Ontario Health atHome

Short Stay Respite
Long Term Care Home Choice List

Patient ______________________________ ______________ ______________

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

Please select up to five long-term care homes 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 long-term care homes 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
	Stittsville	**Extendicare Crossing Bridge**	
	Ottawa	**Extendicare Laurier Manor**	
	Kanata	**Garden Terrace (S)**	
	Orleans	**Saint-Louis Long-Term Care (S)**	
	Ottawa	**St. Patrick's Home (S)**	
Rank	**Location**	**East**	**Requested Dates**
	Cornwall	**Glen-Stor-Dun Lodge**	
	Hawkesbury	**Résidence Prescott et Russell**	
Rank	**Location**	**West**	**Requested Dates**
	Almonte	**Fairview Manor (S)**	
	Pembroke	**Marianhill Nursing Home**	
	Pembroke	**Miramichi Lodge**	
	Deep River	**North Renfrew Long-Term Care Services**	

(S) = Secure unit available.

		Out of Region LTC Home	Requested Dates

ACCOMMODATION RATES

Short Stay Daily Rate is $44.38/Day (July 1, 2025 – 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.

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CONSENT FOR PLACEMENT

- I consent that the Ontario Health atHome, as the designated Placement Coordinator, can disclose my personal health information to the long-term care home 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 Ontario Health atHomes, other health professionals involved in my care, and the long-term care homes of my choice.
- I understand that I may withdraw my consent at any time.

Patient / Substitute Decision-Maker	Signature	Print Name	Day/Month/Year

If Substitute Decision-Maker, please complete the following	Your relationship to patient	☐ Personal care power of attorney	☐ Public guardian and trustee