BRITISH COLUMBIA | Ministry of Health

APPLICATION FOR A TEMPORARY REDUCTION OF THE MONTHLY RATE FOR LONG-TERM RESIDENTIAL CARE SERVICES

The personal information requested on this form is collected under the authority of and used for the purposes of administering the *Continuing Care Act* and the *Hospital Insurance Act,* and will be kept confidential in compliance with the *Freedom of Information and Protection of Privacy Act.* Questions about how the *Freedom of Information and Protection of Privacy Act* applies to the personal information collected on this form can be directed to your responsible assessor.

A. PERSONAL INFORMATION (please print)

CLIENT'S NAME		SPOUSE'S NAME *(if applicable)*
CLIENT'S PERSONAL HEALTH NUMBER	CLIENT'S IDENTIFICATION NUMBER	NUMBER OF SPOUSE / DEPENDENTS _____ SPOUSE + _____ DEPENDENT CHILDREN = _____ TOTAL
NAME OF RESIDENTIAL CARE FACILITY		
NAME OF CLIENT'S LEGAL REPRESENTATIVE *(if applicable)*	ADDRESS OF CLIENT'S LEGAL REPRESENTATIVE *(if applicable)*	

B. ALLOWABLE MONTHLY EXPENSES

		Client	Spouse/Dependents
HOUSING	Mortgage / Rent	N/A	
	Property Taxes / Condo Fees	N/A	
	Water Charges	N/A	
	Hydro / Heat Charges	N/A	
	Garbage Charges	N/A	
	Homeowner's or Renter's Insurance	N/A	
MEDICAL	Medical Services Plan (MSP) Premiums		
	Extended Health and Dental Insurance Premiums		
	Prescription Drugs		
	Dental Care		
	Medical Transportation Services		N/A
	Medical Equipment / Supplies		
	Prescribed Special Food and Dietary Supplements		
FINANCIAL	Canada Pension Plan (CPP) Deductions		
	Employment Insurance Premiums		
	Payments Dictated by the Courts		
	Public Guardian and Trustee Commissions		
OTHER	Exceptional Expenses *(please specify; must be approved by an authorized individual)*		
TOTAL MONTHLY EXPENSES *(add all expenses listed above)*			

C. CALCULATION OF TOTAL ANNUAL EXPENSES

	Client	Spouse/Dependents
1. Client's Annual Expenses *(multiply client's 'Total Monthly Expenses' by 12)*		N/A
2. Client's Discretionary Spending Amount	$2,347	N/A
3. Spouse / Dependent's Annual Expenses *(multiply spouse/dependent's 'Total Monthly Expenses' by 12)*	N/A	
4. Spouse / Dependent's Expenses of Daily Living Amount	N/A	
5. TOTAL ANNUAL EXPENSES *(add rows C1, C2, C3, C4)*		

D. FINANCIAL CALCULATIONS

	Client	Spouse	Joint
1. Net Income *(line 236, or other income info if approved by an authorized individual)*			
2. Income Tax Paid *(line 435)*			
3. Universal Child Care Benefit *(line 117)*			
4. Registered Disability Savings Plan *(line 125)*			
5. Total Annual Expenses *(line C5)*			
6. Adjusted Annual After Tax Income *(deduct rows D2, D3, D4, and D5 from D1)*			

7. ASSESSED MONTHLY RATE FOR RESIDENTIAL CARE SERVICES (as per HLTH 1.6)	8. TEMPORARY MONTHLY RATE FOR RESIDENTIAL CARE SERVICES (divide line D6 by 12)	9. EFFECTIVE FROM (YYYY / MM / DD)	10. EFFECTIVE TO (YYYY / MM / DD)

SIGNATURE OF RESPONSIBLE ASSESSOR	PRINTED NAME OF RESPONSIBLE ASSESSOR	DATE SIGNED (YYYY / MM / DD)

E. APPLICANT AGREEMENT (please read carefully)

I hereby declare that I have examined this statement carefully and that the disclosure of financial information stated is accurate, complete and true to the best of my knowledge. I agree to pay the temporary monthly rate as calculated. I accept the responsibility of informing the local health authority in writing within 10 days of any changes in my monthly income/expenses which may affect my eligibility for a temporary reduction of my monthly rate.

SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE	DATE SIGNED (YYYY / MM / DD)	SIGNATURE OF SPOUSE OR LEGAL REPRESENTATIVE	DATE SIGNED (YYYY / MM / DD)

F. HEALTH AUTHORITY AUTHORIZATION (only to be completed by an authorized individual within the health authority)

☐ APPROVED ☐ DECLINED	SIGNATURE(S) OF AUTHORIZED INDIVIDUAL(S)	DATE SIGNED (YYYY / MM / DD)

PRINT RESET

INSTRUCTIONS AND GUIDE

Please ensure one copy of the completed application form is included in the client's file and one copy is provided to the client. If client is a sponsored immigrant, refer to additional instructions in manual.

A. PERSONAL INFORMATION

- For 'Number of Spouse/Dependents', enter 1 if client has a spouse or 0 if client does not have a spouse. Enter number of dependent children (if applicable). Dependent children are children under the age of 19 and living in the family home or children 19 to 25 years of age and attending school full-time and living in the family home. Add 'Spouse' plus 'Dependent Children' to get 'Total'. 'Total' will be used to determine the 'Expenses of Daily Living Amount' for line C4.

B. ALLOWABLE MONTHLY EXPENSES

- Include all allowable monthly expenses for the client, their spouse (if applicable), and any dependent children (if applicable). Record the allowable monthly expenses for the client in the 'Client' column and the allowable monthly expenses for the spouse and any dependent children in the 'Spouse/ Dependents' column.
- Most expenses for clients receiving long-term residential care services are included in the cost of care. As such, clients may not claim monthly expenses with a 'N/A' in the 'Client' column. See below for the complete list of allowable and non-allowable monthly expenses.
- Add all allowable monthly expenses to calculate 'Total Monthly Expenses' for the client and their spouse (if applicable) and any dependent children (if applicable).

ALLOWABLE MONTHLY EXPENSES

- First mortgage or rent for the family home
- Property taxes/condo fees
- Water, hydro/heat, and garbage charges (utilities)
- Homeowner's or renter's insurance
- Medical Services Plan (MSP) premiums
- Extended health and dental insurance premiums – The non-reimbursable portion (i.e., deductible) of extended health and dental care costs are allowed.
- Prescription drugs – Prescription drugs not covered by PharmaCare or the non-reimbursable portion of prescription drug costs under an extended health and dental insurance plan are allowed. Use a prorated monthly rate for high monthly/yearly estimates. The PharmaCare deductible is allowed for spouse/ dependents only.
- Dental care costs – The non-reimbursable portion of dental care costs under an extended health and dental insurance plan are allowed. Repayment of, or defaulted debt owed for services rendered is not allowed.
- Formal medical transportation services required due to a medical condition (e.g., ambulance/medi-van transfers) are allowed for the client only.
- Medical equipment (e.g., oxygen equipment, wheelchair, walker or scooter), including purchases, instalment payments, rentals or maintenance.
- Medical supplies (e.g., incontinence products, wound care supplies) – Clients may not claim medical supplies that are paid for by the facility.
- Prescribed special food and dietary supplements
- Canada Pension Plan deductions
- Employment Insurance premiums
- Payments dictated by the court (e.g., alimony or child support). This does not include defaulted credit payments.
- Public Guardian and Trustee commissions

NON-ALLOWABLE EXPENSES

- Client rate for home and community care services
- Loan payments (e.g., 2nd or 3rd mortgage against the family home)
- Mortgage and associated expenses for any additional properties – Expenses allowed are for the primary family residence only. All associated expenses would be deducted and reflected under 'Net Income' (line 236). Current losses are not an allowable expense.
- Reimbursable extended health and dental care costs
- Non-prescribed vitamins
- Outstanding bills or debts for services (e.g., arrears on monthly rate for residential care services, legal, accountant, ambulance or dental charges, income tax prepayments or repayments).
- Credit card payments (e.g., VISA, department store credit cards)
- RRSPs, bonds, mutual funds or other types of savings
- Bank service charges
- Life insurance
- Tuition and education expenses, scholarship funds
- Charitable donations
- Costs associated with employment income or volunteer activities
- Child care
- Non-medical transportation costs (e.g., bus fare or passes, including Handi-dart, taxicabs, loans, maintenance, insurance or gas)
- Clothing or footwear
- Newspapers, magazines, books, entertainment
- Cable television
- Telephone service (landline or cellular telephone)
- Personal comfort items and incidentals (e.g., gifts, beautician fees, toiletries, cigarettes, alcohol, membership fees)
- Pet supplies or veterinarian bills

