OMA Ontario Medical Association

The FHO Handbook 2026

A resource for family medicine physicians practising in a Family Health Organization

How to use the FHO handbook

The FHO handbook was created to support family medicine physicians working in a Family Health Organization. It is intended to help physicians understand the 2026 FHO Agreement (also known as the FHO contract), including the requirements for FHO groups and physicians, the rules they must follow and key details about compensation. It also explains the Ministry of Health's (ministry)operational requirements on ministry directed processes, such as patient enrolment, making changes to a FHO group and the monthly revenue cycle.

This handbook is intended for all FHO physicians, regardless of career stage and/or existing familiarity with the FHO model. While it can be read from beginning to end, it is designed primarily as a reference tool. Readers should use the table of contents to navigate to topics of interest based on their own specific issues or needs.

Disclaimer: This document has been prepared as a complimentary resource to the 2026 FHO Agreement. It is provided as a guidance tool only and is not a substitute for the agreement itself or any subsequent legally binding documents including applicable terms under the Physician Services Agreement(s) and/or amending agreements, if any. If there is any inconsistency between this document and the FHO agreement or other applicable agreements, the agreement(s) governs. Physicians with questions or seeking clarification should contact the OMA and/or the ministry for direct guidance.

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Part I: FHO group operations

1. The FHO agreement

The Family Health Organization agreement (FHO agreement) is a contract between FHO physicians, the Ministry of Health and the Ontario Medical Association. The first contract took effect in 2007 in conjunction with the introduction of the FHO patient enrolment model and outlines the rules and expectations for physicians who practise in that model. The FHO agreement includes (but is not limited to):

- Governance requirements
- Application process
- Rules for creating a FHO group and co-location guidelines
- Making changes to the group including:
    - Additions and removal of FHO physicians
    - FHO contracted physicians (i.e., locums)
- Enrolment
- Compensation structure
- Terms of payment
- Service obligations
- Reporting

From time to time, amendments are made to the FHO agreement, and FHO groups are notified and provided guidance for these amendments through ministry INFOBulletins. The OMA also provides continuing guidance for all aspects of the agreement.

What is FHO+?

FHO+ is a new payment model included in the 2026 FHO Agreement — the first contract update since the 2007 FHO Agreement. Although many aspects of the 2007 agreement have been maintained, the new agreement has modernized FHOs and introduced significant changes, including:

- Updates to capitation payments
- Inclusion of a billable hourly rate
- Updates to accountability measures toward patient access (i.e. Continuity of Care)
- Group formation and co-location guidelines

2. FHO governance agreement

A FHO governance agreement is a formal written agreement created amongst the physicians in a FHO group to outline how they will work together to meet their collective responsibilities under the FHO agreement with the ministry.

A governance agreement must be created by the time a FHO group is first formed and required to be in place at all times while the FHO is operating. It sets out the key rights, responsibilities and obligations of being part of the group and provides a framework for how the group operates.

The ministry requires the agreement to cover certain minimum elements, such as:

- How physicians are approved to join the group
- How physicians leave or are removed from the group
- How contracted (locum) physicians are approved
- How leadership roles and authority are assigned
  (i.e. lead FHO physician and an associate lead FHO physician)
- How financial information from the ministry is shared among group members
- How specific FHO elements (e.g. funding) apply to each physician
- How after-hours and on-call service is organized and determined

While the agreement must address certain required elements, groups also have flexibility to include additional operational provisions that make sense for the group and reflect how they want to work together in practice. These optional elements can help clarify expectations and support smoother operations. Examples include:

- How decisions are made and how disputes are resolved
- Leave of absence: How is time away from practice is defined and dealt with
- Group Management and Leadership Payment and Enhanced GMLP: How will this money be distributed? Are there thresholds that must be met?
- EMR management: How will the EMR be shared, accessed and maintained within the group? Who is the health information custodian?

Ultimately, a governance agreement helps set clear expectations, reduce future conflicts and support the group in delivering high-quality, co-ordinated care within the FHO model. The agreement is also a living document. It can be reviewed and updated over time as the group evolves.

Governance agreement support

OMA Legal provides a governance compliance checklist for groups to validate their agreement meets the contract's minimum requirement. OMA Legal also offers governance agreement template that can be used as a starting point when developing a governance agreement. However, groups need to modify the template to meet their FHO's specific needs. Pre-existing FHOs whose governance agreement does not comply with the governance requirements in the 2026 FHO

contract have until March 31,2027, to update their governance agreement and provide a new compliance certificate to the ministry.

3. Lead FHO physician and associate lead FHO physician

It is mandatory that every FHO group elects two officers to represent the group at the time of formation. These are known as the lead FHO physician (FHO lead) and associate FHO physician (associate lead). As per the FHO agreement, these officers, either together or independently, are empowered to bind the group for purposes of:

- Executing any amendments to the FHO agreement, extensions or renewals with the ministry
- Entering into agreements with other persons, health-care providers, health organizations and institutions, as may be required or desired, for the purpose of supporting FHO activities and operations
- Authorizing banking transactions
- Executing certain subsequent or supplementary agreements, as may be required

The FHO lead also serves as the ministry's primary point of contact for the group, particularly for applications and change notifications. All official documents are sent only to the FHO lead, who is responsible for acting upon and sharing information with the other signatories of the group. Acting as the communication link between the ministry and the entire FHO, the FHO lead is essential to ensuring compliance with FHO guidelines, service expectations and deadlines. Their signature is mandatory on all required forms, applications and contracts, and the ministry will only accept submissions that originate from the FHO lead. Some routine correspondence that requires the FHO lead is:

- The addition of any FHO group members
- The completion of any FHO contracted physician (locum) applications, extensions and declarations
- The disposition (or de-rostering) of any enrolled patients
- After-hours exemption forms
- Annual reporting for the Office Practice Administration funding (due annually by April 30)

The FHO lead must keep their contact information up to date, as the ministry primarily communicates with them by email. They should maintain an organized and transparent system for storing and tracking all FHO documents and correspondence. The FHO lead is also responsible for responding to ministry audits and providing any requested documentation on behalf of the group or individual members. These may include financial records, as well as enrolment-related forms and declarations.

To update your contact email with the ministry, please email primarycareinquiries@ontario.ca

In the case that the FHO lead is temporarily unavailable, the associate lead assumes the duties and responsibilities of the lead.

4. How to form a FHO or change to a FHO

When forming a FHO, the following requirements should be considered:

- A minimum of six physicians in the group (unless an exemption is authorized)
- It must be demonstrated that the total enrolment for the group will be a minimum of 4,000 patients (unless an exemption is authorized)

I. The elected FHO lead needs to submit an expression of Interest Application to create a FHO (EOI) to the ministry to initiate the process. (See Appendix A)

II. Once the EOI is reviewed and approved by the ministry, the FHO lead applicant physician will receive a complete registration package with a unique registration number. All subsequent correspondence must include this registration number. Approval time from the ministry is 12 to 16 weeks.

When forming a FHO, the following location guidelines must be considered:

- At least two physicians at any location
- Five km radius of one another, where an OMA RIO score is 0
- Ten km radius of one another, where an OMA RIO score is 1-5
- Thirty km radius of one another, where an OMA RIO score is >5
- OMA RIO score is based on the location of the primary clinic

- Please note that the co-locations guidelines in appendix do not reflect the current guidelines

To find out your clinic location's OMA RIO score, please see the OMA RIO Score Postal Code Look-Up Tool

5. FHO physicians

FHO physician (sometimes referred to as signatory physicians) is any member of the FHO group. To be approved as members by the ministry, any physician who intends to join a FHO must sign the FHO physician declaration form. The signed physician declaration form is an acknowledgement that the physician has read the FHO agreement and agrees to its terms.

5.1 How to add a FHO physician

The size of a FHO is set when the group is created and can only be increased with prior ministry approval. A vacancy arises when a physician leaves the group. Once the group identifies a physician to fill the vacancy, the following steps apply:

I. The FHO lead needs to submit an Expression of Interest to add a signatory physician to a Family Health Organization form to the ministry to initiate the process (see Appendix B). The form cannot be completed without the input of the applicant physician.

II. Once the EOI is reviewed and approved by the ministry, the FHO lead and the applicant physician will receive a registration package (FHO add-on complete package) with a unique registration number. All subsequent correspondence must include this registration number.

While there is no guaranteed timeline for how long it will take to process the EOI, the registration package may take up to 12 weeks to process, and the ministry will not respond to inquiries regarding the status of the application until the 12 weeks have lapsed. If an error is made on the registration package, the timeline for approval will restart from the day the correction is submitted. The applicant cannot enroll patients during the waiting period.

When approved, the commencement date will be the first day of the month. For example, if the application is approved on Sept. 2, the actual commencement date to begin as a member of the FHO would be the first of October. The applicant may work as a locum for the group during the processing time and is indicated at the time that the EOI is completed.

5.2 Income stabilization

When a physician completes the EOI to join a FHO group, they may opt to enter the income stabilization program. The Income Stabilization program supports eligible physicians who have joined certain capitation-based patient enrolment models while they develop their rosters. To be eligible for the IS program, a physician must meet each of the following criteria:

- Is in his/her first year of comprehensive primary care practice (commenced within three years following their graduation); or has a minimum of 12 consecutive months of Ontario fee-for-service (FFS) billing history
- Regularly provide between 20 and 40 hours per week of FHO services as defined in the FHO agreement
- Has not previously participated in the IS program
- Is not currently registered in a:
    - Family Health Organization
    - Family Health Network
    - Family Health Group
    - Comprehensive Care Model

The option to enter the IS program is indicated by the FHO lead on the EOI to Add a Signatory Physician to a FHO (see Appendix C).

The IS program provides guaranteed compensation for up to 12 consecutive months from the commencement, provided that the physician meets the agreed monthly enrolment target. Compensation and enrolment targets are based on a physician's service commitment, which is measured using a Full-Time Equivalency ratio. 1.0 FTE is considered no less than 40 hours per week. Enrolment targets are cumulative monthly, so physicians must account for vacation time, illness, and any patient de-rostering when planning to meet their targets. The option to enter the IS program is indicated by the FHO lead on the EOI to add a signatory physician to a FHO, as is the service commitment based on targeted roster size (see Appendix C).

Physicians who are enrolled in the IS program commit to enrolling "new" and "unattached" patients who have not been enrolled to any other physicians in the group or to the group itself (see patient declaration forms) and are eligible for all unattached patient fee codes when the criteria for applicable codes are met.

When a physician ends participation in the IS program, their compensation will change to those set under the terms of the FHO agreement. A physician may choose to exit the program anytime regardless of whether they have met their annual enrolment target by providing a minimum of 30 days written notice to the ministry of their intent.

5.3 Physician departure

When a physician decides to leave a FHO group, the FHO lead must submit a Patient Enrolment Model physician departure notice at least **60 days** before the planned departure (see Appendix D). The departure date will always be the last day of the month. On that date, all capitation payments for patients enrolled with that physician in that FHO group will end. Patients may be transferred to another physician in the same FHO group, or they may continue to be enrolled to the departing

physician within a different FHO group or another PEM. The notice must list all intended changes, and the receiving physician must sign the notice if a roster transfer is planned. Please see appendix H of the FHO agreement.

5.4 FHO contracted physicians (Locums)

To support physician coverage and maintain patient access, FHO groups may affiliate a contracted physician (locum) with the group. The number of locums affiliated with a group cannot exceed the number of FHO physicians in that group. For example, a group with eight FHO physicians may have up to eight locums affiliated at the same time. There is no limit on the number of groups a locum may be affiliated with, unless the locum is already a signatory physician in another PEM. In that case, the locum may hold no more than three locum contracts at the same time.

To add a locum to the group, the FHO lead must complete the application, contracted physicians joining a Family Health Organization group, which consists of a contracted physician's start and end date form and a FHO contracted physician declaration (see Appendix P).

The contract term may be for up to one year. If the group and the locum mutually agree to end the affiliation before the scheduled end date, the FHO lead may request the change by email to primarycareinquiries@ontario.ca.

Locum compensation is determined by the group or negotiated between the locum and the signatory for whom they may be providing coverage. The terms should be articulated in a contract signed by both parties. For support with locum contracts, please reach out to the OMA Legal Team at legal.affairs@oma.org.

To extend an affiliation without any gap beyond the current term, the physician can submit an updated contracted physicians start and end date form at least 30 days in advance of the expiry of the current term. If not completed 30 days in advance, the entire package including the declaration form, will also need to be completed and re-submitted.

When working with the FHO, the locum must bill and submit claims using the FHO group billing number, and their billing profile in the EMR needs to be configured appropriately. If a claim is submitted without using the group billing number, FHO payment rules may not apply, including shadow billing, after-hour bonus and hourly rate codes will be rejected. Also, all visits with the locum will count negatively toward the Continuity of Care metric of the FHO physicians they are working for. The contracted physician cannot enroll patients or receive capitation payments.

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Part II: Enrolment

This section outlines the ministry's expectations and rules for patient enrolment in the FHO model. Understanding how to enrol a patient is essential to receiving capitation payments and accessing other enrolment-based compensation, such as bonuses, premiums and hourly rate payments.

