ACE NEWSLETTER

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CORONER'S INQUEST LOOKS AT OLDER DRIVERS

By Graham Webb
Barrister & Solicitor

The Ontario Division of Canadian Pensioners Concerned was recently represented by the Advocacy Centre for the Elderly at a coroners' inquest into the tragic death of Beth Kidnie. The inquest attracted national media attention over the issue of older drivers. After hearing from 17 witnesses, on March 15, 2002 the coroner's jury made 16 recommendations in relation to road safety.

Mrs. Beth Kidnie was a 43 year-old business executive and mother of three. She was crossing the street on a green light within a marked pedestrian crosswalk when she was struck by a car operated by an 84 year old widow, Pilar Hicks. Mrs. Hicks did not stop after the collision, but continued to drive three-quarters of a kilometer to her home dragging Mrs. Kidnie's body underneath the vehicle all the way to the boulevard in front of her driveway. This tragic set of facts focused national public attention on older drivers.

Major Recommendations of the Coroner's Jury

The inquest was concerned with the screening, identification and management of physically and medically impaired drivers, with special attention to medical conditions often encountered by older adults. After hearing from 17 witnesses that included medical and transportation experts, the coroner's jury made the following recommendations:

- the screening and evaluation of medically-impaired drivers should focus on medical condition without regard to age;
- the government should find out how many people with cognitive impairments that impair their ability to drive are still driving;
- the government should make improvements to the present medical-review process for drivers and to the existing 80+ drivers'-testing program;

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- the general public and the medical community should be better educated about driving safety for older adults;
- the government and the medical community should develop a diagnostic screening tool to identify those drivers who need more testing because of possible cognitive impairments; and
- the government should explore graduated de-licencing as an alternative to outright licence suspensions.

Older Drivers are Safe Drivers

The overwhelming evidence at the inquest was that, on a per-driver basis, older drivers age 65 and up are safe drivers. Older drivers police and regulate themselves exceptionally well. They drive much less than other drivers, and only under the safest conditions. They often do not drive at night and they drive much less at morning rush-hours. They frequently tend to avoid high-speed expressways. They do not drive in bad weather, or when road conditions make it unsafe to drive. Most importantly, they are usually very experienced drivers who have safe driving habits, and are not risk-takers. All of these factors combine to give older drivers the lowest crash rate per licenced driver of any age group. Insurers know that within any given year, an older driver is much less likely to have a crash than is a similarly-situated younger driver.

However, the whole picture is not entirely rosy for older drivers. People do become more frail as they age, and for that reason older drivers who are in a crash are more likely to have serious injuries or die. Older drivers therefore have a higher mortality rate relative to other factors than do younger drivers. Despite their risk-averse behaviour, older drivers are more likely to commit certain types of driving errors that include improper lane changes, collisions on turns and on entering and exiting driveways. Most importantly, they also have a high crash rate on a per-kilometer-driven basis that is comparable only to teenaged drivers.

Experts told the inquest that the driving tendencies of older drivers can be explained in part by the aging process and the types of skills that are needed for safe driving. While it is true that reflexes, vision and reaction times do diminish on an individual basis as people age, those changes are unlikely to greatly affect driving ability. Driving skills mainly depend on automatic learned memory responses, such as automatically signaling and checking for traffic before changing lanes, which older, experienced drivers usually continue to do well despite declining physical abilities. The single most important crash-risk factor is not the myriad of physical abilities that go into safe driving, but cognitive impairment.

While many cognitively-impaired drivers may, because of their good driving habits, continue to drive safely, the presence of moderate to severe cognitive impairments can rob drivers of the more complex reasoning abilities and executive "planning" functions that are needed to drive safely. The result is that the presence of a moderate to severe cognitive impairment is reported to increase crash risk by seven times, dwarfing any other risk factor.

