1 Falcon Ridge Drive
Winnipeg MB
R3Y 1V9

SAUL & CLARIBEL
SimkinCentre

Shalom! Thank you for choosing The Simkin Centre as your Personal Care Home of choice. We are honoured to have you here. We kindly ask that you and/or your Power of Attorney review the enclosed package.

Please find enclosed documentation that we kindly ask you to review and sign. Should you have any questions regarding the enclosed, please call or email me and I will be happy to discuss. We ask that the enclosed be completed within 3-5 days upon admission.

Should you prefer to meet with me to complete this package, please call 204-589-9006 or email me at Aujah.fowler-thomas@simkincentre.ca.

If you wish to complete on your own, the documentation can be placed in the enclosed envelope and left with Security.

The below check list has been provided to assist you during this process:

Social Work:

- ☐ Review *Admission, Residency and Trust Agreement*
- ☐ Sign *General Terms and Conditions*
- ☐ Sign *Consent for Internal Transfer*
- ☐ Sign *Personal Health Information Consent Form*
- ☐ Review and select *Goals of Care;* information booklet enclosed

Additional Documentation required by Social Work:

- Photocopy of Power of Attorney
- Photocopy of existing Health Care Directive

Sincerely,

Aujah Fowler-Thomas, BA (Hons), BSW, RSW
Social Worker
Phone: (204)589-9006
aujah.fowler-thomas@simkincentre.ca

ADMISSION, RESIDENCY AND TRUST AGREEMENT

ADMISSION, RESIDENCY AND TRUST AGREEMENT

BETWEEN

THE SAUL AND CLARIBEL SIMKIN CENTRE

AND

(Herein after referred to as the "Resident")

The Resident, whose admission to the Simkin Centre has been approved, agrees that such residence shall be subject to the following terms and conditions.

Dear Resident and/or Designated Responsible Party,

Welcome to The Saul and Claribel Simkin Centre. The information requested within the following Admission, Residency and Trust Agreement will assist The Simkin Centre in the provision of financial services/arrangements and ensure a complete medical record for the Resident.

Personal Care Services

I. The following personal care services are the responsibility of The Simkin Centre:

a) Accommodation

b) meals

c) necessary nursing services

d) routine medical and surgical supplies such as

- medical nursing supplies, e.g., wound management supplies, catheters, needles, syringes, diagnostic and testing materials, ostomy supplies
- diabetic supplies, e.g. lancets, glucometer strips
- disinfectant and antiseptic preparations
- dietetic supplies, nutritional aids or supplements (as per WRHA and facility policies)
- mechanical lifts, mechanical lift slings for *isolated* use
- pressure reducing mattresses (limited availability)
- transport wheelchairs for occasional transportation
- oxygen and oxygen concentrators (as per WRHA policies)
- continence care products (excluding pull-ups)

e) prescribed drugs, biologicals, and related preparations approved by the Minister of Health; those drugs listed as benefits under the Pharmacare program; specific over-the-counter drugs that have been approved as a benefit under the personal care home drug program by the personal care home drug utilization committee

f) occupational therapy in institutions approved by the Minister of Health

g) routine laundry and linen services including minor clothing repair.

Your responsibilities:

1. The following personal care services are the financial responsibility of the resident and/or family.
    a) purchase of clothing (labelling will be done by The Simkin Centre)
    b) major repairs and alterations to clothing
    c) alcoholic beverages
    d) cosmetics, deodorants
    e) hair salon services*
    l) support hose
    g) hearing aids and batteries ---
    h) eye glasses and Optician services
    i) dentures, denture adhesive and dental services*
    j) insurance for personal belongings
    k) canes, walkers, crutches, raised toilet seats, commodes, wheelchairs including repairs, specialized seating, pressure cushions, slings for mechanical lifts and transfer poles when purchased solely for one resident.* These items remain the property of the resident. Payment for new equipment must be received in advance of delivery
    l) preventative maintenance costs for "resident owned" equipment (i.e. wheelchairs, walkers)
    m) continence care products different from those provided by the personal care home
    n) transportation costs when not covered as insured benefit (i.e. ambulance, stretcher, bus, taxi)
    o) Prescription medications not covered by the Manitoba Health Drug Formulary
    p) non-prescription biologics and related preparations including skin-care powders, lotions, creams, ointments, jells, cleansers, except those approved by Manitoba Health, if the resident does not want to use the brand supplied by the personal care home
    q) health-food products (as per facility policy)
    r) herbal remedies (as per facility policy)
    s) Podiatrist services *

t) outing expenses

u) Garden Cafe, guest meals and catering charges

v) specialized equipment and/or medical or surgical supplies not covered by the insured program additional/supplemented food over and beyond what is already provided by the Centre

*Available for a nominal charge to family

2. The completed Admission, Residency and Trust Agreement form, Application for Reduced Residential/Authorized Charge and a copy of the Notice of Assessment must be returned prior to admission or completed on site the day of admission. For assistance in completing the form, contact the Financial Services Assistant in regards to financial concerns at (204) 589-9047

3. Provide photocopies of the following:

   a) The Power of Attorney and Committeeship papers

   b) The Manitoba Blue Cross Card (where applicable, please provide evidence of other types of coverage)

   c) The Revenue Canada Notice of Assessment for the current taxation year _____.

