Australian Government

Department of Health and Ageing

HOME CARE PACKAGES PROGRAM GUIDELINES

AUGUST 2013

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FOREWORD

These Guidelines provide policy guidance to support the delivery and management of the Home Care Packages Program, including the policy context for the *Living Longer Living Better* aged care reforms.

The Home Care Packages Program commences on 1 August 2013, replacing the former packaged care programs – Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) packages and Extended Aged Care at Home Dementia (EACHD) packages.

The Guidelines refer to elements of the legislative framework, but they are not intended to be a source of legal advice for providers, consumers or other stakeholders.

Most of the information in these Guidelines is relevant to all types of packages, whether delivered on a Consumer Directed Care (CDC) basis or not. In some cases, the Guidelines relate specifically to the packages delivered on a CDC basis, for example, the individualised budget described in Part D.

The Guidelines are primarily for use by home care providers, although they have been written with a broader audience in mind. The Guidelines will be complemented by other resources, including frequently asked questions and information resources for consumers.

The development of the Guidelines was informed by advice from the National Aged Care Alliance, and feedback received from peak groups, organisations and individuals during consultations on the draft Guidelines in April and May 2013.

The Guidelines will be updated in the first half of 2014 to include information on the new income testing and care subsidy reduction arrangement that will apply in home care from July 2014.

Terminology

Consumer

In the Guidelines, the term "consumer" is used to refer to the person receiving care and services through a Home Care Package.

"Consumer" is the terminology preferred by the National Aged Care Alliance, rather than "client", "customer" or "care recipient".

It should be noted that the term "care recipient" is used in the legislation (the *Aged Care Act 1997* and in the associated Principles and Determinations made under the Act). "Consumer" is not a defined term under the legislation.

It is recognised that the consumer is often supported by a carer/s, who may be a spouse, partner, an adult child, or another family member. In some cases, the carer or another person may be legally authorised to act on behalf of the consumer. In these Guidelines, references to the consumer include other people authorised to act on behalf of the consumer.

Home care provider

In these Guidelines, the term "home care provider" is generally used to refer to the corporation that has been approved by the Department of Health and Ageing under Part 2.1 of the Act as suitable to provide home care.

The term "approved provider" is used in the legislation.

In some parts of the Guidelines, there are a number of legislative references to matters affecting approved providers, eg Part F (Rights and Responsibilities) and Part I (Administrative Arrangements for Approved Providers). In these parts, the term "approved provider" is used rather than "home care provider".

Glossary of terms

There is a glossary of terms at the end of these Guidelines – Part K.

PART A – INTRODUCTION

Covered in this part

- Aged Care Reforms
- New Home Care Packages Program
  - Package levels
  - Program objectives
  - Target population
  - Special needs groups
  - People with dementia
- Consumer Directed Care
  - CDC in the context of Home Care Packages
  - CDC Principles
- Use of innovative and digital technology
- Evaluation
- Legal Framework
- Pathway for the Consumer

1. *Living Longer Living Better* Aged Care Reforms

On 20 April 2012, the Australian Government unveiled *Living Longer Living Better*, a comprehensive 10 year package to reshape aged care in Australia.

The *Living Longer Living Better* aged care reform package provides $3.7 billion over five years. It encompasses a 10 year reform program to create a flexible and seamless system that provides older Australians with more choice, control and easier access to a full range of services, where they want it and when they need it.

As part of these reforms, the Australian Government is significantly expanding home care to assist people to remain living at home for as long as possible, and to introduce more choice and flexibility for people receiving care at home.

The Government is providing $880 million over five years to increase the total number of Home Care Packages from around 60,000 packages (in 2012) to around 100,000 packages (by 2016-17). More than 40,000 additional packages are expected to be available over the following five year period, from 2017-18 to 2021-22.

2. Home Care Packages Program

2.1 Package levels

There are four levels of Home Care Packages, including two new levels:

- Home Care Level 1 – a new package to support people with basic care needs.
- Home Care Level 2 – a package to support people with low level care needs, equivalent to the former Community Aged Care Package (CACP).

- Home Care Level 3 – a new package to support people with intermediate care needs.
- Home Care Level 4 – a package to support people with high care needs, equivalent to the former Extended Aged Care at Home (EACH) package.

These packages form a new Home Care Packages Program which commences on 1 August 2013.

The Home Care Packages Program replaces the former Community Packaged Care Programs, which comprised Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) packages and Extended Aged Care at Home Dementia (EACHD) packages. Transitional arrangements are explained in Part B, Section 2.

It is no longer necessary to have a separate EACHD level, as a Dementia and Cognition Supplement will be available to all home care providers that provide care to consumers who meet the eligibility criteria for the supplement (across any of the four levels of Home Care Packages). There is also a Veterans' Supplement for veterans with an accepted mental health condition. Further information on the supplements is at Part H.

The first group of Home Care Packages (a total of 5,835 packages) is being allocated through the 2012-13 Aged Care Approvals Round (ACAR).

For successful applicants in the 2012-13 ACAR, there are conditions of allocation requiring all of the packages to be delivered on a Consumer Directed Care (CDC) basis. Successful applicants are also required to participate in an evaluation of the Home Care Packages Program, including the CDC arrangements.

2.2 Program objectives

The objectives of the Home Care Packages Program are:

- to assist people to remain living at home for as long as possible; and
- to enable consumers to have choice and flexibility in the way that care and support is provided at home.

These objectives are relevant to all packages funded under the Home Care Packages Program, whether delivered on a CDC basis or not. CDC provides an additional framework to assist providers and consumers to maximise the amount of choice and flexibility in the delivery of the packages.

2.3 Target population

There is not a minimum age requirement for eligibility purposes, but the Home Care Packages Program is targeted at frail older people. In 2011-12, the average age of admission into a CACP, EACH or EACHD package was 81 years. For Aboriginal and

Torres Strait Islander people, the average age of admission into a CACP, EACH or EACHD package was 66 years.

In some cases, younger people with disabilities, dementia or special care needs may be able to access a Home Care Package – if the person has been assessed and approved by an ACAT, and a home care provider is able to offer an appropriate package for the person.

Eligibility requirements are explained further in Part C, Sections 2 and 3.

2.4 Special needs groups

Under the *Aged Care Act 1997*, people with special needs include people who identify with or belong to one or more of the following groups:

- people from Aboriginal and Torres Strait Islander communities;
- people from culturally and linguistically diverse backgrounds;
- people who live in rural and remote areas;
- people who are financially or socially disadvantaged;
- veterans;
- people who are homeless, or at risk of becoming homeless;
- people who identify as lesbian, gay, bisexual, transgender or intersex;
- people who are care leavers; and
- parents separated from their children by forced adoption or removal.

Packages are sometimes allocated to a home care provider on the condition that priority of access is given to people who belong to defined special needs groups. However, all home care providers are expected to have policies and practices in place to ensure services are accessible to people with special needs. Providers should have regard to consumer diversity, taking into account consumers' individual interests, customs, beliefs and backgrounds. Providers should also work collaboratively with advocacy services and specialist service providers for people from special needs groups, where appropriate.

In December 2012, the Government released national strategies for two of the special needs groups:

- *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*; and
- *National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy.*

2.5 People with dementia

While not a separate special needs group under the legislation, all home care providers should also have policies and practices that address the provision of care for people with dementia.

3. Consumer Directed Care (CDC)

3.1 What does CDC mean in the context of Home Care Packages?

From 1 August 2013, all new packages (including the packages allocated to providers in the 2012-13 ACAR) are required to be delivered on a CDC basis. From July 2015, all packages will operate on a CDC basis.

The introduction of CDC is a significant change to the way that home care is delivered in Australia. This Section provides an overview of CDC, but the various elements are also explained throughout these Guidelines.

CDC is a way of delivering services that allows consumers to have greater control over their own lives by allowing them to make choices about the types of care and services they access and the delivery of those services, including who will deliver the services and when. Under a CDC approach, consumers are encouraged to identify goals, which could include independence, wellness and re-ablement. These will form the basis of the Home Care Agreement and care plan.

The consumer decides the level of involvement they wish to have in managing their package, which could range from involvement in all aspects of the package, including co-ordination of care and services, to a less active role in decision-making and management of the package. There should also be ongoing monitoring and a formal re-assessment by the provider (at least every 12 months) to ensure that the package continues to be appropriate for the consumer.

Through the introduction of an individualised budget, CDC provides greater transparency to the consumer about what funding is available under the package and how those funds are spent.

CDC models were trialled in around 1,000 home-based packages, as part of a pilot program funded by the Australian Government from 2010 to 2012.

3.2 CDC principles

The following principles underpin the operation and delivery of packages on a CDC basis.

3.2.1 Consumer choice and control

Consumers have managed their own lives for a long time. They should be empowered to continue to manage their own life by having control over the care and support they receive. This requires the provision of, and assistance to access, information about service options that enables a consumer to build a package that supports them to live the life they want.

3.2.2 Rights

CDC should acknowledge an older person's right (based on their assessed needs and goals) to the individualised services and support that will assist them.[1]

3.2.3 Respectful and balanced partnerships

The development of respectful and balanced partnerships between consumers and home care providers, which reflect the consumer and provider rights and responsibilities, is crucial to consumer control and empowerment. Part of creating such a partnership is to determine the level of control the consumer wants to exercise. This will be different for every individual, with some people requiring or wanting assistance and others choosing to manage on their own.

Consumers should have an opportunity to work with the home care provider in the design, implementation and monitoring of a CDC approach and cultural change in the provider's organisation. Home care providers should be encouraged to include consumers in their CDC redesigns.

3.2.4 Participation

Community and civic participation are important aspects for wellbeing. CDC in aged care should support the removal of barriers to community and civic participation for older people, if they want to be involved.

3.2.5 Wellness and re-ablement

CDC packages should be offered within a restorative or re-ablement framework to enable the consumer to be as independent as possible, potentially reducing the need for ongoing and/or higher levels of service delivery.

Many people enter the aged care system at a point of crisis. Such situations may require the initial provision of services designed to address the immediate crisis. However, there should always be an assumption that the older person can regain their previous level of function and independence with re-ablement services being offered at a time that suits/supports the individual circumstances.

3.2.6 Transparency

Under a CDC package, older people have the right to use their budgets to purchase the services they choose.[2] To make informed decisions about their care, older people need to have access to budgeting information, including the cost of services, the contents of their individualised budgets and how their package funding is spent.

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[1] Care and services must be within the scope of the Home Care Packages Program.
[2] Care and services must be within the scope of the Home Care Packages Program.

4. Use of innovative and digital technology

Where safe, effective and clinically appropriate, home care providers are encouraged to use innovative and digital delivery options to provide services to consumers. This could include the use of telehealth, video conferencing and digital technology, such as remote monitoring and other assistive technology.

Home Care Package funding can be used for innovative and digital technology items to support the consumer, if required.

5. Evaluation

The first group of new Home Care Packages allocated through the 2012-13 Aged Care Approvals Round will provide an opportunity to further evaluate the potential of CDC to deliver better care for consumers, and to test the effectiveness of the new Home Care Package levels in providing a seamless continuum of care.

Over the first two years of the program, the Home Care Packages and the CDC arrangements will be closely monitored and evaluated. The evaluation is expected to focus on the impact of the new home care arrangements, including the new supplements, on:

- consumer experience and outcomes, including people from special needs groups and people with dementia;
- carers and family members;
- provider operations;
- assessment processes, including the impact on Aged Care Assessment Teams;
- the interface between the Home Care Packages Program and other elements of the aged care system such as the Home and Community Care Program and residential care; and
- the effectiveness of the new arrangements in delivering a graduated continuum of care, as well as choice and flexibility for consumers.

The evaluation will also consider:

- the range of supports used by people with a disability and the ability of Home Care Packages and particularly the new CDC arrangements to meet their needs; and
- whether CDC has supported increased access to digital technology by consumers and providers.

The scope and timeframes for the evaluation will be finalised early in 2013-14. Details will be published on the Department of Health and Ageing website.

Any lessons learned during the evaluation will be used to refine the CDC arrangements before they are applied across all Home Care Packages from July 2015.

6. Legal framework

The legal framework for the Home Care Packages Program is underpinned by:

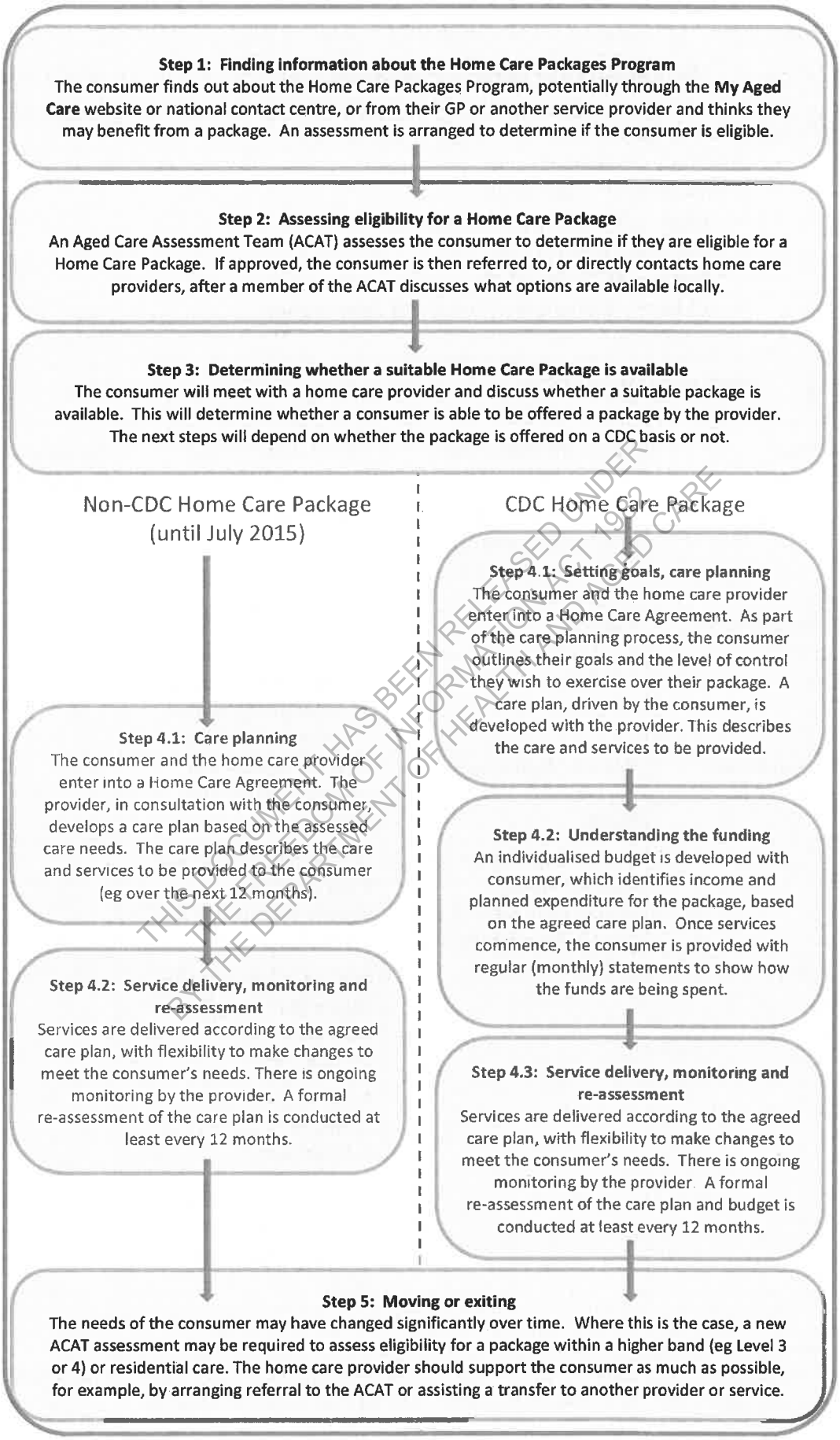
- the *Aged Care Act 1997*;
- Principles made under the Act;
- Determinations made under the Act (for example, setting relevant subsidy and supplement levels); and
- conditions of allocation made under the Act (for example, conditions applying to all packages and/or specific conditions applying to individual providers or services such as CDC).

7. Pathway for the consumer

The pathway for the consumer involves a series of steps from finding information about the Home Care Packages Program, assessment by an Aged Care Assessment Team, contacting local home care providers, being offered a package by a provider, care planning and budget setting, service delivery, understanding how funds are being spent, monitoring and re-assessment, and exiting the program.

The pathway is summarised in the following chart. The steps provide the structure for Part C and Part D of the Guidelines.

The Guidelines describe what is involved at each step and what home care providers are expected to do to support the consumer.



PART B – SUMMARY OF CHANGES AND TRANSITIONAL ARRANGEMENTS – 1 AUGUST 2013

Covered in this part

- Summary of changes
- Transitional arrangements
  - Existing allocations of packages
  - Existing consumers
  - Existing ACAT approvals
  - Changes to approved provider arrangements

1. Summary of changes

Issue	Up until 1 August 2013	From 1 August 2013	Reference in Guidelines
Program name	Community Packaged Care Programs – comprising the CACP, EACH and EACHD Programs	Home Care Packages Program	Part A
Package levels	3 levels: – CACP – EACH – EACHD	4 levels : – Home Care Level 1 – Home Care Level 2 – Home Care Level 3 – Home Care Level 4	Part A
Supplements	Viability Supplement applies to all package levels Oxygen Supplement and Enteral Feeding Supplement apply to EACH and EACHD packages, but not CACPs	Viability Supplement applies to all package levels Oxygen Supplement and Enteral Feeding Supplement applies to all package levels[3] Dementia and Cognition Supplement or Veterans' Supplement applies to all package levels[4] Aged Care Workforce Supplement applies to all package levels[5] Top-up Supplement applies to existing EACHD consumers (as at 31 July 2013)	Part H

[3] Payable to the home care provider where the consumer meets the relevant eligibility requirements for the supplements. Both supplements may be claimed if the consumer is eligible.

Issue	Up until 1 August 2013	From 1 August 2013	Reference in Guidelines
Consumer Directed Care (CDC)	Limited application[6]	Applies to all new Home Care Packages from August 2013, and to all packages (including existing packages) from July 2015 Option to convert existing packages to CDC earlier than July 2015 if the provider wants to	Parts A & D
Care and services	CACP: – does not include nursing and allied health, or aids and equipment in the range of care and services EACH/EACHD: – include nursing and allied health, as well as some aids and equipment in specified care and services – contain exclusions such as motorised wheelchairs and custom-made aids	A single list of care and services applies to all package levels[7] (the care and services listed do not provide an exhaustive list) All package levels, regardless of whether delivered on a CDC basis or not, will have: – greater flexibility through other care and services required to support the consumer at home – access to nursing, allied health and other clinical services – access to a wider range of aids and equipment – limited number of specified exclusions	Part E
Approved provider status	Approved provider of Community Care required for CACP packages Approved provider of Flexible Care required for EACH/EACHD packages	Approved provider of Home Care required for all package levels	Part B

[4] Payable to the home care provider where the consumer meets the relevant eligibility requirements. Funding will be provided for either the Dementia and Cognition Supplement or the Veteran's Supplement, but both supplements cannot be claimed for the same person.
[5] Payable to the home care provider if they meet the relevant eligibility requirements for the supplement and choose to participate in the Aged Care Workforce Supplement.
[6] Applies to 1,000 packages from the former CDC trial (converted to mainstream packages in July 2012).
[7] Part 1 of Schedule 4 to the *Quality of Care Principles 1997*

Issue	Up until 1 August 2013	From 1 August 2013	Reference in Guidelines
Age eligibility	Targeted at frail older people aged 70 years and over	No minimum age requirement for eligibility purposes, but the program is targeted at frail older people	Part C
ACAT approval	Separate approval required for each package level Approval for EACH/EACHD enables access to a CACP	Broadbanded approval – two assessment points (Level 1 / 2, Level 3 / 4) Approval to access a particular level enables access to any level of home care package that is lower than the approved level	Part C
Lapsing ACAT approvals	CACP approvals automatically lapse if care is not provided within 12 months after the approval No automatic lapsing of EACH and EACHD approvals	Existing approvals (including CACP approvals in force on 31 July 2013), and all new approvals from 1 August 2013, do not automatically lapse at any package level	Part C
Agreement between the home care provider and the consumer	Care Recipient Agreement	Now called a Home Care Agreement There are also some changes to the information that must be included in the Home Care Agreement	Part D
National Translating and Interpreting Service (TIS)	Service is available to residential care providers	Service is available to residential care and home care providers	Part D
Standards	Community Care Common Standards	Now re-named as the Home Care Common Standards (also known as the Home Care Standards)	Part F
Charter	Charter of Rights and Responsibilities for Community Care	Now re-named as the Charter of Rights and Responsibilities for Home Care	Part F

Issue	Up until 1 August 2013	From 1 August 2013	Reference in Guidelines
Care fees (care recipient contribution fees)	Consumers can be asked to pay a care recipient contribution fee of: – Up to 17.5% of basic pension, plus up to 50% of income above the basic pension	From 1 August 2013 – no changes from previous arrangements From 1 July 2014 – new income testing arrangements, including hardship provisions, will apply	Part G
Leave provisions (determining for how long and at what rate the home care subsidy will be paid when a consumer takes leave from a package)	A range of different leave provisions applied across CACPs and EACH/EACHD packages, with different rules depending on the type of leave taken by the consumer	New leave provisions apply to the Home Care Packages Program – with common rules applying across all package levels, and greater consistency between the different types of leave	Part E
Security of tenure	Security of tenure provisions are set out in Division 1, Part 3 of the *User Rights Principles 1997*	In addition to the existing provisions, a home care provider may also reallocate a package to another person if: – the consumer does not meet his/her responsibilities, as described in the Charter of Rights and Responsibilities for Home Care, for a reason within the consumer's control[8]	Part E

[8] Paragraph 23.21(e) of the *User Rights Principles 1997*

Issue	Up until 1 August 2013	From 1 August 2013	Reference in Guidelines
Agreements between the Commonwealth and home care providers	Requirement to enter into a Deed of Agreement for CACPs, and separate Payment Agreements for EACH and EACHD packages	No new agreements from 1 August 2013. Requirements are set out in the legislation (the Act, Principles and Determinations) and in conditions of allocation Existing agreements will cease from 1 August 2013, but existing conditions of allocation will continue to apply. All approved provider responsibilities will be set out in the legislation	Part I
Interface with other programs	Some information was included in the former Community Packaged Care Guidelines	The interface between the Home Care Packages Program and other programs is explained in these Guidelines	Part J

2. Transitional arrangements

2.1 Existing allocations of packages

From 1 August 2013, all existing allocations of:

- CACP packages will become Home Care Level 2.
- EACH packages will become Home Care Level 4.
- EACHD packages will become Home Care Level 4.

