**Ministry of Health**
Health Services Branch
Integrated Community Health Services Centres Program
49 Place d'Armes
P.O. Box 48
Kingston ON K7L 5J3
ICHSC@ontario.ca

# Licence Transfer Application

*Integrated Community Health Services Centres*

**A licence is not transferable without the prior approval of the Director of Integrated Community Health Services Centres ("Director"), pursuant to section 11 of the *Integrated Community Health Services Centres Act, 2023*, S.O. 2023, c. 4, Sched. 1 (ICHSCA)**

The Current Centre Operator licensed under the ICHSCA must complete **Part 1** of this Application. The Proposed Centre Operator ("Proposed Transferee") must complete **Part 2** of this Application along with **Appendix A** if the Proposed Transferee is a corporation, or **Appendix B** if the Proposed Transferee is a sole proprietor.

In the event the Proposed Transferee intends to relocate the centre or have the licence amended in any way, the Proposed Transferee should contact the Integrated Community Health Services Centres Program for further information regarding applicable ministry policies and the appropriate application process. **The Director's prior approval is required in respect of any proposed centre relocation and/or licence amendment**.

**Note: In the event the Director approves of the proposed licence transfer, the ministry will send the Proposed Transferee a registration package to complete and return to the ministry. The Director's consent to the proposed transfer is conditional on the ministry receiving a completed registration package within 90 days from the date the ministry sends out the registration package.**

The completed Licence Transfer Application ("Application"), along with the relevant Appendix and any other supporting material, should be submitted by email: ICHSC@ontario.ca

**Collection of personal information**

In accordance with the *Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. F.31 (FIPPA), and subsection 58(1) of the ICHSCA, the ministry may collect, use and disclose personal information in connection with assessing a Licence Transfer Application. The ministry is authorized to collect personal information relating to persons other than those who are completing the application form, such as physicians providing insured services for the centre or the shareholders of a corporation that owns the centre. "Personal information" as defined in FIPPA includes information about an identifiable individual relating to the individual's education, criminal or employment history and contact information, among other things. Please ensure that all persons about whom you are providing personal information to the ministry are aware that:

- You are providing information about them to the ministry pursuant to a Licence Transfer Application under the ICHSCA
- The information provided may be used to assess, verify and monitor the centre's eligibility for licensing and for the assessment and inspection of centres, and
- Questions about the collection of personal information may be directed to the Manager, Integrated Community Health Services Centres Program, telephone 613-548-6637, email ICHSC@ontario.ca.

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## Part 1 - To be completed by the Current Centre Operator Licensed Under the ICHSCA ("Current Centre Operator licensed under the ICHSCA")

### Section A: Details of the Centre

Name of Centre

**Address of Centre**

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province | Postal Code |
|---|---|---|
| | | |

| Licence Number | Current ICHSC Billing Number |
|---|---|
| | |

### Section B: Details of Current Centre Operator licensed under the ICHSCA

Name of Current Centre Operator

**Mailing Address**

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province | Postal Code |
|---|---|---|
| | | |

| Telephone Number | Fax Number | Email Address |
|---|---|---|
| | | |

### Section C: Statement of Current Centre Operator licensed under the ICHSCA

I, hereby request that the Director of Integrated Community Health Services Centres approve the proposed transfer of Licence number to:

Name of proposed transferee

Proposed Effective Date for Change in Ownership: Date (yyyy/mm/dd)

The information provided in this Application is complete and true and I understand that the Director may revoke or suspend a licence if false information is provided in connection with this Application.

I understand that the information provided in this Application is subject to the *Freedom of Information and Protection of Privacy Act*, and to any other applicable laws and regulations.

I have disclosed to the Proposed Transferee the results of the most recent quality assurance inspection conducted of the above-noted centre pursuant to the ICHSCA.

I have disclosed to the Proposed Transferee the existence of any current or pending administrative appeals or other legal proceedings related to licensing action proposed or taken by the Director, and I understand that the Director may withhold approval to a proposed licence transfer pending the resolution of any such proceedings.