5. The Administration Office will provide a schedule of the residential charges for each month based on the assessed per diem rate as outlined in the Manitoba Health Daily Residential Rate Schedule. This will be updated on an annual basis.

NOTE:

Failure to provide the Revenue Canada Notice of Assessment for the_____taxation year within 30 days or signing of the Pre-authorized Payment Plan Registration Form could delay the admission procedure or result in payment of the maximum daily charge as per the Manitoba Health Daily Residential Rate Schedule.

GENERAL TERMS AND CONDITIONS FOR:

_____

NAME OF RESIDENT

1. I acknowledge that I have received and read The Simkin Centre Resident Handbook.

2. I agree to comply with all policies, procedures, rules and regulations established by The Simkin Centre.

3. I acknowledge that I have received and/or I am informed of the Manitoba Health Daily Residential Rate Schedule, and I agree to pay the determined residential charge and the Non-Insured Goods and Services Charges. Residential charges are determined in accordance with the fee structure established by Manitoba Health and these are reviewed August of each year.

4. I agree to provide and/or replace personal toiletries and clothing as required by the resident.

5. I agree that it is the resident/family responsibility for cleaning and maintaining personal furniture, including cleaning of personal sitting/lounge chairs.

6. The Simkin Centre will not be responsible for the loss or damage of my personal property due to any cause. This includes the personal property of residents, family, companions and other visitors.

7. The Simkin Centre is a teaching facility, therefore, I am aware that students from approved educational/vocational institutes may be assigned to work with our residents. Students are fully supervised and will be introduced to our residents if they are involved in their care.

8. I/we wish to receive electronic communication from the Simkin Centre; example Simkin weekly newsletter. My/our email address is: _____.

Signature _____ Date _____

Staff signature & designation _____ Date _____

PERSONAL EFFECTS UPON SEPARATION

_____

Resident's name

We, at The Simkin Centre, recognize the grief and sorrow experienced when a loved one passes. We also acknowledge the challenges our families face with planning services immediately following this loss. As we are a long term care facility that works directly with Winnipeg Regional Health, we do have an obligation to admit awaiting applicants within a very short period of time. With this in mind, we would like to review our expectations upon separation.

I acknowledge that upon separation, arrangements will be made to remove personal effects within 24 hours. _____ (initial)

I give permission to family/friends, not acting in the capacity of Power of Attorney, to assist with the removal of personal items on my behalf, and further acknowledge that I will not hold The Simkin Centre responsible for these items and/or decisions made by family/friends during this process.

_____ (initial)

If personal effects cannot be removed by myself, and family/friends are not available, I give permission to the Simkin Centre staff to prepare items informally (boxes and/or bags) at a cost of $100.00; to be debited from the resident's Trust account or billed directly to the Power of Attorney. I agree to have either myself and/or family/friends arrange for items to be picked up by a courier company, at cost to myself, within 24 hours. I agree to not hold Simkin Centre responsible for lost or damaged items during this process.

_____ (initial)

Failure to comply with the above options will result in items being informally prepared for shipment by Simkin Centre staff at a cost of $100.00; to be debited from the resident's Trust account or billed directly to the Power of Attorney, and will be couriered COD to the address of the primary contact. Simkin Centre will not be held responsible for lost or damaged items during this process.

_____ (initial)

Signature _____ Date _____

Staff signature and designation _____ Date _____

(Place in the Resident Record)

CONSENT FOR INTERNAL TRANSFER

The Simkin Centre has an Aging in Place philosophy in place which means that the room a Resident is admitted into remains their room throughout their stay. Pre-admission assessments and admission placement consider both the needs of the new Resident as well as the unit's care mix. With the exception of the secure unit, all units have a mix of care needs, varied levels of cognition, and a mix of men and women. It is the policy of The Simkin Centre that, upon the recommendation of the Bed Utilization Committee, a Resident may be transferred at any time to a unit within the Simkin Centre where his/her care needs are best met, including transfer onto and off of the secure unit. While you, as a family member, may be involved in the Resident's care plan, the decision to transfer a Resident remains solely that of the professional staff at The Simkin Centre. This policy is enforced in order for The Simkin Centre to provide the best care possible to all of the Residents given the resources available to The Centre.

I,_____, acknowledge that I have been informed of the
(substitute decision maker/Resident)

Simkin Centre Internal Transfer Policy and agree to abide by the terms mentioned above. I understand that charges related to the transfer of the phone and cable television are the responsibility of the Resident/Family and that there will be a fee for non- medical requests for internal transfers.

This agreement must be signed upon admission to The Simkin Centre.

If I do not agree with the proposed change, I will contact the Social Worker if I wish to make arrangements to waitlist or transfer my family member to another home.

