ACE

Advocacy Centre for the Elderly

ACE Newsletter

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SCAM ALERT

OLDER ADULT HOMEOWNERS BEWARE

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Since January 2022, the Advocacy Centre for the Elderly ("ACE") has regularly received calls from older adults who are shocked to discover that a mortgage or a lien (called a "notice of security interest" or "NOSI")[1] has been registered against title to their home without their knowledge or consent.

This type of scheme was recently the subject of a CBC Marketplace story: https://www.cbc.ca/news/business/seniors-mortgages-marketplace-1.6795104

[1]Notices of security interest are liens against equipment that are registered to the title of your home. When it comes time to sell or refinance your home, these notices of security interest usually need to be paid out.

ACE

Advocacy Centre for the Elderly

YOU ARE INVITED TO

THE ADVOCACY CENTRE FOR THE ELDERLY'S

39TH AGM

TUESDAY, OCTOBER 24, 2023

6:30 P.M. - 9:00 P.M.

BUSINESS MEETING FOLLOWED BY GUEST SPEAKER

WELLINGTON ROOM

GROUND FLOOR OF
55 UNIVERSITY AVENUE,
TORONTO, ONTARIO, M5J 2H7

REFRESHMENTS WILL BE SERVED

THE SCHEME

Many of the calls we receive follow the same pattern:

⇒ The older adults are highly vulnerable individuals, typically with limited means and education, and sometimes with marginal mental capacity.

⇒ The older adults are duped into signing a flurry of unfair door-to-door home service contracts for products and services that they do not need and cannot afford. In most cases the products and services are grossly overpriced and provide little to no value. In some cases they are completely bogus and fraudulent.

⇒ Financing for these door-to-door contracts is obtained and secured by NOSIs, "micro-mortgages" (typically less than $40,000) and/or lodgements of title registered against title without the homeowner's knowledge or consent.

⇒ The older adults are then approached by a "groomer", who makes repeated visits and falsely promises to get them out of these unfair contracts, free of charge. The older adults are often falsely promised "rebates" if they sign documents presented to them, which can pay for "free" renovations. The older adults are not given time to read the documents and copies of the documents are generally not left with them.

⇒ The older adults later discover that a private mortgage has been placed on their home with unfair terms, including high interest rates (of up to 25%); high brokerage, referral and lenders' fees,; and, pre-payment of interest for the full one-year term (making the mortgage difficult to discover until it becomes due).

⇒ The mortgages are unaffordable given the small fixed pension income of the older adults. As a result, the older-adult homeowners often default on the mortgage payments and are served with legal proceedings to sell or foreclose on their home.

⇒ The majority of the callers are low-income and cannot afford to retain lawyers in the private bar. As far as ACE is aware, there is currently no accessible remedy other than civil litigation.

Similarly, ACE has received many calls from older adults who discovered they have liens on their homes in extremely large amounts, $40,000 to $60,000 each, for products and services they deny agreeing to.

STEPS TO TAKE IF YOU BELIEVE YOU HAVE BEEN A VICTIM OF THIS SCHEME

If you believe you have been the victim of a mortgage or home service scheme, **seek legal advice right away.**

Aside from contacting us at ACE, you can contact the following organizations for referrals or legal assistance:

- Law Society Referral Service at www.findlegalhelp.ca or 1-855-947-5255 to speak to a lawyer or paralegal at no cost for up to 30 minutes.

- Pro Bono Ontario for 30 minutes of free legal advice: 1-855-255-7256 (toll free).

- JusticeNet www.justicenet.ca, which offers sliding scale legal fees to people who do not qualify for legal aid services.

If you have title insurance on your home, you should contact your title insurer immediately to see if this type of matter is covered under your policy. If you are not certain if you purchased title insurance when you purchased your home, we strongly recommend that you contact title insurance companies and ask if you have a title insurance policy on your property with each company. There are five title insurance companies in Canada: Stewart Title, First Canadian Title, Chicago Title, Travelers Canada and TitlePLUS.

If you are concerned that a crime has been committed, you can contact your local police department. You may also consider reporting the matter to the Canadian Anti-Fraud Centre at 1-888-495-8501 or www.antifraudcentre-centreantifraude.ca/report-signalez-eng.htm.

You may also wish to contact TransUnion (1-800-663-9980) and Equifax (1-800-871-3250) to have a fraud alert placed on your credit report, and to request copies of your credit report to see if there is any unusual activity.

If you provided a void cheque to an individual or business that you believe has engaged in unfair practices, contact your financial institution and consider changing your bank account.

If you have been repeatedly targeted by businesses calling you at home, consider changing your phone number and registering the number on the national **Do Not Call List**: https://lnnte-dncl.gc.ca/en.

Complaints to the Ministry of Public and Business Service Delivery

In Ontario, door-to-door sales of goods and services worth more than $50 are generally regulated by the *Consumer Protection Act, 2002*.

Under the *Consumer Protection Act, 2002*, you must be given a written contract. As well, if a business has represented their goods or services in a false, misleading or deceptive way, you can withdraw from the contract by giving notice to the business within one year to get a full refund.

If a business refuses to give you a refund, you can file a complaint with the Ministry of

Public and Business Service Delivery or take legal action. There is a complaint form on the Ministry website at www.ontario.ca/page/consumer-protection-ontario or call 1-800-889-9768.

Complaints to the Financial Services Regulatory Authority of Ontario ("FSRA")

All individuals and businesses in Ontario who carry out regulated mortgage brokering activities are required to be licensed with the FSRA unless otherwise exempted by the relevant legislation.

If you have a complaint about a mortgage agent, broker, brokerage and/or administrator, or if you are concerned that an individual or business carried out regulated mortgage brokering activities without a licence, you can make a complaint to FSRA: www.fsrao.ca/submit-complaint-fsra or call 1-800-668-0128.

Complaints to the Law Society of Ontario

If you discover that there was a lawyer who purported to represent you in placing any encumbrance on your property and you believe they failed to provide you with appropriate legal advice, you may wish to consider bringing a complaint to the Law Society of Ontario. Information about making a complaint is linked here: https://lso.ca/protecting-the-public/complaints/how-to-make-a-complaint

If you would prefer to fill out a complaint form on paper versus online, you can contact the Law Society at lawsociety@lso.ca or 1-800-668-7380 and ask them to mail you a complaints package.

Bringing a Claim in Court

In Ontario, there is a general two **year limitation period** to commence civil actions ("suing someone"), which begins when you knew or ought to have known you had a claim. If you are considering bringing a civil action, we recommend seeking legal advice right away.

How to Protect Myself from Door-to-Door Schemes

To protect yourself further from scams, we recommend the following measures:

- Do not give information about yourself, your family, your household or your finances over the telephone unless you place the call.
- Do not give information about yourself, your family, your household or your finances to any uninvited persons who might appear at your door.
- Do not allow unsolicited door-to-door salespeople into your home.

- If you require home equipment or services, do research on reputable companies and contact them directly. Make sure that the company you choose has a working phone number and/or email address, and check to see if the address provided is a real location, and not a mailbox in a UPS Store, for example.

- Search the company's name with the Better Business Bureau (https://www.bbb.org/) and the government's Consumer Beware List: https://www.consumerbewarelist.mgs.gov.on.ca/en/CBL/search.

- Be aware that local utility companies, government agencies, and regulatory organizations do not send salespeople door-to-door.

- Do not sign any contracts on the spot. Take the time to review contracts carefully and make sure you fully understand all the terms you are agreeing to.

- Know that you have the right to cancel a contract without any reason within a 10-day cooling off period, beginning the day you receive a written copy of the agreement.

- Do not sign any documents with any potential lender unless you have received independent legal advice from a lawyer of your own choosing (not a lawyer referred to you by the lender).

- Request copies of your TransUnion and Equifax credit reports to see if there are any irregularities.

- Regularly check your bank statements to make sure there are no unauthorized withdrawals.

- Do not give information or do any business over the internet unless you are completely satisfied that you fully understand with whom you are dealing and exactly what you are doing.

FOR MORE READING :

CBC Marketplace: 'Elaborate scam' leaves seniors with high-interest mortgages they didn't want or understand https://www.cbc.ca/news/business/seniors-mortgages-marketplace-1.6795104

Pro Bono Ontario: You Found a Lien on Your Home. Now What? https://www.probonoontario.org/2022/03/29/you-found-a-lien-on-your-home-now-what/

FSRA: Watch Out For Mortgage Fraud: https://www.fsrao.ca/consumers/how-fsra-protects-consumers/mortgage-brokering/watch-out-mortgage-fraud

ACE Involved in Precedent — Setting Homeless Encampment Case

Karen Steward

Staff Litigation Lawyer

On January 23, 2023, Justice Valente of the Ontario Superior Court released a landmark decision in an application where the Region of Waterloo sought to evict the residents of an outdoor homeless encampment located in a vacant lot in Kitchener.

In the decision, *The Regional Municipality of Waterloo v. Persons Unknown and to be Ascertained*, 2023 ONSC 670, Justice Valente held that a municipal bylaw, relied upon by the Region of Waterloo to evict the encampment residents, violated section 7 of the *Charter of Rights and Freedoms* (the "*Charter*"). Section 7 of the *Charter* provides that laws or state actions that interfere with a person's life, liberty, or security of the person adhere to the principles of fundamental justice – that is, the basic principles that underlie our notions of justice and fair process.

