

In This Issue

- 2 Executive Director's message
- 3 Changes to the law impacting retirement home tenants
- 5 Calculating Guaranteed Income Supplement or Spousal Allowance entitlement immediately after retirement
- 9 Grandparents now explicitly entitled to apply for access or custody of grandchildren
- 10 Mauvais traitements à l'égard des personnes âgées
- 11 Transportation to medical appointments for residents in long-term care
- 13 Chronic care co-payment: Important facts you need to know
- 18 Save the date: ACE annual general meeting



Short-Term Transitional Care—A Flawed Model

- Graham Webb, Lawyer, Executive Director, and Jane E. Meadus, Staff Lawyer, Institutional Advocate

The Ontario Ministry of Health and Long-Term Care [the “Ministry”] is rolling out short-term transitional care beds in the fall of 2017 as one part of its strategy to reduce hospital ALC (alternative level of care) rates. ACE takes the position that this model is flawed because it takes hospital patients who need admission to a long-term care home and places them outside of the health-care system in housing that requires private payment, has little or no oversight, and puts them in crisis while they wait for admission to long-term

care. A better solution would be to make room within the health-care system to accommodate everyone who requires long-term care.

ALC Pressures Within the Hospital Sector

The Ministry has identified ALC pressures within the hospital sector as an area of pressing concern. ALC patients are those who no longer require acute hospital care and are waiting in hospital to move to their most appropriate discharge destinations.

While there are many different types of destination, the one

Continued on page 4

Executive Director's Message

Thank you for reading the Spring/Summer 2017 edition of the *ACE Newsletter*.

Our Mission is to uphold the rights of low-income seniors. Our purpose is to improve the quality of life of seniors by providing legal services which include direct client assistance, public legal education, law reform, community development and community organizing. The *ACE Newsletter* is an integral element of our public legal education mandate.

In our lead article, I have collaborated with Jane Meadus in writing about the short-term transitional care program that was announced in the May 2017 provincial budget. This program has been piloted in the Hamilton-Niagara-Haldimand-Brant region, and we have serious concerns about its implementation for long-term care home applicants across Ontario. The Ministry of Health and Long-Term Care expects that the program will be rolled-out across the province in the fall of 2017, and we are expecting increased call volumes about this.

Staff litigation lawyer Karen Steward points out that despite recent rent control amendments to the *Residential Tenancies Act*, retirement-home and care-home tenants are still vulnerable to “backdoor” rent increases in the guise of unlimited increases to the cost of meals and care services. ACE made submissions to the Ontario Legislature on this topic in May 2017, and while we are glad to see a more equitable form of rent control for residential tenancies, we are distressed that older adults in retirement-home and care-home settings still do not enjoy similar protections.

Staff litigation lawyer Rita Chrolavicius writes about the correct method of calculating the Guaranteed Income Supplement in the first year of retirement, when a new pensioner has had a recent loss of employment income. Special rules apply that will assist new pensioners in the first year of retirement.

Our paralegal Angeline Douglas writes about two important amendments to the *Children's Law Reform Act*. First, the *Act* specifically names a grandparent as a party entitled to apply for custody or access to a child. Second, the *Act* now directs a court to consider a child's relationship with his or her grandparent on an application for custody or access.

Staff litigation lawyer Clara McGregor describes a pressing problem that we have recently encountered in our work: residents of long-term care homes who lack the financial resources to arrange private transportation might not be able to attend medically necessary appointments. This is an area that cries out for attention to close a gap in the health-care system.

Institutional advocate Jane Meadus describes important facts you need to know about the Chronic-Care Co-payment. We receive many calls about the Chronic-Care Co-payment, and this information is extremely relevant to the many thousands of Ontarians receiving chronic care.

We hope you will enjoy reading the Spring/Summer 2017 edition of the *ACE Newsletter*. Please also visit our website at www.ancelaw.ca

—Graham Webb
Lawyer/Executive Director

Published by
Holly Street Advocacy Centre for the Elderly, Inc.
o/a Advocacy Centre for the Elderly [“ACE”]
701-2 Carlton St., Toronto, ON M5B 1J3
www.ancelaw.ca

Layout: Kathy Pearsall

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Changes to the Law Impacting Retirement Home Tenants

- Karen Steward
Staff Litigation Lawyer

On May 30, 2017, the Ontario government passed Bill 124, *An Act to amend the Residential Tenancies Act, 2006*.¹ The Bill expands the application of the rent increase guidelines to all residential tenancies, including retirement homes.

Under the previous legislation some tenancies were exempt from the guideline increase rules. As a result, landlords could raise the rent by any amount, as long as they complied with the rules that an increase only occur once every 12 months and with 90 days' written notice.

The guideline did not apply to “new” rental units: (1) units that were not occupied for any purpose before June 17, 1998; (2) units that have not been rented since July 29, 1975; and (3) units that were not occupied for residential purposes before November 1, 1991.² Nearly 20% of private rental housing in Ontario met this definition of “new” rental housing and were therefore exempt from the guideline rules. At ACE, many of the retirement homes that we have received calls about fell under this exemption.

Bill 124 has repealed the “new” unit exemption, and the guideline rent control increases now apply to all notices of rent increase given on or after April 20, 2017. The Act also removes above-guideline rent increases for

exceptional utility costs and prohibits above-guideline rent increases in buildings where elevator maintenance orders have not been addressed.³

Landlords are permitted to raise rent every 12 months by a percentage set annually by the provincial government (called the “guideline”).⁴ The guideline for 2017 is 1.5%.