Signature _____ Date _____

Staff signature and designation _____ Date _____

(Place in Resident Record)

CONFIDENTIALITY

The Saul and Claribel Simkin Centre

AT THE SIMKIN CENTRE, WE RESPECT YOUR PRIVACY IN REGARDS TO YOUR PERSONAL HEALTH INFORMATION

At The Simkin Centre, we collect, record, store, use and disclose facts about you and your health in keeping with Manitoba's ***Personal Health Information Act.***

Personal health information includes any facts we collect to help provide health care or payments for health care:

- Your name, address and Personal Health Identification Number (PHIN);
- Facts about your health, health care history and the care you have been given;
- Facts about payment for your health care

We will use this information in keeping with the Act, sharing it only with those who need to know and/or those authorized to process your information. For instance, we might use it in:

- Care planning with health services; (OT, dietician, SLP, etc.)
- Teaching and training health care students;

Unless you tell us not to, we can:

- Share your general health status and location in our facility with friends/family.
- Share your name, health status and location in our facility with a representative of a religious organization.
- Share your name and address with charitable fundraising foundation associated with our facility.
- Share your personal health information with any health care provider who has, is or will be providing you with health care.

These are your rights under the law:

- **You may see or have access to your personal records.**
- **You may ask for and receive a copy of your health records.**
- **You may ask us to correct your records**
- **Your information is private. Unless sharing it with others is authorized by law, we can not and will not give out any information without your consent.**
- **You may make a complaint to Manitoba's Ombudsman's office about access to your personal health information, or about how it is collected, stored, used or disclosed to others. (204)982-9130 or 1-800-665-0531 (toll free)**

SAUL & CLARIBEL
SimkinCentre

Personal Health Information Consent Form

In accordance with the Personal Health Information Act (PHIA), your consent, or your family's consent on your behalf, is required.

Please indicate decision for the following:

Yes	No	
☐	☐	Your name and birthday can be posted on the units
☐	☐	Your name and birthday can be posted externally
☐	☐	Individual or group pictures depicting participation in facility events can be displayed within Simkin Centre
☐	☐	Individual or group pictures depicting participation in facility events can be posted externally – newsletter, website, facebook etc
☐	☐	Share general health status and location within the Simkin Centre with friends/family on request
☐	☐	Share general health status and location with an outside spiritual care representative
☐	☐	In the event of death, a Memorial notice may be displayed within the Simkin Centre
☐	☐	A Celebration of Life is held on the unit to offer co resident's, families, and staff the opportunity to honour residents who have passed away
☐	☐	The release of resident and primary contact to The Saul and Claribel Simkin Foundation to receive written/verbal communication regarding social events and fundraising opportunities
☐	☐	Information can be shared with family via email

Signature _____ Date _____

Staff signature and designation _____ Date _____

Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / À l'écoute de notre santé

ADVANCE CARE PLANNING GOALS OF CARE

Refer to WRHA Advance Care Planning Policy # 110.000.200 prior to completing this form

Is there an existing Health Care Directive? ..... ☐ No ☐ Yes
(If yes, it shall guide further discussions as an indication of the Patient/Client/Resident's wishes at the time of writing)

Advance Care Planning (ACP) is the overall process of dialogue, knowledge sharing and informed decision making that needs to occur at any time when future or potential life threatening illness treatment options and Goals of Care are being considered or revisited. This form is used to record agreed upon Goals of Care reached through full and complete ACP discussions with the Patient/Resident/Client and/or Substitute Decision Maker about the nature of the individual's current condition, prognosis, treatment/procedural/investigation options, and expected benefits or burdens of those options.

GOALS OF CARE (Check the box that best describes the Patient/Resident/Client Goals of Care)

☐ **C =** **Comfort Care** - Goals of Care and interventions are directed at maximal comfort, symptom control and maintenance of quality of life ***excluding*** attempted resuscitation.

☐ **M =** **Medical Care** - Goals of Care and interventions are for care and control of the Patient/Resident/Client condition. The Consensus is that the Patient/Resident/Client may benefit from, and is accepting of, any appropriate investigations/ interventions that can be offered ***excluding*** attempted resuscitation.

☐ **R =** **Resuscitation** – Goals of Care and interventions are for care and control of the Patient/Resident/Client condition. The Consensus is that the Patient/Resident/Client may benefit from, and is accepting of, any appropriate investigations/ interventions that can be offered ***including*** attempted resuscitation.

If the required care is not available in current location or setting, does the Patient/Resident/Client want to be transferred to alternate facility? ..... ☐ No ☐ Yes

Indicate all individuals who participated in Goals of Care discussion(s) by checking appropriate box(es).

☐ Patient/Resident/Client Print Name: _____

☐ Family Member(s) Print Name(s): _____

☐ Substitute Decision Maker Print Name(s): _____

☐ Health Care Provider(s) Print Name(s): _____

Document details of the Patient/Resident/Client specific instructions or wishes and/or details of discussion with the individuals indicated above. (Refer to date/time of Progress Note entry if more space is required):

_____

_____

_____

_____

_____

Name & Designation of Health Care Provider | Signature of Health Care Provider (Physician's signature is required when patient is a client of the Public Trustee) | D D M M M Y Y Y YA

The Goals of Care were reviewed with the Patient/Resident/Client and/or Substitute Decision Maker and no change to the form is required.

