Indian and Northern Affairs Canada
Affaires indiennes et du Nord Canada

Social Development Policy and Procedures Handbook

BC Region

Volume 2

Assisted Living Program

Canada

For any additional information or if you have any questions on the Social Development Policy and Procedures Handbook – BC Region, you may contact the BC Region Band Social Development Worker Policy Support Line, through any of the following:

Telephone (toll free): 1-888-440-4080
E-Mail: AANDC.BSDWSupportBC-TSDBsoutienCB.AADNC@aandc-aadnc.gc.ca

---

Please note:

This program handbook is an on-going document and will be updated from time to time. The latest version will be available through the BC Region Band Social Development Worker Policy Support Line.

Hard copy updates will not be distributed to non-Administering Authorities.

Indigenous and Northern Affairs Canada assumes no responsibility for any reproduction derived from this handbook.

The Terms and Conditions of the program are the ultimate authority; the purpose of this handbook is to explain those authorities.

The Cabinet of Canada establishes the program authority for the Assisted Living program and the Treasury Board of Canada Secretariat establishes the funding authority.

The purpose of the National Social Programs Manual and this handbook is to provide information to Administering Authorities on how to administer INAC's Social Development programs in British Columbia.

- Volume 1: Income Assistance Program
- Volume 2: Assisted Living Program
- Volume 3: Appendices
- Volume 4: National Child Benefit Reinvestment Initiative

Published under the authority of the Minister of Indian and Northern Affairs Canada, Ottawa, 2004
www.aandc-aadnc.gc.ca
1-800-567-9604; TTY only: 1-866-553-0554
QS-B045-000-EE-A1

Assisted Living
Table of Contents

		CIDM	Version	Issue Date
	Cover Page	687678	5	July 2016
	Table of Contents	660511	6	Aug 2016
Chapter 1 Introduction				
1.1	Introduction to this Manual	682677	5	July 2016
Chapter 2 Homemaker Services				
2.1	Eligibility Criteria	379412	4	Aug 2016
2.2	Application Process	379422	5	Aug 2016
2.3	Service Provider Rates and Payment Methods	379425	4	Aug 2016
2.4	Client User Charges	379428	6	Aug 2016
2.5	Reviews	379455	4	Aug 2016
2.6	Monthly Reports	379460	4	Aug 2016
2.7	Other Support Services	379463	4	Aug 2016
Chapter 3 Adult Institutional Care Services				
3.1	Eligibility and Admission Criteria	379483	4	Aug 2016
3.2	Application and Review Processes	379485	5	Aug 2016
3.3	Responsibility of the Administering Authority	379498	3	Aug 2016
3.4	Levels of Care	379504	4	Aug 2016
3.5	Continuing Care Facility Per Diem Costs	379509	3	Aug 2016

		CIDM	Version	Issue Date
3.6	Client User Charges	379515	6	Sept 2016
3.7	Responsibility for the Payment of Continuing Care Facility Per Diem Costs	379517	4	Sept 2016
3.8	Financial Exemptions and Allowances	379891	3	Sept 2016
3.9	Other Services	379894	3	Sept 2016

Chapter 4 Adult Family Care Homes

		CIDM	Version	Issue Date
4.1	Eligibility, Roles and Responsibilities	379896	3	Sept 2016
4.2	Recruitment and Screening	379908	3	Sept 2016
4.3	Approval of Homes	379915	3	Sept 2016
4.4	Financial Requirements	379941	3	Sept 2016
4.5	Placement of Client	379943	5	Sept 2016
4.6	Operation of Home	379954	5	Sept 2016
4.7	Closure of Home	379966	3	Sept 2016

Note:

See the *Social Development Policy and Procedures Handbook Vol. 1* for Income Assistance Program policy and program information.

See the *Social Development Policy and Procedures Handbook Vol. 3* for Appendices.

See the *Social Development Policy and Procedures Handbook Vol. 4* for National Child Benefit Reinvestment Initiative policy and program information.

The Program Guide and Recipient Reporting Guide contain INAC's reporting forms and instructions. This information is available at Reporting Guide

Introduction to This Handbook

Welcome to BC Region's *Social Development Policy and Procedures Handbook.*

This Handbook is divided into four volumes:

- Volume 1: Income Assistance program
- Volume 2: Assisted Living program
- Volume 3: Appendices
- Volume 4: National Child Benefit Reinvestment program

This handbook is designed for those individuals involved in administering the Social Development Program in BC.

The Social Development program is administered by the federal Department of Indian Affairs and Northern Development (DIAND), also known as Indigenous and Northern Affairs Canada (INAC), and provides financial support to Funding Recipients to deliver the Social Development program to eligible individuals living on-reserve.

This handbook may also be useful to others involved in the delivery of socio-economic programs on-reserve.

On-line Version of the BC Region Social Development Policy and Procedures Handbook

An Electronic copy of this Handbook is available through the BC Region BSDW Policy Support Line, which can be accessed by:

Telephone (toll free): 1-888-440-4080
E-Mail: AANDC.BSDWSupportBC-TSDBsoutienCB.AADNC@aandc-aadnc.gc.ca

Handbook Amendments

Registered handbook holders are band staff members who directly administer the Social Development program in BC. All registered handbook holders receive amendments or updates to the handbook.

Band staff members who receive a handbook amendment are expected to read the cover letter describing the changes, remove the old sections of the

handbook, and insert the new sections of the handbook. Changes to the content of the Handbook are marked on each page.

Each handbook amendment package also includes a new table of contents and index. Band staff members are expected to ensure that the handbook contains all the sections listed on the table of contents, and that the date printed on the bottom of each section matches the date shown on the table of contents. The CIDM number and Version number refer to the Comprehensive Integrated Document Management (CIDM) system that is used by INAC.

Handbook Administrator

Contact the handbook administrator, noted below, if:

- the handbook amendment/update package is going to the wrong person;
- the band staff member responsible for administering the program is not receiving updated information;
- the handbook is missing sections, or if some of the sections are out of date; or
- when a band staff member has found errors and wishes to forward their findings

Band Social Development Worker Support Line
Telephone (toll free): 1-888-440-4080
E-Mail: AANDC.BSDWSupportBC-TSDBsoutienCB.AADNC@aandc-aadnc.gc.ca

Chapter 2: Homemaker Services

Eligibility Criteria

General Principle

The Assisted Living Program provides funding for non-medical social support services. Homemaker services provide financial assistance for non-medical personal care for adults who need assistance for daily living.

Homemaker Services are intended to:

- Assist clients to live in their own homes as long as it is practical and in the best interest of the clients and their families;
- Supplement, but not replace, the care provided by families, other unpaid caregivers and communities;
- Promote independence and well-being of clients, their families and other unpaid caregivers and communities;
- Provide respite care to the family member or other caregiver ordinarily caring for the person in the person's home.

Services range from housekeeping, meal preparation and attendant care to community supports such as adult care, meals on wheels, psycho-social programs, short-term respite care for caregivers and non-health transportation. Services do not include major home repairs

The objective of the Homemaker Services program is to support and enhance the dignity and independence of physically disabled, mentally disabled or elderly adults, and to assist them to remain in their own communities with family and friends, and avoid institutionalization.

The program recognizes the right and responsibility of the individual to remain at home for as long as it is reasonable, safe, and practical to receive support services in the home setting. Individuals are encouraged to participate, to the fullest degree possible, in the development and implementation of a plan of service delivery structured to meet their assessed care needs.

It is the responsibility of the administering authority to determine the nature, amount, cost and duration of the services to be provided. The provision of service is based on available funding.

Eligibility

A person can only receive Homemaker Services if the person:

- Is a registered, status Indian;
- Has been assessed as requiring Homemaker services (see Volume 2; Chapter 2.2, Application Process);
- Pays the daily User Charge, if applicable (see Volume 2; Chapter 2.4, Client User Charges)

INAC has established eligibility criteria related to the age, residency and health of the client. For example:

Age

In order to apply for Homemaker Services, an individual must be 19 years of age or older.

Residency

An applicant for Homemaker Services must be resident on-reserve or ordinarily resident on-reserve at the time of application.

For the purposes of Assisted Living programs and services, “ordinarily resident” means that an individual client:

- Lives at a permanent address on-reserve more than 50% of the time;
- Does not have a primary residence off-reserve;
- Is an individual who is off-reserve for the purpose of obtaining care not available on-reserve or who is off-reserve for the primary purpose of accessing social services because there is not reasonably comparable services available on-reserve.

Note: the term “ordinarily resident” is more broadly defined in the National Social Programs Manual (see *Chapter on Assisted Living Program, Section 2.1.5*) for both Assisted Living and Income Assistance Programs and Services.

Citizenship

If an applicant is a non-status person residing on-reserve (except individuals who are occupying commercial rental accommodation on reserve), in order to be eligible for home and community care services, he or she must provide documentation which establishes that they:

- Are a citizen of Canada, or lawfully admitted to Canada for permanent residence; or
- Have applied for permanent resident status, and as a result have been issued a Temporary Residence Permit (TRP) by the federal minister responsible for immigration, if issuance of the TRP has been recommended by the committee established by the minister responsible for the *Medicare Protection Act* to review the admissibility of individuals on medical grounds.

Applications will not be considered from individuals applying from outside Canada or from individuals applying on behalf of a non-Canadian resident.

Eligible Services

Homemaker Services are intended for non-medical personal care such as:

- Meal programs, meal planning and preparation
- Day programs
- Attendant care
- Short-term respite care (as described below)
- Group care
- Laundry
- Ironing
- Mending
- Carrying water and/or wood
- Home management which may include making beds, dusting, washing clothes, dishes, sweeping, wiping counter tops, vacuuming, taking out the garbage, scrubbing a bathroom or floor, washing walls or shampooing carpets
- Minor home maintenance (i.e., fixing a door knob or attaching a railing)
- Non-medical transportation
- Guide dogs

Administering Authorities may approve the delivery of INAC-billable Homemaker Services (see above) to eligible clients consistent with all of the following requirements:

- Allocation of home support services must be based on completion of a *Homemaker Services Application* (SA-215);
- Assessment of the client's health and functional status (see *Homemaker Service Evaluation Form* (901-30));
- The ability of the client and caregivers to manage care needs with available community supports provided;
- The client's established health care goals; and
- Assessment of risk to staff (Homemaker Services may be denied, as a final resort, if providing service to the client puts the Homemaker at risk);
- Priority must be given to clients who have been assessed as having the highest care needs or as living at the highest levels of risk;
- Services must be provided in a manner that reflects the requirement to balance care needs and safety issues within available resources – no client will be denied home support services solely on the basis of the cost of the service required by that client;
- Services will be available for a 24-hour period, on a short-term basis, where feasible and appropriate; and
- Services may be authorized prior to assessment in urgent, exceptional situations, including outside of regular business hours.

Health of the Applicant and Access to Service

Homemaker Services are designed for those individuals who cannot live independently because of on-going, health related problems which do not require care in an acute or rehabilitation program. These problems are typically:

- Of at least three months in duration;
- Due to a progressive and/or chronic condition

The goal is to provide clients with services appropriate to their long-term functional needs.

Access to services is to be based on the client's health and functional status, and the availability of family and other community supports.

Client Service Needs Determination

The *Administering Authority* can approve Homemaker Services for a client who:

- Has been assessed as requiring Homemaker Services (see *Homemaker Service Evaluation Form* (901-30);
- Is appropriately matched with the residence
- Is compatible with existing clients
- Has agreed to pay the assessed client rate (For more information, see chapter 2.2 Client Rates), if applicable.

It is the responsibility of the *Administering Authority* to determine the nature, amount, cost and duration of the service to be provided. The provision of service is based on available funding.

Family Members Providing In-home Care Services

Within the limits of their means and capacity, individuals and their relatives have primary responsibility for home management and supports. Payments may not be issued, therefore, when there is another person in the home, or a family member in the community who may reasonably be expected to provide the assistance required by the disabled or elderly person.

Services shall be withdrawn when a family member becomes available to provide assistance.