A guideline rent increase is only valid if your landlord provides you with at least 90 days' written notice. Landlords can also seek an above-the-guideline rent increase at the Landlord and Tenant Board in specific instances such as an extraordinary increase in municipal taxes, eligible capital expenditures or operating costs related to security services.⁵

Given that the average rent for seniors grew by 6.7% in 2016, ACE is supportive of the rent control amendments to the *Residential Tenancies Act*. However, ACE remains very concerned that retirement home tenants continue to be exposed to arbitrary and unfair increases to care service costs. Under the current legislation, retirement home landlords can increase the cost of care services more than once annually as long as certain requirements are met, including 90 days' written notice.

As a result, retirement home landlords subject to guideline increases have no incentive to apply for above-guideline rent increases through the Landlord Tenant Board, when any desired increases can be attained through an increase to the price of care services and meals.

The use of care service increases as a “backdoor” mechanism for landlords to raise rent above the guideline without an application to the Landlord Tenant Board erodes transparency and accountability, undermines the purpose of the current and proposed rent control provisions and risks the security of tenure of some of the province's most vulnerable tenants.

¹ 2nd Sess, 41st Leg, Ontario, 2017 (assented to May 30, 2017 SO 2017, c 13.

² *Residential Tenancies Act, 2006*, SO 2006 c 17, s 6(2), as repealed by Bill 124 *An Act to amend the Residential Tenancies Act, 2006*, SO 2017 c 13.

³ *Residential Tenancies Act, 2006*, SO 2006 c 17, ss 126(1) and 126(12.1), as amended by Bill 124 *An Act to amend the Residential Tenancies Act, 2006*, SO 2017 c 13.

⁴ Ontario Rent Increase Guideline, Online: Ontario <<https://www.ontario.ca/page/rent-increase-guideline>>.

⁵ *Supra* note 3, s 126(1).

that is of the most concern is placement into a long-term care home.

The Ministry estimates that as of January 2017 there were 4,734 ALC patients across Ontario, of which 3,774 were persons aged 65 and over, and 2,051 were waiting for admission to a long-term care home. At these rates, the total “cost” of ALC patients is estimated to be \$3.5 million per day. This includes the cost of those over age 65 waiting for admission to long-term care at \$1.5 million per day. However, since hospitals do not actually receive extra dollars to fund ALC patients, these are merely estimated or notional costs and true cost of caring for ALC patients is unknown.

ALC pressures within the hospital sector have everything to do with money, including the underfunding of the home-care and long-term care sectors. The Government’s solution, as discussed below, is to require older adults to pay privately for care that they should be receiving through publicly funded health care in a less regulated setting. We have three questions: (1) why are older adults who require admission to long-term care not being provided with necessary health care within the health care system; (2) why are older adults required to pay privately for that health care; and (3) why are older adults placed into inappropriate settings to wait for care?

Short-Term Transitional Care Models

In the May 2017 Ontario budget, the Government announced its intention to develop a temporary short-term transitional care model in response to the pressures associated with maintaining ALC patients within the hospital sector. This initiative initially appeared hopeful, as it was suggested that it would provide subsidies to low-income older adults who were having trouble coping in the community. It would target those who could

otherwise manage in a retirement home, but could not afford one. Instead, the actual program shifts the care of older adults waiting for long-term care home beds to the less regulated and unfunded private sector.

The model moving forward is based on the Hamilton Niagara Haldimand Brant Local Health Integration Network (the HNHB LHIN) transitional bed program, which has been operating since 2014. According to statistics provided by the HNHB LHIN, almost 90% of those in their program were admitted directly to a long-term care home from a transitional bed. This model moves patients whose care needs cannot be met in the community and puts them in the private sector, often waiting for an appropriate long-term care home as a crisis admission. The model fails to meet the needs of the patient, or the Government’s obligation to Ontario residents.

Ontario Local Health Integration Networks (LHINs), which are responsible for the overall administration and allocation of important health-care resources within their catchment areas, have solicited proposals from service-providers for short-term transitional care models. These proposals were due on June 30, 2017. Under this program, the Ministry expects to have additional short-term transitional care beds in place by the fall of 2017.

Problems With Short-Term Transitional Care Beds

Transitional care beds are not long-term care beds. They are a community-based response that is completely outside the health-care setting. They are often not even located in a retirement home. These beds are not licenced, inspected or overseen by the Ministry of Health and Long-Term Care, and they are not required to meet the same standards

Continued on page 6

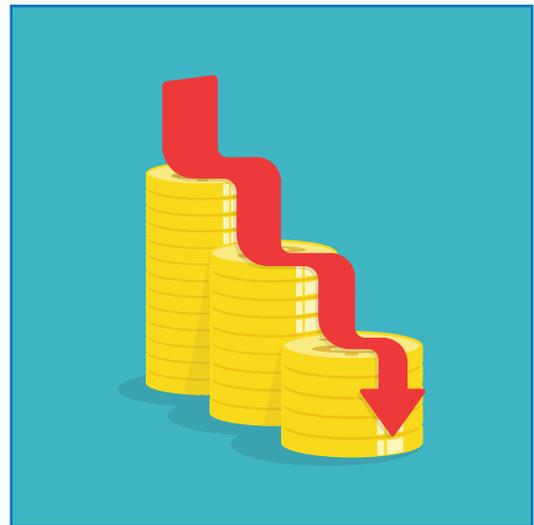
Calculating Guaranteed Income Supplement or Spousal Allowance Entitlement Immediately After Retirement

- Rita Chrolavicius
Staff Litigation Lawyer

The *Old Age Security Act* sets out the entitlements to the Guaranteed Income Supplement (GIS) for low-income seniors aged 65 and older and the Spousal Allowance for low-income spouses between the age of 60 and 65. Where a person has a spouse, both the GIS and the spousal allowance are based on the combined income of the senior and their spouse.

