Ministry of Health and Long-Term Care

Community Health Capital Programs Policy

Health Capital Investment Branch

March 2017

Ontario

Change Log

Version #	Date	Change	Approved by
1.0	2015-12-16	• Original document	Peter Kaftarian, Executive Director, Health Capital Division
2.0	2017-03-31	• Updated document to meet Accessibility for Ontarians with Disabilities Act (AODA) requirements, added further clarifications to eligibility criteria and removed details related to the Community Infrastructure Renewal Fund (CIRF) which are provided in the CIRF Guidelines	Peter Kaftarian, Assistant Deputy Minister, Health Capital Division

Ministry of Health and Long-Term Care

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Abbreviations

Short Form	Long Form
AHACs	Aboriginal Health Access Centres
ALB	Accountability and Liaison Branch
CHC	Community Health Centre
CHCP	Community Health Capital Programs
CIRF	Community Infrastructure Renewal Fund
CSA	Canadian Standards Association
FHTs	Family Health Teams
HCIB	Health Capital Investment Branch
HPPA	Health Protection and Promotion Act
HSPs	Health Service Providers
IPAC	Infection Prevention and Control
LHIN	Local Health Integration Network
MH&As	(Community Based) Mental Health and Addictions Agencies
MPGs	Midwifery Practice Groups
NPLCs	Nurse Practitioner-Led Clinics
OPHS	Ontario Public Health Standards
PHCB	Primary Health Care Branch
PHUs	Public Health Units

1. Policy Overview

The Community Health Capital Programs (CHCP) policy provides a unified approach for the review, approval and funding of community health care infrastructure capital projects in Ontario by the Ministry of Health and Long-Term Care ('the ministry').

The CHCP policy outlines the following:

- Eligibility criteria for community sector Health Service Providers (HSPs), including a process for expanding eligibility to additional community HSPs and operational models of service for co-located and integrated proposals;
- Capital cost share and space standards; and
- Unified project management and funding framework.

The CHCP policy provides capital funding through three (3) streams:

1. **Single Provider-Led Community Capital Projects**: provides funding for specific renovation or new build projects involving service expansion and/or repair and renewal based on an assessment of project benefit and risk;

2. **Co-located and Integrated Facilities Community Capital Projects**: provides funding for projects involving co-location at a single site or integration of multiple community HSPs at different sites; and

3. **Community Infrastructure Renewal Fund (CIRF)**: provides funding for ongoing repair and renewal needs of agencies meeting specific criteria relating to asset ownership and lease length, based on an assessment of asset condition.

In response to stakeholder feedback, the ministry's CHCP policy introduced a new streamlined capital planning and implementation process model in December 2015. This process reduced the number of stages from six (6) in the previous model to four (4) in the new model for Single Provider (Stream 1) and Co-located and Integrated Facilities (Stream 2) capital projects (see Table 1 on page 14).

The CHCP policy is designed to be used with additional resources as outlined below including, but not limited to:

- Community Health Service Provider Cost Share Guide ("Community Cost Share Guide")
- Space Standards for Community Health Care Facilities ("Community Space Standards")
- Community Health Program Toolkit ("Community Toolkit")

For CIRF projects, the capital planning and implementation process model is further streamlined to enable rapid planning and completion of simple infrastructure projects, which is outlined in the CIRF Guidelines.

The CHCP capital planning and implementation process addresses key factors that were identified by stakeholders and the ministry as challenges in the planning and implementation of community sector capital projects, including:

1. Improved alignment of space needs with site selection and implementation funding approval;
2. Defining and expanding eligibility criteria for ministry funded space; and
3. Defining a methodology for inclusion of new community HSP organizations under the funding umbrella.

This policy is subject to revision based on changing needs and/or operational models in the community sector and any changes to ministry organizational structure.

2. Organizational Eligibility and Operational Models

The CHCP policy allows additional ministry-funded community sector HSPs to be considered for capital funding subject to meeting specific eligibility criteria. This approach improves the ministry's ability to analyze and coordinate investment in infrastructure that supports ministry strategies and priorities, including health system capacity planning.

Under this policy, HSPs or organizations that meet the eligibility criteria for a Lead Organization are able to apply for capital project funding consideration.

The CHCP policy framework addresses the following key areas:

- Defining ministry funded programs and services as it relates to determining eligibility for ministry funding for community sector HSP capital investment;
- The eligibility of partner organizations for ministry funded space within community sector HSP physical locations (e.g., Community Health Centres and Aboriginal Health Access Centres);
- Calculation and allocation of space allowances for ministry funded direct service delivery health models (e.g., number of examination rooms and administrative space); and
- Timing of site selection for leasehold projects in the capital planning process.

