Ontario

Call for Applications to License Community Surgical and Diagnostic Centres for Orthopedic Services in Ontario

Application Form
Submission Deadline: August 27, 2025, 11:59PM

Ministry of Health

July 2, 2025

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INTRODUCTION

Call for Applications Notice
The Director of Integrated Community Health Services Centres (ICHSCs) has issued this Call for Applications in accordance with section 5 of the *Integrated Community Health Services Centres Act*, *2023* (ICHSCA), to consider the issuance of new ICHSC licences in accordance with section 6 of the ICHSCA.

The Call for Applications specifies the procedures required, the minimum eligibility requirements for Applicants and the deadlines by which the Applications must be submitted. This is **not** a procurement process. It is a Call for Applications process for the selection of Transfer Payment (TP) recipients and the Director has full discretion and decision-making power in the approval process.

Application Form
This Call for Applications to License ICHSCs for Orthopedic services in Ontario Application Form (Application) is to be completed by Applicants wishing to apply for an ICHSC licence under the ICHSCA. The term “Application” used in this document refers to the completed Application Form and the attachments required per the Application and Application Guidelines.

Application Guidelines
Instructions and helpful information for completing this Application are provided in the Call for Applications to License Integrated Community Health Services Centres for Orthopedic services in Ontario Application Guidelines (Application Guidelines). Applicants should refer to the Application Guidelines to ensure that their Application is complete.

Glossary of Common Terms
The Application Guidelines include a glossary of the common terms that are used throughout the Application and the Application Guidelines.

Notice of Collection of Personal Information
The Ministry collects the personal information provided in this Application, and any additional information submitted in connection with the Application, for purposes related to the administration of the ICHSCA per subsection 58(1) of the Act. The information will be used to assess the Applicant’s Application and to verify and monitor eligibility for licensing and operation of Centres under the ICHSCA.

The Applicant must ensure that all persons whose personal information is provided in the Application are made aware of this use of personal information.

If further information is required about this collection and use of information, Applicants may email ICHSC.Applications@ontario.ca .

Note that any information that the Director of ICHSCs collects in relation to an Application shall be deemed, for the purposes of section 17 of the *Freedom of Information and Protection of Privacy Act*,

to have been supplied in confidence to the Director, in accordance with subsection 19(3) of the ICHSCA.

APPLICATION COVER SHEET

Applicant Name(s):			
Email Address:			
Phone Number:			
Health Facility Name:			
Health Facility Address:			
Estimated Annual Service Volumes (Minimum and Maximum)[1]			
Proposed timing to begin providing services upon receiving conditional approval (MM-YYYY)[1]			
***Ontario Health Region* where the facility is located[2]**			
Type:	☐ Sole Proprietor	☐ Corporation	☐ Not-For-Profit
Only complete the below section if "Corporation" was selected above			
Corporation Information:	Corporate Name:	Corporate Number:	
Corporation Address:			

[1]To be completed based on response to Section 2.2 in the Application below.
[2]See Glossary of Terms in Application Guidelines for full definition.

APPLICATION QUESTIONS

1 Minimum Eligibility Requirements

Minimum eligibility requirements found below are foundational requirements that applicants must meet to be considered for licensing.

Please Note: If the applicant answers "No" to any of the questions included in the Minimum Eligibility Requirements, the application will not be considered for a licence.

1.1 Integrated Community Health Services Centres Act, 2023

Does the Applicant confirm that they comply with all requirements of the *Integrated Community Health Services Centres Act, 2023* (ICHSCA)?

☐ Yes ☐ No

1.2 Service Location

Does the Applicant fully understand that the licensed services must be performed in Ontario?

☐ Yes ☐ No

1.3 Accessibility for Ontarians with Disabilities Act

Does the Applicant confirm that the Health Facility will comply with the requirements of the *Accessibility for Ontarians with Disabilities Act, 2005* (AODA)?

☐ Yes ☐ No

1.4 Personal Health Information Protection Act

The *Personal Health Information Protection Act, 2004* (PHIPA) applies to the collection, use, and disclosure of personal health information by a Health Information Custodian such as an Integrated Community Health Services Centre (see s. 3(1)4 of PHIPA).

Does the Applicant confirm that they comply with the requirements of the *Personal Health Information Protection Act, 2004* (PHIPA) ?

☐ Yes ☐ No

1.5 Integrated Community Health Services Centres Surgical/Medical Standards

Does the Applicant agree to ensure that the Centre complies with all Standards established in the Integrated Community Health Services Centre Quality Assurance program under the Inspecting Body, Accreditation Canada, while operating an ICHSC?

☐ Yes ☐ No

1.6 Healing Arts Radiation Protection Act

Does the applicant confirm that they agree to comply fully with all requirements of the *Healing*

Arts Radiation Protection Act (HARPA) and regulations, including seeking any necessary approvals under HARPA, if applicable?

☐ Yes ☐ No

1.7 Pre-Licensing Inspection

Does the Applicant agree to comply fully with the mandatory pre-licensing inspection conducted by Accreditation Canada that is required, and that the Centre will need to successfully pass, if the applicant is offered a licence to become an Integrated Community Health Services Centre?

☐ Yes ☐ No

1.8 Ontario Fire Code Fire Safety, Emergency and Evacuation Planning

Does the Applicant confirm that they will abide by the Ontario Fire Code certified fire safety, emergency and evacuation planning for the Health Facility, including any related policies and procedures?

☐ Yes ☐ No

1.9 Hospital Site Location

Does the Applicant confirm that the Health Facility will not be located at or within the same building/premises/place where a public hospital site is operated under the *Public Hospitals Act*?

☐ Yes ☐ No

1.10 Infection Prevention and Control (IPAC)

Does the Applicant confirm that the Health Facility complies with and will continue to comply with public health directives, and any future public health requirements?

☐ Yes ☐ No

1.11 TPA Reporting and Data Collection

Applicants who are issued an ICHSC licence will be required to submit information in the format and frequency as specified in the Transfer Payment Agreement (TPA) that the Ministry will establish with the licensee. This may include requirements for data entry into specific information systems. Data and reporting may include, but is not limited to, the following information:

Type of Information

a) ICHSC service volumes
b) Staffing details (e.g., headcount and earned hours by employment status, occupational class)
c) Quality-based indicators (e.g., hospital admission rates, timely access to rehabilitation care)
d) Priority populations being served and how the Health Facility is meeting health equity needs
e) Financial report

Check “Yes” below if the Applicant agrees to the above data collection and reporting requirements and acknowledges that data collection and reporting requirements will be specified in the TPA:

☐ Yes ☐ No

1.12 National Ambulatory Care Reporting System (NACRS)

Applicants who are issued an ICHSC licence will need to provide data, as required, to the National Ambulatory Care Reporting System (NACRS), including reporting to the Canadian Joint Replacement Registry (CJRR). More information on the requirements for NACRS data submission is included here: NACRS. Please note that this may result in additional costs incurred to the successful Applicant.

Check “Yes” below if the Applicant agrees to submit data as required to the National Ambulatory Care Reporting System.

