Primary Caregiver Tax Credit – Application

Pursuant to Section 5.11 of *The Income Tax Act* (Manitoba)

Manitoba

FIPPA release: Pursuant to *The Freedom of Information and Protection of Privacy Act*, I understand the information on this form is being collected under the authority of *The Income Tax Act* and may be used and disclosed as necessary for the purpose of administering the Primary Caregiver Tax Credit. I hereby permit the Regional Health Authority (RHA) or Manitoba Family Services to provide the personal information about me on this form (and the Level of Care Equivalency Guideline form, if applicable) and/or subsequent changes in the information, to Manitoba Finance or to Manitoba Health for the purpose of administering the tax credit. I understand I may contact the Manitoba Tax Assistance Office at 204-948-2115 (toll-free 1-800-782-0771) if I have questions about privacy implications.

PART A: Declaration by the person receiving care

Last Name:	First Name:	Middle Name:
Social Insurance Number:	Phone Number:	
Home Address (House Number & Street Name):	City/Municipality & Province:	Postal Code:
Name of the Regional Health Authority where the person receiving care resides:		
Does the person receiving care live in a group home, foster home, hospital, or personal care home; in supportive housing; or on a reserve? ☐ Yes ☐ No If yes, explain: _____		
Mailing Address (if different from home address) House Number & Street Name:	City/Municipality & Province:	Postal Code:
The person receiving care hereby designates the following individual as his/her primary caregiver for the purposes of Manitoba's Primary Caregiver Tax Credit: Last Name: First Name:		
☐ Check this box if this is an application for a **replacement of a designated primary caregiver**. **Note:** The person receiving care or alternate signatory is responsible for notifying the previous caregiver of the change in designated primary caregiver.	Effective date: _____ (yyyy/mm/dd)	

Declaration by the person receiving care: I hereby declare the foregoing to be true to the best of my knowledge. I understand that it is an offence to make false statements knowingly under *The Income Tax Act* (Manitoba). I have read and accept the FIPPA release above.

Signature of person receiving care: _____ Date: _____ (yyyy/mm/dd)

Note: If the person receiving care is unable to sign, please complete Part B.

PART B: Identification and declaration of alternate signatory (if required)

To be completed by the **alternate signatory** only if the person receiving care, listed in Part A, is not able to complete and sign the application form. **(Must not be completed by the primary caregiver nor by the person receiving care.)**		
Last Name (Alternate Signatory):	First Name:	Middle Name:
Social Insurance Number:	Phone Number:	
Home Address – (House Number & Street Name):	City/Municipality & Province:	Postal Code:
Alternate signatory's relationship to the person receiving care identified in Part A:		

Declaration by alternate signatory: I hereby declare all the information provided in Part A and B of this form, including the Declaration and the FIPPA release sections, to be true and accurate to the best of my knowledge. I understand that it is an offence to make false statements knowingly under *The Income Tax Act* (Manitoba). I have read and accept the FIPPA release above.

Signature of alternate signatory: _____ Date: _____ (yyyy/mm/dd)

PART C: Declaration by the primary caregiver

Last Name (Primary Caregiver):	First Name:	Middle Name:
Social Insurance Number (Primary Caregiver):	Phone Number:	
Home Address (House Number & Street Name):	City/Municipality & Province:	Postal Code:
Mailing address (if different from home address) House Number & Street Name:	City/Municipality & Province:	Postal Code:
Primary caregiver's relationship to the person receiving care, identified in Part A:		

Declaration of the primary caregiver: For the purposes of the Primary Caregiver Tax Credit, I am serving, or am about to serve, as primary caregiver for the person receiving care listed in Part A and confirm that this person resides in a private residence. I have not been, nor am I being paid by any party for the care that I provide to this individual. (Note: the tax credit is not considered payment.) I have received, read and understand information about the program, including the requirement that I maintain an up-to-date log on the form required. I hereby declare the foregoing to be true to the best of my knowledge. I understand that it is an offence to make false statements knowingly under *The Income Tax Act (*Manitoba). I have read and accept the FIPPA release at the top of Page 1 of this form.

Signature of the primary caregiver: _____ Date: _____ (yyyy/mm/dd)

Please forward the completed application to the Regional Health Authority office in which the individual receiving care (identified in Part A) resides. If you do not know how to locate the Regional Health Authority office, please call Manitoba Government Inquiry at 1-866-626-4862. For clients of Manitoba Family Services, please refer to the submission instructions provided.

PART D: Declaration of eligibility – FOR OFFICE USE ONLY

To be completed by an authorized employee of the Regional Health Authority or Manitoba Family Services.

Note: Eligibility requires a "Yes" answer for Box A and either B1 or B2.

Yes	No	
☐	☐	A: The person receiving care, identified in Part A, is resident in our catchment area, AND
☐	☐	B1: The person receiving care has been assessed by the Regional Health Authority as requiring home care at Level 2 or higher; OR
☐	☐	B2: The person receiving care has not been formally assessed by the Regional Health Authority but requires care equivalent to Levels 2 to 4, as determined by the information provided on the Primary Caregiver Tax Credit Level of Care Equivalency Guideline form, attached to this application.

Comment:

If the person receiving care is a home care client:	Care plan effective date (yyyy/mm/dd):	Reassessment date (if applicable):	Care plan termination date (if applicable):

RHA employee identification:	Name (print):	Position:	RHA and Office Location:	Phone:
Signature of authorized employee:				Date (yyyy/mm/dd):

For office use only:

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