In reaching his decision, Justice Valente found that the Region of Waterloo did not have sufficient, accessible shelter beds to meet the needs of the homeless population:

> To be of any real value to the homeless population, the space must meet their diverse needs, or in other words, the spaces must be truly accessible. If the available spaces are impractical for homeless individuals, either because the shelters do not accommodate couples, are unable to provide required services, impose rules that cannot be followed due to addictions, or cannot accommodate mental or physical disability, they are not low barrier and accessible to the individuals they are meant to serve. [1]

Justice Valente also held that there were benefits of living in an encampment, including having a safe place to rest, access to social services and healthcare, a sense of community, and privacy. Eviction from the encampment, however, placed the encampment residents at risk of significant physical and psychological health problems, including a lack of stability, difficulty accessing services, increased health problems, and risk of death.

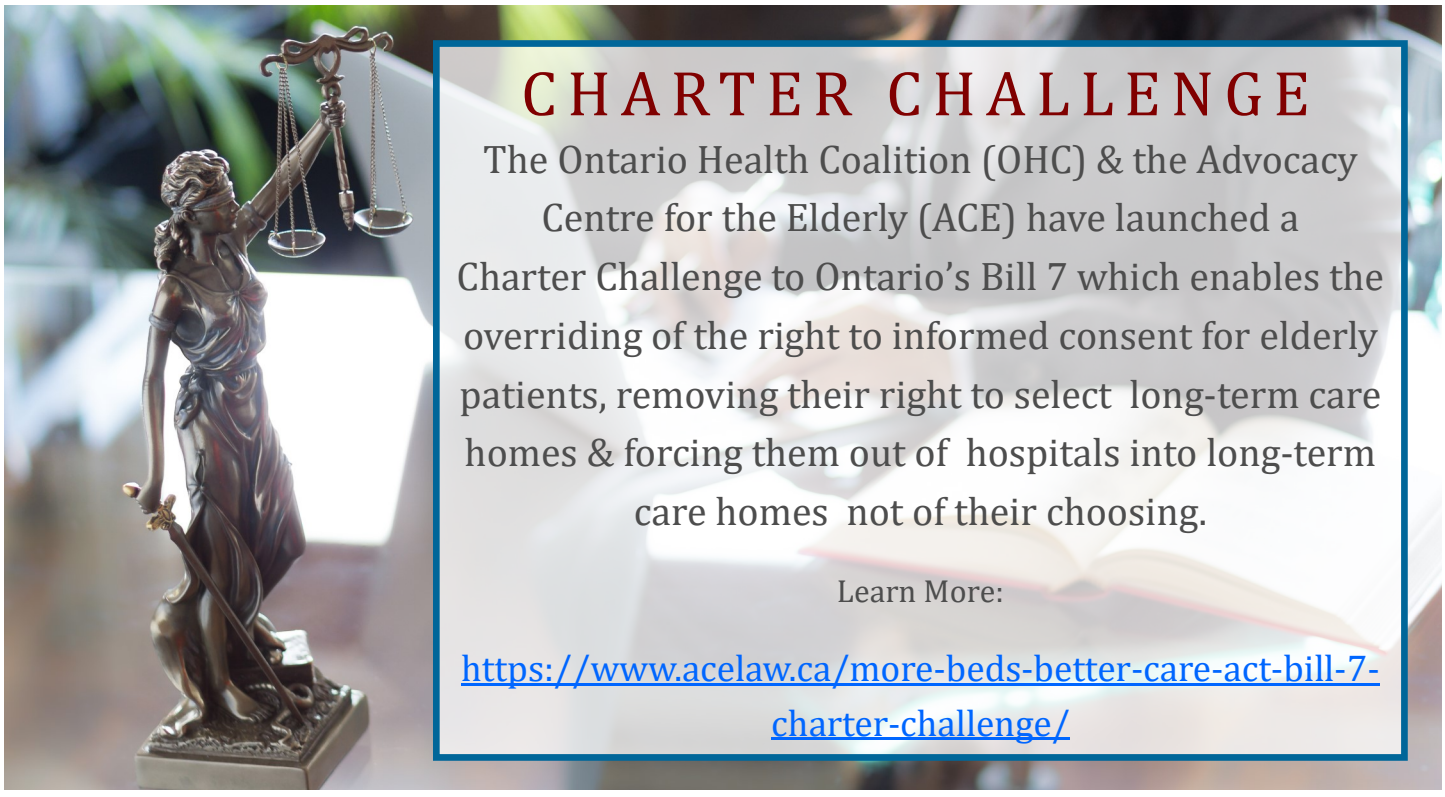
Significantly, Justice Valente held that eviction from the encampment would have a more severe impact on residents who suffer from mental health and/or substance abuse issues and who lacked the capacity to understand the consequences of enforcement of the bylaw.

Given the finding that the bylaw breached the constitution, Justice Valente declared that the bylaw is inoperative insofar as it applies to prevent the encampment residents from living and erecting temporary shelters on the vacant lot when the number of homeless individuals in the Region of Waterloo exceeds the number of accessible shelter beds. The Region of Waterloo did not appeal Justice Valente's decision.

Fellow legal clinic lawyers Shannon Down and Ashley Schuitema of Waterloo Region Community Legal Services acted on behalf 16 encampment residents as respondents to the application. The Court also appointed *amicus curiae* (or "friend of the court") in the case to put forward the perspectives of the many other encampment residents who lacked the mental capacity to instruct counsel. Lawyer Mercedes Perez was assisted in her role as amicus curiae by ACE staff litigation lawyer Karen Steward and Swadron Associates' Jen Danch.

This case is significant for ACE's clients as it highlights the harsh impact an eviction can have on a person with capacity issues, and the need for those perspectives to be carefully considered by a court or tribunal.

[1] *The Regional Municipality of Waterloo v. Persons Unknown and to be Ascertained*, 2023 ONSC 670, at para 93.



CHARTER CHALLENGE

The Ontario Health Coalition (OHC) & the Advocacy Centre for the Elderly (ACE) have launched a Charter Challenge to Ontario's Bill 7 which enables the overriding of the right to informed consent for elderly patients, removing their right to select long-term care homes & forcing them out of hospitals into long-term care homes not of their choosing.

Learn More:

https://www.acelaw.ca/more-beds-better-care-act-bill-7-charter-challenge/

MY DRIVER'S LICENCE WAS SUSPENDED FOR MEDICAL REASONS

How Can I Get My Licence Back?

Sarah Tella

Staff Litigation Lawyer

For many older adults, driving is an important part of their daily life. ACE often receives calls from older adults whose drivers' licences are suspended for medical reasons and who are now trying to navigate the process to get their licence back. This process can be confusing and expensive. This article will briefly discuss the general process to get your licence reinstated after it has been suspended for medical reasons.

MINIMUM MEDICAL STANDARDS TO DRIVE

The *Ontario Highway Traffic Act* (*HTA*)[1] regulates the licensing of drivers in Ontario.[2] All drivers have to meet minimum medical standards in order to be able to drive.[3] In particular, Ontario law provides that:

> a holder of a driver's licence must not,
>
> a) suffer from any mental, emotional, nervous or physical condition or disability likely to significantly interfere with his or her ability to drive a motor vehicle of the applicable class safely; or
>
> b) be addicted to the use of alcohol or a drug to an extent likely to significantly interfere with his or her ability to drive a motor vehicle safely.[4]

The *HTA* states that certain health professionals -- physicians, nurse practitioners and optometrists[5] -- are required to report specific medical conditions, functional impairments or visual impairments (all referred to in this article as "medical conditions" for ease of reference) that could prevent a person from driving safely to the Ministry of Transportation (MTO).[6] Mandatory reports relate to cognitive impairments, sudden incapacitation, motor or sensory impairment, visual impairment, substance abuse disorder or psychiatric illness under conditions that make it dangerous to operate

a motor vehicle,[7] unless the impairment is transient or non-recurrent[8] or is a modest or incremental change in ability attributable to the natural process of aging and that cumulatively does not constitute a danger.[9]

In addition, these medical practitioners can make discretionary reports of a non-prescribed medical condition, functional impairment or visual impairment that may make it dangerous for the person to operate a motor vehicle.[10]

On occasion, medical practitioners have made medical reports to the MTO on the basis of conversations or reports from family members and loved ones of an older adult, without having actually seen the driver whose rights are in issue. This is not lawful. One of the protections offered to allegedly medically incapable drivers is a legal requirement that the medical practitioner must "actually meet the reported person" for the purpose of the provision of medical or other services, or under some other prescribed circumstance, before making such a report.[11] This is a very important legal protection, as medical reports leading to a licence suspension should not be based on hearsay evidence.

If a mandatory report is made to the MTO about you under s. 203 (1) of the *HTA*, your licence will be immediately and automatically suspended.

However, a discretionary medical report to the MTO under s. 203 (2) of the *HTA* will not necessarily result in a licence suspension. A discretionary medical report will instead trigger a medical review process, and the outcome of that review will depend on an individual driver's medical condition and circumstances.

The MTO can also receive requests for a drivers' licence review from police officers,[12] which appears to a matter of government policy not based on any specific statutory authority. Although the MTO publishes a form for these requests,[13] neither the form itself nor the accompanying guide[14] offer any specific statutory authority for this form of request.

However, as with discretionary medical reports made under s. 203 (2) of the *HTA*, a request for a licence review by a police officer will not result in an immediate and automatic licence suspension, but rather will initiate a process of licence review that could eventually result in a drivers' licence suspension on a medical basis.

GETTING YOUR LICENCE BACK AFTER IT HAS BEEN SUSPENDED

If the MTO receives a medical report about you and they decide to suspend your licence, they will send you a formal notice of suspension and a letter letting you know what type of medical information they need from you to consider reinstating your licence. This information may include forms about your medical condition that a health professional will have to fill out. It is up to

you to find a health professional to fill out the forms for you. The documents from the MTO will be sent to the address that is on your driver's licence.

