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 RELCOATION TO A NEW PHYSICAL LOCATION ARE NEW APPLICATIONS AND REQUIRE A NEW APPLICATION PACKAGE TO BE SUBMITTED.

TYPE OF AMENDMENT (tick all that apply and complete corresponding section)

AMENDMENT: (*Complete yellow area for All Requests)*

☐ **Facility Name** _____ ☐ **Licence Number** _____

☐ Facility Mailing Address [Section 1]	☐ Change of Manager [Section 3]	☐ Amend or Addition of Service Type [Section 7]
☐ Facility Name [Section 1]	☐ Incident Portal Contact [Section 4]	☐ Relocation within Existing Site [Section 7]
☐ Licensee Mailing Address [Section 2]	☐ Days/Hours/Months of Operation [Section 7]	☐ Other: _____
☐ Existing Licensee Name Change Only [Section 2]	☐ Capacity Change [Section 7]	

Complete ONLY the sections below that require changes

1. FACILITY INFORMATION

FACILITY NAME & LICENCE NUMBER

FACILITY LOCATION ADDRESS

CITY PROV POSTAL CODE

TELEPHONE FAX EMAIL

FACILITY MAILING ADDRESS IF DIFFERENT FROM ABOVE:

Water Source
☐ COMMUNITY (SYSTEM NAME) ☐ WELL ☐ OTHER (SPECIFY): _____

Sewage Disposal ☐ SEWER ☐ ONSITE SEWAGE DISPOSAL

Will your facility be providing full meals/food service? ☐ YES ☐ NO

Is your facility located in an Indigenous Community? ☐ YES ☐ NO

Yes, please state Community name: _____

2. LICENSEE INFORMATION

LICENSEE NAME

MAILING ADDRESS

CITY PROV POSTAL CODE

TELEPHONE FAX EMAIL

LICENSEE CONTACT PHONE

☐ SOCIETY ☐ SOLE PROPRIETOR ☐ PARTNERSHIP ☐ INCORPORATED

☐ OTHER (SPECIFY): _____

☐ FOR PROFIT ☐ NOT FOR PROFIT

Is the Licensee or a Board Member at least 19 Years Old? ☐ YES ☐ NO

Is the Organization Registered? ☐ YES ☐ NO

If "yes", Registration #: _____

Has The Licensee Previously Applied To Be A Licensee or Manager of a Community Care Facility? ☐ YES ☐ NO

3. FACILITY MANAGER INFORMATION

MANAGER NAME

MANAGER MAILING ADDRESS

CITY PROV POSTAL CODE

TELEPHONE FAX EMAIL

Is the Manager at least 19 Years Old? ☐ YES ☐ NO

Is this Manager Currently the Manager of Any Other Community Care Facility? ☐ YES ☐ NO

Has the Manager Previously Applied to be a Licensee or Manager of a Community Care Facility? ☐ YES ☐ NO

4. *INCIDENT PORTAL CONTACT(S) INFORMATION

INCIDENT PORTAL CONTACT NAME	INCIDENT PORTAL CONTACT NAME
EMAIL	EMAIL

**Incident Portal Contact is the Person(s) submitting Incident Reports through the Electronic Incident Reporting Portal to Licensing when a reportable incident occurs. (Facilities can have more than one Incident Portal Contact)*

5. BUILDING INFORMATION

IF THE FACILITY IS PART OF A MALL, NAME OF MALL

BUILDING NAME (IF DIFFERENT FROM FACILITY)

ADDRESS CITY POSTAL CODE

☐ **BUILDING OWNER information *same* as Facility Owner**

☐ **BUILDING/PROPERTY address information same as Facility address**

6. OWNER OF BUILDING/COMPLEX & CONTACT FOR BUILDING

REGISTERED NAME

MAILING ADDRESS

CITY PROV POSTAL CODE

CONTACT/AGENT NAME POSITION

TELEPHONE FAX EMAIL

☐ SOCIETY ☐ SOLE PROPRIETOR ☐ PARTNERSHIP ☐ INCORPORATED

☐ OTHER (SPECIFY) _____

Is your facility located in an Indigenous Community? ☐ YES ☐ NO

Yes, please state Community name: _____

7. PROPOSED SERVICE – Check the applicable service and include the proposed capacity

Child Care	Capacity	Room #	Residential Care	Capacity
☐ 301 - Group Child Care (Under 36 Months)			☐ 400 – Long Term Care Funded	
☐ 302 - Group Child Care (30 Months to School Age)			☐ 401 – Long Term Care Non-Funded	
☐ 303 – Preschool (30 Months to School Age)			☐ 410 – Community Living	
☐ 304 – Family Child Care			☐ 420 – Mental Health	
☐ 305 – Group Child Care School Age			☐ 421 – Substance Use	
☐ 308 – Occasional Child Care			☐ 440 – Acquired Injury	
☐ 309 – Child-minding			☐ 450 – Hospice	
☐ 310 – Multi-Age Child Care			☐ 430 – Other	
☐ 311 – In-Home Multi-Age Child Care			☐ 500 – Child and Youth Residential	
☐ 312 –School Age Care on School Grounds				
☐ 313 – Recreational Care				
Maximum Capacity			**Maximum Capacity**	

Months of Operation	**Days of Operation**
Hours of Operation	**Home-based facility?** ☐ **Yes** ☐ **No** If yes, number of people over the age of 12 living in home: _____

VERIFICATION

I hereby apply for a 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.

Funded by Government:

☐ FUNDED ☐ NON-FUNDED 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.

LICENSEE, LICENSEE CONTACT OR BOARD MEMBER SIGNATURE:	**DATE** DD / MMM / YYYY
NAME (print)	**PROPOSED OPENING DATE** DD / MMM / YYYY
TITLE (in organization)	**FOR OFFICIAL USE ONLY – FACILITY #**