vancouver coastal Health
Promoting wellness. Ensuring care.

Central Addictions Intake Team (CAIT)
Vancouver Mental Health & Addiction Services
320 – 1669 E. Broadway, Vancouver, BC V5N 1V9
Ph: 604-675-2455 Ext:22573, Fax: 604-877-1504

APPLICATION FOR ACCOMMODATION FEE SUBSIDY

APPLICATION DATE ______ / ______ / ______ (MONTH DAY YEAR) BILLING REFERENCE # ______

CLIENT NAME ______ BIRTHDATE ______ / ______ / ______ (MONTH DAY YEAR)

NET MONTHLY INCOME $ SOURCE
CASH ASSETS $ SOURCE
TOTAL $ NUMBER OF PERSONS DEPENDENT ON THIS INCOME (Including client)

NOTE: MUST ATTACH PROOF OF INCOME & CASH RESOURCES

ACCOMMODATION FEE PORTIONS ______ (CLIENT) + ______ (VCH) = $45 PER DAY

ELIGIBLE FOR INCOME ASSISTANCE? ______ APPLIED FOR IA? ______ DATE APPLIED ______ / ______ / ______
ELIGIBLE FOR EMPLOYMENT INSUR.? ______ APPLIED FOR EI? ______ DATE APPLIED ______ / ______ / ______

NOTE: MUST ATTACH DOCUMENTATION FOR ABOVE

REFERRING SERVICE (eg. CHC NAME) Emerge Addiction Recovery Program
REFERRAL AGENT John Heron
FAX NUMBER **604-696-6769**
TEL NUMBER 604-639-8237

REFERRAL(S) TO RESIDENTIAL FACILITY(IES) **If more than one referral, list all – NOTE: only one placement will be funded**

NAME OF TREATMENT FACILITY	PROJECTED ADMISSION DATE (MONTH / DAY / YEAR)	# DAYS FOR FEE SUBSIDY
Emerge Addiction Recovery Program	/ /	
	/ /	
	/ /	

SIGNATURES

I certify that I have carefully reviewed my financial situation & the information provided is true to the best of my knowledge. I understand that the information provided will only be used to process my application for accommodation fee subsidy and will be protected under the Freedom of Information and Privacy Act. ______ DATE ______

CLIENT Signature

______ REFERRAL AGENT Signature ______ SUPERVISOR Signature

FACILITIES MUST COMPLETE THIS SECTION & FAX or EMAIL TO MALGORZATA DZIUBEK
FAX: 604.681.1894 Email: Malgorzata.dziubek@vch.ca

- **IMPORTANT: ADMISSION DATE MUST BE CONFIRMED OTHERWISE INVOICES WILL NOT BE PAID**
- If client is approved for Income Assistance, SDSI will pay the per diem. Complete the “Departure / Subsidy End Date” & “Reason for Subsidy Termination”
- If client leaves, complete the “Departure / Subsidy End Date” & “Reason for Departure”
- Any extra days over the number approved must be requested & approved. Complete the “Request for Extension”

FACILITY NAME **Emerge Addiction Recovery Program** ADMISSION DATE ______ / ______ / ______ (MONTH DAY YEAR)

REQUEST EXTENSION TO ______ / ______ / ______ (MONTH DAY YEAR) DATE OF REQUEST ______ / ______ / ______ (MONTH DAY YEAR)

DEPARTURE / SUBSIDY END DATE ______ / ______ / ______ (MONTH DAY YEAR)

REASON FOR DEPARTURE / SUBSIDY END
IA FUNDING EI FUNDING OTHER FUNDING COMPLETED
OPTED OUT RELAPSE BEHAVIOUR UNSUITABLE
OTHER

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