Eastern Health

Long Term Care and Personal Care Homes

FINANCIAL SUBSIDY APPLICATION FOR:

☐ **PERSONAL CARE HOME**

☐ **LONG TERM CARE**

(Please indicate above the type of subsidy you are seeking)

FINANCIAL PACKAGE PROVIDED BY:

_____

_____

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APPLICATION FOR FINANCIAL SUBSIDY

INFORMATION SHEET

FINANCIAL ELIGIBILITY CRITERIA

For PCH or LTC subsidies the client contribution amount, if any, will be determined by an income test financial assessment. This assessment is based on your Line 236 Net Income, as found on your Canada Revenue Agency Notice of Assessment.

Required Documents:

1. **Verification of Birth** of Applicant and spouse/common law spouse (if applicable)
2. **MCP Number** for applicant and spouse
3. **Social Insurance Number** of applicant and spouse
4. **Income of Client and Spouse**. Please provide:
    A. Copy of your **Notice of Assessment** from Canada Revenue Agency for the most recent taxation year. If necessary, contact CRA at 1-800-959-8281 and request a copy of your latest "Option C" printout
    B. Verification of **Veteran's Allowance (DVA)** if applicable, in form of cheque stub or direct deposit
5. **Verification of burial insurance and/or pre-paid funeral expense** for Applicant and Spouse. (Photocopy of policy or contract identifying monthly cost, total benefit, and beneficiary).

    Pre-arranged funeral and/or burial insurance **may** be considered as an expense upon initial application to a PCH or LTC home. Existing policies (i.e. policies in place prior to admission) may be considered as an expense not exceeding $120.00 per month, and to a maximum value of $10'000.00. **Note**: monthly allowance is calculated by the income test, and is a product of your total income. You may be entitled to full or partial coverage of the monthly payment based on the outcome of your income test.

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6. **Household Expenses. Single individuals** applying for a LTC or PCH subsidy who have a home in the community may have expenses related to maintaining the home considered in the financial assessment for a period of up to 3 months.

If you are **single** and currently have household operating expenses, please provide verification, as listed below. *Please note that expenses submitted are only for consideration in the financial assessment process and are not guaranteed for approval.*

☐ Verification of Mortgage (provide a copy of mortgage agreement)

☐ Verification of household operating costs for the past 12 months:

- Utilities (Heat and Light only). Provide statement for past 12 months usage.
- Municipal Taxes (provide most recent year's invoice)
- Property Insurance (provide copy of policy)

Please return this completed form, marked "Confidential" to:

Financial Assessment Officer - Eastern Health
Personal Care Homes
P.O. Box 70, Holyrood, NL A0A 2R0
Tel: (709) 229-1638 Fax: (709) 229-1596

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Financial Self-Declaration

Office Use Only: **File #:** _____ **CRMS #:** _____

Subsidy requested for:
□ Single Applicant □ Applicant and Spouse □ Applicant with Spouse in Community

Personal Care Home Preference: _____

Long Term Care Home Preference: _____

Applicant	Spouse
Name: _____ □ Male □ Female □ Other	Name: _____ □ Male □ Female □ Other
Date of Birth: _____	Date of Birth: _____
Social Insurance #: _____	Social Insurance #: _____
MCP #: _____	MCP #: _____

Marital Status: □ Married □ Single □ Common-Law Relationship □ Widow/Widower
Has your marital status changed in the past 2 years (i.e.: death, divorce, recent marriage)?
□ Yes □ No If yes, when did this change occur? _____

Street Address: _____

Mailing Address: _____

Postal Code: _____ Telephone #: _____

ALTERNATE CONTACT INFORMATION

I hereby give consent for the following to make inquiries or act on my behalf regarding this application:

Name: _____ Relationship: _____

Address: _____

Telephone #: _____ Correspondence to be sent to: □ Applicant □ Contact Person

INCOME

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FINANCIAL INFORMATION

INCOME: Please provide a copy of the **Income Tax Notice of Assessment (applicant and Spouse)** from Canada Revenue Agency for the most recent taxation year. For **DVA**, please provide copy of cheque or direct deposit

Applicant's Income (per month)	Spouse's Income (per month)
OAS:	OAS:
CPP:	CPP:
Veteran's Allowance (DVA):	Veteran's Allowance (DVA):
Pension:	Pension:
Other:	Other:

BURIAL INSURANCE OR PRE-ARRANGED FUNERALS

Do you and/or your spouse have burial insurance or a pre-arranged funeral in place? □ Yes □ No

Applicant: Value $_____ Funeral Home: _____ Monthly Payment $_____

Spouse: Value $_____ Funeral Home: _____ Monthly Payment $_____

If Yes, please provide a copy of your insurance policy showing: Funeral provider, value, monthly payment and beneficiary.

Please note: If approved for a subsidy, pre-paid funeral or burial insurance may be considered an allowable expense to a maximum of $120 per month for a maximum value of $10,000 providing the beneficiary is either "The Estate of" the individual or the Funeral Home. To be considered an allowable expense, funeral arrangements must be in place at the time of admission and meet the terms stated above.

MEDICAL INSURANCE

Do you or your spouse have Medical Insurance Coverage? □ Yes □ No

Name of Company:_____

Percentage of Coverage: _____

Long Term Care Applicants: ***Please provide a copy of your medical insurance card for pharmacy billing purposes.***

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MONTHLY HOUSEHOLD EXPENSES

To be completed by Single applicants only who currently have household expenses in their name.

Mortgage	$	Provide copy of mortgage agreement
Utilities (Heat and light)	$	Provide 12 month statement.
Property Taxes	$	Provide statement for current year.
Insurance	$	Provide a copy of policy.

Please note the following:

Expenses submitted are for consideration only in the financial assessment process and are not guaranteed for approval. **Ensure verification of all expenses are attached to this application**. If approved, community household expenses may be considered for a period of up to three months.

Any change in circumstances which impact the above expenses must be reported to the Financial Assessor immediately.

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DECLARATION

1. I/We declare that the information provided in this application is complete and accurate and is provided solely for the purpose of determining eligibility for a financial subsidy.

2. I/We understand that the information provided will be disclosed only to applicable Eastern Health personnel and to other organizations that may need to be contacted in order to process the application.

3. I/We hereby grant Eastern Health or its agents, permission to carry out necessary inquiries for the purpose of determining my income and liabilities.

4. I/We hereby grant Eastern Health or its agents, permission to investigate any or all of the statements made herein, being fully aware that discovery of any false statements may void this application.

5. I/We understand that the provision of such information and the completion of this application does not necessarily guarantee approval of a financial subsidy by Eastern Health or its representatives.

Applicant Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

Completed by: _____ Date: _____

Witness Signature (required if applicant signed with an "X")

Name: _____ Signature: _____

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PRIVATE PAY FORM
Personal Care Home or Long Term Care

Applicant's Name: _____

MCP: _____ SIN: _____

Date of Birth: _____

This is to certify that I, _____ accept full responsibility for payment of
Personal Care Home or Long Term Care applicant/representative

the cost of care and accommodation _____
Applicant Name or Self

Responsibility is limited to that which can be provided from the income and liquid assets of the individual applying for admission to _____ Personal Care Home or Long Term Care.
Specify if known

I can choose to apply for a subsidy should my financial status change at any time.

_____ _____
Applicant/Representative Signature Date

_____ _____
Signature of Witness Date

Please return this completed form, marked "Confidential" to:

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Personal Care Homes
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If you require further information, contact the Financial Assessment Officer at (709) 229-1638.