Dr. Barry Goldlist, a practicing geriatrician and professor of medicine at the University of Toronto, testified that cognitive impairment is not part and parcel of the aging process. The most comprehensive Canadian studies show that about 30% of adults over age 80 have a moderate to severe cognitive impairment. Dr. Goldlist pointed out that this means that fully 70% of older adults over age 80 have no cognitive impairment that would even marginally affect their driving.

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Dr. Alan Dobbs is a professor emeritus of psychology at the University of Alberta and the founder and stakeholder in a private for-profit company that develops and sells driving evaluations. Dr. Dobbs testified that the high per-kilometer-driven crash rate for older adults is likely caused by a small minority of cognitively-impaired drivers that are very highly unsafe, even while the majority of older adults continue to be safe drivers in every way. The central issue then is to develop methods of screening and identifying those cognitively-impaired drivers who are not safe to drive, without needless harm to the rest of the older driving population.

Most Cognitively-Impaired Adults Stop Driving

There is a difference of opinion on whether the number of cognitively-impaired drivers who continue to drive poses a serious public-safety risk. Dr. Dobbs told the inquest that in the future older drivers can be expected to drive more kilometers per driver, and longer into old age than in the past. Given current demographic trends of a burgeoning older population, Dr. Dobbs felt that if pro-active steps were not taken, crash-risk due to cognitively-impaired older adults would soon dwarf the crash-risk attributed to impaired drivers.

Other experts, such as Dr. Goldlist, were less certain of that result. Dr. Goldlist said that "once you start putting a lot of time and effort to developing tools and screening tests, you want to make sure that you're dealing with an important public health problem." While he suspected that the problem might be significant, he said that "we know that the majority of people who have significant cognitive impairment are not driving . . . and the 70% who don't have cognitive impairment are just like any other age group. They have the same kind of judgment and insight to determine whether they should drive or not . . . whether you're 82 or 42."

Canadian Pensioners Concerned was the only party that asked the jury to follow Dr. Goldlist's suggestion that a study be carried out to determine the number of cognitively-impaired drivers still driving. It is hoped that the results of such a study will be the basis of policies that are not prejudicial to older drivers.

Ontario Has Safe Roads

The inquest heard that Ontario has the safest roads of any Canadian province, and the second-safest of any other North American jurisdiction. Its safe roads could be due to this province's advanced and sophisticated driver safety programs.

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See ACE News Bulletin
LEGISLATION INTRODUCES CHANGES TO ADMISSION AND DISCHARGE PROCESS FOR NURSING HOMES AND HOMES FOR THE AGED

The **Advocacy Centre for the Elderly (ACE)** is a legal clinic for low income seniors 60 years of age and over, funded by Legal Aid Ontario. ACE is incorporated as a non-profit corporation under the name "Holly Street Advocacy Centre for the Elderly Inc.".

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OBTAINING A REFUND FROM A LONG-TERM CARE FACILITY

By Amy Shoemaker
Institutional Advocate
Barrister & Solicitor

Residents of long-term care facilities usually pay accommodation fees in advance at the beginning of each month. There are a number of situations where a resident may leave a facility before the end of the month. ACE has had many inquiries as to whether in these situations, residents are entitled to a refund. In what follows, we will answer this question.

There are three kinds of long-term care facilities: nursing homes, charitable institutions and municipal homes for the aged. It is important for the purposes of this article to distinguish long-term care facilities from retirement homes (care homes). Residents of retirement homes are tenants. There are different notice provisions for retirement homes and tenants are required to pay their rent pursuant to their tenancy agreement and the relevant provisions of the *Tenant Protection Act*. This article does not apply to retirement homes.

General Rule Regarding Payment and Refunds

Legislation governs the maximum accommodation rate that a long-term care facility can charge. It also sets out the circumstances under which an accommodation rate can be charged. If a resident has paid the monthly accommodation fee and is discharged from the facility, the resident is entitled to a refund for the balance of the month following the date of discharge. In other words, a resident only pays for the days that he/she is living at the facility. If a resident leaves in the middle of the month and has paid for the entire month, the resident is entitled to a refund for the days that the resident was not living at the facility.

