



Indian and Northern
Affairs Canada

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Social Development Policy and Procedures Manual

BC Region

Volume 2 of 4

Assisted Living Program

For any additional information or if you have any questions on the Social Development Policy and Procedures Manual, BC Region, you may contact the Resource Centre, First Nations Social Development Society (FNSDS), through any of the following:

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Please note:

This program manual is an on-going document and will be updated from time to time. The latest version will be available on the FNSDS website: www.fnsds.org.

Hard copy updates will not be distributed to non-Administering Authorities, but may be printed from the FNSDS website.

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

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Volume 1 of 4–*Social Development Policy and Procedures Manual BC Region, Income Assistance Program*

Volume 2 of 4–*Social Development Policy and Procedures Manual BC Region, Assisted Living Program*

Volume 3 of 4–*Appendices*

Volume 4 of 4–*Social Development Policy and Procedures Manual BC Region, National Child Benefit Reinvestment Initiative*

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

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

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

Note: The Program Guide, along with the most recent Recipient Reporting Guide, which contains the INAC reporting forms and instructions, can be accessed on the INAC extranet site at <http://www.inac.gc.ca/extranet> password: bc.

All Income Assistance & Assisted Living forms can be downloaded, printed and saved from the FNSDS web site at www.fnsds.org

If an administering authority would prefer to receive a CD with forms, please contact FNSDS at 1-800-991-7099 or go to www.fnsds.org

Introduction to This Manual

Welcome to the *Social Development Policy and Procedures Manual* which has been divided into four binders, the Income Assistance Program under Volume 1, the Assisted Living Program under Volume 2, the Appendices under Volume 3, and the National Child Benefit Reinvestment Initiative under Volume 4.

These manuals are designed for those involved in administering the Social Development Program in BC. The program is administered by the federal Department of Indian Affairs and Northern Development (DIAND), which is also known as Indian and Northern Affairs Canada (INAC) and provides financial support to eligible individuals living on-reserve. The manual may also be useful to others involved in the delivery of socio-economic programs on-reserve.

Online Version of BC Region Manuals

Electronic copies of these manuals are posted to the First Nations Social Development Society's web site at www.fnsds.org or INAC Extranet web site at www.inac.gc.ca/extranet

- Select fiscal year
- Region: British Columbia
- Password: bc

Manual Amendments

Registered manual holders are workers that are directly involved in administering the DIAND Social Development Program in BC. All registered manual holders will receive regular amendments or updates to the manual.

Workers who receive a manual amendment are expected to read the cover letter describing the changes; then remove the old sections and insert the new ones with the changes marked on each page.

Each manual amendment package also includes a new table of contents and index. Workers are expected to check and ensure that the manual 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.

Manual Administrator

Contact the manual administrator if:

- The update packages are going to the wrong person.
- A worker is not getting update packages.
- There are missing sections of the manual, or some of the sections are out of date.
- A worker has found errors in the manual and forwarding findings.

SDPP Manual Administrator
Funding Services Programs and Partnerships
Indian and Northern Affairs Canada
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Vancouver, BC, V6E 4S3

What This Manual Contains

The Assisted Living manual, volume 2 is divided into a table of contents and 4 chapters. Each chapter is divided into a series of sections.

Table of Contents - provides heading for each chapter and section with current policy issue date.

Chapter 1, Introduction – serves as an introduction to the policies and procedures that are to be followed in the administration of the Social Development Program in the British Columbia Region.

Chapter 2, Homemaker Services – covers eligibility for homemaker services, client user charges, application process, rates, methods of payment, reviews, monthly reports and other support services.

Chapter 3, Adult Institutional Care Services – covers eligibility and admission criteria, application and review processes, responsibility of administering authority, levels of care, continuing care facility per diem costs, client user charges, responsibility for the payment of care facility per diem costs, financial exemptions and allowances and other services.

