

SCHEDULE "B"

GUIDELINES FOR APPLICATION AND INFORMATION REQUIREMENTS FOR LICENSURE OF COMMUNITY CARE FACILITIES

This document sets out the requirements that must be followed to obtain an initial license for a Community Care Facility. The initial application (*CCF and NH Acts*. 8, CCF Reg s. 2) and, thereafter, the annual renewal application (CCF Reg s. 5) to license a Community Care Facility is to be submitted to the Community Care Facilities and Nursing Homes Board (herein referred to as the "Board").

Completed applications, together with all other information and the application fee, are to be submitted to the Community Care Facilities and Nursing Homes Board for review.

Ongoing site visits will be required throughout the application process.

Definitions

Applicant: The person applying for a license to operate a Community Care Facility

Operator: The person or organization responsible for the management and operation of a Community Care Facility

Information to be provided for an initial license:

To be eligible for licensure, the application package must include the completed application form and the following:

1. Proof of ownership/lease of facility.
2. Architect stamped floor plans of the facility with exact measurements.
3. A business plan completed on a form approved by the Board.
4. Proof of insurance coverage as per the *Operational and Care Service Standards for Community Care Facilities* Standard 2.4.
5. A Care Service Management Plan completed on a form approved by the Board.
6. Inspection reports from the Provincial Fire Marshal's office, Environmental Health Inspector, Building Inspector, Elevator Inspector, Boiler and Pressure Vessel Inspector, Electrical Inspector, Dietary and Care Service Inspectors.
7. Any applicable permits, letters from the zoning authorities stating that the location complies with proper zoning bylaws, if a new building or expansion.
8. A recent criminal record/vulnerable sector checks for the applicant and operator; criminal record/vulnerable sector checks for staff/managers must be available upon inspection.
9. The names contact information or reference letters of at least three persons (unrelated to the applicant and operator) capable of providing references regarding applicant's and operator's management skills, public interpersonal relationship skills, ethical conduct and integrity. Categories should include manager/supervisor, clients/residents and other. It is advantageous to provide a name for each category.
10. A resume for the operator and applicant with proof of education, business management skills, training in a health-related occupation and/or related experience working with people who have long-term care needs.
11. Declaration from operator/manager.
12. Consent to release information

**LICENSED COMMUNITY CARE FACILITY
BUSINESS PLAN**

Business Plan Section

Please note that you are required to complete a business plan as part of the requirements to apply for a license TO OPERATE a Community Care Facility.

Business Profile

Name(s) of Applicant(s): _____

Operating Name of Business: _____

Location of Business: _____

Mailing Address of Business (if different) _____

Residence Phone: _____ Business Phone: _____

Form of Organization:

_____ Incorporated	_____ To be Incorporated
_____ Sole Proprietorship	_____ Partnership
	_____ Other (Specify) _____

NOTE: All partners or shareholders must complete the personal information Section of the Business Plan.

Explain how you will devote time to the management of the Business:

CRA Business Number: _____

Personal Information Section:

NAME: _____

ADDRESS: _____ **PHONE (H):** _____

_____ **PHONE (W):** _____

(Additional sheet for personal information will be provided if required)

Financial

Summarize the sources of your funding and the uses. (You may need to complete the cash flow forecasts prior to completing this section.)

USES		SOURCES OF FUNDS	
Land	\$ _____	Loans (Specify) _____	_____
		_____	\$ _____
Buildings and/or Leasehold Improvements	\$ _____	Other (Specify) _____	_____
		_____	\$ _____
Equipment	\$ _____	Operating Credit Line	\$ _____
Other Capital Costs (Specify)		Attach all banking confirmations for the loans and line of credit	
_____	\$ _____		
Start-Up Costs (Specify)			
_____	\$ _____		
Working Capital	\$ _____		
TOTAL:	\$ _____	TOTAL:	\$ _____

(These two columns must balance)

Itemize major equipment, building and/or other capital expenditures that you plan to purchase in the future (attach additional sheets if required).

