Call for Applications to License Community Surgical and Diagnostic Centres for Magnetic Resonance Imaging (MRI) Services in Ontario

Application Form
Submission Deadline: August 12, 2024, 11:59PM

Ministry of Health

June 3, 2024

Table of Contents

Table of Contents 2

INTRODUCTION 4

Call for Applications Notice 4
Application Form 4
Application Guidelines 4
Notice of Collection of Personal Information 4

APPLICATION COVER SHEET 6

APPLICATION QUESTIONS 7

1 Minimum Eligibility Requirements 7
1.1 Integrated Community Health Services Centres Act, 2023 7
1.2 Service Location 7
1.3 Accessibility for Ontarians with Disabilities Act 7
1.4 Personal Health Information Protections Act 7
1.5 Integrated Community Health Services Centres Diagnostic Standards 7
1.6 Ontario Fire Code Fire Safety, Emergency and Evacuation Planning 7
1.7 Hospital Site Location 8
1.8 Infection Prevention and Control (IPAC) 8
1.9 Pre-Licensing Inspection 8
1.10 TPA Reporting and Data Collection 8
1.11 Other Health System Digital Connectivity and Reporting Requirements 8
1.12 Facility Costs 9
1.13 Additional Legislative Requirements 9
2 Service Delivery Requirements 9
2.1 Operating Timelines 10
2.2 Access to Equipment 10
2.3 Approximate Annual Volumes and Hours of Operation 11
2.4 Financial/Economic Assessment 11
2.5 Benefits to Patients and Health System 11
3. Quality Assurance Program 12
3.1 Quality Assurance Advisor 12
3.2 Infection Prevention and Control (IPAC) Plan 13
4 Business, Clinical and Professional Experience 13
4.1 Business and Criminal/Regulatory Offence History 13
4.2 CPSO Certificate of Professional Conduct 14
4.3 Legal Status 14
4.4 Business and Professional Experience 20
4.5 Decision Making Process 21
4.6 Organizational Chart 21
4.7 Providers 21

4.8 Administrator for the proposed Health Facility 21
4.9 Officers and Directors 21
4.10 Leadership and Oversight 24
4.11 Management and Administration Continuity Plan 24
4.12 Past Service Delivery 24
5 Physical Nature 24
5.1 Health Facility Location 24
6 Staffing Model 25
6.1 Staffing Plan 25
6.2 Sustainability of Staffing Plan 26
7 Health System Linkages 26
7.1 Build and Maintain Health System Linkages 26
7.2 Benefits to Patients and Health System 26
7.3 Patient Referrals 27
8. Health Equity 27
8.1 Broad Access to Procedures for Diverse and Underserviced Populations 27
8.2 Description of Impact 28
8.3 Linguistic Availability of Services 28
9. Uninsured Services 28
9.1 Uninsured Services Provided 28
9.2 ICHSC Compliance 29

DECLARATIONS 30

10.1 Applicant Declarations 30
10.2 Officers and Directors or Person with an Interest Affecting Control of the Corporation Declarations 30
10.3 Declaration Templates 30

DECLARATION 1- Applicant Declaration 31

DECLARATION 2- Applicant Conflict of Interest Declaration 33

DECLARATION 3- Applicant Tax Compliance 35

DECLARATION 4- Officer and Director or a Person with an Interest Affecting Control of the Corporation Declaration 36

DECLARATION 5- Officer or Director or a Person with an Affecting Control of the Corporation Conflict of Interest Declaration 38

SIGNATURES 40

FINAL CHECKLIST 41

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 MRI 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.

MRI Services Only: Scope of Application
This application applies specifically to applicants applying for a licence for MRI services. If the Applicant intends to apply for a licence for CT services in addition (or only), they must complete and submit the CT application form provided separately.

If the Applicant is seeking to provide both MRI services and CT services, both the MRI Application and CT Application must be completed and submitted prior to the deadline. Applicants must submit the appropriate Application form to ensure that each Application is accurately evaluated.