Respite Benefit for Families

While the Homemaker Services program does not provide financial subsidies to families who care for their relatives, the program may provide funds for respite to families and relatives. The client must be eligible and assessed for Homemaker Services for their families to access financial support for respite services.

Veterans' Benefits

Veterans Affairs Canada provides services to veterans on and off-reserve.

Where it is considered that a veteran would benefit from additional services, a referral can be made to the nearest Veterans Services District Office or Veterans Affairs Canada.

Eligibility Exclusions – Third Party Liability

Where the disability necessitating Homemaker Services is due to an illness or injury for which a third party is liable, the Administering Authority does not assume financial responsibility.

It is the responsibility of the applicant to inform the Administering Authority of the existence of, or a possibility of, a third party liability claim.

When there appears to be third party liability, the applicant is referred to the appropriate individual, agency or organization. The most common referrals involve the Workers Compensation Board (WCB) and the Insurance Corporation of British Columbia (ICBC).

If the applicant is turned down by the third party and wishes to pursue the question of eligibility for Homemaker Services, the applicant is requested to have the agency concerned write directly to the Health Authority outlining details of the claim and the reasons why the requested services cannot be provided.

If the need for service becomes urgent or critical and the applicant is otherwise eligible for Homemaker Services, payment for the necessary service may be provided by the Administering Authority on an interim basis. Such authorization will occur by exception only.

Application Process

General Principle

The application process is to describe Administering Authorities' responsibilities in determining eligibility for homemaker services. The Administering Authorities' responsibilities include working with the *assessor* to identify and evaluate the needs, capabilities and potentials of the individual in order to determine the appropriate level of care. Administering Authorities determine the most suitable services, within available resources, to meet their clients' needs and develop potential capabilities for clients through creating appropriate service delivery plans for each client.

The intent of the homemaker services program is to complement other federal government programs for individuals living on-reserve, for example, the entity responsible for delivering the First Nations and Inuit Home and Community Care Program and services offered by Veterans Affairs Canada.

Policy

Administering Authorities may approve Homemaker Services for a client who:

- Has been assessed as requiring Homemaker Services;
- Meets the eligibility criteria outlined in Volume 2; Section 2.1;
- Does not have a family member who may reasonably be expected to provide assistance;
- Has agreed to pay the assessed residential services client rate, if applicable.

Description, Recruitment, and Screening

Homemaker Services are inclusive of meals, laundry and other housekeeping services as determined by the local assessor. Administering authorities are responsible for:

- Recruiting, screening, and approving homemaker services
- Ensuring that the homemaker services reflect the specific needs of the client, through an appropriate client, service provider match
- Relaying accurate and timely information for service providers, clients, and families regarding homemaker services.

Homemaker Services Requirements

The Administering Authority must ensure that all Homemaker Services meet acceptable standards for:

- Fire safety by complying with regulations including smoke alarms, fire extinguishers and a fire evacuation plan
- Safe and secure outdoor environment to ensure the safety of clients who wander
- General safety regarding floor surfaces, lighting and stairs
- General cleanliness
- Basic nutrition/food preparation and safety including special/therapeutic diets if required
- Appropriate insurance including personal liability, fire and automobile insurance
- Local municipal requirements

Safekeeping and Financial Affairs

Administering Authorities must ensure service providers establish reasonable accounting and security measures to make adequate provisions for the custody and safekeeping of the client’s personal belongings when the client is unable to on their own behalf.

Client at Risk

Administering Authorities must assess the situation and determine whether to remove a client from the home when it is determined that the client may be at risk or is no longer appropriately cared for through the Homemaker Services program.

Unsatisfactory Service

Administering Authorities must have a process for dealing with a service provider who is not providing satisfactory services up to and including termination of the contract.

Procedures

Step 1

An individual may apply for Homemaker Services on their own behalf or on behalf of another person living on-reserve by contacting a Band Social Development Worker at the Administering Authority Office in their home community.

Step 2

The Band Social Development Worker will provide an *Application for Homemaker Services (901-38)* and inform the applicant that they must complete Part 1 and Part 2 of this form before a case file is opened.

Step 3

Once the individual has completed Part 1 and Part 2 of the application, the Band Social Development Worker will arrange for an assessor to determine the care requirements of the applicant.

Note: *The assessor may be a Public Health Nurse, a Community Health Nurse, a Community Health Representative, or another person who has the expertise and capable of making an accurate assessment of the applicant's care needs.*

Step 4

The Band Social Development Worker will arrange for the assessor to visit the applicant as soon as possible after the application is received at the Administering Authority office to determine their care requirements and complete a *Homemaker Service Evaluation Form (901-30).*

The assessor should also determine whether there is another person in the home or a relative in the community who may reasonably be expected to provide either a portion, or all, of the required assistance.

Requests for assessments will be prioritized on the basis of urgency of health care need, availability of family and community supports, suitability of present living situation and length of time awaiting an assessment.

Step 5

Following the assessment, the Band Social Development Worker will meet with the assessor to review the application and make an appropriate decision and recommendation concerning provision of Homemaker Services.

If the applicant is ineligible for Homemaker Services, the reason for the decision will be s hared with the applicant by the Band Social Development Worker.

If provision of Homemaker Services is recommended, the Band Social Development Worker will assist the applicant to arrange for the delivery of services in accordance with the specific care requirements identified by the assessor.

Step 6

Part 3 of the *Application for Homemaker Services (901-38)* will be completed by the Band Social Development Worker on behalf of the Administering Authority.

Step 7

The Band Social Development Worker will meet with the applicant to explain the Terms of Service, and to complete Part 4 of the *Application for Homemaker Services (901-38).* The BSDW must ensure that the applicant understands the purpose and content of the form, especially the arrangement for payment of services.

Resources

Eligibility	Documentation and Forms
Applicant or Recipient	• *Budget and Decision Form* (901-25) • *Application for Homemaker Services (SA - 215)* • *Homemaker Service Evaluation Form (901-30)* • Copies of required identification • Copy of any assessments required • All other required income assistance and assisted living documents
Resources	• Assisted Living Report (DCI #455937) • Recipient Reporting Guide http://www.aadnc-aandc.gc.ca/dci/dcilog_e.asp • Ministry of Health http://www.gov.bc.ca/health/

Budget and Decision Form (901-25)

The *Budget and Decision Form* (901-25) is to be *completed in full* and document the benefit decision as follows:

1. Comment section – indicate:
    a. The “under 19”
    b. The type of need being provided (i.e., income assistance)
    c. The amount of shared shelter and show the family units portion for each eligible item (see chapter 5.1 Shelter Allowances Overview)

2. Under Monthly Requirements section –write the amount for each benefit and sub-total each category:
    a. (A) Basic, (B) Shelter, and (D) Special
        i. Items not applicable write N/A or put a strike through to show reviewed
    b. Under Resources, enter the amount of each item in categories (1) Earned Income, (2) Income from Self-Employment (3) Unearned Income (4) Recovery and total all items to determine the total monthly deduction amount (5)
        i. Items not applicable write N/A or put a strike through to show reviewed
        ii. Enter amount of Foster Home payment under (3) and copy of cheque or bank statement required to verify payment
    c. Enter the amount of (5) from Resource section to Less Deductions under Monthly Requirements
    d. Monthly Entitlement amount to be issued
3. Under Temporary Allowance Issued by Administering Authority section enter:
    a. the unit size (i.e., family unit size)
    b. the amount entitled
    c. the from and to dated (i.e., April 1, 2015 to March 31, 2016)
4. Any section not applicable like Transfer to Band Work Project (i.e., WOP)
    a. write N/A or put a strike through to show reviewed
5. Signatures of both the recipient and Administering Authority required.
6. If the ‘From and To’ date are for entire fiscal year. A new B&D Form (901-25) needs to be prepared only when a change occurs as:
    a. the *Monthly Renewal Declaration* (901-28) must be provided each month and describe all changes (i.e., copy of paystub or new utility bill) [see chapter 3 Application and Assessment]
7. All expenditures must have the required documentation attached to the B&D form.

Application for Homemaker Services (SA – 215)

The *Administering Authority* is to provide a *Homemaker Services Application* (SA-215) and inform the applicant to complete Section A and Section B before a case file is opened.

1. Review Sections A and B for completeness

2. Arrange for an assessor to determine the care requirements of the applicant. Assessors may be:
   a. Public health nurses
   b. Community health nurses
   c. Community health representatives
   d. Another individual capable of making an accurate assessment of the applicant's care needs.

3. Following the completion of the *Homemaker Service Evaluation Form* (901-30), the *Administering Authority* will proceed with Sections C and D of the *Application for Homemaker Services* (SA-215) if the assessor deemed the applicant in need of services.

4. Section C of the *Homemaker Services Application* (SA-215) will be completed by the band social development worker. Level of income is based on the client's personal Income Tax and Benefits Return.

5. The Band Social Development Worker will meet with the applicant to explain terms of service, and to complete Section D of the *Homemaker Services Application* (SA-215). The worker must ensure that the applicant understands the purpose and content of the form, especially the arrangement for payment of services.

Homemaker Service Evaluation Form (901-30)

The *Administering Authority* will arrange for the assessor to visit the applicant as soon as possible after the application is completed. The assessor will complete a *Homemaker Service Evaluation Form* (901-30).

1. Requests for assessments will be prioritized on the basis of urgency of health care need, availability of family and community supports, suitability of present living situation, and length of time awaiting an assessment.

2. The assessor will determine whether there is another person in the home or a relative in the community who may reasonably be expected to provide a portion, or all, of the required assistance.
3. Following an assessment, the band social development worker will meet with the assessor to review the application and make an appropriate decision and recommendation concerning the provision of homemaker services

4. If the applicant is ineligible for homemaker services, the reason for the decision will be shared with the applicant by the band social development worker

5. If the provision of homemaker services is recommended, based on the assessment, the band social development worker will assist the applicant to arrange for the delivery of services in accordance with the specific care requirements identified by the assessor.

ASSISTED LIVING REPORT (DCI # 455937)

The *Administering Authority* is to report all expenditures and caseload information by completing:

1. The Recipient, Region, and Reporting Period information requested on the report
2. Complete the Client Information Section of the report:
    a. Assessment Date refers to the date when the individual was last assessed for care by a designated social service or health professional.
    b. Type of Service Need Assessed refers to the type of service the individual was assessed as needing.
    c. Type of Service refers to the type of service by code.
    d. Care Start Date refers to the start date when the individual began receiving the current service provided.
    e. Care End Date refers to the date on which the client was discharged or stopped receiving services.
    f. Rate ($) refers to the rate for the service provided.
    g. Rate Unit refers to the hour, day, week, or moth the service provision is measured in.
    h. Total Number of Units refers to the total units provided by rate unit.
    i. Total refers to the total cost of services provided during the reporting period paid by the Assisted Living program.

3. Complete the Approval Block section of the report.

Service Provider Rates and Payment Methods

Payment for Services

Service Provider Rates

Payment may be issued for Homemaker Services at the following service provider rates, as applicable:

- The prevailing negotiated rate when services are available from an established agency;
- A rate comparable to the local prevailing rate and negotiated between the administering authority and a qualified service provider; or, if no established agency or qualified homemaker is available;
- The statutory minimum hourly wage.

Payment Methods

Payment to the service provider may be issued by an Administering Authority as follows:

- The Administering Authority may pay the homemaker agency or individual service provider directly, on behalf of the client;
- Should the client be responsible for a portion of the daily User Charge, this charge should be paid directly by the client to the service provider or homemaker agency. The balance of the cost will be paid directly to the service provider by the Administering Authority on behalf of the client.

Responsibility of the Service Provider

At the end of each month the service provider will prepare a statement of account and forward this to the Administering Authority. This statement must be validated by the client prior to the issuance of a payment for services received.

Client User Charges

General Principle

For a client who is required to pay a daily User Charge for the Homemaker Services program, this charge is based on the client's available income and assets and takes into account:

- All earned income
- All unearned income
- Limitations and exclusions and assets

This section describes the Administering Authorities' responsibilities in determining income-based or subsidized client rates for Homemaker Services.

