Primary Caregiver Tax Credit – Registration Form

Manitoba

A refundable credit of $1,400 may be claimed per year by individuals who act as primary caregivers.

Instructions for Completing This Registration Form:

1. Complete the registration form.
2. Keep the original registration form for income tax purposes.
3. Submit a copy of the registration form to the Manitoba Tax Assistance Office.

Mail: Manitoba Tax Assistance Office
110A – 401 York Avenue
Winnipeg, MB R3C 0P8

Phone: 204-948-2115
Toll free: 1-800-782-0771
Email: TAO@gov.mb.ca

Important Message: As of 2019 tax year, the due date for the registration form is the same due date for filing your personal income tax return. No retroactive claims allowed prior to registration.

Keep original copies of all relevant documentation in case it is requested by Manitoba Finance or the Canada Revenue Agency to substantiate your tax credit claim.

Pursuant to Section 5.11 of The Income Tax Act (Manitoba)

To be eligible for this tax credit:

The care recipient must:

- be a resident of Manitoba;
- reside in an area under the jurisdiction of a Regional Health Authority;
- reside in a private residence (e.g., not a group home, foster home, hospital, personal care home, or in supportive housing);
- assessed as having care level requirements equivalent to level 2 or higher; and
- designate only one primary caregiver to claim this credit.

The primary caregiver must:

- be a resident of Manitoba;
- provide caregiving for longer than 90 days;
- personally provide care or supervision to the care recipient without reward or compensation of any kind; and
- not be the spouse or common-law partner of a person who receives compensation or reward for providing care to a qualified care recipient.

Level of Care or Equivalent:

To be eligible, the care recipient must have been assessed to need care level requirements equivalent to level 2 or higher.

If an individual is assessed as qualifying for the Primary Caregiver Tax Credit by Manitoba home care services operated by a Regional Health Authority or the Department of Families (Children's disABILITY Services or Community Living disABILITY Services), the care recipient has already been determined to have the equivalent of level 2 care needs and it is NOT necessary to complete part C of this Registration Form.

If an individual has not been determined to have level 2 or higher care needs by Manitoba home care services or the Department of Families, an equivalency of level 2 or greater may be determined by a doctor or nurse practitioner completing part C of this Registration Form.

Please direct any questions regarding this tax credit to the Manitoba Tax Assistance Office at the contact information noted above.

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 administering the Primary Caregiver Tax Credit. I hereby permit home care services in Manitoba operated by a Regional Health Authority (RHA), Manitoba Families, or Manitoba Finance to exchange the personal information contained on this form for the purpose of administering the tax credit. I understand I may contact the Manitoba Tax Assistance Office at 204-948-2115 (toll-free 1-800-782-0771) if I have questions about privacy implications.

Primary Caregiver Tax Credit – Registration Form

PART A: Declaration by the Primary Care Recipient

To be completed by the person receiving care or on behalf of the care recipient if the care recipient is a dependent minor or not able to complete and sign.

Last Name:	First Name:		Middle Name:
Social Insurance Number:	Phone Number:		
Home Address (House Number & Street Name or legal description):	City/Municipality:	Province:	Postal Code:
Mailing Address (if different from home address):	City/Municipality:	Province:	Postal Code:

Date Caregiving began (yyyy/mm/dd): __________ /______ /______
(Use the "Qualification Date" for those determined eligible by Manitoba Department of Families Children's disABILITY Services or Community Living disABILITY Services.)

☐ Check if this is a replacement designation.

Please select ONE of the following options:

The care recipient is determined to have level of care requirements of Level 2 or higher by:

☐ Home care services in Manitoba operated by a Regional Health Authority.

☐ A doctor or nurse practitioner assessment under Part C of this form.

OR

The care recipient qualifies for the Primary Caregiver Tax Credit as determined by:

☐ Manitoba Department of Families Children's disABILITY Services or Community Living disABILITY Services.

Declaration by the Care Recipient:

I hereby declare the foregoing to be true to the best of my knowledge. I understand that it is an offence to make false statements knowingly under The Income Tax Act (Manitoba). I have read and accept the FIPPA release on Page 1 of this form.