2.1. Lead Organizations

2.1a. Eligible Community HSPs

Community sector HSPs and organizations that provide direct service-related programming that were specifically-named in the prior community capital policy continue to be eligible under the current CHCP policy. Below is a current list of eligible Lead Organizations from the community sector (refer to Appendix 1 for descriptions of these community HSPs):

- Aboriginal Health Access Centres (AHACs);
- Community Based Mental Health and Addictions (MH&As) Agencies (including on-site residential treatment);
- Community Health Centres (CHCs);
- Family Health Teams (FHTs);
- Nurse Practitioner-Led Clinics (NPLCs);
- Public Health Units (PHUs)*; and

- Midwifery Practice Groups (MPGs)**.

*Please note that for those Public Health Units governed by boards of health made up of municipal and provincial representatives, the board of health can act as a lead organization and is eligible to apply for capital funding.

**Organizations that were developed by the ministry with the intent to provide funding for direct service delivery and support space will retain that ability to be funded. Under the expanded eligibility criteria, ministry funded Midwifery Practice Groups are eligible.

Hospitals are eligible to be a Lead Organization only for Fund Type 2 programs and their respective space. Please refer to Appendix 1 for a description of 'Fund Type 2'.

There may be additional community sector HSPs or organizations not specifically named above which could become eligible for capital funding, provided they meet the Lead Organization criteria requirements identified in Section 2.1b and fulfill the requirements of the application and submission process. HSPs are encouraged to contact their respective endorsing organization to determine whether they would be considered for CHCP funding.

2.1b. Lead Organization Eligibility Criteria

Lead Organizations are HSPs or organizations that meet the eligibility criteria for receiving capital funding from the ministry under the CHCP policy. Please refer to the glossary (Appendix 1) for the definitions of terms discussed in this section and the CHCP Eligibility Flowchart for Lead Organizations (Appendix 2) for additional details. These HSPs or organizations may be an organization leading a project where only that organization is seeking new or renovated/expanded space for the delivery of programs and services (Single Provider-Led Community Capital Project) or an organization leading and coordinating a project where multiple organizations will be providing programs and services from an accessible location.

In order to be classified as a Lead Organization, the organization must meet all of the following eligibility criteria:

- **Service and Organization Types**: Organization type(s) within the community sector that are not-for-profit (either unincorporated or incorporated) organizations and that directly provide health care services in Ontario;
- **Direct Health Service Provider:** The organization delivers one or more of a range of health care services on its premises that include: primary care, health assessment, diagnosis and treatment services, mental health and/or addictions treatment (including on-site residential treatment - see definition in Appendix 1), counselling and/or therapy services, allied health care, and health promotion (see definition of Public Health Unit in Appendix 1);

- **Operational Funding**: There must be an ongoing funding relationship between the organization and the ministry and/or the Local Health Integration Network (LHIN), that provides a minimum of 50% of the HSP's total operating revenue;
- **Operational Oversight**: The ministry or LHIN has a clearly defined accountability structure in place for oversight of the HSP (e.g., accountability agreements); and
- **Endorsement**: The LHIN or area within the ministry that is responsible for providing operational funding will fulfil the role of Endorsing Organization in the capital process.

2.2. Co-located and Integrated Facilities

Project proposals involving provision of services from multiple community sector HSPs in a co-located and/or integrated setting may also be eligible for funding under the CHCP. For these Co-located and Integrated Facility proposals, eligibility may be granted if the following conditions are met:

- In a co-located or integrated model, the Lead Organization must meet all the eligibility criteria listed in Section 2.1 and Appendix 2. This could include establishment of a centre to address specific needs in the local health system.
- In addition, all of the following eligibility criteria must be met. To qualify, the Lead Organization must:
    - Occupy a minimum of 50% of total space dedicated to community healthcare service provision;
    - Demonstrate that there are operational linkages between the various community partner HSPs;
    - Demonstrate that the funding for operational costs of service delivery has been secured by all co-located and integrated community partner HSPs; and,
    - Demonstrate that agreements are in place with partner organizations to secure their share of ongoing operating costs of the facility/facilities.

3. Capital Cost Sharing

The ministry will provide funding to lead community organizations that are eligible for funding under the CHCP policy. Please refer to Section 2.1 of this document for examples of lead organizations. Any additional organizations applying for capital funding would need to meet all eligibility criteria as defined in the flowchart in Appendix 2.

As a companion document to the CHCP Policy, the ministry has developed the Community Health Service Provider Cost Share Guide. The cost share guide provides

a planning tool to assist and support the development of a proposed capital project for eligible community HSPs.