Leaves of Absence

This general rule does not apply to situations where residents are on a medical or psychiatric leave of absence. In those cases, the resident will continue to pay the daily rate at the long-term care facility. There are special provisions in the regulations that allow long-term care facilities to charge bed-holding fees when the resident's leave has exceeded the number of days set out in the legislation. A resident on a medical leave of absence will only be discharged if the resident has been out of the long-term care facility for a maximum number of days set out in the regulations.

Resident Returning Home

In the case of long-stay residents who are leaving a long-term care facility to return home, the facility will charge the resident for the period of time that the resident lived at the long-term care facility. For example, Mr. X was admitted to the facility on April 1. He paid for his accommodation for the month of April on April 1. On April 15, Mr. X is discharged from the facility to return home. Mr. X has to pay for April 1 to April 15. He is required to pay for 15 days of accommodation, including the date of discharge.

Short-Stay Residents

In the case of a short-stay resident (residents staying at a long-term care facility for a maximum of 90 days), the regulations do not permit the facility to charge the resident for the date of discharge.

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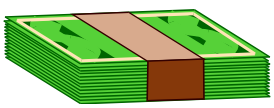

Refund Con't From P. 4

Residents Transferring to Another Facility

There is a special provision in the regulations that applies to residents who are transferring from one long-term care facility to another on the same day. In those cases, the resident does not pay the facility that they are leaving for the date of discharge. They pay the facility that they are transferring to for the date of admission. Therefore, the resident does not pay for accommodation in two places on the same day.

This transfer scenario is easily illustrated with an example. Mrs. Z currently lives in facility A. At the beginning of April, she paid her accommodation fees for the month. On April 15, she transferred to facility B. Mrs. Z must pay facility B for her accommodation from April 15 to April 30. Facility A is paid for Mrs. Z's accommodation from April 1 to April 14. But because Mrs. Z transferred to another long-term care facility on April 15, she does not pay facility A for the discharge date. Instead, she pays facility B for her admission date. Therefore, Mrs. Z. is entitled to a refund from facility A for April 15 to April 30.

Death of a Resident

In the case of a resident's death, the facility will discharge the resident when they are aware that the resident has died. This is found in the regulations. Where a resident has been transferred to the hospital and dies there, it is important that the resident's next-of-kin inform the long-term care facility of the resident's death as soon as possible so that the facility has notice to discharge the resident. The resident's estate will be entitled to a refund for the days following discharge in the event that the accommodation fees have been paid for the month. For example, Mr. B has paid for the month of April. On April 15, Mr. B dies. Mr. B's estate is entitled to a refund of his accommodation fees for April 16 to April 30.

Payment for Day Following Discharge

In some cases, a resident or a resident's relative may wish to have access to the resident's room on the day after discharge. This situation is most likely to occur when a resident is moving out of the facility and must arrange for belongings to be collected and moved. This also occurs where the resident has died and family members need some time to make arrangements and collect the resident's personal belongings. There is a special provision in the regulations that permits a resident, a resident's family member or a person notified of the resident's discharge to request access to the resident's room on the day following discharge. Where this request is made to the facility, the regulation permits the facility to charge the discharged person for the day following discharge. However, the facility can only charge the accommodation fee for the day following discharge if it is specifically requested by the resident, the resident's family or a person notified of the resident's discharge.

This is illustrated by the following example. Mr. A has paid his accommodation fees for the month of April. On April 15, Mr. A dies at the facility. This is the date of discharge. Mr. A's son wants to attend at the facility on April 16 to access his father's room and collect his personal belongings. Mr.A's son makes this request to the facility. Pursuant to the regulations, Mr. A will be charged for his stay at the facility from April 1 to April 15 (date of discharge.) Mr. A will also be charged the accommodation fee for April 16 as his son requested access to his room on the day following discharge. Mr. A's estate will be entitled to a refund of the accommodation fees for the period from April 17 to April 30.