In order to receive the GIS benefits, seniors must specifically apply for these benefits. The application form (SC-ISP-3025) requires income information from the previous year for both the senior and the spouse. Spouses between the ages of 60 and 65 who wish to apply for the Spousal Allowance must specifically apply for this benefit (SC-ISP-3008).

These benefits are normally based on a person's and spouse's combined income for the previous year. However, this can be problematic in some instances. For example, what happens to seniors in the year after retirement? A senior can be earning an income of \$50,000.00 per year prior to retirement, but have no private pension income whatsoever subsequent to retirement. The *Old Age Security Act* contains provisions that enable individuals to request that their GIS be



paid at a rate based on the actual income that they will receive either subsequent to retirement or subsequent to experiencing a loss of pension income. The *Old Age Security Act* provides that this mechanism is available to a person who “ceases to hold an office or employment or ceases to carry on a business” and a person who “suffers a loss of income due to termination of or reduction in pension income.”

Seniors or spouses of seniors in this situation should contact the Service Canada offices at 1-800-277-9914 and request a form called “Statement of Estimated Income after Retirement or Reduction in Pension Income.” This form is not available online, and is only sent on request by the pensioner.

The form requires detailed information about all sources of income, including information about

Continued on page 12

¹ *Old Age Security Act*, RSC, 1985, c O-9, s 14.

as long-term care home beds. Those in retirement homes would have to be licenced and inspected by the Retirement Home Regulatory Authority (RHRA) and meet some minimal standards. Other beds are in accommodation that is not subject to any legislation regulating care standards. In fact, some may be operating illegally contrary to s. 95 of the *Long-Term Care Homes Act* and/or s. 33 of the *Retirement Homes Act*.

Transitional beds were piloted by the HNHB LHIN. Since the program's inception ACE has received constant complaints from older adults, their substitute decision-makers and families over the poor quality of this program.

Initially, callers often question the appropriateness of the program given the requirements of the older adult. In many instances, older adults or their substitute decision-makers are told that they must go to one of these beds and only then can they apply for admission to a long-term care home, which is untrue.

After touring the facility, it is common for callers to complain about poor design, inadequate services and accommodations that do not meet the standards of a long-term care home. These facilities may be a retirement home, or may be private, unregulated accommodations that merely act as a holding area to house discharged hospital patients with ongoing care needs while they wait for admission to a long-term care home.

In some cases, the lack of standards is shocking to our callers, and the risk of harm to vulnerable residents in these facilities is predictable and foreseeable. In the 2009 *Nineteenth Annual Report of the Geriatric and Long-Term Care Review Committee to the Chief Coroner of the Province of Ontario*, the Committee was critical of the use of such facilities

where the person required long-term care, and specifically stated at page 41:

Programs in private care or retirement homes in the Province of Ontario providing care to the frail elderly residents awaiting placement in a licensed long-term care home should be held to the same standards for care and services as a licensed long-term care home. Implicit in this recommendation is the need to ensure the same regulations and inspections with regular public reporting of findings that exists for licensed long-term care homes.

We see the use of these transitional beds as a coroner's inquest waiting to happen.

Short-Term Transitional Care is Not Appropriate for Long-Term Care Home Applicants

The total lack of standards and regulation of short-term transitional beds may be surprising to hospital patients who require long-term care, and to their families, loved ones and decision-makers. Persons who apply for long-term care in Ontario are only eligible for admission if they require around-the-clock access to nursing care, or at frequent intervals require assistance with the activities of daily living, on-site supervision or monitoring to ensure safety and well-being that is not available in the community. In short, they must have care needs that cannot be met in the community.

Cost to Participants

The cost of the transitional bed program is borne by the person. While some of the care may be provided through provincially funded home-care, the cost to the person is still high, from \$40 - \$110 per day in the HNHB program. In some programs,

Continued on page 8

Le calcul de Supplément de Revenu Garanti et du Droit à L'allocation de Conjoint Post-Retraite

- Rita Chrolavicius
Avocate Salariée

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En plus de préciser les droits à la pension de vieillesse, la *Loi sur la sécurité de la vieillesse* prévoit aussi les droits de Supplément de revenu garanti pour les aînés à faible revenu, âgés de 65 ans ou plus ainsi que leur allocation de conjoint. Si la personne aînée est en relation conjugale, le Supplément de revenu garanti et le droit à l'allocation de conjoint sont basés sur le revenu combiné de l'aîné et du conjoint.

Afin de recevoir les prestations de Supplément de revenu garanti, les personnes aînées doivent en faire une demande concrète. Le formulaire de demande (SC-ISP-3025) exige des renseignements sur le revenu de l'aîné et de son conjoint pour l'année précédente. Les conjoints âgés de 60 à 65 ans qui désirent recevoir un versement d'allocation de conjoint doivent en faire une demande (SC – ISP-3008).

Ces prestations sont en général basées sur le revenu combiné du requérant et de son conjoint pour l'année précédente. Cela pourrait toutefois être problématique dans certains cas. À titre d'illustration, on pourrait se demander ce qu'il adviendrait des aînés durant l'année qui suit la

retraite. Une personne âgée peut gagner un revenu de 50, 000.00 \$ par an avant sa retraite et n'avoir aucun revenu de régime de retraite privé à la suite de celle-ci. Ainsi, sans Supplément de revenu garanti ou d'allocation de conjoint, il pourrait y avoir une nette diminution du revenu familial.