☐ Yes ☐ No

1.13 Wait Time Information System

Applicants who are issued an ICHSC licence will be required to connect, and remain connected, to the Ontario Wait Time Information System (WTIS) and work with Ontario Health to establish and maintain this connection as required. ICHSC licence holders will be expected to establish a secure connection between their local information system and the WTIS to facilitate data exchange. The licensee must also report wait times and efficiency data as required by WTIS reporting requirements. More information on the requirements to connect to the WTIS is included here: WTIS Connection Requirements

Check “Yes” below if the Applicant agrees to establish connection with the WTIS and support the integration and data reporting requirements including the costs associated with integration and reporting:

☐ Yes ☐ No

1.14 Other Health System Digital Connectivity and Data Reporting Requirements

Given evolving initiatives to bring greater connectivity and integration of patient care to Ontario’s health system, successful Applicants for an ICHSC licence may have other digital connectivity and data reporting requirements. Applicants may be required to participate in various initiatives as they are implemented in the system, such as participating in the centralized waitlist management program, the regional central intake program, the surgical efficiency target program, Ontario surgical quality improvement network and contributing to the provincial electronic health record, etc. Please note that these systems may result in additional costs incurred to the successful Applicant.

Check “Yes” below to confirm the Applicant’s understanding that part of future ICHSC licensing requirements can include additional digital connectivity and reporting requirements.

☐ Yes ☐ No

1.15 Facility Costs

Check “Yes” below to confirm the Applicant agrees to the Facility Costs currently payable for Orthopedic services detailed in the Application Guidelines and summarized below:

Primary Unilateral Hip Joint Replacement: $6,530
Primary Unilateral Knee Joint Replacement: $5,797

☐ Yes ☐ No

1.16 Patient Referral Pathway to a Centre

All patients receiving funded Orthopedic services at ICHSCs are required to be referred to the Centres from respective regional intake programs that are supported by Rapid Access Clinics (RACs). Check “Yes” below to confirm the Applicant has established a connection with and agrees to receive all patients through referral by a regional intake program, which has assessment support through RACs, as detailed in the Application Guidelines.

☐ Yes ☐ No

1.17 Hospital Partnerships

All Orthopedic Surgery ICHSCs will be required to demonstrate partnerships with at least one local hospital, as per the requirements specified in the Application Guidelines.
Check “Yes” below to confirm the Applicant will establish a partnership with at least one local hospital, prior to delivering ICHSC services as detailed in the Application Guidelines.

☐ Yes ☐ No

1.18 Post-Surgery Rehabilitation Services for Patients

All patients receiving funded Orthopedic services at ICHSCs, who clinically require it, are required to be provided with funded rehabilitation care after the surgical procedure, as specified in the Application Guidelines. Check “Yes” below to confirm the Applicant agrees to ensure they will provide rehabilitation services for all patients (who clinically require it).

☐ Yes ☐ No

1.19 Physician Privileges

Do all physicians proposed to be providing insured Orthopedic Surgery or Anesthesia at the ICHSC have active hospital privileges at a local hospital(s) to the ICHSC?

☐ Yes ☐ No

2 Service Delivery Requirements

Applicants will be asked to describe the services offered in the Centre, emphasizing how it will ensure patients receive connected and convenient care. A full list of Orthopedic services licensed under the ICHSCA can be found in the Application Guidelines.

2.1 Operating Timelines

What is the proposed timeline (measured in weeks) that the Health Facility will begin providing Orthopedic services upon issuance of a conditional ICHSC license (i.e., 4 weeks, 10 weeks, 30 weeks, etc.)? Provide an explanation of how this timeline is feasible. (max. 200 words)

2.2 Approximate Annual Volumes and Hours of Operation

Please provide the following information related to the Orthopedic services at the proposed Health Facility (max. 300 words):

- an approximation of both projected minimum and maximum volume of each Orthopedic procedure that could be provided annually at the proposed Health Facility;
- the number of Operating Rooms, pre-operative areas, post anesthetic recovery areas and/or multipurpose rooms;
- the average duration of time to complete each Orthopedic procedure;
- the approximate projected average number of each Orthopedic procedure provided per day;
- the proposed hours of daily operation; and
- the estimated days of operation per year.

Please include in the applicant's response any plan to provide services at the Health Facility during off-peak hours (e.g., evenings or weekends) to improve patient access to insured services.

2.3 Financial/Economic Assessment

Please provide details about the financial sustainability and feasibility of the proposed Health Facility. Please include reference to the facility costs ($6,530 for hip joint replacement and $5,797 for knee joint replacement) for Orthopedic services and the expected volumes of insured service delivery annually that the proposed Health Facility predicts it will need to be viable for at least the next five years, should it be licensed as an ICHSC. As part of your response, please ensure that you provide a full financial breakdown (max. 500 words).

Consider factors such as, but not limited to:

- Staffing costs (please refer to Section 6.1 for additional details required on the staffing plan)
- Operating hours and operating days
- Overall procedure volumes based on average daily procedure throughput rates
- Upfront investment to stand up the proposed health facility
- Overhead costs including connectivity to digital and data systems
- Uninsured services

Please Provide File Name:_____

2.4 Patient Referral Pathway to a Centre

All patients receiving funded Orthopedic services at ICHSCs are required to be referred to the Centres from respective regional intake programs that are supported by Rapid Access Clinics (RACs) following a medical determination that the patient is appropriate for the ICHSC setting. Provide details to confirm that all patients will be received at the centres via RAC referrals. This description should include (max. 500 words):

- A list of all RACs from which the centre may receive referrals, including the address of these clinics
- Evidence of established connections with these RACs and with the local regional intake program. This evidence can include letters of endorsement/agreement from the RACs or the regional intake program

Please Provide File Name:_____

2.5 Patient Pre-Operative Planning and Assessment

All patients that are receiving funded Orthopedic services at ICHSCs are required to receive pre-operative planning including a pre-operative assessment. Describe how the proposed Health Facility will organize appropriate pre-operative care and assessments, including (max. 500 words):

- What components will be included in pre-operative planning
- Where the assessment will be performed
- Which personnel/staffing roles will perform the pre-operative assessment
- What assessment tools will be used to support clinical evaluation in the pre-operative assessment (e.g., checklists)
- An outline of the alternative care pathway for patients who are deemed ineligible for surgery or not recommended for the orthopedic surgery to be performed at the proposed Health Facility

In the response, please also consider aspects of patient safety, readiness and multidisciplinary coordination, and how these will be addressed at the proposed Health Facility. Please note that Accreditation Canada Integrated Community Health Services Centres (ICHSC) Surgical/ Medical Standards for Orthopedic Services has guidelines for pre-operative planning and assessments at ICHSCs.

Please Provide File Name:_____

2.6 Post-Operative Patient Pathway

Orthopedic ICHSCs will be responsible for providing and organizing the patient's post-operative care and discharge from the Centre. Please describe the post-operative care plan for patients receiving Orthopedic Surgery at the Centre, including (max. 500 words):

- The physical space in the health facility where the patient will receive post-operative care, prior to being discharged
- The discharge plan and tools that will be leveraged to ensure patients are safely discharged from the Centre, including the staff responsible for overseeing discharge protocols
- The plan for obtaining any appropriate post-operative diagnostic imaging
- A description of the care pathway that patients will follow if hospital care is required, including a list of all local hospitals capable of receiving patient transfers and a description of the patient transfer process;
- A description of how, when, and where patients will receive follow-up care from the Orthopedic surgeon who performed the surgery at the Orthopedic ICHSC, post discharge, when applicable
- A description of how the Orthopedic ICHSC will capture Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) following patient discharge

Note: It is expected that all physicians who provide Orthopedic Surgery at the proposed Health Facility will have the capability to directly refer, admit and treat a patient who requires hospital care as a result of their hospital privileges with local hospitals. Please also note that the Accreditation Canada Integrated Community Health Services Centres (ICHSC) Surgical/ Medical Standards for Orthopedic Services has guidelines for post-operative patient care requirements for ICHSCs.