You will then have to send the requested documents to the MTO at drivermedicalreview@ontario.ca or by mail to:

Ministry of Transportation
Transportation Safety, Driver and Vehicle Services Driver Medical Review Office
77 Wellesley St. West, Box 589
Toronto, Ontario M7A 1N3

The MTO will review what you have sent and look at the details of the medical condition reported. The MTO will also look at the national medical standards for drivers in Canada when reviewing your information.[15] The MTO will then send you another notice in the mail to let you know if your licence has been reinstated or if you need to send them more information for them to consider. There may be a due date that the MTO will give you to send them more information.

The MTO may require that you perform a functional driving assessment. If this is the case, the MTO will send you a letter with a list of approved functional assessment centres. You can choose which functional assessment centre you would like to go to from the list. A functional assessment is an assessment that will occur with an occupational therapist and a driving instructor. The functional assessment includes an on-road driving test and in-clinic tests, including a physical examination and vision screening. The functional assessment takes a few hours. Unfortunately, these assessments are expensive and are not funded by the Ontario Health Insurance Plan (OHIP) or the MTO. You will have to pay for the cost of the assessment yourself. A functional assessment or driving evaluation is provided on a fee-for-service basis at a cost of hundreds of dollars.

ACE has written to the MTO expressing our concern over the cost of functional assessments. ACE receives calls from low-income older adults whose licences are suspended for medical reasons and who cannot afford the cost of the functional assessments they must have in order to get their licence back. ACE is not aware of any subsidies currently available to low-income drivers. Some drivers in remote rural locations have to travel many hours to get to an approved functional assessment centre. This is a significant barrier for low-income older adults to have their licence reinstated.

MTO reviews of medical suspensions should be completed within 15 days of their receipt of the requested medical information. However, these reviews are performed on a first-come first-serve basis, and there is no triage process for urgent applications.

THE APPEAL PROCESS

If your licence is not reinstated after you have provided the requested medical documentation, or after you have attended a

functional assessment if this was requested, you can submit an appeal to the Licence Appeal Tribunal (LAT).

Generally, the best evidence to bring before the LAT will be reports about you and your medical condition from health professionals. When you appeal to the LAT, it is up to the MTO to prove that your licence should remain suspended. The MTO will have to prove that:

1. you have either a mental, emotional, nervous or physical condition or disability, or an addiction to the use of alcohol or a drug; and,
2. this condition, disability or addiction is likely to significantly interfere with your ability to drive safely.[16]

The substance of the legal test is all about the medical condition at issue and how it may affect your ability to drive safely. All of the evidence you bring before the LAT should be relevant to this legal test. Other evidence, such as needing your licence to visit family or for other essential purposes, is not relevant to the legal test at hand. If you have any reports from a health professional that you would like to use for your appeal you must send them to the MTO at least 20 days before the hearing for the appeal.

In certain situations you may be able to request that the LAT reconsiders their decision. A "reconsideration" is not an appeal. A request for reconsideration will only be allowed in limited situations, which are set out in the Licence Appeal Tribunal Rules.

If the LAT does not reinstate your licence after your appeal, you could consider appealing their decision to the Ontario Superior Court of Justice. You will have 30 days from the date the LAT issues its decision. You will need to complete a Notice of Appeal form. Legal representation is recommended, and this process will cost you more money that you will again have to pay out of pocket and can be very time consuming.

CONCLUSION

Driving privileges and access to automobile transportation is a highly important element of independence for many, many older adults. At the same time, road safety is also a very high priority for older adults and Ontarians of all ages. However, Ontario's medical condition review process has come under criticism as unduly intrusive, expensive and difficult to process for drivers of all ages, let alone older adults.[17]

We need effective, transparent and affordable programs to screen and test drivers of all ages. The current process to get a licence reinstated after a medical suspension can take a very long time and places a significant burden on older adult drivers. ACE believes that there should be greater government involvement, assistance and financial subsidies available for functional assessments. ACE suggests that interested persons contact their local MPP or the Ontario Ombudsman to voice their concerns regarding the cost of functional assessments or any other relevant issue or barrier they encounter when trying to get their licence back after a medical suspension.

[1] *Highway Traffic Act*, R.S.O. 1990, c. H.8 (*HTA*).
[2] *Ibid.*, s. 1.2 and Part IV, ss. 31-58.2; and O.Reg. 340/94.
[3] O.Reg. 340/94, s. 14.
[4] *Ibid.*, s. 14 (1) (a) and (b).
[5] *Ibid.*, s. 14.2
[6] *HTA*, s. 203 (1).
[7] O.Reg. 340/94, s. 14.1 (3)
[8] *Ibid.,* s. 14.1 (4)
[9] *Ibid.,* s. 14.1 (5)
[10] *HTA*, s. 203 (2) and (3).
[11] *Ibid.*, s. 203 (4)
[12] See, e.g.: "Reporting process for police (Ontario: *Reporting a driver for medical review*: https://www.ontario.ca/page/reporting-driver-medical-review#section-6, accessed Sept. 15, 2023).
[13] *Medical Condition Report, Form 5108E (2022/11)*, available on-line at https://forms.mgcs.gov.on.ca/en/dataset/023-5108 (accessed Sept 15, 2023).
[14] *How to Complete the Medical Condition Report, Form 5108E_Guide* (2022/11), also available on-line at https://forms.mgcs.gov.on.ca/en/dataset/023-5108 (accessed Sept. 15, 2023).
[15] See O.Reg. 340/94, s. 14 (3) and "Medical Standards for Drivers" (being Part II of "Standard 6: Determining Driver Fitness in Canada" in the *National Safety Code*: Canadian Council of Motor Transport Administrators), available on-line at https://www.ccmta.ca/web/default/files/PDF/National%20Safety%20Code%20Standard%206%20-%20Determining%20Fitness%20to%20Drive%20in%20Canada%20-%20February%202021%20-%20Final.pdf (accessed Sept. 15, 2023).
[16] Tribunals Ontario, Information Sheet – Driver's Licences: Medical Suspensions and Downgrades LAT | Information Sheet – Driver's Licences: Medical Suspensions and Downgrades (tribunalsontario.ca)
[17] See, e.g.: John Marcheson, *Why is Ontario suspending so many licences?* (CityNews 680, posted March 11, 2023 at https://toronto.citynews.ca/2023/03/11/why-is-ontario-suspending-so-many-licenses/) (accessed Sept. 15, 2023, with embedded audio podcast).

LONG-TERM CARE HOME ACCOMMODATIONS CHARGES

Basic Accommodation Rates

As off July 1 2023, the co-payment for basic accommodation in LTC homes increased to $63.32 per day or $1,986.82 per month

Preferred Accommodation Rates

The premium charge for semi-private accommodation increased to $78.75 per day, and the premium for private accommodation increased to $93.32 per day.

Canada Pension Plan Benefits
Retirement Benefits and Post Retirement Benefits

Rita Chrolavicius

Staff Litigation Lawyer

The amount of your Canada Pension Plan (CPP) benefits will be affected by when you apply for and when you start receiving the CPP retirement benefits. Persons who apply early for benefits will receive less than individuals who delay applying. Persons should think carefully before deciding when to apply, and should contact Service Canada to get information about what CPP benefits they may have already built up.

STATEMENTS OF CONTRIBUTION

The decision about when to apply can be a complex one. It is a good idea for individuals to request a copy of their Statement of Contributions. This will show not only a history of their contributions for each year, but how much they may expect to receive if they retire at age 60, age 65 or age 70.

Service Canada is the office that administers CPP, Old Age Security (OAS) and the Guaranteed Income Supplement (GIS). Service Canada may be contacted at 1 800 277 9914. The Statement of Contributions can also be obtained online at: https// www.servicecanada.gc.ca

EARLY APPLICATIONS FOR CPP RETIREMENT BENEFITS

Individuals may apply for CPP Retirement at age 60 or at any time after age 60. This does not mean that the individual has to stop working.

If contributors start receiving their CPP retirement benefits at age 60, they will receive **36%** less than if they start receiving the benefits at age 65. Payments will decrease by **0.6%** each month you apply early (before age 65), or **7.2%** per year.

The proportional reduction in CPP retirement benefits that derive from an application for early payment of a CPP retirement benefit will continue for the full duration of the pension. In other words, if someone applies to receive a CPP retirement benefit at age 60, that person will receive 64% of the full pension they would have received at age 65, for life. **The 36% reduction in retirement benefits will last for life.**

APPLYING AFTER AGE 65

If you start receiving benefits after age 65, payments will increase by **0.7%** each month, up to a maximum of **42%** if you start at age 70 or later. There is no benefit in waiting to apply after you turn 70.

This proportional increase in CPP retirement benefit payments will, of course, also continue for life.

POST RETIREMENT CPP BENEFITS

If individuals continue to work between the ages of 65 and 70, they have the option of continuing to make CPP contributions. The employer must continue to contribute to the CPP benefits if the individual works after reaching age 65. To opt out of this arrangement, both the employer and the individual must sign forms to confirm that they are opting out of the arrangement. The CPP Post Retirement Benefits are different than the CPP Retirement Benefits. Post Retirement benefits are not subject to CPP splitting by a spouse

OTHER FACTORS

Other factors may affect a person's decisions about when to apply for CPP retirement benefits. If the individual has immediate cash flow needs, that may be a factor that influences their decision. If the individual has a short life expectancy, it may make sense to apply for early CPP retirement benefits.

In all cases, it makes sense to get a Statement of Contributions so that the individual is informed of what their CPP payments would be if they choose to retire at different ages.

2023 / 2024

PUBLIC PENSION RATES

More information on the Canada Pension Plan, Old Age Security pension and related benefits, the Canadian retirement income calculator and retirement planning can be found at https://www.canada.ca/en/services/benefits/publicpensions.html

Old Age Security pension (OAS)

A pension you can receive if you are 65 years of age or older and have lived in Canada for at least 10 years - even if you have never worked.