La *Loi sur la sécurité de la vieillesse* contient des dispositions qui permettent aux particuliers d'exiger que leur Supplément de revenu garanti soit payé à un taux qui serait basé sur le revenu effectif qu'ils recevront soit après leur départ à la retraite ou après qu'ils aient subi une perte de revenu de régime de retraite privé. La *Loi sur la sécurité de la vieillesse* prévoit que ce mécanisme est disponible à un particulier qui cesse d'exercer ses fonctions, dont l'emploi prend fin ou qui cesse d'exploiter une entreprise et à une personne qui subit une perte de revenu en raison du fait que son revenu de retraite a pris fin ou qu'il a été réduit.

Les aînés ou leurs conjoints qui se retrouvent dans cette situation devraient contacter les bureaux de Service Canada au 1-800-277-9914 et demander le formulaire «Déclaration du revenu prévu après la retraite ou diminution du revenu de retraite». Ce formulaire n'est pas disponible en ligne. Il n'est fourni que sur demande du pensionné. Le formulaire exige des renseignements détaillés concernant toutes les sources de revenu, y compris des renseignements sur les dates de début et de fin à l'égard de divers types de revenu, tels que les prestations d'assurance-emploi, les indemnités de licenciement et les primes.

¹ *Loi sur la sécurité de la vieillesse* RSC, 1985, c O-9, s 14.

the care is provided in subdivided suites, meaning that private operators actually receive more money from transitional bed tenants than they would from regular tenants, but provide little or no personal care for that amount. Had the tenants been living in long-term care in a basic accommodation, the maximum they could be charged is \$58.99 per day, with rate reductions available depending on income.

Crisis Admissions to Long-Term Care

The Ministry envisions transitional care as an option for those who can be transitioned to temporary care and accommodation while they wait for space in their most appropriate discharge destination. The goal is to transition to permanent care within 90 days. To achieve this goal, those waiting for admission to long-term care must be designated as “crisis admissions.” Had they been in hospital, they would likely be ineligible for this designation, as hospitals are seen as safe places. This begs the question, why are patients being discharged to a situation which, is by definition, unsafe?

Another implication of the crisis designation is that it clogs the long-term care admission system. Persons who have applied for admission to long-term care from the community, and who have made the necessary arrangements to wait at home until an appropriate bed offer is made, will have little or no hope of ever being admitted to their home of choice unless they too are designated as a crisis admission. For example, in the HNHB LHIN where this program runs, the publicly available waiting lists indicate that homes are ONLY admitting from the crisis list.

Predictably, this causes some of those waiting at home for admission to reach their own crises that result in a hospital admission, ALC designation, and eventual long-term care admission from

a transitional bed. An already clogged long-term care admission system only becomes more clogged, more circuitous and more disempowering and intrusive for older adults wishing to gain admission to long-term care.

Transitional Care vs. Convalescent Care

Short-term transitional beds may be appropriate temporary accommodation for those who will eventually be discharged to the community. However, this appears to be a small group, based upon the present utilisation of these beds. Where patients require a period of up to 90 days to return to the community, use of the convalescent care beds, which are housed in long-term care homes, makes more sense. The added benefit to the older adult is that convalescent care is offered at no cost, removing the monetary barrier of keeping the older adult’s original home while working towards a return to the community.

Conclusion

In conclusion, transitional beds are a highly flawed model for older adults who do have care needs that cannot be met in the community and genuinely require admission to a long-term care home. In our view, the correct model would be to expand the capacity of the long-term care sector by adding permanent or interim long-term care beds that meet all applicable standards of the *Long-Term Care Homes Act* and would come under the oversight of the Ministry of Health and Long-Term Care.

In situations where additional time to recover is required, convalescent care, not short-term transitional care, should be used for hospital patients who are returning to the community, either before return to their own homes, or while they wait for an appropriate retirement home or supportive housing placement.

New Law: Grandparents Now Explicitly Entitled to Apply for Access or Custody of Grandchildren

- Angeline Douglas
Paralegal

Approximately 75,000 grandparents in Ontario are denied access to their grandchildren for no valid reason, according to Kim Craitor, the Liberal backbencher who has made several attempts to update the *Children's Law Reform Act* to correct this issue.¹ On December 8, 2016, the Ontario government passed Bill 34, *An Act to amend the Children's Law Reform Act with respect to the relationship between a child and the child's grandparents*.² The Act amended s. 21(1) of the *Children's Law Reform Act* to specifically include a grandparent as a party who may apply for custody or access to a child.

This amendment to the law is a welcome change from the previous version of the *Children's Law Reform Act*, which only provided that “[a] parent of a child or any other person may apply to a court for an order respecting custody of or access to the child or determining any aspect of the incidents of custody of the child,”³ broadly including grandparents under the category of “any other person.”



The amendments specifically name grandparents as entitled to apply for custody or access to a grandchild:

s. 21(1) A parent of a child or any other person, including a grandparent, may apply to a court for an order respecting custody of or access to the child or determining any aspect of the incidents of custody of the child.⁴

On an application for custody or access, the amendments also direct the court to consider the child's relationship with a grandparent when determining the best interests of the child:

s. 24(2) The court shall consider all the child's needs and circumstances, including,
(a) the love, affection and emotional ties

Continued on page 14

¹ Keith Leslie, “Grandparents rights bill will get public hearings in Ontario”, *The Globe and Mail* (April 21, 2013) online: *The Canadian Press* <<http://www.theglobeandmail.com/news/national/grandparent-rights-bill-will-get-public-hearings-in-ontario/article11443192/>>.

² 2nd Sess, 41st Leg, Ontario, 2016 (assented to December 8, 2016) SO 2016 C28.

³ *Children's Law Reform Act*, RSO 1990, c C12, s 21(1), as amended by Bill 34 An Act to amend the Children's Law Reform Act with respect to the relationship between a child and the child's grandparents, SO 2016 c 28.

⁴ *Ibid* [emphasis added].