Please Provide File Name:_____

2.7 Post-Operative Rehabilitation Services for Patients

All patients receiving funded Orthopedic services at ICHSCs, who clinically require it, are required to be provided with funded rehabilitation care after the surgical procedure, as specified in the Application Guidelines. These rehabilitation services can include, but are not limited to, self-education, home-care rehabilitation and out-of-hospital/community-based rehabilitation. Please describe how the proposed centre will ensure effective and timely rehabilitation pathways for patients receiving funded Orthopedic Surgery. Where rehabilitation will be received in an out-of-hospital/community-based setting, please provide the following descriptions (max. 500 words):

- A list of all rehabilitation clinics to which the Centre may refer patients, including the addresses of these clinics and a description of the type of rehabilitation services offered
- Evidence of established connections with these rehabilitation clinics. This evidence can include letters of endorsement/agreement from the rehabilitation clinics to receive referrals from the Centre

In the response, please also consider aspects of rehabilitation such as programming that can be offered by the Centre directly, including self-education for patients, in-house rehabilitation services and virtual/tele-rehabilitation services.

Please Provide File Name:_____

3. Quality Assurance Program

Under the ICHSCA, licensed ICHSCs are required to comply with the established quality assurance inspection framework and facility standards for services provided in the Centre. Accreditation Canada has developed quality and safety standards for ICHSCs providing licensed surgical services.

Accreditation Canada is also appointed as the Inspecting Body under the ICHSCA for proactive and reactive quality assessments and inspections, including pre-licensing inspections.

Successful Applicants that are conditionally approved will be required to prove that they comply with the established Orthopedic Standards through a pre-licensing facility quality inspection that is required for any Applicant offered a licence. The pre-licensing quality inspection occurs in two components:

A. an inspection of the facility prior to the licence being issued and the provision of service; and

B. six months after the provision of services where patient records and imaging results are inspected.

Please refer to the Application Guidelines for additional information regarding the Accreditation Canada Quality Assurance Program.

3.1 Quality Assurance Advisor

If the Applicant is successful and an ICHSC licence is issued, the ICHSCA requires that every licensee appoint a Quality Assurance Advisor to advise the licensee with respect to the quality and safety standards of services provided in the ICHSC. The Quality Assurance Advisor must be a physician who ordinarily provides insured Orthopedic services in or in connection with the ICHSC and whose training enables them to advise the licensee with respect to the quality and safety standards of services provided in the facility. The Quality Assurance Advisor will also be required to have active hospital privileges at local hospital(s). Please see ss. 7-9 of O. Reg 215/23 under the ICHSCA for full details regarding the requirements and obligations of a Quality Assurance Advisor.

Provide the name and information of the proposed quality assurance advisor:

Quality Assurance Advisor's Name:	
CPSO Physician Licence #:	
Ministry Issued Solo Billing Number:	
Hospital where the Quality Assurance Advisor has active privileges	
Phone Number:	
Email Address:	

By providing the information above, the Applicant acknowledges that the proposed quality assurance advisor has been informed of and is aware of the obligations of a Quality Assurance Advisor set out in s. 7 of O.Reg. 215/23 of the ICHSCA.

Please provide a description of the qualifications of the Quality Assurance Advisor. The response should include professional experience, academic affiliations and any other qualifications for the role (max. 300 words).

3.2 Infection Prevention and Control (IPAC) Plan

The Applicant must attach the current or proposed IPAC and Medical Device Reprocessing (MDR), and if applicable, clinic policy for the Health Facility.

Please Provide File Name:_____

4 Business, Clinical and Professional Experience

The Applicant will be asked to provide an overview of business, clinical and professional experience, including how all governance and management responsibilities of the proposed Health Facility will be met.

Please Note: When providing information about an officer, director or any person with an interest affecting control of the corporation or administrator (individual who will oversee day-to-day operations) in the Application, it is the Applicant's responsibility to ensure everyone's consent is obtained to provide the information. By providing the information on behalf of the officer, director or any person with an interest affecting control of the corporation or administrator, the Applicant is thereby indicating that all necessary consents have been obtained from each member.

4.1 Business and Criminal/Regulatory Offence History

Please check "Yes" or "No" to answer the following questions and attach the required documentation to the Application per the "Action Required" instructions where the answer is "Yes":

Question	Answer	Action Required (if Answer is "Yes")
a) Facility Operations Experience: Has the Applicant, or any officer, director or any person with an interest affecting control of the corporation or administrator ever operated or provided services to or in a licensed ICHSC or other Health Facility in Ontario or any other jurisdiction?	☐ Yes ☐ No	Please attach a separate sheet and provide the details about the operation of, or provision of services to, the facility for each applicable person. **Please Provide File Name(s):** _____
b) Bankruptcy/Receivership History: Has the Applicant, or any officer, director, or any person with an interest affecting control of the corporation or administrator made an assignment, proposal, compromise or arrangement for the benefit of creditors, or been petitioned into bankruptcy, or filed for the appointment of a receiver in the last five years?	☐ Yes ☐ No	Please attach a separate sheet and provide the details about the occurrence for each applicable person. **Please Provide File Name(s):** _____
c) Criminal or Regulatory Offence History: Has the Applicant, or any officer, director, or any person with an interest affecting control of the corporation or administrator been convicted of a criminal or regulatory offence for which a pardon/record suspension has not been granted, resulting in any disciplinary action, reduced scope of practice or loss of privileges?	☐ Yes ☐ No	Please attach a separate sheet for each applicable person and provide information for the following headings: 1) Convicted Person's Name, 2) Nature of the Conviction, 3) Date of the Conviction, and 4) Result of the Conviction **Please Provide File Name(s):** _____
d) Facility Licence Suspension History: Has the Applicant, or any officer, director or any person with an interest affecting control of the corporation or administrator ever operated or provided services in a licensed ICHSC or Health Facility in Ontario or any other jurisdiction, where the facility licence was suspended, revoked or not renewed?	☐ Yes ☐ No	Please attach a separate sheet and provide details about the licence suspension, revocation or non-renewal for each applicable person. **Please Provide File Name(s):** _____

e) Professional Discipline History: Has the Applicant, or any officer, director or any person with an interest affecting control of the corporation or administrator ever been subject to regulatory or professional disciplinary proceedings by any regulatory body in Ontario or other jurisdiction, resulting in disciplinary action.	☐ Yes ☐ No	Please attach a separate sheet and provide details about the adverse findings for each applicable person. **Please Provide File Name(s):**

4.2 CPSO Certificate of Professional Conduct

The Applicant should initiate an institutional request for a Certificate of Professional Conduct (CPC) to be issued by the College of Physicians and Surgeons of Ontario (CPSO) to the Director of ICHSCs, Ontario Ministry of Health for the Applicant, if registered with the CPSO, and any officer or director of the corporation or administrator who is registered with the CPSO. Ensure that the CPSO has the correct addressee information for the ICHSC Application Contact as listed in the Application Guidelines.

The Institutional Request must be submitted for:

a) the Applicant, if registered with the CPSO; and
b) any officer or director or administrator of the corporation who is registered with the CPSO.

The institution email address for the CPSO to issue the CPC is ICHSC.Applications@ontario.ca:

Has the Applicant initiated a CPC request for the Applicant and for each officer or director of the corporation or administrator, as applicable?

☐ Yes ☐ No

Note: By indicating "No" above, the Applicant acknowledges that the Director will **not** issue an ICHSC licence if any required CPC is outstanding.

Please list all officers, directors of corporation, or administrators who will be submitting a CPC request relevant to this application:

Full Name:	
Full Name:	
Full Name:	
Full Name	
Full Name:	
Full Name:	

4.3 Legal Status

Indicate legal status of the Applicant (check one) and complete the tables in section 4.3, as applicable:

☐ Sole Proprietor

☐ Corporation (including Not-for-Profit)

Please complete the below sections as applicable.

a) Sole Proprietor

Complete this section if the proposed Applicant is a Sole Proprietor.