Chapter 4, Adult Family Care Homes – covers eligibility for adult family care homes, including recruitment and screening, approval of homes, financial requirements, placement of clients, operation of homes, and closure of homes.

Eligibility Criteria

General Principle

Homemaker services means the minimum set of household tasks required to maintain a safe and supportive environment for the client. Services may include: cleaning, laundry and meal preparation and by exception, transportation, banking or shopping. 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, thereby avoiding institutionalization.

Homemaker services are intended to:

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

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 service to be provided. The provision of service is based on available funding.

Philosophy

The underlying philosophy of the program is the belief that individuals are responsible, and wish to care for themselves and their families for as long as they are able to do so. The program is therefore supportive in nature, and provides services only to the extent that personal and family resources are unable to meet care needs.

The philosophy of the program is based on:

- the promotion of personal independence;
- the promotion of personal and family responsibility in planning and providing care;
- the encouragement of family and community involvement in providing care;
- the encouragement of a lifestyle consistent with community norms; and,
- working in partnership with other complementary programs and services offered by other federal government departments. For example, Veterans Affairs Canada and/or Health Canada's First Nations and Inuit Home and Community Care Program.

Eligibility

A person can only receive homemaker services if the person:

- is an eligible client;
- has been assessed as requiring homemaker services (see Chapter 1.2 vol. 2, Application Process); and,
- pays the daily client User Charge, if applicable (see Chapter 1.4 vol. 2, Client User Charges).

DIAND 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 at the time of application.

Health of the Applicant

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 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.

Access to Services

Administering authorities may provide homemaker services for eligible clients which are consistent with the following:

- Access to services is to be based on:
 - the client's health and functional status; and,
 - the availability of family and other community supports.
- Priority for service provision is to be given to clients who have been assessed as having the highest care needs or those who are living with the highest levels of risk.

Notwithstanding items #1 and #2, homemaker services may be denied, as a final resort, if providing service to the client puts the homemaker at risk.

Family Members Excluded from Providing Homemaker 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 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 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 of Veterans Affairs Canada.

Health Canada's First Nations and Inuit Home and Community Care Program

Health Canada's First Nations and Inuit Home and Community Care Program coordinates and links with existing programs and services at the community and/or provincial/territorial level.

The program is comprised of essential service elements and may be expanded to include supportive service elements provided the essential service elements are met. When communities already have all essential services through alternate sources, the program will not duplicate these services, but will allow communities to augment, through the supportive service components, the current services.

Essential service elements include:

- a structured client assessment process that includes on-going reassessment and determines client needs, family supports and service allocation. It is recommended that clients be assessed by an appropriately trained registered nurse;
- a managed care process that incorporates case management, referrals and service linkages to existing services provided both on and off reserve;
- home care nursing services that includes direct service delivery as well as supervision and teaching of personnel providing personal care services;
- the delivery of home support services that are determined by the community needs assessment plan and that do not duplicate, but enhance existing DIAND homemaker services. Home support covers a range of services such as personal care services (e.g. assistance with Activities of Daily Living such as bathing, grooming, dressing, care of bed bound clients including turning, back rubs and routine skin care, etc.) and home management (e.g. light housekeeping, laundry, meal preparation);

- provision of in-home respite care;
- established linkages with other professional and social services that may include coordinated assessment processes, referral protocols and service links with such providers as hospitals, physicians, respite and therapeutic services;
- provision of and access to specialized medical equipment, supplies and specialized pharmaceuticals to provide home and community care; and,
- a system of record keeping and data collection to carry out program monitoring, ongoing planning, reporting and evaluation activities.

For further information, please contact Health Canada's First Nations and Inuit Home and Community Care Program.

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 and the Insurance Corporation of British Columbia.

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 service 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 fundamental to the delivery of homemaker services. This process assists to:

- confirm the client's eligibility for homemaker services;
- identify and evaluate the needs, capabilities and potential of the individual;
- determine the appropriate level of care;
- determine the most suitable services, within available resources, to meet the individual's needs and to develop potential capabilities; and
- to develop an appropriate plan of service delivery for the client.