Name & Designation of Health Care Provider | Signature of Health Care Provider (Physician's signature is required when patient is a client of the Public Trustee) | D D M M M Y Y Y Y

Name & Designation of Health Care Provider | Signature of Health Care Provider (Physician's signature is required when patient is a client of the Public Trustee) | D D M M M Y Y Y Y

Name & Designation of Health Care Provider | Signature of Health Care Provider (Physician's signature is required when patient is a client of the Public Trustee) | D D M M M Y Y Y Y

If review results in any changes to the Patient/Resident/Client Goals of Care, a new form must be completed.

PROVIDE COPY OF COMPLETED FORM TO PATIENT/RESIDENT/CLIENT OR SUBSTITUTE DECISION MAKER

Funeral Arrangements

If known at this time, please provide us with your loved one's funeral arrangements.

Funeral Home: _____

Address: _____

Phone number: _____

Thank you

1 Falcon Ridge Drive
Winnipeg MB
R3Y 1V9

SAUL & CLARIBEL
SimkinCentre

FINANCIAL DOCUMENTATION

The attached documentation should be reviewed and filled in prior to meeting with Ira Sandler. Following the meeting with social work, a brief meeting will be held with Ira to review the attached. Please ensure all areas of the forms are completed in advance with the required documentation attached; see bottom check list.

The business office is located on our main floor just to the right of the café in the atrium. The hours of operation are 10:00 am to 4:00 pm; closed for lunch 12:15 -1:00 pm.

For any questions regarding the enclosed, please contact Ira at 204-589-9047 or ira.sandler@simkincentre.ca

The below is a checklist that has been provided for your convenience.

- ☐ *Sign Pre-Authorized Payment Plan (PAP) and attach a void cheque or bank verification letter.*
- ☐ Sign *Trust Agreement;* **optional**, but highly recommended for foot care services, hair salon services, recreation outings and café purchases
    - o You may choose to deposit a set amount monthly from the SAME account from where per diems are withdrawn OR
    - o You may choose to deposit a starting an amount and adding funds as needed
- ☐ Sign and **complete** *Tax Information Release Form*; **optiona**l. **MUST** have photocopies of Power of Attorney if signing on behalf of someone
- ☐ Sign and **complete** *Application for Reduced Residential Charge*
    - o *Notice of Assessment(s) will be required to be attached for previous taxation year*
    - o *Social insurance number(s) are required*
    - o *Section C must be signed even if you are not applying for the reduced rate*
    - o *Section D must be signed.*

Additional Documentation Required:

- ☐ *Power of Attorney*; photocopies
- ☐ *Notice of Assessment* from previous taxation year both resident and spouse, if applicable
- ☐ Void cheque (not a photocopy) for pre-authorized payment, or Bank Verification form

PRE-AUTHORIZED PAYMENT PLAN (PAP) –FACILITY POLICY FOR:

_____

NAME OF RESIDENT

The Pre-authorized payment plan (PAP) is a monthly payment plan by which the Resident/responsible parties will make consecutive monthly payments for residential charges as determined in accordance with the fee structure established by Manitoba Health.

Terms and Conditions

- All payments will be made from your bank account on the 1st banking day of the month.
- If you change bank accounts, it is your responsibility to inform The Simkin Centre, in writing, of the change at least two weeks in advance of the next payment. All unpaid residential charges become due and payable and are subject to penalties as determined by the policies of The Simkin Centre.
- PAP payments are non-transferable.

This is your PAP registration form. It must be completed in conjunction with the Manitoba Health Application for Reduced Residential/Authorized Charge. ATTACH A SAMPLE CHEQUE marked VOID and return it to us along with your application.

Please print

Resident's Name:_____

Name of Financial Institution:_____

Account Number:_____

Branch # & Address:_____

Joint account: Yes_____ No_____

If yes, please provide name of joint account holder:_____

I/We the applicant(s) authorize my/our above named financial institution to electronically debit my/our account for the monthly residential/authorized charge (rent) payable to The Simkin Centre on the first banking day of each month. The amount of each payment shall be determined in accordance with the policies of Manitoba Health and I will be provided with a Manitoba Health Daily Residential Rate Schedule for the year commencing August 1st of each year. The treatment of each payment shall be the same as if the undersigned had personally issued a cheque. A statement will be provided for tax purposes at the end of each taxation year.

I/We acknowledge the right of The Simkin Centre to cancel my/our participation in the payment plan if any debits are not honored by the participant's financial institution. A collection process will be initiated on any overdue accounts of more than 30 days that may include the Office of the Public Trustee.

Unless under appeal, I/we acknowledge that the per diem rate will not change from August 1st through July 31st of the following year as determined annually by the Manitoba Health Application for Reduced Residential/Authorized Charge. The payment will vary from month to month based on the number of days in each month (please refer to schedule).

Items charged will be reimbursed, subject to notification by me/us, to The Simkin Centre under any of the following conditions:

a) I/We never provided the authorization to the Payee.
b) The pre-authorized debit was not drawn in accordance with this authorization.
c) My /Our authorization was revoked.
d) The debit was posted to the wrong account due to invalid/incorrect account information supplied.

Authorized Signatories Of The Above Account Must Sign This Registration Form:

Resident/Responsible Party Signature	Date
Second Signature (if required)	Date

SECTION IV

TRUST AGREEMENT FOR:

_____

NAME OF RESIDENT

I request The Simkin Centre to administer my Resident trust funds on the following terms and conditions:

1. All monies entrusted to The Sharon Home Inc. shall be deposited into a general resident bank account used exclusively for trust account transactions.