1. Patient enrolment and consent form

1.1 Enrolment

Patients voluntarily enrol with a physician by completing and signing the patient enrolment and consent to release personal health information form (enrolment form). Adult patients can enrol themselves, while children under the age of 16 years or dependent adults must be enrolled by a parent or guardian. Physicians in FHO models also have the option of enrolling patients who reside in a long-term care facility. (see Appendix E for a copy of the enrolment form)

As Feb. 1, 2013, physicians no longer need to submit the signed enrolment form to the ministry. However, in accordance with general professional requirements for the retention of medical records for their patients, a copy must be retained in the patient's chart. Effective March 24, 2020, enrolment forms may be sent and received electronically, however, the returned copy must be a scanned or photocopy with a legible signature. For more information please see ministry bulletin 11260.

FHO signatory physicians can order enrolment kits, enrolment forms, new patient declaration forms and other resource materials by completing a primary care enrolment material order form.

1.2 Consent

By signing the enrolment form, a patient is also giving consent to the ministry, their family physician and other physicians in the FHO group to exchange and release personal health information regarding (but limited to):

- Dates of immunizations
- Dates of preventive care screening services (e.g. cervical cancer screening, mammograms, FIT tests)
- Dates of services, fees paid and fee codes of primary health-care services provided to the patient by a family physician outside the FHO (outside use)

Consent ends when:

- Enrolment with the physician ends (i.e. patient moves, physician retires, etc.)

- The ministry will automatically end consent on an enrolled patient's 16th birthday. Patients turning 16 receive a notice from the ministry advising them to obtain a photo OHIP card and contact their family physician to sign a new enrolment form and renew their consent. If this is not done, the patient remains enrolled, but consent ends until the updated form is completed and resubmitted. Code Q200A must be submitted to notify the ministry that consent has been renewed
- A patient chooses to revoke consent

Patients may remain enrolled with their physician even though they choose to revoke consent to release personal health information. Patients must inform the ministry in writing if they wish to revoke consent, or to end enrolment with their physician, by contacting the ministry INFOline at 1-888-218-9929, as indicated on the back of the enrolment form.

2. Patient declaration forms

A "new" patient must sign a new patient declaration form (see Appendix F). A new patient is defined as one of the following:

- The patient has not previously been enrolled as a patient to the group or a physician in the group
- The patient's family physician has moved to another community
- The patient has moved to another community
- The patient's physician is no longer available due to illness/death/retirement
- The patient's physician is no longer available due to change of practice type
- Up until now the patient has not had, or felt the need for a family physician

A new patient who has recently been discharged from hospital must sign an Unattached patient declaration form (see Appendix G) These patients meet the same criteria as identified above and are also defined by one of the following:

- The patient is a newborn admitted to a Neonatal Intensive Care Unit within the last three months and who's mother is not already enrolled with a physician

- The patient was an acute care patient in a hospital within the last three months, previously without a family physician

The completed new patient and unattached patient declaration forms must be kept in the patient file and made available upon the ministry's request. To bill the unattached patient fee code, the declaration forms must be signed and dated on the same day as, or after, the date of the first eligible billed service.

3. Per patient rostering codes

Once an enrolment form is completed and a patient record is created in the physician's EMR, an enrolment code must be submitted to the ministry. When processed, this will enrol the patient to the physician and triggers monthly roster-based capitation payments, which are prorated starting from the service date submitted with the code. (See compensation)

Some enrolment rules to remember:

- When submitting enrolment codes, the service date on the invoice must be the same date as on the signed enrolment form
- The enrolment form must be retained in the patient record in case of audit
- Declaration forms that are completed by eligible patients also need to be retained in the patient record in case of audit
- See Appendix H for enrolment codes and unattached patient fee codes

4. Enrolment transfers

When a FHO physician retires or leaves their primary care practice, they may transfer some or all their enrolled patients to another family physician. Similarly, if the physician is joining a new group, they may transfer some or all of their roster with them. Roster transfers can be indicated when completing either a physician departure notice form or an EOI to add a signatory physician form.

Through the transfer process, a patient's enrolment with the current physician or group ends one day before the transfer takes effect. Enrolment with the new physician or group begins on the ministry-approved transfer date, which is always the first day of the month. Transfers between two physicians are subject to the re-enrolment requirements of a time-limited transfer (see below). Physicians who are transferring their own roster from one group to another do not need to re-enrol patients or obtain consent again.

A physician must provide 60 days' written notice to their lead physician and the ministry prior to any enrolment transfers. As well, they must ensure that they carefully review and follow CPSO

guidelines when transferring an enrolment between either groups or physicians, including timelines for notifying patients.

Batch Roster End

If a physician is retiring or leaving the practice and is not transferring patients to another physician, the total patient enrolment can be ended through the Batch Roster End process. A BRE is done through a physician departure notice. In the case where a physician dies, enrolment with the group may end if other physicians in the group do not take on the deceased physician's roster. There is no obligation to enrol a deceased colleague's patients, however the FHO group must cooperate with the ministry to assist with their re-enrollment.

Batch Roster Transfer

The Batch Roster Transfer process transfers a physician's entire or partial patient roster to:

- The same physician in a different group
- Another physician in the same group
- Another physician in a different group

Time-limited transfer

A time-limited transfers a process that assigns an end date to transferred enrolments. Enrolments may be transferred from one physician to another, or to multiple physicians. The receiving physician must re-enrol the transferred patients using the enrolment form by the specified end date, which is typically six months from the transfer date. During this period, FHO physicians will continue to receive capitation and other FHO-based payments. Patients who are not re-enrolled by the end date will be removed from the physician's roster by the ministry, and capitation and other FHO payments will stop.

Batch Roster End, Batch Roster Transfers and Time-Limited Transfers are all initiated through the physician departure notice. See Appendix D.

5. Enrolment restriction rules

Enrolment restriction rules are printed on the back of both the patient copy and physician copy of the enrolment form.

Six-week rule

Patients can end enrolment with their physician and enrol with another physician only after six weeks have passed from the original effective date of enrolment unless the patient moves (either out of province or more than 100 km from the physician's address). If a patient tries to enrol with another physician before six weeks, the enrolment claim will be rejected.

12-month rule

A patient can only change the physician to whom they are enrolled three times in any twelve-month period, except if the patient has moved.

These are the two scenarios for how this could look:

- ABC: Patient enrols with physician A, then enrols with physician B and then enrols with physician C.
- ABA: Patient enrols with physician A, then enrols with physician B and then re-enrols with physician A.

6. Roster and capitation payment reconciliation report

FHO physicians receive a monthly roster and capitation payment reconciliation report. It is provided in both an XML (excel) and a PDF format. This report provides a complete list of all enrolled patients, as well as changes made during the reporting month. The report is divided into the following three sections:

Reconciliation activity

This section reports enrollment changes that occurred outside the dates of the current reporting month and capitation payment adjustments due to the retroactive changes. A termination code is provided every time a patient is removed from an enrolment, regardless of whether the physician, the ministry or the patient initiates it. However, if a patient initiates the removal, an explicit reason is often not provided to the practice due to the simultaneous removal of consent.

Enrolment additions and removals

This section reports any changes to the current reporting month's enrolment as well as the prorated capitation payments. As above, a termination code is also provided in this section when a patient is removed from an enrolment.

No activity

This section lists all other patients currently on the physician's roster and the current month's capitation payments. It provides other patient information, such as whether a patient:

- Is in long-term care
- Has had changes made to their consent
- Has had changes made to their capitation rates

7. De-rostering

There are three different de-rostering codes that may be submitted depending on the reason for the removal:

- Q401A – Patient is deceased. When submitting this invoice, the service date must be the same as the date of death. When this code gets approved, it ends all OHIP coverage. Claims submitted after this date, even for services completed before the date of death, will be rejected once this code is approved
- Q402A – Enrolment ended by provider. This code is used for any other circumstance other than when a patient is deceased or they have moved out of province. The reason why this code has been submitted needs to be documented in the patient's chart. There are many reasons why an enrolment may need to be ended. However, if this is initiated by the physician, please carefully review the CPSO guidelines for ending the physician – patient relationship
- Q403A – Patient has moved from the province. When this code gets approved, it ends all OHIP coverage

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Part III: Compensation and terms of payment

FHO physicians and groups are compensated using a blended capitation model. This is a combination of capitation payments based on enrolment size and demographic composition, blended fee-for-service premiums for in-basket services (informally referred to as shadow billing), fee-for-service payments, and hourly rate as well as other bonuses and premiums. FHO groups also receive additional administrative payments that can vary depending on the size of the FHO group and the number of enrolled patients.

1. Roster-based capitation payments

FHO physicians' capitation consists of base rate payments and base acuity payments. Whereas both the base rate and base acuity are based on the age and sex of a patient, base acuity payment includes a third consideration: the complexity of the patient due to both acute conditions and chronic disease diagnoses. Capitation payments are reported monthly on a FHO physician's solo remittance advice and roster and capitation payment reconciliation report as well as the FHO group's RA.

Although there is a monthly cutoff date for processing claims, capitation payments are processed automatically through to the end of the month for all enrolled patients unless an enrolment change is submitted before ministry processing. Enrolment changes submitted after monthly processing result in retroactive adjustments to the following month's capitation payment.

Base rate payment

- The base rate is compensation for "in-basket" (core) services
- It is a per-patient monthly payment that is age and sex adjusted
- Payment is prorated per day based on a calendar month
- Retroactive enrolment activity (adding and removing patients) may cause adjustments to base rate capitation payments in any given month
- Reported on the monthly remittance advice as network base rate payment
- See Appendix I for annual rates

Base rate acuity payment

- Additional compensation based on both acute and chronic conditions that impact a patient's need for physician services
- As well as being age and sex adjusted, acuity rates are divided into five bands depending on the complexity of a patient's condition(s) as reported through diagnostic codes
- Payment is prorated per day based on a calendar-month
- Physicians receive base rate acuity payments regardless of whether they provided services to those patients during the payment period

- Retroactive enrolment activity (adding and removing of patients) may cause adjustments to a base rate acuity payment in any given month
- Reported on the monthly remittance advice as base rate acuity payment
- See Appendix J for annual rates

2. Fee-for-service and blended fee-for-service

Fee-for-service payments

Fee-for-service payments are payments for services that are paid at the full value of the fee schedule code as listed in the OHIP Schedule of Benefits. FHO physicians can receive FFS payments for different reasons:

- For providing any insured service (regardless of whether in-basket or out-of-basket), to non-enrolled patients
- For providing insured out-of-basket services to either their own enrolled patients or the enrolled patients of physicians within the same FHO group (network colleagues)
- Services submitted to WSIB that are provided for under the Workplace Safety and Insurance Act
- Reciprocal medical billing for services provided to out-of-province patients (excluding Quebec)

FFS payments are comprehensively itemized on a monthly report called the detailed categorization of claims. The totals for each payment category and type are summarized on the remittance advice in a section called the Summary categorization of claims.

FHO groups have an annual limit on the amount they can be paid for FFS in-basket codes for non-enrolled patients. This limit is commonly called the FFS hard cap. It is calculated by multiplying the maximum payment multiplier by the number of FHO physicians in the group. As of April 1, 2026, the multiplier is $59,709. For example, for a group with six physicians, the FFS hard cap is $59,709 × 6 = $358,254. This amount is reported on the monthly group RA under ee-For-Service core payment ceiling and shows the month-to-date and year-to-date accruals, as well as each physician's contribution to the total.

Blended fee-for-service premiums (shadow billing)

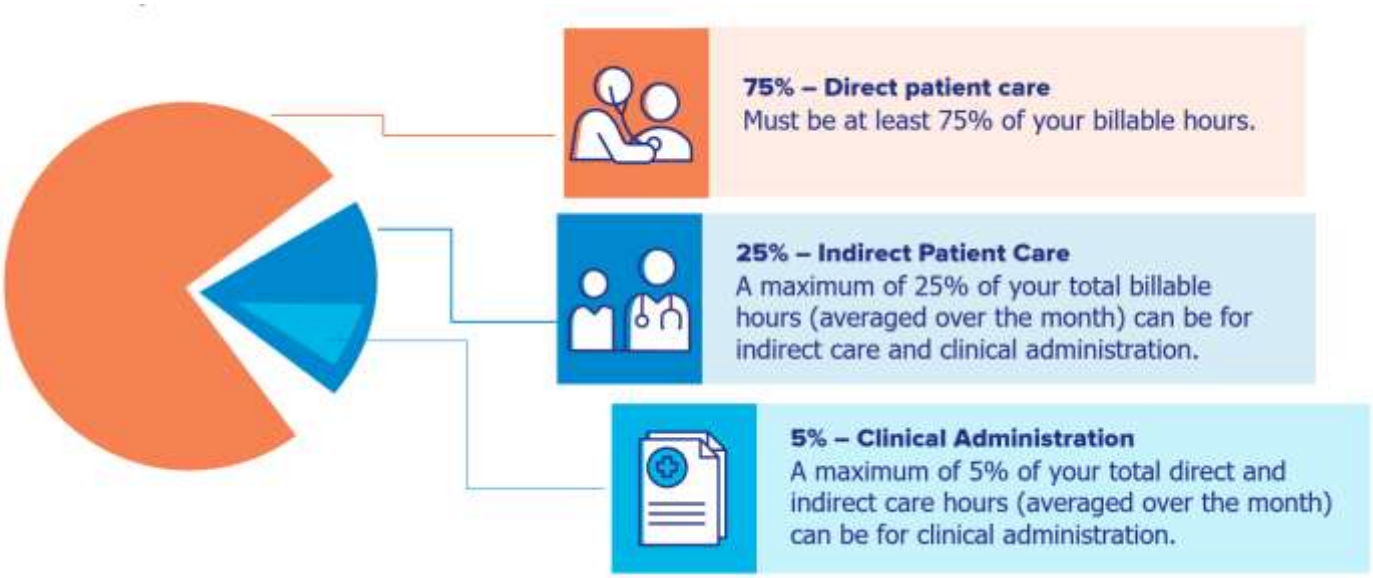
In addition to the base rate, they receive for in-basket services, FHO physicians also receive an FFS premium when providing in-basket services. This premium is commonly referred to as shadow billing. The shadow billing rate can vary based on the terms agreed upon in the most current Physician Services Agreement. As of April 1, 2026, the shadow billing premium rate is 30 per cent for all in-basket services, except for certain procedures, which are eligible for a 50 per cent premium (see Appendix K for eligible procedures).

