



1. RESIDENCE INFORMATION

Form section for residence information including fields for Residence Name, Address, Campus Name, Phone/Fax Numbers, Email, and Website.

2. APPLICANT INFORMATION

Form section for applicant information including legal name and checkboxes for legal entity types like Person, Sole Proprietorship, Partnership, etc.

LIST NAME(S) OF PERSON(S), PROPRIETOR, PARTNERS, OR AUTHORIZED REPRESENTATIVE (ATTACH ADDITIONAL SHEET IF NECESSARY)

Table with 4 columns: LAST NAME, FIRST NAME, INITIAL, POSITION TITLE (IF APPLICABLE) for listing multiple individuals.

APPLICANT CONTACT INFORMATION

Form section for applicant contact information including mailing address, phone/fax numbers, and email.

APPLICANT BACKGROUND (If you check "yes" to any of questions 1-5, attach additional sheets if space is insufficient. See instructions for details.)

Five numbered questions regarding background checks, interest in community care facilities, and experience in supportive housing.

3. RESIDENCE SITE CONTACT INFORMATION

Form section for residence site contact information including last name, first name, middle initial, position title, and phone/fax numbers.

#### 4. RESIDENCE PROFILE

<input type="checkbox"/> NEW CONSTRUCTION	PROPOSED OPENING DATE	<input type="checkbox"/> UNDER RENOVATION	<input type="checkbox"/> VACANT	<input type="checkbox"/> OCCUPIED	DATE OPERATING SINCE
ATTACH A COPY OF THE FOLLOWING PERMITS AS APPLICABLE:			IF NEW CONSTRUCTION, UNDER RENOVATION OR VACANT, ATTACH AS APPLICABLE:		
<input type="checkbox"/> FOOD PREMISES PERMIT			<input type="checkbox"/> SEWAGE DISPOSAL PERMIT		
<input type="checkbox"/> FINAL BUILDING PERMIT			<input type="checkbox"/> CHANGE IN USE PERMIT		
<input type="checkbox"/> OCCUPANCY PERMIT					
TOTAL NUMBER OF UNITS	NUMBER TO BE REGISTERED AS:	ASSISTED LIVING	PRIVATELY FUNDED	PUBLICLY FUNDED	
OF THE REMAINING UNITS, IF ANY, INDICATE NUMBER OF EACH:	LICENSED CARE	SUPPORTIVE HOUSING	OTHER (LIST NUMBER AND SPECIFY TYPE)		
RESIDENT POPULATION	<input type="checkbox"/> SENIORS	<input type="checkbox"/> ADULTS WITH PHYSICAL DISABILITIES	<input type="checkbox"/> ADULTS WITH MENTAL DISORDERS		<input type="checkbox"/> ADULTS WITH ACQUIRED BRAIN INJURIES
		<input type="checkbox"/> ADULTS WITH SUBSTANCE USE DISORDERS			

#### 5. RESIDENCE SERVICES

PLEASE COMPLETE AND ATTACH THE **PERSONAL ASSISTANCE SERVICES, SELF-ASSESSMENT WORKSHEET** (PROVIDED WITH THE ACCOMPANYING BOOKLET TITLED "ASSISTED LIVING, SHOULD I REGISTER MY RESIDENCE?") TO DETERMINE IF YOU PROVIDE PRESCRIBED SERVICES.

##### PERSONAL ASSISTANCE SERVICES AT PRESCRIBED LEVEL

CHECK AS APPLICABLE	PROVIDED BY OR THROUGH
<input type="checkbox"/> ACTIVITIES OF DAILY LIVING	<input type="checkbox"/> OPERATOR <input type="checkbox"/> CONTRACT
<input type="checkbox"/> MEDICATION CENTRAL STORAGE, DISTRIBUTION, ADMINISTRATION AND MONITORING	<input type="checkbox"/> OPERATOR <input type="checkbox"/> CONTRACT
<input type="checkbox"/> MONITORING OF FOOD INTAKE OR THERAPEUTIC DIETS	<input type="checkbox"/> OPERATOR <input type="checkbox"/> CONTRACT
<input type="checkbox"/> MAINTENANCE OR MANAGEMENT OF CASH RESOURCES OR PROPERTY	<input type="checkbox"/> OPERATOR <input type="checkbox"/> CONTRACT
<input type="checkbox"/> PSYCHOSOCIAL REHABILITATION OR INTENSIVE PHYSICAL REHABILITATION	<input type="checkbox"/> OPERATOR <input type="checkbox"/> CONTRACT
<input type="checkbox"/> STRUCTURED BEHAVIOURAL PROGRAM	<input type="checkbox"/> OPERATOR <input type="checkbox"/> CONTRACT