Guaranteed Income Supplement (GIS)

A benefit you may be eligible to collect if you are an Old Age Security recipient with low income.

Benefit	Your Situation	Max Monthly	Max Annual Income
OAS	AGE: 65 to 74	$698.60	Less than $134,626
OAS	AGE: 75 and over	$768.46	Less than $137,331
GIS	If you're single, widowed or divorced pensioner	$1,043.45	$21,168 (individual income)
GIS	If your spouse receives full OAS pension	$628.09	$27,984 (combined income)
GIS	If your spouse does not receive OAS pension	$1,043.45	$50,736 (combined income)
GIS	If your spouse receives the Allowance	$628.09	$39,168 (combined income)

Discharge from Hospital to Long-Term Care in the Wake of Bill 7:

IMPORTANT INFORMATION YOU NEED TO KNOW[1]

Jane E. Meadus
Staff Lawyer/Institutional Advocate

Alyssa Lane
Staff Lawyer/Institutional Advocate

The Advocacy Centre for the Elderly receives hundreds of calls each year with requests for assistance relating to discharge from hospital and admission to long-term care (LTC).

Long-term care homes (LTCHs) in Ontario are publicly funded and governed by the *Fixing Long-Term Care Act* (*FLTCA*), which was enacted on April 11, 2022[2] and replaces the *Long-Term Care Homes Act* (*LTCHA*), which had been in effect since July 2010.[3] While the *FLTCA* is a new piece of legislation, the bulk of the legislation and regulations remain the same as the *LTCHA*.

However, on September 21, 2022, the *More Beds, Better Care Act*[4] (Bill 7) was enacted and amended the *FLTCA*. The amendments now allow Home and Community Care Support Services (HCCSS)[5] placement co-ordinators to perform certain actions for patients in hospital requiring admission to a LTC without obtaining consent from the patient/substitute decision-maker (SDM), including: determining eligibility; selecting LTCHs; and, authorizing a patient's admission to a LTCH. Related amendments now require hospitals to charge patients $400 per day when the patient remains in hospital for more than 24 hours following a discharge order. [6]

In this article, we explain the recent changes to the LTCH admission process for patients in hospital. We also address common issues with hospitals and HCCSS that patients and SDMs contact our office about.

1. LTC ADMISSION PROCESS

a. Regular Process

Admission to LTC is governed by the *FLTCA*. When a hospital patient is no longer acutely unwell and requires admission to a LTCH, the HCCSS placement co-ordinator will be contacted to complete an application in hospital. Contact with HCCSS may be initiated by hospital staff, the patient, an SDM or family members. HCCSS placement co-ordinators are responsible for determining eligibility and keeping information up-to-date, processing applications to LTCHs, authorizing admissions, and keeping waiting lists. [7]

While awaiting LTC placement in hospital, the person should be designated by the attending clinician[8] as an "Alternate Level of Care" or "ALC" patient. This means that the person is in hospital and the attending clinician is of the opinion that the person no longer requires the intensity of resources or services provided in the hospital care setting.[9]

To determine eligibility and the ALC patient's care requirements, the HCCSS placement co-ordinator will require that the following assessments be completed for the patient: i) physical and mental health, and requirements for medical treatment and health care (completed by a doctor or nurse in the required form); ii) functional capacity, requirements for personal care, current behavior, and behaviour during the previous year; and iii) any other assessments or information provided for in the regulations.[10] The HCCSS placement co-ordinator will use this information to complete the Resident Assessment Instrument (RAI) assessment. Once completed, a score is generated indicating the level of care required which assists the placement co-coordinator in determining eligibility for admission to LTC. An evaluation of the patient's mental capacity to make placement decisions will also be completed to determine whether the patient is able to make their own decision about placement in a LTCH.[11] If the patient is not mentally capable of their own placement decision, their highest-ranking SDM will make the decision on their behalf.[12]

Once an ALC patient is determined to be eligible for admission to LTC,[13] the patient/SDM will be asked to select LTCHs to which they wish to apply. The placement co-ordinator will provide the patient/SDM with information about the process for being admitted to LTCHs: choices the patient/SDM has and implications of those choices; alternative services; the patient's responsibility to pay LTCH accommodation fees and the maximum amounts that may be charged; rate reductions that are available and application requirements; approximate length of waiting lists; vacancies; and how to obtain information (including inspection reports) from the Ministry of Long-Term Care.[14] Where the patient/SDM wishes, the HCCSS placement co-ordinator will assist them in choosing LTCHs.[15] When choosing homes, the placement co-ordinator must consider the patient's preferences relating to

admission based on ethnic, religious, spiritual, linguistic, familial and cultural factors.[16] The patient/SDM may choose any LTCH in the province of Ontario and the HCCSS shall work with the HCCSS in that area regarding the application.[17]

The HCCSS placement co-ordinator will then provide each selected LTCH with a copy of the patient's assessments and information.[18] LTCHs have five business days to review the patient's application and either approve or deny their admission.[19] Where a LTCH requests further information from the placement co-ordinator about the patient, the LTCH has an additional three business days to approve or deny the patient after receiving this information.[20]

Once the patient is approved by the home, the HCCSS placement co-ordinator will add the patient to the home's waitlist and will contact the patient/SDM once a bed offer becomes available. Patients/SDMs typically only have 24 hours to accept or refuse a bed offer.[21] Patients can hold a bed for up to five days by paying the accommodation rate before losing the bed. The patient must move in before noon on the fifth day and must pay the applicable accommodation rate even if they do not move in on the fifth day.[22] However, patients would not be penalized if there are reasons beyond their control that prevent them from moving into the home within this timeframe, such as the patient suffering from a health condition, short-term illness or injury, or an emergency or outbreak of disease at the home.[23]

Currently, ALC patients in hospital waiting for admission to LTC are designed as "Category 1 - Crisis"[24] for all LTCH choices, which puts them in one of the highest waiting list categories. Persons in the "crisis category" are not restricted to applying to a maximum of five homes and may apply to mores LTCHs if they wish.

If a patient in hospital has already applied for LTCH admission while in the community, the HCCSS may be required to update the patient's LTCH application to ensure that the most up-to-date information is available.[25] A new evaluation of capacity may be required if it appears the patient's capacity to make the decision has changed.[26]

b. Bill 7 Amendments

The amendments resulting from Bill 7 modified the admission process for ALC patients requiring admission to a LTCH. HCCSS placement co-ordinators are now authorized to take the following actions, with or without the consent of the ALC patient/SDM:

- Commence an application for admission to LTC on behalf of a patient;
- Determine the ALC patient's eligibility for admission to a LTCH;
- Collect and release personal health information from a variety of sources and provide the LTCH with assessments and information, including personal health information;
- Select LTCH(s) for the ALC patient in

accordance with the prescribed geographic restriction;

- ◊ Authorize the ALC patient's admission to a LTCH; and,
- ◊ Transfer responsibility for the placement of the ALC patient to another placement co-ordinator who, for greater certainty, may carry out the actions listed above with respect to the ALC patient.[27]

The amendments also allow an attending clinician who reasonably believes that a patient in hospital may be eligible for LTCH admission to contact the HCCSS placement co-ordinator and request that any or all of the above actions be carried out, with or without the patient/SDMs consent.[28]

The HCCSS placement co-ordinator, as well as a physician or registered nurse (who is not employed by HCCSS) are now permitted to determine eligibility for LTC admission for an ALC patient in hospital.[29] While an ALC patient cannot be forced to participate in an assessment to determine eligibility, if they refuse, their eligibility will be determined without their co-operation based on all information available to the placement co-ordinator at the time.[30] Information can be now be collected, used and disclosed to the HCCSS placement co-ordinator from a variety of sources, without the patient/SDM's consent, to determine the patient's eligibility for LTC admission or to carry out their admission to a home.[31]

Once the ALC patient is determined to be eligible for admission to a LTCH, the HCCSS placement co-ordinator will provide the patient/SDM with information about the approximate length of waiting lists in relevant LTCHs, vacancies in relevant LTCHs, and how to obtain information (including inspection reports) from the Ministry of Long-Term Care.[32] At that point, if the patient/SDM refuses to apply to LTCHs or refuses to add additional homes (particularly homes with idle beds or short-waitlists where admission would occur within six months or less),[33] the HCCSS placement co-ordinator will select one or more homes for the patient without consent. [34]

When selecting LTCHs without consent, the HCCSS placement co-ordinator must consider the ALC patient's condition and circumstances, class of accommodation requested (if any), and the proximity of the home.[35] If no class of accommodation has been selected, the placement co-ordinator will select basic accommodation.[36] LTCHs selected by the placement co-ordinator must be within 70 km of the patient's "preferred location", which is the address supplied by the patient/SDM. If no preferred address is provided, then it is either the patient's primary address or, if there is none, the hospital.[37]

If the patient's preferred location is in the North East or North West HCCSS, homes selected by the placement co-ordinator must be within a 150 km radius of their preferred location. However, if there are no homes with vacancies within the 150 km radius, the placement co-ordinator will choose the next

closest home or homes to the patient's preferred location.[38] Additionally, HCCSS placement co-ordinators have been "encouraged" by the government to select LTCHs with idle beds and short-waitlists.[39]

The HCCSS placement co-ordinator will then provide each LTCH with the patient's assessments and information (including personal health information). This includes homes selected by the placement co-ordinator which the ALC patient/SDM did not consent to.[40]