2. In accordance with the policies of The Simkin Centre, which permits the charging of certain supplies and services to my individual Resident trust account, I authorize payment by The Simkin Centre for such supplies and services from my individual Resident trust account on the following terms:

   a) All transactions shall be supported by an invoice or receipt which will be maintained on file by Simkin Centre.

   b) The Simkin Centre will only be responsible for payment of invoices received in the Business Office in sufficient time to allow processing.

   c) Any uninsured ambulance charges which are billed to The Simkin Centre on behalf of the Resident. Claims for third party reimbursement ie, Blue Cross, taxi, stretcher service etc, are the responsibility of the Resident.

   d) Such reasonable charge as may be levied by The Simkin Centre for the provision of supplies or service requested or required by the Resident. *Please refer to page 2 of this document and the "Environment Section" of the RESIDENT HANDBOOK.*

   e) Special equipment or supplies will be ordered by The Simkin Centre for the resident but only on a prior approval of purchase from the resident/legal representative. These purchases will be billed directly to the resident/legal representative and he/she will be responsible for payment. As these items are purchased solely for one resident's use they will remain the property of that resident.
   Resident specific equipment or supplies may include: walkers, wheelchairs (subsequent wheelchair repairs), canes, crutches, pressure cushions, mechanical lift slings, bed and/or chair monitor and sensor mat and commode chairs.

3. As recommended by the Executive Management Team and approved by the Fiscal Advisory Committee of the Board, interest earned on the general resident trust account shall be used for the benefit of the Residents as a whole. A record of all expenditures shall be maintained.

4. All documentation pertaining to the general Resident trust account including records of withdrawals and deposits, and copies of all invoices and receipts shall be maintained in proper order for a period of seven years after my separation.

5. Each month, I shall be provided with a statement of my individual account in the general resident trust account.

6. I understand that the general Resident trust account shall be audited annually by an independent auditor and that Manitoba Health may at any time conduct its own audit of the general resident trust account.

7. Upon my separation from The Sharon Home Inc., the balance of my account shall be disbursed to myself or my estate within 60 days upon receipt of proper authorization.

8. For my convenience, a petty cash fund shall be maintained by The Simkin Centre to enable me to obtain small sums of cash required. Cash withdrawals may be dependent upon:
   a) cash availability. In such cases a cheque will be issued
   b) the withdrawal is not in the best interest of the Resident. In such cases a member of the executive staff or the Resident's legal representative will be consulted.

9. I understand that it is my responsibility to ensure that sufficient funds remain in my individual trust account balance. When the account is getting close to a zero balance a deposit is required to maintain a positive balance.

10. I agree to the monthly trust fee of $7.50 as established by The Simkin Centre. This fee is subject to change without notice.

11. To maintain a sufficient balance of funds in the resident's trust account, an automatic withdrawal is available. The sum of the monthly deposit will differ from each individual's activity on the account.

THIS AGREEMENT IS BINDING UPON THE HEIRS AND EXECUTORS OR ADMINISTRATORS OF THE RESIDENT. IF THIS AGREEMENT IS SIGNED BY A PARTY ON BEHALF OF THE RESIDENT, THAT PARTY REPRESENTS AND WARRANTS THAT THEY HAVE THE AUTHORITY TO SIGN ON BEHALF OF THE RESIDENT AND THAT THIS AGREEMENT WILL BIND THE RESIDENT.

PRE-AUTHORIZATION WITHDRAWAL

Amount: $50 $100 $150 Other: _____

Same account as rent payment: Yes / No If NO, please complete the following:

Please print and attached a sample cheque marked "VOID" and return to us along with your application.

Place cheque here

SIGNED THIS ____ DAY OF _____, _____ AT THE SIMKIN CENTRE.
(day) (month) (year)

_____ Witness

_____ Resident or Resident's Legal Representative (Public Trustee, Committeeship, Power of Attorney)

☐ **I/We chose not to establish a Trust Account and are aware that any "fee for services" will require pre-payment**

Instructions for Completing Application for Reduced Residential Charge

The Application for Reduced Residential Charge is to be completed for those individuals who do not complete the Tax Information Release Form and for all clients who are admitted or panelled after August 31, 2024.

SECTION A To be completed for all clients.

SECTION B To be completed by clients applying for a reduction to the maximum rate of $101.10.

Part I If response is **yes** to receiving financial assistance from Employment and Income Assistance, complete **Section D** and return to facility.

The facility representative will complete **Section E** by entering rate of $41.80.

If response is **no**, proceed to **Part II** or **Part III**.

Part II To be completed if the client is single, divorced, widowed or separated.

The 2023 Canada Revenue Agency - Notice of Assessment (**NOT INCOME TAX AND BENEFIT RETURN**) must be used to calculate the client's net income less total tax payable (line 236 less line 435). Enter the amount in the space provided. Complete **Section D** and return the Application Form to the facility representative along with a photocopy of the 2023 Notice of Assessment.