The change from the former CACP, EACH and EACHD packages to new Home Care Packages will take effect from 1 August 2013, when Schedule 1 to the *Aged Care (Living Longer Living Better) Act 2013* and the relevant subordinate legislation commences.

From 1 August 2013, there will no longer be a requirement for home care providers to enter into an agreement with Commonwealth in respect of allocations of new Home Care Packages.

Existing agreements (Deeds of Agreement for CACPs and Payment Agreements for EACH/EACHD packages) will automatically cease from 1 August 2013 when the transitional provisions in the legislation take effect. However, all existing conditions of allocation in respect of those places will continue to apply.

2.2 Existing consumers

Existing consumers receiving CACP, EACH or EACHD packages will continue to receive home care from 1 August 2013. Existing consumers will not need to be re-assessed by an ACAT. The transitional provisions in the legislation mean that existing consumers receiving:

- a CACP will receive services under a Home Care Level 2 package.
- an EACH package will receive services under a Home Care Level 4 package.
- an EACHD package will receive services under a Home Care Level 4 package.

  - The Dementia and Cognition Supplement and the Top-up Supplement will also be paid to the home care provider for existing EACHD consumers (ie people receiving services under an EACHD package on 31 July 2013).
  - Where the existing EACHD consumer is eligible for the Veterans' Supplement, the Veterans' Supplement (and the Top-up Supplement) may be paid to the home care provider rather than the Dementia and Cognition Supplement.[9]

Care Recipient Agreements (which, after 1 August 2013, will be known as Home Care Agreements) will continue to remain in force.

2.3 Existing ACAT approvals

Where a person has an ACAT approval for a CACP, EACH or EACHD package (valid on 31 July 2013) but the person has not yet been offered a package by a home care provider, the approval will continue to have effect from 1 August 2013 as an approval for the relevant level of home care.

From 1 August 2013, ACAT approvals will not automatically lapse across any of the four home care levels. Previously, a CACP approval automatically lapsed if care was not provided within 12 months after the approval.

Further details are in Part C, Section 4.

2.4. Changes to approved provider arrangements

From 1 August 2013, the arrangements for obtaining approved provider status are being simplified for home care.

Prior to 1 August 2013, providers of CACPs were required to be approved providers of **community care**. Providers of EACH and EACHD packages were required to be approved providers of **flexible care**. Providers delivering both types of packages (CACP and EACH/EACHD) were required have approval to provide both types of care.

[9] The Dementia and Cognition Supplement, the Veterans' Supplement, and the Top-up Supplement are explained in Part H

From 1 August 2013, there will be a single approval to be a provider of **home care**. This will enable an approved provider to deliver services at any of the four levels of Home Care Packages (as long as they have an allocation of packages under the Act, eg usually this will occur through the Aged Care Approvals Round).

For existing approved providers (ie those who have approved provider status on 31 July 2013):

- an approved provider of community care is deemed to be an approved provider of home care; and
- an approved provider of flexible care is deemed to be an approved provider of home care. They also retain their status as an approved provider of flexible care, which is relevant to providers (mostly state and territory governments) providing services under the Multi-Purpose Services (MPS) Program and the Transition Care Program.

PART C – ACCESSING A HOME CARE PACKAGE

Covered in this part

- Finding out information about packages
- Eligibility for a package
  - Age
  - Residency or citizenship
  - Assessment by an ACAT
  - Broadbanded assessments
- Issues to be considered by ACATs in determining eligibility
  - Eligibility criteria
  - Aged care client record and information about the ACAT decision
- ACAT approvals
  - Existing approvals (valid on 31 July 2013) will not lapse
  - Removal of automatic lapsing of approvals
- Referral from an ACAT to a home care provider
- Being offered a package by a home care provider
  - Moving between package levels or bands
  - Waiting lists

1. Finding information about Home Care Packages

From 1 July 2013, older people, their families and carers will be able to access the My Aged Care website at www.myagedcare.gov.au or the national contact centre on **1800 200 422** for information about the aged care system and services.

2. Eligibility for a Home Care Package

2.1 Age

There is not a minimum age requirement for eligibility purposes, but the Home Care Packages Program is targeted at frail older people. In 2011-12, the average age of admission into a CACP, EACH or EACHD package was 81 years. For Aboriginal and Torres Strait Islander people, the average age of admission into a CACP, EACH or EACHD package was 66 years.

In some cases, younger people with disabilities, dementia or special care needs may be able to access a Home Care Package – if the person has been assessed and approved by an ACAT, and a home care provider is able to offer an appropriate package for the person.

2.2 Residency or citizenship

There are no citizenship or residency restrictions on accessing the Home Care Packages Program. However, the packages are not intended for visitors to Australia or people requiring temporary or short-term care.

2.3 Assessment by an Aged Care Assessment Team

In order to access a Home Care Package, a person needs to be assessed and approved as eligible for home care by an ACAT[10], and then offered a Home Care Package by a home care provider.

2.4 Broadbanded assessments

ACAT assessment requirements for home care will be "broad-banded".

For the first year (commencing 1 August 2013), the two assessment bands for eligibility will be:

- *Home Care Levels 1 and 2* – to be eligible to access either a Level 1 or 2 package, a person would be assessed by an ACAT (if they applied for approval to receive residential care) as eligible for low level residential care; and
- *Home Care Levels 3 and 4* – to be eligible to access either a Level 3 or 4 package, a person would be assessed by an ACAT (if they applied for approval to receive residential care) as eligible for high level residential care.

The concept of two assessment bands for eligibility is likely to continue until at least July 2015, pending the results of the evaluation of the Home Care Packages Program.

However, the definitions used to describe the eligibility bands (above) will be reviewed during the first year of the program, to take effect from 1 July 2014. The review will consider whether a person's eligibility for home care should continue to be dependent on whether that person would have been assessed as eligible to receive residential care. The review will also consider how eligibility for home care within each assessment band should be defined once the distinction between low level and high level residential care is removed from the *Aged Care Act 1997* on 1 July 2014.

The ACAT does not need to determine whether a person's care needs are at a particular level within each band.

Similar to the previous arrangements, if a person has been assessed as eligible for a particular level of package, but none is available, the person can be offered a lower level package, as an interim measure, until a higher level package is available.

[10] In Victoria, ACATs are known as Aged Care Assessment Services (ACAS).

The decision to offer an eligible person a package, including at what level the package is offered (within scope of the approval) is made by the home care provider.

3. Issues to be considered by ACATs in determining eligibility

3.1 Eligibility criteria

An ACAT will conduct a multidisciplinary and comprehensive assessment, taking account of a person's physical, medical, psychological, cultural, social and restorative care needs. The assessment should take into account any relevant information available from the person's medical practitioner and other specialist reports. The ACAT will then need to determine that a person meets all the eligibility criteria before approving the person to receive a Home Care Package.

The requirements of the legislation[11] mean that, for a person to be eligible for a Home Care Package, the person must be assessed:

- as having needs that can only be met by a co-ordinated package of care services;
- as someone who would be eligible to receive at least low level residential care (for Home Care Levels 1 or 2) or high level residential care (for Home Care Levels 3 or 4) if they applied for residential care;
- have expressed a preference to live at home (including as a resident of a retirement village); and
- be able to remain living at home with the support of a Home Care Package.

3.2 Aged Care Client Record and information about the ACAT decision

Part of the ACAT approval process involves the creation of an Aged Care Client Record (ACCR) for each person who is approved as eligible for a Home Care Package. The onus remains on the home care provider to check that a consumer has a valid assessment approval before commencing services, as a home care subsidy is unable to be paid without this approval.

The consumer is advised promptly in writing of the decision arising from their ACAT assessment and receives contact details for further advice if required. The ACAT delegate must provide sufficient information in writing to allow a person to understand why a decision has been made and the evidence on which it was based.

An ACAT approval to receive a Home Care Package takes effect from the day the approval is given, but a subsidy is not payable to a provider until the consumer has been offered and accepted a package by a home care provider and the Home Care Agreement is entered into (see Part D, Section 2).

[11] Sections 5.6 and 5.7 of the *Approval of Care Recipient Principles 1997.*

4. ACAT approvals

4.1 Existing approvals (valid on 31 July 2013) will not lapse

Where a person has an ACAT approval for a CACP, EACH or EACHD package (valid on 31 July 2013) but the person has not yet been offered a package by a home care provider, the approval will continue to have effect from 1 August 2013 as an approval to receive the relevant level of home care.

This means that:

- a person already approved for a CACP can be offered a Home Care Level 1 or 2 package without the need for another ACAT assessment; and
- a person already approved for an EACH or EACHD package can be offered a Home Care Level 3 or 4 package, or a lower level package as an interim arrangement, without the need for another ACAT assessment.

4.2 Removal of automatic lapsing of approvals

Previously, CACP approvals automatically lapsed if care was not provided within 12 months after the approval date.

From 1 August 2013, ACAT approvals will not automatically lapse after 12 months across any of the four package levels – unless there is a specific time limitation placed on the approval as part of the ACAT decision. A consumer or provider is still able to request a new assessment at any time, for example, if the consumer's needs have changed.

Therefore, as long as the CACP approval is valid on 31 July 2013, the approval will not lapse and the person does not need to be re-assessed by an ACAT in order to receive a Home Care Level 1 or 2 package.

5. Referral from an ACAT to a home care provider or other services and practitioners

Once a person is approved as eligible for a Home Care Package, the ACAT may refer the consumer to individual home care providers or provide information to the consumer on how to contact local providers, eg by providing a list of all home care providers with packages in the area.

Where appropriate, an ACAT representative may refer a consumer to other care services that do not require an ACAT approval, such as Home and Community Care (HACC) or the Veterans' Home Care (VHC) program.

The ACAT may also refer a person to a medical or health practitioner/service for more specialised assessment of needs, eg associated with vision impairment or blindness, hearing loss, other disabilities or nutrition. These assessments could form part of the overall assessment.

6. Being offered a package by a home care provider

Once a person has been assessed by an ACAT and approved for home care, a person may be offered a package by a home care provider, at either level within the relevant band (eg Level 1 or 2, or Level 3 or 4) for which they have been approved.

The decision to offer an eligible person a package, including at what level the package is offered (within scope of the approval) is made by the home care provider, taking into account the person's needs and the availability of packages at the relevant levels.

People on a waiting list do not necessarily access care purely on a "first come, first served" basis. Home care providers are encouraged to assess each individual's care needs relative to others also waiting for home care. They must also take into account any conditions of allocation for the package, including priority of access for people from special needs groups.

If a person has been approved by an ACAT as eligible for a higher level/band of package (eg Level 3 or 4), but none is available, the person can be offered a lower level package (eg Level 1 or 2) as an interim measure until a higher level package is available – without the need for another ACAT assessment.

6.1 Moving between package levels or bands

A consumer does not have to be reassessed by an ACAT to move from one package level to another **within the broadbanded levels approved by the ACAT**. This means that a home care provider can offer a higher level package when a consumer's needs require a higher level of care – from Level 1 to 2, or from Level 3 to 4 – without the need for another ACAT assessment.

A new assessment and approval from an ACAT is required before the consumer can be offered a package **in a higher band**, ie moving from a Level 1 or 2 package to a Level 3 or 4 package – except where the consumer already has an ACAT approval at the higher band (Level 3 or 4).

6.2 Waiting lists

While the number of Home Care Packages will increase significantly across Australia over the coming years, there may be waiting lists for packages in some areas.

Home care providers and some ACATs manage their own waiting lists, giving access and priority according to each individual's need and the provider's capacity to meet that need.

As explained in Section 6 (above), people on a waiting list do not necessarily access care purely on a "first come, first served" basis. Home care providers are encouraged to assess each individual's care needs relative to others also waiting for home care. They must also take into account any conditions of allocation for the package, including priority of access for people from special needs groups.

PART D – MAKING USE OF A HOME CARE PACKAGE

Covered in this part

- For all packages
  - Being offered a package by a home care provider
  - Home Care Agreement
- For packages delivered on a CDC basis
  - Care planning
  - Individualised budget
  - Monitoring, review and reassessment
- For packages delivered on a non-CDC basis
  - Overview
  - Level of consumer control over the management of the package
  - Giving effect to the consumer's choices and preferences
  - Individualised budget
- Topping up services under a package (both CDC and non-CDC)
- Converting packages delivered on a non-CDC basis to a CDC basis

1. Being offered a package by a home care provider

Once a person is approved as eligible for a Home Care Package, the ACAT may refer the consumer to individual home care providers or provide information to the consumer on how to contact local providers, eg by providing a list of all home care providers with packages in the area.

The home care provider will determine whether they are able to offer a package suitable for the consumer. The consumer is able to choose whether or not to accept the package.

The ACAT Aged Care Client Record (ACCR) supplies the home care provider with important information about the characteristics, needs and circumstances of the prospective consumer. The home care provider should always review the consumer's ACCR. This should be considered, together with other information provided by the consumer, including any relevant information from the consumer's medical practitioner, in determining whether a package can be offered and if so, at what level (within the scope of the approval). Home care providers can also access ACCRs from the Department of Human Services – Medicare Online Claiming facility.

2. Home Care Agreement

2.1 Overview

For all Home Care Packages, whether delivered on a CDC basis or not, a Home Care Agreement (previously known as a Care Recipient Agreement) must be offered to the consumer before the package commences. This is a legal requirement.[12]

[12] Section 23.94 of the *User Rights Principles 1997*.

The Home Care Agreement is an agreement between the home care provider and the consumer, which sets out a number of key elements about how the package will be delivered (see Section 2.2 in this Part).

The consumer's care plan forms part of the Home Care Agreement. Often the care plan will be an attachment or schedule to the Agreement.

The care planning process for packages being delivered on a CDC basis is described in Section 3 in this Part. Section 4 in this Part summarises the requirements for packages that are not being delivered on a CDC basis. In practice, there will be a number of common elements in the way that care planning is conducted, whether the package is delivered on a CDC basis or not.

Once the Home Care Agreement is entered into, care and services can formally commence under the package and the home care provider is able to commence claiming the government subsidy for the package (see Part I, Section 4).

Given the importance of the Home Care Agreement, the home care provider should ensure that the consumer and/or their authorised representative understand the terms of the agreement. The consumer can ask for an advocate to represent them during this process. Advocacy services are further explained in Part F, Section 2. The consumer may also seek their own legal advice before signing the Home Care Agreement.

While a Home Care Agreement recognises the consumer's rights and may spell out the consumer's responsibilities, it cannot exclude any rights the consumer has under Commonwealth or state/territory law.

The Home Care Agreement should be written in plain language, be easily understood and at a minimum contain the information in the checklist at Section 2.2 in this Part.

Where required, the provider should arrange for the Home Care Agreement, including the care plan, to be made available to the consumer in a language other than English. Any additional costs associated with the translation must be clearly explained to the consumer.

The Department of Immigration and Citizenship provides a national Translating and Interpreting Service (TIS) – phone **131 450**.

Home care providers are able to use TIS to provide interpreting services to assist Home care consumers to understand their Home Care Package, including the Home Care Agreement, the individualised budget and monthly statements. Arrangements for accessing this service will be the same as the TIS arrangements for residential aged care providers, ie providers will be given a unique code to access interpreting services from TIS. The arrangements for home care providers will commence in mid 2013.

In the future, home care providers will be offered opportunities to apply for funding through the Aged Care Service Improvement and Healthy Ageing Grants fund for the translation of template documents related to Home Care Packages.

2.2 Items to be included in the Home Care Agreement

Under the legislation[13], the following information must be included in the Home Care Agreement:

Check	Item
☐	Start date for the care
☐	The level of the Home Care Package to be provided (ie Level 1, 2, 3 or 4)
☐	Whether the Home Care Package will be provided on a CDC basis
☐	Details outlining how the consumer can suspend care
☐	An explanation of security of tenure
☐	Conditions under which either party may terminate care
☐	An explanation that any variation must be by mutual consent, following consultation between the consumer and the home care provider, and may only be made after the provider has given reasonable notice in writing to the consumer
☐	A copy of the consumer's care plan, plus any subsequent changes to the care plan
☐	Details of the consumer's rights about the service they are to receive. A copy of the *Charter of Rights and Responsibilities for Home Care* must also be provided to the consumer
☐	A statement that the consumer is entitled to make, without fear of reprisal, any complaint about the Home Care Package, and an explanation of how to make a complaint. This refers to both internal complaint mechanisms and the Aged Care Complaints Scheme
☐	A guarantee of the confidentiality, as far as legally permissible, of information provided by the consumer and the use to be made of the information
☐	A clear itemised statement of the fees payable (if any) by the consumer and how they were calculated
☐	Other financial information relevant to the care and services provided to the consumer
☐	An explanation that a consumer is entitled to request a statement of the home care service's financial position, including a copy of the most recent version of the home care provider's audited accounts. This must be provided within seven days of the request

[13] Section 23.95 of the *User Rights Principles 1997*.

The Home Care Agreement may be varied as required. Changes agreed between the consumer and the home care provider should be documented.

For packages being delivered on a CDC basis, the individualised budget and regular statement of income and expenditure will also provide financial information to the consumer.

2.3 Cases where the consumer does not want to sign the Home Care Agreement

While the home care provider must always offer and be prepared to enter into a Home Care Agreement, the consumer may choose not to sign a Home Care Agreement.

In such cases, the home care provider is still required by legislation to observe its responsibilities to negotiate and deliver the level and type of care and services the consumer needs.

It is important that the home care provider documents the reasons for not having a signed Home Care Agreement and the basis on which agreed care will be delivered.

The home care provider should always be ready to provide evidence that an "in-principle" agreement is in place. Documentation may include a copy of the agreement as offered to the consumer, a file note of the discussion with the consumer about the terms of the agreement (including the date that the discussion took place) and evidence that the consumer is receiving a Home Care Package as described in the Home Care Agreement.

2.4 When can the home care subsidy be claimed?

The home care subsidy can only be paid once the Home Care Agreement has been entered into. The subsidy cannot be claimed for discussions/meetings with the consumer (or carers and family members), or any services provided to the consumer, before the Home Care Agreement is entered into.

The date that the Home Care Agreement is entered into is the date that the consumer and the home care provider agree on the terms of the Home Care Agreement, as evidenced either by the signature of both parties or a file note as described in Section 2.3 in this Part.

3. Packages delivered on a CDC basis

3.1 Care planning

3.1.1 Overview

A key feature of a package being delivered on a CDC basis is that the consumer must have ownership of decision making. This requires an empowering decision making framework, which supports the consumer to set goals and determine the amount of control they want to exercise in relation to their package.

The care planning process must be driven by the consumer, in partnership with the home care provider. Throughout the process, there should also be an emphasis on:

- consumer choice and control;
- support for consumer decision-making;
- being responsive to the consumer's customs, beliefs and background, including their relationship with carers and family members;
- wellness and re-ablement; and
- maintenance of independence and continuation of participation in the community (if this is what the consumer wants).

3.1.2 Goal setting

Before determining what services are to be provided, it will be important for the consumer to be asked what they would like to achieve through their Home Care Package. In other words, what their goals are, what is most important to the consumer?

The objectives of the program – to assist people to remain living at home for as long as possible and to enable consumers to have choice and flexibility in the way that care, services and support is provided at home – establish an overall framework for goal setting.

A purpose statement that outlines why the package is being provided to the consumer (eg *"to maintain me at home as independently as possible"*) could be developed to provide a clear understanding of the consumer's goals.

Individual goals will be shaped by the consumer's own circumstances, including the amount of support available from family, friends and carers, the consumer's level of health and well-being, and cultural and personal values. This requires effective communication between the consumer and home care provider.

3.1.3 Level of consumer control over the management of the package

As part of the care planning process, the consumer must be asked about, and given the option of, exercising different levels of control over the management of the package.

This could range from a high level of involvement, particularly in areas such as care co-ordination and administration, to very little or no active involvement in the management of the package.

The level of consumer involvement and control that has been agreed must be documented in the consumer's care plan. This may vary over time as the consumer's needs change. Any changes to the level of consumer involvement and control must also be documented in the care plan.

The consumer's involvement in managing their package could include, but is not limited to, making contact with service providers, negotiating fees, scheduling appointments to provide services required by the consumer, and monitoring the quality of services provided. Administration activities could include record keeping and managing invoices.