I hereby designate the individual named in Part B as my primary caregiver for the purposes of the Manitoba Primary Caregiver Tax Credit.

Care Recipient's signature: ____ Date (yyyy/mm/dd): __________ /______ /______

PART B: Declaration by the Primary Caregiver

Last Name:	First Name:		Middle Name:
Social Insurance Number:	Phone Number:		
Home Address (House Number & Street Name or legal description):	City/Municipality:	Province:	Postal Code:
Mailing Address (if different from home address):	City/Municipality:	Province:	Postal Code:

Declaration of the Primary Caregiver: For the purposes of the Primary Caregiver Tax Credit, I am serving, or am about to serve, as primary caregiver for the care recipient listed in Part A and confirm that this person resides in a private residence. I have not been, nor am I being paid by any party for the care that I provide to this individual. I have received, read and understand information about the program. I hereby declare the foregoing to be true to the best of my knowledge. I understand that it is an offence to make false statements knowingly under The Income Tax Act (Manitoba). I have read and accept the FIPPA release on Page 1 of this form.

Caregiver's signature: ____ Date (yyyy/mm/dd): __________ /______ /______

PART C: Level of Care Equivalency

To be completed by a doctor or nurse practitioner. Please complete ONE of the Adult or Child section.

If the care recipient is not receiving Home care services in Manitoba operated by a Regional Health Authority, Children's disABILITY services, or Community Living disABILITY Services, their care needs must be assessed by a doctor or nurse practitioner. Complete either the Adult or Child section below, whichever applies.

Name of the Care Recipient: ____

ADULT: To be eligible, the care recipient requires care/assistance on a daily basis in Category 1 and in at least two of the three remaining categories, as outlined below. Check yes or no for each:

YES	NO	Care Category
☐	☐	1. (Required) Assisting and/or supervising with personal care such as bathing, feeding, dressing, grooming/hygiene, mobility, transfers, toileting/elimination, administration of medication.
☐	☐	2. Assisting and/or supervising with routine activities such as shopping, transportation, meal preparation, laundry, and housekeeping.
☐	☐	3. Arranging for supports/system navigation/community access, such as recreational activities, support groups, medical follow-up, counselling.
☐	☐	4. Providing regular and sustained advice, decision-making or emotional support.

OR

CHILD (under 18 years old): To be eligible, a child's care needs require assistance in Category 1 and in at least two of the three other categories below due to a significant life-altering and/or life-threatening medical condition that creates physical, cognitive, or behavioural barriers to the child performing activities of daily living and independent activities of daily living.

YES	NO	Care Category
☐	☐	1. (Required) Assistance and/or supervision with personal care such as bathing, feeding, dressing, grooming/hygiene, mobility, transfers, toileting/elimination, administration of medication: There is a requirement of extra personal care beyond what is required at the child's age (e.g. three years or older and unable to feed, transfer, or toilet self). Also, medical interventions are beyond what is usually expected of the age group (e.g. tube feedings, intramuscular injections, regular suppositories.)
☐	☐	2. Assistance and/or supervision with routine activities such as shopping, transportation, meal preparation, or laundry, housekeeping: These tasks are normally performed for younger children but may be considered if lifting or transferring equipment is required. For the pre-teen and teenage child, a serious condition that affects life and independence enhancing choices that are considered part of normal development, such as driving, shopping, or cooking may be considered.
☐	☐	3. Arranging for supports/system navigation/community access such as recreational activities, support groups, medical follow up, and counseling: Medical condition(s) affect the child's ability to perform recreational, sports and other activities that are normally expected at their developmental age. The child requires additional time of the parent(s)/caregiver(s) or a substitute.
☐	☐	4. Providing regular and sustained advice, decision-making or emotional support: These functions are normally performed for, or in conjunction with, younger children; however, there are situations where additional supervision is required for some children's health and safety. Increased responsibility is expected in teenage years and can be significantly affected by a medical condition (e.g. where life choices such as driving and working are affected by the illness causing continued dependency on the parent/caregiver and or continuous adaptations of the home environment).

Doctor or Nurse Practitioner:

Name: ________________________________ Profession/Position: ____________________

Signature: ______________________________ Date (yyyy/mm/dd): ________ /______ /______

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