Table 1: Sole Proprietor Information

Full Name:	
Is the Sole Proprietor a physician in the province of Ontario?	☐ **No** ☐ **Yes, specify Ministry assigned billing number #_____**
Street Address:	
City/Town:	
Province:	
Postal Code:	
Telephone Number:	
Fax Number:	
Email Address:	
Website URL (if applicable)	

b) Corporate Ownership

Complete this section if the proposed Applicant is a corporate applicant, including a not-for-profit corporation.

Please complete the Legal Status Summary table below for every person in the corporation with beneficial ownership or control as detailed in the Application Guidelines and attach a copy of the Certificate of Incorporation/Letters Patent. Please complete Table 2 for the applicable number of person(s) involved in the corporation.

Table 2: Legal Status Summary

Full and complete legal name of Applicant (exactly as set out in Articles of Incorporation or other applicable legal document):	
Date of Incorporation:	
Name under which Applicant is carrying on business (if different from the legal name):	
Corporation is (check one):	☐ **Public** ☐ **Private** ☐ **Not-for-Profit**
Corporate Address:	
Street Number and Name:	
City/Town:	

Postal Code:	
Telephone Number:	
Fax Number:	
E-mail Address:	
Address where notice may be given (if different from above):	
Website URL (if applicable)	

Full and complete legal name of Applicant (exactly as set out in Articles of Incorporation or other applicable legal document):	
Date of Incorporation:	
Name under which Applicant is carrying on business (if different from the legal name):	
Corporation is (check one):	☐ **Public** ☐ **Private** ☐ **Not-for-Profit**
Corporate Address:	
Street Number and Name:	
City/Town:	
Postal Code:	
Telephone Number:	
Fax Number:	
E-mail Address:	
Address where notice may be given (if different from above):	
Website URL (if applicable)	

Full and complete legal name of Applicant (exactly as set out in Articles of Incorporation or other applicable legal document):	
Date of Incorporation:	
Name under which Applicant is carrying on business (if different from the legal name):	
Corporation is (check one):	☐ **Public** ☐ **Private** ☐ **Not-for-Profit**
Corporate Address:	
Street Number and Name:	
City/Town:	
Postal Code:	
Telephone Number:	
Fax Number:	
E-mail Address:	

Address where notice may be given (if different from above):	
Website URL (if applicable)	

Full and complete legal name of Applicant (exactly as set out in Articles of Incorporation or other applicable legal document):	
Date of Incorporation:	
Name under which Applicant is carrying on business (if different from the legal name):	
Corporation is (check one):	☐ **Public** ☐ **Private** ☐ **Not-for-Profit**
Corporate Address:	
Street Number and Name:	
City/Town:	
Postal Code:	
Telephone Number:	
Fax Number:	
E-mail Address:	
Address where notice may be given (if different from above):	
Website URL (if applicable)	

Full and complete legal name of Applicant (exactly as set out in Articles of Incorporation or other applicable legal document):	
Date of Incorporation:	
Name under which Applicant is carrying on business (if different from the legal name):	
Corporation is (check one):	☐ **Public** ☐ **Private** ☐ **Not-for-Profit**
Corporate Address:	
Street Number and Name:	
City/Town:	
Postal Code:	
Telephone Number:	
Fax Number:	
E-mail Address:	
Address where notice may be given (if different from above):	
Website URL (if applicable)	

1. Shareholding Structure

Please provide a description of the shareholding breakdown for the corporation.

Voting Shares	Classes of Voting Shares			
a) Identify authorized classes				
b) Number of shares authorized				
c) Number of shares issued				
d) Number of voters per share				
e) Total number of votes – by class				
f) Total number of votes – all classes				

List the names of the person(s)/corporation(s) who alone, or with associate(s), directly or indirectly beneficially own(s) or control(s) sufficient voting shares to direct management and policies of the applicant corporation.

Beneficial Ownership

Table 3: Beneficial Ownership or Control

List all person(s)/corporation(s) who directly or indirectly own or control voting shares. Copy and complete this page as many times as may be necessary to identify the ultimate owner/parent of the proposed applicant corporation.

Full Name:	
Is shareholder a physician in the province of Ontario?	☐ Yes ☐ No
Billing Number (if applicable):	
Street Address:	
City	
Province	
Postal Code	
Telephone Number	
Total No. of Voting Shares Held	
% of Total Voting Shares:	
Association with other Shareholders:	☐ Yes ☐ No
Name of Association(s) (First & Last name)	

Nature of Association	

Full Name:	
Is shareholder a physician in the province of Ontario?	☐ Yes ☐ No
Billing Number (if applicable):	
Street Address:	
City	
Province	
Postal Code	
Telephone Number	
Total No. of Voting Shares Held	
% of Total Voting Shares:	
Association with other Shareholders:	☐ Yes ☐ No
Name of Association(s) (First & Last name)	
Nature of Association	

Full Name:	
Is shareholder a physician in the province of Ontario?	☐ Yes ☐ No
Billing Number (if applicable):	
Street Address:	
City	
Province	
Postal Code	
Telephone Number	
Total No. of Voting Shares Held	
% of Total Voting Shares:	
Association with other Shareholders:	☐ Yes ☐ No
Name of Association(s) (First & Last name)	
Nature of Association	

Full Name:	
Is shareholder a physician in the province of Ontario?	☐ Yes ☐ No

Billing Number (if applicable):	
Street Address:	
City	
Province	
Postal Code	
Telephone Number	
Total No. of Voting Shares Held	
% of Total Voting Shares:	
Association with other Shareholders:	☐ Yes ☐ No
Name of Association(s) (First & Last name)	
Nature of Association	

Full Name:	
Is shareholder a physician in the province of Ontario?	☐ Yes ☐ No
Billing Number (if applicable):	
Street Address:	
City	
Province	
Postal Code	
Telephone Number	
Total No. of Voting Shares Held	
% of Total Voting Shares:	
Association with other Shareholders:	☐ Yes ☐ No
Name of Association(s) (First & Last name)	
Nature of Association	

2. Membership Structure

Please provide a description of the membership structure if the Applicant is a not-for-profit corporation (e.g., type of membership structure, voting rights for classes of members, etc.), (max. 200 words):

4.4 Business and Professional Experience

Please provide an overview of the business and professional experience of the Applicant, the officers or directors or any person with an interest affecting control of the corporation (if applicable) (max. 200 words per person).

Please Provide File Name: _____

4.5 Organizational Chart

Please **attach** an organizational chart for the proposed Health Facility.

Please Provide File Name:_____

4.6 Providers

Provide the names and Ministry issued solo billing numbers of all physicians who will be providing Orthopedic Surgery and Anesthesia in the proposed Health Facility. Please indicate the category of privileges at a local hospital(s) of each physician. Please note that the Quality Assurance Advisor and all physicians who will be providing Orthopedic Surgery and Anesthesia at the proposed Health Facility must have active hospital privileges.

Physician Name (First Name, Last Name)	Physician Role in Health Facility	Ministry Issued Solo Billing Number	CPSO Registration Number	List of Hospital(s) with Privileges and Category of Privileges (e.g., Active)

4.7 Oversight of the Proposed Health Facility

Identify the individual who will oversee day-to-day operations.

Full Name:	
Phone Number:	
Email Address:	

4.8 Officers and Directors

Complete the table below for **each** officer and director of the corporation if the proposed Health Facility is owned by a corporation.