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

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 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 I and Part II of this form before a case file is opened.

Step 3

Once the individual has completed Part I and Part II of the application, the band social development worker will arrange for an assessor to determine the care requirements of the applicant.

The assessor may be a public health nurse, a community health nurse, a community health representative or other person 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 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 assessment 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 shared 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 III 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 IV of the *Application for Homemaker Services* (901-38). The worker must ensure that the applicant understands the purpose and content of the form, especially the arrangement for payment of services.

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. If no established agency exists in the locality,
- 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; and,
- limitations and exclusions on assets.

A client is not required to pay a daily User Charge for homemaker services if the client receives any of the following:

- the Guaranteed Income Supplement, the Spouse's Allowance or the Widowed Spouse's Allowance under the *Old Age Security Act* (Canada);
- DIAND's income assistance support and shelter allowance;
- DIAND's disability allowances under the Persons with Disabilities or the Persons with Persistent Multiple Barriers programs; or,
- a war veteran's allowance under the *War Veterans Allowance Act* (Canada).

Where both members of a couple are eligible for and receiving homemaker services, each member will have the full client rate charged. However, the administering authority will bill only one member of the couple per service day. When one member of the couple is:

- in hospital or care facility awaiting assessment;
- in hospital or care facility assessed for placement; or,
- resident in a care facility.

The financial assessment should be recalculated for the individual remaining in the home.

Administering authorities will calculate a revised client User Charge upon notification by the client that the client's or the spouse's net income has changed by 20% or more.

Rate changes are effective the first day of the month following the date the administering authority was notified by the client of the change in income.

Procedures

In assessing the amount of the daily User Charge that is 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 (Note: 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; and,
- 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			
<ul style="list-style-type: none"> • 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

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; and
- 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); and
- 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 *First Nations National Reporting Guide*.

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; and
- other programs.

See Chapter 1.7 Vol. 2, 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 the DIAND Funding Services Officer in their area 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

Eligibility and Admission Criteria

General Principle

The adult institutional care services program provides assistance to eligible residents living on-reserve who, by reason of incapacity, require placement in a licensed continuing care facility.

Eligibility criteria are set by the provincial Ministry of Health Services and DIAND, 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 DIAND for clients placed in designated continuing care facilities, subject to the clients meeting the eligibility criteria.

Conditions of Eligibility

The provincial Ministry of Health Services has established eligibility criteria related to the age, residency and health of the client.

Age

In order to apply for adult institutional care services, an individual must be 19 years of age or older.

Residency

An applicant for adult institutional care services must be resident on-reserve at the time of application, preceding placement, and be either a:

- Canadian citizen;
 - person who has received permanent resident authorization (landed immigrant status);
 - person who holds a Minister's Permit, granted by the Minister of Employment and Immigration from the Government of Canada and has been approved by the Medical Advisory Committee of the provincial Ministry of Health Services;
- or

- person who has been granted refugee status by Employment and Immigration Canada, except where a sponsorship is in effect (i.e., the individual has been admitted to Canada on condition that some other party, already in Canada, will provide necessary assistance to that individual for a specific period of time).

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

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

Health of the Applicant

Adult institutional care 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 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 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 local administering authority and DIAND, 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 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 band social development worker or the administering authority's health department will contact the local health authority's home and community care manager to request an assessment of the applicant.

Requests for assessment are prioritized by the local health authority 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 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; and, where appropriate
- complete a provincial *Application for Home Support* (LTC 10) form; and,
- complete a provincial *Financial Profile and Calculations* (HLTH 1.6) form and a consent of release of information from Canada Customs and Revenue Agency (CCRA) 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 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:

- the home and community care manager
- a home and community care case manager
- a psychiatric social worker (geriatric program) or boarding home social worker, Mental Health Services
- a representative from the band or administering authority

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

- a physiotherapist
- an occupational therapist
- a community home care nurse
- a community health representative
- a nutritionist
- the family physician
- the 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

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 to the continuing care facility, the band social development worker will assess the applicant to determine their eligibility for income assistance. Also, see Chapter 2.6 Vol. 2, Client User Charges for a list of programs where the applicant is exempt from the requirement to pay the daily User Charge. In these cases, DIAND will pay the User Charge.