Definitions

After tax income is the client's net income (line 236) less the sum of taxes payable (line 435), the Universal Child Care Benefit (line 117) and the Registered Disability Savings Plan (line 125), as reported on the client's income tax return and confirmed by the Canada Revenue Agency, in the appropriate taxation year.

Client rate is the daily or monthly rate charged to a client for in-home care services.

Earned income is the sum of the following amounts as reported on the client's income tax return:

- Employment income (line 101);
- Other employment income (line 104);
- Net business income (line 135);
- Net professional income (line 137);
- Net commission income (line 139);
- Net farming income (line 141); and
- Net fishing income (line 143).

Income benefit includes:

- the Guaranteed Income Supplement (including benefits under International Agreements) under the *Old Age Security Act* (Canada);
- the Widowed Spouse's Allowance or the Spouse's Allowance under the *Old Age Security Act* (Canada);
- INAC's income assistance for support and shelter allowance.

- INAC's disability allowances under the Persons with Disabilities or the Persons with Persistent Multiple Barriers Program
- A War Veterans Allowance under the *War Veterans Allowance Act* (Canada).

Subsidized client rate is a client rate that is less than the maximum client rate established for the specific home and community care service.

Policy

The Band Development Social Worker (BSDW) must determine the appropriate income-based client rate for a client receiving Homemaker Services (form SA-215).

Assessment of client rate

The BSDW must ensure a client who receives Homemaker Services is **not** charged a client rate if they are in receipt of an income benefit (see definitions section).

To be eligible for a subsidized client rate for Homemaker Services, the client and (where applicable) the client's spouse must:

- Have filed an income tax return with the Canada Revenue Agency (CRA) for the appropriate taxation year;
- Provide their Social Insurance Number (SIN). If the client or spouse does not have a SIN, he or she must obtain a SIN; and
- Provide income information from the CRA or a copy of a current financial bank statement to the BSDW in order to establish the client rate.

The BSDW should use the following document to establish the client rate:

- For an initial client assessment for the client and their spouse, the most recent notice of assessment available at the time of the application, but for no more than two years prior to the year for which client rates are being assessed; and
- Proof of receipt for a client receiving income benefits under the *Old Age Security Act* (Canada), *Employment and Assistance Act,* the *Employment and Assistance for Persons with Disabilities Act,* or the *War Veterans Allowance Act* (Canada), where applicable.

A copy of an income tax return or notice of assessment from the CRA does not constitute **consent** for the purposes of this policy.

If the client or the client's spouse is incapable of providing consent, BSDW's must accept consent given by another person on behalf of the client or spouse if the person has **legal authority**. If another person provides consent on behalf of the client or spouse, health authorities must obtain a copy of the document conferring legal responsibility for providing consent at the same time as consent is given. The document must show that the person has legal responsibility to provide consent on behalf of the client or spouse under:

- an Enduring Power of Attorney;
- a Committeeship of Estate; or
- a Representation Agreement

If consent is revoked, the client is no longer eligible for a subsidized client rate for Homemaker Services, effective the first day of the month following the date consent is revoked.

Homemaker Services Application

The BSDW must use the Budget and Decision Form (901-25), and follow the steps described in the procedures section below to assess the client rate:

- for an initial client assessment; or
- when the client reports a significant change in their financial circumstances

The BSDW should provide a signed copy of the Budget and Decision Form (901-25) to the client.

The BSDW will provide the client rate **only** to the service providers; client income information cannot be shared with service providers.

The BSDW will keep all submitted Budget and Decision Forms (901-25) and a copy of documents conferring legal responsibility for providing consent on file for a period of no less than five years after the last day of the taxation year for which consent was provided.

Changes in Client Rates

The Band Development Social Worker is responsible for managing changes in client rates as follows:

- Notify clients and service providers of annual client rate changes based on updated client income and rate information provided by INAC;

- Calculate a revised client rate upon notification from the client or client's representative of a significant change in the client's financial circumstances, and notify providers of the manually revised client rate; and

- Make client rate changes effective the first day of the month following the date the BSDW receives complete documentation from the client or the client's representative demonstrating the change in the client's financial circumstances.

The Administering Authority can require a client to report a change in the client's or spouse's income to the BSDW, and provide proof of that income change.

Temporary Reduction or Waiving of the Client Rate

The BSDW may authorize a temporary reduction of the assessed client rate for up to one year, where a client or their family will experience serious financial hardship by paying the assessed client rate for Homemaker Services.

The BSDW may temporarily waive all, or a portion, of the assessed client rate for eligible clients. A client is considered eligible if the client and the client's spouse are not in receipt of monthly income assistance and shelter allowance under INAC Income Assistance program, and one of the following is met:

- The client, where the client does not have a spouse and/or dependent children, will experience serious financial hardship if the assessed client rate is charged;

- The client and the client's spouse and/or dependent children will experience serious financial hardship if the assessed client rate is charged; or

- For clients receiving short-term residential care services, the client or the client's spouse is unable to pay the client rate and still maintain the family home or unit.

Serious financial hardship is when payment of the assessed client rate would result in the client or client's spouse being unable to pay for:

- Adequate food;
- Monthly mortgage/rent;
- Sufficient home heat;
- Prescribed medication; or
- Other required prescribed health care services.

To process the temporary reduction of the client rate, the BSDW must:

- Itemize the monthly income for the client and the client's spouse (if applicable) and the monthly expenses for the client, the client's spouse and/or dependent children (if applicable) on the Budget and Decision form (901-25);
- Require the client or the client's legal representative provide complete supporting documentation to the BSDW to verify the income and expenses claimed on the B&D form;
- Make the financial calculations on the joint income of the client and the client's spouse, if the client has a spouse.

The BSDW should process a client's application for a temporary reduction or waiving of the client rate within 30 business days of receiving complete documentation supporting the application for a temporary reduction or waiving of the client rate from the client or the client's legal representative.

After assessing the Budget and Decision Form (901-25), the BSDW must:

- Provide the client with a copy of the completed B&D form;
- Notify the client of the decision in writing; and
- Inform the client that they must re-apply for a temporary reduction of the client rate one month prior to the date their current reduced client rate expires, if necessary.

Approved Applications for a Temporary Reduction of the Client Rate

Once an application for a temporary reduction of the client rate is approved, the BSDW must:

- Make the reduced client rate for Homemaker Services effective the date the BSDW receives complete documentation supporting the approved application for a temporary rate reduction from the client or the client's legal representative;
- Advise service providers of the reduced client rate; and
- Reimburse service providers for the difference between the assessed client rate and the reduced client rate.

Re-Applying for a Temporary Reduction of the Client Rate

The BSDW may authorize a new temporary reduction of the assessed client rate where a client or their family will continue to experience serious financial hardship by paying the assessed client rate when their current reduced client rate expires.

The BSDW must:

- Require a client to re-establish his or her eligibility for a temporary reduction of the client rate
  - at least once each calendar year; or
  - within ten days of a declared change in the financial circumstances of the client or the client's spouse (if applicable);

- Complete a new Budget and Decision Form (901-25) for eligible clients who are re-applying for a temporary reduction of the assessed client rate;

- Require the client or the client's legal representative to provide complete supporting documentation to the BSDW to verify the income and expenses claimed on the new application;

- Make the new reduced client rate effective the first day of the month following the date the BSDW receives complete documentation supporting the approved application for a temporary rate reduction from the client or the client's legal representative; and

- Require that a client who fails to re-establish his or her eligibility for a reduced client rate to repay all charges that were waived after the expiry date of the previously approved Budget and Decision Form (901-25).

Procedures

In assessing the amount of daily User Charge payable by the client, the Band Social Development Worker will calculate the rate based on information contained in the client's previous year's income tax return and the size of the client's family unit using the following steps (**For a case example see Table 1**):

Step 1

- **Add** the net income of the client as reported on line 236 of the client's income tax return to the net income of the client's spouse as reported on line 236 of the spouse's income tax return.

Step 2

- **Minus** the total income tax paid by the client and the client's spouse as reported on line 435 of their income tax returns.

Step 3

- **Minus** the annual earned income for the client and the client's spouse (this is the total of lines 101, 104, 135 137, 139, 141 and 143 from each persons' last income tax return), up to a maximum of $15,000 per person.

Step 4

- **Minus** the "allowable deduction for calculation of the client's remaining annual income" as indicated in Table 2 that corresponds with the client's family unit size. The family unit size includes the client, the client's spouse and any children under the age of 19 residing in the client's home.

Step 5

- **Multiply** the **remaining annual income** by 0.00138889 to determine the client's maximum daily User Charge.

Step 6

- Determine the amount that the client is to pay for homemaker services. As per the case example (Table 1):

- If the daily cost for the service is less than $23.23 per day, the client will pay the lesser amount up to a maximum of $23.23 per day;
- If the daily cost of the homemaker service is $23.23 per day, the applicant will pay the entire cost of this service.
- If the daily cost of the homemaker service is more than $23.23 per day, the client will only pay $23.23. For example, if the cost of the service is $50 per

day, the client will pay a daily User Charge of $23.23 and the administering authority will pay the balance of the costs, $26.77.

Table 1: Example of the Daily Client User Charge for Homemaker Services

- Family Unit Size is 2 (two adults, no children)
- The applicant is employed, the spouse is recently unemployed and both people are under 65 years of age.

	Applicant	Spouse	Joint
Step 1 - Add net income (line 236 from the applicant's and their spouse's, previous years' income tax returns)	**$35,000**	**$23,000**	**$58,000**
Step 2 - Minus income tax paid (line 435 from the applicant's and their spouse's, previous years' income tax returns)	**$10,500**	**$5,520**	**<$16,020>**
Step 3 - Minus earned income (up to a maximum of $15,000 for each person). Earned income means income earned due to employment, not pension income etc., and includes lines 101, 104, 135, 137, 139, 141 and 143 from the applicant's and their spouse's, previous years' income tax returns).	**$8,500**	**$0**	**<$8,500>**
Step 4 - Minus "Allowable Deduction for Calculation of Client's Remaining Annual Income" - Table 2 (for a Family Unit Size of 2)			**<$16,752>**
Total remaining annual income			**$16,728**
Step 5 - Multiply the remaining annual income by 0.00138889 to establish the required daily User Charge to be paid by the client for homemaker services. For example a remaining annual income of $16,728 x 0.00138889 = $23.23/day.			**$23.23/day**

Table 2 – Allowable Deduction for Calculation of Client's Remaining Annual Income

Family Unit Size	Allowable Deduction for Calculation of Client's Remaining Annual Income
1	$10,284 per year
2	$16,752 per year
3	$19,164 per year
4	$20,880 per year
5	$22,716 per year
6	$24,312 per year
7	$25,908 per year
8	$27,384 per year
9	$28,860 per year
10	$30,366 per year

Resources

Eligibility	Documentation and Forms
Applicant or Recipient	• *Budget and Decision Form* (901-25) • *Application for Homemaker Services (SA - 215)* • *Homemaker Service Evaluation Form (901-30)* • Copies of required identification • Copy of any assessments required • All other required income assistance and assisted living documents
Resources	• *Ministry of Health, Home and Community Care Policy Manual* http://www2.gov.bc.ca/gov/topic.page?id=8F569BDA913540DCAB75145DBB6070CE • *CRA General Income Tax and Benefit Guide* http://www.cra-arc.gc.ca/E/pub/tg/5000-g/5000g-14e.pdf • *War Veterans Allowance* http://www.veterans.gc.ca/eng/services/financial/war-veterans-allowance • *Old Age Security* http://www.servicecanada.gc.ca/eng/services/pensions/oas/pension/index.shtml • *Supporting Documentation Checklist for Temporary Rate Reduction Applications (to be used as a reference for BSDWs)* http://www2.gov.bc.ca/gov/DownloadAsset?assetId=C0036A554DE7418C85CEA9663CE5BB52

Establishing the Client-Rate

The BSDW must complete form SA-215 to establish the client rate.