##### HOSPITALITY SERVICES

CHECK AS APPLICABLE	PROVIDED BY OR THROUGH
MEAL SERVICES	<input type="checkbox"/> OPERATOR <input type="checkbox"/> CONTRACT
HOUSEKEEPING SERVICES	<input type="checkbox"/> OPERATOR <input type="checkbox"/> CONTRACT
LAUNDRY SERVICES	<input type="checkbox"/> OPERATOR <input type="checkbox"/> CONTRACT
SOCIAL AND RECREATIONAL OPPORTUNITIES	<input type="checkbox"/> OPERATOR <input type="checkbox"/> CONTRACT
24-HOUR EMERGENCY RESPONSE SYSTEM	<input type="checkbox"/> OPERATOR <input type="checkbox"/> CONTRACT

#### 6. RESIDENCE OPERATION

PLEASE CHECK ALL APPROPRIATE BOXES UNDER EACH TOPIC TO BEST DESCRIBE YOUR RESIDENCE OPERATION AT THIS POINT IN TIME.

##### RESIDENCE ENVIRONMENT

1. LOCATION	2. BUILDING
<input type="checkbox"/> SUBURB/RESIDENTIAL AREA <input type="checkbox"/> COMMERCIAL DISTRICT/CITY CENTRE <input type="checkbox"/> NEIGHBOURHOOD STREET WITH MINIMAL TRAFFIC <input type="checkbox"/> MAJOR THOROUGHFARE/HIGHWAY WITH HEAVY TRAFFIC	<input type="checkbox"/> SINGLE STOREY <input type="checkbox"/> MULTI-STOREY <input type="checkbox"/> WOOD FRAME CONSTRUCTION <input type="checkbox"/> CONCRETE CONSTRUCTION <input type="checkbox"/> ELEVATOR AVAILABLE <input type="checkbox"/> SPRINKLER SYSTEM INSTALLED
3. COMMON AREAS AND GROUNDS	
ARE THE COMMON AREAS (E.G., DINING ROOM) AND GROUNDS (E.G., GARDEN) WHEELCHAIR ACCESSIBLE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
4. RESIDENCE UNITS	
ARE ALL THE RESIDENCE UNITS LOCKABLE BY THE RESIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DO ALL THE RESIDENCE UNITS MEET THE MOBILITY AND PHYSICAL DISABILITY NEEDS OF THE RESIDENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO	

##### 24-HOUR EMERGENCY RESPONSE SYSTEM

1. STAFF AVAILABILITY
DO YOU HAVE STAFF AVAILABLE TO RESPOND TO RESIDENT EMERGENCY CALLS? <input type="checkbox"/> YES (CHECK ALL APPLICABLE BOXES BELOW) <input type="checkbox"/> NO
<input type="checkbox"/> STAFF ONSITE 24 HOURS A DAY <input type="checkbox"/> STAFF ONSITE DURING THE DAY ONLY <input type="checkbox"/> STAFF ONSITE DURING THE DAY AND PART OF THE NIGHT <input type="checkbox"/> OFFSITE STAFF ON CALL DURING THE DAY <input type="checkbox"/> OFFSITE STAFF ON CALL AT NIGHT AND/OR WHEN THERE IS NO STAFF ONSITE <input type="checkbox"/> OFFSITE STAFF ON CALL AT ALL TIMES
2. WHAT EMERGENCY CALL DEVICES ARE INSTALLED?
<input type="checkbox"/> MECHANICAL/ELECTRONIC CALL DEVICE IN UNITS <input type="checkbox"/> TELEPHONE IN UNITS <input type="checkbox"/> INTERCOM SYSTEM IN UNITS <input type="checkbox"/> PERSONAL ALARM DEVICE WORN BY RESIDENTS <input type="checkbox"/> OTHER (SPECIFY)