As part of the ministry's capital cost share policy, the ministry will provide up to 100% capital cost sharing for all eligible costs as defined in the cost share guide.

For Integrated Models, cost share eligibility will be assessed based on the policy applicable to the eligible lead organization HSP with the highest percentage of facility use. This approach will improve access for the community to a suite of complementary health and social services.

4. Community Space Standards

As a companion document to the CHCP Policy, the ministry has developed the Space Standards for Community Health Care Facilities ("Community Space Standards").

The underlying principle for space allocation is that the ministry, the Endorsing Organization and the Lead Organization, share a responsibility to ensure that the project is appropriately sized to deliver programs and services approved in the Business Case.

The types and size of rooms eligible for ministry funding are defined in the Community Space Standards. These generally reflect Canadian Standard Association (CSA) recommended standards for ambulatory care and direct/indirect service delivery and support spaces. As CSA standards evolve, the Community Space Standards will be updated to reflect emerging best practices recommended for space standards.

The space standards employ uniform and consistent space eligibility criteria across all community sector HSPs.

To achieve the goal of implementing best practice standards in the community sector, the Endorsing Organization will:

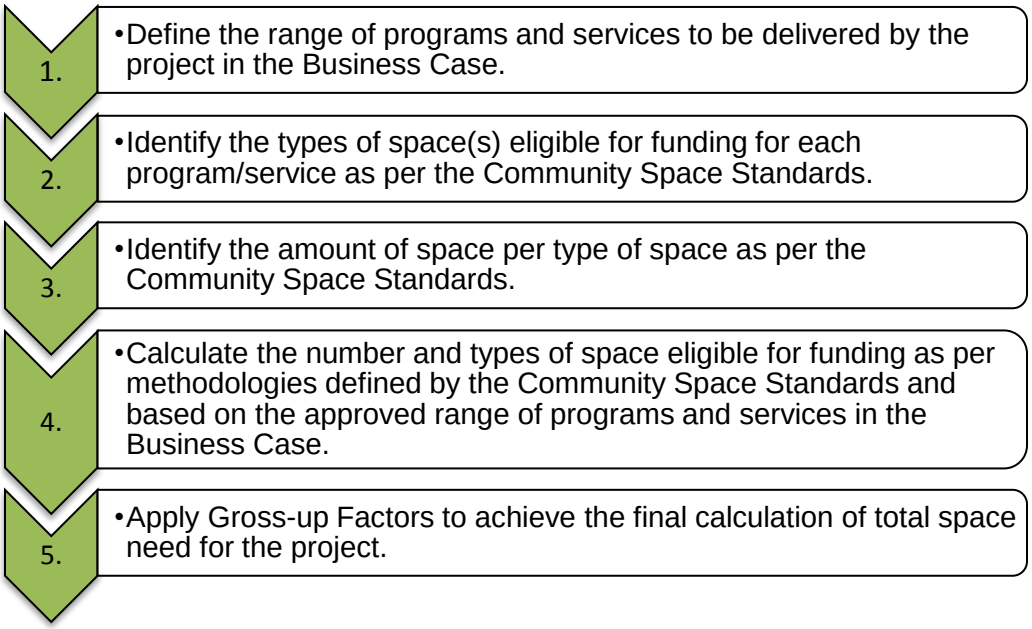
- Endorse programs and services that meet the needs of the community and integrate with those of other community and HSP organizations;
- Endorse projected volumes of service that are achievable within the approved staffing model and model of care of that organization; and
- Ensure any increased operational costs associated with space allocation can be financially managed by the HSP organization.

To achieve this goal, the ministry will review:

- The types of space necessary to support the functions of the organization as approved in the Business Case (located in the CHCP Toolkit and provides relevant details regarding the given project);
- The size of space in accordance with the Community Space Standards; and

- The number of spaces necessary to support projected service volumes that can be achieved by approved staffing. Additional growth volumes will be applied where there is evidence of a funding commitment for increased end project state staffing.

Figure 1. Steps for Calculating Eligible Ministry Funded Space for Community Capital Projects



5. Community Health Capital Program Toolkit

The specific type and amount of space the ministry will approve for funding in a community capital project is based on the list of approved programs and services, and associated volumes. The CHCP Toolkit ("Community Toolkit") supports the HSP in moving through the steps of:

- Identifying programs and services that are eligible for ministry space funding;
- Identifying volumes and staffing to deliver services;
- Identifying the space necessary to deliver those services;
- Identifying site options and project costs for each option; and
- final site selection and total project cost.