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Some Ontario programs are generally designed to disqualify unsafe drivers of all ages, whereas other programs are specifically targeted to older drivers. Drivers over age 70 who are convicted of an offence in an at-fault collision are required to undergo a driving test. Until 1996, all drivers over age 80 were also given annual vision and road tests. However, those tests were felt to be ineffective since the vast majority of drivers passed the tests and the failure rate was extremely small. Since 1996, 80+ drivers instead undergo mandatory vision and written road knowledge tests, and a group driving-safety discussion conducted by a driving improvement counsellor every second year. The counsellor will review the driving record of each participant before the session and, based on the results of the session, will identify those drivers who must take road tests. Even though fewer drivers are tested under the new program, about the same number are disqualified as had been the case under the previous program.

Further, successful participants receive a beneficial educational component that had not previously been available. The current 80+ program is intended to be more sensitive, less cumbersome and expensive, and more effective than its predecessor.

The existing Ontario medical review program is already intended to disqualify cognitively-impaired drivers. Physicians, ophthalmologists and optometrists are required by law to report any person to the Ministry of Transportation who has a medical condition that may impair his or her ability to drive. Also, a police officer who believes a medical condition may have contributed to a crash may make the same report. These reports to the medical review section do not necessarily result in an automatic disqualification. Instead, a medical analyst will review and prioritize the reports and make a decision based on degree of risk. High-risk drivers will be immediately disqualified. Medium-risk drivers may be asked to provide more detailed medical reports or undergo a driving evaluation before a disqualification decision is made. Low-risk drivers whose condition is controlled will not be disqualified. The medical review section has access to a panel of medical specialists to assist with the complex conditions and the more difficult disqualification decisions. Failure to provide the medical reports or driving evaluation requested within 6 weeks will trigger a licence suspension. A driver who complies with the process but is then disqualified may appeal as of right to a statutory review tribunal.

Ontario's existing road safety programs are complex, sophisticated, and consistent with the most advanced such programs in the world.

Alternatives to Licence Suspensions

The jury recommended that government explore "graduated de-licencing" as a less-restrictive alternative to outright licence suspensions. Dr. Ted Boadway, Executive-Director of the Ontario Medical Association, told the inquest that the similar concept of medically restricted licences will soon be studied by the OMA. Under these programs, drivers may be allowed to drive under certain safe conditions that can reflect the self-regulating behaviour already adopted by many older adults.

Older Driver Does Not Equate to Poor Driver

Age is not a good indicator of driving ability. Older drivers are good drivers. Most older drivers are not cognitively impaired. Despite the horrific events that led to the Kidnie inquest, there is no conclusive evidence that cognitively-impaired older drivers form a serious public-safety risk. Ontario's existing road-safety

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As part of Alzheimer Initiative Number 7, the Ontario Seniors Secretariat of the Ministry of Citizenship, Culture and Recreation has produced a *Guide to Advance Care Planning.* This 48 page booklet provides information on how to ensure your wishes about health care are honoured in the event that you become mentally incapable. This is called "advance care planning".

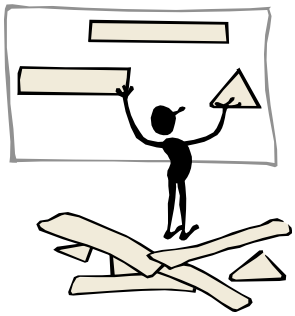
The *Guide to Advance Care Planning* explains that you can prepare a Power of Attorney for Personal Care and choose your own health care substitute decision-maker (SDM). You may also express wishes about your future care in that document. The *Guide* also explains how the law includes a list of people who would act as your health care SDM, primarily family members, even if you have not prepared a Power of Attorney for Personal Care.

A key message in the *Guide* is how important it is for you to communicate your wishes about health care to your SDM and other family members. You can do this verbally or in written documents, and you can always change your wishes as long as you are mentally capable of doing so.

