HOME AND COMMUNITY CARE SUPPORT SERVICES
Champlain

Family-Managed Home Care

Application Form

Applicant Information

1) First Name: _____ Last Name: _____

Street address:_____

City: _____ Postal Code: _____

Telephone: _____ Alt Telephone: _____

Health Card #: _____ Date of Birth: _____

Language of Choice: ☐ English ☐ French ☐ Other _____

Care Direction & Services Requested

2) I can direct my own care: ☐ Yes ☐ No

If no, please provide name of who will be directing your care: _____

Relationship: ☐ Power of Attorney ☐ Parent ☐ Spouse ☐ Other: _____

Telephone: _____ Alternate Telephone: _____

3) Do you belong to one of the following patient groups?

☐ Children with Complex Medical Needs

☐ Adults with Acquired Brain Injuries (ABI)

☐ Eligible Home-Schooled Children

☐ Patient in Extraordinary Circumstances.

Ontario

4) Please check off each service for which you are seeking Family-Managed Home Care

Children with Complex Medical Needs	Patients in Extraordinary Circumstances
☐ Nursing services ☐ Occupational therapy services ☐ Physiotherapy services ☐ Speech-language pathology services ☐ Dietetics services ☐ Social service work services ☐ Personal support services ☐ Homemaking services	☐ Nursing services ☐ Occupational therapy services ☐ Physiotherapy services ☐ Speech-language pathology services ☐ Dietetics services ☐ Social service work services ☐ Personal support services ☐ Homemaking services
Services for Eligible Home-Schooled Children ☐ Nursing services ☐ Occupational therapy services ☐ Physiotherapy services ☐ Speech-language pathology services ☐ Dietetics services ☐ School health personal support services	**Adults with Acquired Brain Injuries** (ABI) ☐ Personal support services ☐ Homemaking services

Medical / Functional Information

5) Please list your medical conditions:

_____

_____

_____

_____

6) Do you have a communication disability? ☐ Yes ☐ No. If yes, please describe how you communicate with others:

_____

_____

_____

_____

7) Within the last year, has your need for assistance with the services requested above changed? ☐ Yes ☐ No. If yes, please describe:

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8) Living arrangements: ☐ Live Alone ☐ Live with family/others

Care Provision & Management

9) For the services requested in Question 4, how do you plan to hire the care?

☐ Hire individuals as employees	☐ Hire independent contractor	☐ Hire health care service-provider agency
Management Requirements: • Recruit, verify credentials, hire, and employ staff • Review Police Vulnerable Sector Check • Employee payroll deductions: basic salary, overtime/premium wages, vacation pay, taxes, statutory holiday pay, and employer contributions for WSIB, EI, CPP (it is highly recommended that you hire a bookkeeper for this task) • Pay notice of termination or pay in lieu of such notice in accordance with *Employment Standards Act*. **The individual must maintain:** • At least $2,000,000 Commercial Liability Insurance • At least $25,000/$2,000,000 recommended Abuse Liability Insurance **Patient Homeowner/Tenant Liability Insurance:** • Minimum $2,000,000 third party liability insurance coverage.	**Management Requirements:** • Recruit, verify credentials, and hire independent contractor • Review Police Vulnerable Sector Check • Employee payroll deductions: not applicable – this is the responsibility of the independent contractor **Independent Contractor must maintain**: • Pay WSIB premiums for workplace insurance, where applicable. • Pay both the employee and employer portions of CPP contributions • At least $2,000,000 Commercial Liability Insurance • At least $25,000/$2,000,000 recommended Abuse Liability Insurance **Patient Homeowner/Tenant Liability Insurance:** • Minimum $2,000,000 third party liability insurance coverage.	**Management Requirements:** • Interview and hire service provider agency • Ensure agency requires its employees to have Police Vulnerable Sector Check • Employee payroll deductions: not applicable – this is the responsibility of the service provider agency • Pay service provider invoices **Patient Homeowner/Tenant Liability Insurance**: • Minimum $2,000,000 third party liability insurance coverage.

10) In the space below, or on a separate page, please describe any strengths, experience, and/or training that demonstrate your ability to be a self/family-manager of health care services.

11) Name of Person completing form: _____

Relationship to Applicant: _____

12) Declaration

I have read and understand the General Information Booklet and the Application Guide. I am prepared to undertake the functions, responsibilities, and possible risks of participating in the Family-Managed Home Care Program, which may include being an employer to my own service providers.

I understand and accept that I will be interviewed and questioned about my medical condition, health care needs, past and current services and any other aspect of my application. I hereby confirm that the above information is true and accurate.

Applicant or Substitute Decision Maker Signature or Mark Date

13) Mailing Instructions

Please send in your ORIGINAL, signed application. **Be sure to keep a copy for your own records**.

Home and Community Care Support Services Champlain
Family-Managed Home Care Program
100-4200 Labelle Street
Ottawa, ON K1J 1J8