The ministry will only fund space where the HSP or partner organizations can demonstrate that there is the operational funding in place to provide staffing to support a reasonable service volume provision.

The Community Toolkit includes an Application Form to gather the basic information necessary for the Endorsing Organization and the ministry to understand the purpose, need, scope and operational funding source(s) of the proposed capital project.

5.1 Unified Project Management Framework

5.1a Capital Approvals and Planning Process Overview

The CHCP provides a unified framework to manage intake, ministry review, approval and oversight of capital projects. For all Single Provider, Co-located and Integrated Facilities projects, the approval pathway is as follows:

Intake and Application Review

- For all project types there is one (1) standardized application form available as part of the Community Toolkit from your respective Endorsing Organization;
- The application form will be submitted to the Endorsing Organization (i.e., the area with operational funding/oversight for the community sector HSP);
- The Endorsing Organization will:
    - ensure that there is a need for the project, review and approve the operational model;
    - ensure that the project aligns with regional integration and health system capacity planning; and that
    - there is a funding commitment for any operating costs associated with the proposed capital project.
- Where the Endorsing Organization is a LHIN, the LHIN will submit the endorsed application to the Health Capital Investment Branch (HCIB) for capital funding consideration. Where the Endorsing Organization is the Accountability and Liaison Branch (ALB) or Primary Health Care Branch (PHCB), the Lead Organization will submit the endorsed application to the respective area for capital funding consideration (see Appendix 3 for a summary); and
- Once endorsed, proposed projects are reviewed and then assigned to the relevant funding streams mentioned (i.e., Single Provider, Co-located and Integrated Facilities stream(s)).

Approval and Funding

- Funding recommendations will take into account the review of application information, current funding allocation, and current funded project commitments.
- Funding recommendations will coordinate and balance the needs of all community HSPs.
- Approvals and funding of the projects will be in accordance with ministry fiscal policies, approved program policy and delegations of authority.

- HCIB will manage the development and approval, and management of projects through the stages of planning, design, construction and settlement process for all community HSPs and where the LHIN is the Endorsing Organization (currently for CHC and MH&A HSPs).
- PHCB will manage the development and approval, and management of projects through the stages of planning, design, construction and settlement process for those community HSPs where PHCB is the Endorsing Organization (currently AHACs, NPLCs, and FHTs).
- ALB will manage the development and approval, and management of projects through the stages of planning, design, construction and provide oversight of the settlement process for those community HSPs where ALB is the Endorsing Organization (currently PHUs).
- If new sectors become eligible for capital funding, there may be additional endorsing organizations identified to provide similar process oversight for HSPs within these sectors.
- Those proposed projects selected by the ministry at the Application stage will be eligible for a capital Planning Grant to develop a Business Case. The Business Case will define programs and service composition, space requirements, site search, overall size, cost and all other elements required to fully understand scope, size, cost and timelines of the project.
- Site selection (lease or purchase option) occurs for those projects that the ministry plans to advance to implementation. Once a site has been selected and full costing on the project is known, an Implementation Grant is provided for those projects approved to proceed. This grant would carry the project through design, development of contract documents, tender, award of contract and construction.
- Following approval of either a Planning or an Implementation Grant, there will be a standardized capital planning and implementation process for each funding stream (Single Provider, Co-located and Integrated Facilities).

5.2. Single Provider, Co-located and Integrated Facilities Project Process

As outlined in Table 1, Single Provider, Co-located and Integrated Facilities projects will be managed under the streamlined four-stage capital planning and implementation process. Please refer to Appendix 3 for roles and responsibilities of Endorsing Organizations.

Table 1: Streamlined Four-Stage Capital Planning and Implementation Process

Stage	Process Components
Stage 1: Application	• HSP submits application to Endorsing Organization for review and endorsement of the application • Ministry selects and approves applications to advance to planning
Stage 2: Business Case	• Planning Grant provided to create Business Case • At end of Business Case, full scope and cost of project is understood and site is identified • If project is endorsed and Ministry approved, the project is eligible for an Implementation Grant
Stage 3: Planning, Tender, Award of Contract	• Implementation Grant approved • Site secured • Detailed design, contract documents, tender and award of contract
Stage 4: Implementation and Settlement	• Implementation • Project completion • Financial settlement • Post-project evaluation

The new four (4) stage process is intended to:

- Simplify the amount of information required to approve and plan the project;
- Reduce the time required in early planning;
- Align site selection with space requirement approvals; and
- Ensures that when implementation funding is provided at the end of Stage 2, the project will move immediately into planning and construction.