The *Guide* contains a wallet card on which you can write the name and contact number of your SDM. You can use the card to indicate your SDM, whether that person is someone you have chosen by completing a Power of Attorney for Personal Care, or is the person highest on the list in the legislation.

The *Guide to Advance Care Planning* is available from your local Alzheimers' Society chapter. It may also be downloaded from the Ontario Government Website either in a PDF version or full-text version by going to www.gov.on.ca/citizenship/seniors/index.html.

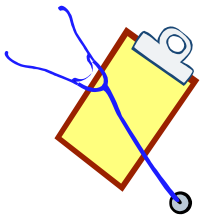
The *Guide* is part of an education campaign on this issue that is under the direction of the Alzheimers Society of Ontario. Contact your local Alzheimers Society chapter for information on education sessions in your own area. *



Inquest Con't From P. 6

programs already provide an effective safety net for the driving public. The jury's recommendations justifiably avoid knee-jerk responses to a problem that may or may not be significant. The recommendations do not unfairly target older drivers without promoting safe roads. Canadian Pensioners Concerned should be congratulated for its part in assisting the jury to arrive at these recommendations which will serve to improve future road safety.*

MEDICAL REPORTS FOR LONG-TERM CARE APPLICATIONS: IS THIS AN INSURED SERVICE UNDER THE HEALTH INSURANCE ACT?



By Amy Shoemaker
Institutional Advocate
Barrister & Solicitor

At ACE, we have received a number of inquiries about whether a physician can charge a patient for preparing the Medical Report required for a long-term care application. The short answer is that a doctor cannot charge a patient for preparing this report. This article provides information about the remedies available to the patient when a doctor attempts to charge or has charged a patient a fee for the preparation of the report required for a long-term care application. Patients may contact the Investigations and Recoveries Clerk at the Provider Services Branch of the Ministry of Health and Long-Term Care (MOHLTC) to make a complaint and apply for a refund for unauthorized charges.

The Health Assessment Form (formerly known as the Medical Report)

When a person makes an application for long-term care, there are several reports that must be filled out by health care practitioners. These forms include the functional assessment, social assessment and the Medical Report. The functional and social assessments describe the functions and abilities of the applicant and the applicant's social history, respectively. A doctor, registered nurse, physiotherapist or social worker can fill out the functional and social assessments.

An application for long-term care must include a medical report. The MOHLTC requires that a standardized form be used. Prior to May 1, 2002, the Medical Report had to be filled out by a "legally qualified medical practitioner", meaning a physician. The Medical Report included details of the applicant's diagnosis and date of onset, a brief health history, including drug sensitivities and allergies, details of the applicant's present condition, prognosis, lists of treatments, medications and special needs. However, as of May 1, 2002, amendments to the regulations of the *Nursing Homes Act* came into effect and this has resulted in two key changes regarding the Medical Report. The report has been redrafted and renamed the Health Assessment Form. The new amendments now permit a doctor, registered nurse practitioner or registered nurse to complete the Health Assessment Form. Despite this change, it is likely that in most cases, the applicant's doctor will still fill out this form.

The Ontario Health Insurance Plan (OHIP): Insured vs. Uninsured services

The *Health Insurance Act* and regulations set out the health services that are insured services in Ontario. Physicians bill OHIP for insured services provided to Ontario residents. OHIP publishes a Schedule of Benefits that lists all of the insured services and the amount physicians are permitted to bill for the services. Doctors are not permitted to charge patients privately for insured services (i.e., services covered by OHIP). However, there are a number of uninsured services for which a doctor is entitled to charge the patient directly. These are found in s.24 of Regulation 552 under the *Health Insurance Act*. Examples of uninsured services for which a doctor can charge include reports for a legal proceeding, reports for an absence from work, or for admission to an educational institution.

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Remedies Con't From P. 8

Can a physician charge a patient for completion of the Medical Report/Health Assessment Form?

