

| Facility Information                        |  |   |   |
|---|--|---|---|
| FACILITY NAME                               |  | TELEPHONE NUMBER<br>(     )   |   |
| PHYSICAL ADDRESS                            |  |   |   |
|   | STREET   | CITY  | PROVINCE                      POSTAL CODE |
| Type (check one)                            | <input type="checkbox"/> Adult Residential Care - 100<br><input type="checkbox"/> Child / Youth Residential Care – 200   | Proposed Date of Opening _____  |   |
| Premise ownership                           | <input type="checkbox"/> Leased  | <input type="checkbox"/> Owned  |   |
| Business Type                               | <input type="checkbox"/> Society<br><input type="checkbox"/> Corporation   | <input type="checkbox"/> Sole Proprietorship (e.g. an individual)<br><input type="checkbox"/> Partnership (e.g. two or more individuals or companies) |   |
| Funding Contract with (check if applicable) | <input type="checkbox"/> FH – Residential Contracts & Services<br><input type="checkbox"/> FH – Mental Health<br><input type="checkbox"/> FH – Substance Use<br><input type="checkbox"/> FH – Acquired Brain Injury<br><input type="checkbox"/> FH – End of Life | <input type="checkbox"/> Community Living BC<br><input type="checkbox"/> Other: _____   |   |

| Proposed Types of Care  |   |                   |             |
|---|---|-------------------|-------------|
| Types of Care (check only those applicable)   | Proposed Capacity<br>(# of persons in care) | Office Use Only   |             |
|   |   | Approved Capacity | LO Initials |
| <b>Hospice</b> – being residential care and short-term palliative services for persons in care at the end of their lives.   | <input type="checkbox"/>                    | - 110             |             |
| <b>Mental Health</b> – being residential care for persons who are in care primarily due to a mental disorder.   | <input type="checkbox"/>                    | - 120             |             |
| <b>Substance Use</b> – being residential care for persons who are in care primarily due to substance dependence.  | <input type="checkbox"/>                    | - 125             |             |
| <b>Long Term Care</b> – being residential care for persons with chronic or progressive conditions, primarily due to the aging process.  | <input type="checkbox"/>                    | - 130             |             |
| <b>Community Living</b> – being residential care for persons with developmental disabilities.   | <input type="checkbox"/>                    | - 140             |             |
| <b>Acquired Injury</b> – being residential care for persons whose physical, intellectual and cognitive abilities are limited primarily due to an injury, including persons suffering from brain injuries or injuries sustained in accidents.  | <input type="checkbox"/>                    | - 150             |             |
| <b>Child &amp; Youth Residential</b> – being a program that provides residential care to children and youths that may include the types of care described above or promotes or supports the behavioural, intellectual, physical or social development of a child or youth in a therapeutic residential setting. | <input type="checkbox"/>                    | - 201             |             |
| <b># of persons in care</b><br><b>Maximum Capacity</b> (at any one time)  |   |                   |             |

| Licensee Information |  |                            |                           |
|----------------------|--|----------------------------|---------------------------|
| LICENSEE NAME        |  | TELEPHONE NUMBER<br>(    ) |                           |
| BUSINESS ADDRESS     |  |                            |                           |
| STREET               |  | CITY                       | PROVINCE      POSTAL CODE |
| E-MAIL ADDRESS       |  |                            |                           |

| Designated Director of the Corporation or Society Information  |  | (Do not complete if Licensee is an Individual or a Partnership of 2 individuals) |
|--|--|--|
| NAME   |  | TELEPHONE NUMBER<br>(    )   |
| E-MAIL ADDRESS   |  |  |
| Province or Territory where Director resides _____   |  |  |
| Will the Director agree to be available to respond to inquiries within 24 hours of request and provide financial/other records of the community care facility upon request? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |

| Appointed Licensee Contact Information |                            |
|--|----------------------------|
| LICENSEE CONTACT NAME                  | TELEPHONE NUMBER<br>(    ) |
| E-MAIL ADDRESS                         |                            |

| Facility Manager Information |                            |
|------------------------------|----------------------------|
| NAME                         | TELEPHONE NUMBER<br>(    ) |
| E-MAIL ADDRESS               |                            |

| Mailing Address and Email Address for Receiving Correspondence |                                     |
|--|-------------------------------------|
| (Check only one)   | E-MAIL ADDRESS                      |
| <input type="checkbox"/> Same as Facility                      |                                     |
| <input type="checkbox"/> Same as Applicant / Licensee          |                                     |
| <input type="checkbox"/> Other address                         |                                     |
| STREET   | CITY      PROVINCE      POSTAL CODE |

I am the Licensee / authorized by the Licensee to submit this Application for Licence.  
 The personal information collected relates directly to, and is necessary for program operation per Section 26 of the *Freedom of Information and Protection of Privacy Act*.

|                    |  |  |
|--------------------|--|--|
| Date (dd/mmm/yyyy) | Applicant/Licensee or Licensee Contact Name (Please Print) | Applicant/Licensee or Licensee Contact Signature |
|                    | Title in the Organization                                  |  |