Residential Care Rate Authorization

PROGRAM
☐ MR
☐ MH
☐ IA

Manitoba

1 AUTHORIZATION FOR:

CHANGE OF RATE FOR CLIENT IN SAME FACILITY

☐ INCREASE ☐ DECREASE ☐ PLACEMENT (NEW) ☐ DISCHARGE (OUT OF RESIDENTIAL CARE) ☐ TRANSFER (ONE FACILITY TO ANOTHER)

CLIENT'S NAME _____ BIRTHDATE _____
SURNAME GIVEN NAME(S) YEAR MONTH DAY

PAYMENT SOURCE ☐ SELF PAY ☐ SOCIAL ALLOWANCE ☐ PUBLIC TRUSTEE

ASSESSED LEVEL OF CARE OF CLIENT ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

NAME OF PLACING WORKER (PLEASE PRINT) _____ PHONE NO. _____

REGION _____ ADDRESS _____

2 PLACEMENT INFORMATION:

EFFECTIVE DATE OF PLACEMENT/RATE CHANGE _____

CARE PROVIDERS NAME _____

ADDRESS _____ POSTAL CODE _____

FACILITY ADDRESS (IF DIFFERENT FROM ABOVE) _____ FACILITY PHONE NO. _____

LICENCE/APPROVAL STATUS FACILITY/HOME HAS CURRENT LICENCE OR LETTER OF APPROVAL ☐ YES ☐ NO

TYPE OF FACILITY (CHECK ONE) ☐ 4 OR MORE RESIDENTS ☐ 3 OR FEWER RESIDENTS ☐ COMMUNITY RESIDENCE (SPECIAL RATE)

☐ FAMILY OR RELATIVE ☐ OTHER

ASSESSED CARE LEVEL OF FACILITY ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 CARE RATE $ _____

(LEVELS OF CARE PAID ONLY TO LICENSED/APPROVED FACILITIES HOME)

3 DISCHARGE INFORMATION:

EFFECTIVE DATE OF DISCHARGE _____

DISCHARGE TO ☐ INDEPENDENT ☐ FAMILY ☐ RELATIVES ☐ HOSPITAL (GENERAL) ☐ INSTITUTION (MH/MR)
☐ RESIDENTIAL CARE FACILITY (TRANSFER) ☐ PERSONAL CARE/NURSING HOME ☐ OTHER (SPECIFY) _____

DISCHARGED FROM

CARE PROVIDERS NAME _____

FACILITY ADDRESS _____ POSTAL CODE _____

TYPE OF FACILITY (CHECK ONE) ☐ LICENSED (SIZE 4+) ☐ APPROVED (SIZE 1 - 3) ☐ NOT LICENSED/APPROVED
☐ COMMUNITY RESIDENCE ☐ FAMILY OR RELATIVE ☐ OTHER

4 PAYMENT INSTRUCTIONS:

CARE PAYMENT ☐ ADVANCE ☐ ARREARS ☐ TRANSPORTATION ALLOWANCE ☐ YES ☐ NO

PERSONAL ALLOWANCE ☐ DIRECT TO CLIENT ☐ TO CARE PROVIDER ☐ DEFERRED

CLOTHING ALLOWANCE ☐ DIRECT TO CLIENT ☐ TO CARE PROVIDER ☐ DEFERRED

5 AUTHORIZATION:

_____ DATE

_____ AUTHORIZING SIGNATURE FOR PLACEMENT

_____ AUTHORIZATION FOR LEVELS 4 & 5

CASE MANAGEMENT TRANSFERRED TO _____