ITEM	COST
_____	_____
_____	_____
	TOTAL: _____

How are you going to finance the purchase? _____

How do you plan to cover the cost of operating the facility during the start-up period when your facility will not be at full occupancy?

Market Analysis Community Care Facilities

Who are your competitors: _____

Where are they located and how long have they been in business: _____

Give an estimate of their size and scale of activity in your selected market area: _____

How do your care/services differ from your competitors? What are your advantages over your competition?

Are you aware of the price of your competitor's care services: _____

If so, how do these prices compare to yours: _____

Who are your proposed residents? _____

In the event that a License is issued, what form of advertising will you use to inform potential residents about your Community Care Facility?

Have you included advertising costs in your budget: _____

PRICING

Provide the monthly fee charged to residents and break down the direct cost of the care services set out in the care services plan.

Revenue

Monthly Fee: \$ _____ per resident

Number of residents _____

Monthly revenue _____

Yearly revenue _____

Expenses

Expenses \$ _____
(Detailed on next page)

Wages \$ _____

Total expenses \$ _____

Residents

Level 1 number of residents _____

Level 2 number of residents _____

Level 3 number of residents _____

Attach a copy of the staffing summary

Income and Expense Statement

	YEAR 1	YEAR 2
REVENUE	\$ _____	\$ _____
EXPENSES		
Rent or Mortgage principal payments	\$ _____	\$ _____
Equipment/furnishing	\$ _____	\$ _____
Wages & Benefits	\$ _____	\$ _____
Food costs	\$ _____	\$ _____
Ground Maintenance	\$ _____	\$ _____
Cleaning Supplies	\$ _____	\$ _____
Laundry Supplies	\$ _____	\$ _____
Professional Fees (Accounting, Etc.)	\$ _____	\$ _____
Legal	\$ _____	\$ _____
Utilities (Heat, Electricity, Water)	\$ _____	\$ _____
Telephone	\$ _____	\$ _____
Repairs & Maintenance	\$ _____	\$ _____
Business License, Taxes & Permits	\$ _____	\$ _____
Insurance	\$ _____	\$ _____
Vehicle	\$ _____	\$ _____
Freight & Express	\$ _____	\$ _____
Travel	\$ _____	\$ _____
Advertising & Promotion	\$ _____	\$ _____
Office Supplies & Postage	\$ _____	\$ _____
Bank Charges	\$ _____	\$ _____
Interest on long term debt	\$ _____	\$ _____
Interest charges	\$ _____	\$ _____
Other Expenses _____	\$ _____	\$ _____
Bad Debts	\$ _____	\$ _____
Amortization expense		
Buildings	\$ _____	\$ _____
Equipment/furnishing	\$ _____	\$ _____
Vehicles	\$ _____	\$ _____
TOTAL EXPENSES	\$ _____	\$ _____
NET PROFIT FOR YEAR	\$	\$
(Before Tax)	=====	=====

Please attach a copy of the previous year financial statement that was submitted to Revenue Canada

INSURANCE REQUIREMENTS

The Facility, without limiting its obligations or liabilities, provides and maintains policies of insurance satisfactory to the Department of Health and Wellness and in accordance with the minimum requirements as determined by the Risk Management and Insurance Section, Department of Provincial Treasury.

Principle:

The Facility has current and adequate insurance coverage relative to the services provided and the property owned and/or operated.