I confirm that no person has charged a facility cost, or accepted payment of a facility cost, for or in respect of a service or services provided in the above-noted Integrated Community Health Services Centre, except in compliance with the provisions of the ICHSCA and its regulations, and I further certify that the above-noted centre is not indebted to the ministry in respect of any amounts improperly charged or paid.

I am not aware of any reason that the proposed transfer of the above-noted licence should not be approved by the Director. In the event the Director approves the proposed transfer, I will comply with all relevant provisions of the ICHSCA and its regulations, including the requirement to transfer patient records as prescribed in the regulations under the ICHSCA.

| Name (First and Last Name) | Date (yyyy/mm/dd) |
|---|---|
| | |

| Witness Name (First and Last Name) | Date (yyyy/mm/dd) |
|---|---|
| | |

**1. If the signatory is signing on behalf of a corporation, the signatory must attach evidence of signing authority.**

## Part II - To be completed by the Proposed Centre Operator ("Proposed Transferee")

Note that the Director is authorized under the ICHSCA to amend the limitations and conditions of a licence at any time. Further, in approving the transfer of a licence, the Director may attach such limitations and conditions as the Director considers necessary.

In the event the Proposed Transferee wishes to relocate the centre or have the licence and/or the conditions and limitations of the licence amended in any way, the Proposed Transferee should contact the Integrated Community Health Services Centres Program for further information regarding applicable ministry policies and the appropriate application process. **The Director's prior approval is required in respect of any proposed centre relocation and/or licence amendment**.

### Section A: Details of the Proposed Transferee

**Name**

**Mailing Address**

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province | Postal Code |
|---|---|---|
| | | |

| Telephone Number | Fax Number | Email Address |
|---|---|---|
| | | |

**Legal Status of Proposed Operator** (check one)

☐ Corporation - You are required to complete **Appendix A**

☐ Sole Proprietor - You are required to complete **Appendix B**

**If the Proposed Transferee has a charitable status or is a corporation without share capital, complete the chart below by providing the registration number and identifying the statute under which the operator is registered and/or incorporated**

| Number | Status | Statute |
|---|---|---|
| | Corporation Without Share Capital "Non-profit" Status | |
| | Charitable Status | |

**Contact Person** - Identify the person who is to be contacted with respect to this Application.

| Contact Name (First name, Last name) | Position Title |
|---|---|
| | |

| Telephone Number | Fax Number | Email Address |
|---|---|---|
| | | |

Mailing Address

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province | Postal Code |
|---|---|---|
| | | |

**Business and Professional Experience/Background**

(a) Briefly set out the business and professional experience of the Proposed Transferee. Include details of any direct experience in operating a health care facility. Attach additional pages to this Application if necessary.

(b) Has the Proposed Transferee (sole proprietor or, if the Proposed Transferee is a corporation, any officer or director of the corporation) been declared bankrupt or made any proposal for the benefit of creditors pursuant to bankruptcy legislation at any time within the three (3) years immediately preceding the submission of the within Application?

☐No ☐Yes

If "yes", provide full details, signed, dated and appended to this Application. Attach extra pages if necessary

**Criminal Offences**

Has the Proposed Transferee (sole proprietor or, if the Proposed Transferee is a corporation, any director or officer of the corporation), or any administrator intended by the Proposed Transferee to assume responsibility for day-to-day operations of the centre, been convicted of any criminal or other offence under the laws of any country, state or province at any time within the ten (10) years immediately preceding the submission of the within Application, or are there any criminal proceedings currently pending or in progress?

☐No ☐Yes

**Note**: You are not required to disclose any conviction for which a pardon has been granted under the *Criminal Records Act* and for which the pardon has not been revoked.

If "yes", provide full details, signed, dated and appended to this Application. Attach extra pages if necessary

**Contact Person for the Centre**

Identify the individual who will be in charge of day-to-day operations if other than the Proposed Transferee.

| Contact Name (First name, Last name) | Position Title | Telephone Number |
|---|---|---|
| | | |

**Management**

Will the centre be managed by a management firm?

☐No ☐Yes

If "yes", please provide the following information for the management firm:

| Name of Firm | Telephone Number |
|---|---|
| | |

Mailing Address

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province | Postal Code |
|---|---|---|
| | | |

## Section B: Professional and Other Staff

**Organization** - Describe the proposed organizational structure of the centre. Attach an organizational chart to the Application.