Where the consumer chooses to be more involved in the management of the package, the individualised budget should reflect this role – with lower care co-ordination and administration costs charged by the provider.

3.1.4 Determining who has authority to make decisions

The determination of who has the authority to make decisions (eg the individual consumer, a family member or carer, a guardian, or (in some states) a person with power of attorney) will be a crucial part of the care planning process. The home care provider will need to determine who has the legal authority to make decisions. There should be shared decision-making between the consumer (to the extent that they are able to participate in decision-making), their appointed representative (if they have one) and the home care provider. This will be particularly important in situations where the consumer has some degree of cognitive impairment.

3.1.5 Case management

In the context of the Home Care Packages, case management refers to advisory and support services associated with:

- the initial assessment by the home care provider;
- identification of the consumer's goals;
- development of the Home Care Agreement, care plan and individualised budget;
- ongoing monitoring and informal reviews of the consumer;

- formal re-assessment of the consumer's needs, and adjustment of the Home Care Agreement, care plan and individualised budget if required; and
- referral to an ACAT (eg if a reassessment is needed to move to a higher broad-banded level of package).

It is not expected that a consumer would take on the functions of a case manager, although the consumer may choose to have an active role in the management of the package. Ongoing monitoring, reviews and re-assessment must be undertaken by the home care provider, not by the consumer.

The case management role should not generally be sub-contracted to another provider, although this may be necessary in some cases (particularly for special needs groups or in rural and remote locations).

In some cases, a consumer may wish to have a specific person as a case manager. This can be negotiated between the consumer and the home care provider. If agreed, the home care provider will need to establish a contractual or employment relationship with the case manager suggested by the consumer. The case manager should have appropriate skills and qualifications to perform this role.

3.1.6 Choosing care and services

Once a consumer's goals and the level of involvement in the management of the package have been identified, the consumer and the provider will determine what care and services are needed to support the consumer's goals – including what will be provided, by whom, the timing and frequency of services, and the cost. See Care and Services at Part E.

In a CDC environment, the consumer should not be limited by a "standard" menu of services or service providers. Providers and consumers should be thinking about innovative ways to meet the consumer's goals and care needs. This may involve the use of sub-contracted or brokered services if the home care provider is unable to provide the service/s itself or where the consumer would prefer the service be delivered by a particular worker. Sometimes this may involve additional costs of setting up sub-contracting or brokerage arrangements and these costs should be made clear to the consumer.

Whatever is agreed must be affordable within the total budget available for the package.

3.1.7 Care plan

Care plan development needs to be driven by the consumer, in consultation with the home care provider. The care plan should clearly spell out the following:

- the consumer's goals – what it is the consumer would like to achieve through their package;

- the care and services to be provided to support the identified goals;
- who will provide the care and services;
- when care and services will be provided, including the frequency of services and days/times when regular services are expected to be provided;
- the level of involvement and control the consumer will exercise over the management of the package;
- case management arrangements, including how ongoing monitoring and informal reviews will be managed; and
- the frequency of formal reassessments (which must be undertaken at least every 12 months).

The care plan must be supported by an individualised budget for the consumer.

Care planning discussions may also cover end of life planning such as advance care directives.

3.1.8 Giving effect to the consumer's choices and preferences

In a CDC environment, the provider must always encourage and support the consumer to make informed choices about the type of services to be provided through the package to meet the consumer's goals, including how the services are delivered and by whom.

Wherever possible, the home care provider should try to accommodate the consumer's goals and preferences. In some cases, this may require the home care provider to purchase (sub-contract or broker) services from another service provider.

The home care provider should always inform the consumer of any risks or additional costs of purchasing services from another source.

In some circumstances, the home care provider may not be able to accommodate the consumer's preferences. This will need to be considered on a case-by-case basis, based on what is reasonable in the circumstances.

The following list provides a guide to home care providers as to when it might be reasonable to decline a request from a consumer.

- The proposed service may cause harm or pose a threat to the health and/or safety of the consumer or staff.
- The proposed service is outside the scope of the Home Care Packages Program (see Part E, Section 3.6).
- The home care provider would not be able to comply with its responsibilities under aged care legislation or other Commonwealth or state/territory laws.
- The consumer's choice of service provider is outside the home care provider's preferred list of service providers and all reasonable effort has been made to broker an acceptable sub-contracting arrangement.

- The requested service provider will not enter into a contract with the home care provider.
- There have been previous difficulties or negative experiences with the consumer's suggested service provider.
- Situations in which a consumer may want to go without necessary clinical services (resulting in a possible compromise of their health and/or wellbeing) in order to "save" for a more expensive non-clinical service.
- The cost of the service/item is beyond the scope of the available funds for the package.

Where the home care provider is not able to give effect to the consumer's preferences or request for services, the reasons must be clearly explained to the consumer and documented.

3.1.9 Sub-contracted or brokered services

Services may be provided directly by the home care provider, sub-contracted to another service provider (individual or organisation), or brokered through another organisation.

Regardless of how services are delivered and by whom, the home care provider remains responsible for service quality and meeting all regulatory responsibilities.

Home care providers are encouraged to develop a list of "preferred service providers" to support consumers' needs and choices.

Home care providers should also endeavour to build relationships with other organisations that specialise in providing services to people from special needs groups. Some consumers may request or prefer service providers that work with, or are from, the same special needs group.

It is possible that, even where there are extensive sub-contracting or brokerage arrangements in place, some consumers may still request a different service provider.

The home care provider should meet any reasonable request, noting that establishing a new service agreement (with an organisation not on the home care provider's preferred service provider list) may result in a delay in providing services and/or lead to additional costs. This should be disclosed to the consumer and be made clear in the individualised budget.

3.1.10 Requests for services to be provided by particular individuals or service providers

The consumer can request that services be provided by a particular individual or service provider, for example, someone who has previously provided services to the consumer.

In such cases, the home care provider is still responsible for ensuring that the police check requirements are met, and for ensuring that the worker is appropriately qualified and trained for the service being provided. Police check requirements are set out in Part F, Section 4.

3.1.11 Contracting to informal carers, family members or friends

Contracting service provision to informal carers, family members or friends is not encouraged under the Home Care Packages Program.

However, it is recognised that in some areas, for example, remote parts of Australia, this may already occur and may continue to do so where there is no other workable alternative.

The following factors need to be considered by the home care provider in considering whether to contract service provision to informal carers, family members or friends of the consumer:

- elder abuse safeguards;
- the home care provider's responsibility for service quality, including the need to include the person providing the service in the provider's employee, volunteer or sub-contractor systems;
- legal responsibilities, including ensuring that police check requirements are met;
- industrial implications;
- insurance requirements;
- workplace health and safety; and
- qualifications and training required to provide certain types of care.

Carers may be eligible for support and assistance from the Australian Government through programs such as the Carer Allowance or Carer Payment. These programs are administered by the Department of Human Services and are not part of the Home Care Packages Program. Further information is available at the Department of Human Services carers website.

3.2 Individualised budget

3.2.1 Overview

For packages delivered on a CDC basis, the government subsidy for the package is still paid to the home care provider, not directly to the consumer.

The home care provider is the fund holder and will administer the budget on behalf of the consumer in a transparent manner, meeting quality and accountability requirements.

All packages that are delivered on a CDC basis must have an individualised budget, and the consumer must be provided with a regular monthly statement of income and expenditure, including the balance of funds.

All information must be provided in a format that is simple for consumers to understand. Where required, the provider must arrange for the individualised budget and/or regular statements to be made available to the consumer in a language other than English.

As explained in Section 2.1 of this Part, home care providers are able to use the national Translating and Interpreting Service (TIS) to provide interpreting services to assist home care consumers to understand their Home Care Package, including the Home Care Agreement, the individualised budget and monthly statements.

3.2.2 What is an individualised budget?

An individualised budget is a proposed budget for the consumer's package (broken down by income and planned expenditure) that is prepared as part of the care planning process.

The budget should be developed in partnership between the consumer (or their representative) and the home care provider, based on the agreed care plan. The budget must be in a format that is simple to understand for the consumer.

The time period covered by the individualised budget should be agreed between the home care provider and the consumer. It could be prepared on a weekly, monthly, quarterly or annual basis.

Income

The budget should clearly identify the total funds available under the package, comprising:

- the full amount of the government subsidy for the package level (including relevant supplements[14], eg Dementia and Cognition, Veterans', Oxygen, Enteral Feeding and Top-up Supplements (where applicable); and
- any consumer contribution/care fee.

[14] Funding paid to the approved provider through the Aged Care Workforce and Viability Supplements (if applicable) does not have to be included in the individualised budget.

Planned expenditure

The expenditure plan in the budget should be grouped into three broad categories, although other sub-groups under these categories can also be used:

- administrative costs;
- core advisory and case management services; and
- service and support provision and/or purchasing.

These categories are explained below.

- *Administration costs* – reflect establishment costs for the organisation and would also include the costs of meeting government quality and accountability requirements. Administrative costs include:

  - insurance and government reporting
  - corporate overheads
  - capital costs
  - ongoing research and service improvement
  - CDC administrative overheads including staff and IT
  - developing statements and other consumer communication
  - establishing contracts with sub-contracted providers
  - setting up and cancelling appointments.

- *Core advisory and case management services* – this category will include the costs associated with:

  - care planning
  - set up costs for new consumers
  - periodic reviews or re-assessments
  - case co-ordination or case management
  - provision of support to consumers who elect to manage their package themselves.

  The budget should describe and quantify what tangible services will be provided to the consumer, eg costs are based on personal and phone contact of X hours per week at $Y per hour (or appropriate service unit). The budget should also specify when reviews or re-assessments are to be conducted.

- *Service and support provision and/or purchasing* – this category will include the costs of direct service provision. This part of the budget should confirm the decisions made in the care plan about what services have been chosen to be delivered or purchased (eg nursing, domestic assistance) and the individual cost of those services.

3.2.3 Contingency

The budget may also include a small "contingency" to make provision for emergencies, unplanned events or increased care needs in the future, but this is not a requirement.

As a guide, if a contingency is set aside, it should be no more than 10% of the total annual budget for the package. The contingency amount must be clearly identified in the individualised budget and in the monthly statement of income and expenditure provided to the consumer. The ongoing balance of funds available to the consumer (if separate from the contingency amount) must also be clearly identified in the monthly statement.

Contingency amounts cannot be pooled across consumers.

3.2.4 Regular income and expenditure statement to the consumer

The home care provider must provide the consumer with a monthly statement income and expenditure, in a format that enables the consumer to understand where funds have been expended, as well as the balance of available funds.

Any unexpended package funds, including contingency funds, must carry over from month to month, and from year to year, for as long as the consumer continues to receive care under the package.

The format of the statement must be clear and easy to understand and should be consistent with the individualised budget. The means by which the statement is provided to the consumer, eg hardcopy, email or web-based, can be negotiated between the home care provider and the consumer.

3.2.5 Unspent funds when a consumer leaves a package

When a consumer leaves a package, there may be unspent funds in the budget from the contingency or any other funds not expended. It will depend on the circumstances as to how these unspent funds are used.

- If the consumer continues to receive a package from the home care provider (at a different package level), any unspent funds from the previous package must continue to be available under the consumer's new package.

- If the consumer moves to a different home care provider (eg to take up a package with another home care provider or to enter residential care), any unspent funds can be retained by the previous home care provider to support service delivery for other consumers, or for infrastructure purposes.

- However, if the consumer returns to a package within 28 days, there is discretion for the home care provider to make available the unspent funds in a future package offered to the consumer.

- There is also the discretion for a home care provider to agree to transfer unspent funds to another home care provider to support the ongoing care needs of the consumer. This would need to be negotiated and agreed between the relevant providers, in consultation with the consumer.

- Any unspent funds remain with the home care provider on the cessation of the Home Care Package where the consumer is deceased. These funds should be used to support service delivery for other consumers, or for infrastructure purposes.

- Where the consumer has provided their own money to top-up or purchase additional services through the home care provider, any unspent money provided by the consumer must be returned to the consumer when they leave the package, or to the consumer's estate if the consumer is deceased. See Section 5 below.

3.3 Monitoring, review and re-assessment

3.3.1 Ongoing monitoring and review by the home care provider

The home care provider is responsible for ensuring that the needs of the consumer are being met on an ongoing basis. This will require ongoing monitoring or review of the appropriateness of the package, including whether the consumer's goals and care needs are being met and whether the consumer is satisfied with the services being received.

Review is a continuous process between the home care provider and the consumer, informed by observations and feedback from staff and service providers who are in contact with the consumer.

3.3.2 Re-assessment by the home care provider

Note – this Section refers to the formal review (re-assessment) of the consumer by the home care provider, not an assessment undertaken by the ACAT.

Re-assessment by the home care provider involves assessing the consumer's needs, goals and preferences in order to update their care plan and, if necessary, change services the consumer is receiving. This may also result in changes to the Home Care Agreement and the individualised budget.

There must be a formal re-assessment of the consumer by the home care provider at least every 12 months. The cost of the re-assessment should be included in the individualised budget.

The consumer should not be able to opt out of the formal re-assessment, although the scheduling and style of the re-assessment should match the consumer's preferences wherever possible.

A re-assessment can occur more frequently than 12 months. Reasons for an additional or earlier re-assessment may include:

- a request by the consumer;
- a request by a carer;
- a health crisis or episode;
- a change in care need that cannot be met within the budget available for the package;
- a change in living or carer arrangements;
- ongoing or increasing use of clinical services by a consumer; or
- the use of a large amount (or all) of the contingency funds.

The re-assessment should have a re-ablement and wellness focus that does not assume a decline in the consumer's health and functioning. The re-assessment should involve:

- a review of the consumer's goals;
- an evaluation of the quality and success of the services and supports that have been provided;
- a renegotiation and update of the care plan and individualised budget; and
- support for the consumer to continue to make informed decisions, including whether the consumer wishes to change their level of involvement and decision-making in the management of the package.

The re-assessment should be done in person, wherever possible. Video technology or other remote monitoring digital technology may also be used, where clinically appropriate.

3.3.3 Support for the consumer following re-assessment by the home care provider and changes to the care plan

Re-assessment of the consumer's care needs could lead to significant changes in the nature of support being provided to a consumer. The home care provider should support the consumer, as much as possible, in any changes resulting from the review of the care plan.

If the consumer's care needs have increased significantly so that the person potentially requires home care in a higher band (eg Level 3 or 4, rather than Level 1 or 2), or entry to residential care, the consumer will need another assessment by an ACAT. The home care provider can assist in arranging the ACAT assessment, with the permission of the consumer.

4. Packages not being delivered on a CDC basis

4.1 Overview

Many of the requirements set out in this Part, which apply to CDC packages, are also relevant to packages that are not being delivered on a CDC basis. These include:

- being offered a package by a home care provider (see Section 1 in this Part);
- developing the Home Care Agreement (see Section 2 in this Part);
- most elements of the care planning process (see Section 3 in this Part) and the monitoring, review and re-assessment process (see Section 3.3 in this Part); and
- topping up services under a package (see Section 5 in this Part).

The main requirements of non-CDC packages are summarised below. Care and services are outlined in Part E.

- After the ACAT assessment and approval, the next step is for the consumer to be offered a package by a home care provider. The provider will determine whether they are able to offer a package suitable for the consumer.
- A Home Care Agreement must be offered to the consumer before the package commences.
- The consumer's care plan forms the basis of the Home Care Agreement.
- The care planning process should be about the consumer. The consumer should be asked about their goals in developing (and reviewing) the care plan – while this is an important element of care planning under a CDC approach, this should be undertaken in all packages.
- Throughout the care planning process, there should also be an emphasis on wellness and re-ablement, as well as maintenance of independence and control for as long as possible.
- There is flexibility for the consumer and the home care provider to negotiate a broad range of care and services under a package – see Part E.
- Services may be provided directly by the home care provider, sub-contracted to another service provider (individual or organisation), or brokered through another organisation.
- The home care provider is responsible for ensuring that the needs of the consumer are being met on an ongoing basis.
- The care plan (and if necessary, the Home Care Agreement) must be formally re-assessed by the home care provider at a minimum, every 12 months. However, this can occur more frequently as required or agreed between the consumer and the provider.
- A consumer may choose to "top up" their package by purchasing additional care and services (ie paid for by the consumer). This would need to be negotiated and agreed between the consumer and the home care provider.

4.2 Level of consumer control over the management of the package

While not a requirement of non-CDC packages, wherever possible, the consumer should be asked about and given the option of exercising different levels of control over the management of the package. Providers are encouraged to incorporate this element into both existing and new packages.

4.3 Giving effect to the consumer's choices and preferences

Wherever possible, the home care provider should encourage and support the consumer to make choices about the type of services to be provided through the package to meet the consumer's goals, including how the services are delivered and by whom.

4.4 Individualised budget

The individualised budget (as described in Section 3.2 in this Part) is an important element of packages being delivered on a CDC basis.

While there is no requirement for an individualised budget in a non-CDC package, all providers are expected to deliver all Home Care Packages in an open and transparent manner, so that the consumer is aware of the budget/funding available and how funds are being spent. An individualised budget (or elements of the budget) can be incorporated into an existing package at any time, even if the package is not formally being delivered on a CDC basis.

5. Topping-up services or additional services under a package (both CDC and non-CDC)

A consumer may choose to "top up" their package by purchasing additional care and services through their home care provider. This would need to be negotiated and agreed between the consumer and the provider.

Any additional monetary contribution from the consumer to the home care provider for top up services must be separately identified, either within the individualised budget (if the package is being delivered on a CDC basis) or in separate documentation.

In such cases, the additional care and services would be organised by the home care provider under the same conditions, rights and responsibilities that underpin the delivery of the Home Care Package.

In some cases, the home care provider may not be able to provide or organise for care and services to be delivered as a top-up to the package. Where this is the case, the consumer (or their representative) is responsible for organising any additional care and services themselves. This would be a private matter between the consumer and a third party (another service provider) with no involvement of the home care provider.

Where the consumer has provided their own money to top-up or purchase additional services through the approved provider, any unspent money provided by the consumer must be returned to the consumer when they leave the package, or to the consumer's estate if the consumer is deceased.

6. Converting packages delivered on a non-CDC basis to a CDC basis

All Home Care Packages, including packages allocated before the 2012-13 ACAR[15], must be delivered on a CDC basis from 1 July 2015. The period leading up to this date is a transitional period for home care providers to introduce any changes in administration, systems and training that may be needed to deliver Home Care Packages on a CDC basis.

Home care providers do not have to wait until 1 July 2015, but can elect to convert existing packages to a CDC basis once they are ready to make the transition. Providers must advise the Department when they intend to start offering pre-existing packages on a CDC basis, so that this can be incorporated in new conditions of allocation for the relevant packages.

The Department will provide further advice about how home care providers can convert existing packages to a CDC basis.

[15] Packages allocated to providers before the 2012-13 ACAR were allocated as CACP, EACH or EACHD packages. These will become Home Care Level 2 or 4 packages from 1 August 2013.

PART E – WHAT HOME CARE PACKAGES PROVIDE

Covered in this part

- Home care subsidy
- Existing EACHD consumers
- Care and services
  - Overview
  - Nursing, allied health and other clinical services
  - Telehealth and digital technology
  - Aids and equipment
  - List of care and services – inclusions
  - Excluded items
- Security of tenure
  - Responsibilities for the provider
  - Consumers moving locality
- Leave provisions
  - Overview
  - Leave arrangements
  - Impact of leave on consumer fees (care fees)
  - Impact of leave on supplements
  - Subsidy and care fees during leave periods (CDC packages)

1. Home care subsidy

The government subsidy paid in respect of a home care place (the "home care subsidy") is paid to the home care provider, not directly to the consumer.

The subsidy is paid to the home care provider monthly in advance through the Department of Human Services aged care payment system.

The subsidy is calculated on a daily basis where there is an approved care recipient (consumer) receiving care through a package.

The basic subsidy amounts for 2013-14 (effective 1 August 2013) are set out below.[16] Other supplement amounts may also apply – see Part H of these Guidelines.

Details of subsidy and supplement amounts are also published on the Department of Health and Ageing Australian Government subsidies and supplements website. The information on the website is updated when subsidy and supplement amounts change.

[16] Changes to subsidy amounts usually take effect from 1 July each year. Providers are advised about changes in subsidy amounts by the Department of Health and Ageing, usually through a mailstream or faxstream notice.

Level of Home Care Package	Basic home care subsidy in 2013-14 (per day)	Basic home care subsidy in 2013-14 (per annum[17])
Level 1	$20.55	$7,501
Level 2	$37.38	$13,644
Level 3	$82.20	$30,003
Level 4	$124.95	$45,607

2. Existing EACHD consumers

From 1 August 2013, the previous Extended Aged Care at Home Dementia (EACHD) package will convert to a Home Care Level 4 with a Dementia and Cognition Supplement paid in addition to the basic home care subsidy amount (or the Veterans' Supplement if the consumer meets the eligibility criteria and agrees that their eligibility can be disclosed to the home care provider).

To ensure that existing EACHD consumers (ie those who were receiving an EACHD package on 31 July 2013) continue to receive the same level of funding plus indexation, there will be a "Top-up" Supplement paid in respect of existing EACHD consumers. This will apply from 1 August 2013.

The Top-up Supplement will be paid automatically to the home care provider in respect of the eligible consumer.