Mauvais Traitements à L'égard Des Personnes Âgées

Les mauvais traitements à l'égard des personnes âgées sont un préjudice causé à une personne âgée par quelqu'un entretenant une relation privilégiée avec la personne âgée.

Les mauvais traitements à l'égard des personnes âgées incluent:

La violence physique, par exemple le fait de gifler, pousser, battre ou séquestrer;

L'exploitation financière, par exemple le vol, la fraude, l'extorsion ou l'abus du pouvoir conféré par une procuration;

La violence sexuelle, par exemple une agression sexuelle ou toute forme non désirée d'activité sexuelle;

La négligence, par exemple l'omission de fournir à une personne âgée dont vous prenez soin des vivres, des soins médicaux ou tout autre soin nécessaire, ou l'abandon d'une personne âgée dont vous prenez soin;

La violence émotionnelle, par exemple le fait de traiter une personne âgée comme un enfant ou le fait d'humilier, d'insulter, d'apeurer, de menacer ou d'ignorer une personne âgée.

Les mauvais traitements à l'égard des

personnes âgées peuvent aussi parfois constituer un crime en vertu du Code criminel du Canada. Voici des exemples possibles de crimes :

Violence physique, par exemple voies de fait, agression armée ou infliction de lésions corporelles, voies de fait graves, agression sexuelle armée, agression sexuelle grave, séquestration, meurtre ou homicide involontaire coupable;

Exploitation financière, par exemple vol, vol par une personne détenant une procuration, fait d'arrêter la poste avec intention de vol, extorsion, faux ou fraude;

Violence sexuelle, par exemple agression sexuelle armée ou agression sexuelle grave;

Négligence, par exemple le fait de causer la mort ou des lésions corporelles par négligence criminelle ou manquement au devoir de fournir les choses nécessaires à l'existence;

Violence émotionnelle, par exemple intimidation, proférer des menaces ou communications harcelantes.

Transportation to medical appointments for low-income seniors living in long-term care

- Clara McGregor
Staff Litigation Lawyer

In recent months, several seniors living in long-term care homes have contacted the Advocacy Centre for the Elderly with a pressing problem – they do not have the money or social/family supports to travel to medically necessary, non-emergency appointments. Without access to transportation, these seniors are unable to have their health issues diagnosed or receive essential treatments, putting their health and recovery in jeopardy.

Seniors living on fixed government income in long-term care typically spend their full monthly income on long-term care fees, less the regulated “comfort allowance” which is currently \$143.00/month. A resident may use this allowance to pay for, among other things, their telephone, hearing aids, clothing, dental care, and medical assistive devices. Once these “comfort” items are paid for, there is often no money left to cover even modest travel expenses to medical appointments.

Depending on the location of a long-term care home, a resident may need to travel several hours to a specialist appointment, thereby ruling out travel by local low-cost public transit. Further, a resident may require, depending on their health conditions, a wheelchair accessible vehicle or even non-emergency ambulance transportation resulting in trips that can cost hundreds of dollars.

At ACE, we take the position that cost should not be a barrier to treatment in Canada where we have a universal health care system. Long-term care homes are health facilities, and yet, under the current system, some residents who live in them are unable to access specialized care. It is the government’s responsibility to support these vulnerable individuals and to ensure that they get the health care that they need, regardless of their particular health condition or stage of treatment. In some cases, access to proper care may improve a resident’s condition to such an extent that they could leave long-term care and return to his or her home in the community.

ACE has raised this issue with the Ministry of Health and Long-term Care (“the Ministry”) on behalf of several clients. Unfortunately, there is no dedicated funding to ensure that long-term care home residents living on a fixed income can travel to medically necessary appointments. While the Ministry manages a pool of money known as the High Intensity Needs Fund, this money can only be used for limited, prescribed transportation costs such as travel to and from dialysis appointments.

There are some community programs that offer low-cost or free transportation for low-income individuals who need to get to specific types of appointments. For example, individuals may qualify for transportation to and from chemotherapy appointments through their local branch of the Canadian Cancer Society.

Continued on page 14



Individuals who receive GIS or Spousal Allowance benefits must file a tax return each year in order to continue receiving their benefits.

Guaranteed Income Supplement Continued from page 5

start dates and termination dates of various types of income, such as employment insurance benefits, severance pay and salary bonuses. Once this form is completed and sent to the Service Canada offices, the amount of the GIS benefit may be increased to reflect the individual's estimated income for the coming year.

If it is later determined that the person's actual income was different than the person's estimated income, a retroactive adjustment to the individual's GIS entitlement would be made to reflect any

overpayment or underpayment.

Individuals who receive GIS or Spousal Allowance benefits must file a tax return each year in order to continue receiving their benefits. If they do not file a tax return or send in an application for GIS or provide information about their annual income for the Spousal Allowance, their GIS or Spousal Allowance benefits will stop in July of that year until the required steps are taken to renew the benefits.

Supplément de Revenu Garanti Continued from page 7

Une fois que le formulaire est rempli et envoyé aux bureaux de Service Canada, le montant du Supplément de revenu garanti peut être augmenté afin de refléter le montant du revenu de travail estimatif du particulier en question pour l'année à venir.

S'il est déterminé par la suite que le revenu réel déclaré par le particulier était différent de son revenu estimatif, un ajustement rétroactif serait effectué au Supplément de revenu garanti du particulier afin de refléter tout excédant de paiement ou sous-paiement.

Les personnes qui reçoivent le Supplément de revenu garanti ou l'allocation de conjoint doivent remplir une déclaration de revenu chaque année afin de pouvoir continuer à recevoir leurs prestations. Si elles ne remplissent pas une telle déclaration, qu'elles ne soumettent pas une demande de prestations de Supplément de revenu garanti ou qu'elles ne fournissent pas de renseignements concernant leur revenu annuel pour l'allocation de conjoint, leur Supplément de revenu garanti ou leur allocation de conjoint cesseront en juillet de cette même année jusqu'à ce que les démarches nécessaires aient été prises afin de renouveler les prestations.