Step 10

Prior to admission to a designated continuing care facility, the band social development worker 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: DIAND, BC Region Data Services Unit and the local Funding Services Officer. The dedicated reporting fax number is 604-775-7400.

Step 12

DIAND, 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 band social development worker will ensure that the client's case file includes:

- DIAND *Medical Release and Report (SA 115)*
- provincial *Application and Assessment (LTC 1)* form
- provincial *Mini Mental Status Examination (MMSE)* form
- a provincial *Financial Profile and Calculations (HLTH 1.6)* form
- DIAND *Adult Institutional Care & Adult Family Care Homes Client Admission Form*

- DIAND, 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 band social development worker will:

- submit an *Adult Institutional Care and Adult Family Care Homes Report* form on a monthly basis to DIAND, 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:

- the client
- a service provider
- a family member
- a physician
- a 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 provide these services.

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 administering 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, DIAND, 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.

DIAND 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 Chapter 2.1 Vol. 2, Eligibility and Admission Criteria.

DIAND 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.

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.

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; and
- 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; and
- have difficulty in orientation as to day, time, 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.

A person 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 person may:

- be a chronically psychiatrically disabled person who requires training for independent living; or
- 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 individual may:

- exhibit destructive, aggressive or violent behaviour;
- may continually wander away; or
- may endanger own life.

The individual 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 Chapter 2.7 Vol. 2, 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 services program, persons may be admitted to provincially licensed continuing care facilities.

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

The facility Per Diem Cost is paid by the client (User Charge) and the funding agency (Funding Agency Charge). See Chapters 2.6 Vol. 2, Client User Charges and 2.7 Vol. 2, Responsibility for the Payment of Continuing Care Facility Per Diem Costs.

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.

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 Chapter 2.6 Vol. 2, Client User Charges and 2.7 Vol. 2, 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

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

The local health authority under the policies of the provincial Ministry of Health Services calculates the daily client User Charge, annually, based upon the following individual income levels:

Table 1: Daily Client User Charges (effective January 1, 2009)

Remaining Net Income	Client User Charge
\$0.00 – \$7,000	\$30.90/day
\$7,000.01 – \$9,000	\$33.50/day
\$9,000.01 – \$11,000	\$37.20/day
\$11,000.01 – \$13,000	\$40.40/day
\$13,000.01 – \$15,000	\$44.90/day
\$15,000.01 – \$18,000	\$49.70/day
\$18,000.01 – \$21,000	\$54.30/day
\$21,000.01 – \$24,000	\$59.10/day
\$24,000.01 – \$27,000	\$63.90/day
\$27,000.01 – \$30,000	\$69.00/day
\$30,000.01 or more	\$74.30/day
Couples in receipt of GIS at the married rate & sharing a room	\$24.20/day
Persons with Disabilities Benefit	\$30.90/day

- 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 DIAND Income Assistance program (including the Persons with Persistent Multiple Barriers category) or DIAND's Social Assistance for Persons with Disabilities program; or a war veterans allowance under the *War Veterans Allowance Act*), their remaining annual income will be assumed to be \$7,000 or less if the client is residing in a continuing care facility.
- Clients with income less than \$7,000, and who are in receipt of Guaranteed Income Supplement (GIS) at the married rate are eligible for a subsidized rate of \$22.80 per day. The married rate applies only to married couples sharing the same room.
- Clients who receive an income benefit through the Persons with Disabilities program are eligible for a subsidized rate of \$21.90 per day.
- Clients receiving respite care pay the lowest rate. The respite care rate applies to all beds used for respite care in residential facilities.
- If the client is married, the rate will be the lower of the two rates determined using:
 - the client's financial information alone; or
 - the client's and spouse's financial information combined.

