Ontario Health atHome

Short Stay Respite
Long Term Care Home Choice List

(Last Name, First Name)	Health Card Number	Version Code

Please select up to five long-term care homes (LTCHs) for short stay respite, including any out-of-Champlain choices, and rank them in order of your preference. The applicant's name will be added to the wait lists for the chosen homes if eligible, and if the chosen LTCHs can provide the required care. Ontario Health atHome will confirm with you the availability of the requested dates.

Rank (1-5)	Location	Central	Requested Dates
	Ottawa	**Extendicare – Laurier Manor**	
	Stittsville	**Extendicare – Crossing Bridge** (replacing Extendicare West End Villa in Fall 2024)	
	Ottawa	**Extendicare – West End Villa** (being replaced by Extendicare – Crossing Bridge in Fall 2024)	
	Ottawa (Kanata)	**Garden Terrace (S)**	
	Ottawa (Orleans)	**Résidence Saint-Louis (S)**	
	Ottawa	**St. Patrick's Home (S)**	
Rank	**Location**	**East**	**Requested Dates**
	Cornwall	**Glen-Stor-Dun Lodge**	
	Maxville	**Maxville Manor (S)**	
	Hawkesbury	**Résidence Prescott and Russell**	
Rank	**Location**	**West**	**Requested Dates**
	Almonte	**Fairview Manor (S)**	
	Pembroke	**Marianhill**	
	Pembroke	**Miramichi Lodge**	
	Deep River	**North Renfrew LTC**	

(S) = Secure unit available.

		Out of Region LTC Home	Requested Dates

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Patient ______________________________ ______________ ____________
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ACCOMMODATION RATES

Short Stay Daily Rate is $43.34/Day (July 1, 2024 – Subject to yearly increase)

By signing this Short Stay Respite Choice Form, I confirm that I have been informed of the daily rate of a Short Stay Respite stay.

CONSENT FOR PLACEMENT

- I consent that Ontario Health atHome, as the designated Placement Coordinator, can disclose my personal health information to the LTCH of my choice.
- I acknowledge that I have been counselled about the reasons why this information is needed and I understand them. I understand that Ontario Health atHome will update and share this information with other health professionals involved in my care, and the LTCH of my choice.
- I understand that I may withdraw my consent at any time.

Patient / SDM ______________________ ______________________________ ______________
Signature Print Name Day/Month/Year

If SDM, please complete the following ______________________________
Your relationship to patient

☐ Personal care power of attorney

☐ Public guardian and trustee