C. CALCULATION OF TOTAL ANNUAL EXPENSES

- C1 and C3 – Multiply 'Total Monthly Expenses' by 12 to calculate 'Annual Expenses' for the client and their spouse (if applicable) and any dependent children (if applicable).
- C2 – The client's annual 'Discretionary Spending Amount' is $2,347 per year.
- C4 – Enter the spouse/dependent's annual 'Expenses of Daily Living Amount' from the table, below. Refer to 'Total' from 'Number of Spouse/Dependents in Section A to determine the appropriate amount. Do not include the client in this count.

Spouse/Dependent's Expenses of Daily Living Amount

No Spouse/Dependent:	$ 0 per year
1 Spouse/Dependent:	$11,733 per year
2 Spouse/Dependents:	$16,593 per year
3 Spouse/Dependents:	$20,322 per year
4 Spouse/Dependents:	$23,466 per year
5 Spouse/Dependents:	$26,236 per year
6 Spouse/Dependents:	$28,740 per year

- C5 – Add lines C1, C2, C3, and C4 to calculate 'Total Annual Expenses' for the client and their spouse (if applicable) and any dependent children (if applicable). Transfer the amount for 'Total Annual Expenses' to line D5.

D. FINANCIAL CALCULATIONS

- D1, D2, D3, and D4 – If client has no spouse, complete 'Client' column only. If client has a spouse, complete both 'Client' and 'Spouse' columns and combine numbers on lines D1, D2, D3, and D4 to obtain 'Joint' column. If spouse's expenses are claimed, spouse's income MUST be included in Section D.
- D5 – 'Total Annual Expenses' as calculated on line C5.
- D6 – Subtract lines D2, D3, D4 and D5 from line D1 to calculate 'Adjusted Annual After Tax Income'.
- D7 – Enter client's assessed monthly rate for residential care services (as calculated on the HLTH 1.6).
- D8 – Divide 'Adjusted Annual After Tax Income' (line D6) by 12 to calculate 'Temporary Monthly Rate for Residential Care Services'.
- D9 – Enter the effective date ('Effective From') for the temporary monthly rate. Once the temporary monthly rate is approved, it is effective the first day of the month following the date that the health authority receives complete documentation supporting the client's application for a temporary reduction of their monthly rate from the client or the client's legal representative.
- D10 – Enter the expiry date ('Effective To') for the temporary monthly rate. The temporary monthly rate should be in place for the shortest amount of time necessary to alleviate the client's serious financial hardship but cannot exceed one year.
- Responsible assessor signs and dates the completed application form.

E. APPLICANT AGREEMENT

- Client signs and dates the completed application form. If client cannot sign but can make their mark, the responsible assessor enters the client's name, the words "his/her Mark", and countersigns. If the client cannot sign or mark, the client's legal representative may sign on behalf of the client.
- If the client has a spouse and the spouse's income and expenses were included on the application form and used to calculate the client's temporary monthly rate, the spouse must also sign and date the completed application form.
- The responsible assessor ensures the client is aware he/she is certifying that the answers to Sections A, B and D are correct, and that he/she is agreeing to pay the temporary monthly rate as calculated in Section D.
- The responsible assessor forwards the completed application form to an authorized individual within the health authority for review and approval.

F. HEALTH AUTHORITY AUTHORIZATION

- Only to be completed by an authorized individual within the health authority.
- Authorized individual ticks one box, signs and dates signature.

Reference: Home and Community Care Policy Manual, Chapter 7.D (Temporary Reduction of Client Rates).