Home care	Total funding available in 2013-14 (per day)	Total funding available in 2013-14 (per annum)
Existing EACHD consumers only	$139.92 (see note below)	$51,071

Total funding for existing EACHD consumers comprises the Home Care Level 4 basic subsidy ($124.95 per day), plus 10% for the Dementia and Cognition Supplement or Veteran's Supplement ($12.50 per day), plus the Top-up Supplement ($2.47 per day).

If the consumer moves to a different home care provider after 1 August 2013, the Top-up Supplement can continue to be paid to the new provider in respect of the consumer, as long as the period between ceasing the former package and commencing the new package is not more than 28 days.

3. Care and services

3.1 Overview

There will be flexibility in the way consumers can choose care and services under Home Care Packages, across all four levels.

[17] Annual subsidy amounts have been rounded to the nearest dollar.

There is a common (single) list of care and services across all four package levels. There is also a single list of excluded items that applies across all four package levels.

The list of care and services and the excluded items are set out in the following tables (Sections 3.5 and 3.6). These tables are based on the information contained in Schedule 4 to the *Quality of Care Principles 1997.*[18]

The list of care and services is not an exhaustive list, nor is it expected that all of the care and services listed will be provided to an individual consumer through a Home Care Package.

The main difference between the home care levels is the amount of care and services that can be provided to the consumer, rather than the type of care at each package level. More care and services can be provided under Home Care Level 4, compared to the other home care levels, reflecting the higher subsidy amount that is paid for the Level 4 package.

The consumer and the home care provider can also negotiate other care and services required to support the consumer to live at home where this will assist the consumer to achieve his/her goals, consistent with the consumer's care needs.[19] The home care provider must also be able to provide the care and services within the limits of the resources available for the package, and the care and services must not be an excluded item (ie outside the scope of the Home Care Packages Program).

This increased flexibility applies to all Home Care Packages, including packages that were previously allocated as CACP, EACH or EACHD packages.

The care and services must be provided by the home care provider in a way that meets the Home Care Common Standards.

3.2 Nursing, allied health and other clinical services

Where required, a consumer can access nursing, allied health or other clinical services (such as hearing or vision services) under any level of Home Care Package. This is a change from the former CACPs, which did not include these types of services.

While nursing, allied health or other clinical services may be provided as part of Home Care Level 1 and 2 packages, these packages are not intended to provide comprehensive clinical or health services. Home Care Level 3 and 4 packages have a greater emphasis on delivering complex care in the home, including more clinical care where required.

[18] As amended by the *Quality of Care Amendment (Home Care) Principle 2013.*
[19] The consumer's goals and care needs should be identified in the consumer's care plan.

The home care provider is responsible for ensuring that all home care consumers receive quality care and services that are safe and appropriate to their assessed needs.[20] This includes putting in place appropriate systems to support consumers in an emergency situation, including access to a person or service who can give emergency assistance when needed. Where a consumer has been assessed as requiring nursing services, the home care provider should consider whether there is a need to include in the Home Care Package 24-hour on-call access to care provided by, or under the supervision of, a registered nurse.

3.3 Telehealth and digital technology

The care and services in all package levels may also be used to support the use of:

- telehealth, video conferencing and digital technology (including remote monitoring) where appropriate, to increase access to timely and appropriate care; and
- assistive technology, such as aids and equipment (particularly those that assist a person to perform daily living tasks), as well as devices that assist mobility, communication and personal safety.

3.4 Aids and equipment

The Home Care Packages Program is not intended to be an aids and equipment scheme. However, some aids and equipment, including custom made aids, can be provided to a consumer where this is identified in their care plan and the item/s can be provided within the limits of the resources available for the package.

The home care subsidy can be also used to assist a consumer who requires a motorised wheelchair (or motorised scooter). However, given the high cost of these items, in most cases, it expected that these items would be hired or leased, rather than purchased for the consumer.

If the home care subsidy is used to purchase, or contribute towards the cost of purchasing, a motorised wheelchair or scooter for the consumer, there will need to be a clear understanding between the home care provider and the consumer as to who owns the item, what will happen to the item once the consumer ceases in the package, and who is responsible for ongoing maintenance and repair costs. The agreed position and the responsibilities of each party should be documented and preferably included in the Home Care Agreement between the home care provider and the consumer.

State and territory governments operate specialised aids and equipment schemes to assist people with disabilities, including older people. It is expected that consumers will continue to be able to access specialised aids and equipment schemes where there is a need for support.

[20] *Charter of Rights and Responsibilities for Home Care.*

3.5 List of care and services

The range of care and services available at any level of Home Care Packages includes the following:

A. Care services

Personal services	Personal assistance, including individual attention, individual supervision and physical assistance, with: • bathing, showering including providing shower chairs if necessary, personal hygiene and grooming, dressing and undressing, and using dressing aids • toileting • dressing and undressing • mobility • transfer (including in and out of bed)
Activities of daily living	Personal assistance, including individual attention, individual supervision and physical assistance, with: • communication including assistance to address difficulties arising from impaired hearing, sight or speech, or lack of common language, assistance with the fitting of sensory communication aids, checking hearing aid batteries, cleaning spectacles and assistance in using the telephone
Nutrition, hydration, meal preparation and diet	Includes: • assistance with preparing meals • assistance with special diet for health, religious, cultural or other reasons • assistance with using eating utensils and eating aids and assistance with actual feeding if necessary • providing enteral feeding formula and equipment
Management of skin integrity	Includes: • providing bandages, dressings, and skin emollients
Continence management	Includes: • assessment for and, if required, providing disposable pads and absorbent aids, commode chairs, bedpans and urinals, catheter and urinary drainage appliances and enemas • assistance in using continence aids and appliances and managing continence
Mobility and dexterity	Includes: • providing crutches, quadruped walkers, walking frames, walking sticks and wheelchairs • providing mechanical devices for lifting, bed rails, slide sheets, sheepskins, tri-pillows, and pressure relieving mattresses • assistance in using the above aids

B. Support services

Support services	Includes: • cleaning • personal laundry services, including laundering of the consumer's clothing and bedding that can be machine-washed, and ironing • arranging for dry-cleaning of the consumer's clothing and bedding that cannot be machine washed • gardening • medication management • rehabilitative support, or helping to access rehabilitative support, to meet a professionally determined therapeutic need • emotional support including ongoing support in adjusting to a lifestyle involving increased dependency and assistance for the consumer and carer if appropriate • support for consumers with cognitive impairment, including individual therapy, activities and access to specific programs designed to prevent or manage a particular condition or behaviour, enhance quality of life and provide ongoing support • providing 24-hour on-call access to emergency assistance including access to an emergency call system if the consumer is assessed as requiring it • transport and personal assistance to help the consumer shop, visit health practitioners or attend social activities • respite care • home maintenance, reasonably required to maintain the home and garden in a condition of functional safety and provide an adequate level of security • modifications to the home, such as easy access taps, shower hose or bath rails • assisting the consumer, and the homeowner if the home owner is not the consumer, to access technical advice on major home modifications • advising the consumer on areas of concern in their home that pose safety risks and ways to mitigate the risks • arranging social activities and providing or coordinating transport to social functions, entertainment activities and other out-of-home services • assistance to access support services to maintain personal affairs
Leisure, interests and activities	Includes: • encouragement to take part in social and community activities that promote and protect the consumer's lifestyle, interests and wellbeing

C. Clinical services

Clinical care	Includes: • nursing, allied health and therapy services such as speech therapy, podiatry, occupational or physiotherapy services • other clinical services such as hearing and vision services
Access to other health and related services	Includes: • referral to health practitioners or other service providers

3.6 Excluded items

The following services or items are outside the scope of the Home Care Packages Program and must not be included in a package (at any of the four levels of home care).[21]

Excluded items	• use of the package funds as a source of general income for the consumer • purchase of food, except as part of enteral feeding requirements • payment for permanent accommodation, including assistance with home purchase, mortgage payments or rent • payment of home care fees • payment of fees or charges for other types of care funded or jointly funded by the Australian Government • home modifications or capital items that are not related to the consumer's care needs • travel and accommodation for holidays • cost of entertainment activities, such as club memberships and tickets to sporting events • payment for services and items covered by the Medicare Benefits Schedule or the Pharmaceutical Benefits Scheme • gambling activities • illegal activities

4. Security of tenure

4.1 Responsibilities for the provider

Under the legislation, home care providers are responsible for ensuring a consumer's security of tenure.[22]

The Home Care Agreement must specify how either party may terminate the Home Care Agreement[23] and must not contradict the security of tenure provisions set out in the *User Rights Principles 1997*.[24]

[21] These items are excluded under Part 2 of Schedule 4 to the *Quality of Care Principles 1997*.
[22] Section 56-2 of the *Aged Care Act 1997* and Division 1, Part 3 of the *User Rights Principles 1997*.
[23] Section 23.95 of the *User Rights Principles 1997*.
[24] Division 1, Part 3 of the *User Rights Principles 1997*.

When a consumer commences on a Home Care Package, the home care provider should explain that, at some time in the future, the consumer may no longer be able to continue on the package.

The home care provider may re-allocate the consumer's package to another person only if:

- the consumer cannot be cared for in the community with the resources available to the home care provider;
- the consumer tells the home care provider, in writing, that they wish to move to a location where home care is not available through the home care provider;
- the consumer tells the home care provider, in writing, that they no longer wish to receive the care; or
- the consumer's condition changes so that:
  - they no longer need home care; or
  - the consumer's needs, as assessed by the ACAT, can be more appropriately met by other types of services or care.
- the consumer does not meet his/her responsibilities, as described in the Charter of Rights and Responsibilities for Home Care, for a reason within the consumer's control.

If a transfer to another type of care is necessary, the home care provider should work with the consumer and alternative providers to ensure a smooth transition. This may include arranging another ACAT assessment.

4.2 Consumers moving locality

When a consumer moves to a different location (that is outside the home care provider's service delivery area), the consumer may have to change to another provider. The consumer's package does not transfer with them in these circumstances. In order to continue to receive services under a Home Care Package, the consumer will need to be offered a package from a different home care provider.

The current home care provider should ensure continuity of service delivery during the transfer and assist where possible to arrange services in the new location.

5. Leave provisions

5.1 Overview

A consumer may choose or need to take temporary leave from their Home Care Package for various reasons – for social purposes such as a holiday, a hospital stay which may sometimes be followed by transition care, or to receive respite care.

There were previously different leave provisions between CACP and EACH/EACHD packages.

With the introduction of the new Home Care Packages Program, leave arrangements will be the same across all four home care levels. There will also be more consistent rules across the different types of leave.

5.2 Leave arrangements

The following arrangements will apply to all Home Care Package levels (1 to 4).

Type of leave	Impact on payment of subsidy to approved provider
Hospital	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 *consecutive* days in a financial year, for each episode of hospitalisation. • After 28 consecutive days, the subsidy is payable at 25% of the basic subsidy rate.
Transition care	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 *consecutive* days in a financial year, for each episode of transition care. • After 28 consecutive days, the subsidy is payable at 25% of the basic subsidy rate.
Respite care	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 *cumulative* days in a financial year. • After 28 cumulative days, the subsidy is payable at 25% of the basic subsidy rate.
Social leave	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 *cumulative* days in a financial year. • After 28 cumulative days, the subsidy is payable at 25% of the basic subsidy rate.

A consumer's tenure will not be affected while on leave as long as they advise the home care provider in writing they are taking leave. The consumer must also advise the home care provider in writing of any extension to a planned episode of leave.

A consumer may wish to temporarily suspend some or all of the care and services they receive under their package while they are on leave. The consumer must advise the home care provider of the relevant dates for the proposed suspension of services.

Leave entitlements are usually calculated on a financial year basis from 1 July. However, in 2013-14, leave entitlements will be calculated from the commencement of the Home Care Packages Program on 1 August 2013. This means that any leave taken by a consumer in during the period 1 - 31 July 2013 under the former CACP, EACH or EACHD packages will be re-set from 1 August 2013, once these packages convert to Home Care Level 2 or 4 packages.

If a consumer transfers to a different Home Care Package level, such as from Level 3 to Level 4, within the same financial year, their full leave entitlements are available under the new level.

5.3 Impact of leave on consumer fees (care fees)

A consumer may be required to pay an ongoing care fee to the home care provider while the consumer is on leave from their package. This amount must be no more than the usual fee agreed between the consumer and the home care provider.

Care fees must not be charged by the home care provider where the consumer takes leave for transition care or residential respite care.

5.4 Impact of leave on supplements

Where the home care provider is eligible to receive a supplement/s in relation to a home care consumer, the supplement/s will continue to be paid when the consumer takes leave from their package, during the period where the home care subsidy is paid at the full basic subsidy rate.

The Viability Supplement and the Aged Care Workforce Supplement will also continue to be paid during a period of leave, including where the home care subsidy is paid at the reduced (25%) rate. The amount payable for the Aged Care Workforce Supplement will be based on the basic subsidy amount applicable at that time, ie the 25% rate. The amount of the Viability Supplement remains unchanged while the consumer is on leave.

No other supplement will be paid when the home care subsidy is paid at the reduced (25%) rate (as explained in the above table at Section 5.2).

5.5 Subsidy and care fees during leave periods (in packages delivered on a CDC basis)

For Home Care Packages being delivered on a CDC basis, any subsidy, relevant supplements[25] or care fees paid to the home care provider while the consumer is on leave must be included in the regular statement of income and expenditure provided to the consumer.

[25] Dementia and Cognition, Veterans, Oxygen, Enteral Feeding and Top-Up Supplements (where applicable).

PART F – RIGHTS AND RESPONSIBILITIES

Covered in this part

- Context
- Consumers
  - Rights and responsibilities
  - Advocacy
  - Complaints (including the Aged Care Complaints Scheme)
- Approved providers
  - Responsibilities
- Police check/certificate requirements
- Quality Reporting Program
- Qualifications of staff and workers

1. Context

The information contained in this Part is an overview and a guide to assist approved providers and consumers understand their rights and responsibilities in home care, including resources and programs relating to advocacy and complaints.

However, this information is not intended to be a legal resource for providers or consumers. In the case of any discrepancy between the information contained in the Guidelines and the legislation, the legislative provisions take precedence.

Note – In this Part, the term "approved provider" is used rather than "home care provider". This is because there are a number of legislative references to matters affecting approved providers in this Part.

2. Consumers

2.1 Rights and responsibilities

The rights and responsibilities of the consumer in relation to Home Care Packages are set out in the *Charter of Rights and Responsibilities for Home Care* (the Charter).[26]

The Charter is contained in Schedule 2 to the *User Rights Principles 1997*. The full Charter will be available on the Department's website.

The rights and responsibilities should be clearly explained to the consumer by the approved provider. A copy of the Charter must be provided to the consumer with the Home Care Agreement.

[26] The Charter was previously called the *Charter of Rights and Responsibilities for Community Care*.

2.2 Advocacy

The consumer (either the care recipient or their representative) can request that another person assist them in dealings with the approved provider.

A consumer has the right to call on an advocate of their choice to represent them in managing their care. Services provided by an advocate may include:

- establishing or reviewing the Home Care Agreement and care plan;
- negotiating the fees the consumer may be asked to pay by the approved provider; and
- presenting any complaints the consumer may have.

The approved provider must allow an advocate acting for an authorised body access to the home care service if the consumer or their representative has requested the assistance of such a person.[27]

Approved providers must accept the consumer's choice of advocate.

Approved providers should give consumers information about the role of advocates.

The National Aged Care Advocacy Program (NACAP) is a program funded by the Australian Government under the *Aged Care Act 1997*. The program promotes the rights of people who are seeking or are receiving Australian Government funded aged care services.

The National Aged Care Advocacy line is **1800 700 600** (free call).

2.3 Complaints

If consumers are concerned about any aspect of service delivery, they should, in the first place, approach the approved provider. In most cases, the approved provider is best placed to resolve complaints and alleviate the consumer's concerns. Approved providers must accept a complaint regardless of whether it is made orally, in writing or anonymously.

Approved providers must have appropriate processes in place to receive, record and resolve complaints.[28] These processes are to include consideration of people with special needs such as people with vision or hearing impairments and people from culturally and linguistically diverse backgrounds. Approved providers are required to inform consumers about these mechanisms and they must be identified in the Home Care Agreement.

[27] Section 23.23 of the *User Rights Principles 1997*.
[28] Section 56-4 of the *Aged Care Act 1997*.

Approved providers must not discontinue provision of goods or services, refuse access or otherwise take recrimination against any person because they have made a complaint. Approved providers must handle and address any complaints fairly, promptly and confidentially.

Approved providers are to record, monitor, collate and analyse trends in complaints so that this information can be used to improve services.

Consumers should be actively encouraged to provide feedback about the services they receive. Approved providers must also make available information about the Aged Care Complaints Scheme, including information about how to make contact with the Complaints Scheme.

2.4 Aged Care Complaints Scheme

The Complaints Scheme is a free service for people to raise their concerns about the quality of care or services being delivered to people receiving aged care services that are subsidised by the Australian Government.

The Complaints Scheme can be contacted on **1800 550 552**. Complaints can also be made to the Scheme in writing and via the Scheme website (see link below).

When someone lodges a complaint with the Aged Care Complaints Scheme, the Complaints Scheme will explain the process, options for resolution and what can be achieved through those options. Options for resolution open to the Complaints Scheme include:

- asking the service provider to resolve concerns directly with the complainant and report back to the Complaints Scheme on the outcomes;
- conciliating an outcome between the provider and the complainant; and
- investigating the concerns.

The processes of the Complaints Scheme, including options for resolution, are governed by the *Complaints Principles 2011* under the Act.

The Complaints Scheme assesses quality of care and services in line with a provider's responsibilities under the Act including those outlined in:

- the Charter of Rights and Responsibilities for Home Care; and
- the Home Care Standards.

The Complaints Scheme has the capacity to require a provider to take action where they are not meeting these responsibilities.

More information can be found on the Aged Care Complaints Scheme website.

3. Approved providers

3.1 Responsibilities

Approved providers have a number of responsibilities under the *Aged Care Act 1997*. These responsibilities relate to:

- quality of care – Part 4.1 of the Act;
- user rights (ie the rights of the consumer) – Part 4.2 of the Act; and
- accountability for the care that is provided, including the suitability of their key personnel – Part 4.3 of the Act.

Compliance action, including sanctions, under Part 4.4 of the Act may be taken against approved providers who do not meet their responsibilities.

3.1.1 Quality of care

Division 54 of the Act outlines the responsibilities of approved providers in relation to the quality of care.

This includes providing care and services in accordance with the *Quality of Care Principles 1997* and complying with the Home Care Standards.

Through the Quality Reporting Program, the Department undertakes reviews of approved providers against the Home Care Standards. The Quality Reporting Program is explained below (see Section 5 in this Part).

Approved providers must also maintain an adequate number of appropriately skilled staff to ensure that the needs of consumers are met (see Section 6 in this Part).

3.1.2 User rights

Division 56 of the Act outlines the general responsibilities of approved providers in relation to consumers (users and proposed users) of Home Care Packages. These responsibilities are described in further detail in Part 4.2 of the Act and in the *User Rights Principles 1997*.

In summary, the responsibilities of approved providers include:

- charging fees in accordance with the Act;
- providing security of tenure;
- entering (or offering to enter) into a Home Care Agreement;
- protecting personal information;
- resolving complaints;
- complying with any rights and responsibilities of consumers that are specified in the Users Rights Principles.

As explained in the consumer rights and responsibilities (earlier in this Part of the Guidelines), the approved provider must also allow an advocate acting for an authorised body access to the home care service if the consumer or their representative has requested the assistance of such a person.

3.1.3 Accountability

Division 63 of the Act deals with the accountability requirements for approved providers, including:

- record keeping;
- complying with powers being excercised by authorised officers;
- complying with conditions of allocation;
- complying with responsibilities specified in the *Accountability Principles 1998* (includes police check/certificate requirements); and
- obligations in relation to key personnel.

4. Police check/certificate requirements

4.1 Key personnel

Section 22.3B of the *Sanctions Principles 1998* outline the reasonable steps to be taken by an approved provider to ensure none of its key personnel is a disqualified individual. Approved providers are required to obtain a signed statutory declaration from its key personnel stating whether he or she has been convicted of an indictable offence or is an insolvent under administration.

The approved provider must:

- seek (with the person's permission) a report from the Australian Federal Police about a person's criminal conviction record;
- conduct a search of bankruptcy records;
- conduct previous employment and referee checks;
- ensure the person understands the obligations of the Act in relation to disqualified individuals;
- be satisfied the person is mentally capable of performing the duties as key personnel; and
- ensure a disqualified individual ceases to be one of the approved provider's key personnel.

Sections 1.19 to 1.22 of the *Accountability Principles 1998* and section 19.5A of the *Records Principles 1997* outline the responsibilities of approved providers in relation to police checks or police certificates (the names are used interchangeably) for staff members, contractors and volunteers.

Approved providers are required to ensure that police certificates, not more than three years old, are held by:

- all staff members who are reasonably likely to have access to care recipients, whether supervised or unsupervised; and
- volunteers who have unsupervised access to care recipients, except in the case of volunteers sourced by an approved provider through the Community Visitors Scheme (CVS). Organisations funded under the CVS to recruit, train and place volunteers are required to undertake the police checks for such volunteers.

The approved provider must be satisfied that the police certificate does not record that the person has been:

- convicted of murder of sexual assault; or
- convicted of, and sentenced to imprisonment for, any other form of assault.

Any person with a conviction for such offences listed above must not be allowed to provide any other care or ancillary duties.