The facility representative will confirm the amounts from lines 236 and 435, check the calculation, and complete the Rate using the Table of Residential Charges.

Part III To be completed if the client is married or in a common-law relationship

The 2023 Canada Revenue Agency - Notice of Assessment (**NOT INCOME TAX AND BENEFIT RETURN**) must be used to calculate the client's and their spouse's/common-law partner's net incomes less total taxes payable (line 236 less line 435). Enter the amount calculated in the space provided. Complete **Section D** and return the Application Form to the facility representative along with photocopies of the 2023 Notices of Assessment.

(Français au verso)

The facility representative will confirm the amounts from lines 236 and 435 and check the calculation. If the spouse/common-law partner resides in the community or in the same facility, the facility representative will complete the Rate using the Table of Residential Charges. If the spouse/common-law partner resides in a different facility, the rate will be reassessed by Manitoba Health.

SECTION C To be completed by clients who accept responsibility for the full daily rate of $101.10.

Facility representative will complete **Section E** by entering rate of $101.10.

SECTION D To be completed by the applicant who completed both **Sections A** and **B**.

SECTION E To be completed by the facility representative.

Rates are to be determined as follows:

1. Client has a spouse/common-law partner residing in another facility: Rate temporarily set at previous year's assessed rate or, if new client, rate $41.80. Applications for clients are to be forwarded to Manitoba Health for reassessment. Refer to Residential Charges Review Process for the procedure.

2. Client has a dependant(s) other than spouse/common-law partner: Rate temporarily set at previous year's assessed rate or, if new client, rate $41.80. Applications for clients are to be forwarded to Manitoba Health for reassessment. Refer to Dependant Policy and Residential Charges Review Process for the procedure.

3. Client receives financial assistance from Employment and Income Assistance: Rate $41.80.

4. Client is single, widowed, divorced or separated with no dependant(s): Refer to Column 1 on the Table of Residential Charges to determine rate.

5. Client is married or in a common-law relationship with the spouse/common-law partner in the community and has no dependant(s) other than spouse/common-law partner: Refer to Column 2 on the Table of Residential Charges to determine rate.

(Français au verso)

6. Client is married or in a common-law relationship with the spouse/common-law partner in the same facility and has no dependant(s) other than spouse/common-law partner: An Application Form must be completed for each spouse/common-law partner. Divide amount entered in **Section B**, **Part III** by 2 and refer to Column 1 on the Table of Residential Charges to determine the rate for each spouse/common-law partner.

7. Client has accepted responsibility and completed **Section C**: Rate $101.10.

8. Client has not returned the Application Form to the facility, or has returned the Application Form without the required Notice(s) of Assessment: Rate $101.10.

The facility provides the client or representative with a copy of the Application Form once **Section E** has been completed and a rate assessed.

(Français au verso)

Manitoba
Health
Santé

Application For Reduced Residential Charge
Demande de frais réduits de résidence

Facility / *Établissement* : _____

Why We Require Your Information / Pourquoi nous avons besoin de vos renseignements personnels

The information requested on this form is necessary for the facility to determine and verify your, your spouse's, or your common-law partner's annual entitlement to a reduced residential/authorized charge as provided for under *The Health Services Insurance Act, The Mental Health Act* and regulations made thereunder. Any information you provide will be protected in accordance with *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act*. If I have any questions, I understand that I may contact the facility representative responsible for handling residential/authorized charges. / *Nous avons besoin des renseignements inscrits sur ce formulaire pour déterminer et vérifier si* vous, votre conjoint ou votre conjoint de fait êtes admissible à bénéficier d'une réduction annuelle des frais de résidence ou des frais admissibles, en vertu de la Loi sur l'assurance-maladie, la Loi sur la santé mentale et des règlements y afférents. Tout renseignement fourni sera protégé conformément à la Loi sur l'accès à l'information et la protection de la vie privée et à la Loi sur les renseignements médicaux personnels. Je comprends aussi que je peux communiquer avec le coordonnateur des frais de résidence ou des frais admissibles si j'ai des questions.

SECTION A: TO BE COMPLETED BY ALL CLIENTS / *DOIT ÊTRE REMPLIE PAR TOUS LES CLIENTS*

Surname / *Nom*	Given Name / *Prénom*	Initials / *Initiales*	Sex / *Sexe* M F

Date of Birth / *Date de naissance* Day/ *Jour* Month/ *Mois* Year/ *Année*	Social Insurance No. (SIN) / *N° d'assurance sociale (NAS)*	Current Marital Status / *État civil actuel*
		Single/Widowed/Divorced / *Célibataire/Veuf(veuve)/Divorcé(e)* ☐
Manitoba Health Registration No. / *Numéro d'inscription auprés de Santé Manitoba*	Personal Health Identification No. / *N° d'identification personnelle*	Married/Common-Law Relationship / *Marié(e) / Conjoint de fait* ☐
		Separated / *Séparé(e)* ☐

If client is transferred from another facility, state name of facility. /
Si le client vient d'un autre établissement, indiquez le nom :

Dependents other than spouse/common-law partner / *Personnes à charge autres que le conjoint/conjoint de fait* : Yes / *Oui* ☐ No / *Non* ☐