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 MRI and CT services in Ontario Application Guidelines (Application Guidelines). Applicants should refer to the Application Guidelines to ensure that their Application is complete. For questions where an attachment is the more appropriate response format, please indicate the name of the relevant attachment in the fillable response box below each question.

Glossary of Common Terms
The Application Guidelines includes 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

Please complete this Application Cover Sheet and **attach** it as the first page of the Application:

Applicant Name(s):		
Health Facility Name:		
Health Facility Address:		
Ontario Health Region in which the Proposed Health Facility is located:		
Applicant Type:	☐ Sole Proprietor	☐ Corporation
Only complete the below section if "Corporation" was selected above		
Corporation Information:	Corporate Name:	Corporate Number:
Corporation Address:		

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 Protections Act

Does the Applicant confirm that they comply with all Personal Health Information Protections Act (PHIPA) standards as part of overall operations?

☐ Yes ☐ No

1.5 Integrated Community Health Services Centres Diagnostic 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 Ontario Fire Code Fire Safety, Emergency and Evacuation Planning

Does the Applicant confirm that it 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

1.7 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

1.8 Infection Prevention and Control (IPAC)

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

☐ Yes ☐ No

1.9 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

1.10 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
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

Please note that 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).

1.11 Other Health System Digital Connectivity and 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 reporting requirements they may be required to meet as initiatives are implemented in the system, such as participation in the centralized waitlist management program, the regional central intake program, the provincial electronic health record, etc.

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

☐ Yes ☐ No

1.11.1 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

1.12 Facility Costs

Check “Yes” below to confirm the Applicant’s understanding that the Facility Cost payable for MRI services is $297 per hour.

☐ Yes ☐ No

1.13 Additional Legislative Requirements

Does the applicant confirm that they have reviewed the *Regulated Health Professions Act*, 1991 (RHPA) and its regulations, including O.Reg 107/96 (Controlled Acts), especially for the requirements around performing a controlled act. Please be advised that applying or ordering the application of a form of energy, such as electromagnetism for magnetic resonance imaging is a controlled act that is restricted under the RHPA and subject to specific exemptions that are set out under O.Reg 107/96.

☐ Yes ☐ No

2 Service Delivery Requirements

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

2.0 Operational Status

Does the Applicant currently operate a Health Facility in Ontario?

☐ Yes ☐ No

If yes, does the Applicant have an existing ICHSC licence?

☐ Yes ☐ No

If yes, please provide the licence number(s): ______________

2.1 Operating Timelines

What is the proposed timeline to begin providing MRI services upon issuance of an ICHSC licence? Please provide the estimated date for beginning to provide MRI service delivery and provide an explanation of how this date is feasible. (max. 200 words)

Please provide file name: ____

2.2 Access to Equipment

Does the Applicant have access to existing MRI machine(s) for operations at the proposed Health Facility or will the Applicant need to procure new machine(s)?

If the Applicant has access to existing MRI machine(s) that will be used in the proposed Health Facility, please provide the following details for each machine: (max. 300 words)

- Manufacturer
- Model
- Strength
- Bore Size
- Year of manufacture (if the machine has been refurbished, please indicate in what year the machine was refurbished)
- Where the machine(s) are located
- The current primary use of the machine(s)
- When the machine will be operational in the proposed Health Facility

If the Applicant will be procuring new MRI machines to be used at the proposed Health Facility, please provide the following details for each machine that the Applicant is proposing to procure if known: (max. 300 words)

- Manufacturer
- Model
- Strength
- Bore Size
- Year of manufacture (if the machine has been refurbished, please indicate in what year the

machine was refurbished)

- When the machine will be received and operational in the proposed Health Facility (including key procurement milestones)

Please provide file name: ____

2.3 Approximate Annual Volumes and Hours of Operation

Please provide the following information related to service volumes and hours of operation at the existing or proposed Health Facility:

- an approximation of both the projected minimum and maximum number of hours of insured MRI service delivery that could be provided annually at the proposed Health Facility,
- the average number of MRI scans provided per hour,
- 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 on weekends) to improve patient access to insured services. (max. 300 words)