4.2 Staff member

A staff member is defined in section 1.18 of the *Accountability Principles 1998* as a person who:

- has turned 16 years of age; and
- is employed, hired, retained or contracted by the approved provider (whether directly or through an employment or recruitment agency) to provide care or other services under the control of the approved provider; and
- has, or is reasonably likely to have, access to care recipients.

4.3 Volunteer

Under section 1.18 of the *Accountability Principles 1998*, a volunteer is defined as a person who:

- is not a staff member; and
- offers his or her services to the approved provider; and
- provides care or other services on the invitation of the approved provider and not solely on the express or implied invitation of a care recipient; and
- has, or is reasonably likely to have, unsupervised access to care recipients; and
- has turned 16 years of age or, if the person is a full-time student, has turned 18 years of age.

4.4 Contractors

Where an approved provider has a contract with an agency that provides staff who work under the control of the approved provider, the contracted individuals may be considered staff members under the Act. Sub-contractors who work under the control of the approved provider may also be considered as staff members under the Act.

The contract between the agency and the approved provider should state that any staff provided that are considered staff members under the Act must have a current police certificate, which does not preclude them from working in aged care.

4.5 Independent contractors

Police check requirements are not intended to extend to people engaged on an ad hoc basis. For example, trades people engaged as independent contractors generally do not require police checks.

Services that are also provided to the public at large, such as a gym, would generally be regarded as services provided by independent contractors. If a home care consumer is attending a gym as part of his/her package, the approved provider is not required to ensure that staff or employees of the gym have undergone a police check (unless the person is also a staff member of the approved provider).

Visiting medical practitioners, pharmacists and other health professionals who have been requested by, or on behalf of, a consumer but are not under contract to the approved provider also do not require police checks. The policy intention is to allow for reasonable judgments to be made.

Approved providers have an overarching responsibility to protect the health, safety and wellbeing of consumers, and independent contractors and health professionals should be subject to appropriate supervision.

Approved providers can use the following indicators as a guide to establish whether a person is an independent contractor:

- the contractor has an ABN;
- the contractor advertises his or her services;
- the contractor has clients other than the approved provider;
- the approved provider does not determine the working hours and wages of the contractor;
- the approved provider does not make superannuation payments on behalf of the contractor; and
- the approved provider does not pay the contractor holiday pay or sick leave.

The difference between a contractor and an independent contractor is generally decided on the basis of the degree of control that is exercised over the person's

work. A precise determination of whether a contractor is under the control of an approved provider can be difficult, and whether someone is a staff member or an independent contractor is a matter that might ultimately be determined by the courts.

To assist employers to determine whether an individual is a staff member or an independent contractor, a Contractor Decision Tool is available at the business.gov.au website.

Further information about police checks is available:

- by phone: **1800 200 422**
- in writing to:
  - the Department's inbox "Police Checks@health.gov.au"
  - Police Checks MDP 452
    Department of Health and Ageing
    GPO Box 9848
    Canberra ACT 2601
- online: at the Police Certificate Guidelines for Aged Care Providers website.

5. Quality Reporting Program

The Home Care Standards apply to the delivery of Home Care Packages. The Standards are contained in Schedule 5 to the *Quality of Care Principles 1997*.

The Home Care Standards set the standards for the quality of care and services for the provision of home care to older Australians. They serve to ensure that a service provider:

- demonstrates it has effective management processes based on a continuous improvement approach;
- ensures all consumers (current and prospective) have access to care and services that are appropriate to their assessed needs; and
- ensures all consumers (current and prospective) are provided with information that enable them to make choices about the care they receive, are consulted about the care to be provided and are given information about their rights and responsibilities.

A copy of the Home Care Standards will be available on the Department's website.

All approved providers are required to undertake a quality review once during each three-year cycle. These reviews encourage service providers to improve the quality of their service delivery within a continuous improvement model and show how they are addressing the Home Care Standards.

The quality review process is currently managed by the Department of Health and Ageing. From 1 July 2014, this will be one of the responsibilities of the Australian Aged Care Quality Agency.

Further information about the Home Care Standards and Quality Reporting arrangements will be available on the Department's website.

6. Qualifications of staff and workers

The Department does not set specific levels of qualifications or training for case managers or workers involved in the delivery of Home Care Packages. However, it is expected that case managers, care co-ordinators and care workers will have the appropriate level of skills and training in order to provide quality care to consumers, and for the approved provider to meet its responsibilities.

The approved provider should regularly monitor roles and tasks of case managers, co-ordinators, staff and sub-contractors to ensure that all staff and workers are adequately trained, supported and supervised where required.

With the introduction of CDC in new Home Care Packages from August 2013, and in all packages from July 2015, it is important for all staff and workers to understand what CDC means, including how care and services should be delivered on a CDC basis. In many cases, this will require additional training and support for staff and workers.

PART G – CONSUMER CARE FEES

Covered in this part

- Overview
  - Arrangements from 1 August 2013
  - Arrangements from 1 July 2014
- Determining care fees
- Payment of care fees in advance
- Review of care fees
- What constitutes income

1. Overview

1.1 Arrangements from 1 August 2013

Under the former CACP, EACH and EACHD packages, an approved provider could charge a care recipient contribution (also known as a care recipient fee, care fee or consumer fee) in certain circumstances.

These arrangements will continue to apply from 1 August 2013 under the Home Care Packages Program – as set out in this Part, Sections 2 to 5 below.

1.2 Arrangements from 1 July 2014

As part of the *Living Longer Living Better* aged care reforms, from 1 July 2014, new arrangements will apply to the way that the home care subsidy is calculated.

Consumers entering home care after 1 July 2014 may be asked to make a contribution towards their care, based on their income (similar to current arrangements), with additional safeguards of annual and lifetime caps and financial hardship provisions. Under the new arrangements, the subsidy payable by the Government will be reduced according to the income tested care fee payable. The income testing arrangements and the care subsidy reduction will be administered by the Department of Human Services.

Further information about these changes will be available from the **My Aged Care** website and national contact centre prior to the introduction of the new subsidy and fee arrangements in July 2014. The Home Care Packages Guidelines will also be updated in the first half of 2014 to explain the new income testing and care subsidy reduction arrangements.

2. Determining care fees

The maximum fee that a consumer can be asked to pay in a care recipient contribution (referred to in these Guidelines as a care fee) is determined by the legislation.[29]

If the consumer's income is ...	Then ...
the basic rate of the single pension	the maximum fee is 17.5 per cent of the basic rate of the single pension; this applies to both single and married consumers
more than the basic rate of the single pension	the maximum fee is 17.5 per cent of the person's income to the level of the basic pension plus up to 50 per cent of income above the basic pension

Example: Where a consumer receives the maximum single pension, for example $733.70 per fortnight, the maximum fee they would pay is $128.40 per fortnight. This is a notional calculation. For the most up to date basic pension amount refer to the Centrelink website.

For a consumer receiving the maximum single pension, the maximum amount payable is updated twice a year and published on the Department of Health and Ageing care recipient contributions and subsidies for Home Care Packages website.

If a consumer is married, the calculation is made based on the maximum basic rate of the single pension.

The maximum amount that can be levied depends on the consumer's income but the provider must also have regard to unavoidable expenses such as high pharmaceutical bills, rent, utilities and other living expenses.

Where two consumers live together and both are receiving packages, they may elect to pool their resources by sharing costs of the services across their individualised budgets.

A consumer's access to a Home Care Package must not be affected by their ability to pay fees, but should be based on the need for care, and the capacity of the home care provider to meet that need.

The legislation also requires that information about fees, including how fees are calculated and the fees payable, is included in the Home Care Agreement between the consumer and the home care provider.[30]

[29] Paragraph 56-2(b) and Division 60 of the *Aged Care Act 1997* and Part 7 of the *User Rights Principles 1997.*

[30] Paragraph 23.95(a) of the *User Rights Principles 1997.*

3. Payment of care fees in advance

Home care providers may ask for fees to be paid up to one month in advance. If a consumer leaves the care program, any payment in advance beyond the date of leaving must be refunded to the consumer or their representative as soon as possible.

4. Review of care fees

A review of fees must be conducted at least annually, or more often if requested by the consumer. The consumer should be encouraged to seek such a review if their financial circumstances change.

The maximum fee may need to be varied when new rates for the aged pension are announced each March and September. Home care providers may need to discuss the impact of these changes on fees with the consumer.

5. What constitutes income?

Income is defined as income after income tax and the Medicare levy. When home care providers are calculating income for the purpose of determining ongoing fees, they will exclude:

- any pharmaceutical allowance, rent assistance or telephone allowance received by the consumer;
- the pension supplement;
- the Clean Energy Supplement; and
- in the case of a pension payable under the *Veterans' Entitlements Act 1986* (except a service pension), an amount equal to four per cent of the amount of the pension.

PART H – SUPPLEMENTS

Covered in this part

- Eligibility for supplements
  - Dementia and Cognition Supplement and Veterans' Supplement
  - Oxygen Supplement
  - Enteral Feeding Supplement
  - Viability Supplement
  - Aged Care Workforce Supplement
  - Top-up Supplement

1. Eligibility for Supplements

In addition to the base level of subsidy for a Home Care Package, consumers may be eligible for one or more supplements.

Supplements are paid to a home care provider, in recognition of the additional costs associated with certain care and service requirements for the consumer. The range of supplements is described below along with the eligibility criteria for each.

1.1 Dementia and Cognition Supplement and Veterans' Supplement

From 1 August 2013, a new Dementia and Cognition Supplement will be available to all home care consumers who meet the eligibility criteria for the supplement (across any of the four levels of Home Care Packages). The Dementia and Cognition Supplement will provide an extra 10% funding on top of the basic subsidy amount for the relevant Home Care Package.

There will also be a new funding supplement for veterans with an accepted mental health condition. Like the Dementia and Cognition Supplement, the Veterans' Supplement will provide an extra 10% funding on top of the basic subsidy amount for the relevant Home Care Package level for eligible consumers. A home care provider can receive either the Dementia and Cognition Supplement or the Veterans' Supplement in respect of an eligible consumer, but not both supplements.

The purpose of these supplements is to provide additional financial assistance to home care providers in recognition of the additional costs associated with dementia and mental health care.

Guidelines for these supplements are available on the *Living Longer Living Better* website.

Supplements amounts for 2013-14 are outlined in the following table.

Home Care Package	Level 1	Level 2	Level 3	Level 4
Home Care Package basic subsidy	$20.55	$37.38	$82.20	$124.95
Dementia and Cognition Supplement (10%)	$2.06	$3.74	$8.22	$12.50
Veterans' Supplement (10%)	$2.06	$3.74	$8.22	$12.50

1.2 Oxygen Supplement

The Oxygen Supplement is available to consumers at any Home Care Package level, who have a clinical need (ie meet the eligibility criteria). Previously, it was only available to consumers receiving an EACH or EACHD package.

The Oxygen Supplement is paid to the home care provider for a consumer who has an ongoing medical need for oxygen. There is no supplement available for episodic or short-term illnesses such as bronchitis.

The need for consumers will normally be met by an oxygen concentrator. The standard supplement allows for some cylinder oxygen for the consumer's outings. A higher supplement may be approved if an oxygen concentrator does not meet the medical requirements.

A higher supplement is not available unless the costs incurred are at least 25% above the standard supplement. This higher supplement will not be approved where higher costs are due to a more expensive source of supply than is required, for instance, a higher level supplement cannot be approved where cylinder oxygen is used in circumstances where concentrator oxygen would meet the consumer's needs.

The general practice for oxygen usage is that, subject to the various conditions, the home care provider must manage the package (and the supplement) to provide the best result for the consumer. If the consumer chooses to use more expensive options, then the provider would have to negotiate on the services or the consumer could pay the extra cost themselves.

An application form seeking the supplement for consumers receiving eligible oxygen treatment, titled, *Application for Eligible Oxygen Treatment and/or Enteral Feeding Supplement* must be submitted (with a medical certificate by a doctor stating the particular requirements) to the relevant state or territory Department of Human Services office in which the service is located. This form can be downloaded from the Department of Human Services Aged Care Forms website.

Once approved, any change in circumstances relating to the eligibility for the supplement must be notified to the relevant Department of Human Services state office with the monthly subsidy claim.

The rates for the Oxygen Supplement are the same as the Residential Aged Care Supplements (Care Related) rates. The rates are available on the Department of Health and Ageing Australian Government subsidies and supplements website.

1.3 Enteral Feeding Supplement

The Enteral Feeding Supplement is available to consumers at any Home Care Package level, who have a clinical need (ie meet the eligibility criteria). Previously, it was only available to consumers receiving an EACH or EACHD package.

The Enteral Feeding Supplement is paid to the home care provider for a consumer who requires enteral feeding on an ongoing basis. To be eligible for an enteral feeding supplement, the consumer must be receiving a complete food formula by means of a nasogastric, gastrostomy or jejunostomy tube. Enteral Feeding Supplements are not provided if formula is taken orally.

A higher supplement may be approved when, for example:

- a consumer requires greater than the standard volume of 1892 mls per day;
- a more expensive formula is required to meet special medical needs (for example diabetes or rehabilitation/weight gain required); and/or
- a mechanical pump may be required for the formula to be delivered over time or if a thicker formula is required. (An additional flexitainer is also usually required in these circumstances.)

There are two levels of the supplement, one for bolus and another for non-bolus feeding. A higher supplement may only be approved where a medical certificate is provided and the costs incurred are at least 25% above the standard supplement. A higher-level supplement cannot be approved if the higher costs are due to a more expensive source of supply for the formula or equipment.

An application form seeking the supplement for consumers receiving eligible enteral feeding titled, *Application for Eligible Oxygen Treatment and/or Enteral Feeding Supplement* must be submitted (with a medical certificate by a doctor or dietician stating the particular requirements) to the relevant state or territory Department of Human Services office in which the service is located. This form can be downloaded from the Department of Human Services aged care forms website.

Once approved, any change in circumstances relating to the eligibility for the supplement must be notified to the relevant Department of Human Services state office with the monthly subsidy claim.

The rates for the Enteral Feeding Supplements are the same as the Residential Aged Care Supplements (Care Related) rates. The rates are available on the Department of Health and Ageing Australian Government subsidies and supplements website.

1.4 Viability Supplement

The Viability Supplement is available across all Home Care Package levels and recognises the higher costs associated with attracting and retaining staff as well as other resource implications faced in providing home care services in rural and remote areas.

The Viability Supplement is dependent on the consumer's location according to their Accessibility Remoteness Index of Australia (ARIA) value. The amount of the supplement varies depending on the remoteness of the consumer's location. ARIA values for geographical locations in Australia can be found on the Department of Human Services useful links and information website.

The home care provider is automatically paid the supplement through the Department of Human Services payment system, when the Home Care Package subsidy claim form is submitted, and where the location of the consumer receiving the Home Care Package has been provided.

Information about the Viability Supplement including the subsidy rates is available on the Department of Health and Ageing Australian Government subsidies and supplements website.

1.5 Aged Care Workforce Supplement

The *Living Longer Living Better* aged care reform package includes funding to better support the people who work in aged care. All home care providers that meet the requirements of the Aged Care Workforce Supplement will be eligible to apply for the Workforce Supplement.

From 1 August 2013, the Australian Government will provide additional funding through the Aged Care Workforce Supplement to participating home care providers that meet the eligibility requirements. This additional funding will assist participating providers to pay higher wages to aged care workers.

The amount of the Aged Care Workforce Supplement payable to home care providers is 1% of the basic subsidy amount.

Further information about the supplement and details on how to apply can be found in the Aged Care Workforce Supplement Guidelines on the *Living Longer Living Better* website.

1.6 Top-up Supplement (for existing EACHD consumers)

The Top-up Supplement provides an additional payment to the home care provider, on top of the basic subsidy amount, in respect of a consumer receiving care under an EACHD package on 31 July 2013. The Top-up Supplement is explained in Part E, Section 2.

PART I – ADMINISTRATIVE ARRANGEMENTS FOR APPROVED PROVIDERS

Covered in this part

- Conditions of allocations to replace agreements
  - Conditions of allocation
  - Commencement of packages
- Variations, transfer and surrender or relinquishment of places (packages)
  - Variations of places
  - Transfer of places
  - Surrender or relinquishment of places
- Financial reporting to the Department
- Claims process
  - Home care subsidy payments
  - Home care subsidy is GST free
  - Other taxation requirements

Note – In this Part, the term "approved provider" is used rather than "home care provider". This is because there are a number of legislative references to matters affecting approved providers in this Part.

1. Conditions of allocation to replace agreements

Prior to 1 August 2013, approved providers were required to enter into contractual agreements with the Commonwealth in relation to allocations of community care places (CACP) or flexible care places (EACH or EACHD packages).

CACPs were governed by a Community Care Deed of Agreement, and EACH and EACHD packages were governed by separate Payment Agreements.

From 1 August 2013, there will no longer be a requirement for approved providers to enter into an agreement with the Commonwealth in respect of allocations of new Home Care Packages. This change will take effect when Schedule 1 to the *Aged Care (Living Longer Living Better) Act 2013* and the transitional provisions in the *Allocation Principles 1997* commence.

Instead, the types of matters contained in the previous agreements will be included in the various Principles made under the *Aged Care Act 1997* or will be part of the conditions of allocation for the package. For all new packages, including those allocated to providers in the 2012-13 ACAR, the conditions of allocation will include a requirement that the packages must be delivered on a CDC basis.

Existing agreements (Deeds of Agreement for CACPs and Payment Agreements for EACH/EACHD packages) will automatically cease from 1 August 2013, once the transitional provisions in the legislation take effect. However, all existing conditions of allocation in respect of those places will continue to apply.

1.1 Conditions of allocation

The conditions of allocation for Home Care Packages form part of the Notice of Allocation issued to the approved provider under section 14-8 of the Act.

Approved providers are required to comply with all conditions of allocation. The conditions may cover matters such as:

- the number of home care places (packages) for which the home care subsidy is payable;
- the aged care planning region, including, as necessary, specific locations in a planning region, in which the packages must be provided;
- the minimum number or proportion of packages to be provided to people from special needs groups;
- specific undertakings made by the approved providers in any application for new or in respect of existing packages, and approved by the Secretary of the Department as a condition of allocation;
- delivering the package on a CDC basis;
- participating in an evaluation of the Home Care Packages Program, including the CDC arrangements;
- financial reporting obligations;
- other conditions as appropriate.

Additional conditions of allocation may be issued from time to time under section 14-6 of the Act.

1.2 Commencement of packages

An allocation of packages to an approved provider takes effect when the Secretary of the Department (or delegate) determines that the approved provider is in a position to provide care in respect of those packages. The approved provider will be advised of this through a Notice of Allocation from the Department issued under section 14-8 of the Act.

Packages may be allocated with immediate effect (from a specified date), or on a provisional basis (if the approved provider is not ready to commence the package immediately).

If the package has been allocated on a provisional basis, the approved provider must advise the Department in writing when they are able to commence providing services. An approved provider must apply in writing to the Secretary using the form

titled, *Application for a Determination that an Approved Provider is in a Position to Provide Care – Home Care*. This application form will be available on the Department's website.

Once this information has been considered by the Department, the delegate will make a determination under section 15-1 of the Act, and once approved, this will enable the approved provider to commence claiming a subsidy for the package. Such determinations cannot be backdated.

2. Variations, transfers and surrender or relinquishment of packages

2.1 Variations of packages

An approved provider can apply to the Secretary of the Department to vary an allocation of places (Home Care Packages) in certain circumstances, for example, to change conditions of allocation relating to geographic locations or special needs groups.

There are separate application forms for the variation of packages that have taken effect (operational places) and packages that are yet to take effect (provisionally allocated places). These forms will be available on the Department's website from mid 2013.

A variation cannot take effect unless it has been approved by the Secretary.

An application for a variation of packages should not be made in the following circumstances:

- Where an approved provider is seeking to change the name of a service, the approved provider should advise the Department in writing. However, this does not have to be done via an application form.
- There is no capacity under the legislation to approve a variation in the level of the Home Care Package that has been allocated to an approved provider, for example, from a Level 1 or 2 package to a Level 3 or 4 package. Providers seeking to obtain packages at a different level should apply through the Aged Care Approvals Round.
- There will be a separate process for approved providers seeking to "convert" existing packages from a non-CDC basis to a CDC basis. Further information about this process will be available on the Department's website after the commencement of the Home Care Packages Program. Information will also be communicated to existing providers through a mailstream/faxstream.

2.2 Transfer of packages

An approved provider may apply in writing to the Secretary of the Department to transfer operational places under sections 16-1 and 16-2 of the Act.

Further information, including an application form, will be available on the Department's website.

The application form must be completed by both the approved provider holding the allocation of packages (the transferor) and the party seeking the packages (the transferee). If the packages proposed to be transferred are to be allocated to more than one service, a separate application form must be submitted in respect of each service.

A transfer of a package cannot take effect unless it has been approved by the Secretary. An application to transfer packages can only be considered in respect of operational places, not provisionally allocated places.

2.3 Surrender or relinquishment of packages

While an approved provider would not normally surrender or relinquish an allocation of packages, there is capacity to do this under the Act.

In these circumstances, the approved provider should contact the relevant state or territory office of the Department.

3. Financial reporting to the Department

Approved providers are required to provide an audited Financial Accountability Report (FAR) and Statement of Compliance to the Department of Health and Ageing each financial year.

These requirements were previously specified in the relevant agreements for the CACP, EACH and EACHD packages. While these agreements will no longer have effect from 1 August 2013, providers must continue to provide financial reporting information to the Department (in the same format used in previous financial years).