Shadow billing payments are summarized and reported on the monthly RA as blended fee-for-service premium.

3. Hourly rate payments

As of April 1, 2026, an hourly rate has been included as part of the compensation for FHO physicians when providing direct care and indirect care for their enrolled patients and for certain clinical administrative activities for their roster. Hourly rate codes are not applied directly to a patient. Instead, the total time spent in each category is submitted once per day as a cumulative daily total. Each code represents one 15-minute unit, and the number of units submitted should reflect the total time spent that day.

The hours submitted must be tracked by the physician and are limited to 14 hours per day and 240 hours per 28-day billing period, prorated based on the month. Indirect care and clinical administration combined, cannot exceed 25 per cent of total hours (direct/indirect/administrative) claimed per month and clinical administration cannot exceed five per cent of the sum of direct care hours and indirect care hours combined per month.



Direct care

This is time spent personally providing clinical services for enrolled patients or their family (as permitted) during a patient encounter. As of April 1, 2026, the payment rate is $20/15-minute billing unit when seeing patients in-person, by video or by telephone from the physician's office and $17/15-minute billing unit when providing care remotely by telephone outside of the normal clinical setting.

Indirect care

- This is time spent by the physician personally providing patient-specific insured services to rostered patients of the FHO group where there is no direct patient contact, whether in office or out of office. As of April 1, 2026, the payment rate is $20/15-minute billing unit

Included services are:

a. Documentation of patient interactions and charting
b. Review of results: labs, imaging, consultations and other reports
c. Preparing referrals and requisitions
d. Chart review
e. Discussion with and providing advice and information to the patient or the patient's representative before or after the provision of direct patient care for an insured service, via synchronous or asynchronous communication
f. Care co-ordination and care planning
g. Conferencing, consulting and meeting with other physicians and/or other health professionals for a specific patient or patients
h. Conferencing and meeting with family members and/or patient medical representatives
i. Reviewing and analyzing clinically related information/research directly related to the needs of a particular patient (e.g.: investigating diagnostic and therapeutic interventions)
j. Completion of clinically required forms, reports and medical certificates of death (excluding services requested or required by a third party for other than medical requirements and for which the physician can bill the patient directly, such as insurance forms and reports, medical-legal letters and reports, insurance/industrial examinations, and physical fitness examinations for school/camp). Please see the OMA Physician's Guide to Uninsured Services
k. Patient-specific clinical teaching arising from direct patient care. Teaching that is unrelated to direct patient care is not payable as indirect patient care time

Clinical administration

This is time spent on other activities not related to direct or indirect care but requires the professional expertise of a family physician for management of the patient. As of April 1, 2026, the payment rate is $20/15-minute billing unit.

Clinical administration includes:

l. Proactive patient management and review for screening interventions, disease management and provision of care (e.g., mammograms, colon cancer screening, immunizations, diabetes management)
m. Electronic Medical Record updating and management that requires physician expertise
n. Quality improvement planning and implementation (e.g. patient access/equity and digital solution initiatives)

Documentation

It is up to each FHO physicians/group to determine how they will document hours as they pertain to the hourly rate calculation and submission. Documentation needs to include:

- Daily duration

- Time spent providing care when in office vs. time spent providing care when out of office, when applied to direct care
- A summary description of activities when providing indirect care and clinical administration

Hourly rate fee codes

Q310 – Direct patient care – in person and video, telephone – in office

Q311 – Direct telephone-based patient care – not in office

Q312 – Indirect patient care

Q313 – Clinical administration time

Please see the OntarioMD Educates website for tips on tracking hours and documentation

4. Premiums, special premiums and bonuses

After-hours premium

After-hours premiums are premiums applicable to services provided during an after-hours clinic. These are appointments that are scheduled after 5 p.m. Monday through Friday, weekends or on certain statutory holidays. As of April 1, 2026, the premium rate is 50 per cent. This premium is only available for enrolled patients. To claim the after-hours premium, code Q012 needs to be added to the same invoice as the service being provided.

Age premiums

Age premiums are premiums applicable to certain fee service codes. The actual age premium rate is dependent both on the fee code submitted and the age of the patient. The most common age premiums are for geriatric assessments, but age premiums are also applicable for certain procedures performed on patients under the age of 16. Because most services that are eligible for age premiums are in-basket, age premiums for enrolled patients will also have the shadow billing rate applied. Age premiums that are applied to eligible services for non-enrolled patients are paid at the full premium rate. See Appendix L for available age premiums.

Special premiums

Special premiums are available to all physicians who meet specific care thresholds for enrolled and non-enrolled patients. As set out in the FHO agreement, a premium becomes payable once a threshold is reached based on the number of services provided, the value of service fees billed, or the number of patients seen.

Each fiscal year, all physicians may qualify for special premiums for both enrolled and non-enrolled patients in the following categories: home visits, long-term care, labour and delivery, and palliative care. FHO physicians may also qualify for additional premiums for office procedures, prenatal care, and hospital services provided to their enrolled patients or to the enrolled patients of other physicians in their FHO. Special premium accumulations and payments are reported monthly on both the physician's solo RA and the group RA.

An additional premium is available for providing primary care to patients diagnosed with serious mental illness, such as bipolar disorder or schizophrenia. Unlike the other premiums, which are tracked and paid automatically, the PC-SMI premium requires submission of tracking codes Q020/Q021 once per ministry fiscal year. For a detailed list of the criteria and thresholds for each special premium, see Appendix M.

Preventive care bonus

The preventive care bonuses are paid to a physician when certain percentages of defined preventive care services have been provided to their targeted enrolled patients. These are submitted annually at the end of the fiscal year. The invoice date must be March 31 but are not billable until April 1. Submissions made before April 1 will be rejected. As of April 1, 2024, FHO physicians are eligible for preventive care bonus for influenza immunizations administered to patients 65 and older and childhood immunizations for patients aged 30 to 42 months only

See Appendix M for preventive bonus details.

5. Administrative payments

Group Management and Leadership Payment and Enhanced GMLP

The Group Management and Leadership Payment is an administrative payment paid monthly to the group. The payment is $1 per rostered patient per year to a maximum of $25,000 and is prorated depending on the patient's enrolment start or end date. GMLP payments are paid monthly to the FHO account and reported on the group RA as the accounting transaction "Group management and leadership payment." Both physician's and the group's GMLP accumulations are reported monthly on their solo RA and group RA.

As of April 1, 2026, the Enhanced Group Management and Leadership Payment is paid in addition to the GMLP. It is calculated at a rate of $4 per rostered patient per year, prorated to a maximum of $100,000.

Purpose and responsibilities

The E-GMLP is intended to support the FHO lead in carrying out leadership responsibilities related to FHO contract compliance, including the responsibilities described in section I.3, Lead FHO physician and associate lead FHO physician. However, each FHO group may decide how responsibilities are shared among the FHO lead, associate lead, and other group members. The FHO lead (and associate lead, where applicable) remain ultimately responsible for completing required forms and communicating with the ministry.

Allocation of payments

Each FHO group has discretion over how the GMLP and E-GMLP are allocated. Governance agreements should clearly describe how these payments will be distributed.

Payment schedule

The GMLP is paid monthly. For the 2026-27 fiscal year, the E-GMLP is paid quarterly and will transition to monthly payments beginning in April 2027. The combined annual value of the GMLP and E-GMLP will be at least $25,000.

Office practice administration

The Office Practice Administration payment is a grant available to support physician groups of five or more who hire an administrator. The amount of the OPA grant will be determined by the size of the physician group as follows:

- Groups of five to seven: $12,500
- Groups of eight to 14: $17,500
- Groups of 15 to 25: $25,000

The FHO lead must also notify the ministry within 21 days of any change in the number of signatories or any change in the administrator's employment that could affect OPA funding.

The administrator's responsibilities include, but are not limited to group administration, co-ordinating on-call coverage and extended hours, supporting IT implementation and planning for interdisciplinary teams. The administrator cannot be a physician within the FHO.

The ministry emails the Office Practice Administration funding grant annual reporting form to the FHO lead, which must be completed and returned to the ministry by April 30 of each year. The report is a confirmation of the administrator's employment, including the total hours worked and a description of the administrative functions performed in support of the FHO (see Appendix N).

6. Rurality gradient

Beginning with an OMA RIO score of 40 points, a FHO physician is eligible to receive an additional payment of $5,000 per fiscal year. This payment is increased by $1,000 for each five-point increment above 40. The RIO score is based on the location of the office in which the FHO physician regularly provides FHO services as registered with the ministry. This payment is made across 12 equal, monthly payments and reported to the RA as rural gradient premium.

7. Submitting claims, the monthly revenue cycle and reporting

Claim files

FHO physicians are responsible for creating their own invoices after a patient encounter using the EMR or billing system specified in the FHO governance agreement. Although FHO physicians receive capitation payments for in-basket services, they must still submit the applicable codes to receive shadow billing payments and other premiums, and to support tracking of medical services their patients use. Each invoice must include both a service code and a diagnostic code, as well as the date the service was provided. Bills must be submitted within 90 days of the service date to avoid being rejected as stale dated.

When a physician submits invoices to the ministry, they are submitting what is known as a claim file. When a claim file is created, it is given its own unique identifier based on the provider's billing number and can be created and submitted in one of two ways:

1. Group submission: These are claims that are created by adding the group billing number with a physician's solo billing number. Compensation for claims submitted this way will be deposited in the group bank account
2. Solo submission: These are claims that are created using the physician's solo billing number only. Compensation for claims submitted this way will be deposited into the physician's bank account

A FHO governance agreement can specify whether compensation will be paid to the group bank account or into an individual physician's own bank account. Payment directions are given at the time of FHO commencement. Any locum physicians need to be set up using the group billing number to receive FHO benefits as well to not negatively impact the FHO reporting. The FHO is responsible for ensuring that EMR billing software is set up accordingly.

The monthly OHIP revenue cycle

The monthly OHIP revenue cycle is:

a. Claims can be submitted any time. The ministry will provide a report called a Batch Edit every time a claim file is received as a confirmation of receipt.
b. The ministry's guaranteed monthly cut-off date for claim submissions is generally the 18th, unless that date falls on a weekend or holiday. In those cases, the cut-off may be earlier or later, depending on the calendar. The ministry posts all cut-off dates for the year in advance on its medical claim electronic data transfer webpage resource. Claims submitted after the cut-off may still be processed in the same billing period, but only claims submitted by the cut-off date are guaranteed to be processed that month.
c. The monthly Remittance Advice for that month's payment is generally made available within the first five days of the month following the cutoff. Its delivery can also be affected by weekends and holidays. Other reports, such as roster and capitation payment reconciliation report, outside use reports and detailed categorization of claims, are also available in the same approximate window as the RA.

d. The deposit date for payments is reported on the RA. The deposit date is generally around the 15th of each month depending on the calendar and whether that day lands on a weekend or holiday. These are reported on the ministry website as well.

Although fee-for-service and shadow billing claims normally processed before the last day of the month, capitation payments are calculated up to the end of the month. For example, if the reporting month is September, the fee-for-service/shadow billing payments will be based on claims submitted from the previous processing date to the current processing date (e.g. Aug. 19 to Sept. 18). but the capitation payments will be from Sept. 1 to 30.

Ministry reporting

The ministry provides several monthly reports so FHO physicians can track their revenue and enrolment. All reports are available through the medical claims electronic data transfer, which is securely accessed through a physician's OPS BPS account. Accredited EMRs are enabled to securely connect with the MC-EDT platform for convenient uploading and downloading of claims and reports. Please see the ministry's MC-EDT website as well as the MC-EDT reference manual.

The following are reports that FHO physicians should expect each month:

Remittance advice

The monthly remittance advice is an itemized record of monthly payments provided to all FHO physicians (solo RA) and FHO groups (group RA). It is produced at the end of each month after claims processing is complete and is delivered within the first three to four days of the following month. Capitation payments, fee-for-service payments, bonuses and premiums are each listed on separate accounting lines, along with any adjustments from previous payment periods. The RA also provides useful practice-level information, including tracking of special premium thresholds, itemized payments by invoice and patient, and summaries of other monthly reports. In addition, it includes a two-character explanatory code indicating when a claim was rejected or paid at a different rate than what was submitted. For more information on explanatory codes, see the ministry resource on remittance advice explanatory codes.

For help reading and understanding an RA please see the OMA Remittance Advice document tour resource or email info@oma.org

Roster capitation and payment reconciliation report

See Section 6 in enrolment management

Detail categorization of claims

The detail categorization of claims is a detailed report of all fee-for-service payments during the reporting period. It organizes payments based on patient enrolment status, category of payment and type of claim (in-basket or out-of-basket). The payments in each category are listed by patient.

As these payments are FFS, the paid claims reported here are not exclusive to patients seen within the FHO practice, but also includes any payments for services provided at other locations (e.g. hospital work or locum work at another site).