5.3 Community Infrastructure Renewal Fund (CIRF) Project Process

The CIRF provides an annual allocation for capital repair and renewal investments for eligible community sector HSPs that meet specific criteria relating to asset ownership and lease requirements, based on a standard assessment of asset condition.

For further information on the CIRF funding and operational policy, please refer to the current version of the Community Infrastructure Renewal Fund Guidelines. This document is available through the HCIB of the ministry.

5.4. Technical Review Requirements

Ministry funded projects through the CHCP further refines the previous technical review process through the application of a risk-based approach to ensure:

- Compliance with legislated standards (e.g., Building code/CSA standards) to ensure the safety of those delivering services, receiving services and visiting the facility;
- Compliance with Infection Prevention and Control practices as appropriate to the programs and services being delivered within the facility; and
- Value for public investment in the capital project and ongoing operational costs.

There are three levels of technical review based on the risk presented by the project (project class).

Please note that HCIB is available to work with the Endorsing Organization in the technical review process to provide any assistance as required.

Refer to Appendix 4 for an overview of these risk levels:

1. Class A Risk

Projects that are infrastructure-only related (i.e., building envelope/structure/electrical/ mechanical whether funded through CIRF or the community stream) will follow an expedited pathway depending on the technical review requirements.

2. Class B Risk

For projects that have no clinical space/clinical service delivery components (e.g., office space renovations, expansion of meeting room space), the Endorsing Organization will engage HCIB in the completion of the Technical Review as required and ensure that space standards as defined in the “Space Standards for Community Health Care Facilities Guidelines” are applied.

In addition, the Endorsing Organization will be required to obtain from the Lead Organization and/or its consultants attestations that there is compliance with Ontario Building Code, and Infection Protection and Control (IPAC), as required, from a qualified IPAC specialist (e.g., HVAC requirements). Please note that where the Endorsing Organization is the LHIN, HCIB will assume these responsibilities. Records of project details including attestations will be retained in the project record files by HCIB.

3. Class C Risk

For those capital projects that have a clinical component, the Endorsing Organization will be responsible for initially assessing the size, scope and complexity of the project through review of the CHCP Toolkit: Application Form.

Where the Endorsing Organization determines that the size, scope and/or complexity of the project require additional resources, the Endorsing Organization will engage the HCIB in the technical review process. Once engaged in the technical review process, HCIB will work with the Endorsing Organization and the Lead Organization to define the range of information necessary for the technical review to inform the approval process.

5.5. Own Funds Projects

For own funds capital projects, community HSPs must follow the most recent version of the Community Capital Projects Directive. The purpose of this directive is to ensure that LHINs/Endorsing Organizations review all community capital projects from community HSPs within their operational funding authority. The ministry reviews the projects to ensure compliance with applicable building codes, ministry standards, and other guidelines as applicable.

All community HSPs that are eligible as Lead Organizations for capital funding per the criteria defined in the CHCP policy are required to comply with this directive.

Appendix 1: Glossary

Aboriginal Health Access Centres

Aboriginal Health Access Centres (AHACs) are Aboriginal community-led, primary health care organizations that combine traditional healing, primary care, cultural programs, health promotion programs, community development initiatives and social support services to First Nations, Metis, and Inuit communities.

AHACs in Ontario provide services both on and off reserve, in urban, southern and northern locations.

Allied Health

For the purposes of the CHCP policy, Allied Health is defined as Regulated Health Care Professionals under the Regulated Health Professions Act, 1991 and those non-regulated health care providers that provide services to clients/patients that do not require examination rooms, but do require dedicated specialized spaces that support their specific programs and services. Allied Health services are part of the Direct Service Provider category. Some examples include audiologists and speech language pathologists; physical therapists, occupational and respiratory therapists; nutritionists and dietitians. Others often included in allied health include dental personnel (dental hygienists and dental assistants); health educators (asthma educators, diabetes educators); counselors (mental health counselors, family therapists).

Community Health Centres

Community Health Centres (CHCs) are non-profit organizations established and governed by a community-elected board of directors. They serve priority populations, traditionally clients who have experienced barriers to access based on culture, language, literacy, age, socio-economic status, mental health status and homelessness.

CHCs play a key role in delivering on each of the three identified priorities for Ontario's health care system, including increased access to doctors and nurses and the delivery of these primary care services closer to home; reduced pressures on hospital emergency departments; and reduced wait times to access services.

Community Mental Health & Addictions

This includes community mental health programs and addiction programs (MH&As) (including substance abuse programs and problem gambling programs). These programs serve the needs of consumers and their families by incorporating a strong recovery and harm reduction approach to address the health and social outcomes, as well as long-term consequences associated with living with mental illness, problematic substance use or gambling problems.