Use the following letter code for main position held: (A) Chairman of the Board, (B) President, (C) Vice President, (D) Treasurer, (E), Secretary, (F) Comptroller, (G) Auditor, (H) Other - specify

Name:	
CPSO Physician Licence # (if applicable):	
Ministry Assigned Billing # (if applicable):	
Address:	
Phone Number:	
Email:	
Proposed position in ICHSC:	
Key Functions of position:	

Name:	
CPSO Physician Licence # (if applicable):	
Ministry Assigned Billing # (if applicable):	
Address:	
Phone Number:	
Email:	
Proposed position in ICHSC:	
Key Functions of position:	

Name:	
CPSO Physician Licence # (if applicable):	
Ministry Assigned Billing # (if applicable):	

Address:	
Phone Number:	
Email:	
Proposed position in ICHSC:	
Key Functions of position:	

Name:	
CPSO Physician Licence # (if applicable):	
Ministry Assigned Billing # (if applicable):	
Address:	
Phone Number:	
Email:	
Proposed position in ICHSC:	
Key Functions of position:	

Name:	
CPSO Physician Licence # (if applicable):	
Ministry Assigned Billing # (if applicable):	
Address:	
Phone Number:	
Email:	
Proposed position in ICHSC:	
Key Functions of position:	

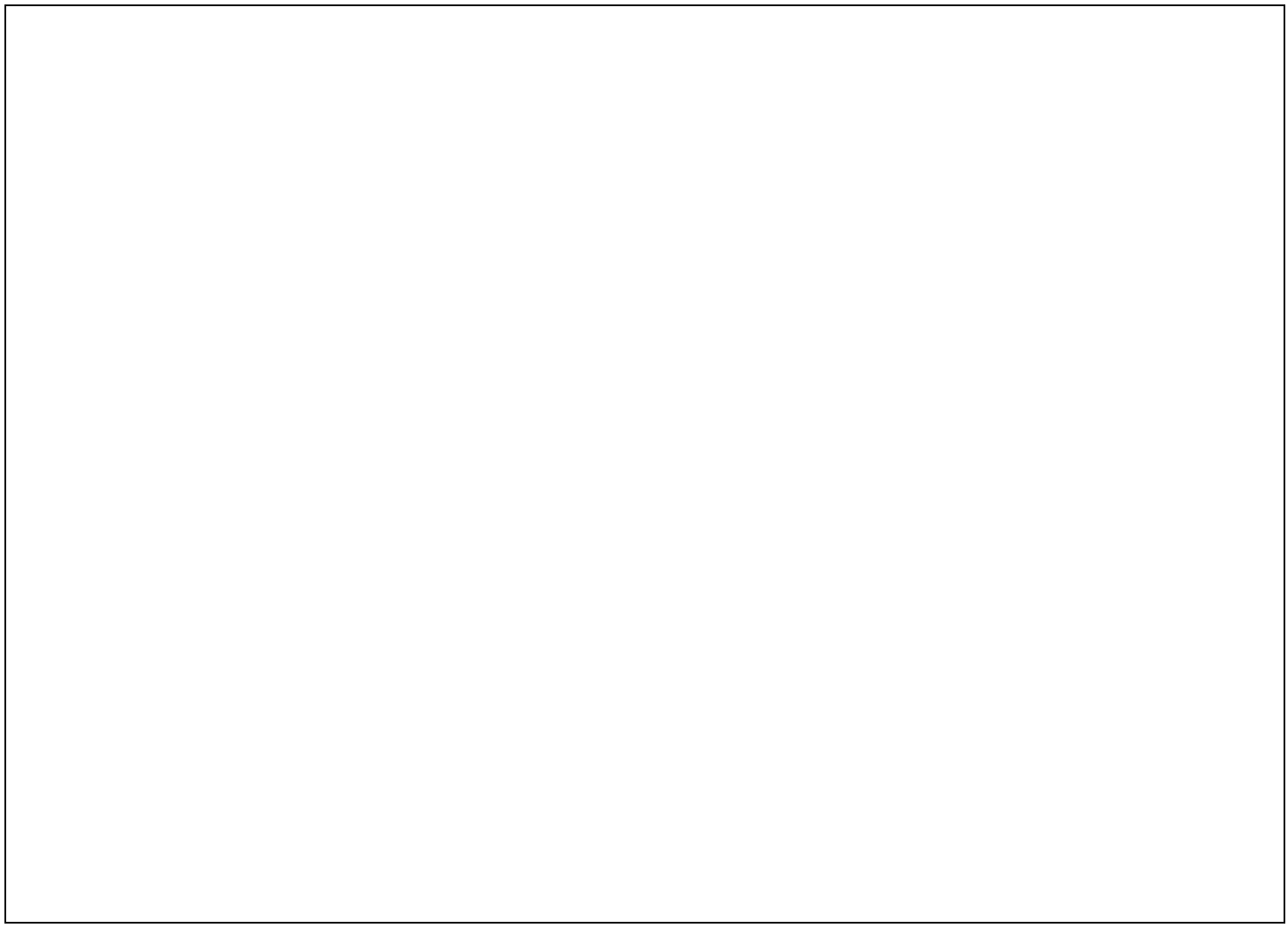
Name:	
CPSO Physician Licence # (if applicable):	
Ministry Assigned Billing # (if applicable):	
Address:	
Phone Number:	
Email:	
Proposed position in ICHSC:	
Key Functions of position:	

Name:	
CPSO Physician Licence # (if applicable):	
Ministry Assigned Billing # (if applicable):	
Address:	
Phone Number:	
Email:	
Proposed position in ICHSC:	
Key Functions of position:	

Name:	
CPSO Physician Licence # (if applicable):	
Ministry Assigned Billing # (if applicable):	
Address:	
Phone Number:	
Email:	
Proposed position in ICHSC:	
Key Functions of position:	

4.9 Leadership and Oversight

The Applicant must describe how the officers or directors and management team identified in the organizational chart will meet all governance and management responsibilities of an ICHSC including, but not limited to, the decision-making process, financial accountability, clinical, educational, operational (including development and management, quality assurance) and human resources requirements. Please describe the leadership and oversight of the proposed Health Facility (max. 200 words).



4.10 Management and Administration Continuity Plan

Applicants must describe a continuity plan for the proposed Health Facility's operations to ensure that the clinical and business expertise that has been proposed in the Application will be maintained should there be changes to the membership of the management team or the officers or directors of the corporation. Provide a description of the Applicant's continuity plan for the proposed Health Facility as detailed in the Application Guidelines (max. 200 words).

5. Health Facility Location

Applicant will be asked to provide details of the physical location of the proposed Health Facility, including its address and distance to other Health Facilities that provide Orthopedic services.

5.1 Health Facility Location

Please attach a current or proposed map, which includes a distance scale and north arrow, showing the following:

a) The catchment zone of the Health Facility,
b) The location of the Health Facility,
c) The location of the hospital(s) that may receive transfers from the Health Facility and that the ICHSC is partnered with,
d) The location of current and potential referring health care providers (RACs) and any other relevant health system partners that the Centre may partner with in the delivery of services, such as rehabilitation clinics where ICHSC patients may also receive services.

If available, please provide a floor plan for the proposed facility that includes identification of all relevant areas (e.g., operating room(s), medical device reprocessing, pre-operative, post anesthetic recovery, office, etc).

Please Provide File Name:_____

6. Staffing Model

Applicants will be asked to provide a detailed staffing model for the proposed ICHSC and evidence of its sustainability.