Please provide file name: ____

2.4 Financial/Economic Assessment

Please provide details about the financial sustainability and feasibility of the proposed Health Facility. Please include reference to the facility cost of $297 per hour for MRI services and the required volumes of scans and hours 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 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
- Overhead costs
- Uninsured services

Please provide file name: ____

2.5 Benefits to Patients and Health System

Please provide a description of the MRI services to be provided in the proposed Health Facility and how you will ensure that the Health Facility provides connected and convenient patient care. As part of your response please include how the Health Facility will:

2.5.1 improve patient wait times; (max. 200 words)

2.5.2 improve patient experiences and access to care in the proposed ICHSC; and (max. 500 words)
2.5.3 integrate with the health system. (max. 500 words)

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 the core and modality specific standards for ICHSCs providing licensed MRI 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 Diagnostic 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:

1. an inspection of the facility prior to the licence being issued and the provision of service, and

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

3.1 Quality Assurance Advisor

If the application 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 MRI 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. Please see s. 7 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:	
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.

3.1.1 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)

Please provide file name: ____

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 or director or 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 or 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) **Criminal or Regulatory Offence History:** Has the Applicant, or any officer or 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
b) **Bankruptcy/Receivership History:** Has the Applicant, or any officer or director, or 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.

c) **Facility Operations Experience:** Has the Applicant, or any officer or 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.
d) **Facility Licence Suspension History:** Has the Applicant, or any officer or 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.
e) **Professional Discipline History:** Has the Applicant, or any officer or 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.

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 CPSO to the Director of the 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.

4.3 Legal Status

Indicate legal status of the Applicant (check one):

☐ Sole Proprietor – please complete Section 4.3.1
☐ Corporate Ownership – please complete Section 4.3.2

4.3.1 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)	

4.3.2 Corporate Ownership

Complete this section if the proposed Applicant is a:

a) A corporate applicant, and
b) Is a shareholder that is also a 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 (if applicable):	
Name under which Applicant is carrying on business (if different from the legal name):	
Corporation is (check one):	☐ **Public** ☐ **Private**
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):	
Phone Number:	
Website URL (if applicable)	

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 (if applicable):	
Name under which Applicant is carrying on business (if different from the legal name):	
Corporation is (check one):	☐ **Public** ☐ **Private**
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):	
Phone Number:	
Website URL (if applicable)	

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 (if applicable):	
Name under which Applicant is carrying on business (if different from the legal name):	
Corporation is (check one):	☐ **Public** ☐ **Private**
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):	
Phone Number:	
Website URL (if applicable)	

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 (if applicable):	
Name under which Applicant is carrying on business (if different from the legal name):	
Corporation is (check one):	☐ Public ☐ Private
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):	
Phone Number:	
Website URL (if applicable)	

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 (if applicable):	
Name under which Applicant is carrying on business (if different from the legal name):	
Corporation is (check one):	☐ Public ☐ Private
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):	
Phone Number:	
Website URL (if applicable)	

4.3.2.a Shareholdings

Please provide a description of the shareholding's 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. Photocopy 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/	☐ No ☐ Yes
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/	☐ **No** ☐ **Yes**
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/	☐ **No** ☐ **Yes**
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/	☐ **No** ☐ **Yes**
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/	☐ **No** ☐ **Yes**
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	

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 Decision Making Process

Please provide an overview of the decision-making processes of the proposed Health Facility as detailed in the Application Guidelines. (max. 200 words)

Please provide file name: ____

4.6 Organizational Chart

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

Please provide file name: ____

4.7 Providers

Provide the names and Ministry issued solo billing numbers of all physicians who will be performing or interpreting MRI Scans in the proposed Health Facility.

Physician Name (First Name, Last Name)	Solo Billing Number

4.8 Administrator for the proposed Health Facility

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

Full Name:	
Phone Number:	
Email Address:	

4.9 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:	

4.10 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, 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)

Please provide file name: ____

4.11 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)

Please provide file name: ____

4.12 Past Service Delivery

If the proposed Health Facility has pre-existing operations, please list the other Insured Services and volumes the Applicant provided at the proposed Health Facility in the last 3 years before the date of the Application Submission Deadline.

