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# Veterans Independence Program - Benefits at Home Policy

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This policy replaces the following policies, which have been repealed: Assessments (Veterans Independence Program), Survivors – Veterans Independence Program, Primary Caregivers (Veterans Independence Program), Exceptional Health Needs (Veterans Independence Program), Benefit Arrangement (Veterans Independence Program), Frail Disability Benefits Recipients, Principal Residence (Veterans Independence Program), Client Relatives (Veterans Independence Program), Home Care Services (Veterans Independence Program), Ambulatory Health Care Service (Veterans Independence Program), and Transportation Service (Veterans Independence Program).

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# Authority

*Veterans Health Care Regulations*, Part II and Part IV enacted under the authority of the *Department of Veterans Affairs Act*

# Objective

The Veterans Independence Program(VIP) assists eligible recipients to remain in their homes and communities if possible, by contributing financial assistance towards services which support and promote independence and health.

Depending on circumstances and health needs, the program can contribute to services such as health and support services, personal care, housekeeping, access to nutrition, grounds maintenance, ambulatory health care, transportation and home adaptations.

When care in the home is no longer practical, VIP provides eligible individuals with funding for intermediate care in a community facility. See the Community Facilities (Veterans Independence Program - Intermediate Care and Long-term Care) policy.

# Definitions

**Allied Veteran,** for the purpose of eligibility for VIP, is defined in paragraphs 6, 7 and 8, and Appendix C to this policy. See also the Eligibility for Health Care Programs - Allied Veterans policy.

**Assessable income** means "income" as defined in section 7 of the *War Veterans Allowance Act* (i.e. gross income less applicable deductions permitted under Division B of the *Income Tax Act*), current monthly benefits as defined in paragraph 4(3)(c) of that Act, and any War Veterans Allowance benefit being paid to the eligible Veteran. See the Income Assessment – War Veterans Allowance Program policy.

**Assessment** means, for the purposes of VIP services, an evaluation of an individual's circumstances, including home situation, individual's functional status and available supports, to identify unmet health needs and appropriate interventions.

**Day,** for the purpose of the limitation to personal care in paragraph 59, a is defined as the actual personal care service needs of an individual within a 24-hour period.

**Eligible individual** for the purposes of this policy means:

a. Veteran pensioner, income-qualified Veteran, overseas service Veteran, or a Veteran who satisfies the age and service requirements to be recognized as a Canada service Veteran;
b. civilian pensioner, income-qualified overseas service civilian;
c. military service pensioner;
d. special duty service pensioner;
e. a prisoner of war entitled to basic compensation under subsection 71.2(1) of the *Pension Act*;
f. an allied veteran entitled to VIP.
g. a former member or Reserve Force member who is entitled to a disability award or entitled to a pain and suffering compensation; or
h. a former member or Reserve Force member who has received a detention benefit under Part 3 of the *Veterans Well-being Act*.

The conditions for eligibility for each group listed above are set out in sections 15, 17 and 18 of the *Veterans Health Care Regulations*, paragraphs 4, 5 and 6 of this policy, and are outlined in Appendix B – VIP Eligibility> . For Allied Veterans eligible for VIP see paragraphs 7, 8 and 9 of this policy and Appendix C – Allied Veterans.

**Primary caregiver** means, for the purposes of this policy, the adult person (18 years or older) who, on the day of the client's death or admission to a health care facility:

a. had been the person primarily responsible for ensuring that care was provided to the client;
b. had not been receiving a wage for ensuring the care;
c. had been maintained by or had been maintaining the client for a continuous period of at least one year (this could include emotional support and companionship and is not only related to financial support); and
d. had been resident in the principal residence of the client for a continuous period of at least one year.

Primary caregivers would be eligible spouses and common-law partners, although adult children and others may qualify.

**Survivor**, in relation to the eligible individual, means the adult person (18 years or older) who, immediately before the Veteran/civilian pensioner or income-qualified Veteran/Civilian died; or, if the eligible individual died in a health care facility, immediately before the eligible individual was admitted into the health care facility, was:

a. the person primarily responsible for ensuring that care was provided to the Veteran;
b. not receiving a wage for ensuring that care was provided to the eligible individual;
c. residing in the principal residence of the eligible individual for a continuous period of at least one year; and
d. maintaining or maintained by the eligible individual for a continuous period of least one year.

# Policy requirements

# Eligibility

### General

1. Eligibility criteria and services provided to eligible individuals, primary caregivers and survivors can be found in sections 15 to 18 of the *Veterans Health Care Regulations*.

### Veterans, Civilians and Reserve Force Members

2. The eligibility criteria and services funded for each eligible individual varies depending on such factors as type of service, where and when they served, income, disability benefit entitlement, and health needs.
3. See sections 15, 17 and 18 of the *Veterans Health Care Regulations*, and Appendix B – VIP Eligibility for information about the eligible individuals, eligibility criteria and eligible services.
4. Some eligible individuals who have access to VIP-like services from federal, provincial and community programs that are meeting their needs may be granted entitlement only to ensure that they receive treatment benefits they would be eligible for as VIP recipients (i.e. B-line coverage).
5. If an eligible individual with entitlement only has needs that increase over time and the provider of VIP-like services is no longer fully meeting the needs, the Veteran can receive VIP from VAC as a second payer to top up services.

### Allied Veterans

6. An Allied Veteran is defined in the *War Veterans Allowance Act* as "… a former member of an Allied Force..." Veterans Affairs Canada interprets the term "former member" to mean an individual who served in a formal military capacity as an enlisted member of the "armed forces" (i.e. army, navy or air force). Service as a former member of a resistance group cannot be recognized.
7. The provisions of the *Veterans Health Care Regulations* recognize various types of Allied Veterans depending on when and where the Veteran served, whether the Veteran was domiciled in Canada prior to or after serving in the Allied Force, and whether the Veteran is entitled to a disability pension. For the VIP this recognition can be broken down into two categories: Allied Veterans with pre-war Canadian domicile, and Allied Veterans with post-war Canadian domicile. Regardless, if the Veteran is an Allied Veteran,

they must still meet the criteria for being an Overseas Service Veteran, an Income-qualified Veteran, or a Veteran Pensioner before they can be eligible for VIP.

8. See Appendix B for information about Allied Veteran eligibility criteria and eligible services and see Appendix C for Allied Veteran definitions.

**Primary Caregivers**

9. See section 16 of the *Veterans Health Care Regulations* and Appendix B – Veterans Independence Program Eligibility for information about primary caregiver eligibility criteria and eligible services.
10. A primary caregiver is entitled to receive financial support to obtain the housekeeping and/or grounds maintenance services that the Veteran was receiving at the time the Veteran died or began residing in a health care facility, if:
    a. within one year after either the Veteran's death or admission into a health care facility (whichever comes first), the primary caregiver is assessed; or, at any point in time, the primary caregiver presents evidence relating to their health condition during that period on the basis of which an assessment can be made;
    b. the assessment and all subsequent assessments indicate that the provision of the housekeeping and/or grounds maintenance services are necessary for health reasons and to assist the primary caregiver to remain self-sufficient at their principal residence;
    c. the primary caregiver is resident in Canada; and
    d. the services are not available to the primary caregiver as insured services under a provincial health care system or a private insurance policy.
11. A primary caregiver of an eligible individual who was receiving housekeeping and/or grounds maintenance services because of exceptional health needs (see section 18 of the *Veterans Health Care Regulations*), or who has entitlement only is entitled to continue to receive those services if the primary caregiver meets the eligibility criteria, and:
    a. the provincial/community services cease when the eligible individual dies or is admitted to a health care facility; or,
    b. the primary caregiver must pay to continue receiving the services.
12. When an eligible individual is no longer able to stay in their family home and moves into an assisted-living or similar facility, the primary caregiver is entitled to receive the housekeeping and/or grounds maintenance services that were in place at the family home. The primary caregiver must meet the eligibility criteria.
13. A person who does not satisfy the criteria to be recognized as a primary caregiver may be eligible for housekeeping and/or grounds maintenance services as a "survivor" (see paragraphs 16 to 21).
14. The needs of the primary caregiver are to be assessed initially within one year after the Veteran's death (or admission to a health care facility) and on a periodic basis thereafter. Alternatively, the initial assessment may be conducted later, provided it is based on evidence relevant to the one-year period after the veteran's death or admission to a health care facility.
15. A primary caregiver is entitled to receive only the housekeeping or grounds maintenance services that the Veteran was receiving. If a Veteran was receiving only housekeeping services, then the primary caregiver may only continue to receive housekeeping. The same applies for grounds maintenance.

