

**Applicant Information**

Applicant's Legal Name (e.g., corporation, society or individual's name)				Please select the appropriate entity <input type="radio"/> Corporation <input type="radio"/> Individual/Sole Proprietorship <input type="radio"/> Partnership <input type="radio"/> Other <input type="radio"/> Society <input type="radio"/> Health Authority			
Contact Person			Position Title				
Mailing Address				City/Town		Province	Postal Code
Phone Number	Cell		Fax Number		Email		

List Name(s) of Partners or Names of the Board of Directors, if applicable (attach a separate sheet if necessary)

Last Name		First Name		Position Title (if applicable)		Phone Number	
Address						Email	
Last Name		First Name		Position Title (if applicable)		Phone Number	
Address						Email	
Last Name		First Name		Position Title (if applicable)		Phone Number	
Address						Email	
Last Name		First Name		Position Title (if applicable)		Phone Number	
Address						Email	

NOTE: You cannot be a registered Assisted Living operator if you are a Limited Liability Partnership.**Premises Information**

Residence Name		Website		Email		Phone Number	
Address			City/Town		Province	Postal Code	
Mailing Address (if different from above)			City/Town		Province	Postal Code	
Type of Existing Building <input type="radio"/> Single Family Dwelling <input type="radio"/> Commercial <input type="radio"/> Duplex/Triplex <input type="radio"/> Apartment						If New Construction, Proposed Opening Date	
Structure <input type="radio"/> Single Storey <input type="radio"/> Multi-Level – if multi-level, indicate the floor number(s) where AL residents will be located:							

Proposed Site Manager Information

Last Name		First Name		Position Title	
Phone Number	Cell		Fax Number		Email

Proposed Secondary Site Manager Information					
Last Name		First Name		Position Title	
Phone Number		Cell		Fax Number	
				Email	

PROPOSED RESIDENCE OPERATION

Assisted Living Services - please attach a detailed description of the nature and scope for each service		
Check as Applicable	Provided by Operator or through Contractor	
<input type="checkbox"/> Assistance with Activities of Daily Living (including eating, moving about, dressing and grooming, bathing and other forms of personal hygiene)	<input type="radio"/> Operator	<input type="radio"/> Contractor, Name:
<input type="checkbox"/> Assistance with Managing Medication (can include one or more of the following: receiving, storing, distributing and administering medication)	<input type="radio"/> Operator	<input type="radio"/> Contractor, Name:
<input type="checkbox"/> Assistance with Safekeeping of Money and Other Personal Property	<input type="radio"/> Operator	<input type="radio"/> Contractor, Name:
<input type="checkbox"/> Assistance with Managing Therapeutic Diets	<input type="radio"/> Operator	<input type="radio"/> Contractor, Name:
<input type="checkbox"/> Assistance with Behaviour Management	<input type="radio"/> Operator	<input type="radio"/> Contractor, Name:
<input type="checkbox"/> Psychosocial (or Programming) Supports	<input type="radio"/> Operator	<input type="radio"/> Contractor, Name:
Hospitality Services - please attach a detailed description of the nature and scope for each service		
Check as Applicable	Provided by Operator or through Contractor	
<input type="checkbox"/> Meal Services	<input type="radio"/> Operator	<input type="radio"/> Contractor, Name:
<input type="checkbox"/> Housekeeping Services (cleaning premises)	<input type="radio"/> Operator	<input type="radio"/> Contractor, Name:
<input type="checkbox"/> Laundry Services	<input type="radio"/> Operator	<input type="radio"/> Contractor, Name:
<input type="checkbox"/> Social and Recreational Opportunities	<input type="radio"/> Operator	<input type="radio"/> Contractor, Name:
<input type="checkbox"/> 24-hour Personal Emergency Response System	<input type="radio"/> Operator	<input type="radio"/> Contractor, Name:
Class of Residence		
Check the Class of Residence for this Application: <input type="radio"/> Seniors and Persons With Disabilities <input type="radio"/> Mental Health <input type="radio"/> Supportive Recovery Population: <input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> Co-Ed PLEASE NOTE: A separate application for registration must be completed and a fee of \$250 submitted for each class of residence.		
Are you currently providing assisted living services? <input type="radio"/> Yes <input type="radio"/> No If yes, number of people:		
Are you currently operating any of the following? (please select all that apply and list number of people)		
<input type="checkbox"/> Independent Living	number of people:	<input type="checkbox"/> Other (please explain)
<input type="checkbox"/> Supportive Housing	number of people:	
<input type="checkbox"/> Long Term Care	number of people:	

Residence Units, Common Areas and Grounds			
Proposed Number of Private Pay Units:		Proposed Number of Total Units	
Proposed Number of Units Subsidized by the Health Authority:		Proposed Number of Persons for Each Unit:	
Proposed Number of Units Receiving Per Diem Funding:			
<input type="radio"/> Yes <input type="radio"/> No Residence units and common areas are walker and wheelchair accessible (dining room, activity room, garden area, etc.)			
<input type="radio"/> Yes <input type="radio"/> No Units for each class of residents and non-residents (as above) are located in separate and distinct location on the premises.			

Declaration and Authorization									
<p>My signature below indicates I declare, understand and acknowledge:</p> <p>All the information given is true and complete to the best of my knowledge. I am aware the Assisted Living Registrar may refuse my application for registration if I have failed to disclose a material fact required by this application or I have made a false or misleading statement on the application form.</p> <p>Upon receiving approval of my application for registration, I understand I will be bound by the <i>Community Care and Assisted Living Act</i> and the Assisted Living Regulation as published and amended from time to time.</p> <p>My signature authorizes the Registrar to make reasonable and lawful inquiries about me and my residence management and operations, including inquiries seeking and verifying confidential or personal information from any regulatory authority, health authority, funding body, government body or law enforcement agency and to then consider and use that information to determine my fitness for registration as an operator of an assisted living residence under section 25 of the <i>Community Care and Assisted Living Act</i>.</p>									
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Prior to Submission
<ol style="list-style-type: none"> 1. Ensure the Application for Registration form is complete and signed. 2. Make a copy of the completed form, the required document checklist, and the attached documents for your files. 3. Include a one-time non-refundable application fee in the amount of \$250.00, payable to the Minister of Finance.

Privacy Protection: The information in this form is collected under the *Community Care and Assisted Living Act*. The information collected will be used by the Registrar in processing your application for registration and, if your application is accepted, to make general details about your registration available to the public. A registrant may access the information contained in their registration file in accordance with the provisions of the *Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection, use or disclosure of this information, contact the Registrar.