



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 IN FULL FOR EACH FACILITY USING BLOCK PRINTING WHERE POSSIBLE AND COMPLETELY FILLING IN THE APPROPRIATE BOXES

STATUS

☐ NEW

☐ FACILITY

☐ LICENSEE

☐ LOCATION

1. FACILITY INFORMATION

FACILITY NAME

FACILITY LOCATION ADDRESS

CITYPROVPOSTAL CODE

TELEPHONEFAXEMAIL

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

CITYPROVPOSTAL CODE

TELEPHONEFAXEMAIL

LICENSEE CONTACTPHONE

☐ 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

CITYPROVPOSTAL CODE

TELEPHONEFAXEMAIL

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)

ADDRESSCITYPOSTAL CODE

☐ BUILDING OWNER information same as Facility Owner

☐ Child Care Only - If not the building owner [renting/leasing], Applicants must provide Licensing written confirmation that the Landlord is aware that a community care facility will be operating in the building

☐ BUILDING/PROPERTY address information same as Facility address

5. OWNER OF BUILDING/COMPLEX & CONTACT FOR BUILDING

REGISTERED NAME

MAILING ADDRESS

CITYPROVPOSTAL CODE

CONTACT/AGENT NAMEPOSITION

TELEPHONEFAXEMAIL

☐ SOCIETY ☐ SOLE PROPRIETOR ☐ PARNTERSHIP ☐ INCORPORATED

☐ OTHER (SPECIFY) \_\_\_\_\_

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

If yes, please state Community name: \_\_\_\_\_

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

Child Care	Capacity	Room #	Residential Care	Capacity
<input type="checkbox"/> 301 - Group Child Care (Under 36 Months)			<input type="checkbox"/> 400 – Long Term Care Funded	
<input type="checkbox"/> 302 - Group Child Care (30 Months to School Age)			<input type="checkbox"/> 401 – Long Term Care Non-Funded	
<input type="checkbox"/> 303 – Preschool (30 Months to School Age)			<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			<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"/> 500 – Child and Youth Residential	
<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				
Maximum Capacity			Maximum Capacity	

Months of Operation	Days of Operation
Hours of Operation	Home-based facility? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

LICENSEE, LICENSEE CONTACT OR BOARD MEMBER SIGNATURE:

NAME (print)

TITLE (in organization)

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.

DATE DD / MMM / YYYY

PROPOSED OPENING DATE DD / MMM / YYYY

FOR OFFICIAL USE ONLY – FACILITY #

Application for a Community Care Facilities Licence  
Community Care Facilities Licensing  
Updated: September 10, 2024