**Survivors**

16. See section 16.1 of the *Veterans Health Care Regulations*, and Appendix B – Veterans Independence Program Eligibility for information about survivor eligibility criteria and eligible services. **All criteria** must be satisfied at the time of application to be eligible.

17. To qualify, at the time of application, the survivor must be an adult, 18 years of age or older and:
    a. not be eligible to receive any services as a primary caregiver under section 16 of the *Veterans Health Care Regulations*;
    b. be in receipt of the Guaranteed Income Supplement under the *Old Age Security Act*, or be approved for the Disability Tax Credit under section 118.3 of the *Income Tax Act*;
    c. be residing in Canada (where a survivor is absent from Canada for 183 days or less in a calendar year, their residence in Canada is presumed not to be interrupted);
    d. have a need for the housekeeping and/or grounds maintenance services. It must be established that the need is due to a health reason and that the health reason must be addressed in order for the survivor to remain independent in their principal residence; and
    e. confirmation that the services are not available to them under a provincial health care system or private insurance policy.
18. The *Veterans Health Care Regulations* were amended to provide eligibility for housekeeping and/or grounds maintenance services to a qualified survivor of an income-qualified civilian, an income-qualified Veteran, a Veteran pensioner or a civilian pensioner who, at the time of their death, was not in receipt of housekeeping and/or grounds maintenance services; and includes a survivor of a Veteran/civilian who died prior to the establishment of the VIP.
19. If the Veteran/civilian, at the time of death, was not an income-qualified Veteran/civilian as defined in section 2 of the *Veterans Health Care Regulations*, but was qualified at some point during their lifetime, the survivor would be eligible.
20. The Veteran/civilian cannot have been in receipt of grounds maintenance and/or housekeeping services at the time of their death, although they may have been in receipt of funding for other VIP services, such as personal care.
21. Survivors of those Veterans/civilians who were in receipt of housekeeping and/or grounds maintenance services at the time of their death or admission into a health care facility may be eligible for those benefits as “primary caregivers” (see paragraphs 9 to 15).

### Exclusions

22. Royal Canadian Mounted Police (RCMP) members and former members are not eligible for funding for services under VIP related to their RCMP disability pension entitled conditions. RCMP members and former members who also have VAC disability benefits entitlement related to service with the Canadian Armed Forces (CAF) may receive from VAC all the benefits to which they may be entitled as a former member of the CAF.
23. CAF members are not eligible for VIP services. However, some Reserve Force members of the CAF who are entitled to a disability benefit may be eligible for funding for services under VIP.
24. Former members of Resistance Forces are not eligible for funding for services under VIP.

## Qualifying conditions and considerations

### Residency

25. An eligible individual, survivor or primary caregiver must be resident in Canada to access funding to services under VIP. VIP-like services acquired while an eligible individual, survivor or primary caregiver is temporarily outside Canada (e.g. snowbirds) may not receive payment for VIP-like services.

### Determination of need

26. Funding for services under VIP may be granted only if a need is identified through a current assessment which indicates that:
    a. the requested Home Care Service, Ambulatory Health Care Service, Transportation Service or Home Adaptations Service is appropriate and required to assist an eligible individual to remain self-sufficient at their principal residence; or
    b. the provision of the requested intermediate care in a community facility, other than a contract bed, is appropriate under the circumstances, i.e. an eligible individual cannot or should not be maintained in a home environment, and the type and degree of care provided addresses the eligible individual's health needs.

## Reassessment

27. If an eligible individual believes that a change of circumstances has occurred, they can request a reassessment.

## Access to treatment benefits

28. If an eligible individual qualifies for funding for any service under VIP that could also be covered under the Treatment Benefits program (e.g. health and support services, home adaptations), access must be considered under treatment benefits policies and procedures first.

## Exceptional health needs

29. See section 18 of the *Veterans Health Care Regulations*, and Appendix B – Veterans Independence Program Eligibility for information about eligible individuals who can receive funding for services under VIP because they have exceptional health needs and insufficient income.
30. Exceptional health needs are health needs arising through some unfortunate circumstance, such as an illness or accident, which requires that an eligible individual either receive intermediate care or clearly places an eligible individual at risk of entering intermediate care if home care services, ambulatory health care, transportation and/or home adaptations under VIP are not provided.
31. An eligible individual would normally require care in response to a Type II health need, as identified through a health professional assessment, to be considered for funding for services or intermediate care under VIP under the exceptional health needs provision. However, in certain cases (e.g., unavailability of community support services, social isolation, the existence of serious impairments/barriers to the performance of the activities of daily living, or risk of institutionalization), applicants who do not meet the Type II level of care criteria may also be considered.

## Frail

32. Where possible, every effort will be made to establish that the need for VIP services is linked to the disability benefits entitled condition. In absence of a link to a disability benefit entitled condition, a frail assessment may be needed to determine if they have other needs that can be addressed through VIP. See Appendix B – Veterans Independence Program Eligibility for information on eligible individuals who can receive funding for services under VIP because they are frail.
33. Frail is defined as the occurrence of a critical mass of physiological conditions that place an eligible individual at risk for falls, injuries, illnesses or the need for supervision or hospitalization. Frailty also results in a severe and prolonged impairment of function with little or no likelihood of improvement. The designation of "frail" is based on the premise that for eligible individual's suffering from multiple health

conditions, one of which is a disability benefits entitled condition; this complex interplay of disabilities impairs their ability to remain self-sufficient at their principal residence.

34. Prolonged impairment means the impairment(s) has lasted, or is expected to last, for a continuous period of at least 12 months (i.e. an ongoing health issue that has a significant impact on the lives of a person and/or their family, or other caregivers). Life expectancy is not a consideration when determining if an eligible individual is suffering from a prolonged impairment, and an eligible individual who has been diagnosed to be in the last stages of life (i.e. palliative) may be deemed frail.
35. Further information on establishing whether a disability benefits recipient satisfies the criteria to be considered frail can be found in the Frail Criteria Tool (VAC 1697).

# Description of services

36. The services funded under VIP are listed in section 19 of the *Veterans Health Care Regulations*.

## Principal residence

37. Part II of the *Veterans Health Care Regulations* provides that eligible individuals, primary caregivers and survivors may receive funding for services under VIP, excluding intermediate care, provided at their principal residence.
38. The term "principal residence" is not defined in the *Veterans Health Care Regulations*, however, for the purpose of providing VIP services to an eligible individual, the "principal residence" is deemed to be the dwelling in which the eligible individual normally lives. A principal residence can be the person's privately owned house or mini home, cottage, condominium, apartment, seniors' complex, retirement home, communal housing, assisted-living or supportive-housing unit, or the home of a friend or relative where the eligible individual permanently resides.
39. VIP services may only be provided at one principal residence at a time. An eligible individual may have two places of residence, such as one in the city and one in the country, but only one may be designated as the principal residence at any given time.
40. When an eligible individual is receiving funding for VIP intermediate care or for the Long-Term Care (LTC) program, their accommodation does not constitute a principal residence.
41. Housekeeping and/or grounds maintenance services may be approved whether the qualified survivor remains in the home that had been shared with the deceased eligible individual or moves to another principal residence in Canada, provided that the survivor continues to meet the criteria.