The BSDW must calculate a daily client rate for a client who receives Homemaker Services by dividing the client's remaining annual income by 720. Joint income is used if the client lives with his or her spouse.

If the calculated daily client rate is higher than the actual cost of the service to the Administering Authority, the Administering Authority must not charge the client more than the actual cost of the service.

The BSDW must ensure that a client receiving Homemaker Services who has earned income or whose spouse has earned income is not charged more than $300 per month for in-home care services.

If both members of a couple are eligible for and receiving Homemaker Services, the BSDW must assess each individual for the full client rate. However, the BSDW must ensure only one member of the couple is charged per service day.

If a couple become permanently separated, the BSDW must recalculate the client rate based on the remaining spouse's income.

Budget and Decision Form (901-25)

The *Budget and Decision Form* (901-25) is to be *completed in full* and document the benefit decision as follows:

1. Comment section – indicate:
    a. "In-Home Care Services"
    b. The type of need being provided (i.e., PWD benefits, PPMB benefits)
    c. The amount of shared shelter and show the family units portion for each eligible item (see chapter 5.1, Shelter Allowances Overview)

2. Under Monthly Requirements section –write the amount for each benefit and sub-total each category:
    a. (A) Basic, (B) Shelter, and (D) Special
        i. Items not applicable write N/A or put a strike through to show reviewed
    b. Under Resources, enter the amount of each item in categories (1) Earned Income, (2) Income from Self-Employment (3) Unearned Income (4) Recovery and total all items to determine the total monthly deduction amount (5)

i. Items not applicable write N/A or put a strike through to show reviewed

c. Enter the amount of (5) from Resource section to Less Deductions under Monthly Requirements (i.e., funds for student assistance see chapter 4.9)

d. Monthly Entitlement amount to be issued

3. Under Temporary Allowance Issued by Administering Authority section enter:
   a. the unit size (i.e., family unit size)
   b. the amount entitled
   c. the from and to dated (i.e., April 1, 2015 to March 31, 2016)

4. Any section not applicable like Transfer to Band Work Project (i.e., WOP)
   a. write N/A or put a strike through to show reviewed

5. Signatures of both the recipient and Administering Authority required.

6. If the 'From and To' date are for entire fiscal year. A new B&D Form (901-25) needs to be prepared only when a change occurs as:
   a. The *Monthly Renewal Declaration* (901-28) must be provided each month and describe all changes (i.e., copy of paystub or new utility bill) [see chapter 3 Application and Assessment].

7. All expenditures must have the required documentation attached to the B&D form.

ASSISTED LIVING REPORT (DCI # 455937)

The *Administering Authority* is to report all expenditures and caseload information by completing:

1. The Recipient, Region, and Reporting Period information requested on the report
2. Complete the Client Information Section of the report:
   a. Assessment Date: refers to the date when the individual was last assessed for care by a designated social service or health professional.
   b. Type of Service Need Assessed: refers to the type of service the individual was assessed as needing.
   c. Type of Service: refers to the type of service by code.

d. Care Start Date: refers to the start date when the individual began receiving the current service provided.
e. Care End Date: refers to the date on which the client was discharged or stopped receiving services.
f. Rate ($): refers to the rate for the service provided.
g. Rate Unit: refers to the hour, day, week, or moth the service provision is measured in.
h. Total Number of Units: refers to the total units provided by rate unit.
i. Total: refers to the total cost of services provided during the reporting period paid by the Assisted Living program.

Reviews

General Principle

Reviews are documented follow-up visits for the purpose of re-evaluating the client's health status and care requirements.

The client must be seen in-person by an assessor and the Band Social Development Worker for the review. Telephone contact and third party reports are not considered to be a review.

The circumstances of each client receiving Homemaker Services must be reviewed at least once every six months.

Procedures

Role of the Assessor

Following the initiation of Homemaker Services, the assessor will make periodic follow-up visits to the client at least once every six months.

These visits are made for the following reasons:

- A client's health condition and personal circumstances may be unstable at the time services commenced. Follow-up is required to confirm that the recorded health care needs and services authorized following the initial assessment are still valid;
- A client who has received services for some time may undergo changes in their health status, personal circumstances, the family or informal support systems available to the client, etc. These changes must be recorded and reviewed with the client and the service provider so that appropriate alterations in care planning and service delivery may be implemented.

The review is an on-site check of the client which establishes that either a change in care level or service delivery is not warranted or that a change in care level and/or service delivery is warranted.

Reviews consist of:

- A visit to the client in the home;
- Discussion of the client’s condition and circumstances with the client and/or the client’s family members, physician, care providers and other health care professionals as appropriate and necessary;
- An examination of the record of care;
- Contact with service providers and/or representatives of other community agencies to amend service delivery plans and/or new services;
- Documentation of the contact;
- Updating of the client file.

The assessor provides a recommendation to the administering authority whether a change in the level of service is required by using the *Homemaker Service Evaluation Form* (901-30).

Role of the Band Social Development Worker

The Band Social Development Worker:

- Determines whether financial arrangements must be modified by using the *Application for Homemaker Service* (901-38);
- Makes the decision to provide, or not provide, homemaker services to the client as per the assessor’s recommendation, the client’s continued eligibility for the program and available resources.

Request for Reviews

Reviews of the client’s needs may be undertaken at any time upon the request of the client or upon the recommendation of the homemaker.

Monthly Reports

General Principle

The Administering Authority is required to complete and submit the monthly *Social Development Financial and Statistical Report - SDFSR* (SA-700). For more information see the INAC National Reporting Guide . It is important to note that Assisted Living Reports are updated on an annual basis.

Procedures

The Social Support section on the *Social Development Financial and Statistical Report - SDFSR* (SA-700) form is where Homemaker Services are reported.

The form requires the following information:

- The number of individuals who received services in each category during the month;
- The number of hours of care provided in each category during the month; and
- The total expenditures for each category during the month for services provided.

The categories are:

- Homemakers;
- Meal Program;
- Adult Day Program;
- Other programs.

See Vol. 2; Chapter 2.7 for Other Support Services for examples of other services which the Administering Authority may wish to offer.

Other Support Services

General Principle

Within budget limitations, and subject to available resources, an Administering Authority may implement other support services and programs designed to promote the independence of the client.

These support services may be coordinated with Health Canada's First Nations and Inuit Home and Community Care Program

Description

Examples of the services or programs that may be offered by the Administering Authority for clients are:

- Counselling programs
- Meal programs
- Psycho-social programs
- Non-medical transportation programs
- Home maintenance programs
- Companion care programs
- Respite care for caregivers programs
- Social assessment and case management services
- Coordination and referral services
- Coordination of volunteer and support group services
- Services to support councils for seniors and/or persons with disabilities.

Procedure

Administering Authorities must contact their INAC Funding Services Officer to discuss the reporting requirements for the new program, which may include the:

- Type of social development program or service to be established
- Number of clients who will be served by the new program

- Program management structure
- Number of hours per type of service
- Number and training of service providers
- Budget for the respective program or service
- Indicators of comparability with provincial programs
- Client profile
- Fee structure and financial eligibility

Chapter 3: Adult Institutional Care Services

Eligibility and Admission Criteria

General Principle

The Assisted Living Program provides funding for non-medical social support services.

The Adult Institutional Care Services Program provides financial assistance to eligible residents living on-reserve who, by reason of incapacity, require placement in a licensed continuing care facility.

Policy

To be eligible to access INAC's Adult Institutional Care Services Program, the individual must undergo a health assessment administered by the Local Health Authority. Eligibility criteria pertaining to the individual's health condition are set by the provincial Ministry of Health Services and INAC, BC Region.

It is the responsibility of the Local Health Authority to determine the nature, amount, cost and duration of the service to be provided to the client.

Administering Authorities will be reimbursed by INAC for clients placed in designated continuing care facilities, subject to the clients meeting the eligibility criteria.

Residents living on-reserve prior to being admitted into institutional care do not jeopardize their residency status by virtue of being placed in an off-reserve institution. They remain the financial responsibility of INAC, so long as other qualifying requirements continue to be met.

Conditions of Eligibility

A person is eligible to access INAC's Adult Institutional Care Services Program if he or she is:

- Is a registered, status Indian;
- Has been assessed by the Local Health Authority as requiring Adult Institutional Care ;
- Pays the daily User Charge, if applicable

Age

In order to apply for adult institutional care services, an individual must be19 years of age or older.

Residency

An applicant for Adult Institutional Care Services must be resident on-reserve or ordinarily resident on-reserve at the time of application and preceding placement.

For the purposes of Assisted Living programs and services, "ordinarily resident" means that an individual client:

- Lives at a permanent address on-reserve more than 50% of the time;
- Does not have a primary residence off-reserve;
- Is an individual who is off-reserve for the purpose of obtaining care not available on-reserve or who is off-reserve for the primary purpose of accessing social services because there is not reasonably comparable services available on-reserve.

Note: the term "ordinarily resident" is more broadly defined in the National Social Programs Manual (see *Chapter on Assisted Living Program, Section 2.1.5*) for both Assisted Living and Income Assistance Programs and Services.

Citizenship

If an applicant is a non-status person residing on-reserve (except individuals who are occupying commercial rental accommodation on reserve), in order to be eligible for home and community care services, he or she must provide documentation which establishes that they:

- Are a citizen of Canada, or lawfully admitted to Canada for permanent residence; or
- Have applied for permanent resident status, and as a result have been issued a Temporary Residence Permit (TRP) by the federal minister responsible for immigration, if issuance of the TRP has been recommended by the committee established by the minister responsible for the *Medicare Protection Act* to review the admissibility of individuals on medical grounds.

A Non-status person residing on commercial leased reserve lands, and persons who have established residence off-reserve, are not eligible for INAC funding, and should be referred to their local health authority.

Applications will not be considered from individuals applying from outside Canada or from individuals applying on behalf of a non-Canadian resident.

Health of the Applicant

Adult Institutional Care Services Program are designed for those individuals who cannot live independently because of on-going, health related problems which do not require care in an acute or rehabilitation program. These problems are normally:

- Of at least three months duration, and
- Due to a progressive and /or chronic condition.

The goal is to provide clients with services appropriate to their long term functional needs.

Application and Review Processes

General Principle

Entry into the Adult Institutional Care Services Program requires that each applicant meet with a qualified assessor (a Home and Community Care Case Manager) from the local health authority who will evaluate the needs of the individual, the appropriate level of care, the most suitable services and facility, and the client's urgency for care based on a standardized assessment.

The application and review processes are a joint responsibility of the Ministry of Health Services, the local health authority, the Administering Authority and INAC, BC Region.

Procedures

Application Process

Referral of an applicant to the Adult Institutional Care Services Program may be initiated by any one or more of the following:

- The applicant
- A friend or relative of the applicant
- An acute care, rehabilitation or psychiatric hospital
- A physician or other health or social service professional (e.g., nurse, social worker, psychologist)
- A care facility which does not provide service to the health authority
- Band social development worker
- Others (e.g., landlord, neighbour, community agency)

Once a referral has been made, the next steps are:

Step 1

The Band Social Development Worker (BSDW) will open a case file on the applicant at the time of referral.

Step 2

The band social development worker will ask the applicant to complete a *Medical Release and Report* (SA 115).

Step 3

The BSDW or the Administering Authority's health department will contact the local health authority's Home and Community Care Case Manager to request an assessment of the applicant.

Requests for assessment are prioritized by the local health authority on the following basis:

- Urgency of health care need;
- Availability of family and community supports;
- Suitability of present living situation;
- Length of time awaiting assessment.

Step 4

An assessor (a Home and Community Care Case Manager) will be assigned by the local health authority to visit the applicant to:

- Explain the program, discuss care needs and any alternatives with the applicant and the family;
- Complete a provincial *Application and Assessment* (LTC 1) form;
- Complete a provincial *Mini Mental Status Examination* (MMSE) form;
  - Where appropriate complete a provincial *Application for Home Support* (LTC 10) form;
- Complete a provincial *Financial Profile and Calculations* (HLTH 1.6) form and consent of release of information from Canada Revenue Agency (CRA) so that the home and community care assessor may determine the applicant's daily User Charge for continuing care services.