Batch edit reports and error reports

These reports may be received multiple times per month. A Batch Edit report is sent to a physician every time a batch of claims (claims file) is submitted to the ministry as a confirmation of receipt. The BE includes the number of claims received and their total value. If a claim is flagged for error on a BE, the claim needs to be corrected and resubmitted.

Error reports are also provided whenever a claim batch is submitted to the ministry. This report flags invoices that have errors that prohibit the ministry from processing the claim. An error is identified by an error code. The most common example of an error code is EH2 for invalid/expired health card. See the ministry resource error report conditions/error codes.

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Part IV: Service obligations

The FHO agreement requires that the FHO physicians within the group provide, co-ordinate and oversee the provision of their own services. This includes setting appropriate guidelines for ratios regarding full-time equivalent hours required per size of enrolment to ensure appropriate access to care is provided, how vacation time is managed or covered and how their after-hours care is scheduled and organized, as long the AHC requirements as set out by the ministry are complied with.

1. After-hours care requirements

The scheduling, staffing and organization of After-Hours Care are determined by the FHO group in accordance with its governance structure, provided all requirements are met based on the group's size. FHO leads are responsible for ensuring current AHC clinic times are published on the Ontario Health family health clinic directory.

The following chart outlines the ministry requirements for AHC:

FHO group size	Total evening and weekend	Required evenings	Required weekends
5-7	5	4	1
8-9	6	5	1
10-14	8	6	2
15-19	9	6	3
20-24	10	7	3
25-29	11	8	3
30-39	14	10	4
40-49	15	11	4
50-59	16	11	5
60-74	17	12	5
75-99	22	16	6
100-199	30	24	6
200+	35	29	6

Other ministry rules that also must be considered when coordinating AHC are:

- Patients need to be provided an option of in-person or virtual
- Weeknight blocks must be on Monday to Thursday, be a minimum of three hours and not begin until 5 p.m.
- If a FHO is required to provide one block of weekend coverage, that block will be on Saturday or Sunday
- If two weekend blocks are required, they may be scheduled any time on Saturday or Sunday, provided there is no overlap between the blocks
- If three weekend blocks are required, the FHO may schedule those blocks on Friday evening, Saturday or Sunday, provided there is no overlap between the blocks.
- If four or more weekend blocks are required, one block must be provided on Saturday, one block must be provided on Sunday, and any remaining blocks may be as determined by the FHO provided there is no overlap.
- The FHO can also provide a weekend block on Saturday in place of an evening block and a weekend block on Sunday in place of an evening block.
- Each FHO must provide at least one evening block

Some FHO physicians may be exempt from AHC. The criteria are based on individual FHO physicians' service commitments to other health organizations, such as hospitals and long-term care facilities. Applications for exemption can be obtained by emailing primarycareinquiries@ontario.ca (see Appendix O for a sample exemption form)

2. Continuity of Care

The Continuity of Care measure was added to the FHO agreement on April 1, 2026. The CoC stipulates that 75 per cent of enrolled patients' visits for in-basket services per fiscal quarter need to be provided by their enrolling physician, another physician within their FHO group (signatory or locum) or another acceptable physician (for example, a GP focus practice designated physician).

CoC measure (%) =

Numerator

The number of in-basket primary care visits (in person and virtual) provided to your rostered patients by you, someone in your FHO group or another acceptable provider.

x100

Denominator

The number of in-basket primary care visits provided to your rostered patients by all family physicians (OHIP specialty code 00).

If this threshold is not met in two related measurement quarters, 15 per cent of the capitation in the first measurement quarter is adjusted. These are reported on the RA of the corresponding month that the adjustments are made. CoC reports are provided monthly so physicians can monitor their enrolment's visits for in-basket services.

Continuity of care accountability metric

	CoC measure status	What you will receive
Q1	Falls below 75% (first instance)	100% capitation payment this quarter
Q2		100% capitation payment this quarter
Q3		**Notification from ministry via MCEDT** (allows time for Q1 billings) 100% capitation payment this quarter
Q4	Falls below 75% (second instance)	100% capitation payment this quarter
Q5		100% capitation payment this quarter
Q6		**Adjusted capitation payment** (adjustment total will be 15% of Q1 capitation payment)

Monthly reports are provided monthly so physicians can monitor their enrolment's visits for in-basket services. These are emailed to the FHO lead around the 15th of each month.

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Appendices

Appendix A: Expression of interest to form a FHO

Ontario Ministry of Health

Expression of Interest

To be completed by the Proposed Lead Physician of the new Group

Please read the following before you proceed to complete the Expression of Interest (EOI) form to form a FHO.

This is not a **registration package** but an expression of interest to start the process of forming a FHO group.

You may only proceed to complete this EOI form and submit it to the ministry if you are able to confirm each of the following statements by checking off the box beside each:

☐ All proposed members have General Practitioner specialty designation.

☐ We are a group with a minimum of six members.

☐ We will have a shared EMR

☐ We will be all co-locating or will be practicing in group sites within a radius of 5kms with each site having at least 3 physicians. If your group will not meet this guideline, please explain why it is not possible.

Click or tap here to enter text.

Natural person or Medical Professional Corporation
Please identify each member appropriately on the Applicant Information section, natural person or full name of the Medical Professional Corporation if the applicant has registered one.

What happens after the EOI has been reviewed and approved to proceed:

If approved to apply, the Ministry will forward a set of registration documents and a unique registration file identifier number to the proposed Lead Physician for completion and submission to the Ministry for processing, for example, *ABCD-C20220101AA01_abcfho*. This number must be indicated on the submitted registration documents.

Some important points to take note of once you submit the registration package back to the ministry.

Processing timelines:

The minimum processing time under a priority stream could take up to **12-16 weeks** depending on when the registration package was received, plus FHO Groups can only commence on the first day of the month. As for applications under the non-priority stream -since these applications are processed based on first come first served, processing of these applications could take more than 16 weeks, as such we request that you do not inquire the status of a non-priority application unless 16 weeks have lapsed.

Incomplete registration package

Registration package with missing or incomplete information will be returned to the proposed Lead Physician of the Group. The processing timeline (**12-16 weeks**) of resubmitted documents will be based on the date when the documents were **last received with all the corrected information**.

Ministry's communication:

Unless otherwise authorized in writing, the ministry will only communicate with the proposed Lead physician of the group. It is imperative that the proposed Lead physician provide their email address and cell number for ease of contact.

Click or tap here to enter text.

Proposed Name of your Group (must end with Family Health Organization (FHO) as applicable):

Member Information

Physician/Medicine Professional Corporation[1]	Role	Billing Number	Current Practice Status	Interested in Income Stabilization?[2]	Email Address	Address where FHO services will be provided	Kms to the closest member[3]
Physician's full name or MPC, for example: John Doe Medical Professional Corporation	*Lead*	*123465*	*FFS*	*No*	*dr.a.example@anywhere.com*	*123 Anywhere Street Anywhere, ON 1A1 2A2*	*0*
	Lead		Select	Select			
	A/Lead		Select	Select			
	Member		Select	Select			
	Member		Select	Select			
	Member		Select	Select			
	Member		Select	Select			
	Member		Select	Select			
	Member		Select	Select			
	Member		Select	Select			
	Member		Select	Select			

[1] *The name of Medicine Professional Corporation (MPCs) if physicians in the group are incorporated.*

[2] *New Graduates building their roster from nil and who have never been in a Patient Enrolment Model (PEM) before have an opportunity to participate in the Income Stabilization Program (IS) if eligible.*

[3] *Practice proximity and group co-location help to increase continuity of patient access to care. If not co-located, please provide distance in Kms to the closest member.*

1. **Section 9.2 of the FHO Agreement requires that all signatory and contract (locum) physicians involved in the care of the enrolled patients have access to all medical records of all patients enrolled to any member of the group in order to provide FHO services. How will your group comply with this requirement?**

☐ All our members are/will be co-located

☐ We have an EMR system that can be accessed by all members from all group locations

2. **For group formation, please select all that apply to your application:**

☐ We are all FFS providers and our proposed practice location has a RIO score = >30 (checked on OMA's RIO Postal Code Look-up page https://apps.oma.org/RIO/index.html), or

☐ We have an endorsement from the Ontario Health to form a group to meet specific community need (please enclose a copy of the written endorsement from the local Ontario Health)

☐ We are involved in activities related to Ontario Health Teams. Please identify which OHT:
More information on this process and how to contact your local OHT will be provided in upcoming communications.

☐ We wish to form a FHO in a location with a RIO = <29 (checked on OMA's RIO Postal Code Look-up page https://apps.oma.org/RIO/index.html)

☐ We are currently members of other PEM Groups (CCM, FHG) and wish to form a FHO.

☐ We are all members of an existing FHO who wish to leave our current group to form our own FHO with at least six members

☐ We are members of an existing FHO applying to form our own group as our current group (consisting of 12 or more members) have agreed to divide the group into distinct groups of at least six members each.

3. **Section 5.2 of the FHO Agreements requires that a sufficient number of physicians are available to provide comprehensive care during reasonable and regular office hours Monday through Friday, as well as outside of regular office hours. The INFOBulletin announcing Primary Care contract changes provides a chart of after-hours block requirement based on group size. It is recommended that your proposed members familiarize themselves with these service obligations.**

4. **Physicians may apply for individual exemption from after-hours coverage where more than 50% of physicians in a group provide "Exemption Services" after 5 pm weekdays and/or on weekends outlined in the INFOBulletin announcing Primary Care contract changes, based on this please confirm the following:**

☐ Yes, members of the group provide the after-hours exemption services and represent more than 50% of the group as such we will be submitting an exemption form with the registration documents later.

☐ No, the group will not be applying for after-hours exemption

5. **For days that a member is not available (i.e. days off/vacation/etc.), what plans will be put in place to ensure continuity of patient access to care? This can include locum coverage, access to group members, etc.**

Click or tap here to enter text.

6. **If any of the proposed members are currently affiliated with a PEM and have enrolled patients, please provide the roster disposition plan of each member in the following chart:**

Member's Name	# of enrolled patients	Roster disposition plan?[1]	If transferring pl. provide receiving physician's info below		
			Name	CPSO #	Email address

1 Roster disposition options are: a) **Port** roster to the new group or, b) **End** roster or, c) **Transfer** to another physician. **Option a and c are subject to ministry's approval.**

5

Appendix B: Expression of interest to add a signatory physician to a FHO

Ontario Ministry of Health

Expression of Interest to Add a Signatory Physician to a Family Health Organization (FHO)

To be completed by the Lead Physician of the FHO Group

This is not a registration package but an Expression of Interest (EOI) form to add a signatory physician to your Patient Enrolment Group (PEM).

You may only proceed to complete this EOI form and submit to the ministry if you are able to confirm all of the following statements by checking off the box beside each:

☐ The applicant has a General Practitioner specialty designation.

☐ The applicant will be co-locating at one of our existing sites having at least one or more members. If the applicant is unable to meet this guideline, please explain why?

Click or tap here to enter text.

☐ The applicant will have access to the Group's shared EMR

Natural person or Medical Professional Corporation

Please identify the physician appropriately in the Applicant Information section, i.e. natural person or name of the Medical Professional Corporation if the applicant has registered one.

What happens after the EOI form has been reviewed and approved to proceed:

If approved to proceed, the Ministry will forward a **registration package** and an unique registration file identifier number to the applicant/ Lead Physician for completion and submission to the Ministry for processing, for example, *ABCD_C20220101AA01_smith,roy (Replacement with BRT)*. This number must be indicated on the submitted registration documents.

Some important points to take note of once you submit the registration package back to the ministry.

Processing timelines:

The minimum processing time under a priority stream could take up to **10-12 weeks** depending on when a completed registration package was received by the ministry, plus FHO physicians can only be affiliated to a group on the first day of the month. As for registration under the non-priority stream - since these are processed based on first come first served, processing of these registration packages could take more the 12 weeks, as such we request that you do not inquire the status of a non-priority registration unless 12 weeks have lapsed.

Incomplete registration package

Registration packages with missing or incomplete information will be returned to the applicant/Lead Physician of the Group. The processing timeline (**10-12 weeks**) of a resubmitted registration document will be based on the date when the documents were **last received with all the corrected information**.

Ministry's communication:

Unless otherwise authorized in writing, the ministry will only communicate with the applicant or the Lead physician of the group. It is imperative that the applicant and the Lead physician provide their email addresses and cell numbers for ease of contact.

Lead Physician Information			
Last Name		First Name	
Email address:			
Full Name of FHO Group		Group ID	
Practice Address Unit Number	Street Number	Street Name	
City/Town		Province ON	Postal Code
Applicant's Information			
Last Name		First Name	
If registered as Medical Profession Corporation, please enter the corporation name here:			
Billing Number	CPSO Number	Email Address	
Current Primary Practice Address Unit Number	Street Number	Street Name	
City/Town		Province ON	Postal Code

1. What is the applicant's current practice status?

☐ New Graduate, i.e. obtained independent family practice license within the last three years. If checked, please provide the license practice certificate date: _____

☐ Fee-for-service provider, i.e. not affiliated with any Patient Enrolment Model (PEM)

☐ Existing member of a PEM, i.e. CCM/FHG/FHN/FHO - **please provide the full name of the Group below that the applicant is currently a Signatory member of:**

Click or tap here to enter text.

If the proposed member is an existing member of a PEM answer questions 2 & 3 below, otherwise skip to question 6.

2. Does the applicant currently have enrolled patients?

☐ Yes ☐ No

If "no" skip to question 6.