## Relatives

42. Funding for services under VIP is not intended to replace services provided by relatives (any person connected by blood or by law) living with the eligible individual, primary caregiver or survivor. However, if a relative is unavailable, unable or unwilling to provide assistance, funding for services under VIP may be approved and provided by someone other than the relative.
43. VAC will provide funding for services under VIP to eligible individuals when they are needed. These services are needed when the eligible individual cannot perform the services him or herself and no one else living in the household is able and willing to perform them. Even if there are able-bodied residents living in the home that could provide the service, if they are not willing to do so, the eligible individual’s need remains unmet and must be addressed.
44. Relatives who reside in the principal residence should only be recognized as a service provider of VIP services in exceptional circumstances. When a relative has made changes to their employment status and has suffered a loss or reduction of wages as a result of providing the VIP services, financial contribution

towards the cost of certain VIP services may be authorized if:

a. the relative demonstrates the exceptional nature of the arrangement and provides proof of the employment change and loss or reduction of wages as a result of providing for the needs of the eligible individual;
b. the relative is providing services that would be performed during the relative's normal working hours such as personal care (services such as housekeeping and grounds maintenance will not be considered);
c. the relative is being compensated as the service provider and not for reduced wages;
d. the cost of the services is comparable to the standard rate for similar services in the area; and
e. the relative is fully aware that receiving compensation as a service provider will prevent them from subsequently being eligible for the applicable VIP services as a primary caregiver.

45. Relatives of an eligible individual, a primary caregiver, or a survivor, who live outside the principal residence are to be treated like any other service provider.

## Home care services

46. Home care services may be provided if an assessment indicates that an eligible individual has a health need that impairs their ability to remain self-sufficient at their principal residence. VIP home care services may be required for an indefinite period or intermittently based upon the eligible individual's, primary caregiver's or survivor's need.
47. The services that may be provided at the principal residence, if appropriate to address an eligible individual's health need, include health and support services, personal care, respite care, housekeeping, access to nutrition, and grounds maintenance.
48. Survivors and primary caregivers are eligible to receive funding to obtain housekeeping and/or grounds maintenance services only. An assessment and all subsequent assessments must indicate that the provision of the services is necessary for reasons related to the health of the survivor or primary caregiver and to assist the survivor or primary caregiver to remain self-sufficient at their principal residence.

### Health and support services

49. In certain circumstances, it may be necessary to provide health and support services in an eligible individual's principal residence if appropriate to address the eligible individual's health need. Health and support services are diagnostic or health care interventions which are provided by a health professional. The professionals must be recognized in the Health Professionals policy. Health and support services may include:

    a. nursing visits by a Registered Nurse (e.g. basic wound care, health teaching, medication administration, catheter and ostomy care and pain management);
    b. nursing foot care (must have a need for a health professional to perform foot care); and
    c. occupational therapy visits by a Registered Occupational Therapist (e.g. pain management, mental health support, analysis and grading of activities to promote independence).

    While the above list is not all inclusive, it provides an example of the scope of services that may be provided.

50. Health and support services may be provided in the principal residence when the home environment is an appropriate setting for the performance of the service.
51. Certain health and support services are normally provided in an institutional setting such as a clinic, or hospital. In general, it may be considered appropriate to provide such health and support services in the

principal residence when:

a. for reasons beyond the control of the eligible individual, they are unable to receive the service outside their place of residence; and
b. in the opinion of the decision-maker, the service can be justified based on the eligible individual's medical condition.

52. When an eligible individual has eligibility for health and support services under both the Treatment Benefits program and the VIP, provision of health and support should be considered under treatment benefits policies and procedures first.
53. Information on in-home treatment can be found in the In-Home Treatment policy.
54. For information on parameters that are to be followed when a nurse is funded under Health and Support Services see the Nursing Services (POC 8) policy.
55. For information on parameters that are to be followed when occupational therapist services are funded under Health and Support Services see the Related Health Services (POC 12) policy.
56. Health and Support Services assistance to remain in the home does not extend to treatments such as physiotherapy, chiropractic services, psychological services and other treatments normally provided under POC 12.

**Personal care**

57. Personal care services may be approved if appropriate to address an eligible individual's health need. Personal care services are provided by an unregulated worker in the eligible individual's principal residence. Such services may include:
    a. services to assist in the performance of the activities of daily living; or
    b. supervision required for an eligible individual who cannot be left unattended.
58. The following examples of "activities of daily living" may be considered:
    a. Transfers - changing the position of the body (e.g. positioning the body from lying to sitting, sitting to standing, lying on the back to lying on the side, etc.);
    b. Ambulation - moving the body from one point in space to another (e.g., climbing stairs, walking, etc.);
    c. Feeding - eating and drinking of prepared foods;
    d. Washing - washing of face, trunk, extremities and hair;
    e. Dressing - putting on and taking off all pieces of indoor and outdoor clothing;
    f. Grooming/personal care - brushing of hair and teeth, shaving; skin and nail care;
    g. Basic foot hygiene, such as washing feet and clipping nails, for eligible individuals who are not able to perform their own foot hygiene, and do not require a health professional to meet this need;
    h. Toileting – continence of bowel and bladder; using toilet facilities;
    i. Taking medication – cue to take medication.
59. As per paragraph 20(1)(a)(ii) of the *Veterans' Health Care Regulations*, an individual who is eligible for an Attendance Allowance under subsection 38(1) of the *Pension Act*, may also receive personal care services provided by a unregulated worker under VIP for up to 59 days per calendar year.
60. A "day" is defined as the actual personal care service needs of an individual within a 24-hour period.
61. An eligible individual who has applied for an Attendance Allowance is not subject to the limit above until they receive a favourable decision on the Attendance Allowance application.
62. Funding for other services under VIP is not affected by an eligible individual's entitlement for Attendance Allowance.

**Respite care**

63. As per the Respite Care policy, individuals eligible to receive health care benefits, VIP services or long-term care under the *Veterans Health Care Regulations* are eligible to receive these benefits, services and care in order to obtain or give respite to a caregiver. Respite, by itself, is not a service. It is defined as a temporary interval of rest or relief for a caregiver. Respite care is the provision of services for the purpose of granting respite to a caregiver.
64. Respite care may be required/provided in two types of situations:
    a. where the eligible individual needs care; or
    b. to a more limited extent, where the eligible individual is the caregiver.
65. See the Respite Care policy for additional information.

**Housekeeping**

66. Housekeeping services may be approved if appropriate to address an eligible individual's, primary caregiver's or survivor's assessed health need. Housekeeping services primarily consist of routine domestic tasks necessary for the daily upkeep of a home. A financial contribution (as calculated by the Grant Determination Tool) may be approved toward the cost of routine domestic tasks, such as:
    a. laundry, ironing and mending;
    b. making beds and changing bed linens;
    c. general cleaning, vacuuming, scrubbing, dusting, appliance cleaning;
    d. meal preparation;
    e. window washing (interior and exterior) and installing/removing storm windows;
    f. errand services such as shopping, banking, paying bills, collecting mail; and
    g. tasks such as changing fuses, changing batteries in smoke detectors.

    While the above list is not all inclusive, it establishes the scope of services that may be provided. Other routine housekeeping services may be approved.