Step 5

A recommendation will be made by the assessor concerning the applicant's eligibility for the program, appropriate level of care and plan of service delivery.

This recommendation is documented in the appropriate sections of the provincial *Application and Assessment* (LTC 1) form and may be referred to an assessment team for review before the proposed care level and/or plan of service delivery is finalized and authorized by the local health authority.

Step 6

If required, an assessment team will be established by the local health authority to make a decision as to an appropriate placement. The team usually includes:

- Home and community care manager
- Home and community care case manager
- Psychiatric social worker (geriatric program) or boarding home social worker, Mental Health Services
- Representative from the band or Administering Authority

Team membership may be augmented on an ad hoc basis by the addition of:

- Physiotherapist
- Occupational therapist
- Community home care nurse
- Community health representative
- Nutritionist
- Family physician
- Pharmacist
- Additional home and community care case managers
- Other professionals as appropriate

The decision of the Home and Community Care Case Manager or assessment team will include:

- Whether the service is required;
- Level of care required;
- A recommendation to the administering authority regarding an implementation plan for continuing care services, if required
- Designation of an institution and placement on waiting list in the event that there is a waiting list.

Step 7

If it is decided that the applicant requires placement in a continuing care facility at the Intermediate Care Level 1, 2 or 3, the Home and Community Care Case Manager will visit the applicant to explain the team's decision and the action being taken to place the applicant into the program.

Step 8

Following the assessment, the band social development worker will send a copy of the applicant's *Medical Release and Report* (SA 115) to the local health authority and request a copy of the applicant's provincial *Application and Assessment* (LTC 1) form and the provincial *Financial Profile and Calculations* (HLTH 1.6) form.

Step 9

If the applicant is unable to pay the daily User Charge for the continuing care facility, the BSDW will assess the applicant to determine their eligibility for financial assistance based on the completed *Financial Profile and Calculations (HLTH 1.6)*. INAC funds for whatever portion of the User Charge (identified as Client Rate by the Local Health Authority) that the client is unable to pay.

Step 10

Prior to admission to a designated continuing care facility, the BSDW will:

- Ask the administrator of the care facility to complete Part A of the *Adult Institutional Care & Adult Family Care Homes Client Admission Form,* indicating the care facility Per Diem Cost as established by the Ministry of Health Services.
- Ask the applicant, or the individual with the legal authority to act on behalf of the applicant, to complete Part B of the *Adult Institutional Care & Adult Family Care Homes Client Admission Form,* confirming the applicant's commitment to pay a daily User Charge to the facility. If the applicant's User Charge is $0 (as per Step 9), then this value ($0) is to be included on the form that the applicant signs.
- Complete Part C of the *Adult Institutional Care & Adult Family Care Homes Client Admission Form* on behalf of the administering authority to verify that the applicant is an on-reserve resident and that the administering authority will pay the continuing care facility, as required.

Step 11

The Administering Authority will fax a copy of the completed *Adult Institutional Care & Adult Family Care Homes Client Admission Form*, the provincial *Application and Assessment* (LTC 1) form and the provincial *Financial Profile and Calculations* (HLTH 1.6) form:

Attention: INAC, BC Region Social Programs Unit c/o Assisted Living Program Advisor. The dedicated reporting fax number is 604-775-7147

OR

The Administering Authority will scan the documents and mail them directly to the INAC Band Social Development Worker Support Line:

AANDC.BSDWSupportBC-TSDBsoutienCB.AADNC@aandc-aadnc.gc.ca

Step 12

INAC, BC Region will send a confirmation letter to the administering authority indicating whether or not the admission form has been accepted. If the admission form is accepted, this letter will state the payment start date.

Step 13

The BSDW will ensure that the client's case file includes:

- INAC *Medical Release and Report* (SA 115)
- Provincial *Application and Assessment* (LTC 1) form
- Provincial *Financial Profile and Calculations* (HLTH 1.6) form
- INAC *Adult Institutional Care & Adult Family Care Homes Client Admission Form*
- INAC, BC Region's confirmation letter to the administering authority that the client's admission form has been approved for funding
- Case notes
- Other documentation as required

Step 14

The BSDW will:

- Submit an *Adult Institutional Care and Adult Family Care Homes Report* form on a quarterly basis to INAC, BC Region's dedicated reporting fax number at 604-775-7400. Note: this form is to be completed even when the client is away from the facility in respite care.

- Use the *Adult Institutional Care and Adult Family Care Homes Report* to report any rate change that may follow, in time, from the local health authority. A copy of the rate change letter from the local health authority must be attached.

- Use the *Adult Institutional Care and Adult Family Care Homes Report* to report the discharge date of the client, if the client is no-longer in care.

- Continue to ensure that the client meets the eligibility requirements to receive funding support for the daily client User Charge, if applicable.

Review and Reassessment Processes

Reviews and reassessments of a client's care level or placement may be undertaken at the request of:

- Client
- Service provider
- Family member
- Physician
- Health care professional

Requests for a review or reassessment must be directed to the Home and Community Care Case Manager.

Responsibility of the Administering Authority

Jurisdiction

Provision of services, including monitoring, counselling and payment of accounts, is normally the responsibility of the Administering Authority in the geographical area in which the designated continuing care facility is situated

In some situations, the Administering Authority from where the applicant originates may wish to take on these responsibilities.

Support Services

Staff of the Administering Authority is required to provide support services for persons funded under the Adult Institutional Care Services Program.

Administering Authorities and health authorities must ensure that clients who are approved for admission to continuing care are supported in the community with:

- An increase in the availability and flexibility of community health supports and homemaker services;
- A plan for crisis management; and,
- Preparation and counselling for admission to continuing care.

On admission of a client to a designated facility, the Administering Authority must ensure that the administrator of the continuing care facility is notified of:

- The contribution rates applicable to the Administering Authority (Funding Agency Charge) and the resident (User Charge);
- Billing procedures; and,
- The name, address and telephone number of the worker who is to provide any required follow-up services.

Following placement, the Administrative Authority having jurisdiction will ensure that a staff member visits the resident **at least once every six months** to provide other social services as required.

Where the facility is responsible for collection of the daily client User Charge, INAC, BC Region will ensure, prior to placement, that the client and family understand and acknowledge the obligation to pay the User Charge. If a problem occurs with respect to client payments following placement, please contact your local Funding Services Officer.

Levels of Care

Authorized and Non-Authorized Levels of Care - Funding Agency Charge

The level of care for clients in a continuing care facility is determined by the local health authority's Home and Community Care Case Manager, based on criteria established by the provincial Ministry of Health Services for each care level.

INAC is responsible for payment of the daily Funding Agency Charge for Intermediate Care Levels I, II and III services in provincially licensed continuing care facilities for eligible persons as described in Vol. 2; Chapter 2.1, Eligibility and Admission Criteria.

INAC does not assume responsibility for the daily Funding Agency Charge for Extended Care services. These costs are normally covered under the provincial hospital services program or through Health Canada's First Nations and Inuit Health Branch (FNIHB).

Personal Care Level

Persons assessed at the Personal Care Level are independently mobile with or without mechanical aids, require minimal assistance with the activities of daily living and require non-professional supervision or assistance.

With the availability of on-reserve community-based support services, individuals assessed at the Personal Care Level should not require institutional placement.

Persons assessed at the Personal Care Level may be candidates for Homemaker Services as outlined in Vol.2; Chapter 2.

Intermediate Care Levels

There are three Intermediate Care Levels established by the provincial Ministry of Health Services.

Each level builds on the Personal Care Level and recognizes a need for care planning and supervision under the direction of a health care professional by introducing a combination of professional and non-professional supervision supports.

Professional supervision is required on a daily, rather than a 24-hour basis. An individual identified as requiring support at one of the Intermediate Care Levels is independently mobile, with or without mechanical aids.

Note: This level of care equates to Type II as outlined in the *National Social Programs Manual (Section 3.3.1):*

- *This level of care identifies a person with a relatively stabilized (physical or mental) chronic disease or functional disability, who having reached the apparent limit of his/her recovery, is not likely to change in the near future, who has relatively little need for the diagnostic and therapeutic services of a hospital but who requires availability of personal care on a 24-hour basis, with medical and professional nursing supervision and provision for meeting psychosocial needs. The period of time during which care is required may consist of a number of months or years.*

Intermediate Care Level I (IC1)

This level of care recognizes the person who is independently mobile with or without mechanical aids, requires moderate assistance with the activities of daily living and requires daily professional care and/or supervision.

The applicant may require:

- Specialized aids for transferring independently;
- A moderate amount of assistance with bathing, dressing and grooming;
- Reminders or assistance with toileting;
- Some supervision in eating;
- Directional assistance;
- Occasional enemas.

The applicant may:

- Have difficulty expressing needs;
- Be unable to adapt to sensory loss;
- Be mildly depressed or agitated;
- Have moderately impaired comprehension;
- Have difficulty in orientation as to day, time, and place.

The applicant:

- Will require daily supervision by professional staff;
- May require nursing procedures;
- May require supervision for visits to doctor, dentist, eye specialist;
- May require therapeutic dietary supports;

- Will require regular review by a physician; and
- May require therapeutic services for a psychiatric problem.

Intermediate Care Level II (IC2)

This level recognizes heavier care needs and supervision requiring additional care time. The basic characteristics of this level are the same as Intermediate Care Level I.

An applicant assessed as Intermediate Care Level II may:

- Need considerable directional assistance and supervision of activities;
- Present management problems due to wandering or impaired comprehension;
- Have multiple or severe disabilities and medical problems;
- Be incontinent of bowel or bladder;
- Need assistance with eating, and/or requires daily professional supervision of catheters, surgical dressing, colostomy, etc.

The applicant may:

- Be a chronically psychiatrically disabled person who requires training for independent living;
- Have marked behavioural problems requiring considerable staff intervention and management.

Intermediate Care Level III (IC3)

This level of care recognizes the psychogeriatric person who has severe behavioural problems on a continuing basis. However, this level of care may also be used for persons requiring a heavier level of care involving considerably more staff time than at the Intermediate Care Level II, but who are not eligible for Extended Care.

The applicant may:

- Exhibit destructive, aggressive or violent behaviour;
- May continually wander away;
- May endanger own life.

The applicant may:

- Be psychiatrically handicapped with one or more severe behavioural problems which makes the person unacceptable in the usual residential resources in the community;
- Require a behaviour modification program on a time-limited or highly structured basis; or
- Be a younger adult who functions adequately in the activities of daily living, but who requires considerable supervision, training and care.

This person is likely to be able to return to an independent lifestyle if given appropriately intensive counselling and a therapeutic program.

Extended Care Level

This level of care recognizes the person with a severe chronic disability which has usually produced a functional deficit requiring 24 hour-a-day professional nursing services and continuing medical supervision, but who does not require all the resources of an acute care hospital. Most persons at this level have a limited potential for rehabilitation and often require institutional care on a permanent basis.

Note: The Funding Agency Charge for clients in Extended Care is normally covered by the provincial Hospital Services Program or Health Canada's First Nations and Inuit Health Branch. Please refer to Vol. 2; Chapter 3.7, Responsibility for the Payment of Care Facility Per Diem Costs for more information.

Continuing Care Facility Per Diem Costs

General Principle

Under the Adult Institutional Care Service Program, persons may be admitted to provincially licensed continuing care facilities.

The provincial Ministry of Health Services establishes the facility Per Diem Costs.

INAC may fund the per diem portion of institutional care on a case by case basis. Clients in an institution are expected to pay the provincial or territorial government established co-insurance or user fee for care and maintenance and clothing and personal expenses to the extent they are financially able to do so.

Procedures

Prior to approval of payment of an account from a facility, the Administering Authority must ensure that the facility is provincially licensed under the authority of the *Community Care and Assisted Living Act*. This information is available by contacting the local health authority.