The current Financial Accountability Report and Statement of Compliance process will continue to apply for the 2012-13 financial year (and possibly for 2013-14). Providers who have previously been involved in the Trial of Alternate Audit Approaches can continue to report to the Department through the use of Segment Notes or Extraction Reports.

The Financial Accountability Report (or Segment Notes and Extraction Reports) and Statement of Compliance for the reporting period, 1 July 2012 to 30 June 2013, must be provided to the Department no later than **31 October 2013**.

The Aged Care Financing Authority (ACFA) has been asked to provide advice to the Minister for Mental Health and Ageing by 31 July 2013 on cost effective options for improving the collection of appropriate financial data from aged care providers.

ACFA's advice will be considered by the Minister in the second half of 2013 and will help to inform future financial reporting requirements. Any new requirements are likely to apply from 1 July 2014 when the new financing arrangements for the aged care system commence.

4. Claims process

4.1 Home care subsidy payments

Subsidy payments for Home Care Packages are paid to an approved provider based on the number of consumers for whom a claim is made, up to the maximum number of packages allocated to that approved provider.

There is information on the subsidy amounts for the Home Care Packages at Part E, Section 1 and on the Department of Health and Ageing Australian Government subsidies and supplements website.

Subsidy payments are made by the Department of Human Services on behalf of the Department of Health and Ageing. An approved provider's initial payment claim form covers the payment period from the date when the Home Care Packages become operational.

The initial payment of the subsidy to a new provider is usually based on the provider's estimated number of consumers in the first month of operation. This is up to the maximum number of Home Care Packages allocated to the provider.

To enable initial payments, or to change bank details to enable ongoing payments, approved providers must supply their aged care service's bank details to the Department of Human Services via a form. The form is available on the Department of Human Services aged care forms website. The form is titled *Add or Change Approved Aged Care Service's Bank Details*.

An *Aged Care Approved Provider Statement*, signed by key personnel of an approved provider to advise that appropriate business and security controls are in place, is also required every three years. It ensures all aged care forms, claims and other relevant documentation to claim payments of subsidy under the Act are appropriately authorised. The provider statement only needs to be completed if the approved provider with services is not registered for Aged Care Online Claiming.

The current provider statement is valid for the period 1 July 2011 to 30 June 2014. The next statement is due 30 June 2014 and will be sent to providers with services not registered for Aged Care Online Claiming from the Department of Human Services in April 2014.

After the initial payment period, future monthly payments are adjusted according to the actual number of consumers in the preceding payment periods.

Home Care subsidies are paid monthly in advance, based on the number of Home Care Packages occupied in the second last preceding payment period. For example, a payment to an approved provider for March is based on occupied places claimed for in January. Monthly payments may include an adjustment to account for any over or under-payment in the previous month.

Approved providers are also able to access the Aged Care Online Claiming (ACOC) website, to view a consumers electronic Aged Care Client Record (eACCR) online.

To register to use the ACOC website to view eACCRs, approved providers need to complete a registration form. The registration form is available on the Department of Human Services aged care forms website.

The form is titled *Register or Amend Access for Aged Care Online Claiming Viewing electronic Aged Care Client Records*. Further information about claiming for Home Care Packages is available at the Department of Human Services aged care website.

Additionally, information about online claiming is available at the Department of Human Services online claiming website.

All aged care services (regardless of their location) can contact the Department of Human Services at the Aged Care enquiries line on **1800 195 206** (charges apply from mobile and pay phones).

4.2 Home care subsidy is GST free

Home care subsidies are considered to be "GST free" under section 38-30 of the *A New Tax System (Goods and Services Tax) Act 1999*.

4.3 Other taxation matters

An approved provider must be able to quote its ABN in any Goods and Services Tax (GST) dealings with the ATO or other government departments and agencies, including the Department of Health and Ageing and Department of Human Services. If an approved provider does not have an ABN, the provider cannot be registered for GST, cannot charge GST and does not have any entitlement to input tax credits.

Approved providers should give their ABN to the Department of Health and Ageing and Department of Human Services so they can process and report payments correctly. Approved providers who do not supply their ABN may be subject to withholding tax.

PART J – INTERFACE WITH OTHER PROGRAMS

Covered in this part

- Interface with other programs
- Commonwealth Home Support Program (from July 2015)
- Home and Community Care
- National Respite for Carers Program
- Residential respite
- Day Therapy Centres Program
- Transition Care Program
- Community Visitors Scheme
- Disability programs
- Continence Aids Payment Scheme
- Palliative care
- Hospital in the Home
- Department of Veterans' Affairs Programs
  - Veterans' Home Care
  - Coordinated Veterans' Care
  - Community Nursing
  - Repatriation Appliance Program
  - Veterans' transport for treatment
  - Consumer Fees – former Prisoners of War and Victoria Cross recipients

1. Interface with other programs

It may be possible for a consumer to access care and services through a range of other programs, where these are not provided as part of the consumer's Home Care Package.

This Part provides a short overview of these programs, including the nature of the interface between each program and the Home Care Packages Program.

From 1 July 2013, more detailed information about the individual programs will be available on the My Aged Care website at www.myagedcare.gov.au or the national contact centre on **1800 200 422**.

2. Commonwealth Home Support Program

2.1 Overview of program

As part of the *Living Longer Living Better* aged care reforms, the Australian Government has announced that a new Commonwealth Home Support Program will commence from 1 July 2015.

The Home Support Program will incorporate the existing Commonwealth HACC Program, the National Respite for Carers Program (NRCP), the Day Therapy Centres (DTC) Program, and the Assistance with Care and Housing for the Aged (ACHA) Program.

2.2 Interface with the Home Care Packages Program

The future interface between the Home Care Packages Program and the Commonwealth Home Support Program will be developed in consultation with stakeholders. Further information will be available prior to the commencement of the Commonwealth Home Support Program.

3. Home and Community Care (HACC)

3.1 Overview of program

The Commonwealth HACC Program provides funding for basic maintenance, care and support services for older people and their carers, who live in the community and whose capacity for independent living is at risk, or who are at risk of premature or inappropriate admission to long term residential care. Older people are people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.

The Commonwealth HACC Program currently does not apply in Western Australia and Victoria. In these states, HACC services for consumers of all ages continue to be delivered via a jointly funded Commonwealth/State program which is administered by state governments. Providers in these states should refer to the relevant HACC program guidelines, which should be broadly consistent with guidance in the Commonwealth HACC Program Manual. The transition of responsibility for delivering HACC to older people in Victoria will occur from 1 July 2015.

Note – The information below relates to both the Commonwealth HACC Program and the HACC Program in Victoria and Western Australia.

The HACC Program provides services such as domestic assistance, personal care as well as goods and equipment, transport, meals, home modifications and maintenance, and counselling, information and advocacy.

3.2 Interface with the Home Care Packages Program

Generally, if a person is receiving a Home Care Package, the package will be the primary source of government funding for care and services to the home care consumer. A home care provider can sub-contract to a HACC service provider to provide services as part of a Home Care Package (see Section 3.2.1 below). Additional HACC services can also be provided to a home care consumer, as part of the HACC Program, in limited circumstances (see Section 3.2.2 below).

3.2.1 Sub-contracting services from HACC service providers as part of a Home Care Package

Can a home care provider sub-contract services to a HACC service provider?

- Yes, a home care provider can sub-contract to a HACC service provider to provide services to a home care consumer, for example, personal care, meals, community transport, nursing or allied health services, social activities, or respite care. In these cases, the full cost for providing the service will be paid out of the budget for the Home Care Package.

3.2.2 Accessing HACC services in addition to a Home Care Package

Can a home care consumer access HACC services in addition to their Home Care Package?

- As much as possible, a home care consumer's care needs should be addressed through their Home Care Package. A consumer may, however, access additional HACC services (funded by the HACC Program rather than out of the budget for the Home Care Package) in an emergency, or when a carer is not able to maintain their caring role. These instances should be time limited, monitored and reviewed.

- A home care consumer receiving a Level 1 or 2 package may also access additional nursing or allied health services funded through the HACC Program, where the budget for the Home Care Package has been fully allocated for care needs identified in the consumer's care plan and additional nursing or allied health services are required to support the consumer to remain living at home.

- When a HACC service provider is assessing a home care consumer's eligibility for services under the HACC Program, the service provider must consider any other services that the consumer is already receiving. Priority for HACC services may be given to people who are not receiving any other services.

Can a home care consumer be asked to pay a consumer fee for a HACC service?

- Yes, where a home care consumer is accessing additional services through the HACC Program, the consumer would be expected to pay any consumer fees charged for the HACC service (as applicable).

- The home care subsidy cannot be used to pay consumer fees charged for the HACC service.

4. National Respite for Carers Program (NRCP)

4.1 Overview of program

The Australian Government funds a range of home support services and programs for carers of frail older people. The National Respite for Carers Program (NRCP) is designed to contribute to the support and maintenance of caring relationships between carers and their dependent family members. The NRCP respite services provide community based respite care in a variety of settings, including in carers' homes, day centres, host families and overnight cottages.

4.2 Interface with the Home Care Packages Program

When assessing a carer's eligibility for NRCP services, service providers must consider any other carer support services the carer is receiving. Priority for NRCP services should be given to carers who are not receiving any carer support services.

The home care subsidy cannot to be used to pay for consumer fees/contributions for NRCP services.

5. Residential respite

5.1 Overview of program

Residential respite care provides short-term care in a residential aged care facility for people who are in temporary need of residential care but who intend to return home.

Residential respite care may be used on a planned or emergency basis to provide a break from normal care arrangements, for example, to help with carer stress, illness, holidays, or when the carer is unavailable for any reason.

5.2 Interface with the Home Care Packages Program

A home care consumer can access residential respite care if they have been assessed as eligible for residential respite care by an ACAT, and a respite place is available. A residential respite subsidy will be paid to the respite facility to support this care and the consumer may be asked to pay a contribution to the cost of the respite care.

The home care subsidy cannot be used to pay the consumer contribution for residential respite care. If the consumer is unable to afford the respite care contribution, this should be negotiated with the respite facility.

Under the legislation, a home care fee must not be charged by the home care provider where the consumer takes leave for residential respite care.[31]

6. Day Therapy Centres program

6.1 Overview of program

The aim of the Day Therapy Centre (DTC) Program is to provide a wide range of therapy and services to frail aged people living in the community and to low-care residents of Commonwealth funded residential aged care facilities. It assists them to regain or maintain physical and cognitive abilities which support them to either maintain or recover a level of independence, allowing them to remain either in the community or in low-care residential aged care.

6.1.1 Therapy and services

The main types of therapy and services provided by DTCs are:

- physiotherapy;
- podiatry;
- occupational therapy;
- diversional therapy;
- nursing services;
- speech therapy;
- social work;
- preventative therapies;
- personal services;
- transport to and from the DTC; and
- food services provided in conjunction with therapies.

Other therapy and services may be provided with the prior written agreement of the Commonwealth, through the Department. The therapy and services listed are not exclusive and not all DTCs are expected to cater for all types. There is no single model of service provision for DTCs and they may operate across a range of therapy types, intensity and services.

6.2 Interface with the Home Care Packages Program

As much as possible, it is expected that consumers' care needs will be addressed through their Home Care Package. Where day therapy services have been identified in the home care consumer's care plan, the funding or budget for the Home Care Package may be used to access these services. However, the home care subsidy cannot be used to pay consumer fees/contributions charged by DTCs.

[31] Section 23.89(4A) of the *User Rights Principles 1997.*

7. Transition Care Program

7.1 Overview of program

The Transition Care Program is a jointly funded initiative between the Australian Government and all states and territories.

Transition care provides short-term care that seeks to optimise the functioning and independence of older people after a hospital stay. Transition care is goal-oriented, time-limited and therapy-focussed. It provides older people with a package of services that includes low intensity therapy such as physiotherapy and occupational therapy, as well as social work, nursing support or personal care. It seeks to enable older people to return home after a hospital stay rather than enter residential care prematurely.

To access the Transition Care Program, a person must be assessed as eligible for transition care by an ACAT and the person can only enter transition care directly following a hospital stay.

7.2 Interface with the Home Care Packages Program

A home care consumer can receive transition care if they meet the eligibility criteria for the Transition Care Program. The consumer is able to take leave from their Home Care Package while receiving transition care.

Under the legislation, a home care fee must not be charged by the home care provider where the consumer takes leave for transition care.[32]

8. Community Visitors Scheme

8.1 Overview of program

The Community Visitors Scheme (CVS) is a national program that provides companionship to socially or culturally isolated people living in Australian Government-subsidised aged care homes or receiving home care.

The CVS funds community-based organisations, which arrange community volunteers to visit identified aged care consumers on a regular basis.

These organisations (known as Community Visitors Scheme auspices) carry out the tasks of:

- recruiting, training and supporting volunteer community visitors;
- matching volunteers to residents of aged care homes; and
- supporting visitor-resident relationships.

[32] Section 23.89(4A) of the *User Rights Principles 1997.*

The CVS is funded by the Australian Government and operates in every state and territory.

8.2 Interface with the Home Care Packages Program

From 1 August 2013, the CVS will be expanded to home care. The expansion will also provide opportunities to use innovative technology in home care environments to encourage social networking and help reduce social isolation.

The CVS is available to any home care consumer who is identified by their service provider as at risk of isolation or loneliness, whether for social or cultural reasons or because of disability. A focus of the CVS home care visitor places is people who are in one of the special needs groups identified in the Act.

Consumers receiving a Home Care Package can access the CVS, but they must not be charged fees for visits provided through the CVS.

9. Disability programs

9.1 Overview of program

Under the National Health Reform Agreement, the provision of specialist disability services, including accommodation, respite, community support and community access services is the responsibility of state and territory governments.

The Australian Government provides funding for these services for people who are aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) to access specialist disability services provided by state and territory governments. This enables older people who have been receiving state and territory disability services to choose whether they wish to continue to access these disability services, or receive aged care services instead, in order to receive care most appropriate to their needs.

These arrangements came into place on 1 July 2012.

9.2 DisabilityCare Australia

From 1 July 2013, DisabilityCare Australia (the national disability insurance scheme) will commence initially in South Australia, Tasmania, the Hunter region in New South Wales, and the Barwon region in Victoria. The Australian Capital Territory and the Barkly region of the Northern Territory will join DisabilityCare Australia on 1 July 2014. Additionally, Queensland will begin to roll-out the scheme from July 2016.

DisabilityCare Australia is expected to be fully operational as a national program by 2019-20.

Further information about DisabilityCare Australia is available at the DisabilityCare Australia website.

DisabilityCare Australia will provide reasonable and necessary supports to participants as per section 34 of the *National Disability Insurance Scheme Act 2013*. To become a participant of DisabilityCare Australia, a person must meet:

- age requirements;
- residence requirements; and
- disability or early intervention requirements.

Each of these requirements is specified in Part 1 of the *National Disability Insurance Scheme Act 2013*.

9.3 Interface with the Home Care Packages Program

In general, a person will not be a participant of DisabilityCare Australia or receive disability services at the same time as they receive Australian Government funded aged care services, including a Home Care Package.

A person accessing a Home Care Package would generally relinquish that package upon becoming a participant of DisabilityCare Australia. However, they may continue to receive services outside of the Home Care Package Program from the same service provider if that provider is also registered as a provider with DisabilityCare Australia.

A participant of DisabilityCare Australia who first receives services through the Home Care Packages Program after the person turns 65 years of age ceases to be a participant of DisabilityCare Australia.

Younger people with a disability (including those with younger onset dementia) can receive care and services under a Home Care Package, if they are assessed by the ACAT as eligible.

The final decision to offer a Home Care Package to a young person is made by the home care provider. The provider will need to consider the appropriateness of their service, including what can be offered under a Home Care Package at the level available, to meet the care needs of the younger person.

10. Continence Aids Payment Scheme (CAPS)

10.1 Overview of program

The Continence Aids Payment Scheme is an Australian Government Scheme that provides a payment to assist eligible people who have permanent and severe incontinence to meet some of the costs of their incontinence products.

Further information about the Scheme, including who is eligible to apply for a payment, is available on the Department of Health and Ageing bladderbowel website.

10.2 Interface with the Home Care Packages Program

A person receiving a Home Care Package may be able to receive a payment under the Continence Aids Payment Scheme. However, if the provision of continence aids is identified in the home care consumer's care plan, they will not be eligible for the Scheme.

11. Palliative care

11.1 Overview of palliative care

The Australian Government has undertaken significant reform to the health system to bolster primary care and preventative care services to keep people out of hospital, help people stay well in their community and importantly to ensure the health and well-being of Australians as they age.

While the Australian Government does not directly fund specialist palliative care services, it provides financial support to state and territory governments to operate palliative care services.

As part of the aged care reform package, the Government is providing access to specialist palliative care and advance care planning expertise for aged care providers and GPs caring for recipients of aged care services, through innovative advisory services. The Government has also funded the development of an online education and training package to assist health workers, including general practitioners, nurses and care workers to implement the principles of the *Guidelines for a Palliative Approach for Aged Care in the Community Setting*. The online training is available on the Palliative Care Online website.

These projects align with the *National Palliative Care Strategy*, which aims to raise awareness of and information about palliative care and its benefits, and help build a skilled workforce across the health system to deliver quality palliative care, and will help aged care recipients to remain in familiar surroundings as their care needs change.

11.2 Interface with the Home Care Packages Program

The Home Care Packages Program provides support for the ongoing symptoms of ageing and is not specifically designed to provide palliative care associated with medical conditions or diseases that cause a life limiting illness.

Home care consumers are able to receive palliative care services in addition to their package, but this needs to be arranged by the person's GP or treating hospital.

As with any palliative care arrangement, the palliative care team would coordinate the skills and disciplines of many service providers to ensure appropriate care services. This would include working with the consumer's home care provider.

12. Hospital in the Home

12.1 Overview of program

Hospital in the Home (HITH) is the delivery of acute and post-acute care in the patient's home as a substitute for being in hospital. HITH care is provided by clinicians from many specialties, eg infectious diseases, gerontology, general practice, emergency medicine, orthopaedics, cardiology, paediatrics, rehabilitation, respiratory, surgery and haematology. Access to HITH varies in each state and territory. Further information can be obtained from the local hospital service.

12.2 Interface with the Home Care Packages Program

A person can continue to access services under a Home Care Package while an inpatient on the HITH program. Where particular clinical services such as nursing or allied health services are required by the person, these services can be provided either under the person's Home Care Package or through the HITH Program.

To ensure services are not duplicated, people in receipt of a Home Care Package, who are also receiving treatment on, or being referred to, the HITH Program, should have their care plan reviewed (preferably prior to commencement of HITH services). Where the care plan includes provision of clinical services and support, it may be necessary for the home care provider to amend the plan to ensure the plan does not include the same services.

13. Department of Veterans' Affairs Programs

The Department of Veterans' Affairs (DVA) offers a range of programs to assist veterans and war widows/widowers with their health and wellbeing and who wish to continue living independently in their own home, but who need some assistance to do so.

Through DVA, eligible veterans and war widows/widowers may also access a range of other services, for example the Coordinated Veterans' Care Program, Veterans' Home Care, community nursing, allied health services such as physiotherapy and podiatry, counseling services and transport for health care. For further information on these programs, including guidelines and fact sheets, refer to the Department of Veterans' Affairs website.

Veterans and war widows/widowers are considered a special needs group under the Act and have the same right of access to Home Care Packages as any other member of the community. Specifically, veterans and war widows/widowers should not be discriminated against when accessing Home Care Package services on an assumption that DVA will provide for their overall care needs. Moreover, it is important to note that some services provided by DVA to veterans complement Home Care Packages, as long as duplication can be avoided.

13.1 Veterans' Home Care program

13.1.1 Overview of program

The Veterans' Home Care (VHC) program is administered through DVA, and provides a range of low-level home care services to veterans and war widows/widowers. The VHC program enhances the independence and health outcomes of veterans by reducing the risk of avoidable illness and injury and assisting them to remain independent in their own homes as long as possible.

VHC services include domestic assistance, personal care, safety-related home and garden services, respite (in-home and emergency respite care and approval for residential respite care) and social assistance services as part of the Coordinated Veterans' Care Program. Eligibility to access the VHC program is determined by DVA. DVA has criteria for access to VHC, as set out in the DVA Fact Sheets available on the Department of Veterans' Affairs website. DVA also has comprehensive guidelines on the VHC program, available on the website.

13.1.2 Interface with the Home Care Packages Program

Where a veteran or war widow/widower has increasingly complex care needs and has been identified as requiring a higher level of services than those being received under the VHC program, the veteran or war widow/widower should be referred for an ACAT assessment. The veteran or war widow/widower will then follow the pathway for accessing a Home Care Package outlined in Part C of these Guidelines.

Once a veteran or war widow/widower has been approved by an ACAT as eligible for a Home Care Package and been offered a package by a home care provider, that package becomes the primary source of care for the veteran or war widow/widower and generally VHC services will no longer be required.

The veteran or war widow/widower should not be accessing the same service tasks simultaneously from VHC and the Home Care Package, eg showering. In some instances, however, the veteran or war widow/widower may supplement the care provided under a Home Care Package with some VHC services, such as additional respite care, if the Home Care Package is not sufficient to meet the veteran's or war widow/widower's needs.

DVA may also provide, where appropriate, non-VHC services to the veteran or war widow/widower, such as DVA-contracted community nursing, rehabilitation aids and appliances, allied health and transport to medical appointments, which may not be part of the Home Care Agreement and care plan.

Any approval for additional services through the VHC program must be negotiated between the veteran or war widow/widower, the VHC Assessment Agency and the home care provider.

