![island health logo]

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]
☐ Facility Name [Section 1]
☐ Licensee Mailing Address [Section 2]
☐ Existing Licensee Name Change Only [Section 2]

☐ Change of Manager [Section 3]
☐ Days/Hours/Months of Operation [Section 6]
☐ Capacity Change [Section 6]

☐ Amend or Addition of Service Type [Section 6]
☐ Relocation within Existing Site [Section 6]
☐ Other: _____

Complete ONLY the section(s) 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. 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

5. 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
If yes, please state Community name: _____

6. PROPOSED SERVICE – Complete all applicable service types to appear on the facility licence and include the proposed maximum 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			☐ 500 – Child and Youth Residential	
☐ 311 – In-Home Multi-Age Child Care				
☐ 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 agree as per section 11(2)(iv) of the *Community Care and Assisted Living Act* to be readily available to respond to inquiries from Community Care Facilities Licensing.

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.

Disclaimer:

Submission of an application for a community care facility licence does not guarantee that a licence will be issued. All applications are subject to review and approval based on compliance with the *Community Care and Assisted Living Act*, the Child Care Licensing Regulation, or the Residential Care Regulation.

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 #**