Continuing Care Facilities

Continuing care facilities are licensed under the authority of the provincial *Community Care and Assisted Living Act*. Entry into continuing care facilities is available only to individuals who are assessed by the health authority, as eligible for residential placement.

The approved facility Per Diem Cost considers the client's assessed level of care and covers standard accommodation, meals (including therapeutic diets), laundry, necessary emergency and routine treatment supplies, skilled care with professional supervision and a planned program of social and recreational activities.

As outlined in the National Social Programs Manual (Section 3.3.5), eligible Institutional Care expenditures to be funded may include:

- Standard accommodation;
- Meals, including therapeutic diets;
- Laundry;
- Necessary emergency and routine treatment supplies;

- Skilled care with professional supervision as needed and planned;
- Programs for social and recreational activities;
- Clothing;
- Special Diets;
- Age allowance;
- Personal living allowance;
- Guide dogs.

The approved facility Per Diem Cost does not include items for the exclusive personal use of the client, for example, personal hygiene and grooming supplies, personal dry cleaning, personal telephone, personal cable television, personal newspapers and personal periodicals.

The applicable facility Per Diem Cost for a continuing care facility can be obtained by contacting the local health authority.

Facilities with Less Than 15 Beds

Facility Per Diem Costs are set by each health authority and may vary significantly between regions. **Administering authorities must contact their local health authority to ensure that they are aware of the current continuing care facility Per Diem Costs for their area**.

The following costs are provided as an **example only.** These costs are not to be used for calculations:

*** EXAMPLE ONLY ***

	"Example" Facility Per Diem Costs Contact your local health authority for the current rates for your area.
Personal Care	$42.76 (Check for current cost)
Intermediate Care I	$53.77 (Check for current cost)
Intermediate Care II	$64.66 (Check for current cost)
Intermediate Care III	$84.02 (Check for current cost)

Note: The daily client User Charge and the Funding Agency Charge is included in the above facility Per Diem Costs. For example, if the client is assessed at Intermediate Care Level III that has a facility Per Diem Cost of $84.02, the client

will pay a User Charge of $27.60 (based on the client's annual remaining income of less than $7,000) and the administering authority will pay the remainder (Funding Agency Charge) of $56.42 (see Vol. 2; Chapter 3.6, Client User Charges and 3.7, Responsibility for the Payment of Continuing Care Facility Per Diem Costs, for more information).

Facilities with More Than 15 Beds

The facility Per Diem Costs for continuing care facilities with more than 15 beds are established by the local health authority. These rates are determined annually and are specific to each individual facility.

Client User Charges / Client Rates

General Principle

Part of the Per Diem Cost of care for a designated continuing care facility must be paid by a client who can afford to contribute financially.

Client User Charges / Client Rates

The Local Health Authority under the policies of the provincial Ministry of Health Services calculates the daily client User Charge, annually, based upon the individual's income levels.

The Local Health Authority must calculate a monthly client rate for a client who receives assisted living services by multiplying 70% of the client's annual after tax income, then dividing by 12, subject to the minimum and maximum rate.

In the case of a married couple who resides in the same assisted living unit, the Local Health Authority must calculate a monthly client rate by multiplying 70% of the couple's joint annual after tax income, then dividing by 12, subject to the minimum and maximum rate. (Note: The Ministry of Health establishes minimum rates on an annual basis)

The maximum rate is based on a combination of the market rent for the housing and hospitality services for the geographic area where the client is receiving assisted living services and the actual cost of the personal care services for the client.

In the event that a couple living together in an assisted living unit become permanently separated, the Local Health Authority must recalculate the assisted living client rate based on the remaining spouse's after tax income.

- If a client receives an income benefit (the Guaranteed Income Supplement under the *Old Age Security Act*; the Widowed Spouse's Allowance under the *Old Age Security Act*; the INAC Income Assistance program (including the Persons with Persistent Multiple Barriers category) or INAC's Social Assistance for Persons with Disabilities program; or a war veterans allowance under the *War Veterans Allowance Act*), **should be in a position to pay for the Client User Charge** that the Local Health Authority calculates. This amount changes on an annual basis.
- Clients receiving respite care pay the lowest rate. The respite care rate applies to all beds used for respite care in residential facilities.

Alternate Payers

When an alternate payer is responsible for paying the daily client User Charge, the alternate payer is charged the non-subsidized client rate (the highest rate). Alternate payers include:

- Insurance Corporation of British Columbia
- Workers Compensation Board
- Veterans Affairs Canada
- Health Canada, First Nations and Inuit Health Branch
- Public Guardian and Trustee

but does not include the provincial Ministry of Human Resources which is not responsible for clients living on-reserve.

Appeals

Appeals of the assessed daily client User Charge must be made by the individual or administering authority on behalf of the individual to the local health authority.

Responsibility for the Payment of Continuing Care Facility Per Diem Costs

General Principle

The Assisted Living Program provides funding for **non-medical social support services** that meet the special needs of seniors, adults with chronic illness, and children and adults with disabilities (mental & physical) with the objective of maintaining functional independence and greater self-reliance.

The following three charts detail the financial responsibilities of clients and relevant funding agencies regarding payable rates for eligible on-reserve residents admitted to continuing care facilities.

Aboriginal persons residing off-reserve are eligible for continuing care services through their local health authority.

The facility Per Diem Costs for continuing care facilities are established by each local health authority.

Facility Per Diem Costs = Daily Client User Charge + Daily Funding Agency Charge.

Table 1: Intermediate Care Facility Per Diem Cost			
Age	**Client Status**	**Responsibility for payment of daily client User Charge**	**Responsibility for payment of daily Funding Agency Charge**
65+	Status or non-status	Client (**OAS/GIS**)	**INAC**
19–64	Status or non-status	Client or Third Party **INAC** (if client has no income and is eligible for income assistance)	**INAC**

Table 2: Extended Care Facility Per Diem Cost			
Age	**Client Status**	**Responsibility for payment of daily client User Charge**	**Responsibility for payment of daily Funding Agency Charge**
65+	Status or non-status	Client (**OAS/GIS**)	BC Medical—Hospital Programs
19–64	Status	Client or Third Party **FNHA** (if the client has no income)	BC Medical—Hospital Programs
19–64	Non-status	Client or Third Party **INAC** (if client has no income and is eligible for income assistance)	BC Medical—Hospital Programs

Table 3: Residents on Commercially Designated Reserve Lands Facility Per Diem Cost			
Age	**Client Status**	**Responsibility for payment of daily client User Charge**	**Responsibility for payment of daily Funding Agency Charge**
65+	Status	Client (**OAS/GIS**)	**INAC**
65+	Non-status	Client (**OAS/GIS**)	**MHR** (if client has no income and is eligible for income assistance)
19–64	Status	Client or Third Party **INAC** (if client has no income and is eligible for income assistance)	**INAC**
19–64	Non-status	Client or Third Party **MHR** (if client has no income and is eligible for income assistance)	**MHR**

Key:

INAC indicates Indigenous and Northern Affairs Canada, BC Region

OAS/GIS indicates Old Age Security/Guaranteed Income Supplement

FNHA indicates the First Nations Health Authority, Health Canada

MHR indicates the provincial Ministry of Human Resources

Third Party Funding Agencies

Where the disability necessitating continuing care services is due to an illness or injury for which a third party is liable, the administering authority does not assume financial responsibility.

It is the responsibility of the applicant to inform the home and community care manager of the existence of, or a possibility of, a third party liability claim.

When there appears to be third party liability, the applicant is referred to the appropriate individual, agency or organization. The most common referrals involve Workers Compensation Board and the Insurance Corporation of British Columbia.

Financial Exemptions and Allowances

General Principle

A resident of a continuing care facility may be eligible for an earned income exemption and/or incentive, comforts and clothing allowance based upon their financial eligibility, as provided in Volume 2; Chapter 4, Eligibility.

Earned Income, Incentive, Comforts and Clothing Allowances

A resident of a continuing care facility may have an earned income exempted for a single person, as provided in Chapter 4 Vol. 1, Eligibility.

If the resident had been receiving financial support through the Persons with Disabilities (PWD) program prior to admission, the exemption level for a single handicapped person would apply.

A resident of a continuing care facility may be issued an incentive allowance, if the conditions specified in Chapter 9 Vol. 1, Special Allowances are met.

Residents of a continuing care facility who have no other means of providing for personal or recreational needs may be eligible for a comforts allowance or clothing allowance under Chapter 11.4 Vol. 1, Comfort Allowance and Clothing Allowance for Recipients in Special Care Facilities).

Payments under the Social Development Program (including PWD) to a client admitted to a continuing care facility shall cease with the payment made for the month in which the client is admitted.

In general, persons aged 65 or over are not eligible for the incentive, comforts or clothing allowances given that they are in receipt of old age security or the Guaranteed Income Supplement.

Other Services

Medical Services

In British Columbia, the First Nations Health Authority is ordinarily responsible for the provision of the following for status residents on reserve:

- Medications
- Dental services
- Prosthetic devices
- Medical transportation
- Other health care services

Any request or billing for such services received by the administering authority should be referred to the First Nations Health Authority as prior approval is required for some services.

INAC is responsible for provision of non-insured health benefits to eligible *non-status* residents on-reserve.

Temporary Absence

If a resident living in a continuing care facility is hospitalized in an acute care hospital, the administering authority may continue to pay the cost of the continuing care facility when there is a reasonable expectation that the person will return, and it appears necessary to hold the room during the person's absence.

Where a resident in a continuing care facility is able to visit relatives or friends, it is appropriate to continue to pay the approved daily rate.

Chapter 4: Adult Family Care Homes

Eligibility, Roles, and Responsibilities

Introduction

The *objective* of a family care home is to provide a protective and supportive environment within a *private family home* to eligible on-reserve elderly or disabled persons as an alternative to admission to a long term care institution. Family care homes are single family residences located on-reserve, intended for on-reserve adults who require 24 hour supervision outside their own home, and who choose to remain in their home communities. The family care home provides a homelike atmosphere, meals, and other housekeeping services, along with caring support and assistance with the activities of daily living to the elderly or disabled client.

The screening, approval, and monitoring of on-reserve family care home operators is the responsibility of the participating administering authority.

The administering authority must receive agreement to proceed from the INAC, BC Region *before* the home begins operation to ensure availability of funding. Funding of family care homes by INAC is subject to the availability of funding from annual parliamentary appropriations.

INAC will reimburse the administering authority the per diem and respite costs of maintaining eligible clients in approved on-reserve family care homes at a rate determined by the client's assessed level of care. The Local Health Authority is responsible for assessing the care levels of on-reserve persons requiring placement in residential care.

Staff of the Local Health Authority may provide advice and guidance to administering authority personnel during the establishment phase of individual on-reserve family care homes. Once the home is successfully established, the involvement of the Local Health Authority would diminish as staff of the administering authority assumes responsibility for the monitoring of the home.

Eligibility and Criteria

Residence and Citizenship

An applicant for an adult family care home must have permanent residence on-reserve at the time of application, and be a Canadian citizen, or be authorized under the Immigration Act to be a permanent resident of Canada.

Responsibility for the provision of residential care to First Nations persons in British Columbia is dictated by the individual's place of residence:

- eligible to apply to INAC:
  - registered, status Indians residing on-reserve at the time of application
  - non-status person residing on-reserve (*except individuals who are occupying commercial rental accommodation on reserve*)
- eligible to apply to the Continuing Care Division, Ministry of Health:
  - registered, status Indians residing off-reserve at the time of application
  - individuals who are not registered status Indians who are occupying commercial rental accommodation on-reserve

Age

An applicant for an adult family care home must be a person nineteen years of age and over who, by reason of incapacity, is assessed by the continuing care division as requiring placement in a residential care facility.

Roles and Responsibilities

The relationship between staff of INAC, the administering authority, and the continuing care division may vary due to local circumstances. Roles and Responsibilities provide a general description of key roles and responsibilities.