**Providers**

Provide the names and billing numbers of all physicians who will provide insured services in respect of which the Proposed Transferee, if licensed, will charge facility costs.

| Physician Name (First name, Last Name) | Solo Billing Number |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

## Section C: Quality Assurance and Monitoring

Describe the system the Proposed Transferee will use to ensure quality of care and to monitor the results of the services provided in the centre.

## Section D: Other Relevant Information

Briefly identify any other information which you believe may be relevant to this Application.

## Section E: Statement of the Proposed Transferee

I, hereby request that the Director of Integrated Community Health Services Centres approves the proposed transfer of Licence number as described by the Current Centre Operator licensed under the ICHSCA in Part I of this Application.

The information provided in this Application is complete and true and I understand that the Director may revoke or suspend a licence if false information is provided in connection with this Application.

I understand that the information provided in this Application is subject to the *Freedom of Information and Protection of Privacy Act*, and to any other applicable laws and regulations.

The Current Centre Operator licensed under the ICHSCA has provided me with the results of the most recent quality assurance inspection conducted of the above-noted facility pursuant to the ICHSCA. I understand that in the event the Director approves the proposed transfer of the licence and the Proposed Transferee is issued a licence under the ICHSCA, I will be responsible for correcting any outstanding deficiencies and implementing the recommendations identified in the most recent quality assurance inspection report.

The Current Centre Operator licensed under the ICHSCA has disclosed to me the existence of any current or pending administrative appeals or other legal proceedings related to licensing action proposed or taken by the Director, and I understand that the Director may withhold approval of a proposed licence transfer pending the resolution of any such proceedings.

I am not aware of any reason that the proposed transfer of the above-noted licence should or may not be approved by the Director. I understand that in the event the Director approves the proposed transfer of the licence, the Current Centre Operator licensed under the ICHSCA will transfer patient records to me as prescribed in the regulations under the ICHSCA, and I will receive and retain such records in accordance with all applicable legislative and regulatory requirements.

I am not aware of any reason that the proposed transfer of the above-noted licence should not be approved by the Director. In the event the Director approves the proposed transfer, I will comply with all relevant provisions of the ICHSCA and its regulations.

| Proposed Transferee Name (First and Last Name) | Date (yyyy/mm/dd) |
|---|---|
| Witness Name (First and Last Name) | Date (yyyy/mm/dd) |

**1. If the signatory is signing on behalf of a corporation, the signatory must attach evidence of signing authority.**

## Appendix A - Corporate Ownership

**Complete this appendix if the proposed transferee is a corporation**

### Part 1: Definitions

**Associate** (s.1(3) of the ICHSCA)
Persons shall be deemed to be associates of each other if,

(a) one person is a corporation of which the other person is an officer or director;

(b) one person is a partner of the other person;

(c) one person is a corporation of which the other person beneficially owns, directly or indirectly, voting shares carrying more than 10 per cent of the voting rights attached to all voting shares of the corporation for the time being outstanding;

(d) both persons are members of a voting trust where the trust relates to shares of a corporation;

(e) one person is the father, mother, brother, sister, child or spouse of the other person or is another relative who has the same home as the other person; or

(f) both persons are associates within the meaning of clauses (a) to (e) of the same person.

**Beneficial Ownership**
Beneficial ownership includes ownership through a trustee, legal representative, agent or other intermediary.

**Direct or Indirect Ownership**
This encompasses all forms of ownership including beneficial ownership.

**Interest Affecting Control** (s.1(2) of the ICHSCA)
A person shall be deemed to have an interest affecting the control of a corporation if the person alone or with one or more associates directly or indirectly beneficially owns or controls the lesser of,

(a) voting shares in the corporation in a sufficient number to permit that person either alone or with more associates to direct the management and policies of the corporation; or

(b) voting shares to which are attached 10 per cent or more of the voting rights attached to all issued and outstanding voting shares of the corporation.

**Other Business Associations**
Other business associations may include contractual relationships such as service contract relationships, debtor/creditor relationships, partnerships, joint ventures or other commercial ventures; or occupancy of a position as an officer, director or some other capacity.