HCCSS placement co-ordinators can now authorize a patient's admission to a LTCH selected by the placement co-ordinator.[41] While a person cannot be physically transferred to a LTCH without consent, if the ALC patient/SDM refuses a bed offer to a home that they have selected OR refuses to move to a LTCH selected and authorized by the HCCSS placement co-ordinator without their consent AND the patient remains in hospital, a discharge order would likely be signed. If the patient remains in hospital more than 24 hours after the discharge order is signed, the hospital is legally required to begin charging the patient $400 per day for each day they remain in hospital.[42] The ALC patient will also be removed from the waitlist for the refused home, but will continue to remain crisis on the waiting list for all remaining homes while in hospital.[43]

It is important to understand that if an ALC patient moves into a LTCH selected by the ALC patient/SDM, the patient would drop in category on the waiting list to transfer to any higher choice homes (i.e. would not maintain their "crisis" status on the waiting list to transfer). In contrast, if an ALC patient/SDM agrees to move into to a LTCH selected and authorized by the HCCSS placement co-ordinator, the patient would remain on the crisis category to transfer for up to five preferred homes.[44]

HCCSS placement co-ordinators can also authorize a patient's admission to preferred accommodation even if only basic accommodation has been requested. The patient would still be charged the basic rate and can apply for any applicable rate reduction.[45] However, the patient would be placed on the LTCH's internal transfer list for basic accommodation.[46] Once basic accommodation becomes available, if the patient refuses to transfer, they will be charged the preferred rate as designated for that room.[47]

The changes resulting from Bill 7 remove the fundamental rights of choice and consent in the placement process for ALC patients in hospital, which we believe to be contrary to the Canadian *Charter of Rights and Freedoms*.[48] However, if the ALC patient/SDM changes their mind and decides to consent at any time during the admission and placement process, the HCCSS placement co-ordinator must ensure that all the requirements of the *FLTCA* are now met, including those related to consent.[49]

Section 52 sets out the requirements for consent under the *FLTCA*.

Elements of consent

52 (1) The following are the elements required for consent to admission to a long-term care home:

1. The consent must relate to the admission.
2. The consent must be informed.
3. The consent must be given voluntarily.
4. The consent must not be obtained through misrepresentation or fraud.

Informed consent

(2) A consent to admission is informed if, before giving it,

(a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the admission; and

(b) the person received responses to their requests for additional information about those matters.

Same

(3) The matters referred to in subsection (2) are:

1. What the admission entails.
2. The expected advantages and disadvantages of the admission.
3. Alternatives to the admission.
4. The likely consequences of not being admitted.[50]

Where there is an SDM, the placement co-ordinator has an obligation to advise them of the decision-making rules contained in section 42 of the *Health Care Consent Act* (*HCCA*),[51] as follows:

Principles for giving or refusing consent

42 (1) A person who gives or refuses consent on an incapable person's behalf to his or her admission to a care facility shall do so in accordance with the following principles:

1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.
2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.

Best interests

(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

(a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;

(b) any wishes expressed by the incapable person with respect to admission to a care facility that are not required to be followed under paragraph 1 of subsection (1); and

(c) the following factors:

1. Whether admission to the care facility is likely to,

i. improve the quality of the incapable person's life,

ii. prevent the quality of the incapable person's life from deteriorating, or

iii. reduce the extent to which, or the rate at which, the quality of the incapable person's life is likely to deteriorate.

2. Whether the quality of the incapable person's life is likely to improve, remain the same or deteriorate without admission to the care facility.

3. Whether the benefit the incapable person is expected to obtain from admission to the care facility outweighs the risk of negative consequences to him or her.

4. Whether a course of action that is less restrictive than admission to the care facility is available and is appropriate in the circumstances.[52]

The placement decision-making requirements for SDMs are restrictive, meaning that they can only make their decision in accordance with these principles. This was not changed by Bill 7. This creates conflict for the SDM when trying to make LTCH choices as they are often being pressured to apply to homes that they do not believe are in the ALC patient's best interests.

Additionally, HCCSS placement co-ordinators must make "reasonable efforts" to obtain the consent of the ALC patient/SDM before they can act without consent.[53] "Reasonable efforts" are not defined in the *FLTCA*. However, the HCCSS placement co-ordinator must continue to engage the ALC patient/SDM at each stage of the admission process and obtain consent whenever possible. The placement co-ordinator must also explain the consequences of not consenting.[54]

However, there is no requirement that they explain the consequences of consenting, which may have a fundamental impact on the placement process as will be discussed in the next section.

2. COMMON ISSUES

a. Hospital discharge "policies"

Hospitals often tell patient/SDMs that LTCH assessments cannot be completed in hospital. Patients may be told that they must return to the community to be assessed and wait for LTCH admission. This is not true. Individuals have the legal right to be assessed for LTC in the hospital OR in the community by HCCSS placement co-ordinators. Hospitals cannot interfere in this process. Also, once a patient has been deemed eligible for admission to a LTCH, they can legally stay in the hospital to await LTC placement.

Regulations to the *Public Hospitals Act* require a person to leave the hospital no later than 24 hours after a discharge order has been made.[55] Looking at this provision, it would appear that once a patient no longer requires treatment, they must be discharged from hospital, with the only exception being a 24-hour grace period. However, the reality is that there are many people in hospital who no longer require treatment but are allowed to stay until their discharge destination, such as a LTC home, becomes available. Hospitals rely on this section of the legislation to require people to comply with their internal "policies". However, we do not believe that these policies are supported in law.

One must understand that it is the attending physician, nurse practitioner, midwife, or dentist who is an oral and maxillofacial surgeon who discharges, not the hospital or discharge planner. In almost all cases, it would be the attending or "most responsible" physician who must discharge. However, the physician owes the patient a duty of care to discharge them to a safe place. LTCHs are part of our healthcare system, and as such, the person is entitled to a seamless transition from one level to the next.

The regulations to the *Health Insurance Act*[56] specifically contemplate that patients will have to wait in hospital until a LTC bed is available. The government has set a maximum daily fee that can be charged while the ALC patient is waiting for placement from hospital into a LTCH (known as the ("hospital chronic care co-payment" or "ALC co-payment"). It is the same maximum amount that a resident in basic accommodation in a LTCH can be charged,[57] subject to any applicable rate reduction.[58] It is therefore clear that those patients waiting for LTCH admission are allowed to remain in hospital until placed, and should not be discharged within 24 hours of no longer requiring acute care.

However, staying in the hospital for any great

length of time is also not ideal. The likelihood of a patient deteriorating while waiting for placement, including loss of mobility and incontinence, is high. There is also increased risk of contracting hospital-borne infections. Nevertheless, for some patients there is no safe place for them to wait in the community and they have to stay in the hospital to await LTC placement. There is often a dispute with the physician/ hospital/HCCSS as to what a "safe discharge" is. This will be discussed in section 2(c) below.

It is possible that the attending clinician could sign a discharge order requiring the patient to return to the community. If the patient/SDM disagrees with the discharge plan and refuses to leave the hospital within 24 hours of the discharge order being signed, the hospital would begin charging the patient $400 per day to remain in hospital. If a clinician discharged a patient unsafely to a place that cannot meet their care needs, that could be grounds for a complaint to their professional college or for potential civil litigation.

b. Refusal by HCCSS to determine eligibility/take application from hospital patients

HCCSS placement co-ordinators are increasingly refusing to take applications for admission to a LTCH from hospital patients.

Patients are being told that they must return to the community before a LTCH application will even be taken. This is based on the Ministry of Long-Term Care's *Field Guide* which states, "Home First should be explored as the preferred discharge destination before LTC is considered".[59] However, the *Field Guide* only states that "Home First" should be explored: it does not make it mandatory.

Patients are also being told that HCCSS policy "requires" a referral from the hospital social worker or other hospital staff worker in order for HCCSS to take the application. In many cases, it is the hospital staff who are actively blocking the patient from being assessed.

This is contrary to the legislation, which requires that an application be taken and eligibility determined, upon request.

The results is that that people who cannot be managed at home, or who have no home to return to, are being told that they must leave the hospital before they are even allowed to apply for admission to LTC. Such rigid "policies" and misinformation are not only against the interest of patients, but they are dangerous to those very individuals that the HCCSS has an obligation to assist. These policies only serve to assist hospitals with their bed capacity issues: they are not created for the benefit of patients.
The law is clear that where requested, the placement co-ordinator must complete an application and determine eligibility for

admission to LTC, even if the patient is in hospital.

HCCSS placement co-ordinators also cannot refuse to take an application because they have pre-determined that the person might be ineligible. If an application for admission to LTC is completed and the person is determined to be ineligible for admission to LTC, then the applicant may have that finding reviewed by an administrative tribunal called the Health Services Appeal and Review Board (HSARB). If an application is not completed, then the person's right to apply to have the finding of ineligibility reviewed by HSARB is negated.[60] Therefore, if the patient/SDM believes that an application is warranted, they must demand that it be completed, so that they can pursue their right to challenge any finding of ineligibility for admission to LTC.

c. Discharge "choices" pending LTC admission

Hospital patients are routinely told that they cannot stay in hospital to await LTCH placement. Patients are often given one of the following so-called "choices": return home or live with family; go to a retirement home; be admitted to a short-term transitional care unit; or go to a residential care facility to wait for admission to LTC. In some cases, patients have even been told they should go to, and in fact have been sent to, homeless shelters to await placement into a LTCH.

First, the fact that a person has been deemed eligible for LTC admission means that their care needs cannot be met in the community using available publicly funded community-based services and other caregiving, support or companionship arrangements available to the person. While the HCCSS placement co-ordinator has an obligation to advise hospital patients about other options that they may wish to consider,[61] a person cannot be forced into one of these "options" outside the healthcare system when they have been deemed eligible for admission to a LTCH.