**24-HOUR EMERGENCY RESPONSE SYSTEM continued**

3. WHICH STATEMENT(S) BEST DESCRIBES YOUR 24-HOUR EMERGENCY RESPONSE PROCEDURE?

- RESIDENTS ARE TRAINED AND ABLE TO CALL 911 AND/OR OTHER APPROPRIATE ASSISTANCE AS REQUIRED  
 STAFF ARE TRAINED TO RESPOND AND ACT ON EMERGENCY CALLS (E.G., ADMINISTER FIRST AID, OPERATE FIRE SUPPRESSION)  
 STAFF ARE TRAINED AS THE FIRST RESPONDER ONLY TO DISPATCH 911 AND/OR OTHER APPROPRIATE ASSISTANCE AS REQUIRED  
 EXTERNAL MONITORING STATION DISPATCHES APPROPRIATE ASSISTANCE

4. WHAT IS YOUR AVERAGE RESPONSE TIME FOR EMERGENCY CALLS?

- < 15 MINUTES     15-30 MINUTES     30-45 MINUTES     45-60 MINUTES     > 60 MINUTES

**PERSONAL SERVICES PLANS**

1. ARE RESIDENTS AND/OR THEIR FAMILIES INVOLVED IN THE DEVELOPMENT, REVIEW AND UPDATE OF PERSONAL SERVICES PLANS?

- ONLY THE RESIDENT IS INVOLVED     RESIDENT AND FAMILY ARE INVOLVED     RESIDENT AND THEIR FAMILY ARE NOT INVOLVED

2. WHEN WOULD YOU DEVELOP THE INITIAL PERSONAL SERVICES PLAN?

- IMMEDIATELY AT TIME OF ENTRY     LESS THAN 1 WEEK AFTER ENTRY     1-4 WEEKS AFTER ENTRY     MORE THAN 4 WEEKS AFTER ENTRY

3. WHO IS ASSIGNED TO DEVELOP AND MAINTAIN PERSONAL SERVICES PLANS (THE "ASSIGNED RESOURCE")?

	POSITION TITLE	PROFESSIONAL/NON-PROFESSIONAL QUALIFICATIONS
<input type="checkbox"/> PROFESSIONAL (E.G., RN)		
<input type="checkbox"/> NON-PROFESSIONAL STAFF		

4. WHAT IS THE STATUS OF THE ASSIGNED RESOURCE?

- STAFF     CONTRACTOR

5. WHAT IS THE FREQUENCY OF REVIEW AND UPDATE OF PERSONAL SERVICES PLANS?

- WHEN REQUESTED BY THE RESIDENT     QUARTERLY  
 WHEN DEEMED NECESSARY BY THE ASSIGNED RESOURCE     SEMI-ANNUALLY  
 BY AGREEMENT BETWEEN THE ASSIGNED RESOURCE & THE RESIDENT     ANNUALLY  
 MONTHLY     OTHER (SPECIFY) \_\_\_\_\_

6. PLEASE PROVIDE AN ACTUAL SAMPLE OF A TYPICAL PERSONAL SERVICES PLAN THAT YOU USE.

**DELEGATION OF PROFESSIONAL TASKS**

1. HOW ARE PROFESSIONAL HEALTH CARE TASKS DELEGATED TO NON-PROFESSIONALS?

- USE PERSONAL ASSISTANCE GUIDELINES AS PUBLISHED BY THE MINISTRY OF HEALTH  
 USE OWN INTERNAL POLICIES AND PROCEDURES BASED ON PERSONAL ASSISTANCE GUIDELINES OF MINISTRY OF HEALTH  
 USE OWN INTERNAL POLICIES AND PROCEDURES DEVELOPED INDEPENDENTLY  
 THE ASSIGNED PROFESSIONAL RESOURCE APPLIES INDEPENDENT JUDGEMENT

2. WHO IS ASSIGNED TO DELEGATE AND MONITOR THE PERFORMANCE OF DELEGATED TASKS?

POSITION TITLE	PROFESSIONAL QUALIFICATIONS

3. WHAT IS THE STATUS OF THE ASSIGNED RESOURCE?

- STAFF     CONTRACTOR

## 7. DECLARATION AND AUTHORIZATION

My signature below indicates I declare, understand and acknowledge:

All of the information given is true and complete to the best of my knowledge. The 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.

Upon receiving approval of my application for registration, I will be bound by the policies of the Registrar as published and amended from time to time.

My signature authorizes the Registrar to make reasonable and lawful enquiries about me and my residence management and operations, including enquiries 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(1) of the *Community Care and Assisted Living Act*.