Criteria:

1. The Facility has Commercial General Liability coverage in an amount not less than \$2,000,000.00 inclusive per occurrence against bodily injury and property damage. The Government is added as an additional insured under this policy. Such insurance includes, but is not limited to:
 - a) Blanket Written Contractual Liability;
 - b) Personal Injury Liability;
 - c) Non-owned Automobile Liability; and
 - d) Cross Liability.
2. Commercial General Liability insurance is endorsed to provide the Government with thirty (30) days advance written notice of cancellation or material damage.
3. In the event that the Facility transports residents as part of the services provided, the Facility carries Automotive liability coverage (Standard Automobile Policy) on all vehicles, owned, leased, operated or licensed in the name of the Facility, in an amount not less than \$1,000,000.00. Attached to and forming part of the Standard Automobile Policy (S.P.F. No. 1) is the Standard Endorsement Form (SEF), 6(a) Permission to Carry Passengers for Compensation Endorsement.
4. The Facility carries a Comprehensive Dishonesty, Disappearance and Destruction Policy in an amount not less than \$5,000.00 to cover the property of residents in the event of dishonest acts committed by the Facility or the Facility's employees.

CARE SERVICE MANAGEMENT PLAN

A Care Service Management Plan (CSMP) must demonstrate, to the satisfaction of the Community Care Facilities and Nursing Homes Board, the applicant's ability to provide a safe and caring environment for its residents. The basic CSMP is the responsibility of the applicant and must include the following:

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Mission Statement:

Provide a mission statement, which reveals the philosophy of the Community Care Facility

Care Services:

List and explain the care services you plan to provide using the Instrumental Activities of Daily Living (IADL) and Activities of Daily Living (ADL) as a guide. Some of these services would include:

- overall supervision of residents
- assistance with transportation
- provision of meals to meet dietary requirements, provision of laundry services, including personal clothing provision of housekeeping services, daily collection of waste planned social, physical, spiritual, recreational activities for residents at least weekly
- provision for resident privacy and independence
- provide means for residents to express concerns about the operation of the facility.

Records:

Explain how you plan to keep records on:

- personal and financial records
- meal planning/meals served
- medications
- care plan with goals/objectives for each resident
- monthly fire drills and evaluations

Residents' Bill of Rights:

- Provide a residents' bill of rights.

Staffing:

- Provide a list of staff positions (including operator), job descriptions noting responsibilities and qualification requirements.
- Provide work schedules and organizational chart.

Policies and Procedures

Provide the following policies:

- administrative procedures reporting a missing person
- handling incidents
- reporting a death
- confidentiality
- complaints
- screening of residents (level of care)
- abuse of residents/staff
- medication management program
- trust accounts
- residents who exceed level 3 care

Social Activities:

- Provide a list of social activities planned for residents.

Menu Plans:

- Provide menu plans, which must meet the approval of the Dietitian Consultant.

Emergency Planning:

- Provide a fire emergency and evacuation plan
- Provide a contingency plan for emergency assistance.
- Provide annual emergency training for all staff.

Minimum Training Requirements

Staff:

- Provide a process to ensure staff are trained in first aid (bi-annually) and CPR (annually).
- List other training taken, scheduled or planned

Other Areas:

- List and explain services or activities not covered in the above-noted sections.

DECLARATION (OPERATOR/ MANAGER)

To be completed at the request of the CCFNH Board, pursuant to section 6 and 6.1 of the Community Care Facilities and Nursing Homes Board Act Regulations

Full Legal Name: _____ Address: _____
Other Name(s) / Aliases: _____
_____ Phone Number: (H) _____
Date of Birth: _____ (C) _____
SIN: _____ Email Address: _____

I, _____, of _____ (city), Province of _____,
SOLEMNLY DECLARE (check correct response, provide information where required):

1) I have never been convicted of a criminal offence _____

I have previously been convicted of a criminal offence (provide details below) _____

2) I have never been licensed to operate, or been employed in, a community care facility, nursing home, or similar care facility in another province or country. _____

I have been licensed to operate, or have been employed in, a community care facility, Nursing home, or similar care facility in another jurisdiction AND I have had the following (*list if any*) conditions applied to my license or employment. _____

(List Jurisdiction(s), and any applicable license conditions in each jurisdiction):

Declared on the _____ day of _____, 20__.

Declarant