A physician is NOT entitled to charge a patient for filling out a medical report for a long-term care application. Specifically, Regulation 552 of the *Health Insurance Act* states that a physician cannot charge for producing or completing documents or transmitting information required to satisfy a condition of being admitted to, or receiving health services in a hospital or nursing home, home for the aged or charitable institution.

What are the remedies?

Contact the Investigations and Recoveries Clerk, Provider Services Branch at the MOHLTC. The Provider Services Branch is responsible for the development and evaluation of program policy relating to payment of fee for service claims for insured services provided by physicians. There are two different remedies available to patients depending on whether the patient has already paid for the service privately or not.

What to do if your physician has requested payment for completion of the Health Assessment Form and you have not yet paid?

We recommend that patients question their physician regarding the authority to charge for completion of the Health Assessment Form. For clarification, the patient can contact the Investigations and Recoveries Clerk at (613) 548-6537. The Clerk deals with inquiries regarding extra-billing by physicians. Callers will be told that the physician cannot charge for completion of the Health Assessment Form.

What to do if you have already paid your physician for completion of the Health Assessment Form? Remedies under the *Health Care Accessibility Act*

If a patient has already paid the physician a fee for completing this Form, the *Health Care Accessibility Act* sets out a remedy. The patient can make a formal complaint to the Investigations and Recoveries Clerk at the Provider Services Branch of the MOHLTC. The patient can ask the Clerk to reimburse them for the fee already paid. Where a patient makes a written complaint, and the Minister of Health is satisfied that the patient paid for a service that the physician is not permitted to bill for, the Minister may direct that the patient be reimbursed. In these circumstances, the Minister may seek recovery of the fee from the physician. In addition, the Minister may recover a $150 administrative fee from the physician.

Where the Ministry is seeking to recover payments made to a physician and the administrative fee, the physician must be notified in writing. Within 15 days of receiving the notice, the physician is entitled to request a review of whether the unauthorized payment was received. This written request must be made to the General Manager who is appointed under the *Health Insurance Act*. The matter will then be referred to the chair of the Health Services Appeal and Review Board. The General Manager, the physician, and the insured person have the right to make written representations to the Board member conducting the review. The presiding Board member shall advise the General Manager in writing as to whether the physician has received an unauthorized payment and the amount of that payment.

Remedies Con't P. 10

Public Guardian and Trustee of Ontario Urgent Investigations

Are you aware of someone who you believe is not able to make decisions for themselves, and as a result, is at risk of losing their property or at risk of physical harm? One way you may be able to help the person is to contact the Office of the Public Guardian and Trustee.

If the Office of the Public Guardian and Trustee receives information that a person is incapable and that serious adverse effects may occur, the law says that they must investigate the allegations. A number of remedies are then available to the Public Guardian and Trustee including applying to a court to be named as guardian of the incapable person.

The *Substitute Decisions Act* contains two sections that are often referred to as the "urgent investigation" provisions of the Act. Section 27(1) provides that loss of a significant part of a person's property, or a person's failure to provide necessities of life for himself or herself or for dependents, are serious adverse effects. Section 62(1) provides that serious illness or injury, or deprivation of liberty or personal security, are serious adverse effects.

Caregivers who provide home care services are generally prohibited by law from disclosing information about persons in their care. The *Long-Term Care Act* does not permit home care workers to release information except in the circumstances set out in the Act. However, the Act does permit home care workers to contact the Public Guardian and Trustee's office with concerns that serious adverse effects may be occurring to an incapable individual. Section 35(2) of the *Long-Term Care Act* expressly provides that the disclosure provisions of the *Long-Term Care Act* do not prohibit a person from making an allegation that a serious adverse effect may be occurring to an incapable person. The person may inform the Public Guardian and Trustee of the grounds for the allegation.

The new draft privacy legislation , the *Privacy and Personal Information Act*, also contains provisions permitting any person to contact the Public Guardian and Trustee and give information that serious adverse effects may be occurring to an incapable person. It is expected that this exemption will appear in the final legislation.