Please provide file name:____

5 Physical Nature

Applicant will be asked to provide details of the physical nature of the proposed Health Facility, including its address and distance to other ICHSCs and Hospitals.

5.1 Health Facility Location

Please attach a map, which includes a distance scale and north arrow, showing the:

a) catchment area of the Health Facility;
b) location of the Health Facility;
c) location of the hospital(s) that may receive transfers from the Health Facility;
d) location and distance to other ICHSCs and hospitals. *Note: a list of all existing ICHSCs can be found at the following website, Community surgical and diagnostic centres | ontario.ca* ; and
e) location of potential main referring health care providers.

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:

i. staff organization chart including position classification with rates of compensation and ranges of compensation, as applicable, (max. 300 words)
ii. the number of staff required for each position,
iii. staff role functions, caseloads, and continuity of services, (max. 500 words)
    a. *Functions:* A description of each of the staff member's 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, Magnetic Resonance Imaging technologists) in a team-oriented, inter-professional model for delivery of care.
    b. *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.
    c. *Continuity of Services:* How continuity of services will be managed at the proposed Health Facility. (max. 300 words)
iv. Any new employee recruitment required,
    a. Will the Applicant be required to recruit employees in order to provide the service volumes described in question 2.5 of the Application?

       ☐ Yes ☐ No

    b. If yes, please describe:
        i. 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 2.5 of the Application.
        ii. How the Applicant plans to recruit employees including specific geographic regions where employees may be recruited from. (max. 500 words)
        iii. How the Health Facility will factor in equity, diversity and inclusion considerations into the recruitment of new employees?
        iv. For physicians employed by the Health Facility, please also

describe the physician affiliation plan including the number of physicians onsite and remote for intervention and interpretation. (max. 300 words)

Please provide file name:____

6.2 Sustainability of Staffing Plan

Please describe the sustainability of the staffing plan, showing evidence of partnership or coordination with local or regional hospital(s) to develop a staffing plan that demonstrates collaboration. If the proposed Health Facility does not currently have partnerships with local hospital(s), please complete question 7.1.

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 also demonstrate any upskilling or training programming built into the proposed Health Facility's staffing program.

Please provide file name:____

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.

7.1 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 if the applicant is successful in obtaining an ICSHC licence (e.g., Ontario Health, Ontario Health Teams, local hospitals, primary care providers, etc.). Please provide evidence of existing linkages with health sector partners or collaborations.

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

(max. 500 words)

Please provide file name:____

7.2 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 provide file name:____

7.3 Patient Referrals

Describe the proposed Health Facility links to the health care system in relation to patient referrals for services offered at the proposed Health Facility and how the Health Facility will share images with other health system partners.

Provide details on how these links prioritize patient needs, improve access to specialty care for the services provided, decrease wait times, and improve the overall patient and provider experience.

Provide information about the use of any digital tools, e.g., eServices (eReferral and/or eConsult), image sharing that will be leveraged to support the patient care pathway for MRI services. Describe how they will be integrated with electronic medical records (EMRs) as part of clinical workflows.

If the proposed Health Facility is not currently operational, please provide an explanation of how the proposed Health Facility will address patient referrals through health system linkages which prioritize faster access to care.

(max. 500 words)

Please provide file name:____

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, 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+)
☐ Children and Adolescents
☐ 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:

8.2.1 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)

8.2.2 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)

8.2.3 Measures that are/will be implemented in the Health Facility to assess the effectiveness of health equity initiatives. (max. 500 words)

8.2.4 Any challenges the Health Facility anticipates encountering in addressing health equity through service delivery and strategies considered to overcome them. (max. 500 words)

Please provide file name:____

8.3 Linguistic Availability of Services

Demonstrate how the need for French language services will be met if you are proposing to establish and operate an ICHSC located in an area of Ontario designated in the Schedule of the French Language Services Act. If the proposed Health Facility will offer services in any other languages for patients, please also describe how these services will be provided. (max. 500 words)

Please provide file name:____

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 MRI services compared to Uninsured Services if licenced as an ICHSC; and

i) how priority will be given to the provision of insured MRI services.