Under the "Home First/Wait at Home" strategy, hospital patients are encouraged to return home with increased levels of care from HCCSS, in the hopes that they can either wait at home until a LTCH bed becomes available, or until a LTCH bed is no longer required. However, what patients are not told is that this increased level of care is generally only provided for a limited amount of time. After a few weeks, services start being pulled back. If the person is not admitted to a LTCH within that period, they would be without the care and services that they require, putting them at serious risk.

Family members are often told that they "must" care for the patient at home. Family members cannot be forced to care for a person. In fact, if a person who had been providing care says they are not able to safely do so any longer, it could be negligent to discharge the patient into that person's care.

Patients are regularly told that they must go to a retirement home pending LTCH placement. Retirement homes are not LTCHs. Rather, they are residential tenancies where meals and care services are also purchased.[62] They are not equivalent to LTCHs, and they are not part of the healthcare system.[63] While some people choose retirement home living even when they are eligible for a LTCH, one cannot be forced into a retirement home as an alternative to a LTCH. Not only are retirement homes less stringently regulated with less detailed caregiving standards, they are entirely private-pay and they are entirely outside of the healthcare system.

Patients might also be told that they must go to a "short-term transitional care unit" pending LTC placement.[64] Community-based short-term transitional care units are not a part of the hospital, and they are located in retirement homes or other kind of congregate living setting. The care is typically provided by a private caregiving service. Short-term transitional care units are not regulated, licensed, inspected or overseen by either the Ministry Long-Term Care or any other Ministry, and they are not required to meet the same standards as LTC beds. Those units located in retirement homes are not part of the retirement home and so are not inspected by the Retirement Home Regulatory Authority (RHRA) or required to comply with the *Retirement Homes Act*. In fact, people living in those units report that they are often not allowed to participate in retirement-home programming. Beds in other non-retirement-home facilities are similar in that the accommodation is usually not governed by any legislation regulating care standards. In fact, some of these facilities, whether in retirement homes or other congregate care settings, may be operating illegally contrary to s. 98 of the *Fixing Long-Term Care Act* and/or s. 33 of the *Retirement Homes Act*. Short-term transitional beds may be appropriate temporary accommodation for those who will eventually be discharged to the community, but they are often not appropriate for people who require admission to a LTCH.

Lastly, there is an increased number of patients being referred to residential care facilities, loosely referred to as "retirement homes", but some of these homes are not able to obtain a retirement-home licence[65] and they are in fact operating illegally. Others are operating as unlicensed group homes. The care in these facilities are also not governed by any legislation or standards.

These units and facilities do have to meet other legal criteria, such as public health and fire safety codes, so if there are issues in these areas public health units and fire service agencies can be contacted for assistance.

Bottom line, patients deemed eligible for admission to LTC are not required to select any of these "choices" outside the healthcare system when they have been deemed eligible for and require admission to

a LTCH. It is something that someone may wish to do if it meets their needs. One must also be aware that if you are admitted to one of these units you are not guaranteed to be a crisis category for admission to your homes of choice. You will need to discuss this with the placement co-ordinator prior to accepting such a bed.

d. Misinformation regarding home choices

Hospitals/HCCSS often have "policies" that ALC patients/SDMs are told that they must comply with when selecting LTCHs. For example, patients/SDMs are frequently told that they must select a certain number of LTCHs or must select LTCHs from a short-list, and if they do not, their application will not be "accepted" by the placement co-ordinator. This is not legal.

There is no requirement that an ALC patient/SDM "must" select a certain number of LTCHs or must select LTCHs from a short-list. Many of the LTCHs included on "shortlists" are homes with idle beds and short wait lists because they have difficulty in attracting residents for some reason. For example, the LTCH may be in a bad location, the physical facility may be a problem due to age or poor upkeep, or they may have a poor inspection record.[66]

Despite being told that they "must" comply with these "policies", this is not the case. The consent would not comply with the legal requirements of informed consent, as it would be based on misinformation.[67] Further, if an SDM were to give substitute consent to admission to a LTCH that the ALC patient, while capable, clearly indicated they would not want to be admitted to, or that the SDM did not believe could meet their needs, they would be in violation of section 42 of the *HCCA*, as it would violate the principles for giving or refusing substitute consent. While the HCCSS placement co-ordinator can apply to and authorize a patient's admission to a LTCH selected by the placement co-ordinator without the patient/SDMs consent in some circumstances, the patient/SDM is not "required" to select LTCHs that are not satisfactory and that they do not want to go to.

Also, it also important to understand that any LTCH a patient/SDM includes on their choice sheet (even ones which they are pressured into adding from a "short-list" that they are told will only be temporary) become one of their "preferred homes". If a patient is then admitted to that home, the patient is no longer designated as being on the crisis list for transfer to another LTCH, as it is a home that they "chose". As a result, the patient is unlikely to ever transfer to one of their higher choice homes because individuals in the crisis category will always take precedence. In contrast, in cases where the placement co-ordinator chooses homes without the patient/SDM's consent and the patient is admitted to that home, the patient retains their crisis status for up to five home choices. While people designated as crisis in

the hospital and the community awaiting admission to LTCH will still take precedence within the crisis category, these individuals still have a higher likelihood of transferring to one of their true preferred homes than those who were coerced by the placement co-ordinator to "choose" one or more short-listed home, thereby losing their crisis status for transfer.

Next, some patients/SDMs are told that a patient in hospital cannot be designated as crisis in hospital for admission to a LTCH or can only be designated as crisis if the patient selects homes in accordance with a hospital "policy". This is not true, and it is not legal. There is no requirement that a patient must comply with an illegal hospital policy to be designated as crisis for LTCHs in hospital. The law is clear: the HCCSS placement co-ordinators must designate all ALC patients in hospital waiting for admission to LTC as crisis for all LTCHs that are on their choice sheet.

Again, it is the obligation of the HCCSS placement co-ordinator to ensure that where consent for admission to LTC is given, the consent is valid, meaning it complies with the *FLTCA* and the *HCCA.* If LTCH "choices" are made based upon misinformation, such as ALC patients/SDMs being told that they "must" choose a certain number of homes or they "must" choose homes from a short-list, then the consent is not legally valid and cannot be accepted by the HCCSS placement co-ordinator.

Where an HCCSS placement co-ordinator does not comply with the law, a complaint should be made to management of the HCCSS directly, as well as to the Long-Term Care Family Support and Action Line (Tel: 1-866-434-0144). While the Ministry of Long-Term Care does not directly inspect hospitals, we also recommend that complaints regarding illegal hospital placement policies be sent to both the Ministries of Health and Long-Term Care.

e. Issues with Hospital "ALC Co-payments"

The chronic care co-payment (sometimes referred to as the "Alternate Level of Care" or "ALC" co-payment) is a fee that hospital may charge ALC patients for the cost of meals and accommodation in certain circumstances while in hospital pursuant to section 10 of the regulations to the *Health Insurance Act*.[68] It is the same maximum amount that residents in basic accommodation in LTCHs are charged, subject to any applicable rate reduction. Rate reductions in hospital are calculated differently than in long-term care. Effective July 1, 2023, the maximum co-payment amount is $65.32 per day or $1,986.82 per month.

The ALC designation in itself does not mean the patient can be charged the chronic care co-payment. An ALC patient can only be charged the co-payment if they meet all the requirements set out in the regulation.[69] First, a doctor must designate the patient as either being chronic care, or more or less

permanently resident in a hospital or LTCH. Second, the patient must be receiving insured in-patient services in a certain category of hospital as set out in the regulations. Additionally, certain patients cannot be charged the co-payment, such as patients receiving income support from ODSP/OW, patients receiving palliative care,[70] patients admitted to hospital under the *Mental Health Act*,[71] patients in a slow-stream rehabilitation bed, or patients whose ultimate discharge destination is back to the community.[71] It is very common for hospitals to try to charge patients the co-payment when in fact the patient is exempt from such charges.

Rate reductions are available for low-income patients and patients with dependents. The rate reduction is calculated based on the patient's estimated CURRENT TAXABLE income less a comfort allowance of $149 per month to cover the cost of personal expenses.[72] Some proof of income must be provided, which can be bank statements, an income-tax Notice of Assessment, etc. If using a Notice of Assessment, taxable income is found on line 260. (The following are examples of non-taxable income that cannot be included in the calculation: Guaranteed Income Supplement (GIS), Spousal or Survivor Allowance under the Old Age Security (OAS) pension, Ontario GAINS payments, WSIB payments, Universal Child Care Benefits, and payments from a Registered Disability Savings Plan (RDSP).) It is very common for hospitals to overcharge patients as administrators are not properly trained in rate reductions and there is no oversight of their work.

Generally, a rate reduction calculation is based only upon the patient's income. If a patient's spouse has a high income, the spouse's income cannot be included when calculating the patient's rate reduction.[73] However, if there are dependents as defined in the regulations and including them would lower the rate the patient had to pay, this should be done. The rate reduction for qualified dependents (which includes spouses under the age of 65 and children under age 18) of hospital patients is more generous than that available in LTCHs.[74] Where there is a spouse aged 65 or older, if they are entitled to receive either OAS or GIS, they are not classified as dependents; however, if they are very low income they may be able to claim a small rate reduction as well.[75]

Next, hospitals frequently do not tell the ALC patient or their attorney for property that they are going to start charge the co-payment; or, alternatively, they fail to charge the co-payment (often due to disputes over the discharge destination of the patient) and then try to illegally "backdate" it to when they now claim it "should" first have been charged. If this happens, the patient or their attorney for property should complain to the hospital and only pay after the date they were notified that a co-payment would apply.