6.1 Staffing Plan

Provide a comprehensive staffing plan for the Health Facility, including (max. 1000 words):

a) Staff organization chart including position classification with rates of compensation and ranges of compensation, as applicable;
b) The number of staff required for each position;
c) Nursing expertise, including details of relevant experience for all nurses providing Orthopedic services;
d) Staff role functions, caseloads and continuity of services,
    i. *Functions:* A description of each of the staff members' functions and type (i.e.; clinical, administrative, educational/research) in the proposed Health Facility. Identify anticipated use of non-physician staff (i.e., RN, RNA, anesthesia assistants) in a team-oriented, inter-professional model for delivery of care.
    ii. *Caseload:* Proposed time commitment of physicians and other staff at the Health Facility; information on the average caseload for physician(s) and other health care providers.
    iii. *Continuity of Services:* How continuity of services will be managed at the proposed Health Facility.
e) Any new employee recruitment required,
    i. Will the Applicant be required to recruit employees in order to provide the service volumes described in question 2.3 of the Application?

        ☐ Yes ☐ No

    ii. If yes, please describe:

- The number of employees (in full time equivalent), including their classification, that the Applicant will need to recruit in order to provide the service volumes described in question 2.3 of the Application.
- How the Applicant plans to recruit employees including specific geographic regions where employees may be recruited from with consideration of current local constraints on health human resources (HHR).
- How the Health Facility will factor equity, diversity and inclusion considerations into the recruitment of new employees.
- For physicians employed by the Health Facility, please describe the physician affiliation plan including:
    a. The number and specialty of physicians who are onsite and immediately available to provide patient care and support urgent clinical issues; and
    b. The number and specialty of physicians who may be off-site but available to provide patient care and support urgent clinical issues

Please Provide File Name:_____

6.2 Sustainability of Staffing Plan

Please describe the sustainability of the staffing plan, showing evidence of partnership(s) or coordination with local and/or regional hospital(s) to develop a staffing plan that demonstrates HHR collaboration and preservation across institutions (max. 500 words).

Please Note: The staffing plan should ensure that health care staff can practice to their full scope of practice, in a safe and healthy workplace. An Applicant is required to demonstrate, through the staffing plan, how the proposed Health Facility will efficiently and effectively maintain operations and foster and build an inter-professional care team with regional Health System Partners. The Applicant should demonstrate any upskilling or training programming built into the proposed Health Facility's staffing program. The Applicant should also demonstrate any cross-training and/or rotation plans that have been built in partnership with training institutions and regional service sites to support HHR training and preservation across the system.

7. Health System Linkages

The Applicant should provide a description of how they have consulted with health system partners in the development of the application, including any endorsement of the application by health system partners. Health system partners who are submitting applications to this Orthopedics Call for their own health facility are also able to endorse other applicants who are responding to this Call.

7.1 Hospital Partnerships

All Orthopedic Surgery ICHSCs will be required to establish and maintain partnerships with at least one local hospital prior to delivering ICHSC services, as per the requirements specified in the Application Guidelines. Please provide a description of any partnership(s), including (max. 300 words):

- A list of all local hospitals with which the Applicant will establish a partnership(s)
- A description of the proposed or agreed upon terms and conditions of the partnership(s)
- Evidence of proposed or established partnership(s) with these local hospitals. This evidence can include letters of intent, or agreement/partnership from the local hospitals

Alternatively, if the proposed Health Facility does not currently have hospital partners, please describe the efforts made to establish these partnerships. Additionally, provide reasons and evidence for any challenges faced in establishing these partnerships. (max. 300 words)

Please Provide File Name:_____

7.2 Build and Maintain Health System Linkages

Provide a description of how the proposed Health Facility will establish and/or continue to maintain health system linkages with health sector partners including if the applicant is successful in obtaining an ICSHC licence (e.g., Ontario Health, Ontario Health Teams, primary care providers, training/educational institutions, etc.). Please provide evidence of existing linkages with health sector partners or collaborations in the form of letters of endorsement/agreement (max. 500 words).

In addition to the established connections with Rapid Access Clinics (RACs), rehabilitation clinics and local hospitals, please outline any additional partners or collaborations and indicate in the list below what type of provider.

☐ Indigenous and priority populations partnership (see section 8.1 for a full list of these priority population groups)
☐ Educational partnership
☐ Providers partnership
☐ Other partnership, please specify _____

Alternatively, if the proposed Health Facility does not currently have health system partners beyond Rapid Access Clinics (RACs), rehabilitation clinics, and local hospitals, please describe the efforts made to establish other health system partnerships. Please provide an explanation and evidence for any challenges faced in establishing these partnerships.

7.3 Benefits to Patients and Health System

Describe how the proposed Health Facility will:

a) Address health procedure backlogs and patient wait times; (max. 300 words)
b) Improve patient experiences and access to care for all patients; and (max. 300 words)
c) Improve health system efficiency in the community. (max. 300 words)

Please note that wait times for Orthopedic Surgery are publicly available on the Ontario Wait Times Information System Wait Times | Ontario Health.

8. Health Equity

The Applicant will provide a description of how the proposed Health Facility will address the health equity needs of diverse, vulnerable, priority and underserviced populations, and considering linguistic needs.

8.1 Broad Access to Procedures for Diverse and Underserviced Populations

Identify all priority populations that would be directly impacted by service delivery in the catchment area of the proposed Health Facility:

☐ First Nations, Inuit and Métis
☐ Black Ontarians
☐ Ontarians who are racialized
☐ Persons with Disabilities
☐ Women
☐ 2SLGBTQQIA+
☐ Aging Ontarians (55+)
☐ Rural Ontarians
☐ Northern Ontarians
☐ Low-income Individuals/Families
☐ Francophones
☐ Newcomers
☐ Additional groups not listed: _____
☐ Does not directly impact any of the specific populations listed

8.2 Description of Impact

Provide and attach a written description for the following:

a) How the proposed Health Facility plans to identify and address the needs of the priority populations selected above (Question 8.1) if an ICHSC licence is granted. (max. 500 words)
b) Provide examples of strategies or initiatives the Health Facility has implemented, or plans to implement, to address the health equity needs of priority populations in the catchment area. (max. 500 words)
c) Measures that are/will be implemented in the Health Facility to assess the effectiveness of health equity initiatives. (max. 500 words)
d) Any challenges the Health Facility anticipates encountering in addressing health equity through service delivery and strategies considered to overcome them. (max. 500 words)
e) If the proposed Health Facility will offer services in any other language for patients, please also describe how these services will be provided, including the languages and proficiency of relevant staff members and/or use of translators (max. 500 words)

9. Uninsured Services

Applicants will be asked to provide a description of any uninsured services that are being provided or will be provided at the proposed Health Facility. Please refer to section 29 of the ICHSCA.

Please Note: It is a violation of subsection 29(4) of the ICHSCA to charge or accept payment of a facility cost unless the facility cost is charged to, and the payment accepted from, the Minister or a prescribed person (currently, Ontario Health).

9.1 Uninsured Services Provided

Provide a description of the Uninsured Services that are being provided, or will be provided at the Health Facility (max. 500 words), including:

a) type of services,
b) existing volumes,
c) fees associated with uninsured services,
d) plans to change or increase service type/volumes,
e) a detailed description of the processes for providing information and obtaining patient consent in connection with any uninsured services,
f) rationale and benefits to patients,
g) promotional materials used to inform patients of Uninsured Services,
h) proportional time offered for insured Orthopedic services compared to Uninsured Services if licensed as an ICHSC; and,
i) how priority will be given to the provision of insured Orthopedic services

9.2 ICHSC Compliance

Insured persons do not have to pay any fees to access insured Orthopedic services. ICHSCs are

required to inform patients about the list of uninsured services offered and that any Uninsured Services and related fees are optional.