3. What does the applicant plan to do with his/her current roster?

☐ Will bring his/her existing roster to the new group

☐ Will sever enrolment of all patients via a Batch Roster End

☐ Will Batch Roster Transfer to another physician(s)

If the applicant plans to Batch Roster Transfer to another physician(s) answer questions 4 & 5 below, otherwise skip to question 6.

4. Please provide all details about the receiving physician(s) including full name, billing number, email address and current PEM affiliations.

Click or tap here to enter text.

5. Will the receiving physician be replacing the applicant in his/her current home position?

☐ Yes ☐ No

If "yes" provide the full practice address (including postal code) of where the replacement physician intends to practice as part of the PEM below.

Click or tap here to enter text.

Please note that all roster transfers are subject to Ministry approval.

6. How is the applicant invited to join? Select all that apply:

☐ A FFS physician having a proposed practice location with a RIO score =>30 (checked on OMA's RIO Postal Code Look-up page https://apps.oma.org/RIO/index.html), or

☐ Recommended by Ontario Health due to a specific community need (please attach a copy of the written endorsement from OH), or

☐ The applicant is involved in activities related to Ontario Health Teams.
Please identify which OHT:
More information on this process and how to contact your local OHT will be provided in upcoming communications.

☐ Joining an Academic FHO

☐ Applying to join a FHO in an area with RIO score =<29

☐ A FHG, CCM physician wishing to join a FHO.

☐ Replacing a physician retiring or leaving the group

☐ Filling an existing vacancy in the Group

7. Income Stabilization is available to physicians who will regularly provide between 20-40 hours per week of Comprehensive Care services if they are: in their first year of comprehensive primary care practice (commenced within three years following their graduation); or has a minimum of 12 consecutive months of Ontario FFS billing history and is not currently registered in any of the following physician services agreement: FHO, FHN, FHG, CCM.

Physicians who answer "not interested" to the IS program are not eligible to be added to the program post commencement.

Weekly clinical service commitment below is for the applicant's hours only and includes patient enrolment, patient treatment and after-hours services.

With this information please confirm the following:

☐ I confirm that I have shared the IS information with the applicant and the response provided below is correct

- ☐ The applicant is interested in participating in the IS program at-
  - ☐ 1.00 FTE requiring weekly 40 hours of clinical service commitment
  - ☐ 0.90 FTE requiring weekly 36 hours of clinical service commitment
  - ☐ 0.80 FTE requiring weekly 32 hours of clinical service commitment

☐ 0.70 FTE requiring weekly 28 hours of clinical service commitment
☐ 0.60 FTE requiring weekly 24 hours of clinical service commitment
☐ 0.50 FTE requiring weekly 20 hours of clinical service commitment
☐ The applicant is not interested in participating in the IS program
☐ The applicant is not eligible to participate in the IS program

8. **Section 9.2 of the FHO Agreement requires that all signatory and contract (locum) physicians involved in the care of the enrolled patients have access to all medical records of all patients enrolled to any member of the group in order to provide FHO services. How will this new member comply with this requirement?**

☐ All our members are co-located
☐ We have an EMR system that can be accessed by all members from all group locations

9. **Registration processing time can vary from 10 -12 weeks from the date a completed application is received and reviewed for accuracy. During this processing time would you like to affiliate the applicant as a contracted (locum) physician with your group until he/she commences as a signatory member?**

☐ Yes ☐ No

Practice proximity and group co-location helps to increase continuity of patient access to care. Based on this understanding, please provide the following information:

10. **Is the applicant's proposed primary practice address the same as the applicant's current primary practice address as outlined under applicant information section?**

☐ Yes ☐ No
If "no" please provide the applicant's full proposed primary practice address (including postal code) below.

Click or tap here to enter text.

11. **How many of the existing members of the Group are practicing at this same address?**

Click or tap here to enter text.

12. **Will the applicant be accepting a full or partial roster transfer from another physician upon commencement?**

☐Yes ☐No
If "yes" provide the transferring/retiring physician's name, billing number, email address, current practice address and the anticipated date of transfer below.
IMPORTANT NOTE: Departing physicians transferring rosters to a replacement physician being affiliated to the group at the same time require End Dates to take into account the 60-day processing time for the replacement's registration to be completed in order for any Roster Transfer to be possible.

Click or tap here to enter text.

13. **Patient Enrolment Model Agreements require that a sufficient number of physicians are available to provide comprehensive care during reasonable and regular office hours Monday through Friday, as well as outside of regular office hours. Based on this requirement, please provide the following information for the physician joining:**
Weekly clinical service commitment below is for the applicant's hours only.

a) Clinical days and hours for the provision of comprehensive care to his/her enrolled patients.

MON	TUES	WED	THURS	FRI	SAT	SUN

b) For days that the applicant is not available (i.e. days off/vacation/etc.), what plans will be put in place to ensure continuity of patient access to care? This can include locum coverage, access to group members, etc.

Click or tap here to enter text.

14. Physicians may apply for individual exemption from after-hours coverage where more than 50% of physicians in a group provide "Exemption Services" after 5 pm weekdays and/or on weekends outlined in the INFOBulletin announcing Primary Care contract changes, based on this please confirm the following:

☐ Yes, currently _____ members of the group are exempt from providing after-hours services and we will submit a new exemption form with the applicant's registration document for continued exemption.

☐ As a Northern/ Rural FHO group 50% of our physicians maintain active in-patient hospital privileges as such our group is only required to provide 5 after-hours blocks. We will submit a new "Provision of Active In-Patient Hospital Privileges form with the registration document to indicate which of our physicians have hospital privileges.

☐ No, the group will not be applying for after-hours exemption

15. I confirm that under the Group's Governance Agreement I have the authority to invite a physician to join the Group.

☐ Yes ☐ No

Appendix C: Income stabilization enrolment targets and compensation

Patient Enrolment Targets

FTE Ratio	Annual Enrolment Target (Cumulative)	Months 1, 2 & 3 Minimum Monthly Enrolment Target	Months 4 through 12 Minimum Monthly Enrolment Target
1	825	50	75
0.9	743	45	68
0.8	660	40	60
0.7	578	35	53
0.6	495	30	45
0.5	413	25	38

- An IS physician will be subject to monthly enrolment target reviews by the Ministry. Failure to achieve monthly enrolment targets will result in the following:
  1. 1st Month: Notification from the Ministry
  2. 2nd Month: Termination from the IS program and transitioned into signatory member of the FHO

Service and Compensation

FTE Ratio	Weekly Service Commitment		Annual IS Compensation from April 1, 2025	
	Hours per week	Days per week	Urban	Rural[1]
1	40	5	$204,773.23	$291,967.00
0.9	36	4 ½	$184,295.91	$262,770.30
0.8	32	4	$163,818.58	$233,573.60
0.7	28	3 ½	$143,341.26	$204,376.90
0.6	24	3	$122,863.94	$175,180.20
0.5	20	2 ½	$102,386.62	$145,983.50

- Service commitment includes meeting patient enrollment targets, patient treatment and after hours services.

Appendix D: Physician departure notice

Patient Enrolment Model (PEM) Physician Departure Notice

This is to confirm that I, _____ (_____) will be
Name of physician — Billing #

leaving the _____, (_____) effective _____
Name of Patient Enrolment Model — Group ID — Date (yyyy/mm/dd)

for the following reason mentioned below (choose from one of the following situations):

[ ] am leaving the community/retiring/changing practice type or leaving due to illness. Please end enrolment for all of my patients and terminate any associated PEM capitation payments as of the date of my departure.

or

[ ] am leaving the community/retiring/changing practice type or leaving due to illness. The receiving physician named below, who is a current PEM member, has agreed to provide comprehensive primary care to all of my enrolled patients and is aware of the requirement to re-enrol my patients within six months from the transfer date of which after this period, patient enrolment will automatically end.

By signing below, the receiving PEM Physician acknowledges that he/she will be accepting the transfer of my enrolled patients.

_____ Name of Receiving Physician

_____ Receiving Physician Billing #

_____ Signature of Receiving Physician

_____ Date (yyyy/mm/dd)

or

[ ] will join another PEM. I will submit all the necessary registration paperwork to the ministry for processing, including a request to transfer my enrolled patients to the new PEM as of the effective date below:

_____ Name of New Primary Care Group Name

_____ New Primary Care Group Identification #

_____ Start Date (yyyy/mm/dd)

****

Acknowledgement of Departing PEM Physician:
I agree to advise my patients in writing prior to my departure date and of the transfer of care to another physician if such arrangements have been made.

_____ Signature of Departing PEM Physician

_____ Date (yyyy/mm/dd)

Please return completed form to:

Manager Blended Models Unit, Primary Health Care Branch
Email: primarycareinquiries@ontario.ca

Appendix E: Patient enrolment and consent to release personal health information

Ontario

Ministry of Health
and Long-Term Care

Patient Enrolment and Consent to Release Personal Health Information

Your family doctor is a member of a primary health care **Patient Enrolment Model (PEM).** Family doctors work in patient enrolment models to give you and your family continued access to quality primary health care services.

Enrolling with a family doctor who is participating in a PEM is your choice. If you choose to enrol, please fill out this form, **using a black or blue ball point pen**, as follows:

- To enrol **yourself** ..... *complete* ***Sections 1 & 3***
- To enrol **yourself** and up to **two** children under 16 years of age and/or dependent adults for whom you are a parent, legal guardian or attorney for personal care ..... *complete* ***Sections 1, 2 & 3***
- To enrol children under 16 years of age and/or dependent adults for whom you are a parent, legal guardian or attorney for personal care but **not** yourself .... *complete* ***Sections 2 & 3***
- To enrol **more than two** children under 16 years of age or dependent adults for whom you are a parent, legal guardian or attorney for personal care ..... *complete* ***Sections 2 & 3*** *on a separate form*

Note: If the mailing address includes a post office box (P.O. Box), rural route (R.R.), or general delivery, you must also complete the residence address.

If your family doctor is not already identified or is incorrectly identified in Section 4, please print his or her name inside the box in Section 4.

Your family doctor will acknowledge your enrolment form in Section 4 and will provide you with a copy for your records.

For questions about enrolment and consent, filling out this form or to receive additional forms, please call INFOline at 1 888 218–9929 (TTY 1 800 387–5559).

Instructions:

1. Remove this instruction page.
2. Complete the form as instructed above.
3. Read the back of the form and Section 3 before signing it.
4. Return all copies of the completed form in the envelope provided.

(Cette formule est aussi disponible en format bilingue. Pour recevoir une copie, composez : 1 888 218–9929)

4383-80 (03/08)

Ontario

Ministry of Health and Long-Term Care

Patient Enrolment and Consent to Release Personal Health Information

Microfilm use only

Please PRINT using black or blue ballpoint pen.

Collection of the information on this form is under the authority of the *Ministry of Health Act*, subsection 6(1) and (2) and the *Health Insurance Act*, R.S.O. 1990, c. H.6, s.4(2)(b) and (f), 4.1(1) and (2), 10 and 11(1). For information about collection practices, contact the Director, Registration and Claims Branch, Box 48, 49 Place d'Armes, Kingston ON K7L 5J3, INFOline tel. 1 888 218-9929 or by mail through the addresses listed for local Ministry of Health and Long-Term Care offices.

Section 1 – I want to enrol myself with the family doctor identified in Section 4

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

Send notices from my family doctor's office to me by:
☐ regular mail ☐ email *(if possible)*

Email Address:

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery | City/Town | Postal Code

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township | City/Town | Postal Code

or ☐ same as mailing address

Section 2 – I want to enrol my child(ren) under 16 and/or dependent adult(s) with the family doctor identified in Section 4

A

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery | City/Town | Postal Code

or ☐ same as Section 1

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township | City/Town | Postal Code

or ☐ same as Section 1

B

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery | City/Town | Postal Code

or ☐ same as Section 1

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township | City/Town | Postal Code

or ☐ same as Section 1

Section 3 – Signature

I have read and agree to the Patient Commitment, the Consent to Release Personal Health Information and the Cancellation Conditions on the back of this form. I acknowledge that this Enrolment is not intended to be a legally binding contract and is not intended to give rise to any new legal obligations between my family doctor and me.

I am signing on behalf of *(check all that apply)*
☐ myself ☐ child(ren) ☐ dependent adult(s)

My Name
last name | first name

Signature
X

Date *(yyyy/mm/dd)*

Home Telephone No.
( )

Work Telephone No.
( )

Section 4 – Family doctor information

(Include Billing no. and Group no.)

Family Doctor's Signature
X

Date *(yyyy/mm/dd)*

4383-80 (03/08)

PATIENT COPY

Patient Enrolment and Consent to Release Personal Health Information

Patient Commitment

I agree to contact my family doctor, (or if applicable the group to which my family doctor belongs or the designated Telephone Health Advisory Service if available to me), when I, or my enrolled child(ren) or dependent adult(s), need primary care medical advice or treatment. I promise to do this unless there is an emergency or I am travelling away from home.

I agree that if I or the person(s) I have signed for move, I will contact my family doctor's office or the ministry (see box below) with a new address and telephone number.

I understand that I can end my enrolment with this family doctor and enrol with another family doctor after six weeks have passed from the date that I complete and sign this form (immediately if I have moved). However, I agree not to change the doctor with whom I am enrolled more than twice a year.

I understand that by enrolling a child under 16 or a dependent adult, my signature on the front of this form means that I agree to these terms and conditions on behalf of that person. When an enrolled child reaches 16 years of age, the ministry will contact him or her to confirm enrolment/consent with the family doctor.