Community Sector

Refers to categories of community based Health Service Providers, for example, Community Health Centres or Primary Health Care Organizations. Please refer to Appendix 3 for examples of community based Health Service Providers.

Direct Health Service Provider:

A community HSP delivers one or more of a range of health care services that includes: primary care, health assessment, diagnosis and treatment services, mental health and/or addictions treatment (including on-site residential treatment of no more than 24 months targeted duration), counselling and/or therapy services, allied health care and/or health promotion.

Endorsing Organizations

Refers to the LHIN and/or those areas within the ministry that are responsible for providing operational funding and/or oversight responsibilities and agree to fulfill this role in the capital planning process (such as the role that the LHINs/HCIB assume for CHCs and MH&A organizations). For examples of additional Endorsing Organizations, please refer to Appendix 3.

Family Health Teams

Family Health Teams (FHTs) are not-for-profit primary health care organizations that include a team of family physicians, nurse practitioners, registered nurses, social workers, dietitians, and other professionals who work together to provide primary health care for their community. They ensure that people receive the care they need in their communities, as each team is set-up based on local health and community needs.

FHTs were created to expand access to comprehensive family health care services across Ontario.

Fund Type 2

For the purposes of the CHCP policy, Fund Type 2 programs as defined in the Ontario Health Care Reporting Standards refer to Community Mental Health & Addictions programs (not part of hospital global budgets), Community Health Centres, and other community HSP programs.

Lead Organization

This includes those organizations that meet the eligibility criteria for receiving capital funding from the ministry. (This may include an organization leading a project where only that organization is seeking new or renovated/expanded space for the delivery of programs and services or an organization leading and coordinating a project where multiple organizations will be providing programs and services from one physical location).

Midwifery Practice Groups

Midwifery Practice Groups (MPGs) are groups of two or more midwives who work together in a group-practice to provide a continuum of midwifery services for their clients.

Nurse Practitioner-Led Clinics

Nurse Practitioner-Led Clinics (NPLCs) are not-for-profit primary health care models in which Nurse Practitioners work collaboratively with an inter-disciplinary team, including consulting physicians, to provide comprehensive, accessible, and coordinated family health care services to the community.

Partner Organization

Organizations that may co-locate or integrate with the Lead Organization to provide services and programs from one physical location. These can be non-ministry funded organizations. The Partner Organization may or may not be eligible for ministry funded space.

Primary Care

For the purposes of the policy, Primary Care is defined as Medical Doctor and Nurse Practitioner-Led services. Primary Care services are part of the Direct Service Provider category.

Public Health Units

Public Health Units (PHUs) are official health agencies established pursuant to the Health Protection and Promotion Act (HPPA) to provide essential public health programs and services, carried out by specially qualified staff in both urban and rural municipalities.

All PHUs administer health promotion and disease prevention programs according to the requirements of the HPPA and Ontario Public Health Standards (OPHS). There may be some variations in the type of services delivered depending on the region.

Each public health unit is governed by a board of health, which is accountable for meeting provincial standards under the HPPA and OPHS, and is administered by a Medical Officer of Health who reports to the local board of health. The board is largely made up of elected representatives from the local municipal councils, but may include provincial appointees. The ministry cost-shares expenses with the municipalities for the delivery of mandatory programs/OPHS. The ministry also provides 75% and 100% provincial funding for a number of related public health programs and services.

PHUs are not-for-profit and every public health unit is a corporation without share capital.