**Spouse** means,
a spouse as defined in section 29 of the *Family Law Act*;

**Voting Share**
Voting share means any share of any class of shares of a body corporate carrying voting rights under all circumstances and any share of any class of shares carrying voting rights by reason of the occurrence of a contingency that has occurred and is continuing.

### Part 2: Information

**Appendix A** must be completed by:

(a) The corporate entity proposing the purchase of this licence, and

(b) Any shareholder listed on Table 2 - Proposed Transferee: Beneficial Ownership or Control of the Corporation, that is a corporation.

(c) Must include a current Certificate of Status from the Ontario Business Registry as part of their applications. Current certificates would be those dated within 15 days of the date of submission to the ministry.

**Corporate Address - Head Office**

| Name of Corporation | | | Telephone Number |
|---|---|---|---|
| Unit Number | Street Number | Street Name | PO Box |
| City/Town | Province/State | | Postal/Zip Code |
| Country | | | |

**Corporation**

Date of Incorporation (yyyy/mm/dd)

Act of Incorporation

☐ Federal - specify Act:

☐ Provincial - specify Province and Act:

☐ Outside Canada - specify:

Manner of Incorporation

☐ Articles of Incorporation ☐ Memorandum of Association ☐ Letters Patent

☐ Special Act - specify:

Corporation is

☐ Public ☐ Private

Documentation: Attach a copy of the

☐ Certificate of Incorporation

☐ Certificate of Status

☐ Letters Patent

☐ Memorandum of Association

## Appendix A - Corporate Ownership (continued)

**Table 1: Current Officers and Directors of the Proposed Transferee Corporation**

**Corporation Directors/Officers - Photocopy this page as many times as necessary**

List all the current officers and directors of this corporation, using the format below. Also provide the residential telephone number of the president of this corporation.

**Position Codes**: C = Chairman of the Board P = President V = Vice President T = Treasurer
S = Secretary X = Comptroller A = Auditor O = Other - specify

| Name (First Name, Last Name) | Initials | Director ☐Yes ☐No | Position Code (if Other - specify) |
|---|---|---|---|
| Telephone Number | Business Hours | Is officer a physician in the province of Ontario? ☐No ☐Yes (specify ministry assigned billing number) | |
| Residential Address | | | |
| Unit Number | Street Number | Street Name | PO Box |
| City/Town | Province | Postal Code | Email Address |

| Name (First Name, Last Name) | Initials | Director ☐Yes ☐No | Position Code (if Other - specify) |
|---|---|---|---|
| Telephone Number | Business Hours | Is officer a physician in the province of Ontario? ☐No ☐Yes (specify ministry assigned billing number) | |
| Residential Address | | | |
| Unit Number | Street Number | Street Name | PO Box |
| City/Town | Province | Postal Code | Email Address |

| Name (First Name, Last Name) | Initials | Director ☐Yes ☐No | Position Code (if Other - specify) |
|---|---|---|---|
| Telephone Number | Business Hours | Is officer a physician in the province of Ontario? ☐No ☐Yes (specify ministry assigned billing number) | |
| Residential Address | | | |
| Unit Number | Street Number | Street Name | PO Box |
| City/Town | Province | Postal Code | Email Address |

| Name (First Name, Last Name) | Initials | Director ☐Yes ☐No | Position Code (if Other - specify) |
|---|---|---|---|
| Telephone Number | Business Hours | Is officer a physician in the province of Ontario? ☐No ☐Yes (specify ministry assigned billing number) | |
| Residential Address | | | |
| Unit Number | Street Number | Street Name | PO Box |
| City/Town | Province | Postal Code | Email Address |

## Appendix A - Corporate Ownership (continued)

**Shareholding**

| Voting Shares | Classes of Voting Shares | | | |
|---|---|---|---|---|
| Identify Authorized Classes | | | | |
| Number of Shares Authorized | | | | |
| Number of Shares Issued | | | | |
| Number of Votes per Share | | | | |
| Total Number of Votes - by Class | | | | |
| Total Number of Votes - All Classes | | | | |

**Voting Shares - ownership or control**

Use Table 2 on the following page to list all person(s)/corporation(s) who directly or indirectly beneficially own or control voting shares.