If yes, provide name, date of birth and reason for dependency if over 18. / *Dans l'affirmative, indiquez le nom et la date de naissance des personnes à charge et, si elles ont plus de 18 ans, la raison qui fait qu'elles sont à charge.* (If additional space is needed attach details. / *Si vous avez besoin de plus d'espace, annexez une feuille à la présente.*)

Surname / *Nom*	Given Name / *Prénom*	Initials / *Initiales*	Sex / *Sexe* M F	Date of Birth / *Date de naissance* Day / *Jour* Month / *Mois* Year / *Année*

Relationship to Client / *Lien de parenté avec le client* :

Reason for Dependency / *La raison qui fait qu'elles sont à charge* :

Note / *Remarque*:

* **If client is not applying for a reduced rate go to Section C. /**
Si le client ne demande pas le tarif réduit, passez à la section C.

* **If client is applying for a reduced rate complete Part 1, 2 or 3 of Section B and sign Section D. /**
Si le client demande le tarif réduit, remplissez les parties 1, 2 ou 3 de la section B et signez la section D.

SECTION B: TO BE COMPLETED IF CLIENT IS APPLYING FOR REDUCED RATE, / DOIT ÊTRE REMPLIE PAR LA PERSONNE QUI DEMANDE LE TARIF RÉDUIT.

PART I / *PARTIE 1*

Is client currently receiving financial assistance from Employment and Income Assistance? / *Le client est-il actuellement bénéficiaire du programme d'aide à l'emploi et au revenu?*

Yes / *Oui* ☐ No / *Non* ☐

If yes, provide copy of Employment and Income Assistance cheque stub. / *Dans l'affirmative, veuillez annexer une copie du talon de chèque du programme d'aide à l'emploi et au revenu.*

SECTION B: TO BE COMPLETED IF CLIENT IS APPLYING FOR REDUCED RATE. / DOIT ÊTRE REMPLIE PAR LA PERSONNE QUI DEMANDE LE TARIF RÉDUIT.

PART II / *PARTIE 2*

To be completed if client is single, divorced, widowed or separated. Information to be based on the 2023 Canada Revenue Agency Notice of Assessment. Please provide copy. / *Cette partie doit être remplie si le client est célibataire, divorcé, veuf ou séparé. Les renseignements doivent être tirés de l'Avis de cotisation de 2023 de l'Agence des douanes et du revenu du Canada. Veuillez annexer une copie de cet avis.*

Net Income (Line 236) / *Revenu net (ligne 236)* $ _____

Total Tax Payable (Line 435) / *Impôt total à payer (ligne 435)* _____

Total (Line 236 less Line 435) / *Total (ligne 236 moins ligne 435)* $ _____

PART III / *PARTIE 3*

To be completed if client is married or in a common-law relationship. / *Cette partie doit être remplie si le client est marié ou en relation conjugale.*

Spouse's/Common-law Partner's Surname / *Nom du conjoint / conjoint de fait*	Given Name / *Prénom*	Initials / *Initiales*	Spouse's/Common-law Partner's SIN / *NAS du conjoint/conjoint de fait*

Is spouse/common-law partner a client of a facility? / *Le conjoint est-il résident d'un établissement?* Yes / *Oui* ☐ No / *Non* ☐

If yes, specify name of facility. / *Dans l'affirmative, indiquez le nom de l'établissement:*

The following information is to be based on the 2023 Canada Revenue Agency Notice of Assessment. Please provide copies. / *Les renseignements doivent être tirés de l'Avis de cotisation de 2023 de l'Agence des douanes et du revenu du Canada. Veuillez annexer une copie de cet avis.*

	Client / *Client*	Spouse/Common-law Partner / *Conjoint/Conjoint de fait*
Net Income (Line 236) / *Revenu net (ligne 236)*	$ _____	$ _____
Total Tax Payable (Line 435) / *Impôt total à payer (ligne 435)*	_____	_____
Total (Line 236 Less Line 435) / *Total (ligne 236 moins ligne 435)*	(a) _____	(b) _____

TOTAL (a & b) **$**

SECTION C:

If client does not wish to apply for reduced rate, read and sign here. / *Si le client ne désire pas demander le tarif réduit, lisez ce qui suit et signez la présente section.*

I hereby declare that I will accept financial responsibility for the full daily rate of $101.10. / *Je m'engage par les présentes à assumer l'entière responsabilité de payer la totalité du tarif quotidien de 101,10 $.*

_____ _____

Signature of Client/Representative / *Signature du client ou de son ayant droit* Date

SECTION D:

I hereby declare that to the best of my knowledge the information given in this application is true and complete. I realize that Manitoba Health may verify the information I have provided with other government departments. I authorize the sharing of this information with Manitoba Health and facility representatives involved in determining the reduced charge. / *Je déclare que les renseignements donnés dans la présente demande sont, pour autant que je sache, vrais et complets. Je reconnais savoir que Santé se réserve le droit de vérifier auprès d'autres ministères les renseignements que j'ai fournis. J'autorise la divulgation de ces renseignements aux personnes de Santé.*

_____ _____

Signature of Client/Representative / *Signature du client ou de son ayant droit* Date

_____ _____

Signature of Spouse/Common-law Partner or Representative (if applicable) Date
Signature du conjoint / conjoint de fait ou de son ayant droit (le cas échéant)

SECTION E:

To be completed by the facility for all clients. / *L'établissement doit remplir cette section à l'égard de tous les clients.*

ASSESSMENT RESULTS / *RÉSULTATS DE L'ÉVALUATION*

Rate / *Tarif* : _____ Effective Date / *Date d'entrée en vigueur* : _____
Day / *Jour* Month / *Mois* Year / *Année*

_____ _____

Signature of Facility Representative / *Signature du représentant de l'établissement* Date

Please provide client/representative with a copy of this form.
Veuillez remettre une copie du présent formulaire au client ou à son ayant droit.

