCORPORATED <input type="checkbox"/> OTHER <small>SPECIFY</small> _____
	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: _____	
FACILITY MANAGER Information	MANAGER NAME			
	MANAGER MAILING ADDRESS			
	CITY		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			
BUILDING Information	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 same as Facility Owner <input type="checkbox"/> BUILDING/PROPERTY address information same as Facility address	
OWNER OF BUILDING /COMPLEX & CONTACT FOR BUILDING	REGISTERED NAME			<input type="checkbox"/> SOCIETY <input type="checkbox"/> SOLE PROPRIETOR <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> INCORPORATED <input type="checkbox"/> OTHER <small>SPECIFY</small> _____
	MAILING ADDRESS			
	CITY	PROV	POSTAL CODE	
	CONTACT/AGENT NAME		POSITION	
	TELEPHONE	FAX	EMAIL	
PROPOSED SERVICE – Check the applicable service and include the proposed capacity.				
CHILD CARE	Capacity & Room Number	Maximum Capacity	RESIDENTIAL CARE	Capacity
<input type="checkbox"/> 301 – Group Child Care < 36 mos.			<input type="checkbox"/> 400 – Long Term Care Funded	
<input type="checkbox"/> 302 – Group Child Care > 30 mos.		Months of Operation	<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		If this is a home-based facility, specify the number of people over the age of 12 living in this home	<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			<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	
Facility addresses are routinely available to the public on request. Community Care Facilities Licensing provides facility contact information to the public: <ul style="list-style-type: none"> • Online with routine inspection reports. I give permission to post facility Manager, address and telephone number online: <input type="checkbox"/> Yes <input type="checkbox"/> No • On request, via a list of all licensed facilities. I give permission for the facility Manager, address and telephone number to be included on a public list of licensed facilities: <input type="checkbox"/> Yes <input type="checkbox"/> No Information from routine inspection reports for Residential Community Care Facilities and Child Care Facilities are available online. Residential Care facility inspections since October 2008 and Child Care facility inspections since March 2010 are posted.				
VERIFICATION				
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.		Funded by Government: <input type="checkbox"/> Funded <input type="checkbox"/> Non-Funded FUNDED BY: _____ <small>SPECIFY</small>		
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.		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.		
LICENSEE OR BOARD MEMBER SIGNATURE		PROPOSED OPENING DATE: DD / MMM / YYYY		
PRINT NAME		DATE: DD / MMM / YYYY		
TITLE (in organization)		FOR OFFICIAL USE ONLY – FACILITY #		