67. Non-routine domestic tasks may be required because of an eligible individual, primary caregiver or survivor's health and safety being at risk. Under housekeeping services, a financial contribution may be approved toward the cost of non-routine tasks, such as:
    a. washing walls and ceilings when environmental pollution is a factor (for example wood is the primary fuel source and a relatively dust-free environment is required);
    b. professional cleaning of carpets, draperies and furniture may be necessary for those suffering from respiratory conditions, skin allergies, incontinence, etc.;
    c. cleaning attics, basements, garages, furnaces and/or chimneys;
    d. air duct cleaning for an eligible individual requiring a relatively dust-free environment;
    e. extermination/fumigation for the presence of rodents, infestation of fleas, ticks, etc.;
    f. industrial cleaning where the lack of cleanliness/ extreme hoarding/ collection of items is to the point that service providers cannot, or refuse to, enter the home until it is professionally cleaned/ deemed safe.

    While the above list is not all inclusive, it establishes the scope of services that may be provided. Other non-routine tasks or domestic chores may be approved.

**Access to nutrition services**

68. Access to nutrition services is intended to ensure an eligible individual has access to nutritional prepared food, whether it is delivered to the eligible individual's principal residence, offered in the community or served at a local restaurant. Access to nutrition covers the cost, up to the maximum per meal rate (refer to Maximum Rates Payable for Veterans Independence Program and Long Term Care Program Services), for the:
    a. delivery of prepared meals to the eligible individual, if the reimbursement is for the delivery charge, which should be clearly indicated on the invoice; or
    b. transportation of the eligible individual to access prepared meals, such as transportation to a local restaurant.
69. Financial contributions toward the cost of access to nutrition does not cover the cost of the prepared meal. The only exception is where the cost of the food and the transportation cost may be considered as one cost (for example meals-on-wheels type programs). In these cases:
    a. the invoice may be paid as billed up to the maximum per meal rate; or
    b. if multiple meals are included in a single delivery and the delivery charge cannot be separated, the eligible individual may be reimbursed for each meal, up to the maximum per meal rate.
70. The number of prepared meals that may be delivered daily depends on the eligible individual's personal circumstances, meaning there is no established limit within the VIP to the number of prepared meals that may be delivered daily.
71. If an eligible individual is unable to obtain access to nutritional food (for example the eligible individual lives in a remote location), a financial contribution toward the cost of meal preparation under housekeeping may be considered (see paragraph 66), if appropriate to address the eligible individual's assessed health need.
72. An eligible individual may receive access to nutrition and meal preparation under housekeeping simultaneously.

**Grounds maintenance**

73. Funding for grounds maintenance services may be approved if appropriate to address an eligible individual's, primary caregiver's or survivor's assessed health need. Grounds maintenance services may be provided if:
    a. the grounds maintenance is the responsibility of, and would normally be performed, by the eligible individual were it not for their limiting health condition; and
    b. the service is not provided under a rental agreement, condominium fee, etc., and no relatives living in the principal residence are willing or capable of performing the grounds maintenance. Refer to Relatives section.
74. Grounds maintenance services are those regularly required to permit independent living and maintain the grounds immediately surrounding the principal residence. Subject to the requirements set out in the paragraph above, a financial contribution (as calculated by the Annual Grant Determination Tool) may be approved toward the cost of the following grounds maintenance services:
    a. removing snow and ice from steps, walkways and driveways to allow safe access to and from the principal residence;
    b. removing snow and ice from roofs and eaves troughs, when such conditions pose a threat to safety and access;
    c. cleaning leaves and debris from eaves troughs;
    d. mowing and raking lawn, sweeping leaves from pathways, trimming hedges and shrubs;
    e. tilling ground to plant a small flower or vegetable garden;

f. pruning or removing trees that pose a threat to the eligible individual's safety, access to the principal residence or the eligible individual's driveway; and
g. blocking, splitting and stacking firewood, when wood is the main source of heat.

While the above list is not all inclusive, it establishes the scope of services that may be provided. Other reasonable grounds maintenance services may be approved.

75. Funding for grounds maintenance services may be provided for that portion of property for which the eligible individual, primary caregiver or survivor is personally responsible for, and which is not maintained by a condominium corporation or similar entity. If an eligible individual, primary caregiver or survivor has sole responsibility for certain non-common areas (for example personal driveways, walkways, personal lawns, balconies, secondary/emergency exits), then VIP may be applicable to those private areas as well.

## Ambulatory health care

76. Funding for ambulatory health care services may be approved if appropriate to address an eligible individual's assessed health need. Ambulatory Health Care Service refers to the provision of the following:
    a. health services such as health assessments, diagnostic services, and social and recreational activities (e.g. adult day care) provided by, or under the supervision of, a health professional in a health centre or other similar facility; and
    b. transportation of the eligible individual to receive the service.
77. Examples of ambulatory health care services include services for a fee, provided by or under the supervision of a health care professional, such as:
    a. health assessments or diagnostic services such as blood pressure, oxygen, and cholesterol checks and monitoring, healthy weight and diet assessments and counseling, or basic visual or hearing screenings;
    b. social and recreational programs, such as adult day care programs;
    c. health condition specific clinics or educational programs, e.g. for diabetes or foot care;
    d. programs promoting self-care or fall prevention; and
    e. medication management programs.
78. For information on health professionals approved by the Minister to provide services under VIP see the Health Professionals policy. A list of approved health professionals can be found at Common health professionals covered by Veterans Affairs Canada - Veterans Affairs Canada

### Acceptable ambulatory health care service charges

79. Under ambulatory health care service, the following costs may be paid:
    a. user fees or similar admission charges;
    b. the cost of meals not included in the user charge (usually included);
    c. user charges required to obtain provincially insured adult day care service; and
    d. transportation to and from the health care centre or similar facility where the service is obtained. This type of transportation does not offer the same coverage as Health-Related Travel and does not include hotel and meals.

### Payment of ambulatory health care service in facilities considered the eligible individual's principal residence

80. Some eligible individuals live in facilities that are considered their principal residence (such as assisted living or retirement homes which are not health care facilities), where ambulatory health care services are provided as part of the monthly fee agreement. Although the service is provided by the facility, the Department may compensate the individual for the cost of the service if the service is performed as a direct, personal service to the eligible individual.
81. Contributions towards the cost of ambulatory health care service may be considered if:
    a. a current assessment identifies a need for the service;
    b. the duration and cost of the service can be identified on an individual client basis; and
    c. the cost of the service is equal to or less than the standard rate for similar services in the area.
82. If the service provider is unable to break down the cost of the ambulatory health care service, the Department may determine the amount of the benefit arrangement by taking the amount of hours that is deemed necessary to provide the service according to the current assessment and multiply those hours by the standard rate for a similar service in the area.
83. If a facility is considered an eligible individual's principal residence (e.g. assisted living or retirement homes which are not health care facilities) and ambulatory health care services are not provided by the facility, then eligible individuals may be entitled to these services in the same manner as if they were in a traditional principal residence.

**Payment of ambulatory health care service to residents of health care facilities - Type II level or higher**

84. Ambulatory health care service may be provided, if required, to eligible individuals residing in a health care facility:
    a. if costs of these services are not included in the facility's per diem rate;
    b. during periods of absence from the facility (e.g. home visits, visiting friends or relatives); and
    c. if the services cannot be expected of the facility.
85. Care should be taken to ensure that the Department is not paying twice for the same benefit (i.e. once through the facility fee, and again for the benefit directly).