INSTRUCTIONS FOR COMPLETION OF TAX INFORMATION

RELEASE FORM

The Tax Information Release Form may be completed by all clients who have not completed a form previously, and who are in a facility as of July 31, 2023. The form authorizes Canada Revenue Agency to release income tax information to Manitoba Health for assessing a reduced charge.

The form should not be completed for clients who receive financial assistance from Employment and Income Assistance, or those who have dependants other than a spouse/common-law partner, or by a married couple or a couple in a common-law relationship where both file on one income tax return, or those who have accepted responsibility for the maximum rate. The Application for Reduced Residential Charge should be completed for this group.

The Tax Information Release Form may also be completed for individuals who become a client after July 31, 2023, however, it will not be used as the basis for determining the rate until the August 1, 2024 to July 31, 2025 assessment year.

SECTION A To be completed by the facility representative.

SECTION B To be completed by the client or their legal representative who is applying for a reduction to the maximum rate.

If the client is single, widowed, divorced or separated, proceed to **Section D**.

If the client is married or in a common-law relationship, proceed to **Section C** and **Section D**.

SECTION C To be completed by the spouse/common-law partner of the client or their legal representative, if the client is requesting a reduction to the maximum rate.

SECTION D To be completed by the legal representative of the client or the spouse's/common law partner's legal representative, if applicable.

The facility representative is to forward the completed original form, and if applicable, a copy of the enduring Power of Attorney or Order of Committeeship to Manitoba Health who will determine the rate and advise the facility of the assessed rate. The facility representative will provide each client with a Notification of Residential Charge.

(français au verso)

Residential Charges
TAX INFORMATION RELEASE FORM

Manitoba Health

Why We Require Your Information

The information requested on this form is necessary for the Residential Charges office to determine and verify your, your spouse's, or your common-law partner's annual entitlement to a reduced residential/authorized charge as provided for under *The Health Services Insurance Act, The Mental Health Act* and regulations made thereunder. Any information you provide will be protected in accordance with *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act.* For additional information, please contact the Residential Charges office, at Manitoba Health, 300 Carlton Street, Winnipeg MB, R3B 3M9 or phone 204-786-7150.

Please Print

Section A Facility Information

Facility Name _____ Facility Number _____

Section B Client Information

Surname _____ Given Name _____

Social Insurance Number __ __ __ __ __ __ __ __ __ Personal Health Identification Number (from Health Registration Certificate) __ __ __ __ __ __ __ __ __ __

Marital Status: Single/Widowed/Divorced ☐ Married/Common-law Relationship ☐ Separated ☐

I hereby authorize the Canada Revenue Agency to release information from my income tax returns and other required tax information to Manitoba Health. I understand that the information is necessary for and will be used solely for the purposes outlined above and will not be disclosed to any person without my approval. I understand that, if I wish to withdraw this consent, I may do so at any time by writing to the Residential Charge Manager. This authorization is valid for the two taxation years prior to the year of signature of this consent, as well as for the current taxation year and each subsequent consecutive taxation year for which a reduced residential/authorized charge is requested by me or on my behalf.

Signature of Client or his/her Legal Representative _____ Date _____

SECTION C Spouse/Common-law Partner Information (if applicable)

Surname _____ Given Name _____

Social Insurance Number __ __ __ __ __ __ __ __ __ Personal Health Identification Number (from Health Registration Certificate) __ __ __ __ __ __ __ __ __ __

Do you reside in a facility? No ☐ Yes ☐ If yes, please name the facility: _____

I hereby authorize the Canada Revenue Agency to release information from my income tax returns and other required tax information to Manitoba Health. I understand that the information is necessary for and will be used solely for the purposes outlined above, and will not be disclosed to any person without my approval. I understand that, if I wish to withdraw this consent, I may do so at any time by writing to the Residential Charge Manager. This authorization is valid for the two taxation years prior to the year of signature of this consent, as well as for the current taxation year and each subsequent consecutive taxation year for which a reduced residential/authorized charge is requested by my spouse/common-law partner or on his/her behalf.

Signature of Spouse/Common-law Partner or his/her Legal Representative _____ Date _____

SECTION D Legal Representative Information (if applicable)

If you have signed this form as a legal representative, please print your name and address below and attach a copy of the Power of Attorney or Order of Committeeship.

Surname _____ Given Name _____

Address _____ Postal Code _____

When complete, this form (and if applicable a copy of Power of Attorney or Order of Committeeship), is to be returned to the facility.