HOME AND COMMUNITY CARE SUPPORT SERVICES

Champlain

Short Stay Respite
Long Term Care Home Choice List

Patient Name: _____ _____ _____
(Last Name, First Name) Health Card No. Version Code

Please select up to five long-term care homes (LTCHs) for short stay respite, including any out-of-Champlain choices, and rank them in order of your preference. The applicant's name will be added to the wait lists for the chosen homes if eligible, and if the chosen LTCHs can provide the required care. Home and Community Care Support Services will confirm with you the availability of the requested dates.

Rank (1-5)	Location	Central	Requested Dates
	Ottawa	Extendicare – Laurier Manor	
	Ottawa	Extendicare – West End Villa	
	Ottawa (Kanata)	Garden Terrace (S)	
	Ottawa (Orleans)	Résidence Saint-Louis (S)	
	Ottawa	St. Patrick's Home	
Rank	**Location**	**East**	**Requested Dates**
	Clarence Creek	Centre d'accueil Roger Séguin	
	Cornwall	Glen-Stor-Dun Lodge	
	Maxville	Maxville Manor (S)	
	Hawkesbury	Résidence Prescott and Russell	
Rank	**Location**	**West**	**Requested Dates**
	Renfrew	Bonnechere Manor	
	Almonte	Fairview Manor (S)	
	Pembroke	Marianhill	
	Pembroke	Miramichi Lodge	
	Deep River	North Renfrew LTC	

(S) = Secure unit available.

		Out of Region LTC Home	Requested Dates

ACCOMMODATION RATES

Short Stay Daily Rate is $42.28/Day (July 1, 2023 – Subject to yearly increase)

By signing this Short Stay Respite Choice Form, I confirm that I have been informed of the daily rate of a Short Stay Respite stay.

CONSENT FOR PLACEMENT

- I consent that the Home and Community Care Support Services Champlain, as the designated Placement Coordinator, can disclose my personal health information to the LTCH of my choice.
- I acknowledge that I have been counselled about the reasons why this information is needed and I understand them. I understand that Home and Community Care Support Services Champlain will update and share this information with other Home and Community Care Support Services, other health professionals involved in my care, and the LTCH of my choice.
- I understand that I may withdraw my consent at any time.

Signature of Patient/
Substitute Decision Maker _____ _____ _____
Print Name (Day/Month/Year)

☐ Substitute Decision Maker:_____ ☐ POA of Personal Care ☐ Public Guardian and Trustee (PGT)
(relationship to patient)