First Nations

The Administering Authority:

- Approves family care home based on information provided during the screening process

- Ensures that the service provider agreement is completed and signed by family care home operator
- Provides ongoing monitoring of the home
- Ensures collection of client daily user fee
- Reimburses the operator based on submitted claims for the number of days of occupancy at the rate established for the client's assessed level of care

The Band Social Development Worker:

- Completes the *Family Care Home Operator Approval Form* (DK02-01) and *Adult Family Care Home Approval Checklist* (DK02-02)
- Identifies eligible clients, and matches client and family care home operator
- Completes needs test, monitors care of individual and serves as link between client, family, and service provider

Ministry of Health, Continuing Care Division – Local Health Authority

The Continuing Care Manager may provide advice and liaison with the administering authority and INAC.

The Continuing Care Manager:

- Provides assessment and establishes level of care of prospective client
- May assist administering authority personnel to complete the *Family Care Home Operator Approval Form* (DK02-01) and *Adult Family Care Home Approval Checklist* (DK02-02)
- In cooperation with band social development worker, may assist in the assessment of the compatibility of home and prospective client
- May assist with ongoing monitoring, as appropriate

Indigenous and Northern Affairs Canada

The manager of the funding services directorate provides agreement to proceed with the placement of persons into a family care home following approval of the home by the administering authority, and based on the availability of funding, subject to annual appropriations by the Parliament of Canada.

The funding services officer approves reimbursement of per diem and associated charges based on the submission of billing from the appropriate administering authority.

Recruitment and Screening

Introduction

The recruitment and screening of potential family care home operators requires a cooperative effort between the Administering Authority and INAC.

Recruitment

The Administering Authority personnel are the best source of information regarding the availability of potential family care home operators on-reserve. They will provide leadership for the matching of operators and clients. The support of Chief and Council will be a crucial factor in the success of the home.

Before recommending approval, the Band Social Development Worker will ensure that the operator understands that operation of the home is ***client specific***, and placements in the home are dependent upon the successful matching of the operator and client.

The operator must clearly understand that there is no ongoing commitment or requirement by the Administering Authority or INAC to guarantee either full or continued occupancy of the home.

In the event that the client leaves the family care home, another placement will be made only if there is another client whose needs can be accommodated in the family care home setting, and if an appropriate client and operator match exists.

Family Care Home Operator Screening

As part of the screening process, a *Family Care Home Operator Approval Form* (DK02-01) will be completed by the Band Social Development Worker, or other staff as designated by the Administering Authority. A Continuing Care Case Manager may provide assistance and guidance to the staff responsible for completing this form, depending upon the relationship between the Administering Authority and the local office of the Continuing Care Division, Ministry of Health (Local Health Authority).

Information required for screening includes the following:

1. **References**

The Band Social Development Worker will request that the band Chief and Council provide a letter of support for the prospective operator.

Letters of reference, covering each of the three following areas, must be submitted to the Administering Authority for review prior to the authorization of a new family care home operator:

2. **Training or Experience**

It is expected that the applicants will have training in an appropriate field (e.g., Long Term Care Aide), or equivalent work experience. Individuals without formal training will be considered on an individual basis. Reference sources may include: previous or present employers or co-workers, well known community figures, band social development or health personnel, or volunteer coordinator.

3. **Financial**

The financial reference should indicate that the applicant has sufficient financial resources to meet the family's own needs and has a stable credit rating. Reference sources include a bank, credit union, or credit bureau.

4. **Personal Suitability**

Operators should be warm, caring individuals with a stable family life, and emotionally capable of caring for an additional individual. Desirable qualities include a friendly personality, a non-judgmental and accepting attitude, and a stable lifestyle. Reference sources may include a spiritual leader or well known elder, band chief or council member, teacher, or night school instructor.

5. **Criminal Record Search**

The applicant, spouse, and other adults living in the home must submit to a criminal record search.

Consent for Criminal Record Search must be signed by the applicant, and presented to the local police authorities. INAC will pay for the cost of the search.

Depending on the findings of the criminal record search, the Band Social Development Worker may be required to conduct a thorough investigation into the relevance of any record to the duties of a prospective family care home

operator. This information must be included in the documentation provided to the administering authority.

6. Health

The applicant will provide a letter from an accredited physician indicating that, in the physician’s judgement, the applicant is physically and emotionally capable of operating a family care home. The applicant is responsible for the cost of the physician’s examination if there is a fee for this service.

Applicants and other family members residing in the home will provide recent information indicating that they are free of tuberculosis. Testing can be done through a physician, the public health nurse at the local health unit, or a tuberculosis clinic.

7. Transportation

The applicant will possess a valid driver’s license, a vehicle in a reasonable state of repair, and adequate automobile insurance, or have ready access to a vehicle with the appropriate insurance coverage.

Approval of Homes

Family Care Home Approval Process

The approval of any proposed on-reserve family care home operator will be the responsibility of the Administering Authority

The screening of prospective family care home operators will be carried out by the Administering Authority. The following documentation must be completed:

- *Family Care Home Operator Approval Form* (DK02-01)
- *Adult Family Care Home Approval Checklist* (DK02-02)
- Letters of Reference
- Criminal Record Searches
- *Family Care Home Service Provider Agreement* (DK02-04)

The decision to proceed with the establishment of a family care home on-reserve requires agreement between the administering authority and the INAC, BC Region Funding Services Directorate. INAC must be informed prior to the establishment of a family care home **to ensure the availability of adequate funding**, based on annual parliamentary appropriations, to support the client in the family care home.

The Continuing Care Division, Ministry of Health (Local Health Authority) could provide staff of the Administering Authority valuable advice and guidance, particularly during the establishment of an on-reserve family care home. The involvement of the continuing care division in this process will depend on the relationship between the Administering Authority and the local Continuing Care Manager of the Local Health Authority.

Upon receipt of the required documentation, the Administering Authority will review the application, and may grant approval to the home if the required standards are met.

The Administering Authority shall finalize a service provider agreement with the family care home operator, outlining the responsibilities of each party. **No payment may be made by INAC for a client in a family care home** until the service provider agreement has been signed by the Administering Authority and the family care home operator, and reviewed by the Funding Services Directorate.

Following approval of the home and the service provider agreement, INAC may initiate a comprehensive funding agreement with the appropriate Administering Authority to provide for the payment of the per diem reimbursements, subject to availability of funding. The contribution funding agreement may be renewed annually, based on client needs and the availability of funding.

Family Care Home Approval Checklist

An *Adult Family Care Home Approval Checklist* (DK02-02) will be used on a pass-or-fail basis when first considering the home for approval. In most instances, the approval checklist will be completed by the Band Social Development Worker.

The checklist must be validated annually. When all relevant areas in the home have achieved a *pass* rating, both the operator and the band social development worker are to sign the document.

The home must meet acceptable standards in each of the following areas:

- Fire safety
- Outdoor environment
- General safety
- General cleanliness
- Living space
- Basic nutrition, food preparation, and meal planning
- Washing and toilet facilities
- Bedrooms
- Furnishings
- Insurance

Fire Safety

The local fire authority must be consulted to determine specific local requirements concerning fire safety.

The Band Social Development Worker must ensure that the home complies with these regulations with respect to smoke alarms, fire extinguishers, etc.

The band social development worker must also ensure that the prospective operator has a suitable fire evacuation plan. Whenever possible, this should be done in consultation with local fire authorities.

Outdoor Environment

The Band Social Development Worker must also ensure that the operator's yard will be safe for the client.

Particular attention must be paid to uneven surfaces and potential hazards such as ditches and wells.

The safety of the client who wanders needs to be a prime consideration.

General Safety

The Band Social Development Worker must approve the general safety of the home. This will include a check of floor surfaces, lighting, and stairs.

General Cleanliness

The Band Social Development Worker must approve the general cleanliness of the home, with particular attention to the kitchen and bathroom. Hygiene, rather than tidiness, should be the goal.

Living Space

The Band Social Development Worker must ensure that there is adequate space in the major living areas of the home to accommodate the client.

Particular attention must be paid to space factors if the client being considered uses mechanical assistance to walk, or needs special equipment such as a wheelchair.

Basic Nutrition, Food Preparation, and Meal Planning

The Band Social Development Worker will ensure that the prospective operator practices basic nutrition and standards set by the Canada Food Guide, or the Native Food Guide. Discussion with the prospective operators regarding meal planning will assist in evaluating their general knowledge and ability.

Washing and Toilet Facilities

There must be clean and safe bathing and toilet facilities, preferably on the same floor as the client's bedroom, and which allow safe and easy access by the client.

Bedroom

Each client shall be provided with a comfortably furnished single room, preferably on the main floor. The room will have a window and shall be warm, dry, well ventilated, and in a good state of repair.

Rooms in basements and those which are more than two stories above the ground must not be used for sleeping accommodation if such an arrangement could constitute a hazard in the event of an emergency.

Furnishings

The family care home shall provide a well furnished room with a comfortable bed, and adequate storage space for the exclusive use of each client.

If a locked drawer is not provided for the client, the operator must provide the client with alternative arrangements for safekeeping of valuables.

Where feasible, clients shall be given the option of using their own furniture if this does not constitute a hazard.

Insurance

The operator must hold valid personal liability, fire, and automobile insurance.

Financial Requirements

Per Diem Rates

Family care home operators are paid at a rate based on the client's assessed level of care as determined through an assessment conducted by the Continuing Care Division, Ministry of Health (Local Health Authority).

Once the client has been assessed and the family care home operator approved following the procedures described in Volume 2; Chapters 4.2 and 4.3, Community Social Services, reimbursement may be authorized by INAC's Funding Services Officer at the per diem rates outlined in Volume 2; Chapter 3 (Adult Institutional Care Services).

Family care homes are not permitted to charge room differentials.

Payments under the Social Development Program, including Social Assistance for Handicapped Persons (SAHP) or Persons with Disabilities (PWD), to a client admitted to a family care home shall cease with the payment made for the month in which the client is admitted.

The Funding Services Officer will establish a comprehensive funding agreement with the Administering Authority for the reimbursement of charges relating to the operation of the home.

The operator will bill the Administering Authority for the number of care days provided each month to the client. The administering authority will then reimburse the operator at the per diem rate established for the client by the Local Health Authority. The Administering Authority, in turn, will submit monthly billing to the INAC Funding Services Directorate for reimbursement.

User Fees or Accommodation Rate

Part of the cost of care in a designated family care home must be paid by a client who can afford to contribute financially, taking into account earned and unearned income in accordance with Volume 1; Chapters 4.8 and 4.9.

The daily user fee or accommodation rate to be paid by the client of a family care home is the same as that charged to a resident of an institutional care facility, as described in Volume 2; Chapter 3, Adult Institutional Care Services.

The Administering Authority is responsible for ensuring the monthly collection of the fee from the client.

INAC will pay the difference between the daily user fee and the rate determined by the client's level of care, as listed earlier in this Volume.

Earned Income, Community Volunteer Supplements, Comforts, and Clothing Allowances

A client of a family care home may have earned income exempted as a single person, as provided in Volume 1; Chapter 4. If the client had been receiving SAHP or PWD at the time of admission, the exemption level for a single in that category would apply.

The client may be issued an incentive allowance, if the conditions of Volume 1; Chapter 9, Community Volunteer Supplements are met.

Clients in a family care home who have no other means of providing for personal or recreational needs may be eligible for a comforts allowance, or clothing allowance, as provided in Volume 1; Chapter 5, Shelter Allowances.

Placement of Client

Number of Residents

Family care homes do not require licensing under the *Community Care Facility Act* because of the restriction in the number of clients.

The placement of **three or more** clients in a family care home **would contravene** legislation and would remove the home from designation as a family care home.

Most family care homes would be limited to one client. However, the placement of a second client in an approved family care home may be approved if, in the opinion of the Administering Authority, this would be beneficial to the client, the operator is deemed capable of caring for two clients, and the clients agree to the arrangement.

The Administering Authority must carefully consider the ability of the operator to handle the care needs of each client. Factors that need to be taken into consideration include the operators' physical health, whether they have a spouse or children to assist with the care, and the amount of space in the home.