## Transportation service

86. Transportation Service refers to the provision of transportation to enable Income-qualified Veterans, Income-qualified Civilians, Canada Service Veterans and Exceptional Health Needs clients to participate in social activities and to foster independence. Support from family members, friends and communities is associated with better health. Social support networks are important in helping people solve problems, deal with difficult situations and maintain some sense of control over their lives.
87. Transportation Service may be approved when:
    a. social isolation is harmful to the health (i.e. physical, mental, social and emotional well-being) of the individual listed in the preceding paragraph; and
    b. the individual listed in the preceding paragraph is also in receipt of VIP Home Care Service or Ambulatory Health Care Service.
88. Transportation Service provides financial assistance to transport eligibile individuals between their principal residence and the location of the social activity. The social activities should be in response to their the basic social, recreational or personal needs, such as: local activities in sports or community centers; attendance at church services and funerals; occasional visits to friends/relatives; banking; and shopping.
89. Travel costs to obtain treatment benefits are not payable under Transportation Service but are payable as Supplementary Benefits. For further information, see Health-related Travel.

**Payment of transportation service in facilities considered the eligible individual's principal residence**

90. Some individuals eligible for transportation services live in facilities that are considered their principal residence (i.e. assisted living or retirement homes which are not health care facilities), where transportation services are provided as part of the monthly fee agreement. Although the service is provided by the facility, the Department may compensate for the cost of the service if the service is performed as a direct, personalized service specific to that VIP recipient.
91. Funding towards the cost of transportation service may be considered if:
    a. a current assessment identifies a need for the service;
    b. the duration and cost of the service can be identified on an individual client basis; and
    c. the cost of the service is equal to or less than the standard rate for similar services in the area.

    If the service provider is unable to break down the cost of the transportation service, the Department may determine the amount for the benefit arrangement by taking the hours that are deemed necessary to provide the service according to the current assessment and multiplying those hours by the standard rate for a similar service in the area.

92. If a facility is considered an eligible individual's principal residence (i.e. assisted living or retirement homes which are not health care facilities) and transportation services are not provided by the facility, then eligible individuals may be entitled to these services in the same manner as if they were in a traditional principal residence.

**Payment of transportation services for residents of health care facilities - Type II level or higher**

93. Transportation Service may be provided, if required, to eligible individuals residing in health care facility:
    a. if costs of these services are not included in the facility's per diem rate;
    b. during periods of absence from the facility (e.g., home visits, visiting friends or relatives); and
    c. if the services cannot reasonably be expected of the facility;

    Care should be taken to ensure that the Department is not, in effect, paying twice for the same benefit (i.e. once through the facility fee, and again for the benefit directly).

## Home adaptations

94. For administering this policy, "home adaptations" are:
    - changes to an eligible individual's principal residence, such as modifications to the existing structure (e.g. installing a stair glide) or the addition of a new structure to the existing residence (e.g. new bathroom), which are necessary to enable the eligible individual to carry out the activities of daily living.

    Refer to paragraph 58 for examples of activities of daily living.

95. Funding for home adaptations under VIP cannot be approved solely to cover instrumental activities of daily living (IADLs). IADLs are those activities which comprise a secondary level of tasks that are not essential to health or survival but which a person should be able to do to function independently. IADLs may include shopping, housekeeping, laundry, errands, grounds maintenance, minor home repairs, and driving or taking public transportation. Other VIP benefits may assist with these activities.

96. Home adaptations may be approved if appropriate to address an eligible individual's assessed health need. Home adaptations may include:
    a. electrical alterations (e.g, garage door openers, remote control unlocking devices);
    b. physical alterations (e.g. stair glides, widening doorways, hallways, corridors or stairways);
    c. plumbing alterations (e.g. cantilevered wash basin, shower seat);
    d. ramps (including rails and ramp landings);
    e. safety alterations (e.g. handrails on a stairway, grab bars, bath spigot or thermostatic mixing valve to prevent scalding, slip-resistant flooring at stairways or entranceways).
97. While the above list is not all inclusive, it establishes the scope of services that may be provided. Other reasonable alterations may be approved.
98. Equipment that is not attached to the home and is free-standing (e.g. canes, wheelchairs) cannot be approved as home adaptations. See the Aids for Daily Living (POC 01) policy and the Equipment (POC 13) policy.
99. The cost associated with the construction of a functional room such as plumbing, electrical, carpentry, installation of drywall, painting and finishing work, etc. may be eligible expenses. Likewise, the conversion or modification of an existing space (e.g. dining room or bedroom to a bathroom) may result in additional necessary expenses, such as installation of a wall and appropriate flooring. Repair of unavoidable damage to adjacent spaces may also be an eligible expense.
100. Home adaptations must be pre-authorized by VAC, based on estimates obtained by the eligible individual. Requests for reimbursement received after-the-fact will be considered based on the same criteria as pre-authorization requests. It should be noted that not seeking pre-authorization could leave the eligible individual financially liable for an already completed home adaptation.
101. Normally, an eligible individual requiring home adaptations must provide two detailed cost estimates of the interventions required to address assessed health needs. In exceptional circumstances, such as for rural areas where it is difficult to obtain two estimates, providing one estimate may be sufficient.
102. When a Veteran has eligibility for home adaptations under both the Treatment Benefits program and the VIP, provision of home adaptations should be considered under treatment benefits policies and procedures first.
103. Home adaptations should be approved based on a hierarchy of effective, efficient and economical interventions that focus on enabling the Veteran to carry out the activities of daily living in their principal residence.
104. Adaptations to a home that an eligible individual is building or buying may be approved if the home adaptations are an appropriate response to the eligible individual's assessed health needs and the home adaptations required would not typically be found in a new home build or in a home for sale. The cost incurred by VAC would be limited to the incremental cost over and above a typical home build or purchase to enable the eligible individual to carry out the activities of daily living in their principal residence.
105. Home adaptations under VIP are subject to a financial limit per eligible individual per principal residence (refer to Maximum Rates Payable for Veterans Independence Program and Long Term Care Program Services). If an eligible Veteran's principal residence changes, a new limit takes effect for the new principal residence.
106. Less costly options should be considered before more complex and costlier options. The costs of the adaptations should be within an acceptable range for the geographic area in which the home is located. The most expensive option may not be required to ensure that the Veteran's assessed needs are met.
107. Home adaptations may not be authorized merely for convenience or as a matter of personal preference. When an eligible individual chooses to purchase an adaptation or product that is more costly than the intervention required to adequately address the eligible individual's assessed level of need, the eligible individual assumes responsibility for the additional cost.

108. For eligible individuals whose principal residence is an apartment, seniors' complex, retirement home, communal housing, assisted-living or supportive-housing unit, home modifications may only be provided within the eligible individual's living space; therefore, all common areas would be excluded.
109. If an eligible individual has a secondary residence (e.g. a summer cottage), home adaptations may be provided there, subject to paragraph 38. A temporary move to a secondary residence is not considered a change of principal residence.
110. Repairs and maintenance required as part of the normal upkeep of a home (e.g. roof repairs, furnace cleaning) are not considered home adaptations.
111. If the eligible individual is not the owner of the principal residence, consent of the owner is required before any home adaptations may be approved. The homeowner must ensure the home adaptations being completed conform to all municipal by-laws and ordinances and do not jeopardize the safety of the eligible individual or other members of the household.
112. VAC is not liable for work undertaken by the provider. As such, VAC does not cover expenses incurred due to issues with the quality of the work undertaken by a provider.
113. Home adaptations will not normally be approved when:
    a. The eligible individual’s health needs would be more appropriately met through the LTC Program (Intermediate Care and Chronic Care), including VIP (Intermediate Care); and
    b. there is medical uncertainty as to whether the home adaptations will have a desirable effect or will only meet the eligible individual’s health needs for a short period of time.
114. If home adaptations are in progress at the time of an eligible individual’s death, the Department may consider a request to restore the residence to its former state.
115. Primary caregivers and survivors are not eligible for home adaptations.

### Intermediate care in a community facility

116. For information applicable to intermediate care in a community facility please see the Community Facilities (Veterans Independence Program-Intermediate Care and Long-term Care) policy.