Chronic Care Co-Payment: Important Facts You Need to Know

- Jane E. Meadus
Staff Lawyer
Institutional Advocate

The “Chronic Care Co-payment” (sometimes referred to as the “Alternate Level of Care” or “ALC” Co-payment”) is a fee that hospital patients may be asked to pay in certain circumstances while in hospital pursuant to s. 10 of the Regulations to the *Health Insurance Act*.¹

ACE has identified common issues that patients and their families need to be aware of when asked to pay the Co-payment.

1. *The Chronic Care Co-payment rate reduction is calculated using only TAXABLE INCOME. This is different than the rate in long-term care homes, which is calculated using NET INCOME.*

When requiring a rate reduction, you must calculate based upon your taxable income. If using a Notice of Assessment, taxable income is found on line 260. The following are examples of non-taxable income that should not be included in the calculation: Guaranteed Income Supplement, Spousal or Survivor Allowance under Old Age Security (OAS) pension, Ontario GAINS, WSIB payments, Universal Child Care Benefits, and payments from a Registered Disability Savings Plan (RDSP).

Unfortunately, until recently hospitals have calculated the rate in error using net income, resulting in a much higher rate than is legally allowed. In September 2016, the Ministry of Health and Long-Term Care published a new rate reduction form,² which clarified that the Co-payment was to be calculated based on taxable income only.

2. *The hospital cannot charge you the Chronic Care Co-payment just because you are in complex continuing care/chronic care program.*

The regulation which allows such fees to be charged is in two parts: (1) the person must be receiving insured in-patient services in a certain category of hospital as set out in the regulations, AND (2) the person must, in the opinion of the attending physician, require chronic care and be more or less permanently resident in a hospital or long-term care home.

If the person is in complex continuing care/chronic care but is expected to move on to another level of care that is not one of the hospital categories or long-term care, then the hospital CANNOT charge the Co-payment.

Hospitals often believe that because the person occupies a complex continuing care/chronic

¹ RRO 1990, Reg 552.

² The Form can be found at <[http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-3264-54E~1/\\$File/3264-54E.pdf](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-3264-54E~1/$File/3264-54E.pdf)>.

Continued on page 15

Grandparents

Continued from page 9

between the child and,

(i) each person, including a parent or grandparent, entitled to or claiming custody of or access to the child...⁵

A court application can take time and may be contentious and expensive. For these reasons, grandparents seeking custody or access should have conversations with the child's parents or

⁵ *Ibid*, s 24(2) [emphasis added].

others seeking custody or access. Where access disputes arise, it may be better to seek mediation before applying to the court.

An application for grandparental access is a family law issue that is brought in the Family Court. Although the Advocacy Centre for the Elderly welcomes a grandparent's right to access and custody of a child, we would not generally provide representation in this area of law as it is not our area of expertise.⁶

Transportation

Continued from page 11

However, like the High Intensity Needs Funds, these community programs fall far short of providing a fair and comprehensive solution to this serious problem.

In one case, we contacted the Ministry on behalf of a client living in long-term care and secured funding for ambulance transportation to and from specialist appointments. The Ministry made an exception in this case and drew the money from the High Intensity Needs Fund. Despite this success story, we remain concerned, as the Ministry has yet to propose a comprehensive solution to this problem. Funding should not be limited to those cases in which a resident retains a lawyer and the Ministry grants an exception to the rule.

We can safely assume that for each long-term care home resident that contacts us regarding transportation barriers, there are many more facing the same challenges who have not contacted our clinic. We plan to continue our discussions with the Ministry in an effort to secure adequate funding for transportation to medically

necessary appointments for all long-term care residents in the province. We encourage anyone who is interested in this issue to contact their local member of provincial parliament to discuss their concerns.

Emergency Medical Transportation:

As a point of clarification, ambulance services in emergency situations are fully funded by the Ministry in situations where:

- The patient is a resident of Ontario; and
- The patient has a valid Ontario Health Card; and
- A physician deems the ambulance services medically necessary; and
- The patient lives in a long-term care home.

Individuals who do not meet the above criteria may be required to pay a \$45.00 or \$240.00 co-payment, depending on the circumstances. More information about Ontario Ambulance Services Billing can be found at:

<http://www.health.gov.on.ca/en/public/publications/ohip/amb.aspx>

If the ultimate goal is discharge to attendant or other community-based care, the hospital cannot charge the Co-payment, no matter how long the patient is in hospital.

care bed they can charge, even when the goal is to discharge the person to the community. If the goal is discharge to the community, then there cannot be any charge no matter how long the person is in hospital.

3. *The hospital cannot charge you the Chronic Care Co-payment because you stay in the hospital a certain length of time.*

Occasionally, a hospital takes the position that even though a person is awaiting placement in the community, for example in attendant care housing, they can charge the Co-payment because of the lengthy wait. This is not true. If the ultimate goal is discharge to attendant or other community-based care, the hospital cannot charge the Co-payment, no matter how long the patient is in hospital.

4. *The hospital cannot charge a patient who is in “slow stream rehab.”*

Some hospitals use complex continuing care/ chronic care beds as “slow stream rehab” beds, and charge for their use. It is not legal to charge

patients for in-hospital rehabilitation, even if those services are provided over a long period of time. If the purpose of the care is rehabilitation, the hospital cannot charge the Co-payment.