Hospitals also may "require" family members

to sign a guarantor agreement consenting to be personally responsible for any outstanding co-payment or other hospital charges. This is not legal. The co-payment is owed by the patient only.[76] Family members, SDMs and attorneys for property are not responsible to pay the chronic care co-payment and should not sign these agreements.

Lastly, where a patient has private insurance to cover the cost for a semi-private or private room in the hospital, they should be aware that, generally, insurance companies will not cover the cost of a semi-private or private room once the patient is designated as "ALC". The patient should immediately contact their insurance company to check their coverage, and if not covered, must notify the hospital that they no longer want a semi-private or private room. Otherwise, they could be personally responsible to cover the cost of a semi-private or a private hospital room, which can run to several hundreds of dollars per day.

CONCLUSION

There is, unfortunately, a great deal of misinformation given to patients and their SDMs concerning the process of applying for admission to a LTCH from hospital. The issue has only been exacerbated by the enactment of Bill 7, which can result in the removal of the fundamental right of choice and consent for hospital patients in the placement process. It is hoped that by having the correct legal information, ALC patients and their SDMs will have the tools to better advocate for the patient's rights during this extremely challenging time.

[1]This article updates the previous article prepared by ACE called *Discharge from Hospital to Long-Term Care: Issues in Ontario*.

[2]S.O. 2021, c. 39, Sched. 1.

[3]S.O. 2007, c. 8.

[4]S.O. 2022, c. 16 – Bill 7. For ease of reference the *More Beds, Better Care Act, 2022*, which was an amendment bill and its regulations will be referred to as "Bill 7" as it is known colloquially, even though the legislation and regulations are now in force.

[5]Previously known as the Local Health Integration Network (LHIN).

[6]R.R.O. 1990, Reg. 965, s. 16(3.1).

[7]*FLTCA*, s. 48-50; O. Reg. 246/22 s.182.

[8]In most cases, this will be the attending physician, nurse practitioner O. Reg. 965 s. 16(6).

[9]*FLTCA*, s. 60.1(1).This definition of "ALC" is very problematic with this population as it is subjective and there are often disputes regarding whether the person is truly ALC, and if they are, what the appropriate destination is.

[10]*FLTCA*, s. 50(4).

[11]*Health Care Consent Act, 1996*, S.O. 1996, s. 2, Sched. 2, s. 40(1). Until a person is evaluated and found incapable of making a decision, no one else can make a personal care decision for them, even if the person has named someone as their attorney in a power of attorney for person care.

[12]*HCCA* s. 20.

[13]If the person is found to be ineligible for LTC, they may apply to the Health Services Appeal and Review Board for a review of the determination of ineligibility. *FLTCA*, s. 60.1(8).

[14]O. Reg. 246/22, s. 171.

[15]*FLTCA*, s. 51(3).

[16]*FLTCA*, s. 51(4).

[17]*FLTCA*, s. 51(6).

[18]O. Reg. 246/22, s. 178.

[19]O. Reg. 246/22, s. 179(4).

[20]O. Reg. 246/22, s. 179(5).

[21]O. Reg. 246/22, s. 203(e).

[22]O. Reg. 246/22, s. 203(f).

[23]*ALC patients who refuse an offer of admission to a prior-chosen LTC home bed*, Memo of Rachel Kampus, ADM (A), Ministry of Health and Long-Term Care, Health System Strategy and Policy Division, May 12, 2012.

[24]O. Reg. 246/22, s. 240.3(2).

[25]*FLTCA* s. 51((11).

[26]*HCCA* s. 4(3).

[27]*FLTCA*, s. 60.1(3)2.

[28]*FLTCA*, s. 60.1(3)1.

[29]*FLTCA*, s. 60.1(3)3. However, given the overall lack of knowledge by doctors and nurses of the placement process s and eligibility criteria, it is likely that the HCCSS placement co-ordinators will continue to determine eligibility in most cases.

[30]O. Reg. 246/22, s. 240.1(8).

[31]Sources include hospitals, primary care providers, home and community care service providers, community mental health and addiction services, and agencies under the *Services and Supports to Promote the Inclusion of Persons with Developmental Disabilities Act, 2008*. O. Reg. 246/22, s. 240.1(8)-(11); s. 240.2(10).

[32]O. Reg. 246/22, s. 240.1(5), 240.2(1)

[33]*Admissions to Long-Term Care Homes for Alternate Level of Care Patients from Public Hospitals: Field Guidance to Home and Community Care Support Services Placement Co-ordinators*, Government of Ontario: September 14, 2022, page 9.

[34]O. Reg. 246/22, s. 240.2(2).There is no set number of homes the HCCSS placement co-ordinator must select for the ALC patient.

[35]O. Reg. 246/22, s. 240.2(5).

[36]O. Reg. 246/22, s. 240.2(6).

[37]O. Reg. 246/22, s. 240.2(12).

[38]O. Reg. 246/22, s. 240.2(7) & (8).

[39]*Field Guide*, page 9.

[40]O. Reg. 246/22, s. 240.2(10).

[41]*FLTCA*, s. 60.1(3) iv; O. Reg. 246/22, s. 240.3(5).

[42]R.R.O. 1990, Reg. 965, s. 16(3.1).

[43]This is different from applicants in the community. If a person in the community refuses a bed offer in a LTCH applied to they previously applied to, the placement co-ordinator will remove the person from every waiting list they are on. The person must wait at least 12 weeks before they can start a new application, unless there is a deterioration in their condition or circumstances. O. Reg. 246/22, s. 184(1).

[44]O. Reg. 246/22, s. 240.3(11).

[45]O. Reg. 246/22, s. 240.3(6).

[46]O. Reg. 246/22, s. 240.3(7).

[47]O. Reg. 246/22, s. 240.3(8).

[48]See www.acelaw.ca for information about our Charter challenge.

[49]*FLTCA*, s. 60.1(6).

[50]*FLTCA*, s. 52.

[51]*M.A. v. Benes*, 1999 CanLII 3807 (ON C.A.).

[52]*HCCA, 1996*, S.O. 1996, c. 2, Sched...A, s. 42.

[53]*FLTCA*, s. 60.1(4).

[54]O. Reg. 246/22, s. 240.1(5) (d) & (e).

[55]R.R.O. 1990, Reg. 965, s. 16.

[56]R.R.O. 1990, Reg. 552.

[57]Effective July 1, 2023, the maximum co-payment amount is $65.32 per day or $1,986.82 per month, subject to any applicable rate reduction.

[58]The rate reduction in hospitals differs from that in LTCHs, see s. 2(e) Issues with Hospital ALC Co-Payment below.

[59]*Field Guide*, page 6.

[60]*FLTCA*, s. 50(9).

[61]O. Reg. 246/22, s. 171(1).

[62]Retirement homes come under the definition of “care homes” which are tenancies under the *Residential Tenancies Act, 2006*, S.O. 2006, c. 7.

[63]Retirement homes must be licensed and there is a process for reporting improper treatment, abuse and neglect to the Retirement Home Regulatory Authority. However, their ability to inspect and take action when problems are found is limited.

[64]Determining the status of these facilities can be tricky as some are part of a hospital, and some are not, and there is often not a clear way of determining this as during COVID, hospitals were allowed to designate space in retirement homes and hotels as being part of the hospital. These units are NOT listed on the government website listing public hospital locations and may be staffed by hospital or third party employees. We have also had issues relating to these units as they may try to operate in non-hospital ways in certain situations. If you are unclear, we suggest you seek legal advice on the status of the beds.

[65]Licenses can be checked at: www.rhra.ca.

[66]Inspection reports on LTCHs can be found on the Ministry of Long-Term Care's website: http://publicreporting.ltchomes.net/en-ca/default.aspx

[67]*FLTCA* s. 52.

[68]R.R.O. 1990, Reg. 552, s. 10.

[69]Reg. 552, s. 10(1) & (2)

[70]The patient does not have to be admitted as a palliative care patient for the exemptions to apply.

[71]*Health Insurance Act*, R.S.O. 1990, c. H.6, s.46.

[72]This includes patients waiting for a short-stay convalescent care bed in a LTCH or for home care, supportive housing, retirement home, etc.

[73]This is different from the rate in LTCHs, which is calculated using NET INCOME from the previous year's notice of assessment.

[74]Reg. 552, s. 10(11).

[75]The form to be completed is Form 3264-54 E/F "Hospital Chronic Care Co-payment Form"

[76]The form to be completed is Form 3266-54 "Application for Reduction of Assessed Co-payment fees".

[77]Reg. 552, s. 10.

The Residential Rent Increase Guideline for 2024

In Ontario, most residential tenancies can only be increased once every twelve months, with at least 90 days' written notice. The amount of the increase in most cases is a maximum percentage of your current rent, set by the provincial government and known as the "guideline" amount.

For increases that take effect in the year 2023, the guideline amount has been set as 2.5%. For increases that will take effect in 2024, the guideline amount will be 2.5%. Be sure to review any notices of rent increase from your landlord carefully to ensure that the proposed increase is lawful. Visit Steps to Justice https://stepstojustice.ca/legal-topic/housing-law/paying-rent/rates-and-increases/ or contact your local community legal clinic if you have questions or concerns about your proposed increase.

A Message from the Executive Director

Graham Webb, LL.B., LL.M.
Lawyer/Executive Director

A RETURN TO IN-PERSON, ON-SITE STAFFING AND SERVICES

In concert with many other businesses and agencies, ACE has gradually returned to providing in-person services on-site using a hybrid in-person/remote staffing model. ACE staff for the most part attend our offices in-person on-site three days per week, and work remotely from home – as they had previously done during the pandemic – the other two days per week.