#### Overseas service Veterans care in a contract bed

117. When an overseas service Veteran has been approved for a contract bed and is awaiting placement, funding for VIP services, excluding social transportation and intermediate care, may be provided to help them continue to live in their principal residence. See the Overseas Service Veterans Who Apply for Contract Beds (Veterans Independence Program and Long Term Care) policy.

## Financial contributions

### Limitations

118. Sections 15 to 18 and 33 of the *Veterans Health Care Regulations* indicate that funding for services under VIP may only be authorized to the extent that:
    a. such services or care are not available under a provincial health care system (see the Requirement to Access Provincial Programs policy);
    b. the cost of such services or care is not recoverable from a third party (see the Costs Recoverable from Third Parties policy);
    c. services are not available as an insured service under a private insurance company (applicable to survivors and primary caregivers); and

d. such services or care are not available from the CAF.

119. An individual who is eligible for VIP services under more than one category (e.g. satisfies the criteria as both an overseas service Veteran and an income-qualified Veteran) may only access VIP services through one eligibility gateway to meet their assessed health needs.
120. The amount of the contribution for each VIP service element or intermediate care shall be either the cost of the service required by the eligible individual, or the annual maximum limit, whichever is lower. See the Maximum Rates Payable section of this policy. Responsibility for the remainder of these costs rests with the eligible individual.
121. In addition to the limitations in paragraphs 118 a. and b., an eligible individual who is determined to have exceptional health needs and insufficient income may be provided funding for services under VIP for the cost of the service required by the eligible individual, or the annual maximum limit, whichever is lower. The Department may only pay the portion of the costs which would reduce the eligible individual's assessable income below the applicable WVA ceiling.
122. In general, it is neither the intention, nor the mandate of the Department to provide services and/or care in the home for an eligible individual (of VIP services) with Type III health needs. However, in certain cases the Department may provide short term funding for services or continue the funding for services already in place. For more information, see the Duration and Continuity section of this policy, the Palliative Care policy and the Exceeding Rates for Veterans Independence Program (VIP) and Long-term Care (LTC) policy.

**Maximum rates payable**

123. Maximum rates may only be exceeded in accordance with section 34 of the *Veterans Health Care Regulations*. For more information, see the Exceeding Rates for Veterans Independence Program (VIP) and Long-term Care (LTC) policy.

## Completing a benefit arrangement

124. A benefit arrangement must be completed:
    a. for every new applicant; and
    b. when a follow-up/renewal is done for an eligible individual identified in paragraph 128 or 129, even if there is no change in benefits.
125. An existing benefit arrangement must be revised if:
    a. a new VIP service is added;
    b. there is a change in the cost of a VIP service;
    c. a recipient reports a change in need, which, upon review, may or may not result in a change in benefits (e.g. a minor change in need may not result in an increase in the results of the Grant Determination Tool); or
    d. a VIP service is suspended or terminated.
126. A review process must be conducted periodically to confirm that the services the eligible individual is receiving are appropriate and meeting their needs.
127. The needs of the primary caregiver are to be assessed initially within one year after the eligible individual's death (or admission to a health care facility, or assisted-living or similar facility) and on a periodic basis thereafter. Alternatively, the initial assessment may be conducted later, provided it is based on evidence relevant to the one-year period after the eligible individual's death or admission to a health care facility.
128. Eligible individuals receiving VIP because of having exceptional health needs are required to reconfirm their income eligibility each year.

129. Survivors are required to reconfirm eligibility for the Guaranteed Income Supplement or the Disability Tax Credit each year.

## Benefit arrangements in shared residence

130. Benefit arrangements for two eligible individuals sharing a residence are based on separate needs assessments, one for each eligible individual.
131. If both eligible individuals require VIP services, a separate benefit arrangement must be completed for eligible individual.
132. Each eligible individual may be approved up to the maximum amount for VIP services, but both eligible individuals cannot receive payment for the same VIP service in respect of cleaning shared living/common areas or grounds maintenance.

## Benefit arrangement for Primary Caregiver and Veteran admitted to an assisted-living or other similar facility

133. When an eligible individual is admitted to an assisted-living or other similar facility (not a health care facility), the eligible individual and the primary caregiver both receive funding for services under VIP under separate benefit arrangements. The benefit arrangement for the primary caregiver is authorized and is not split with the eligible individual.

## Date of application

134. The date of the initial application for VIP services is the earliest of:
    a. the date the applicant or the applicant's representative requests an application (e.g. by telephone, in person);
    b. the date of the postmark, if the applicant or the applicant's representative requests an application in writing;
    c. the date of the visit, if the applicant is seen in person and the applicant or the applicant's representative signs the application; or
    d. the date the application is submitted, if the applicant completes the application online through the My VAC Account portal.
135. When contact with the Department is made in accordance with paragraph 134 a. or b. above, it must be followed by receipt of a signed application.
136. When the Department must confirm eligibility for a program before VIP can be approved (e.g. a Canada service Veteran), the date of application for VIP services is the date described in paragraph 134, not the later date when eligibility is confirmed.

## Date of application for Survivors

137. The date of application for survivors is as outlined in paragraph 134, however, all necessary supporting documents (e.g. proof of receipt of the Guaranteed Income Supplement or proof of eligibility for the Disability Tax Credit) must accompany the application in order to protect the initial application date. If the supporting documents do not accompany the application, they must be provided within a reasonable period and must demonstrate that the requirements were met at the time of the application.

## Effective date of eligibility (excluding Primary Caregivers)

138. No payment can be made for any expenses incurred or services delivered prior to the effective date of eligibility.
139. After an assessment is completed, the following circumstances determine the effective date of a benefit arrangement (i.e. when funding can start):

    a. **Housekeeping and/or grounds maintenance only**

        i. The effective date of a benefit arrangement for housekeeping and/or grounds maintenance services is the date of application (see paragraph 134), whether the housekeeping and/or grounds maintenance services are in place at the time the eligible individual applies.
        ii. If a benefit arrangement already exists and additional housekeeping and/or grounds maintenance services are approved, the effective date for the additional services is the date the services are requested.

    b. **All services excluding housekeeping and/or grounds maintenance and intermediate care**

        i. the date of application (see paragraph 134), if the required services are already in place (e.g. the eligible individual has a personal care service provider in place and is paying for the service).
        ii. the date the service is first delivered if, on the date of application (see paragraph 134), the applicant does not have the service in place (e.g., the eligible individual has been assessed as requiring personal care but has not yet obtained a service provider).

    c. **Intermediate care**

        i. The effective date of a benefit arrangement for Intermediate Care is determined in accordance with the Community Facilities (Veterans Independence Program - Intermediate Care and Long-term Care) policy.

## Effective date of a benefit arrangement (Primary Caregivers only)

140. After an assessment is completed, the following circumstances determine the effective date of a benefit arrangement (i.e. when funding can start):
    a. if a qualified primary caregiver applies within one year of the date that the eligible individual dies or is admitted to a health care facility or assisted-living or similar facility, the effective date of the benefit arrangement will be the day following the eligible individual's death or admission to the facility; or
    b. if a qualified primary caregiver applies later than one year after the date that the eligible individual dies or is admitted to a health care facility, or assisted-living or similar facility, the effective date of the benefit arrangement will be the date of application in accordance with paragraph 134.

## Effective date when adding additional services to an existing benefit arrangement (excluding housekeeping and/or grounds maintenance)

141. If a benefit arrangement already exists and additional services (either a new service or a change to an existing service) are approved, the effective date is:

a. the date the additional service is requested, if the eligible individual already has the service in place; or
b. the date the service is first delivered, if the eligible individual does not have the service in place on the date that it is requested.