5. *If you have been a psychiatric patient during your hospital stay, you cannot be charged the Chronic Care Co-payment, even if you are now in a different unit and designated as “ALC” and waiting for placement.*

The *Health Insurance Act* specifically states that where a person is a psychiatric patient, he or she cannot be charged a Co-payment unless specific regulations allowing that are passed.³ No such regulations exist. Therefore, hospitals are prohibited from charging a Co-payment to someone who meets the definition of a patient under the *Mental Health Act*:⁴ for example, if the person was brought to hospital for example under a Form 1; detained as an involuntary patient under a certificate (Form 3 or 4), was a voluntary or informal psychiatric patient, or was in any other way treated as being a psychiatric patient (for example, were examined by a psychiatrist to determine whether they were capable of managing property pursuant to the *Mental Health Act*.⁵) The *Mental Health Act* does not allow for a

⁴ RSO 1990, c M7, s. 1.

⁵ *ibid*, s 54.

patient to be “undesigned” or discharged as a psychiatric patient during a hospital stay. As a result, the hospital cannot charge the chronic care Co-payment to the patient under the *Mental Health Act* at any time during his or her stay.

6. *You continue to be an insured person when you are “ALC.”*

Often patients or their families are told that they are “no longer covered by OHIP” when they have been designated ALC and this is why they have to pay the Co-payment. This is not true, even if they are designated as ALC. The legislation simply allows for an insured person to be charged an accommodation fee in certain circumstances; however, OHIP continues to cover the costs of healthcare during their stay.

7. *There are special rate reductions available when the patient has qualified dependants.*

One of the most common problems encountered is the failure of the hospital to properly calculate the accommodation rate when there are one or more qualified dependants. Dependants are generally spouses who are under the age of 65, or children under the age of 18.⁶

The rate should first be calculated WITHOUT inclusion of the dependants’ incomes, to determine what the Co-payment would be without dependants. Then the calculation should be made including all of the dependants’ incomes. Only where the rate is LOWER including the dependants

⁶ *Supra* note 1 at s 10(11).

One of the most common problems encountered is the failure of the hospital to properly calculate the accommodation rate when there are one or more qualified dependants.

should they be used in the calculation. It cannot be used to INCREASE the payment.

For example, a 45 year-old accident victim was a stay-at-home parent with one child aged 10. Her husband has a job making \$50,000 per year. She does not qualify for any government benefits and has no other sources of income. Her Co-payment is \$0 based upon her income. You do not need to do the dependant calculation. However, if the role was reversed, and it was the husband who was in the accident, you would include the wife and child as dependants in order to lower the chronic care Co-payment payable.

8. *The hospital is NOT REQUIRED to charge the Chronic Care Co-payment.*

In fact, while the legislation allows a hospital to charge the Co-payment it does not make it mandatory. Any money collected is revenue directly to the hospital. Therefore, they are entitled to use discretion to waive or lower the Co-payment depending on the circumstance of the individuals involved. If you believe that your situation warrants such action, you will need to speak to someone in management, as the person in the accounts department will not likely have such discretion.

Continued on page 17

9. You DO NOT have to provide the hospital with a copy of the patient's NOTICE OF ASSESSMENT from Revenue Canada in order to obtain a rate reduction.

The rate reduction is based upon estimated income,⁷ and therefore the hospital cannot demand a Notice of Assessment in order to determine the Co-payment. Where possible, some proof of income is helpful, including copies of bank statements, T4s, etc.

10. *Families, substitute decision-makers, attorneys for property, etc. are NOT RESPONSIBLE for the Chronic Care Co-payment.*

The Co-payment is owed by the patient, no one else. This is the case even if the patient is under a sponsorship agreement.

11. *You do not have to "agree" to pay the Chronic Care Co-payment.*

If you legally meet the legal criteria, the hospital is entitled to charge you the Co-payment. A hospital's decision not to charge you the Co-payment does not affect your status as an "ALC" patient as set out in the provincial ALC definition.⁸ However, they need to advise you as to a date when they will begin charging you the Co-payment. They cannot

⁷ *Ibid.*

⁸ The definition is set out by Cancer Care Ontario at <<https://www.cancercare.on.ca/ocs/alc/>>. For further discussion, see "Discharge from Hospital to Long-Term Care" at <http://www.aceclaw.ca/appimages/file/Discharge_from_Hospital_to_LTC%20February%202014.pdf>.

⁹ <<http://health.gov.on.ca/en/public/publications/chronic/chronic.aspx>>.

¹⁰ <http://www.aceclaw.ca/hospitals_-_publications.php>.

You cannot be charged the Chronic Care Co-payment if you are receiving palliative care.

fail to charge, then decide to "backdate" the Co-payment to when they now claim it "should" have been charged.

12. *You cannot be charged the Chronic Care Co-payment if you are receiving palliative care.*

There is no "maximum" amount of palliative care to which you are entitled, and the hospital cannot charge you just because you have been in palliative care longer than a fixed period of time. Unless there is a change of prognosis and you are no longer palliative, no fees can be levied. If you are already paying the Co-payment and become palliative, you can no longer be charged the Co-payment.

If the hospital wishes to charge you or someone you know the Chronic Care Co-payment, do not presume that the person calculating the fees will be aware of all of the rules. Make sure that you review the information available both in publications such as this as well as on the Ministry of Health and Long-Term Care website to ensure that any fee calculations are appropriate and legal. If you believe you are being improperly charged, seek legal advice.

General information about the Chronic Care Co-payment can be obtained online at the websites for the Ministry of Health and Long-Term Care⁹ and the Advocacy Centre for the Elderly.¹⁰

Save the Date

ACE Annual General Meeting

October 24, 2017 at 6:30 p.m.
Registration at 6:00 p.m.
Toronto Central Grosvenor Street
YMCA Centre
20 Grosvenor St., Toronto, ON M4Y 2V5

Please join us at the 2017 ACE AGM on the evening of October 24, 2017.