Please provide file name: ____

9.2 ICHSC Compliance

Insured Persons do not have to pay any fees to access insured MRI services. ICHSCs are required to inform patients that any Uninsured Services and related fees are optional.

Describe how the proposed Health Facility will comply with the statutory provisions prohibiting:

a) charges relating to Facility Costs, under the ICHSCA. (max. 500 words)

The Applicant should include:

- a description of how Insured Persons will be made aware of what MRI services are available and any charges planned for Uninsured Services;
- 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 that Uninsured Services and that the related fees are optional and are not required in order to access insured MRI services; and
- plans for posting information about optional fees, including the Ministry's *Protecting Access to Public Healthcare* program hotline for inquiries

Please provide file name: ____

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DECLARATIONS

Attach the completed and signed Declarations from the Applicant and each officer and director or 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 and Directors or Person with an Interest Affecting Control of the Corporation Declarations

Each officer and director or 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 print sufficient copies to account for all members of the management team and officers and directors 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.

Signed, Sealed and Delivered in the presence of	**Signature of Authorized Signing Officer** **(I/we have authority to bind the Applicant)** **Print Name**
Witness	**Title**
Date	**Date**

If second signature required:

Signed, Sealed and Delivered in the presence of	**Signature of Authorized Signing Officer** **(I/we have authority to bind the Applicant)** **Print Name**
Witness	**Title**
Date	**Date**

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:

(i) Strike out paragraph (a) or (b), whichever does NOT apply:

a) 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]

b) 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.

b) 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 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 person 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.			

Dated at: ___________________________ this _____________ Day of _____________ 20__.

If second signature required:

____________________________________	____________________________________
(Signature of Authorized Signing Officer)	**(Signature of Authorized Signing Officer)**
Title	**Title**
____________________________________	____________________________________
Print Name	**Print Name**
____________________________________	____________________________________
Phone Number	**Phone Number**
____________________________________	____________________________________

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.

Dated at: _________________________ this ____________ Day of ____________ 20__.

If second signature required:

______________________________	______________________________
(Signature of Authorized Signing Officer)	**(Signature of Authorized Signing Officer)**
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.

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

Signed, Sealed and Delivered in the presence of	Signature of the or officer or director or a person with an interest affecting control of the corporation Print Name
Witness	Title
Date	Date

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.

I confirm as follows:

(i) Strike out paragraph (a) or (b), whichever does NOT apply:

(a) 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]

(b) 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).

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

(x) 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.

(xi) 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

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

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

Officer and Director of the Corporation Conflict of Interest Declaration

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

(xiii) 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 person 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 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.			

Dated at: __________________ this _____________ Day of _____________ 20_____.

____

(Signature of officer or director or person having an interest affecting control of the corporation)

____

Print Name

____

Title

____

Phone Number

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:____________________ this_______________ Day of________________ 20__.

Name	**Signature**
Title	**Telephone Number**

FINAL CHECKLIST

Please complete this Final Checklist and **attach** it as the last page of the Application. 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
	N/A	**Application Cover Sheet**
	3.2	**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	**Confirmation of Request for Certificate(s) of Professional Conduct**
	4.3	**Certificate of Incorporation/Letters Patent**
	4.6	**Organizational Chart**
	5.1	**Map – Health Facility Location Details**
	6.1	**Health Facility Staffing Plan**
	D1	**Applicant Declaration**
	D2	**Applicant Conflict of Interest Declaration**
	D3	**Applicant Tax Compliance Declaration**
	D4	**Officer and Director or Person with an Interest Affecting Control of the Corporation Declaration**
	D5	**Officer and Director or Person with an Interest Affecting Control of the Corporation COI Declaration**
	N/A	**Applicant Signature**
	N/A	**Final Checklist**