### CORPORATION/NOT-FOR-PROFIT SOCIETY:

\_\_\_\_\_  
*PRINT Legal Entity Name*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*PRINT Name of Authorized Signatory*

\_\_\_\_\_  
*SIGNATURE of Authorized Signatory*

\_\_\_\_\_  
*PRINT Name of Authorized Signatory*

\_\_\_\_\_  
*SIGNATURE of Authorized Signatory*

### PARTNERSHIP/SOLE PROPRIETORSHIP/PERSON(S):

\_\_\_\_\_  
*PRINT Registered Name (if applicable)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*PRINT Name*

\_\_\_\_\_  
*SIGNATURE*

\_\_\_\_\_  
*PRINT Name*

\_\_\_\_\_  
*SIGNATURE*

make a copy of this completed form and any attachments for your files

#### **To submit this application, include:**

- the completed Personal Assistance Services Self-assessment Worksheet
- any other related attachments
- a cheque for the application fee in the amount of \$250.00, payable to the Assisted Living Registrar of British Columbia
- send to the Office of the Assisted Living Registrar

### 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.

# INSTRUCTIONS

## 1. RESIDENCE INFORMATION

- **Residence Name:** Enter the official business name of the residence as it appears on your business license.
- **Other Trade Name:** If applicable, provide any other trade name by which the residence is publicly known.
- **Address:** Enter the full address at which the residence is located.
- **Campus Name:** If the residence is situated in a campus setting, include the campus name.
- **Building Name/Floor Number:** If applicable, include the building name and the floor(s) on which the assisted living units are located.
- **Residence Phone Number:** Enter the published telephone number of the residence.
- **Residence Fax Number:** If available, enter the published fax number of the residence.
- **Email:** If available, enter the published email address of the residence.
- **Website:** If available, enter the published website address of the residence.

## 2. APPLICANT INFORMATION

- **Applicant's Legal Name:** The "Applicant" is the operator of the residence who is legally responsible for the conduct of the business. The Applicant may or may not be the legal owner of the real property on which the residence is located. Enter the legal name of a person, registered sole proprietorship, partnership, not-for-profit society or corporation.
- **If Applicant is a Person/Persons, Sole Proprietorship or Partnership:** Enter the full legal name(s) of the person(s), proprietors or partners. Attach additional sheet if required.
- **If the Applicant is a not-for-profit society or a corporation:** Enter the full name and title of a person who is legally authorized to act on behalf of the society or corporation. This is usually the president or a member of senior management. The Authorized Representative is the person with whom the Registrar will communicate about the application for registration and all other matters related to the residence subsequent to registration, including complaints. The Authorized Representative may, however, delegate subsequent communications with the Registrar's Office to another person named in "3. Residence Site Contact Information."
- **Applicant Contact Information:** Complete the applicant contact information including mailing address and a phone number. Additional phone number, fax number and email address are optional. Indicate "same as above" if the same as in "Residence Information." If your mailing address is a post office box, you must also provide the physical address for courier delivery.
- **Applicant Background:** Check "Yes" or "No" for each question and provide the following additional information if you have checked "Yes":

**Question 1** – Provide details including, name and address of facility, dates and nature of involvement (e.g., owner/manager, other), current status of license/registration of the facility (e.g., in good standing, suspended, cancelled), the jurisdiction (e.g., *BC Community Care and Assisted Living Act*), whether privately or publicly funded and if the latter, include names of funding agencies, etc.

**Question 2** – Indicate whether the experience is related to the Applicant and/or Site Manager and provide details including name and address of the residence, type of residence (supportive housing/assisted living), jurisdiction (e.g., Alberta), nature of experience (e.g., manager, care aide, nurse), number of residents, resident population, etc.

**Questions 3-5** – Under the *Criminal Records Review Act*, employees working with vulnerable adults and having unsupervised access to vulnerable adults must authorize a Criminal Record Check for their employer or authorized organization. This authorization is submitted to the Criminal Records Review Program for review. See link: <http://www.pssg.gov.bc.ca/criminal-records-review/index.htm>.

### 3. RESIDENCE SITE CONTACT INFORMATION

- ▶ **Residence Site Manager:** Provide the full name, position title and phone number of the person who is responsible for the day-to-day operation of the residence and who may be contacted by the Registrar's Office subsequent to registration. Include any alternate phone number, email address, and fax number, if available. Indicate "same as above" if same as in Applicant Contact Information.