The Holly Street Advocacy Centre for the Elderly, Inc., is a non-profit charitable corporation that operates as the Advocacy Centre for the Elderly [“ACE”], a community legal clinic under the Legal Aid Services Act.

We are governed by a volunteer Board of Directors, the majority of whom are older adults.

At our October 24, 2017, AGM we will discuss clinic business, fill any vacancies on the Board of Directors, and make presentations of interest to our membership, older adults and the elder-law community. Anyone is welcome to attend, but only ACE Members in good standing for at least 30 days prior to the AGM may vote on business arising for the ACE Membership.

Our Members are individuals whose membership applications have been approved by the Board of

Directors, and have paid the annual membership dues of \$10/year for an individual and \$25/year for an organization. ACE Members receive two issues of the ACE Newsletter and the ACE Annual Report by mail or e-mail free of charge; receive notice of our AGM; and are entitled to vote on resolutions put to our Membership at our AGM.

Members of ACE are our supporters, our donors, and are a vital connection to the communities we serve. We value your membership as sign of your support for ACE and the work we do.

Your 2016-17 membership in ACE will expire at our October 24, 2017 AGM. Please take this opportunity to renew your membership now for the next funding year.

If you are not already an ACE Member, please apply for membership now for the coming 2017-18 funding year.

We cordially invite everyone to join us at our AGM on October 24, 2017.

Graham Webb
Lawyer
Executive Director

Call for Volunteers

ACE needs volunteers to assist us with answering and returning phone calls, handling documents and general office duties.

If you would like to assist us, please call us at (416) 598-2656 or email us at kabam@lao.on.ca for more information.

If you are not already a member of ACE, please consider joining. Benefits of membership include the ACE Newsletter (published twice a year) and voting privileges at the Annual General Meeting.

ADVOCACY CENTRE FOR THE ELDERLY:*
MEMBERSHIP APPLICATION

2 Carlton Street, Suite 701, Toronto, Ontario, M5B 1J3, www.ancelaw.ca

NAME: _____
(Individual or Representative of Corporation/ Partnership/ Organization -Please print)

(Name of Corporation)

ADDRESS: _____ APT. _____

CITY: _____ POSTAL CODE: _____

TELEPHONE: (Home) _____ (Business) _____

EMAIL ADDRESS: _____
(complete email address if you would like your newsletter via email instead of regular mail)

Membership Fee:

- Individual _____ \$10.00 is enclosed
- In addition to my membership fee, a donation of _____ \$_____ is enclosed**

* Holly Street Advocacy Centre for the Elderly Inc.

** A tax receipt will be issued for donations over \$10.00.

Your membership is important. If the fee presents financial difficulties, please feel free to join anyway at no cost.

Committee Membership: I am interested in seniors' issues and would consider membership on an ACE Committee. Yes ____ No ____

Membership Expiry Date: Annual General Meeting, Fall 2018.

Conflict of Interest Declaration

I confirm that neither I nor my spouse, if I have a spouse, nor the Corporation/Partnership/ Organization I represent (if Corporate, Partnership or other non individual member applicant) have an interest in a proposed or current contract, piece of litigation, client case, law reform, or any other activity or transaction of ACE that would place me in conflict with ACE. I also agree to abide by the conflict of interest guidelines in the ACE bylaw during the period of time I am a member of ACE.

Signature

ACE Bylaw - Conflict of Interest Guidelines - Summary

(Full text of the conflict of interest sections will be provided on request made to the ACE Office Manager at 416-598-2656)

Every Member who is, or may be, in any way directly or indirectly or who has a spouse who is, or may be, directly or indirectly or who is, or whose spouse is, an employee, officer or Director of an organization which directly or indirectly has, or may have, an interest in a proposed or current contract, piece of litigation, client case, law reform, or any other activity or transaction of the Centre shall make a full and fair disclosure of the nature and extent of the interest to the Board of Directors of ACE at the earliest opportunity after learning of the potential or actual conflict.

After making such declaration of such an actual or potential conflict, that member shall not take part in any discussion on the issue nor vote on such contract, piece of litigation, client case, law reform or any other activity or transaction nor shall he or she be counted in the quorum in respect to such contract, piece of litigation, client case, law reform or any other activity or transaction.

If a Member or Representative of a Corporate Member fails to make a declaration of his or her interest or the corporate interest in a contract, piece of litigation, client case, law reform or any other activity or transaction in compliance with this clause, he or she shall account to and reimburse the Centre for all profit realized by him or her and, upon resolution approved by a majority of the Board of Directors, shall submit his or her resignation as a Member.

Where any member feels that another member may be in a conflict of interest, the former may raise the issue at a Board meeting or at a meeting of the membership and the Chairperson shall discontinue discussion of the business at hand until the issue of conflict of interest has been dealt with.

Where a member fails or refuses to declare conflict of interest, the issue of whether or not such conflict exists may be determined by the Board by resolution moved, seconded and passed by a simple vote.

When it is so found, as set above, that a member is in a conflict of interest, he or she shall not take any further part in discussion on the issue and shall not vote on the issue.

No owner or management official of a long term care facility or employee of any organization representing long term care facilities or retirement homes shall be eligible to be elected to the Board of Directors of the Advocacy Centre for the Elderly.

Comments for the Editor

Comments about this newsletter may be sent to the editor, Christine Morano, via regular mail or email at moranoc@lao.on.ca.

Electronic Newsletters

To receive a copy of this and future newsletters electronically, please send an email to Jocelyne Hiley at hileyj@lao.on.ca