List the name(s) of the person(s)/corporation(s) who alone, or with one or more associate(s), directly or indirectly beneficially own(s) or control(s) sufficient voting shares to direct management and policies of the applicant corporation.

**Note**: The ICHSCA requires, among other things, that a licensee that is a corporation must notify the Director in writing within fifteen days of any change in the officers or directors of the corporation, and must notify the Director in anticipation of any change that may affect control of the Corporation.

## Appendix A - Corporate Ownership (continued)

**Table 2: Beneficial Ownership or Control of the Proposed Transferee Corporation**

**Pursuant to section 5 of Appendix A, list the persons that directly or indirectly beneficially own or control voting shares in the Proposed Transferee Corporation.**

Photocopy and complete this page as many times as may be necessary to identify the ultimate owner/parent of the proposed transferee corporation.

| Name (First Name, Last Name) | Is shareholder a physician in the province of Ontario? ☐No ☐Yes (specify ministry assigned billing number) |
|---|---|

Address

| Unit Number | Street Number | Street Name | PO Box | City/Town |
|---|---|---|---|---|
| | | | | |

| Province | Postal Code | Telephone Number | Email Address |
|---|---|---|---|
| | | | |

| Classes of Voting Shares | Number of Shares Held by Class | Total Number of Votes Held | Percentage of Total Shares |
|---|---|---|---|
| | | | |

| Association with Other Shareholders ☐Yes ☐No | Name of Associate(s) (First Name, Last Name) | Nature of Association |
|---|---|---|
| | | |

| Name (First Name, Last Name) | Is shareholder a physician in the province of Ontario? ☐No ☐Yes (specify ministry assigned billing number) |
|---|---|

Address

| Unit Number | Street Number | Street Name | PO Box | City/Town |
|---|---|---|---|---|
| | | | | |

| Province | Postal Code | Telephone Number | Email Address |
|---|---|---|---|
| | | | |

| Classes of Voting Shares | Number of Shares Held by Class | Total Number of Votes Held | Percentage of Total Shares |
|---|---|---|---|
| | | | |

| Association with Other Shareholders ☐Yes ☐No | Name of Associate(s) (First Name, Last Name) | Nature of Association |
|---|---|---|
| | | |

| Name (First Name, Last Name) | Is shareholder a physician in the province of Ontario? ☐No ☐Yes (specify ministry assigned billing number) |
|---|---|

Address

| Unit Number | Street Number | Street Name | PO Box | City/Town |
|---|---|---|---|---|
| | | | | |

| Province | Postal Code | Telephone Number | Email Address |
|---|---|---|---|
| | | | |

| Classes of Voting Shares | Number of Shares Held by Class | Total Number of Votes Held | Percentage of Total Shares |
|---|---|---|---|
| | | | |

| Association with Other Shareholders ☐Yes ☐No | Name of Associate(s) (First Name, Last Name) | Nature of Association |
|---|---|---|
| | | |

| Name (First Name, Last Name) | Is shareholder a physician in the province of Ontario? ☐No ☐Yes (specify ministry assigned billing number) |
|---|---|

Address

| Unit Number | Street Number | Street Name | PO Box | City/Town |
|---|---|---|---|---|
| | | | | |

| Province | Postal Code | Telephone Number | Email Address |
|---|---|---|---|
| | | | |

| Classes of Voting Shares | Number of Shares Held by Class | Total Number of Votes Held | Percentage of Total Shares |
|---|---|---|---|
| | | | |

| Association with Other Shareholders ☐Yes ☐No | Name of Associate(s) (First Name, Last Name) | Nature of Association |
|---|---|---|
| | | |

## Appendix B - Sole Proprietor

**Complete this Appendix if the proposed transferee is a Sole Proprietor**

Sole Proprietor's Name (First Name, Middle Name or Initial, Last Name)

Residential Address

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

Country

| Telephone Number | Fax Number | Email Address |
|---|---|---|
| | | |

Is sole proprietor a physician in the province of Ontario?

☐No ☐Yes (specify ministry assigned billing number)