Consent to Release Personal Health Information

I understand that my family doctor will be able to offer better medical care if I permit my family doctor and the ministry to share appropriate and relevant information relating to my health.

I agree to allow my family doctor, other family doctors in the Patient Enrolment Model (if applicable) and the ministry to exchange the information in this form related to my enrolment.

I agree that my family doctor and the ministry can exchange information about my name, address and telephone number.

I agree to allow the ministry to release the following specific information to my family doctor:

- dates of immunizations (flu shots, etc.)
- dates of preventive care screening services (pap tests, mammograms, etc.)
- dates of service, fees paid and fee codes of primary health care services provided to me by a family doctor outside my family doctor's Patient Enrolment Model (if applicable).

If the Telephone Health Advisory Service is available to me, I agree to allow my family doctor and the ministry to exchange only the following information with the designated Telephone Health Advisory Service: my name, health number and version code, address, date of birth, gender.

I understand that this consent to release personal health information ends when:

- My enrolment with my family doctor ends or
- I cancel my consent by writing or telephoning the Ministry of Health and Long-Term Care (see box below).

The ministry will inform my family doctor when the consent is no longer valid. However, I understand that the information already released to my family doctor will remain in my medical file.

Cancellation Conditions

Enrolment with my family doctor and my consent to release personal health information will end when:

a) I cancel my enrolment by writing my family doctor or by writing or telephoning the ministry *(see box below);*
b) I no longer qualify for health care services under the *Health Insurance Act (Ontario);*
c) the Patient Enrolment Model to which my doctor belongs no longer exists;
d) my family doctor chooses to discontinue acting as my family doctor in accordance with the College of Physicians and Surgeons of Ontario guidelines;
e) I enrol with another family doctor; or
f) the ministry grants me an extended absence.

My enrolment with my family doctor and my consent to release personal health information may end when:

a) I consistently fail to meet the obligations to which I agreed in the Patient Commitment *(above);*
b) my family doctor leaves this Patient Enrolment Model;
c) I become a resident of a long-term care facility;
d) I am imprisoned in a provincial or federal correctional institution; or
e) I move outside the geographic area where the Patient Enrolment Model to which my family doctor belongs regularly provides services.

Contact Information:
Ministry of Health and Long-Term Care
P.O. Box 48, Station Main
Kingston ON K7L 9Z9
Call: INFOline 1 888 218–9929
TTY 1 800 387–5559

(Cette formule est aussi disponible en format bilingue. Pour recevoir une copie, composez : 1 888 218–9929)

4383-60 (00/08)

Appendix F: New patient declaration

Ontario Ministry of Health

Primary Health Care New Patient Declaration

Do not mail this form to the ministry. This form must remain in the physician's office for audit purposes.

Please complete this form if you are a new patient of a primary care physician and have signed a Patient Enrolment and Consent to Release Personal Health Information form. If you are signing on behalf of a child or dependent adult, and have completed a Patient Enrolment and Consent to Release Personal Health Information form on their behalf, complete the applicable sections below.

Declaration

I am signing on behalf of *(check the applicable boxes)*

- ☐ myself *(complete sections A and C)*
- ☐ the children listed below of whom I am the parent or guardian *(complete sections B and C)*
- ☐ the dependent adult (s) listed below for whom I have a power of attorney for personal care *(complete sections B and C)*

I hereby declare that the patient(s) named below does/do not have a family physician due to one or more of the following circumstances: *(check applicable boxes)*

- ☐ The patient's family physician has moved to another community.
- ☐ The patient has moved to another community.
- ☐ The patient's physician is no longer available due to illness/death/retirement.
- ☐ The patient's physician is no longer available due to change of practice type.
- ☐ Up until now the patient has not had, or felt the need for a family physician.

Section A: Patient Information

First Name	Last Name	Health Number

Section B: Children and Dependent Adults

	First Name	Last Name	Health Number
1.			
2.			

For additional children / dependent adults, please complete another New Patient Declaration form.

Section C: Signature and Date

Signature	Date yyyy/mm/dd

Section D: Physician Signature and Date

I declare that the above patient is not presently a patient of mine or, to the best of my knowledge, of any other physician in the primary care group with which I am affiliated (if applicable). I also declare that no child listed (if any) is a newborn of any existing enrolled or non-enrolled patient of mine, or to the best of my knowledge, of any other physician in the primary care group with which I am affiliated (if applicable).

I agree to accept the above-noted patient(s) into my practice and to provide ongoing health care to the patient(s) from the date of this document. I will keep this document available on file in my primary office location and will provide copies to the Ministry of Health as required for verification purposes.

Physician Last Name *(print)*	First Name *(print)*

Physician Signature	Date yyyy/mm/dd

4367-84 (2022/12)

Appendix G: Unattached patient declaration

Ontario Ministry of Health

Primary Health Care Unattached Patient Declaration

Do not mail this form to the ministry. This form must remain in the physician's office for audit purposes.

Please complete this form if you were an in-hospital patient, previously without a family physician, have been discharged from hospital and you have been accepted into the practice of a primary care physician and have signed a *Patient Enrolment and Consent to Release Personal Health Information* form. If you are signing on behalf of a child or dependent adult and have completed a *Patient Enrolment and Consent to Release Personal Health Information* form on their behalf, complete the applicable sections below.

Declaration

I am signing on behalf of *(check the applicable boxes)*

- ☐ Myself
- ☐ The child listed below of whom I am the parent or guardian
- ☐ The dependent adult listed below for whom I have a power of attorney for personal care

I hereby declare that the patient named below does not have a family physician due to one or more of the following circumstances: *(check applicable boxes)*

- ☐ The patient's family physician has moved to another community.
- ☐ The patient has moved to another community.
- ☐ The patient's family physician is no longer available due to illness/death/retirement.
- ☐ The patient's family physician is no longer available due to change of practice type.
- ☐ Up until now the patient has not had or felt the need for a family physician.

Sections A to C to be completed by patient / parent / guardian

Section A: Patient Information ☐ patient is a child or dependent adult

First Name	Last Name	Health Number

Section B: Hospital Stay Information

Name of hospital	Discharge Date
	yyyy/mm/dd

Section C: Patient / Guardian Signature and Date

Signature	Date
	yyyy/mm/dd

Section D: Physician Signature and Date *(to be completed by physician)*

I declare that to the best of my knowledge the above patient is not a patient of mine nor of any other family physician.

I also declare that the newborn listed is one that was admitted to a Neonatal Intensive Care Unit (NICU) within the last three months and is not a newborn of any existing enrolled or non-enrolled patient of mine or of any other physician.

I declare that the patient was an acute care patient in hospital, previously without a family physician and I accepted the patient into my practice, by enrolling the patient with the *Patient Enrolment and Consent to Release Personal Health Information* form within three months of his/her discharge from an in-patient hospital visit.

I agree to accept the above-noted patient into my practice and to provide ongoing primary health care to the patient from the date of this document. I will keep this document available on file in my primary office location and will provide copies of the same to the Ministry of Health as required for verification purposes.

Physician Last Name *(print)*	Physician First Name *(print)*

Physician Signature	Date
	yyyy/mm/dd

4431–84 (2022/11)

Appendix H: Enrolment codes

Code	Description	Fee	Forms Required
Q200A	**Enrolment Code** Used for all enrolments unless otherwise noted. This code pays $0 when submitted on its own; however, it must be submitted to qualify for other attachment fees and to trigger capitation payments, bonuses, and premiums.	$0	*Enrolment and Consent form*
Q202A	**Long-Term Care Enrollment Code** Is submitted when enrolling patients in a Long-Term Care Facility.	$0	*Enrolment and Consent Form*
Q023A	**Unattached Fee – Hospital Patient** Used when enrolling a previously unattached patient who has recently been discharged from the hospital. The patient must not have a family physician, and the patient must have had an acute care in-patient stay within the previous three months; Emergency Department and day surgery do not qualify.	$150	*Enrolment and Consent Form/ Unattached Patient Declaration Form*
Q043A	**Abnormal/Increased Risk Colorectal Cancer (CRC)** As part of the ColonCancerCheck program, Cancer Care Ontario is collecting and maintaining a referral list of physicians who are currently accepting new patients with an abnormal FIT result or at increased risk of CRC. For patients without a family physician and when abnormal results are obtained, the program will contact a physician from the referral list to arrange an appointment for follow-up care (e.g. referral to colonoscopy).	Fees are age-based $150 (< 65) $170 (65-74) $230 (75+)	*Enrolment and Consent Form/ New Patient Declaration*
Q054A	**Mother Newborn New Patient Fee** A one-time payment for physicians enrolling both an unattached mother and newborn within two weeks of giving birth or an unattached woman after 30 weeks of pregnancy.	$350	*Enrolment and Consent Form/ New Patient Declaration Form*
Q055A	**Multiple/Newborn Fee** In the case of multiple births, physicians may bill a Multiple Newborn Q055A fee code per newborn in addition to the Q054A Mother Newborn New Patient code for each additional newborn of an unattached mother.	$150	*Enrolment and Consent Form/ New Patient Declaration (mother only)*
TBD	**Health Care Connect (HCC)** May be claimed for enrolling a new patient through the HCC program where the patient is either: referred to the Physician through the Health Care Connect waitlist and identified as complex and/or vulnerable by Health Care Connect; or initially identified by Health Care Connect as non-complex or not vulnerable, but in the Physician's clinical opinion, is assessed to be complex and/or vulnerable.	$500	*Enrolment and Consent Form/ New Patient Declaration Form*
TBD	**Unattached Patient Code – No Complexity** This is used when enrolling a patient that is unattached and does not meet the eligibility requirements of any of the preceding codes for risk or complexity.	Career stage, patient age and OMA RIO score of primary office dependant	*Enrolment and Consent Form/ New Patient Declaration Form*

Appendix I: Annual network base capitation rates

FHO

Age Band	Annual Base Capitation Rate	
	Female	Male
0 - 4	138.79	145.77
5 - 9	75.87	77.44
10 - 14	65.76	62.63
15 - 19	114.17	65.81
20 - 24	142.37	65.02
25 - 29	147.88	70.28
30 - 34	149.22	82.06
35 - 39	161.97	100.54
40 - 44	167.43	113.17
45 - 49	182.23	123.71
50 - 54	203.98	143.45
55 - 59	206.22	162.78
60 - 64	211.13	180.00
65 - 69	254.80	231.17
70 - 74	274.74	269.71
75 - 79	334.44	328.04
80 - 84	363.36	354.58
85 - 89	444.02	420.57
90+	557.61	524.65

Appendix J: Annual base acuity rates

FHO

	2025-2026 Annual Acuity Rate					
	Band 1		Band 2		Band 3	
Age Band	Female	Male	Female	Male	Female	Male
0 - 4	1.57	1.68	2.99	3.08	3.20	3.30
5 - 9	0.96	0.97	1.48	1.52	2.02	2.07
10 - 14	0.93	0.90	1.32	1.31	1.88	1.85
15 - 19	1.52	0.98	2.07	1.42	2.94	2.08
20 - 24	1.93	1.02	2.68	1.52	3.81	2.38
25 - 29	2.19	1.19	2.85	1.62	3.94	2.48
30 - 34	2.44	1.46	3.18	1.92	4.32	2.86
35 - 39	2.47	1.60	3.41	2.20	4.63	3.26
40 - 44	2.59	1.67	3.65	2.38	4.98	3.59
45 - 49	2.72	1.73	3.90	2.56	5.34	3.87
50 - 54	2.82	1.82	4.16	2.81	5.70	4.16
55 - 59	2.72	1.95	4.17	3.07	5.79	4.50
60 - 64	2.60	2.05	4.14	3.30	5.80	4.80
65 - 69	3.04	2.57	4.59	3.86	6.24	5.34
70 - 74	3.09	2.68	4.77	4.10	6.47	5.60
75 - 79	3.32	2.96	5.13	4.47	6.89	5.98
80 - 84	3.45	3.26	5.33	4.84	7.10	6.36
85 - 89	3.52	3.57	5.45	5.21	7.16	6.71
90+	3.17	3.74	5.09	5.39	6.67	6.83

Source: Ontario Ministry of Health

Note: These rates do not include any temporary increases (ex. relativity)

Prepared by OMA Economics, Policy and Research. September 2025

FHO

	2025-2026 Annual Acuity Rate			
	Band 4		Band 5	
Age Band	Female	Male	Female	Male
0 - 4	3.56	3.69	4.85	5.02
5 - 9	2.72	2.76	4.20	4.20
10 - 14	2.68	2.60	4.52	4.26
15 - 19	4.16	3.05	7.00	5.46
20 - 24	5.26	3.67	8.72	7.02
25 - 29	5.47	3.94	9.20	7.65
30 - 34	5.90	4.46	9.70	8.34
35 - 39	6.34	5.02	10.34	9.00
40 - 44	6.85	5.48	11.21	9.54
45 - 49	7.36	5.84	12.08	10.08
50 - 54	7.86	6.15	12.85	10.50
55 - 59	8.07	6.59	13.28	11.19
60 - 64	8.13	6.94	13.40	11.63
65 - 69	8.55	7.43	13.72	12.05
70 - 74	8.81	7.68	14.01	12.30
75 - 79	9.28	8.07	14.56	12.69
80 - 84	9.50	8.43	14.76	13.01
85 - 89	9.48	8.75	14.64	13.32
90+	8.78	8.70	13.46	12.93

Source: Ontario Ministry of Health

Note: These rates do not include any temporary increases (ex. relativity).