The Public Guardian and Trustee may be contacted at "Guardianship Investigations" at (416) 327-6348 or at 1-800-366-0335. *

Remedies Con't From P. 9

Who to contact to make an enquiry or get a refund.

If you have paid a physician for completing the Health Assessment Form or Medical Report for an application for long-term care, contact:

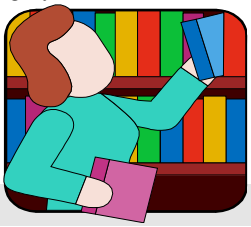
The Investigations & Recoveries Clerk
Ministry of Health and Long-Term Care
Provider Services Branch
P.O. Box 48 49
Place d'Armes, 2nd Floor
Kingston, ON K7L 5J3
Phone: (613) 548-6537

Refund Con't From P. 5

How to Obtain the Refund

In most situations, when a resident is discharged, the staff in the business office at the long-term care facility will perform the necessary calculations and refund any balance of accommodation fees to the resident or the resident's estate. However, we at ACE have become aware of some situations, where long-term care facilities have not advised residents and their families that they are entitled to a refund of their accommodation fees. We have also reviewed some admission contracts that set out lengthy time periods for refunds, such as 90 days. The law does not require a 90-day waiting period to obtain a refund. In fact, for many seniors this can result in significant hardship as they may require the refund money to pay for their accommodation at another long-term care facility. It is important to know that a resident does not have to agree to this time frame and this provision can be removed from an admission contract.

When a resident is discharged from the long-term care facility, the resident or their relative should request a refund of any balance of accommodation fees from the date of the discharge to the end of the month. It is preferable to do this in writing so that there is a record of this request. At this time, it is also a good idea to request a refund of any balance left in the resident's trust account. If the resident has not received the refund in a reasonable period of time, the resident or their relative should contact the facility and request it again. If the cheque still does not arrive, contact the Advocacy Centre for the Elderly for advice. In addition, we recommend the resident make a formal complaint to the compliance adviser assigned to the specific long-term care facility. Residents should contact the Ministry of Health and Long-Term Care and request the name of the compliance adviser for the long-term care facility in question. *



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Old Age Security
Guaranteed Income Supplement
Canada Pension Plan
Spouse's Allowance
Widowed Spouse's Allowance
Survivor Benefits

Are you or your clients receiving all the benefits they are entitled to?

For personal information, the person receiving the pension or their representative will need to contact First Contact Centres, Income Security Programs, Ontario, Human Resources Development Canada
1-800-277-9914

Ontario Celebrates Seniors

June is Ontario's Seniors' Month. Ontario has celebrated Seniors' Month every June for more than 20 years!

Seniors' Month is a tribute to the men and women who have helped build this province and who continue to participate and contribute to the quality of life we all enjoy.

Do you have *Long-Term Care Facilities in Ontario: The Advocate's Manual (2nd edition)* in your library?

If not, call ACE at 416-598-2656 for an order form. The cost is $75.00 + $5.00 shipping and handling.

The ultimate information resource!

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*

2 Carlton Street, Suite 701, Toronto, Ontario M5B 1J3

APPLICATION FOR MEMBERSHIP

NAME: _____
(Individual/Corporate) Please Print

CORPORATE CONTACT (if applicable): _____

ADDRESS: _____ APT. _____

CITY: _____ POSTAL CODE: _____

TELEPHONE: (Home) _____ (Business) _____

Membership Fee:
(a) individual _____ $10.00 Enclosed
(b) corporate (agency, group) _____ $25.00 Enclosed

In addition to my membership fee, a donation of $_____ is enclosed.**

_____
Signature

Your membership is important. If the fee presents financial difficulties, please feel free to join anyway.

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 2002

By-Law No.1, 14.9 states: No owner or management official of a long term care facility, or employee of any organization representing long term care facilities shall be eligible to be elected to the Board of Directors of the Advocacy Centre for the Elderly.

* Holly Street Advocacy Centre for the Elderly Inc.
** A tax receipt will be issued for donations over $10.00.

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