## Financial contributions – General

142. When an assessment has been completed and the health needs of an eligible individual have been identified, a benefit arrangement is established to provide funds for services required to meet those health needs. Once a benefit arrangement is established, VAC's third-party contractor is responsible for processing any claims and providing any payments (i.e. reimbursements, advance payments or grants) associated with the benefit arrangement on behalf of the Department.

## Financial contributions via reimbursement (Excludes housekeeping and grounds maintenance services)

143. The normal preferred payment method for VIP services (excluding payments for housekeeping and grounds maintenance services) is reimbursement. Exceptions are permitted only in those circumstances described in paragraph 147.
144. There are four variations of the reimbursement payment method:
    a. the recipient pays the invoice and is reimbursed;
    b. the recipient submits the unpaid invoice with a request that the payment be sent directly to the service provider (registered providers only);
    c. a service provider submits the invoice directly for payment, including any supporting documentation needed to confirm the services were provided;
    d. the recipient submits the unpaid invoice with a request that payment be issued to both the recipient and the service provider (for non-registered providers).
145. A claim for reimbursement must be submitted within 18 months of the day on which the expenditure was incurred (refer to Payment Time Limits for Benefits, Services, or Care).
146. An eligible individual whose benefit arrangement is based on the reimbursement method must submit receipts or provide the appropriate signed documentation to prove an expenditure was incurred before receiving reimbursement. If invoices or receipts are not available, reimbursement may be made upon receipt of a statutory declaration signed by, or on behalf of, the eligible individual attesting to the validity of the claim.

## Financial contributions via advance pay (Excludes housekeeping and grounds maintenance services)

147. An eligible individual may be placed on the Advance Pay payment method only in the following **exceptional** circumstances:
    a. there is a lack of registered service providers in the eligible individual’s area of residence; and
    b. the eligible individual is experiencing financial hardship (see paragraph 148).

    **Both** conditions must exist for the eligible individual or other qualified person to receive advance pay.

148. To meet the financial hardship requirement, clear evidence must exist and be documented that the cost of the service would impede the eligible individual’s ability to access VIP services. If an eligible individual can access the services of a registered provider in their area, they are not eligible for Advance Pay. Each

application is examined on its own merit.

149. If an eligible individual is eligible to receive Advance Pay, the payment may be issued monthly, semi-annually, or annually, based on need.
150. Recipients whose funding is based on the Advance Pay method must retain receipts and, when asked, account for expenditures. If invoices or receipts are not available, the recipient must provide a statutory declaration signed by, or on behalf of, the recipient attesting to the validity of the claim.

### Payment conditions (Grants or contributions)

151. VIP services are purchased under a fee-for-service arrangement between the VIP recipient and the service provider; there is no employer-employee relationship between VAC and the service provider. Therefore, payments cannot be made to cover Employment Insurance, Canada Pension Plan, or other similar premiums for the service provider.

### Financial contributions via grants for housekeeping and grounds maintenance services

152. The exclusive payment method for VIP housekeeping and/or grounds maintenance services is the grant method wherein the recipient receives an annual grant provided in two installments, subject to continued eligibility of the recipient.
153. The Department determines the amount of the grant for housekeeping and/or grounds maintenance services using the Grant Determination Tool, based on the needs of the recipient, the need for services, the determination of required number of hours for services, the scope of services required, and the rates for services in the recipient's geographical area.
154. The recipient is not required to obtain or retain receipts for housekeeping and grounds maintenance services.
155. The grant method was implemented in January 2013. Where an eligible individual, primary caregiver or survivor is still in receipt of their converted grant amount and the Grant Determination Tool results in a lower grant amount, the converted grant amount is grandfathered.

## Duration and continuity

156. Funding for services under VIP should only be authorized for as long as they are needed to address an eligible individual's health needs. Eligible individuals in need of temporary support (e.g. acute health need where the eligible individual is expected to recover from the health issue, palliative care) may access VIP services intermittently when it is needed for shorter periods. If an eligible individual only requires a VIP service for a specified time, the benefit arrangement should reflect this.
157. If funding for housekeeping and/or grounds maintenance services is terminated due to the absence of a health need, the survivor or primary caregiver cannot be reinstated later, whether a health need is present or not.
158. If funding for housekeeping and/or grounds maintenance services is terminated due to a change in the survivor's status with respect to the Guaranteed Income Supplement and/or the Disability Tax Credit, the services may be reinstated for the survivor, if the survivor once again meets the eligibility criteria.
159. If funding for housekeeping and/or grounds maintenance services is terminated due to a change in the primary caregiver's living arrangements (i.e. remarriage and spouse assumes responsibility for housekeeping and/or grounds maintenance; or relocation to a residence in which the services are provided), the services may be reinstated at a later date, if the primary caregiver meets the eligibility criteria.

160. Initial benefit arrangements, approved for an eligible individual who is determined to have exceptional health needs and insufficient income, are to be established with an end date of September 30. This may result in a benefit arrangement being set up for a period of less than one year. Subsequent benefit arrangements are established for a one-year period commencing on October 1 and must be renewed annually on that date.
161. When the eligible individual has been assessed as having Type II or Type III health needs and refuses a bed in a health care facility, VAC will not terminate funding for services under VIP at an eligible individual's principal residence. This is in keeping with the intent of VIP to respect the eligible individual's wish to remain in their preferred care setting and retain a degree of independence. In these situations, VAC will:
    a. continue services up to the maximum rates of the program (refer to Maximum Rates Payable for Veterans Independence Program and Long Term Care Program Services), or at the level already approved and in place, whichever is greater (including cost of living increases); and
    b. notify the eligible individual that their care needs would be more appropriately met in a care facility and that there are risks to their health if they continue to remain at their principal residence.
162. If an eligible individual moves to a health care facility where they will receive services for Type II or Type III health needs, funding under VIP for services provided in the principal residence must be terminated.
163. For information on the termination of services for those eligible individuals who are no longer eligible to receive funding for the services, see the Termination of Benefits, Services and Care policy. The Termination of Benefits, Services and Care policy does not apply to caregivers or survivors.
164. Eligible individuals may have their benefits suspended where a reassessment is needed and health information is not being provided to establish a health need. Suspensions may also occur in circumstances such as temporary absences (e.g. snowbirds).

# Redress/Appeals

165. For information on the review of decisions see the Review of Health Care Decisions policy.

# Overpayments

166. Overpayments will be addressed in accordance with the Overpayments - Health Care Programs policy.

# Appendix A – References and related policies

## Legislation

*Department of Veterans Affairs Act*

*Income Tax Act* - Division B, Subsection 4(3)(c), Section 118.3

*Old Age Security Act* - Part 2

*Pension Act* - Subsection 38(1)

*Veterans Well-being Act*, Part 3

*War Veterans Allowance Act*, Sections 7, 37; Subsection 4(6), (6.1), (8); Schedule

*Veterans Health Care Regulations*, Sections 15 to 20, 31 to 31.2, 33 to 34

### Policies

Aids for Daily Living (POC 01)

Community Facilities (Veterans Independence Program-Intermediate Care and Long-term Care)

Costs Recoverable from Third Parties

Equipment (POC 13)

Exceeding Rates for Veterans Independence Program (VIP) and Long-Term Care (LTC)

Income Assessment - War Veterans Allowance Program

In-Home Treatment

Nursing Services (POC 8)

Overpayments Health Care Programs

Overseas Service Veterans Who Apply for Contract Beds (Veterans Independence Program and Long-Term Care)

Palliative Care

Payment Time Limits for Benefits, Services, or Care

Related Health Services (POC 12)

Respite Care

Requirement to Access Provincial Programs

Review of Health Care Decisions

Termination of Benefits, Services and Care

### Rates

Maximum Rates Payable for Veterans Independence Program and Long-Term Care Program Services