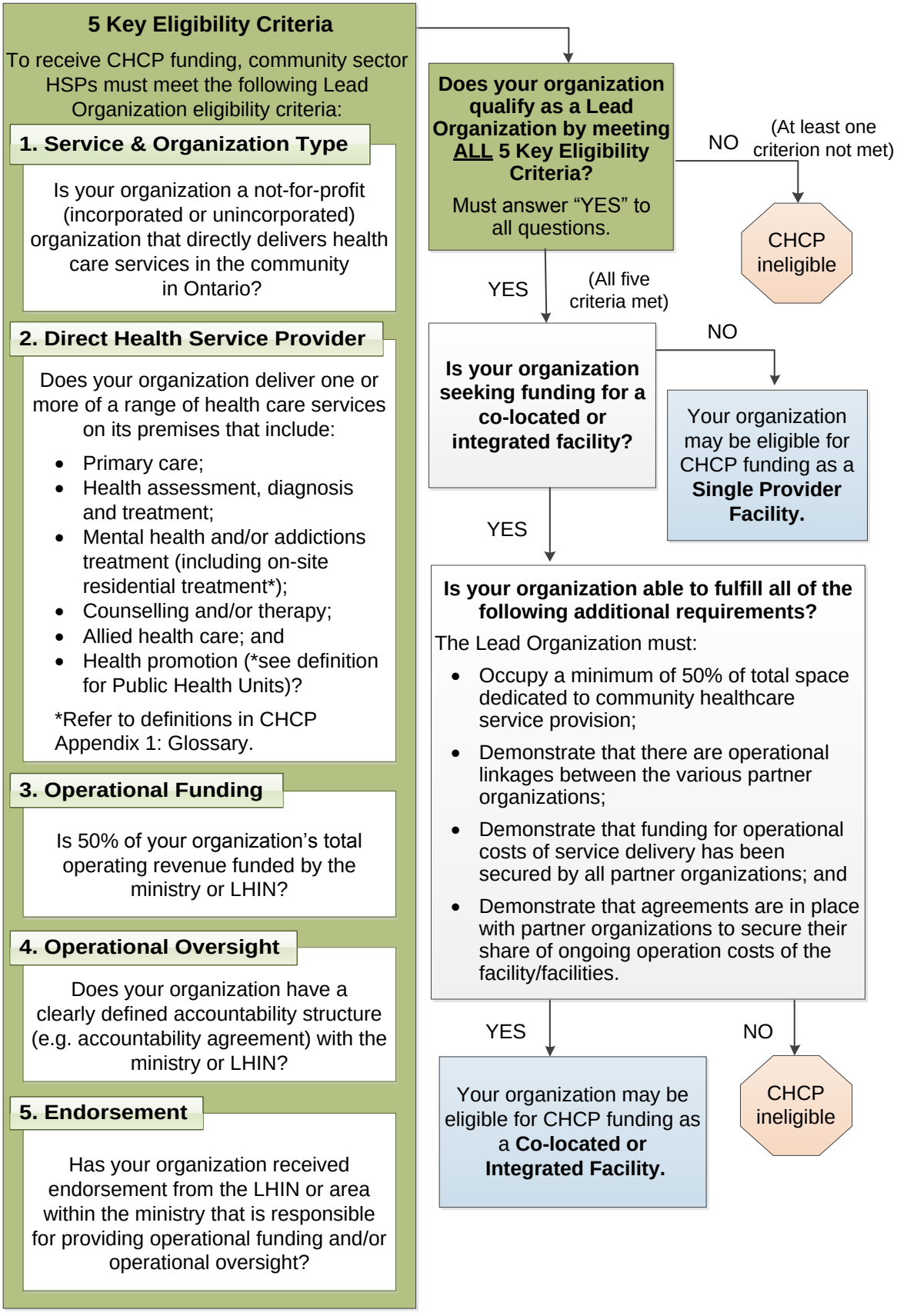
Residential Treatment

Residential addiction treatment facilities provide intensive time-limited treatment (clients' length of stay up to 2 years) in structured, substance-free, in-house environments. Individuals accessing these services are most likely to be those with more complex and/or chronic substance use. Residential treatment programs provide daily programming that supports participants to examine and process issues related to their substance use. Treatment includes counseling/therapy, as well as psycho-social education and life-skills training. In addition to the scheduled program activities, service recipients have 24-hour-per-day on-site access to support and residential treatment. Some programs may also provide medical, nursing, or psychiatric support.

Residential Supportive Treatment

Residential Supportive Treatment programs are less intensive than residential treatment (clients' length of stay up to 2 years). Programs provide safe, substance-free accommodation with low to moderate intensity of services and a level of support appropriate for longer-term treatment of problematic substance use. This type of program would be suitable for individuals who do not require intensive residential treatment, but who need a safe, supportive environment, away from their usual living situation, in which to manage their substance use. Supportive residential services may also meet the needs of individuals who require additional stabilization and support to integrate into the community.

