



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				
<input type="checkbox"/> NEW <input type="checkbox"/> FACILITY <input type="checkbox"/> LICENSEE <input type="checkbox"/> LOCATION				
1. FACILITY INFORMATION				
FACILITY NAME			Water Source	
FACILITY LOCATION ADDRESS			<input type="checkbox"/> COMMUNITY (SYSTEM NAME) <input type="checkbox"/> WELL <input type="checkbox"/> OTHER (SPECIFY): _____	
CITY	PROV	POSTAL CODE	Sewage Disposal <input type="checkbox"/> SEWER <input type="checkbox"/> ONSITE SEWAGE DISPOSAL	
TELEPHONE	FAX	EMAIL	Will your facility be providing full meals/food service? <input type="checkbox"/> YES <input type="checkbox"/> NO	
FACILITY MAILING ADDRESS IF DIFFERENT FROM ABOVE:			Is your facility located in an Indigenous Community? <input type="checkbox"/> YES <input type="checkbox"/> NO Yes, please state Community name: _____	
2. LICENSEE INFORMATION				
LICENSEE NAME			<input type="checkbox"/> SOCIETY <input type="checkbox"/> SOLE PROPRIETOR <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> INCORPORATED	
MAILING ADDRESS			<input type="checkbox"/> OTHER (SPECIFY): _____	
CITY	PROV	POSTAL CODE	<input type="checkbox"/> FOR PROFIT <input type="checkbox"/> NOT FOR PROFIT	
TELEPHONE	FAX	EMAIL	Is the Licensee or a Board Member at least 19 Years Old? <input type="checkbox"/> YES <input type="checkbox"/> NO	
LICENSEE CONTACT			Is the Organization Registered? <input type="checkbox"/> YES <input type="checkbox"/> NO If "yes", Registration #: _____	
			Has The Licensee Previously Applied To Be A Licensee or Manager of a Community Care Facility? <input type="checkbox"/> YES <input type="checkbox"/> NO	
3. FACILITY MANAGER INFORMATION				
MANAGER NAME			Is the Manager at least 19 Years Old? <input type="checkbox"/> YES <input type="checkbox"/> NO	
MANAGER MAILING ADDRESS			Is this Manager Currently the Manager of Any Other Community Care Facility? <input type="checkbox"/> YES <input type="checkbox"/> NO	
CITY	PROV	POSTAL CODE	Has the Manager Previously Applied to be a Licensee or Manager of a Community Care Facility? <input type="checkbox"/> YES <input type="checkbox"/> NO	
TELEPHONE	FAX	EMAIL		
4. BUILDING INFORMATION				
IF THE FACILITY IS PART OF A MALL, NAME OF MALL			<input type="checkbox"/> BUILDING OWNER information same as Facility Owner	
BUILDING NAME (IF DIFFERENT FROM FACILITY)			<input type="checkbox"/> 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	
ADDRESS	CITY	POSTAL CODE	<input type="checkbox"/> BUILDING/PROPERTY address information same as Facility address	
5. 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	
MAILING ADDRESS			<input type="checkbox"/> OTHER (SPECIFY) _____	
CITY	PROV	POSTAL CODE	Is your facility located in an Indigenous Community? <input type="checkbox"/> YES <input type="checkbox"/> NO	
CONTACT/AGENT NAME	POSITION		If yes, please state Community name: _____	
TELEPHONE	FAX	EMAIL		
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 <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 SPECIFY: _____	
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, 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 #	