Prepared by OMA Economics, Policy and Research. September 2025

Appendix K: In-basket procedures with 50 per cent shadow billing

CORE SERVICES PROCEDURES WITH 50% TOTAL SHADOW BILLING

FSC	FSC Descriptor
G365A	D./T. PROC.-GYNAECOLOGY-PAPANICOLAOU SMEAR
G378A	D./T. PROC. GYNAECOLOGY-INSERTION OF IUD
G552A	D./T. PROC. GYNAECOLOGY-REMOVAL OF IUD
R048A	SKIN-EXC.-LOC.MALIG.INCL.BIOPSY-FACE/NECK-1 LESION.
R051A	INTEG.SYST.SKIN-LASER SURG.ON GR.1 TO 4 MALIG.LESIONS
R094A	SKIN-EXC-SIMPLE-MALIG.LESION-OTHER AREA-INCL.BIOPSY-ONE.
Z101A	SKIN-INC.-ABSCESS-SUBCUT.-ONE -LOC.ANAES.
Z110A	INTEGUMENTARY SYST.EXTEN.DEBRIBEMT ONYCHOGRYPHOTIC NAIL
Z113A	INTEGUMENTARY SYST.BIOPSY(S)-ANY METHODSUTURES NOT USED
Z114A	SKIN-INC.-FOREIGN BODY-LOC. ANAES.
Z116A	SURG.PROC SKIN-BIOPSY(S)ANY METHOD WHEN SUTURES USED
Z117A	SKIN.CHEM/CRYOTHERAPY MINOR SKIN LESIONS 1/MORE
Z122A	SKIN-EXC.-GROUP 4-FACE/NECK-ONE LESION-LOC. ANAES.
Z125A	SKIN-EXC.-GROUP 4-OTHER AREAS-ONE LESION-LOC. ANAES.
Z128A	SKIN-DESTRUCTION FINGER/TOENAIL PART/COMP./NAIL PLATE EXC.1

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FSC	FSC Descriptor
Z129A	SKIN-DESTRUCTION-FINGER/TOENAIL-SIMPLE-PART/COMPL.-MULTI
Z154A	SKIN-SUTURE LACER.-UPTO 5CM.-FACE-TIE BLEEDERS/LAYERS.
Z156A	SKIN-EXC-SUT.-BENIGN LESIONS-SINGLE.
Z157A	SKIN-EXC-SUT.-BENIGN LESIONS-TWO LESIONS.
Z158A	SKIN-EXC-SUT.-BENIGN LESIONS-THREE/MORE LESIONS.
Z159A	SKIN-& SUBCUT-REMOVAL BY ELECTROCOAG.-SINGLE LESION
Z160A	SKIN-& SUBCUT-REMOVAL BY ELECTROCOAG.-TWO LESIONS
Z161A	SKIN & SUBCUT.-REMOVAL BY ELECTROCOAG.-THREE/MORE LESIONS
Z162A	SKIN-EXC-SUT.-NAEVUS-ONE.
Z175A	SKIN-SUTURE LACER.-5.1CM-10CM.-OTHER AREA.
Z176A	SKIN-SUTURE-LACERATION-UPTO 5CM.
Z314A	NOSE-EPISTAXIS-CHEM/ELECTROCAUTERY-UNIL.
Z315A	NOSE-EPISTAXIS-ANTERIOR PACKING
Z535A	INTESTINES-ENDOSCOPY-SIGMOIDOSCOPY W/WITHOUT ANOSCOPY
Z543A	ANUS-ANOSCOPY
Z545A	ANUS-INC. THROMBOSED HAEMORRHOID
Z847A	EYE-CORNEA-INCISION-REM. SINGLE EMBEDDED FOREIGN BODY LOC.
E542A	SKIN/SUBCUT TISSUE-INSERTION OF SUTURES OUTSIDE HOSP-ADD
G462A	Administration of oral polio vaccine
G538A	IMMUNIZATION - Other immunizing agents not listed above

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FSC	FSC Descriptor
G840A	IMMUNIZATION - Diphtheria, Tetanus, and acellular Pertussis vaccine/ Inactivated Poliovirus vaccine (DTaP-IPV) – paediatric
G841A	IMMUNIZATION - Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Virus, Haemophilus influenza type b (DTaP-IPV-Hib) – paediatric
G842A	IMMUNIZATION - Hepatitis B (HB)
G843A	IMMUNIZATION - Human Papillomavirus (HPV)
G844A	IMMUNIZATION - Meningococcal C Conjugate (Men-C)
G845A	IMMUNIZATION - Measles, Mumps, Rubella (MMR)
G846A	IMMUNIZATION - Pneumococcal Conjugate
G847A	IMMUNIZATION - Diphtheria, Tetanus, acellular Pertussis (Tdap) – adult
G848A	IMMUNIZATION - Varicella (VAR)

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Appendix L: Age premiums

GENERAL PREAMBLE

AGE-BASED FEE PREMIUMS

1. Despite any other provision in this *Schedule*, the amount payable for the following services to an insured person who falls into the age group described in the Age Group column of the following Age Premium Table is increased by the percentage specified in Percentage Increase column opposite the Age Group:
   - **a.** A consultation, limited consultation or repeat consultation rendered by a *specialist*, as those services are defined in this *Schedule*.
   - **b.** A surgical procedure listed in Parts K to Z inclusive of this *Schedule*.
   - **c.** Basic and time unit surgical assistant services listed in Parts K to Z inclusive of this *Schedule*.
   - **d.** Clinical Procedures associated with Diagnostic Radiological Examinations.
   - **e.** A specific assessment or a partial assessment rendered by a specialist in ophthalmology (23) (A233 or A234).
   - **f.** A Midwife or Aboriginal Midwife-Requested Special Assessment (A815, C815 or A817) or a Midwife or Aboriginal Midwife-Requested Assessment (A813, C813 or A814) rendered by a *specialist*.

age premium table

Item	Age Group	Percentage Increase
1	Less than 30 days of age	30%
2	At least 30 days but less than one year of age	25%
3	At least one year but less than two years of age	20%
4	At least two years but less than five years of age	15%
5	At least five years but less than 16 years of age	10%

2. Despite any other provision in this *Schedule*, the amount payable for the following services to an insured person who is at least 65 years of age, as those services are defined in this *Schedule*, is increased by 15 per cent:
   - **a.** A general assessment (A003, C003, W102, or W109);
   - **b.** A general re-assessment (A004, C004, W004);
   - **c.** An intermediate assessment (A007);
   - **d.** A focused practice assessment (A917, A927, A937, A947, A957 or A967);
   - **e.** A periodic health visit (K132).
   - **f.** Comprehensive assessment and care (H102, H122, H132, H152)
   - **g.** A multiple systems assessment (H103, H123, H133, H153)

GP64 March 9, 2026 (effective April 1, 2026)

Appendix M: Preventive care bonus and special premiums

8.0 SERVICE ENHANCEMENT CODES AND SPECIAL PAYMENTS

8.1 **Cumulative Preventive Care Management Service Enhancement Codes.** A FHO Physician may claim the following Service Enhancement who has administered a high cumulative level of preventive care to their roster of patients.

A FHO Physician may make one claim per year under each of the following two headings per year:

(i) **Influenza Vaccine for Enrolled Patients over 65**
Pursuant to section 3.3 of this Appendix, the Ministry will issue payments for valid claims for Services Enhancement codes. This Service Enhancement Fee is calculated annually on an individual FHO physician basis is based on the percentage of the target population who have received the influenza vaccine appropriate for that influenza season by January 31*st* of the fiscal year for which the bonus is being claimed. The target population consists of enrolled patients who are 65 years or older as of December 31st of the fiscal year for which the bonus is being claimed.

Percentage of Enrolled Patients	*Fee Payable*	*Service Enhancement Code*
60%	*$220*	*Q100A*
65%	*$440*	*Q101A*
70%	*$770*	*Q102A*
75%	*$1100*	*Q103A*
80%	*$2200*	*Q104A*

(ii) **Childhood Immunizations for Enrolled Patients**
This bonus is based on the percentage of the target population who have received all of the Ministry-supplied immunizations as recommended by the National Advisory Committee on Immunization. The **target population** consists of Enrolled Patients who are aged 30 to 42 months of age, inclusive as of March 31st of the fiscal year for which the bonus is being claimed. These patients must have received all applicable immunizations by 30 months of age.

Percentage of Enrolled Patients	Fee Payable	Service Enhancement Code
85%	$440	Q115A
90%	$1100	Q116A
95%	$2200	Q117A

8.2 **Payments for Services Enhancement Codes**. Pursuant to section 3.3 of this Appendix, the Ministry will issue payments for valid claims for Services Enhancement codes payable under section 8.1. For practices less than 1,000 Enrolled Patients the two enhancement codes in that section will be available on a prorated basis.

8.3 **Special Payments.** A FHO Physician is eligible to qualify for each of the special payments described below in any fiscal year. Special payments will not be paid for both labour and deliveries and prenatal care. The provision of any services listed in sections 8.7, 8.8, and 8.9 by a nurse practitioner, registered to the FHO, will count towards the FHO Physician's fulfillment of the obligations to qualify for each of these Special Payments provided that the nurse practitioner submits valid claims billed at $0.00 for these services for Enrolled Patients in accordance with the provisions of this Appendix.

Additionally, the provision of any services listed in sections 8.4-8.11 by a FHO Contracted Physician, registered to the FHO, will count toward the FHO Physician's fulfillment of the obligations to qualify for each of these Special Payments provided that the FHO Contracted Physician submits claims for these services to Enrolled Patients in accordance with the provisions of this Appendix.

8.4 **Special Payment for Labour and Delivery.** Pursuant to section 3.2, a FHO Physician shall receive an additional $5,000.00 after submitting valid claims for five (5) or more services from the following Fee Schedule codes: P006A, P007A, P009A, P018A, P020A, P038A and P041A with an additional $3,000 after submitting valid claims for 23 or more patients in any fiscal year.

8.5 **Special Payment for Hospital Services.** A FHO physician may earn the following Hospital Services Bonus(es) if they accumulate the listed amounts below based on the provision of insured services under the fee codes set out in Schedule 3 to this Appendix I to Enrolled Patients and Non-Enrolled Patients:

(i) $5,000 upon accumulation of $2,000 in any fiscal year;

(ii) $7,500 upon accumulation of $2,000 in any fiscal year if a FHO Physician is located in a Northern and/or Rural Community, as evidenced by the office that the physician regularly provides FHO Services (as registered with the Ministry) or the hospital in which they regularly provide hospital services have a Designated RIO Area of forty (40) or greater or the following Northern Urban Referral Centres: Sudbury, Timmins, North Bay, Sault Ste Marie or Thunder Bay, or such other communities as may be agreed to in writing by the OMA and the Ministry and , as the case may be ("Level A"); or

(iii) Upon accumulation of $6,000 in any fiscal year for those qualifying for the payment in subsection (ii), the Ministry will issue an additional payment of $5,000 for a total of $12,500.

8.6 **Special Payment for Palliative Care.** The following additional Fee Schedule Codes will accumulate to Palliative Care special premium thresholds for enrolled and non-enrolled patients: K023A, C882A, A945A, C945A, W882A, W872A, B997A and B998A.

In order to receive the Premium payment, a Physician must reach the following thresholds:

Bonus Level	A	C
Necessary annual criteria	4 or more patients served	10 or more patients served
Annual Bonus	$2,400	An additional $3,600 for a total of $6,000.

8.7 **Special Payment for Office Procedures.** Pursuant to section 3.2 of this Appendix, a FHO Physician shall receive an additional $2,000.00 after submitting valid claims for services to Enrolled Patients totalling $1,200.00 or more in any fiscal year from the list of services set out in Schedule 4 to this Appendix.

8.8 **Special Payment for Prenatal Care.** Pursuant to section 3.2 of this Appendix, a FHO Physician shall receive an additional $2,000.00 after submitting valid claims for fee schedule codes P003A and/or P004A for prenatal care during the first 28 weeks of gestation for 5 or more Enrolled Patients in any fiscal year.

8.9 **Special Payment for Home Visits (Other Than Palliative Care).** A FHO Physician shall receive the following Home Visit annual bonuses after submitting valid claims for fee codes A900A, A902A, B990A, B992A, B993A, B994A and B996A.

Bonus Level	A	B	C	D
Necessary Annual Criteria	3 or more patients served and	6 or more patients served and	17 or more patients served and	32 or more patients served and
	12 or more encounters	24 or more encounters	68 or more encounters	128 or more encounters
Total Annual Bonus	$1,500	$3,000	$5,000	$8,000

8.10 **Special Payment for Long-Term Care.** The following additional Fee Schedule Codes will accumulate to Long-Term Care premium thresholds for non-enrolled and Enrolled Patients: W001A, W002A, W003A, W004A, W008A, W010A, W102A, W104A, W107A, W109A, W121A, W777A, W903A.

In order to receive the Premium payment, a physician must reach the following thresholds:

Bonus Level	A	C
Necessary annual criteria	12 or more patients served	36 or more patients served

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Annual Bonus	$2,400	An additional $3,600 for a total of $6,000.

8.11 **Premiums for Primary Health Care of Patients with Serious Mental Illness.** Pursuant to section 3.2 of this Appendix, the Ministry shall issue the following payments:

(a) an additional $1,200 per fiscal year when during that fiscal year, at least 5 patients with diagnoses of bipolar disorder or schizophrenia are managed by the FHO Physician.