ACE offices are staffed in-person on-site Monday through Friday from 9 a.m. to 5 p.m., and our phones are live-answered throughout the day. We do receive a very high volume of calls, and it is not always possible for us to answer all incoming calls while we are already on the phone with other callers, and for that reason we still have many calls go to voicemail. However, it is our goal and our practice to answer as many live calls as humanly possible, and to be available to in-person on-site visitors throughout regular business hours.

It is a great pleasure for many of us to return to work on-site. We are once again able to meet in-person and enjoy the informal exchanges of knowledge and information and the camaraderie of our co-workers.

Even more importantly, we value being on-site to meet with the older adults we serve, many of whom may have sensory impairments and a genuine preference to tell their stories and receive legal advice in-person – and it is our great pleasure to serve them in-person as well. Direct, personal service is a core value of ACE and its' staff.

OFFICE MOVE TO 55 UNIVERSITY AVE. NEAR UNION STATION & ST. ANDREW SUBWAY STATION

Over this past winter, ACE moved its office from 2 Carlton St. – at the corner of Yonge and College – to the Co-operative of Specialty Legal Clinics of Ontario (CSLCO) at 55 University Ave. – at the corner of University and Wellington, walking distance from Union Station and steps away from St. Andrew subway station. We moved into our new premises on May 27, 2023, and opened the doors to the public the next week.

"55U" is the fourth office in our clinic's history. We incorporated in 1984 as the Holly St. Advocacy Centre for the Elderly Inc. because our first offices were at 40 Holly St., near Yonge and Eglinton, in North Toronto. Soon after that, we moved to larger offices at 120 Eglinton Ave. E., where were worked

until 1997. We just completed a 26-year tenancy at 2 Carlton St., directly over College Station, and we have now entered into a long-term lease at 55U, which we hope will carry us into the indefinite future.

Our new office offers many advantages, the most important being security of tenure – as our previous site had received a site-plan approval for a new 72-story commercial and residential condo development– and we were at risk of a 12-month termination that was written into our lease. We are grateful to Legal Aid Ontario (LAO) and CLSCO for funding and accommodating the build-out of our new space, and for welcoming our move into our new premises.

Our new space also offers better technology, and more extensive facilities and client meeting spaces for our clients and other visitors, which we share with our clinic co-op partners. We also enjoy the informal in-person contact and collaboration with our clinic co-op partners that is now more easily available on-site.

LAUNCH OF A NEW ACE WEBSITE

www.acelaw.ca

After years of work, ACE launched its new more secure, comprehensive, searchable and interactive website coincidentally with our office move in June 2023.

ACE received substantial support from the LSO-funded CLEO clinic website development project in the early stages of this initiative. Still, due to the large size of our website, the complexity of the materials, and limitations on our internal resources to develop this resource, this project took a great deal longer to complete than had ever been imagined. However, now that the job is done, we feel that the new website is an excellent product that will serve our clients well, and will continue to be an important public-service resource.

As Executive Director, I would like to personally thank our many ACE board members over the years it took to complete this project for their constant support and guidance; in particular our long-standing board member Mary Ann Kim, who brought diligence, perseverance, leadership and an extraordinary measure of skill and expertise to completion of this project; and our Community Outreach Co-ordinator, Kimber-lee Wargalla, without whom the project could not have been completed.

The ACE website continues to undergo changes and further development on a regular basis. Our staff meets monthly to review and revise the website, and we plan to engage our Board of Directors on a regular basis to assist and guide us in this work.

We also strongly encourage active review and participation from our clients and the general public as to their observations and suggestions for improvement on our website

– or any other matter -- which can always be made by phone, in-person at our office, by mail or by email to info@ace.clcj.ca at any time. We are always happy to hear from the public we serve.

BILL 7

As reported by Staff Lawyers/Institutional Advocates Jane Meadus and Alyssa Lane in their extensive article in this issue, "Discharge from hospital to long-term care in the wake of Bill 7: Important information you need to know", the *More Beds, Better Care Act*[1] (Bill 7) was enacted on September 22, 2022.

Sadly, this amendment to Ontario law did not provide any more beds, nor any better care for Ontario long-term care home residents.

Bill 7 did remove freedom of choice for Ontario hospital patients seeking admission to long-term care by allowing Home and Community Care Support Services (HCCSS) and hospital staff to choose a long-term care home for a hospital patient, and to authorize the patient's admission without their consent. This is a gross abrogation of the right of informed consent to admission to a healthcare facility.

Furthermore, Bill 7 also allowed HCCSS and hospital staff to disseminate a patient's personal health information without their consent to the long-term care homes chosen for the patient, also without their consent. This is an extremely intrusive violation of privacy that in large and small communities could be particularly terrifying for older adults who do not want their personal health information so widely shared. There is no end to the type of sensitive personal information that anyone, especially someone from a marginalized community, might not wish to share such as the presence of a communicable disease, mental infirmity, sexual orientation and the like that should not be shared without the person's informed consent.

ACE has joined with the Ontario Health Coalition (OHC) as joint applicants before the Ontario Superior Court to challenge the constitutional validity of this legislation in a legal action that is now in progress and before the courts. Further details – including the Notice of Application filed, summaries, and extensive affidavit evidence from both expert witnesses and fact witnesses -- are available online on the new ACE website: https://www.acelaw.ca/more-beds-better-care-act-bill-7-charter-challenge/

ACE acknowledges the leadership, co-operation and generous support of the OHC and our lawyers, Goldblatt Partners LLP, without whom this important public policy initiative would not be possible.
ACE solicits charitable donations in support of the legal costs of this important test-case litigation.

[1] *S.O. 2022, c. 16.*

MORTGAGE FRAUD

As reported by Staff Litigation Lawyers Karen Steward and Sarah Tella, and Community Outreach Co-ordinator Kimber-lee Wargalla in their article in this issue, "Scam Alert: Older Adult Homeowners Beware", ACE has witnessed a deluge of mortgage frauds against older adults across Ontario. A large part of our response is direct client services: we advise and represent as many older adult homeowners who qualify for Legal Aid services and as our professional staffing and caseloads will allow. However, the demand for service far outstrips our available resources. We have been successful in many cases with effective referrals to private practice lawyers – some of whom are acting *pro bono* – and in some cases we are acting as co-counsel with privately engaged lawyers to assist in their representation of vulnerable older adults.

Lately, we have seen the Law Society of Ontario suspend lawyers engaged in these mortgage fraud schemes. We are hopeful that disciplinary action will follow from the Financial Services Regulatory Authority (FSRA) against mortgage brokers involved in these same schemes. Police services across Ontario – including the OPP Serious Fraud Unit— are conducting active investigations, and we fully expect that criminal charges will eventually be laid.

ACE is devoting considerable effort to systemic responses as well, such as public education and public policy campaigns. We have published materials on the ACE website https://www.acelaw.ca/consumer-protection-resources/warning-scams-targeting-seniors/ — and we are collaborating with agencies such as the FSRA on public education and policy responses. We have also written to Ontario government Ministries seeking systemic changes that would help protect the rights of older adults.

AGM
October 24, 2023 at 6:30 p.m. at 55 University Ave. Toronto, ON M5J 2H7

Notice of the ACE Annual General Meeting (AGM) to be held at 55 University Ave., Toronto, ON M5H 2H7 on the evening of October 24, 2023, is contained in this issue of the ACE Newsletter, along with an application for membership to our clinic, the Holly St. Advocacy Centre for the Elderly Inc., a non-profit charitable corporation. This will be our first in-person AGM held since 2019. We encourage membership applications, and would welcome your attendance at our upcoming AGM. Please support us by joining our clinic, and/or attending our AGM on October 24th at 6:30 p.m.

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o/a Advocacy Centre for the Elderly ["ACE"]

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HOLLY STREET ADVOCACY CENTRE FOR THE ELDERLY INC.

NOTICE OF ANNUAL MEETING

TAKE NOTICE that a meeting of the members of the Holly Street Advocacy Centre for the Elderly Inc. ("ACE") will be held in-person in the Wellington Room at 55 University Ave. Toronto, Ontario, M5J 2H7 at the hour of 6:30 p.m. on the 24th day of October, 2023 for the following purposes:

I. To hear reports presented by the Chairperson of ACE, the Treasurer of ACE, and the Executive Director of ACE.

II. To elect members of the Board of Directors to replace outgoing members of the Board of Directors who are retiring or who have completed their term of office.

III. To appoint Auditors for ACE.

IV. To transact such further or other business as may be necessary or desirable, in connection with the organization of ACE or otherwise.

We hope that you will attend this annual meeting. If you are unable to attend, kindly sign and return the form of proxy provided with this notice.

DATED on the 15th day of September 2023

Sincerely,
The ACE Board of Directors

P R O X Y

The undersigned member of the Holly Street Advocacy Centre for the Elderly Inc. ("ACE") hereby appoints

_____

proxy, with power of substitution, to attend and vote for and on behalf of the undersigned at the Annual Meeting of members of ACE to be held on:

October 24th 2023,

and at any adjournment thereof, with full power to the said proxy to waive notice of such meeting on behalf of the undersigned.

DATED _____, 2023.

_____

Member's Signature

_____

Member's Name

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

Name: _____

Address: _____ Apt: _____

City: _____ Postal Code: _____

Telephone: _____ Email: _____

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 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 2024.**

Conflict of Interest Declaration

I confirm that neither I nor my spouse, if I have a spouse, nor the Corporation/Partnership/ Organization I represent, 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 or full text of the conflict of interest sections will be provided on request made to the Community Outreach Co-ordinator:

Kimber-lee Wargalla
(416) 598-2656 x 1231 or Kimberlee.wargalla@ace.clcj.ca
or visit our website: www.acelaw.ca

ACE
Advocacy Centre for the Elderly