There will be situations where a consumer of a Home Care Package lives with a person who is a veteran or war widow/widower. In these circumstances, the veteran or war widow/widower should continue to access the full range of services available from VHC, provided there is no duplication of service tasks within the household.

13.2 Coordinated Veterans' Care Program

13.2.1 Overview of program

The Coordinated Veterans' Care (CVC) Program provides ongoing, planned and coordinated primary and community care, led by a general practitioner (GP) with a nurse coordinator (either a practice nurse or DVA community nurse) to eligible veterans and war widow/widowers. To be eligible, veteran participants must be Gold Card holders who have targeted chronic conditions, complex care needs and are at risk of unplanned hospitalisation.

An additional enhancement to the CVC Program is the In-Home Telemonitoring for Veterans trial. Under the trial, participants in selected National Broadband Network sites can have vital signs related to their chronic conditions monitored, using telemonitoring equipment, by health professionals, without being required to leave their home. Participants in the CVC program, including those in the telemonitoring trial, will also be encouraged to participate in the national Personally Controlled Electronic Health Record System.

GPs are paid to enrol participants in the CVC Program and provide ongoing quarterly periods of coordinated care. The amounts paid are in addition to all existing items, including all chronic disease management items GPs are currently eligible for. Eligibility for the CVC Program is determined by the GP.

Gold Card holders are ineligible for the CVC Program if they live in a Residential Aged Care Facility or choose to participate instead in a similar Commonwealth program, such as a Home Care Package Level 3 or 4, or Diabetes Care Project.

Veteran and war widow/widowers participation is voluntary and the services provided are at no cost to the veteran.

13.2.2 Interface with the Home Care Packages Program

Services offered under Home Care Levels 1 and 2 generally do not duplicate services provided by the CVC Program. Home Care Package services complement the CVC Program and provide greater support at home for the veteran or war widow/ widower. Therefore, there would be no exclusion in participating in both the CVC Program and the low 'broadband' levels of Home Care Packages (Levels 1 and 2).

Where the veteran or war widow/widower has been approved by an ACAT as eligible for a Home Care Package in the higher broadband of Level 3 and 4, and has asked to be transferred to a Home Care Package at this level, that package becomes the primary source of care for the veteran or war widow/widower and generally CVC Program services will no longer be required.

In some instances, the veteran or war widow/widower may supplement the care provided under a Home Care Package with other DVA services (see Section 13.1 of this Part – Veterans' Home Care Program).

13.3 Department of Veterans' Affairs Community Nursing Program

13.3.1 Overview of program

DVA provides entitled veterans and war widows/widowers with access to community nursing services, through the DVA Community Nursing program, to meet their assessed clinical and/or personal care needs in their own home.

Community nursing services are delivered by DVA-contracted community nursing providers. Prior to delivering services, the provider must first receive a referral from one of the following authorised referral sources:

- general practitioner;
- treating doctor in a hospital;
- hospital discharge planner; or
- Veterans' Home Care (VHC) Assessment Agency.

DVA has comprehensive guidelines for access to community nursing services, available on the Department of Veterans' Affairs website.

13.3.2 Interface with the Home Care Packages Program

Although not intended to provide comprehensive clinical services, some nursing and allied health services may be provided as part of Home Care Level 1 and 2 packages. Where there is an assessed clinical need, and these services are not being provided under a Home Care Level 1 or 2 package, a DVA-contracted community nursing provider may deliver clinical nursing services.

Where a veteran or war widow/widower is in receipt of a Home Care Package, the home care provider must ensure that there is no duplication of services where a veteran or war widow/widower is also receiving DVA community nursing services.

As Home Care Level 3 and 4 will generally provide all assessed clinical and/or personal care needs for a veteran or war widow/widower, DVA community nursing services should not be delivered to a veteran or war widow/widower in receipt of these types of packages, with the exception of Palliative Care services.

13.4 Department of Veterans' Affairs Rehabilitation Appliances Program

13.4.1 Overview of program

Under the Rehabilitation Appliances Program (RAP) the Repatriation Commission and the Military Rehabilitation and Compensation Commission (the Commissions) assist entitled veterans, ex-service personnel, their spouses/partners and dependants (entitled persons) to be as independent and self-reliant as possible in their own home. Health care assessment and the subsequent provision of aids and appliances are intended to minimise the impact of disabilities, enhance quality of life and maximise independence in daily life.

The program provides aids and appliances:

- according to assessed clinical need;
- in a timely manner; and
- as part of the overall management of an individual's health care.

The equipment should be:

- appropriate for its purpose;
- safe for the entitled person; and
- designed for persons with an illness or disability, and not widely used by persons without an illness or disability.

13.4.2 Interface with the Home Care Packages Program

In general, entitled persons receiving a Home Care Package may be able to access RAP aids and appliances where the service provider is not legally required to supply them under the terms of the Home Care Package.

Also, an entitled person who has previously been issued RAP aids and appliances may retain them subsequent to receiving a Home Care Package, and the Commissions may maintain responsibility for the repair, maintenance and, if necessary, replacement of such aids and appliances.

13.5 Veterans' Transport for Treatment

13.5.1 Overview of program

The Repatriation Transport Scheme (RTS) provides eligible veterans and war widows/widowers (entitled persons) assistance with transport when they attend a health provider for medical treatment and travel by:

- private vehicle;
- public transport;
- community transport;
- taxi/hire car; or
- air travel.

The RTS is governed by Sections 84 and 110 of the *Veterans' Entitlements Act 1986* (VEA).

The intention of the Scheme is to provide eligible persons with assistance with the cost of transport, meals and accommodation. The Scheme does not necessarily reimburse the entire cost incurred. Entitled persons can access transport assistance when travelling for treatment in Australia, in the following ways:

Reimbursement (D800) – Eligible persons can arrange and pay for their own transport and seek reimbursement from DVA. Travel, meals and accommodation may be payable for the entitled person and their attendant (if medically required). Entitled persons are able to arrange taxi travel themselves by contacting their local taxi company.

Reimbursement of a taxi fare will only be approved if the age criterion or any one of the medical criteria is met or public, community or private transport are unavailable. To receive the maximum allowable assistance with travelling expenses, eligible persons need to attend the closest practical health provider to their permanent or temporary residence at the time of treatment.

Booked Car With Driver (BCWD) – DVA may arrange for the provision of a Booked Car with Driver (BCWD) service for travel to approved treatment locations. Eligible persons may travel by a DVA arranged taxi or hire car for treatment purposes if they:

- are aged 80 years or older;
- public, community or private transport are not available
- have any of the following **medical conditions**:

- legal blindness;
- dementia;
- psychosis;
- hemiplegia;
- ataxia;
- respiratory insufficiency severely limiting independent activity;
- cardiac failure severely limiting independence;
- recent coronary occlusion severely limiting independence;
- peripheral vascular disease severely limiting independence;
- amputation severely limiting independence;
- arthritis severely limiting independence;
- recent surgery severely affecting your capacity to use public transport;
- conditions that would cause you to be gravely embarrassed or that are unacceptable to other passengers on public transport e.g. incontinence of bladder or bowel, severe, deformity or disfigurement;
- significant trauma; or
- frailty that severely limits your independence.

The following treatment locations are approved BCWD locations for entitled persons *aged* 80 years and older, or legally blind or suffering from dementia:

- Local Medical Officers and general practitioners;
- dental providers;
- allied health services (other than those mentioned above);
- optical dispensers;
- VVCS – Veterans and Veterans Families Counselling Services;
- former Repatriation General Hospitals;
- public and approved private hospitals;
- providers of prosthetics, surgical footwear and orthotics;
- Office of Hearing Services accredited providers;
- medical specialist rooms; or
- radiology, imaging and pathology services.

BCWD locations for entitled persons aged 79 years or younger, not legally blind or not suffering from dementia are limited to:

- former Repatriation General Hospitals;
- public and approved private hospitals;
- providers of prosthetics, surgical footwear and orthotics;
- Office of Hearing Services accredited providers;
- medical specialist rooms; or
- radiology, imaging and pathology services.

Ambulance – Gold Card holders are eligible for ambulance services for the treatment of all health conditions, subject to their clinical need. White Card holders are eligible for ambulance services for the treatment of an injury or disease which has been accepted by DVA as war or service related, subject to their clinical need.

DVA will normally pay for a non-emergency ambulance trip if one of the following criteria is met, subject to treatment eligibility:

- require transport on a stretcher; or
- require treatment while in the ambulance; or
- are severely disfigured; or
- are incontinent to a degree that precludes the use of other forms of transport.

13.5.2 Interface with the Home Care Packages Program

RTS can only be accessed and utilised by eligible persons and only in the context of travelling related to DVA approved treatment and to the closest practical health provider. RTS does not provide travel for shopping or personal needs, nor as a means of preventing social isolation. When travelling interstate for personal reasons, or on holidays, veterans are strongly encouraged to take out travel insurance as travel assistance may be provided based on the temporary residence only, ie DVA funded transport back to the permanent residence will not normally be provided.

13.6 Consumer fees – former Prisoners of War and Victoria Cross recipients

Former Prisoners of War (POW) and Victoria Cross (VC) recipients, who have been assessed as eligible for a Home Care Package by an ACAT, are entitled to have their consumer fees paid for by DVA on receipt of a package. Once eligibility has been established, DVA will pay:

- the basic consumer fee; and
- any income-tested service fees, if the former POW or VC recipient has additional income that incurs an income-tested fee.

The former POW or VC recipient should not be asked to make any payments to the approved provider within the scope of the package.

Where a former POW or VC recipient is already paying consumer fees for a Home Care Package, DVA can reimburse the consumer for fees paid on and after 21 August 2009. Consumers in these circumstances should contact DVA on **133 254**.

PART K – APPENDICES

Appendix A – Glossary of terms

Term	Meaning
ACAR	Aged Care Approvals Round
ACAT	Aged Care Assessment Team. ACATs are known as Aged Care Assessment Services (ACAS) in Victoria
ACFA	Aged Care Financing Authority
Act	*Aged Care Act 1997*
CACP	Community Aged Care Package
care fee (or home care fee)	Refers to the contribution that a consumer may be asked to pay by a home care provider under a Home Care Package (separate to the government subsidy). Also known as a care recipient contribution, care recipient fee or consumer fee
consumer (or home care consumer)	A person who is a receiving care and services under a Home Care Package funded by the Australian Government. In the *Aged Care Act 1997*, this person is described as a "care recipient"
claim form	The Department of Human Services form used by home care providers to claim home care subsidy payments
Commonwealth HACC Program	This program provides home and community care services for frail older people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over. The Commonwealth HACC program does not currently apply in Victoria and Western Australia
CDC	Consumer Directed Care
Department	Department of Health and Ageing
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home package
EACHD	Extended Aged Care at Home Dementia package
home care	A type of aged care for which a home care subsidy is payable under Part 3.2 of the Act

home care consumer (or consumer)	A person who is a receiving care and services under a Home Care Package funded by the Australian Government. In the *Aged Care Act 1997*, this person is referred to as a "care recipient"
home care provider (or approved provider)	A corporation approved by the Department of Health and Ageing under Part 2.1 of the Act as suitable to provide home care. In the *Aged Care Act 1997*, this person or body is referred to as an "approved provider"
Home Care Agreement	An agreement entered into by a consumer and a home care provider outlining rights and responsibilities and what services will be provided to the consumer under the Home Care Package
Home Care Standards	The Home Care Standards means the *Home Care Common Standards*, as set out in Schedule 5 to the *Quality of Care Principles 1997*
Home Care Packages Program	The Australian Government program that provides funding for Home Care Packages aimed at supporting people to remain living at home for as long as possible
home care subsidy	The subsidy payable to a home care provider by the Australian Government under Part 3.2 of the Act
NACAP	The National Aged Care Advocacy Program is a program funded by the Australian Government that promotes the rights of people who are seeking or are receiving Australian Government funded aged care services
NRCP	National Respite for Carers Program
Principles	Aged Care Principles made under section 96-1 of the *Aged Care Act 1997*
re-ablement	The use of timely assessment and targeted interventions to assist people to maximise their independence, choice and quality of life and minimise support required – to enable people to actively participate and remain engaged in their communities
VHC	Veterans' Home Care

Australian Government

Department of Social Services

Home Care Packages Programme Guidelines

July 2014

Table of Contents

Foreword

The Australian Government recognises the preference of many older Australians is to remain living at home and is supporting older Australians by providing better choices and improved access to the types of services which allow them to continue to live active and independent lives.

In 2013-14, the Australian Government provided over $1.2 billion for the Home Care Packages Programme. In 2014-15, the Government has committed over $1.3 billion.

As part of the aged care reforms, the Australian Government is significantly expanding access to home care services by increasing the number of home care places from around 66,000 places to around 100,000 places nationally by 2017.

These Guidelines provide policy guidance to support the delivery and management of the Home Care Packages Programme.

The Home Care Packages Programme commenced on 1 August 2013, replacing the former packaged care programmes – Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) packages and Extended Aged Care at Home Dementia (EACHD) packages.

The Guidelines refer to elements of the legislative framework, but they are not intended to be a source of legal advice for providers, consumers or other stakeholders.

Most of the information in these Guidelines is relevant to all types of packages, whether delivered on a Consumer Directed Care (CDC) basis or not. In some cases, the Guidelines relate specifically to the packages delivered on a CDC basis, for example, the individualised budget described in Part D.

The Guidelines are primarily for use by home care providers, although they have been written with a broader audience in mind. The Guidelines will be complemented by other resources, including frequently asked questions and information resources for consumers.

The development of the Guidelines was informed by advice from the National Aged Care Alliance, and feedback received from peak groups, organisations and individuals during consultations.

Terminology

Consumer

In the Guidelines, the term “consumer” is used to refer to the person receiving care and services through a Home Care Package.

"Consumer" is the terminology preferred by the National Aged Care Alliance, rather than "client", "customer" or "care recipient".

It should be noted that the term "care recipient" is used in the legislation (the *Aged Care Act 1997*, the *Aged Care (Transitional Provisions) Act 1997* and in the associated Principles and Determinations made under the Acts). "Consumer" is not a defined term under the legislation.

It is recognised that the consumer is often supported by a carer/s, who may be a spouse, partner, an adult child, or another family member. In some cases, the carer or another person may be legally authorised to act on behalf of the consumer. In these Guidelines, references to the consumer include other people authorised to act on behalf of the consumer.

Home care provider

In these Guidelines, the term "home care provider" is generally used to refer to the corporation that has been approved by the Department of Social Services under Part 2.1 of the *Aged Care Act 1997* as suitable to provide home care.

The term "approved provider" is used in the legislation.

In some parts of the Guidelines, there are a number of legislative references to matters affecting approved providers, e.g. Part F (Rights and Responsibilities) and Part I (Administrative Arrangements for Approved Providers). In these parts, the term "approved provider" is used rather than "home care provider".

Glossary of terms

There is a glossary of terms at Part K.

Part A – Introduction

Covered in this part

- New Home Care Packages Programme
  - Programme objectives
  - Package levels
  - Target population
  - Special needs groups
  - People with dementia
- Consumer Directed Care
  - CDC in the context of Home Care Packages
  - CDC Principles
- Use of innovative and digital technology
- Evaluation
- Legal Framework
- Pathway for the Consumer

1. Home Care Packages Programme

1.1 Programme objectives

The objectives of the Home Care Packages Programme are:

- to assist people to remain living at home; and
- to enable consumers to have choice and flexibility in the way that the consumer's aged care and support is provided at home.

These objectives are relevant to all packages funded under the Home Care Packages Programme, whether delivered on a Consumer Directed Care (CDC) basis or not. CDC provides an additional framework to assist providers and consumers to maximise the amount of choice and flexibility in the delivery of the packages.

The 2012-13 Aged Care Approvals Round (ACAR) saw the introduction of conditions of allocation requiring all new places to be delivered on a CDC basis. Successful applicants are also required to participate in an evaluation of the Home Care Packages Programme, including the CDC arrangements.

1.2 Package levels

There are four levels of Home Care Packages:

- Home Care Level 1 – a package to support people with basic care needs.
- Home Care Level 2 – a package to support people with low level care needs, equivalent to the former Community Aged Care Package (CACP).
- Home Care Level 3 – a package to support people with intermediate care needs.

- Home Care Level 4 – a package to support people with high care needs equivalent to the former Extended Aged Care at Home (EACH) package.

Transitional arrangements are explained in Part B, Section 2.

The following range of supplements are also available to people across all levels of Home Care Packages who meet the eligibility criteria in recognition of the additional costs associated with certain care and service requirements:

- Dementia and Cognition Supplement and Veteran's Supplement
- Oxygen Supplement
- Enteral Feeding Supplement
- Viability Supplement
- Top-up Supplement
- Hardship Supplement

Further information on the supplements is at Part H.

1.3 Target population

The Home Care Packages Programme has been developed to assist older Australians to remain in their homes, particularly targeting frail older people. However, there are no minimum age requirements for eligibility purposes. In 2012-13, the average age of admission into a Home Care Package was 82 years. For Aboriginal and Torres Strait Islander people, the average age of admission into a Home Care Package was 67 years.

In some cases, younger people with disabilities, dementia or special care needs may be able to access a Home Care Package – if the person has been assessed and approved by an Aged Care Assessment Team (ACAT), and a home care provider is able to offer an appropriate package for the person. This should only occur where there are no other care facilities or care services more appropriate to meet the person's needs. The 'National Guiding Principles for the Referral and Assessment of Younger People with Disability'[1] provides further information on this.

Eligibility requirements are explained further in Part C, Sections 2 and 3.

1.4 Special needs groups

Under the *Aged Care Act 1997*, people with special needs include people who identify with or belong to one or more of the following groups[2]:

- people from Aboriginal and Torres Strait Islander communities;
- people from culturally and linguistically diverse backgrounds;

[1] Aged Care Assessment Programme Policy webpage.
[2] Section 11.3 of the *Aged Care Act 1997.*

- people who live in rural and remote areas;
- people who are financially or socially disadvantaged;
- veterans;
- people who are homeless or at risk of becoming homeless;
- people who identify as lesbian, gay, bisexual, transgender or intersex;
- people who are care leavers; and
- parents separated from their children by forced adoption or removal.

Places are sometimes allocated to a home care provider with a specific condition of allocation that priority of access is given to people who belong to defined special needs groups. However, all home care providers are expected to have policies and practices in place to ensure services are accessible to people with special needs. Providers should have regard to consumer diversity, taking into account consumers' individual interests, customs, beliefs and backgrounds. Providers should also work collaboratively with advocacy services, particularly the National Aged Care Advocacy Programme services, and specialist service providers for people from special needs groups, where appropriate.

In December 2012, the Government released national strategies for two of the special needs groups:

- 'National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds'; and
- 'National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy'.

1.5 People with dementia

While not a separate special needs group under the legislation, all home care providers should also have policies and practices that address the provision of care for people with dementia.

2. Consumer Directed Care (CDC)

2.1 What does CDC mean in the context of Home Care Packages?

From 1 August 2013, all new packages (including the packages allocated to providers in the 2012-13 ACAR) have been required to be delivered on a CDC basis. From July 2015, all packages will operate on a CDC basis.

The introduction of CDC is a significant change to the way that home care is delivered in Australia. This Section provides an overview of CDC, but the various elements are also explained throughout these Guidelines.

CDC is a way of delivering services that allows consumers to have greater control over their own lives by allowing them to make choices about the types of aged care and services they access and the delivery of those services, including who will deliver

the services and when. Under a CDC approach, consumers are encouraged to identify goals, which could include independence, wellness and re-ablement. These will form the basis of the Home Care Agreement and care plan.

The consumer decides the level of involvement they wish to have in managing their package, which could range from involvement in all aspects of the package, including co-ordination of care and services, to a less active role in decision-making and management of the package. There should also be ongoing monitoring and a formal re-assessment by the provider (at least every 12 months) to ensure that the package continues to be appropriate for the consumer.

Through the introduction of an individualised budget, CDC provides greater transparency to the consumer about what funding is available under the package and how those funds are spent.

2.2 CDC principles

The following principles underpin the operation and delivery of packages on a CDC basis.

2.2.1 Consumer choice and control

Consumers have managed their own lives for a long time. They should be empowered to continue to manage their own life by having control over the aged care services and support they receive. This requires the provision of, and assistance to access, information about service options that enable a consumer to build a package that supports them to live the life they want.

2.2.2 Rights

CDC should acknowledge an older person's right (based on their assessed needs and goals) to individualised aged care services and support.[3]

2.2.3 Respectful and balanced partnerships

The development of respectful and balanced partnerships between consumers and home care providers, which reflect the consumer and provider rights and responsibilities, is crucial to consumer control and empowerment. Part of creating such a partnership is to determine the level of control the consumer wants to exercise. This will be different for every individual, with some people requiring or wanting assistance to manage their package and others choosing to manage on their own.

Consumers should have the opportunity to work with the home care provider in the design, implementation and monitoring of a CDC approach. Home care providers should be encouraged to include consumers in their CDC redesigns.

[3] Care and services must be within the scope of the Home Care Packages Program.

2.2.4 Participation

Community and civic participation are important aspects for wellbeing. CDC in aged care should support the removal of barriers to community and civic participation for older people, if they want to be involved.

2.2.5 Wellness and re-ablement

CDC packages should be offered within a restorative or re-ablement framework to enable the consumer to be as independent as practical, potentially reducing the need for ongoing and/or higher levels of service delivery.