## Appendix B - Veterans Independence Program (VIP) Eligibility

| Eligible Recipients | Qualifying Criteria | Available VIP Services |
| --- | --- | --- |
| • Veteran Pensioner<br>• Civilian Pensioner<br>• Special Duty Service Pensioner | • Resident in Canada<br>• Service-related health need<br>• Service not available under provincial or private plan | • Home Care<br>• Ambulatory Health Care<br>• Home Adaptations<br>• Intermediate Care |
| • Medium disabled Veteran Pensioner<br>• Seriously disabled Veteran Pensioner<br>• Medium disabled Civilian Pensioner<br>• Seriously disabled Civilian Pensioner | • Resident in Canada<br>• Non-service-related health need<br>• Service not available under provincial insurance plan | • Home Care<br>• Ambulatory Health Care<br>• Home Adaptations<br>• Intermediate Care |
| • Military Service Pensioner<br>• Former member or reserve force member entitled to a Disability Award or Pain and Suffering Compensation | • Resident in Canada<br>• Service-related health need<br>• Service not available under provincial insurance plan or from Canadian Forces | • Home Care<br>• Ambulatory Health Care<br>• Home Adaptations<br>• Intermediate Care |
| • Income-qualified Veteran<br>• Income-qualified Overseas Service Civilian<br>• Canada Service Veteran | • Resident in Canada<br>• Non-service related health need<br>• Service not available under provincial insurance plan | • Home Care<br>• Ambulatory Health Care<br>• Home Adaptations<br>• Transportation<br>• Intermediate Care |

| Eligible Recipients | Qualifying Criteria | Available VIP Services |
| --- | --- | --- |
| • Totally Disabled Prisoner of War<br>• Totally Disabled former member/reserve force member who has received a Detention Benefit | • Resident in Canada<br>• Non-service related health need<br>• Service not available under provincial insurance plan | • Home Care<br>• Ambulatory Health Care<br>• Home Adaptations<br>• Intermediate Care |
| • Overseas Service Veteran or Veteran Pensioner who is eligible for intermediate or chronic care in a contract bed, but there is no vacancy within a reasonable distance of the community in which they normally reside | • Resident in Canada<br>• Non-service-related health need<br>• Service not available under provincial insurance plan | • Home Care<br>• Ambulatory Health Care<br>• Home Adaptations |
| • Veteran Pensioner or Canada Service Veteran or Overseas Service Veteran or Overseas Service Civilian who meets requirements of VHCR Section 18 as to Exceptional Health Needs | • Resident in Canada<br>• Non-service related health need<br>• Service not available under provincial insurance plan | • Home Care<br>• Ambulatory Health Care<br>• Home Adaptations<br>• Transportation<br>• Intermediate Care |
| • Veteran Pensioner or Civilian Pensioner or Special Duty Service Pensioner or Military Service Pensioner or former member/reserve force member entitled to a Disability Award or entitled to Pain and Suffering Compensation who meets the Frail criteria described in paragraphs 32 to 35 of this policy | • Resident in Canada<br>• Non-service related health need<br>• Service not available under provincial insurance plan | • Home Care<br>• Ambulatory Health Care<br>• Home Adaptations<br>• Intermediate Care |

| Eligible Recipients | Qualifying Criteria | Available VIP Services |
|---|---|---|
| • Primary Caregiver | • Resident in Canada<br>• Service not available under provincial or private insurance plan | • Housekeeping and/or Grounds Maintenance being provided at the time of the client's death or admission to a health care facility |
| • Survivor | • Resident in Canada<br>• Service not available under provincial or private insurance plan | • Housekeeping and/or Grounds Maintenance only as needed |

# Appendix C – Allied Veterans

**Allied Veteran** for the purpose of eligibility for VIP is limited to those Allied Veterans who are in one of the following groups:

**Allied Veteran – Pre-War domicile (World War II)**

A. A former member of an Allied Force who was domiciled in Canada at the time when he or she joined the Allied Force or at any time while a member of that Force, and:
   a. served in a theatre of actual war during World War II;
   b. is in receipt of a pension or was, after death, declared to have been eligible for, or awarded, a pension for a disability under the *Pension Act* in respect of service during World War II; or
   c. has accepted a commuted pension in respect of a disability incurred during World War II.

**Note:** Allied Veterans described in group A above are those who have been eligible for health care benefits since May 1, 1945. They may receive care in a contract bed.

**Allied Veteran – Pre-War domicile (Korean War)**

B. A former member of any of the forces that took part in the Korean War who:
   a. was domiciled in Canada at the time when he or she joined the Allied Force or at any time while a member of that Force, and
   b. served in a theatre of operations during the Korean War.

**Allied Veteran – Post-War domicile (World War II)**

C. A former member of an Allied Force who has resided in Canada for a total period of at least 10 years following the end of World War II; and has been honourably discharged, resigned or retired from the Allied Force, and:
    a. served in a theatre of actual war during World War II; or
    b. is in receipt of a pension or was, after death, declared to have been eligible for, or awarded, a pension for a disability in respect of service during World War II; or
    c. has accepted a commuted pension in respect of a disability incurred during World War II.

**Allied Veteran – Post-War domicile (Korean War)**

D. A former member of an Allied Force who resided in Canada for a total period of at least 10 years following the end of the Korean War ; and has been honourably discharged, resigned or retired from the Allied Force; and
    a. served in a theatre of operations during the Korean War.

**Note:** Allied Veterans described in groups B, C and D above are those who were recognized as eligible for health care benefits, effective January 1, 2010. They are not eligible for care in a contract bed, even if they satisfy the definition of an income-qualified Veteran or an overseas service Veteran.

**Grandfathered Allied Veteran – Post-War domicile (World War II)**

E. A former member who served during World War II as a member of any of His Majesty's allies or powers associated with His Majesty, in respect of whom a determination was made on or before February 27, 1995, that:
    a. the person is or has been an income-qualified veteran, or
    b. the person had submitted a request that has been approved for one of the following benefits:
        i. VIP Services pursuant to section 18 of the *Veterans Health Care Regulations* (refer to paragraphs 29 to 31 of this policy);
        ii. intermediate care or chronic care in a contract bed as an overseas service Veteran; or
        iii. the cost of chronic care in a community facility by virtue of the fact that the Veteran had insufficient income to pay for that care (i.e. the cost of the needed chronic care reduces the Veteran's assessable income to an amount below the maximum War Veterans Allowance income factor applicable to him/her that was in effect on the July 1 preceding the day on which they receive the care).

**Note:** Allied Veterans described in group E above are those who were granted eligibility for benefits authorized by the *Veterans Health Care Regulations* on or before February 27, 1995.

**Definitions**

**Pre-war domicile** is used to describe those World War II or Korean Allied Veterans who were domiciled in Canada at the time of joining the Allied Force or at any time while a member of that Force.

**Post-war domicile** is used to describe those World War II or Korean Allied Veterans who have been domiciled in Canada for a total period of at least 10 years beginning on or after August 15, 1945, for World War II Allied Veterans; and beginning on or after July 27, 1953, for Allied Veterans of the Korean War.

**Domiciled in Canada** refers to that period during which a person made their home and ordinarily resided in any part of Canada. This can normally be confirmed using government-issued documents such as an Income Tax Return, a Canada Pension Plan Record of Contributions, etc.

A person’s domicile in Canada is deemed to be continuous if the person has not been absent from Canada for more than 183 days (consecutive or cumulative) between July 1 of one year and June 30 of the next year. Residence in Newfoundland and Labrador prior to March 31, 1949, (i.e. the date Newfoundland joined Canada) is considered domicile in Canada.