### 4. RESIDENCE PROFILE

- ▶ **Residence Status:** Check the box that best describes the operational status of your residence. Include the proposed opening date if your residence is still under construction or "Operating since" date if your residence has already been in operation. Check the applicable boxes associated with permits from local authorities and attach copies of applicable permits.
- ▶ **Number of Resident Units:**
  - Enter the total number of resident units for your entire premises.
  - If you are applying to register only part of your premises, enter the total number of units you wish to register as an assisted living residence.
  - Of the total units to be registered as assisted living, enter the number of units that are privately and publicly funded.
  - If you are applying to register only part of your premises, indicate the remaining number of units that are used for alternate purposes, e.g., licensed care, supportive housing or other (e.g., rental apartment).
- ▶ **Resident Population:** Check the boxes that best describe the population(s) of your residence.

### 5. RESIDENCE SERVICES

- ▶ **Prescribed Services:** Check to confirm that you have completed and attached the *Personal Assistance Services, Self-assessment Worksheet*.
  - Referring to your completed worksheet, check the applicable boxes to indicate the personal assistance services you offer at the prescribed services level.For each prescribed service offered:
  - Check "Operator" to indicate you intend to deliver the service directly **and/or** "Contract" to indicate you intend to deliver the service through contractual arrangements with third party providers.
- ▶ **Hospitality Services:**  
For each hospitality service:
  - Check "Operator" to indicate you intend to deliver the service directly **and/or** "Contract" to indicate you intend to deliver the service through contractual arrangements with third party providers.

### 6. RESIDENCE OPERATION

- ▶ **Residence Environment:**
  - Check all applicable boxes to best describe your residence environment in terms of:
    1. *Location* – where your physical building and grounds are situated.
    2. *Building* – the type of construction.
    3. *Common areas and grounds* – accessibility to all residents.
    4. *Residence units* – privacy and accommodation of mobility and physical disability needs of residents.

## 6. RESIDENCE OPERATION continued

- ▶ **24-hour Emergency Response System:** (for discussion of this topic, refer to the section titled “What type of 24-hour emergency response system must I have in place?” in the *Information for Applicants* booklet)
  - Answer all questions by checking all applicable boxes to best describe your 24-hour emergency response system in terms of:
    1. *Staffing* – the availability of onsite staff and offsite staff to respond to emergency calls.
    2. *Emergency Call Devices* – the types of mechanical/electronic devices used to enable residents to summon assistance.
    3. *Response Procedures* – the general procedure followed to respond in case of an emergency.
    4. *Timeliness of Response* – the average time that it takes to respond to emergency calls.
- ▶ **Personal Services Plans:** (The personal services plan is an agreement between the individual resident and the operator and includes: the nature of the resident’s needs and service requests, the risks the resident is facing and a plan for the delivery of services. The plan also includes hospitality services, and whether the personal assistance services are offered at either the support or prescribed services level.)
  - Answer all the questions by checking all applicable boxes to best describe your process for developing and monitoring personal services plans in terms of:
    1. *Involvement* – indicate whether the resident and/or their family are involved in the development, review and update of the personal services plan.
    2. *Initial Plan Development* – when the initial personal services plan is developed.
    3. *Assigned Resource* – position titles and professional and non-professional qualifications of persons assigned to develop and maintain personal services plans.
    4. *Status of Assigned Resource* – indicate whether you directly employ the assigned resources or obtain resources through contractual arrangements with a third party.
    5. *Review and Update of Personal Services Plans* – the frequency/trigger for review and update of personal services plans.
    6. *Sample Plan* – attach a sample copy of an actual completed personal services plan that represents a typical plan for your resident population. **Please be sure to remove any personal identification about the particular resident.**
- ▶ **Delegation of Professional Tasks:**
  - Answer all questions by checking all applicable boxes to best describe your process for delegating professional health care tasks to non-professional staff in terms of:
    1. *Delegation Process* – the use of documented policies, procedures and guidelines and/or individual judgement.
    2. *Assigned Resource* – position titles and professional qualifications of persons responsible for delegating and monitoring the performance of delegated tasks.
    3. *Status of Assigned Resource* – indicate whether you directly employ the assigned resources or obtain resources through contractual arrangements with a third party.

## 7. DECLARATION AND AUTHORIZATION

- ▶ Read the declaration and authorization.
- ▶ Sign the form.
- ▶ Make a copy of the application package and any attachments for your records.
- ▶ Attach a cheque for the application fee.
- ▶ Mail the completed form together with any attachments and the cheque for the application fee to:

Assisted Living Registry  
PO Box 9638, STN PROV GOV  
Victoria BC V8W 9P1