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 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 are paid by the daily client User Charge and a 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)	DIAND
19–64	Status or non-status	Client or Third Party DIAND (if client has no income and is eligible for income assistance)	DIAND

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 FNIHB (if the client has no income)	BC Medical—Hospital Programs
19–64	Non-status	Client or Third Party DIAND (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)	DIAND
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 DIAND (if client has no income and is eligible for income assistance)	DIAND
19–64	Non-status	Client or Third Party MHR (if client has no income and is eligible for income assistance)	MHR

Key:

DIAND indicates the Department of Indian Affairs and Northern Development, BC Region

OAS/GIS indicates Old Age Security/Guaranteed Income Supplement

FNIHB indicates the First Nations and Inuit Health Branch, 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 Chapter 4 Vol. 1, 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

The non-insured health benefits program of Health Canada's First Nations and Inuit Health Branch (FNIHB) is ordinarily responsible for the provision of medications, dental services, prosthetic devices, medical transportation and other health care services for status residents on-reserve. Any request or billing for such services received by the administering authority should be referred to FNIHB as prior approval is required for some services.

DIAND is responsible for provision of non-insured health benefits to eligible *non-status* residents on-reserve. For a full description of this program, see Chapter 10 Vol. 1, Health Benefits.

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.

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 DIAND, BC Region *before* the home begins operation to ensure availability of funding. Funding of family care homes by DIAND is subject to the availability of funding from annual parliamentary appropriations.

DIAND 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 Continuing Care Division, Ministry of Health is responsible for assessing the care levels of on-reserve persons requiring placement in residential care.

Staff of the Continuing Care Division 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 continuing care division would diminish as staff of the administering authority assume 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 DIAND:
 - 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 DIAND, the administering authority, and the continuing care division may vary due to local circumstances. Roles and Responsibilities provides 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

The continuing care manager may provide advice, and liaison to the administering authority and DIAND.

The continuing care case 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

Department of Indian Affairs and Northern Development

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 DIAND.

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 dependant 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 DIAND 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.

Screening includes references, criminal record search, health, and transportation.

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:

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.

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.

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.

Criminal Record Search

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

A Consent for Criminal Record Search must be signed by the applicant, and presented to the local police authorities. DIAND 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.

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.

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 DIAND, BC Region Funding Services Directorate. DIAND 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 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.

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 DIAND 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, DIAND 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.

Once the client has been assessed and the family care home operator approved following the procedures described in Appendix 8.3 Vol. 3, Community Social Services, reimbursement may be authorized by the funding services officer at the per diem rates outlined in Chapter 2 Vol. 2, 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 long term care assessment. The administering authority, in turn, will submit monthly billing to the DIAND 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 Chapter 4 Vol. 1, Eligibility.

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 Chapter 2 Vol. 2, Adult Institutional Care Services.

The administering authority is responsible for ensuring the monthly collection of the fee from the client.

DIAND 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 module.

Earned Income, Incentive, Comforts, and Clothing Allowances

A client of a family care home may have earned income exempted as a single person, as provided in Chapter 4 Vol. 1, Eligibility. 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 Chapter 9 Vol. 1, Special Allowances 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 Chapter 5 Vol. 1, 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 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 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
- and 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; and
- 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 both 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 Manual*, the administering authority is responsible for ensuring that family care home operators continue 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 DIAND 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. This includes 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 DIAND funding services officer of any period of paid temporary absence in excess of three days. DIAND 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

DIAND 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. The rate is \$7.12 per resident per day. This rate is to cover the costs of purchasing 24 days of respite over a one-year period.

When on respite leave, the operator continues to receive the DIAND 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 DIAND 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 DIAND 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 three 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 DIAND funding services officer must be notified immediately.