Fee Schedule codes for services provided to these patients must be accompanied by tracking code Q021A for schizophrenia and tracking code Q020A for bipolar disorder, and the patient must be enrolled to the billing physician in order for the premium to be paid; and

(b) an additional $1,200 ($2,400 in total) premium for at least an additional 5 patients (i.e. at least 10 patients in total) subject to the Physician satisfying section 8.10(a) of this Appendix.

8.12 **After Hours Premium Payments.** Pursuant to section 3.5 of this Appendix, the Ministry shall issue a payment equivalent to a 50% premium on the full value of fee codes A001A, A003A, A004A, A007A, A008A, A888A, K005A, K013A, K017A, K030A, K033A, K130A, K131A, K132A, K133A, Q050A, Q888A, for valid claims for Services provided to Enrolled Patients during Recognized Holidays and Evening and Weekend Hours.

A fee service code Q012A must accompany each submitted claim in order for the premium to be paid.

Appendix N: Office practice administration annual reporting form

Appendix B – Office Practice Administration [OPA]
Funding Grant Annual Reporting Form

Date: _____

Harmonized Model Group: _____ **Group ID:** _____

Lead Physician Name: _____ **Tel. No:** _____

Location: _____

Fiscal year: _____ **Total OPA Grant received:** _____

Number of Physicians in Group: _____

Administrator Name(s)	Employment Period(s) From (dd/mm/yy to dd/mm/yy)	Total number of hours worked

Please provide an outline of the administrator's functions:
(Use a separate sheet of paper where necessary)

- ☐ **Group Administration**
- ☐ **Group On-call and Extended Hours Organization**
- ☐ **Assistance with Information**
- ☐ **Technology implementation**
- ☐ **Planning for interdisciplinary teams**

Other (please specify): _____

_____

_____

Please complete the form for the period between April 1, 2025- March 31, 2026, and return the OPA Funding Annual Reporting form by **April 30, 2026**.

N.B. The ministry is unable to accept mailed or faxed submissions

You may only submit your form by email to blendedmodelsreports@ontario.ca

Office Practice Administration *Page 4 of 4*

Appendix O: Request for exemption from after-hours form

REQUEST FOR EXEMPTION FROM AFTER-HOURS

REQUIREMENT PLEASE COMPLETE BOTH

SECTIONS A and B.

The physician(s) of the _____ Family Health Organization (FHO) listed in Section A request exemption from the obligation to provide after-hours services due to:

More than 50% of the group's total physicians regularly providing one or more of the following services listed under Section A ***after 5 pm weekdays and/or on weekends.***

In order to qualify for the after-hours exemption, the individual physician must be engaged in the services listed below in (i), (ii), (iii), and (iv) for at least 6 hours per week or provide services as specified in (v) and (vi), or be on call as specified in (vii).

All exemptions end on December 31st of the calendar year, groups that wish to be exempt from after hours requirements in the coming year must reapply by November 30th for exemption.

Exemptions are based on annual engagement or projected deliverable:

If applying to be exempt for any of i), ii), iv) & vii) below, the physician must be on the hospital/facility roster until December 31st of the calendar year.

If applying to be exempt for any of iii), v) & vi), projected deliverables must be based on the average number of services provided immediately before the application date and within the indicated timeframes per relevant category.

SECTION A:

Instruction for completing Section A:

Please list each group physician requesting exemption and write the weekly hours or service encounters to indicate the service(s) that (s) he is currently providing in the table below. If more lines are needed, please attach a separate sheet to this form.

i) Regular public hospital emergency room coverage – *based on your weekly ED roster with the hospital, please indicate the name of the hospital and only the total hours of services you provide after 5pm on weekdays or during the weekends.*

ii) Public hospital anaesthesia on-call services on a regular basis - *based on your weekly anaesthesia on-call roster with the hospital, please indicate the name of the hospital and only the total hours of services you provide after 5pm on weekdays or during the weekends.*

iii) Obstetrical deliveries outside of regular office hours – *Only indicate the total hours engaged in obstetrical deliveries outside of regular office hours.*

iv) Regular after-hours care of hospital in-patients - *based on your weekly hospital roster for after-hours care of in- patients, please indicate the name of the hospital, the average number of patients visited and the hours of services you provide after 5pm on a weekly basis.*

v) Provision of palliative care as indicated by at least 4 palliative care patient home visits per week averaged over a 3 month period – please *only indicate palliative care home visits that were provided after 5pm weekdays or during the weekend.*

vi) Provision of services in a LTC/nursing home (for non-enrolled patients) as demonstrated by at least 10 patient visits per week averaged over a 3 month period - *please list the name of the LTC/nursing home and the average number of non-enrolled patients visited per week after 5pm weekdays or during the weekend.*

vii) Complex continuing care on-call as established by a call schedule in a complex continuing care facility – *please list the name of the Complex Continuing Care facility where you provide on call services, and only list your average hours of on call per week.*

Please note the ministry may request additional documents if needed to complete the review for exemption.

Name of Physician	Billing #	(i) Regular public hospital emergency room coverage (**starting after 5pm or on weekends) total weekly hours**	ii) Public hospital anaesthesia on-call services on a regular basis (**starting after 5pm or on weekends) total weekly hours**	iii) Obstetrical deliveries outside of regular office hours (**weekly starting after 5pm or on weekends)**	iv) Regular after-hours care of hospital in-patients (**starting after 5pm or on weekends) total weekly hours**	v) Provision of palliative care as indicated by at least 4 palliative care patient home visits per week (after 5pm or on weekends) averaged over a 3 month period	vi) Provision of services in a LTC/ nursing home (for non- enrolled patients) as demonstrated by at least 10 patient visits per week (after 5pm or on weekends) averaged over a 3 month period	vii) Complex continuing care on-call as established by a call schedule in a complex continuing care facility
Example	000000	Centenary hospital – 6hrs	St. Michael's- 6hrs	6 hours	Brampton Civic, Avg. 10 pts., 6 hrs	5	Providence Nursing Home, 10 pts	Michael Garron Hosp. 6hrs per week

SECTION B: TO BE COMPLETED BY LEAD PHYSICIAN

This submission is sent for (please check): Commencement ☐ In-year change ☐ Annual renewal ☐

As the Lead Physician of the group, I am confirming that I have verified each physician's weekly hours and service encounters as listed in Section A and it is true to the best of my knowledge.

☐ **Lead Physician Name: _____ Lead Physician Signature: _____**

Appendix P: Contracted physician start and end date/declaration forms

Ontario Ministry of Health

Contracted Physician Start and End Date

Important Notice: To facilitate timely processing of your Family Health Organization **Contracted Physician** application, please complete the requested information below and submit a scanned copy by email to:

primarycareinquiries@ontario.ca

Fax and mail submissions are not accepted. Additionally, incomplete applications (i.e. missing/incorrect billing number, signatures) will be returned for correction and re-submission.

Contracted Physician

Last Name	First Name	Billing Number
Name of FHO		Group ID

Contracted Physician will practice with the FHO group

from _____ to _____ . (maximum one year)
Date (yyyy/mm/dd) Date (yyyy/mm/dd)

Extension option: To extend an affiliation without any gap beyond the current term, the physician must submit a new completed "Contracted Physician Start and End Date" at least 30 days in advance of the expiry of the current term.

By signing below I confirm that the information provided above is true, complete and accurate.

Practice Address

Unit Number	Street Number	Street Name	PO Box
City/Town		Province	Postal Code
Email Address		Telephone Number (back line)	

Contracted Physician Signature	Date (yyyy/mm/dd)
FHO Lead Physician Signature	Date (yyyy/mm/dd)

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APPENDIX D

FAMILY HEALTH ORGANIZATION
CONTRACTED PHYSICIAN DECLARATION

TO: THE MINISTRY OF HEALTH (the "**Ministry**")

AND TO: THE GENERAL MANAGER OF THE ONTARIO HEALTH INSURANCE PLAN (the "**General Manager**")

SECTION ONE: FHO CONTRACTED PHYSICIAN DECLARATION	
In the event the FHO Contracted Physician is a natural person, please complete the box below:	In the event the FHO Contracted Physician is a medicine professional corporation please complete the box below:
IN CONSIDERATION of the Ministry and the Family Health Organization (the "**FHO**") entering into the Family Health Organization Agreement (the "**Agreement**") under which the Ministry shall remunerate the undersigned physician and the FHO for the services to be provided as set out under the Agreement, the undersigned physician, _____ [Insert name of physician] hereby declares and acknowledges as follows:	IN CONSIDERATION of the Ministry and the Family Health Organization (the "**FHO**") entering into the Family Health Organization Agreement (the "**Agreement**") under which the Ministry shall remunerate _____ [insert name of medicine professional corporation] and the FHO for the services to be provided as set out under the Agreement, _____, [insert name of medicine professional corporation] a body corporate duly incorporated under the laws of the Province of Ontario, hereby declares and acknowledges as follows:

The undersigned confirms:

(a) I will support the Family Health Organization's ongoing efforts to enable patients to receive a response from the group with respect to administrative matters during regular business hours, including via email, text, phone or other combination.

(b) I will support the Family Health Organization's efforts to provide appropriate access that meets the needs of the practice's patients including meeting contractually required after-hours coverage.

(c) I will not direct patients to attend at an Emergency Department during regular business hours, and contractually required after hours, for conditions which can be appropriately assessed by a FHO physician.

(d) I will make best efforts to arrange clinically appropriate coverage when away from the practice which may include arranging cross coverage by other physicians in the Family Health Organization.

The undersigned has received a copy of the Agreement and have reviewed and fully understand the terms of the Agreement. The undersigned agrees to be bound by all applicable terms of the Agreement.

As long as the undersigned is a FHO Contracted Physician the undersigned shall not claim directly or indirectly, or accept payment, or authorize any person to claim for or accept payment from the Ontario Health Insurance Plan (the "**Plan**") or from any other person, for any FHO Services provided to Enrolled Patients other than as provided in the Agreement.

The undersigned acknowledges and agrees that all payments to be made under the Agreement shall be made to the bank account specified by the FHO Physicians in accordance with the Governance Requirements as defined and as set out in the Agreement.

In the event that the undersigned breaches any of the claim, payment or funding provisions set out in the Agreement, or where the undersigned owes a debt to the Minister for any other reason,

(a) the Ministry may retain, by way of deduction or set-off, out of any money that is due and payable to the undersigned by the FHO under the Agreement, all or part of such money as the Ministry sees fit in the circumstances; and

(b) the General Manager may retain, by way of deduction or set-off, under the Health Insurance Act, out of any money that is due and payable to the undersigned by the FHO or by the Plan, all or part of such money as permitted by that Act and the Agreement.

(c) In the event that the General Manager does retain by way of a deduction or set-off any money due and payable to the FHO as a result of such debt of the undersigned, the FHO shall be entitled to deduct such amounts from any amounts payable to the undersigned by the FHO.

The undersigned confirms that Dr. _____, as Lead FHO Physician, and Dr. _____ as Associate FHO Physician, have the authority to act on my/our behalf in accordance with the Governance Requirements as defined and as set out in the Agreement.

Dated at _____ this _____ day of _____ , _____.

Name _____
Billing Number _____
Office Address _____

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Email Address _____
Phone Number _____
Name of FHO _____

In the event the FHO Contracted Physician is a natural person:

_____ _____
Signature: Physician Witness

OR

In the event the FHO Contracted Physician is a medicine professional corporation:

The _____ [insert name of corporation] hereby further represents, warrants to and covenants with the Ministry as follows:

1. The _____ [insert name of corporation] is a corporation duly incorporated and validly subsisting pursuant to the laws of Ontario;
2. The _____ [insert name of corporation] has full power and authority to enter into this Agreement and to observe, perform and comply with the terms and conditions of this Agreement, and all necessary action and procedures have been taken in order to enter into and authorize this Agreement; and
3. The _____ [insert name of corporation] holds and shall continue to hold all registrations and certificates necessary to carry on business in Ontario and to perform its obligations under this Agreement.
4. The Participating Voting Shareholder designated by the [insert name of corporation] to provide FHO Services on behalf of the corporation is: [insert physician name]; and
5. Except for the Participating Voting Shareholder designated in paragraph 4 above and any other FHO Physician or FHO Contracted Physician, no Physician shall provide FHO Services on behalf of the [insert name of corporation] unless agreed to in writing by the Ministry and the OMA.

_____ _____
Signature of Authorized Signing Officer Witness

Name and Title: _____

I have the authority to bind the _____ [insert name of Professional Corporation]

SECTION TWO: SHAREHOLDER ACKNOWLEDGEMENT

To be completed in the event the FHO Contracted Physician is a Medicine Professional Corporation by a Participating Voting Shareholder of that corporation:	
Name of Participating Voting Shareholder: Billing Number:	Office Address: Phone Number: Fax Number:

I, the undersigned physician, being a Participating Voting Shareholder in the _____ _____, [insert name of professional corporation] hereby acknowledge and agree that the Ministry's rights as set out in sections 3 and 4 of this Declaration, and sections 11.8 and 11.9 of the Agreement, shall apply to me in my personal capacity.

Name of the Participating Voting Shareholder(s):

_____ _____

Name: Witness

SECTION THREE: LEAD PHYSICIAN DECLARATION

I, _____ (Lead Physician), confirm that _____ (Physician) has received a copy of the Agreement and the FHO Governance Document(s) and by the signing of this Appendix has agreed to be bound by them. I agree on behalf of the FHO to provide to the Ministry such information as may be reasonably required for the purposes of this Appendix.

_____

Signature: Lead Physician

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