

# PRIMARY CAREGIVER TAX CREDIT

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



## PART A: Declaration by qualified client (see also alternate signatory declaration on reverse)

Name of client ( <i>print</i> ):			
Last	First	Middle	
Client's address: ( <i>ordinary residence-not a hospital, personal care home, group home or other institution</i> )			Regional Health Authority where client lives:
Street			
City		Prov	PC*
Client's SIN:		Client's phone:	
Client's e-mail address ( <i>if available</i> ):			
Other client contact information:			
<b>Designation of primary caregiver:</b> The client hereby designates [ <i>name of primary caregiver</i> ]			
Last			
First			
as the client's sole primary caregiver for the purposes of Manitoba's Primary Caregiver Tax Credit.			
<input type="checkbox"/> <b>Check if this is a replacement designation.</b> Note: The client or alternate signatory is responsible for notifying the previous primary caregiver if there is a change in designated primary caregiver for tax credit purposes. A new application is always required in such cases.			
<b>Declaration:</b> I hereby declare the foregoing to be true to the best of my knowledge. I understand that it is an offence knowingly to make false statements under <i>The Income Tax Act (Manitoba)</i> . I have read and accept the FIPPA conditions below.			
Signature of client [ <i>or alternate signatory – see Part D</i> ]			Date ( <i>yy/mm/dd</i> )

## PART B: Declaration by primary caregiver

Name of primary caregiver ( <i>print</i> ):			
Last	First	Middle	
SIN of primary caregiver:		Relationship to client:	
Caregiver's home address:			
Street			
City		Prov	Postal Code
Phone	Home	Work	Cell
Caregiver's e-mail address ( <i>if available</i> ):			
<b>Declaration:</b> I am the primary caregiver designated above for the purposes of the Primary Caregiver Tax Credit. I am serving or am about to serve as primary caregiver for the client listed above. The client is living at home. I have not been, nor am I being, remunerated by any party for assistance I provide to the Client. (Note: the tax credit is not considered remuneration). I have received, and 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 knowingly to make false statements under <i>The Income Tax Act (Manitoba)</i> . I have read and accept the FIPPA conditions below.			
Signature of primary caregiver:			Date ( <i>yy/mm/dd</i> )

**\*When completed by client (or alternate signatory) and primary caregiver, this form is to be submitted to the Regional Health Authority (RHA) in which the client lives. If you do not know how to contact client's RHA, please call Manitoba Government Inquiry at 1-866-626-4862, and be prepared to provide the client's postal code.**

**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 to provide the personal information about me on this form and/or subsequent changes in the information, to MB Finance or to MB Health and Healthy Living for the purpose of administering the tax credit. I understand I may contact the Manitoba Tax Assistance Office at 204-948-2115 if I have questions about privacy implications.

## PART C: Home care verification

To be completed by an authorized employee of the RHA in which the client identified in Part A resides.

**Declaration of client's qualification:** (please initial boxes as appropriate concerning client)

**Note:** Box A and either B1 OR B2 are required for qualification. – Box C is optional

- A:  The client for tax credit purposes identified in Part A is resident in our catchment area and does not ordinarily reside in a group home or a care facility such as a personal care home.
- B1:  The client has most recently been assessed by the RHA as requiring home care at Level 2 or higher;  
OR
- B2:  The client has not been formally assessed but requires care equivalent to Levels 2-4,
- as determined by applying the most recent *Primary Caregiver Tax Credit Level of Care Equivalency Guideline* issued by Manitoba Health & Healthy Living, OR
  - as determined by applying other criteria formally set by the RHA.
- C:  the primary caregiver identified in Part B has been or will be designated on the client's care plan as the primary caregiver for the purposes of the Primary Caregiver Tax Credit.

**Client's qualification not verifiable:** The RHA cannot verify qualification at this time. Reason:

Comments

Case or Care Plan #  
(if applicable)

Care Plan effective date  
(if applicable) (yy/mm/dd)

Reassessment date  
(if known) (yy/mm/dd)

Care Plan termination date  
(if known) (yy/mm/dd)

Signature of authorized employee

Date: (yy/mm/dd)

Employee identification

RHA and Office Location

Name  
Position

e-mail

## Part D: Identification of alternate signatory and declaration on client's behalf

To be completed in addition to Part A where this form is being completed by an alternate signatory for the client due to the client's inability to fill in this form. **(Must not be completed by the primary caregiver.)**

Name:

Last First Middle

Address:

Street

City

Prov

Postal Code

Phone numbers: Home

Work

Cell

e-mail address (if available):

Relationship to the Client identified in Part A:

**Authority:** I am authorized to act on behalf of the Qualified Home Care Client identified in Part A by virtue of:

**Declaration:** I hereby declare all the information provided in Part A 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 knowingly to make false statements under *The Income Tax Act (Manitoba)*. I have read and accept the FIPPA conditions on the first page.

**Signature:**

Date: (yy/mm/dd)

For Office Use Only (RHA)

For Office Use Only (MHHL)