Describe how the proposed Health Facility will comply with the statutory provisions prohibiting charges relating to Facility Costs, under the ICHSCA. (max. 500 words)

The Applicant should include:

a) a description of how Insured Persons will be made aware of what Orthopedic services are available and any charges for Uninsured Services,
b) a description of the process for providing information and obtaining patient consent in connection with any Uninsured Service, including how Insured Persons will be made aware of Uninsured Services and that the related fees are optional and are not required in order to access insured Orthopedic services,
c) plans for posting information about optional fees, including the Ministry's Protecting Access to Public Healthcare program hotline for inquiries.

DECLARATIONS

Attach the completed and signed Declarations from the Applicant and each officer, director and any person with an interest affecting control of the corporation, as applicable.

10.1 Applicant Declarations

Applicant must complete Declarations 1, 2 and 3.

Declaration #1: Applicant Declaration
Declaration #2: Applicant Conflict of Interest Declaration
Declaration #3: Applicant Tax Compliance Declaration

10.2 Officers, Directors and Any Persons with an Interest Affecting Control of the Corporation Declarations

Each officer, director and any person with an interest affecting control of the corporation, as applicable, must complete Declarations 4 and 5.

Declaration #4: Officer and Director or Persons with an Interest Affecting Control of the Corporation Declaration
Declaration #5: Officer and Director or Persons with an Interest Affecting Control of the Corporation COI Declaration

10.3 Declaration Templates

The templates for the Declarations referenced in sections 10.1 and 10.2 above are provided with this Application Form and commence on the next page. The Applicant should complete sufficient copies to account for all members of the management team and officers and directors of the corporation as well as any persons with an interest affecting control of the corporation.

DECLARATION 1 – Applicant Declaration

On behalf of and with the authority of the Applicant, I/we acknowledge that this Call for Applications process is for the potential selection of candidates for an ICHSC licence and is not a procurement. I/we further acknowledge that the Director of Integrated Community Health Services Centres (Director) is authorized to exercise a statutory power of discretion under the *Integrated Community Health Services Centres Act, 2023* (ICHSCA) and has full discretion with respect to the Call for Applications process and with respect to the licensing of ICHSCs in accordance with the ICHSCA. I/we hereby agree to indemnify and hold harmless his Majesty the King in right of Ontario, his ministers, agents, appointees and employees from and against any and all liability, loss, costs, damages and expenses (including legal, expert and consultant fees), causes of action, actions, claims, demands, lawsuits or other proceedings, by whomever made, sustained, incurred, brought or prosecuted in any way arising out of or in connection with this Application. Having so acknowledged and agreed, I/we:

1. hereby apply to establish and operate an ICHSC in accordance with the provisions and terms and conditions of the Application Guidelines, this Application, and in accordance with applicable legislation, policies, regulations and standards as amended and issued from time to time;
2. certify that the information the Applicant has supplied in support of this Application is truthful, accurate and complete in every respect;
3. warrant and represent that I/we have not made any alterations or amendments to the Application Guidelines or the Application Form template, and understand and agree that any such changes will be disregarded and/or may result in disqualification;
4. confirm that the Applicant has the financial and organizational capacity to provide the services specified in the Call for Applications as outlined in this Application;
5. consent to the disclosure on a confidential basis of the Application by the Director to such individuals or other parties as may be required for the purpose of reviewing the Application and/or to administer the Call for Applications process;
6. consent to the Director performing checks with such persons/sources as the Director in their sole discretion deems is appropriate for the purposes relating to the Application;
7. consent to the Director verifying any information provided in connection with this Application, and making any disclosures incidental to that purpose;
8. have read all the information and agree to all terms set out in this Application and the Application Guidelines; and
9. consent to the disclosure and indirect collection, on a confidential basis, subject to applicable law, of information to and held by any third party (including a municipality) regarding the Application to the Director as the Director may require for the purpose of reviewing the Application to administer the Application process.

Applicant Declaration

The personal information collected by the Director in connection with this Application, including information about prior criminal or regulatory convictions and actual or potential conflicts of interest, is collected because it is necessary for the proper administration of the ICHSC program, with the consent of the Applicant and to whom the information relates, and will only be used and disclosed for the purposes of enabling the Director to administer this Call for Applications process, to carry out related planning, and for purposes permitted or required by law.

DECLARATION 2 – Applicant Conflict of Interest Declaration

For the purposes of this declaration, a conflict of interest includes any circumstances where the Applicant has other commitments, relationships or financial interests that could, or could reasonably, be seen to exercise an improper influence over the Applicant's objective, unbiased and impartial judgment relating to the provision of ICHSC services set out in the Call for Application and the use of the associated funds.

On behalf of and with the authority of the Applicant I/we confirm as follows:

Please check one of the following, which is applicable:

☐ The Applicant does not and will not have any conflict of interest, actual or potential, in submitting its Application or, if the Application is selected, with the obligations of an Applicant in providing the services set out in the Call for Applications.

[or]

☐ The following is a list of situations, each of which may be a conflict of interest or an instance of unfair advantage or appears as potentially a conflict of interest or unfair advantage in submitting the Application or providing the services set out in the Call for Applications.

(i) The Applicant will inform the Director immediately if it becomes aware of any circumstance that constitute or could be perceived as a conflict of interest, of either the Applicant or officers and directors or any person with an interest affecting the control of the corporation.

(ii) The Applicant has not knowingly hired or retained the services of any public servant or former public servant, where in so doing the public servant or former public servant is in breach of the *Public Service of Ontario Act, 2006* and its regulations.

Please check the following that apply:
The Applicant **[☐ does OR ☐ does not] and [☐ has OR ☐ has not]** had access to any confidential information of the Crown, other than confidential information disclosed to Applicants in the normal course of the application process, where the confidential information is relevant to the services required by the Application process, or the Application assessment process and where the disclosure of the confidential information could result in prejudice to the Crown or an unfair advantage to the Applicant

Applicant Conflict of Interest Declaration

(i) The following people participated in the preparation of the Application:

Name	Address	Telephone Number
1.		
2.		
3.		
4.		

(ii) The following is a list of individuals who are current and/or former members of the Ontario Public Service (OPS) employed or previously employed in a ministry/agency or minister's office and whom the officers or directors or any persons having an interest affecting control of the corporation has employed or retained in connection with this Application. In the event any employee or person listed below is a current or former public servant who is/was employed in a Ministry or in a minister's office, the current/former public servant is required to comply with the provisions of the *Public Service Act of Ontario, 2006*.

Name of Individual	Job Classification of last position within OPS	Ministry/Agency of OPS where last employed	Last Date of Employment with OPS
1.			
2.			
3.			

DECLARATION 3 – Applicant Tax Compliance

Applicant Tax Compliance

In order for an Applicant to be eligible for funding, the Applicant must declare below that they are in full compliance with all tax statutes administered by the Canada Revenue Agency (CRA) and that, in particular, all taxes due and payable under all tax statutes have been filed and all taxes due and payable under those statutes have been paid or satisfactory arrangements for their payment have been made and maintained.

Applicants may direct all inquiries regarding the Tax Compliance Declaration to the CRA by calling 416-326-1234, toll free 1-800-267-8097, TTY 416-325-3408 or toll-free TTY 1-800-268-7095 or online https://www.canada.ca/en/services/taxes.html

https://www.ontario.ca/page/check-your-tax-compliance-status

I certify that_____, *(Insert Name of Applicant)* at the time of submitting this Application, is in full compliance with all tax statutes administered by the CRA and that, in particular, all returns required to be filed under all tax statutes have been filed and all taxes due and payable under those statutes have been paid or satisfactory arrangements for their payment have been made and maintained.