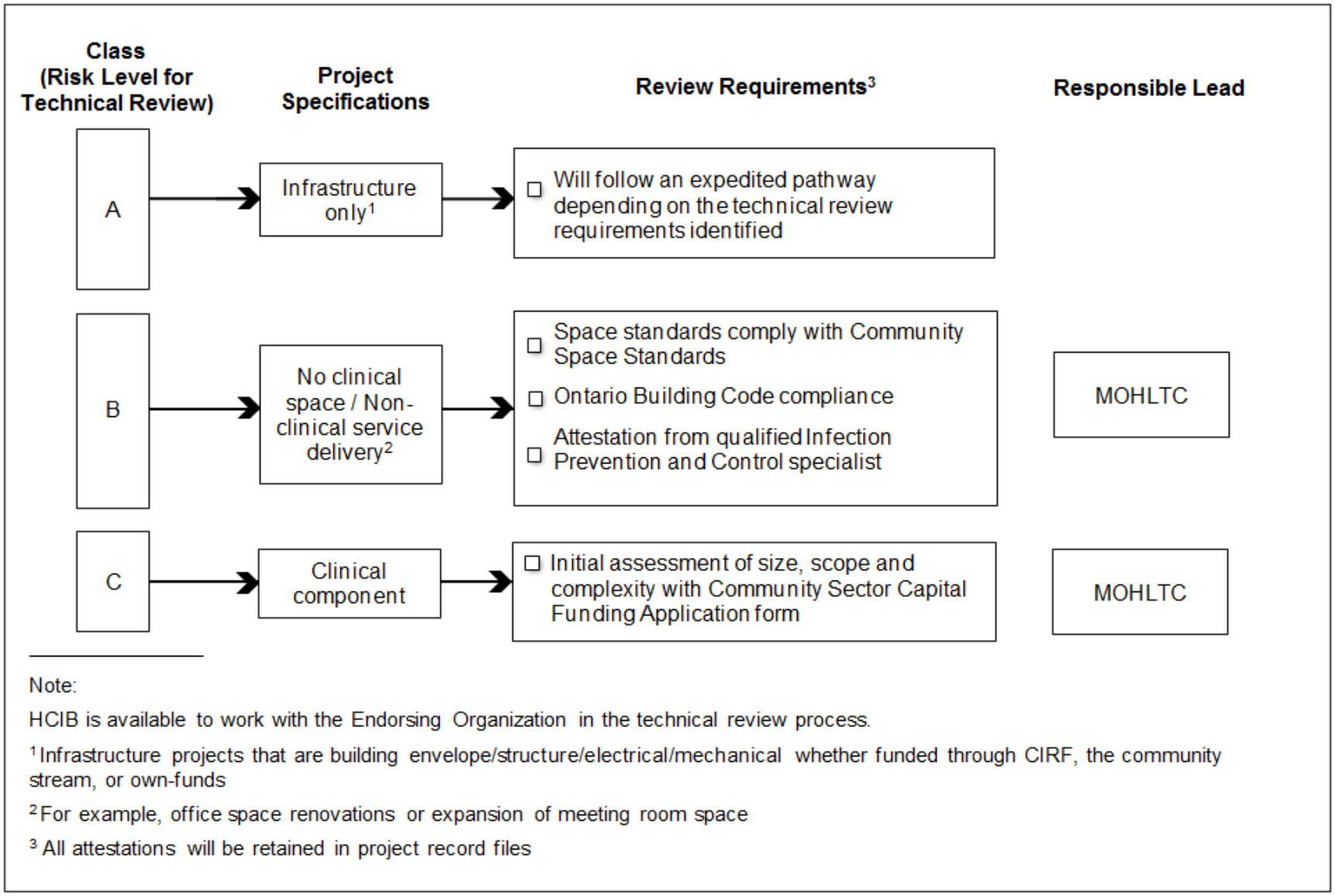
Appendix 2: CHCP Eligibility Flowchart



Appendix 3: Accountabilities by Health Service Provider

Health Service Provider	Endorsing Organization	Receiving Branch for Application Review and Approval	Technical Support, Review and Approvals	Funding Approvals
Community Health Centres (CHCs)	LHIN	Health Capital Investment Branch (HCIB)	HCIB	Minister of Health and Long-Term Care or Delegate
Community Mental Health and Addictions (MH&As)				
Hospital Corporations (only for Fund Type 2 only)				
Aboriginal Health Access Centres (AHACs)	Primary Health Care Branch (PHCB)	PHCB		
Family Health Teams (FHTs)				
Nurse Practitioner-Led Clinics (NPLCs)				
Midwifery Practice Groups				
Public Health Units (PHUs)	Accountability and Liaison Branch (ALB)	ALB		
Co-located and Integrated Facilities	Dependent on Lead Organization	Dependent on Health Service Provider		
Health Service Provider Not Specified in Policy		HCIB and other applicable branches to determine eligibility		

Appendix 4: Overview of the Risk Levels



Note:

HCIB is available to work with the Endorsing Organization in the technical review process.

[1] Infrastructure projects that are building envelope/structure/electrical/mechanical whether funded through CIRF, the community stream, or own-funds

[2] For example, office space renovations or expansion of meeting room space

[3] All attestations will be retained in project record files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