In cases where extensive care is required, the band community health representative or the Medical Services Branch community nurse should be approached to provide regular medical support to the operator. Consideration may also be given to providing additional home support to an operator supporting a client with extensive care needs through the adult in-home care program, depending upon the requirements of the client and the availability of financial resources.

Relationship of Residents and Operators

The client being placed in a family care home **cannot be an immediate family member** (i.e., mother, father, daughter, son, grandmother, grandfather) to the operator.

An exception may be made on an interim basis to pay a family member prohibited by this policy only when the Local Health Authority has determined there is no qualified and available caregiver to meet a client's needs for one or more of the following reasons:

- Rural or remote location.
- Cultural barriers.
- Language barriers.
- Behavioural problems.

In addition to discussing the factors outlined above with the OSIL client or family care home operator, the Local Health Authority must assess each case individually and determine that:

- There have been proven attempts to find a caregiver that is not prohibited by this policy
- All alternative care/support options have been explored; barriers to accessing alternative options have been identified and addressed if possible;
- The client's care plan includes appropriate respite for the family member;
- The client's care plan includes strategies to ensure the client is included in the community and not isolated;
- In situations where one family member will be providing care/support, it is realistic and appropriate to have only one person meeting the needs of a person with complex care needs.

Lifestyles and Compatibility

The fit between the lifestyle, cultural and religious backgrounds of the client and the operator is the basis for making a placement. The Band Social Development Worker, client, and operator need to discuss lifestyle openly prior to the client’s admission to the home. The client and operator should also discuss visiting in the home by the client’s family and friends.

Behavioural Problems

The decision to place a client with behavioural problems in a family care home needs to be carefully discussed between the Band Social Development Worker and the operator.

The operator must be aware that the behaviour may not improve upon placement, and may even deteriorate. However, one of the major advantages of family care homes is that behaviour often improves when the client settles into a normalized family setting.

Safekeeping and Financial Affairs

The Band Social Development Worker must discuss the handling of money and safekeeping of valuables with the client and the operator, prior to placement.

Double Occupancy

Double occupancy may be approved if, in the opinion of the Band Social Development Worker, it is in the best interests of the two clients who will share the room.

The clients involved must be in agreement with this arrangement.

Right to Refuse Placement

Both the operator and the client have the right to refuse a placement in a family care home.

Operation of Home

Administering Authority Responsibility

Once the home is approved following the procedures outlined in other modules in *Social Development Policy and Procedures Handbook*, the Administering Authority is responsible for ensuring that family care home operators continues to deliver high quality service to the client entrusted to their care.

The Band Social Development Worker will visit the family care home on a **monthly basis** to ensure that the operator adheres to the responsibilities detailed in this module.

The Administering Authority will play a crucial role in supporting the family care home operator and in monitoring the operator's effectiveness as a care provider.

If the Band Social Development Worker or other staff of the Administering Authority suspects that the client is at risk, or that the client is receiving unsatisfactory service, they must immediately notify the administering authority who will take the necessary steps to resolve the situation.

Operator Responsibility

Family care homes funded by INAC are paid an established rate which recognizes the level of care required by the client. This rate *includes* the services, programs, and supplies listed later in this module, which are the responsibility of the home operator. *Such items must not be charged to the client*.

The examples cited in this section are provided for explanatory purposes only, and are not intended as an exhaustive list.

Medication

The operator is responsible for contacting the client's pharmacist for instructions regarding the various effects of any medications the client is required to take.

Operators must also ensure, through discussion with the pharmacist, that they understand the safe storage and handling of any medication or medical supplies needed by the client.

Meals and Therapeutic Diets

The operator must provide each resident with meals, including a therapeutic diet as required.

Diet Supplements

The operator must provide a house brand diet supplement (Ensure, Ensure Plus, Enrich, Promix, Sustacal, Sustain, etc.) if required by the client.

Dietary supplements should only be used when the client's medical condition precludes normal food intake, or requires extremely high doses of extra vitamins, minerals, fibre, etc., and should only be administered following **consultation with the client's personal physician**. It is expected that the diet supplement will be provided on a short term basis of up to one month.

Laundry Service

The operator must provide routine laundry services for the client's bedding and clothing. These services include laundry of such items as bed linens, towels and wash cloths, sleepwear, underwear, socks and stockings, shirts, and articles of clothing such as pants and coats, which can be washed without special attention to the laundering process.

General Hygiene Supplies

The operator must provide hygiene supplies for the general use of the client. This includes such items as soap, shampoo, toilet tissue, and facial tissue.

If a client requests a product, such as a special soap, other than the product routinely provided by the home, the client is responsible for payment.

Medical Supplies

In cooperation with the Medical Services Branch, Health Canada (for status persons), and the Administering Authority (for non-status persons), the operator will ensure that the following routine medical supplies are available to the client:

- Sterile dressing supplies
- Bandages, including elastic or adhesive
- Syringes (reusable or disposable)
- All catheters
- Disposable underpads for bed and chair use

Incontinence Care

The operator must establish and maintain a toileting program, such as routine toileting, for incontinence control, and where necessary provide a diapering system for the client.

In cooperation with the Medical Services Branch, Health Canada (for status persons), and the Administering Authority (for non-status persons), the operator will ensure that the following items are available to the client:

- underpads (reusable or disposable)
- briefs (reusable or disposable)
- inserts (reusable or disposable)
- catheters (indwelling, straight, catheterization tray, drainage tubing, drainage bag, irrigation set, irrigation solution, leg bag drainage set)
- condom drainage sets
- disposable gloves

Physical, Social, and Recreational Activities

The operator must provide an ongoing, planned program of entertainment, social functions, and recreational activities for the client. This may include activities such as exercise programs, traditional cultural events, concerts, community meetings, powwows, crafts, and bingo.

Transportation

The operator is expected to provide transportation to medical appointments, to pick up prescriptions, and to shop with the client for necessary items.

The operator will also be expected to provide transportation to some recreational and social activities, the frequency of which will have to be negotiated by the administering authority, operator, and client.

Any exceptional travel requirements are to be discussed with the administering authority.

Client Responsibility

The client is responsible for payment of all items and services not included in the home reimbursement rate.

Items to be charged to the client shall be charged at cost. The operator must not charge an administration fee for these items.

The examples of chargeable items in this section are provided for explanatory purposes only and are not intended as an exhaustive list.

Personal Hygiene and Grooming Supplies

The client is responsible for payment of all hygiene and grooming supplies for personal use, including those items which the client chooses in preference to a product or service which is provided by the operator. Personal use items may include deodorant, toothpaste, talcum powder, hand lotion, denture cleaner, comb and brush, hair shampoo and conditioner, and special soap.

Personal Dry Cleaning

The client is responsible for the cost of personal dry cleaning.

Personal Telephone and Television

The client is responsible for the cost of a personal telephone, and personal cable television, where the client has requested the service.

Personal Newspaper, Periodicals, and Smoking Material

The client is responsible for the cost of individual subscriptions to newspapers, magazines, and periodicals. The client is also responsible for the cost of personal cigarettes and snuff.

Transportation

The client is responsible for the cost of personal transportation for individual purposes.

Extra Craft Supplies and Activities

The client is responsible for the cost of any craft supplies, or entertainment and recreational activities which are required because of the client's personal preference, and which are in excess of the supplies and social functions routinely provided by the operator.

Personal Equipment

These items may be provided to the client by either the medical services branch or the administering authority depending upon the client's status.

Temporary Client Absences

If a family care home client is hospitalized in an acute care hospital, the Administering Authority may continue to pay the cost of care in the family care home when there is a reasonable expectation that the person will return to that home, and it appears necessary to hold the person's room during the absence.

Clients must also continue to pay the daily user fee during their absence from the family care home.

It is the responsibility of the family care home operator to maintain a record of all temporary absences and to report any temporary absences to the administering authority.

The effective date for reporting temporary absence shall in all cases be the first day of absence.

The Administering Authority shall notify the INAC Funding Services Officer of any period of paid temporary absence in excess of three days. INAC will reimburse the Administering Authority for absences in excess of three days only when prior notification has been given to the funding services officer.

The cumulative paid absences of a client due to reasons other than acute illness **shall be limited to 30 days** in any one calendar year.

Where the operator receives payment for a client who is absent from the family care home during a period of approved temporary absence, the client's room must be held.

When an operator fails to comply with the stated policy and a client is found to be absent for more than three days, the Administering Authority will ensure that payment is withheld for the number of days that the unauthorized absence exceeds three days.

Where protracted periods of absence without authority occur, the bed may be considered given up.

Funded Respite

INAC will provide funding so that family care home operators can purchase respite services. Funding for respite is paid by a special adjustment to family care home payments at the end of each quarter of the fiscal year.

The special adjustment is based on an allowance for each day during the preceding quarter that the family care home had a client.

When on respite leave, the operator continues to receive the INAC approved per diem rate for the client, including the allowance for respite, as well as the user fee paid by the resident.

In all situations, the family care home operator is responsible for paying the respite provider.

In arranging respite, the family care home operator may choose one or a combination of the following:

- In-home respite:
  - The family care home operator, in conjunction with staff designated by the Administering Authority, is responsible for recruiting, screening, and hiring workers to provide respite services in the family care home.
  - The operator should obtain the approval of the band social development worker before making a final hiring decision.
  - Respite workers that receive payment *must not be regular members of the family care home operator's household.*
- Out-of-home respite:
  - The operator may purchase out-of-home respite in either a licensed facility or another family care home, where this option is available and suitable and where the client agrees.
- Respite day care services:
  - With the approval of the Administering Authority, the Band Social Development Worker may arrange day care services for the client of a family care home.
  - The payment of any daily fees charged by the day care centre is the responsibility of the operator.

The following assist in planning for and payment of respite care:

- The operator will provide the Administering Authority with an outline of planned respite breaks for the upcoming fiscal year (see *Adult Family Care Home Planned and Actual Respite* (DK02-03) in Appendix 7 Vol. 1, Social Assistance Forms).
- At the end of each fiscal year, the operator will provide the Administering Authority with a report on the actual respite taken during the preceding 12 months (see Appendix 7 Vol. 3, Social Assistance Forms).

- The Administering Authority will review and approve the outline of planned respite breaks and reports on the previous year, and discuss any concerns with the operator.
- Operators are expected to take at least 24 days of respite per year. This amount is pro-rated, at two days per month, for family care homes operating part way through a fiscal year.
- One day of respite is considered to be 24 hours of continuous care.
- Operators should take respite on a reasonably regular basis, usually a minimum of one day of respite every month.
- A family care home operator’s respite funding may be discontinued if the administering authority finds that the operator is not using the funding to purchase an appropriate amount of respite.
- The operator’s annual report on the use of respite services will be forwarded to the INAC Funding Services directorate prior to the renewal of the comprehensive funding agreement.

Closure of Home

Client at Risk

If the Band Social Development Worker determines that a client in a family care home is at risk, the following steps must be taken:

- The Band Social Development Worker must notify the Administering Authority immediately.
- If the Administering Authority concurs with the appraisal of the situation, the Band Chief and Council must be notified and the client removed from the home immediately.
- The Administering Authority must immediately advise the INAC Funding Services Officer of the action taken.

Unsatisfactory Service

If, in the judgement of the Band Social Development Worker, an operator is not providing satisfactory service, the following steps must be taken:

1.) The Band Social Development Worker is to verbally advise the operator of the areas of service that must be improved.

2.) A period of time will be specified in which the operator will be expected to comply with the verbal notification.

3.) The verbal notification must be confirmed in writing by the Band Social Development Worker **within 3 days**.

4.) The Band Social Development Worker must revisit the home at the end of the specified period to ensure that the service is satisfactory.

5.) If the service is still not satisfactory, the Band Social Development Worker must serve written notice to the operators indicating that, if the situation is not corrected, their services may no longer be required.

6.) If service remains unsatisfactory, the Band Social Development Worker must notify the Administering Authority, who will verify the findings.

7.) If the Administering Authority is in agreement with the closure, the operators will be **served with 14 days written notice** that their services will be terminated.

8.) The INAC Funding Services Officer must be notified immediately.