The signature below confirms acceptance of Declarations #1-3 as stated above.

Dated at (location):_____ this _____ Day of _____ , 20_____.

_____ *Signature of Authorized Signing Officer*	_____ *Signature of Second Authorized Signing Officer (if required)*
_____ *Title*	_____ *Title*
_____ *Print Name*	_____ *Print Name*
_____ *Phone Number*	_____ *Phone Number*

DECLARATION 4 – Officer and Director or a Person with an Interest Affecting Control of the Corporation Declaration

The personal information collected by the Director in connection with this Application, including information about prior criminal or regulatory convictions and actual or potential conflicts of interest is collected because it is necessary for the proper administration of the ICHSC program and with the consent of the Applicant and officers and directors or persons with an interest affecting control of the corporation to whom the information relates, and will be only be used and disclosed for the purposes of enabling the Director to administer this Application process, to carry out related planning, and for purposes permitted or required by law.

With respect to an Application made by _____*(Insert Name of Applicant)* (the "Applicant") for funding to establish and operate an ICHSC, I hereby:

1. certify that I have read the Application and I:
   i. acknowledge that I have been identified in that Application as an officer or director or a person with an interest affecting control of the corporation as defined in the Applications Guidelines**,** who will provide support and services to the Applicant in order to implement the services proposed in the Application;
   ii. agree with the information contained in the Application, and, in particular, I confirm that the information contained in the Application about me is accurate, provided to the Ministry with my consent, and that the responses to questions in the Application which refer to information about officers or directors or a person with an interest affecting control of the corporation is accurate insofar as it relates to me;
2. agree, that I will provide services and support to the Applicant as described in the Application, if it is successful in the Call for Applications;
3. consent to the disclosure on a confidential basis of information in the Application about me by the Director to such individuals or other parties as may be required for the purpose of reviewing the Application and to administer the Application process;
4. have read all the information and agree to all terms set out in the Application Guidelines;
5. consent to the Director performing checks about me with such persons as the Director in their sole discretion deems necessary for purposes relating to the Application; and
6. consent to the disclosure and indirect collection, on a confidential basis, subject to applicable law, of information held by the Applicant or any third party (including a municipality) regarding the Application to the Director as the Director may require for the purpose of reviewing the Application to administer the Application process.

DECLARATION 5 – Officer or Director or a Person with an Affecting Control of the Corporation Conflict of Interest Declaration

For the purposes of this declaration, a conflict of interest includes any circumstances where any officer or director or person having an interest affecting control of the corporation has other commitments, relationships or financial interests that could, or could reasonably be seen to, exercise an improper influence over the objective, unbiased and impartial judgment, and advice and services relating to the provision of services set out in the Call for Applications and the use of the associated funds.

Please check one of the following, which is applicable:

☐ I do not and will not have any conflict of interest, actual or potential, in participating in the submission of the Application by _____ *(Insert name of Applicant(s))* or, if the Application is selected, with the obligations of the Applicant(s) in providing the services set out in the Call for Applications;

[or]

☐ The following is a list of situations, each of which may be a conflict of interest or an instance of unfair advantage, or appears as potentially a conflict of interest or unfair advantage in our participation in the submission of the Application or the services which we will perform for the Applicant(s).

(i) I will inform the Applicant immediately if I become aware of any circumstance that constitutes or could be perceived as a conflict of interest involving me.

(ii) I have not knowingly hired or retained the services of any public servant or former public servant, where in so doing the public servant or former public servant is in breach of the *Public Service of Ontario Act, 2006* and its regulations.

(iii) I do/do not and have/have not had access to any confidential information of the Crown, other than confidential information disclosed to Applicants or officer or director or any person with an interest affecting the control of the corporation in the normal course of the application process, where the confidential information is relevant to the services required by the Application process, or the Application assessment process and where the disclosure of the confidential information

Officer and Director of the Corporation Conflict of Interest Declaration

could result in prejudice to the Crown or an unfair advantage to the Applicant or its officers or directors or persons with an interest affecting control of the corporation.

(iv) The following people employed by or contracted to (*Insert Name*) participated in the preparation of the Application:

Name	Address	Telephone Number
1.		
2.		
3.		
4.		

The following is a list of individuals who are current or former members of the Ontario Public Service (OPS) employed or previously employed in a ministry/agency or minister's office and whom the officers or directors or persons having an interest affecting control of the corporation has employed or retained in connection with the Application. In the event any employee or person listed below is a current or former public servant who is/was employed in a ministry or in a minister's office, the current/former public servant is required to comply with the provisions of the *Public Service Act of Ontario, 2006*.

Name	Ministry/Agency of OPS where last employed	Last Date of Employment with OPS
1.		
2.		
3.		
4.		

The signature below confirms acceptance of Declarations #4-5 as stated above.

Dated at (location):_____ this _____ Day of _____ , 20_____.

_____ *Signature of Authorized Signing Officer*	_____ *Signature of Second Authorized Signing Officer (if required)*
_____ *Title*	_____ *Title*
_____ *Print Name*	_____ *Print Name*

_____ *Phone Number*	_____ *Phone Number*

FINAL SIGNATURES

Please attach a signed copy of this “Signatures” page which must be signed by the Applicant.

Applicant Signature

On behalf of, and with the authority of, the Applicant, I:

- certify that the information supplied in support of this Application is truthful, accurate and complete to the best knowledge of the Applicant;
- confirm that the Applicant has the financial and organizational capacity to operate an ICHSC as outlined in this Application;
- acknowledge that this is not a competitive procurement/tender and that determination of the successful candidates for funding shall be made at the Director’s sole and absolute discretion;
- consent to the disclosure on a confidential basis of the Application by the Director to such individuals or other parties as may be required for the purpose of reviewing the Application and/or to administer the Application process;
- consent to the Director verifying any information provided in connection with this Application and making any disclosures incidental to that purpose.

Dated at (location):_____ this _____ Day of _____ , 20_____.

_____ *Signature of Authorized Signing Officer*	_____ *Signature of Second Authorized Signing Officer (if required)*
_____ *Title*	_____ *Title*
_____ *Print Name*	_____ *Print Name*
_____ *Phone Number*	_____ *Phone Number*

FINAL CHECKLIST

Please use this Final Checklist on the last page of the Application as a guide to aid with application submission. The Applicant should ensure all necessary information and documentation has been included with the Application.

Note: The questions and the tables provided throughout the Application that are to be completed by the Applicant are not listed below. There may be additional information required, as identified in the Application and Application Guidelines, unique to the Applicant's circumstances that may not be listed below but are still required with the Application.

Included	Section	What to Submit with the Application Form
	2.4	**Financial/Economic Assessment (if applicable)**
	2.5	**Patient Pre-Operative Planning and Assessment**
	2.6	**Post-Operative Patient Pathway**
	2.7	**Post-Operative Rehabilitation Services for Patients**
	3.1	**Recent Quality Assessments/Inspections (if applicable)**
	3.3	**IPAC Clinic Policy**
	4.1	**Criminal Offence History (if applicable)**
	4.1	**Bankruptcy/Receivership History (if applicable)**
	4.1	**Facility Operations Experience (if applicable)**
	4.1	**Facility Licence Suspension History (if applicable)**
	4.1	**Professional Discipline History (if applicable)**
	4.2	**Certificate of Incorporation/Letters Patent (if applicable)**
	4.3	**Business and Professional Experience (if applicable)**
	4.4	**Organizational Chart**
	5.1	**Map – Health Facility Location Details**
	6.1	**Health Facility Staffing Plan**
	7.1	**Hospital Partnerships**