Many people enter the aged care system at a point of crisis. Such situations may require the initial provision of services designed to address the immediate crisis. However, there should always be an assumption that the older person can regain their previous level of function and independence with re-ablement services being offered at a time that suits/supports the individual circumstances.

2.2.6 Transparency

Under a CDC package, older people have the right to use their budgets to purchase the aged care services they choose.[4] To make informed decisions about their care, older people need to have access to budgeting information, including the cost of services, the contents of their individualised budgets and how their package funding is spent.

3. Use of innovative and digital technology

Where safe, effective and clinically appropriate, home care providers are encouraged to offer innovative and digital delivery options to provide services to consumers. This could include the use of telehealth, video conferencing and digital technology, such as remote monitoring and other assistive technology.

Home Care Package funding can be used for innovative and digital technology items to support the consumer, if required.

4. Evaluation

The first group of new home care places allocated through the 2012-13 and the 2014 ACARs will provide an opportunity to further evaluate the potential of CDC to deliver better care for consumers, and to test the effectiveness of the new Home Care Package levels in providing a seamless continuum of care.

[4] Care and services must be within the scope of the Home Care Packages Program.

Over the first two years of the programme, the Home Care Packages and the CDC arrangements will be closely monitored and evaluated. The evaluation will focus on the impact of the new home care arrangements, including the new supplements, on:

- consumer experience and outcomes, including people from special needs groups and people with dementia;
- the ability of Home Care Packages and particularly the new CDC arrangements to meet consumers' needs;
- carers and family members;
- provider operations;
- assessment processes, including the impact on ACATs;
- the interface between the Home Care Packages Programme and other elements of the aged care system such as the Home and Community Care Programme and residential care; and
- the effectiveness of the new arrangements in delivering a graduated continuum of care, as well as choice and flexibility for consumers.

The evaluation will also consider:

- the range of supports used by people with a disability and the ability of Home Care Packages and particularly the new CDC arrangements to meet their needs; and
- whether CDC has supported increased access to digital technology by consumers and providers.

Any lessons learned during the evaluation will be used to refine the CDC arrangements before they are applied across all Home Care Packages from July 2015.

5. Legal framework

The legal framework for the Home Care Packages Programme is underpinned by:

- the *Aged Care Act 1997*;
- the *Aged Care (Transitional Provisions) Act 1997*;
- Principles made under the Acts;
- Determinations made under the Acts (for example, setting relevant subsidy and supplement levels); and
- conditions of allocation made under the *Aged Care Act 1997* (for example, conditions applying to all packages and/or specific conditions applying to individual providers or services such as CDC).

6. Pathway for the consumer

The pathway for the consumer involves a series of steps from finding information about the Home Care Packages Programme, assessment by an ACAT, contacting local home care providers, being offered a package by a provider, care planning and

budget setting, service delivery, understanding how funds are being spent, monitoring and re-assessment, and exiting the programme.

The pathway is summarised in the following chart. The steps provide the structure for Part C and Part D of the Guidelines.

The Guidelines describe what is involved at each step and what home care providers are expected to do to support the consumer.

Step 1: Finding information about the Home care Packages Programme

The consumer finds out about the Home Care Packages Programme, potentially through the My Aged Care website or national contact centre, or from their GP or another service provider and thinks they may benefit from a package. An assessment is arranged to determine if the consumer is eligible.

Step 2: Assessing eligibility for a Home Care Package

An Aged Care Assessment Team (ACAT) assesses the consumer to determine if they are eligible for a Home Care Package. If approved, the consumer is then referred to, or directly contacts home care providers, after a member of the ACAT discusses what options are available locally.

Step 3: Determining whether a suitable Home Care Package is available

The consumer will meet with a home care provider and discuss whether a suitable package is available. This will determine whether a consumer is able to be offered a package by the provider. The next steps will depend on whether the package is offered on a CDC basis or not.

Existing Non-CDC Home Care Package (until July 2015)

Step 4.1: Care planning

The consumer and the home care provider enter into a Home Care Agreement. The provider, in consultation with the consumer, develops a care plan based on the assessed care needs. The care plan describes the care and services to be provided to the consumer (e.g. over the next 12 months).

Step 4.2: Service delivery, monitoring and re-assessment

Services are delivered according to the agreed care plan, with flexibility to make changes to meet the consumer's needs. There is ongoing monitoring by the provider. A formal re-assessment of the care plan is conducted at least every 12 months.

Step 4.3: Early conversion to CDC

Home care providers do not have to wait until 1 July 2015 to convert packages to CDC. Provider can elect to convert existing packages to a CDC basis once they are ready to make the transition. This can be done either informally or formally. Part D. Section 6 contains more information on this.

CDC Home Care Package

Step 4.1: Setting goals, care planning

The consumer and the home care provider enter into a Home Care Agreement. As part of the care planning process, the consumer outlines their goals and the level of control they wish to exercise over their package. A care plan, driven by the consumer, is developed with the provider. This describes the care and services to be provided.

Step 4.2: Understanding the funding

An individualised budget is developed with consumer, which identifies income and planned expenditure for the package, based on the agreed care plan. Once services commence, the consumer is provided with regular (monthly) statements to show how the funds are being spent.

Step 4.3: Service delivery, monitoring and re-assessment

Services are delivered according to the agreed care plan, with flexibility to make changes to meet the consumer's needs. There is ongoing monitoring by the provider. A formal re-assessment of the care plan and budget is conducted at least every 12 months.

Step 5: Moving or exiting

The needs of the consumer may have changed significantly over time. Where this is the case, a new ACAT assessment may be required to assess eligibility for a package within a higher band (e.g. Level 3 or 4) or residential care. The home care provider should support the consumer as much as possible, for example, by arranging referral to the ACAT or assisting a transfer to another provider or service.

Part B – Summary of changes and transitional arrangements – 1 July 2014

Covered in this part

- Summary of changes
- Transitional arrangements
  - Existing allocations of packages
  - Existing consumers
  - Existing ACAT approvals
  - Changes to approved provider arrangements

1. Summary of changes

Issue	From 1 July 2014	Reference in Guidelines
Consumer Directed Care (CDC)	The transition to delivering Home Care Packages on a CDC basis continues. For providers wanting to convert existing packages to CDC prior to July 2015, information can be found at Part D.	Parts A & D
Care fees	New income testing arrangements will apply to people entering home care. Consumers may be asked to pay an income tested fee.	Part G
Subsidy reduction	For people entering home care, the home care subsidy may be reduced based on the outcome of the income testing process.	Part G
Supplements	New hardship provisions will apply for consumers who commence a package from 1 July 2014. A Hardship Supplement will be paid in respect of the basic daily care fee and/or income tested care fee for consumers who have been granted financial hardship assistance.	Part H

2. Transitional arrangements

2.1 Existing allocations of packages

From 1 August 2013, all existing allocations of:

- CACP packages became Home Care Level 2.
- EACH packages became Home Care Level 4.
- EACHD packages became Home Care Level 4.

The change from the former CACP, EACH and EACHD packages to new Home Care Packages took effect from 1 August 2013.

There is no longer a requirement for home care providers to enter into an agreement with the Commonwealth in respect of allocations of new Home Care Packages.

Existing agreements (Deeds of Agreement for CACPs and Payment Agreements for EACH/EACHD packages) automatically ceased from 1 August 2013 when the transitional provisions in the legislation took effect. However, all existing conditions of allocation in respect of those places continue to apply.

2.2 Continuing consumers

Care Recipient Agreements (after 1 August 2013 are now known as Home Care Agreements) will continue to remain in force.

2.3 Existing ACAT approvals

Where a person has an ACAT approval for a CACP, EACH or EACHD package (valid on 31 July 2013) but the person has not yet been offered a package by a home care provider, the approval will continue to have effect from 1 August 2013 as an approval for the relevant level of home care.

From 1 August 2013, ACAT approvals will not automatically lapse across any of the four home care levels. Further details are in Part C, Section 4.

2.4. Changes to approved provider arrangements

From 1 August 2013, the arrangements for obtaining approved provider status were simplified for home care.

From 1 August 2013, providers of home care only need to be approved once. This enables an approved provider to deliver services at any of the four levels of Home Care Packages, provided they have an allocation of places under the Act.[5] Usually this will occur through the Aged Care Approvals Round.

For existing approved providers (i.e. those who had approved provider status on 31 July 2013):

- an approved provider of community care is deemed to be an approved provider of home care; and

[5] Division 8 of the *Aged Care Act 1997*.

- an approved provider of flexible care is deemed to be an approved provider of home care. Providers also retain their status as an approved provider of flexible care, which is relevant to providers (mostly state and territory governments) providing services under the Multi-Purpose Services (MPS) Programme and the Transition Care Programme.

Part C – Accessing a Home Care Package

Covered in this part

- Finding out information about packages
- Eligibility for a package
  - Age
  - Residency or citizenship
  - Assessment by an ACAT
  - Broadbanded assessments
- Issues to be considered by ACATs in determining eligibility
  - Eligibility criteria
  - Aged care client record and information about the ACAT decision
- ACAT approvals
  - Existing approvals (valid on 31 July 2013) will not lapse
  - Removal of automatic lapsing of approvals
- Referral from an ACAT to a home care provider
- Being offered a package by a home care provider
  - Moving between package levels or bands
  - Waiting lists

1. Finding information about Home Care Packages

For information about the aged care system and services go to the My Aged Care website at www.myagedcare.gov.au or call the national contact centre on **1800 200 422**.

2. Eligibility for a Home Care Package

2.1 Age

There is not a minimum age requirement for eligibility purposes, but the Home Care Packages Programme is targeted at frail older people. In 2012-13, the average age of admission into a Home Care Package was 82 years. For Aboriginal and Torres Strait Islander people, the average age of admission into a Home Care Package was 67 years.

In some cases, younger people with disabilities, dementia or special care needs may be able to access a Home Care Package – if the person has been assessed and approved by an ACAT, and a home care provider is able to offer an appropriate package for the person. This should only occur where there are no other care facilities or care services more appropriate to meet the person's needs. For further information go to the 'National Guiding Principles for the referral and assessment of Younger People with Disability'[6].

[6] Aged Care Assessment Programme Policy webpage.

2.2 Residency or citizenship

There are **no** citizenship or residency restrictions on accessing the Home Care Packages Programme. However, the packages are not intended for visitors to Australia or people requiring temporary or short-term care.

2.3 Assessment by an Aged Care Assessment Team

In order to access a Home Care Package, a person needs to be assessed and approved as eligible for home care by an ACAT[7], and then offered a Home Care Package by a home care provider.

2.4 Broadbanded assessments

ACAT assessment requirements for home care will be "broad-banded".

The two assessment bands for eligibility are:

- Home Care Levels 1 and 2; and
- Home Care Levels 3 and 4.

The ACAT does not need to determine whether a person's care needs are at a particular level within each band.

Similar to the previous arrangements, if a person has been assessed as eligible for a particular level of package, but none is available, the person can be offered a lower level package, as an interim measure, until a higher level package is available.

The decision to offer an eligible person a package, including at what level the package is offered (within scope of the approval) is made by the home care provider.

The concept of two assessment bands for eligibility is likely to continue until at least July 2015, pending the results of the evaluation of the Home Care Packages Programme.

3. Issues to be considered by ACATs in determining eligibility

3.1 Eligibility criteria

An ACAT will conduct a multidisciplinary and comprehensive assessment, taking account of a person's physical, medical, psychological, cultural, social and restorative care needs. The assessment should take into account any relevant information available from the person's medical practitioner and other specialist reports. The ACAT will then need to determine that a person meets all the eligibility criteria before approving the person to receive a Home Care Package.

[7] In Victoria, ACATs are known as Aged Care Assessment Services (ACAS).

The requirements of the legislation[8] mean that, for a person to be eligible for a Home Care Package, the person must:

- be assessed as having needs that can only be met by a co-ordinated package of care services;
- be assessed as requiring a low level of home care (for Home Care Levels 1 or 2) *or* a high level of home care (for Home Care Levels 3 or 4);
- have expressed a preference to live at home (including as a resident of a retirement village);
- be able to remain living at home with the support of a Home Care Package; and
- for a person who is not an aged person – have no other care facilities or care services more appropriate to meet the person's needs.

3.2 Aged Care Client Record and information about the ACAT decision

Part of the ACAT approval process involves the creation of an Aged Care Client Record (ACCR) for each person who is approved as eligible for a Home Care Package. The onus remains on the home care provider to check that a consumer has a valid assessment approval before commencing services, as a home care subsidy is unable to be paid without this approval.

The consumer is advised promptly in writing of the decision arising from their ACAT assessment and receives contact details for further advice if required. The ACAT delegate must provide sufficient information in writing to allow a person to understand why a decision has been made and the evidence on which it was based.

An ACAT approval to receive a Home Care Package takes effect from the day the approval is given, but a subsidy is not payable to a provider until the consumer has been offered and accepted a package by a home care provider and the Home Care Agreement is entered into (see Part D, Section 2).

4. ACAT approvals

4.1 Existing approvals (valid on 31 July 2013) will not lapse

Where a person has an ACAT approval for a CACP, EACH or EACHD package (valid on 31 July 2013) but the person has not yet been offered a package by a home care provider, the approval continues to have effect from 1 August 2013 as an approval to receive the relevant level of home care.

[8] Part 2, section 7 and Part 3, section 11 of the *Approval of Care Recipient Principles 2014.*

This means that:

- a person already approved for a CACP can be offered a Home Care Level 1 or 2 package without the need for another ACAT assessment; and
- a person already approved for an EACH or EACHD package can be offered a Home Care Level 3 or 4 package, or a lower level package as an interim arrangement, without the need for another ACAT assessment.

4.2 Removal of automatic lapsing of approvals

Previously, CACP approvals automatically lapsed if care was not provided within 12 months after the approval date.

From 1 August 2013, ACAT approvals will not automatically lapse after 12 months across any of the four package levels – unless there is a specific time limitation placed on the approval as part of the ACAT decision. A consumer or provider is still able to request a new assessment at any time, for example, if the consumer's needs have changed.

Therefore, as long as the CACP approval was valid on 31 July 2013, the approval will not lapse and the person does not need to be re-assessed by an ACAT in order to receive a Home Care Level 1 or 2 package.

5. Referral from an ACAT to a home care provider or other services and practitioners

Once a person is approved as eligible for a Home Care Package, the ACAT may refer the consumer to individual home care providers or provide information to the consumer on how to contact local providers, they may do this by providing a list of all home care providers with packages in the area or alternatively they can be directed to the My Aged Care website at www.myagedcare.gov.au or the national contact centre on **1800 200 422**.

Where appropriate, an ACAT representative may refer a consumer to other care services that do not require an ACAT approval, such as Home and Community Care (HACC) or the Veterans' Home Care (VHC) programme.

The ACAT may also refer a person to a medical or health practitioner/service for more specialised assessment of needs, such as those associated with vision impairment or blindness, hearing loss, other disabilities or nutrition. These assessments could form part of the overall assessment.

6. Being offered a package by a home care provider

Once a person has been assessed by an ACAT and approved for home care, a person may be offered a package by a home care provider, at either level within the relevant band (e.g. Level 1 or 2, or Level 3 or 4) for which they have been approved.

The decision to offer an eligible person a package, including at what level the package is offered (within scope of the approval) is made by the home care provider, taking into account the person's needs and the availability of packages at the relevant levels.

People on a waiting list do not necessarily access care purely on a "first come, first served" basis. Home care providers are encouraged to assess each individual's care needs relative to others also waiting for home care. They must also take into account any conditions of allocation for the package, including priority of access for people from special needs groups.

If a person has been approved by an ACAT as eligible for a higher level/band of package (e.g. Level 3 or 4), but none is available, the person can be offered a lower level package (e.g. Level 1 or 2) as an interim measure until a higher level package is available – without the need for another ACAT assessment.

6.1 Moving between package levels or bands

A consumer does not have to be reassessed by an ACAT to move from one package level to another **within the broadbanded levels approved by the ACAT**. This means that a home care provider can offer a higher level package when a consumer's needs require a higher level of care – from Level 1 to 2, or from Level 3 to 4 – without the need for another ACAT assessment.

A new assessment and approval from an ACAT is required before the consumer can be offered a package **in a higher band**, i.e. moving from a Level 1 or 2 package to a Level 3 or 4 package – except where the consumer already has an ACAT approval at the higher band (Level 3 or 4).

6.2 Waiting lists

While the number of Home Care Packages will increase significantly across Australia over the coming years, there may be waiting lists for packages in some areas.

Home care providers and some ACATs manage their own waiting lists, giving access and priority according to each individual's need and the provider's capacity to meet that need.

As explained in Section 6 (above), people on a waiting list do not necessarily access care purely on a "first come, first served" basis. Home care providers are encouraged to assess each individual's care needs relative to others also waiting for home care. They must also take into account any conditions of allocation for the package, including priority of access for people from special needs groups.

Part D – Making use of a Home Care Package

Covered in this part

- For all packages
  - Being offered a package by a home care provider
  - Home Care Agreement
- For packages delivered on a CDC basis
  - Care planning
  - Individualised budget
  - Monitoring, review and reassessment
- For packages delivered on a non-CDC basis
  - Overview
  - Level of consumer control over the management of the package
  - Giving effect to the consumer's choices and preferences
  - Individualised budget
- Topping up services under a package (both CDC and non-CDC)
- Converting packages delivered on a non-CDC basis to a CDC basis

1. Being offered a package by a home care provider

Once a person is approved as eligible for a Home Care Package, the ACAT may refer the consumer to individual home care providers or provide information to the consumer on how to contact local providers, e.g. by providing a list of all home care providers with packages in the area.

The home care provider will determine whether they are able to offer a package suitable for the consumer. The consumer is able to choose whether or not to accept the package.

The ACAT Aged Care Client Record (ACCR) supplies the home care provider with important information about the characteristics, needs and circumstances of the prospective consumer. The home care provider should always review the consumer's ACCR. This should be considered, together with other information provided by the consumer, including any relevant information from the consumer's medical practitioner, in determining whether a package can be offered and if so, at what level (within the scope of the approval). Home care providers can also access ACCRs from the Department of Human Services – Medicare Online Claiming facility.

2. Home Care Agreement

2.1 Overview

For all Home Care Packages, whether delivered on a CDC basis or not, a Home Care Agreement (previously known as a Care Recipient Agreement) must be offered to the consumer before the package commences. This is a legal requirement.[9]

[9] Division 4, section 22 of the *User Rights Principles 2014*.

The Home Care Agreement is an agreement between the home care provider and the consumer, which sets out a number of key elements about how the package will be delivered (see Section 2.2 in this Part).

The consumer's care plan forms part of the Home Care Agreement. Often the care plan will be an attachment or schedule to the Agreement.

The care planning process for packages being delivered on a CDC basis is described in Section 3 in this Part. Section 4 in this Part summarises the requirements for packages that are not being delivered on a CDC basis. In practice, there will be a number of common elements in the way that care planning is conducted, whether the package is delivered on a CDC basis or not.

Once the Home Care Agreement is entered into, care and services can formally commence under the package and the home care provider is able to commence claiming the government subsidy for the package (see Part I, Section 5).

Given the importance of the Home Care Agreement, the home care provider should ensure that the consumer and/or their authorised representative understand the terms of the agreement. The consumer can ask for an advocate to represent them during this process. Advocacy services are further explained in Part F, Section 2. The consumer may also seek their own legal advice before signing the Home Care Agreement. A signed Home Care Agreement must be provided to the consumer for their records.

While a Home Care Agreement recognises the consumer's rights and may spell out the consumer's responsibilities, it cannot exclude any rights the consumer has under Commonwealth or state/territory law.

The Home Care Agreement should be written in plain language, be easily understood and at a minimum contain the information in the checklist at Section 2.2 in this Part.

Where required, the provider should arrange for the Home Care Agreement, including the care plan, to be made available to the consumer in a language other than English. Any additional costs associated with the translation must be clearly explained to the consumer.

The Department of Immigration and Border Protection provides a national Translating and Interpreting Service (TIS) – phone **131 450**.

Home care providers are able to use TIS to provide interpreting services to assist home care consumers to understand their Home Care Package, including the Home Care Agreement, the individualised budget and monthly statements. Home care providers have been given a unique code that can be quoted to access TIS interpreting services. This arrangement is also in place for residential aged care providers.

2.2 Items to be included in the Home Care Agreement

Under the legislation[10], the following information must be included as part of the Home Care Agreement:

Check	Item
☐	Start date for the care
☐	The level of the Home Care Package to be provided (Level 1, 2, 3 or 4)
☐	Whether the Home Care Package will be provided on a CDC basis
☐	The care and services the consumer will receive
☐	Details outlining how the consumer can suspend care
☐	An explanation of security of tenure
☐	Conditions under which either party may terminate care
☐	An explanation that any variation must be by mutual consent, following consultation between the consumer and the home care provider, and may only be made after the provider has given reasonable notice in writing to the consumer
☐	A copy of the consumer's care plan, plus any subsequent changes to the care plan
☐	Details of the consumer's rights about the service they are to receive. A copy of the 'Charter of Care Recipients' Rights and Responsibilities – Home Care' must also be provided to the consumer
☐	A statement that the consumer is entitled to make, without fear of reprisal, any complaint about the Home Care Package, and an explanation of how to make a complaint. This refers to both internal complaint mechanisms and the Aged Care Complaints Scheme
☐	A guarantee of the confidentiality, as far as legally permissible, of information provided by the consumer and the use to be made of the information
☐	A clear itemised statement of the fees payable (if any) by the consumer and how they were calculated. (Note: providers must include a statement that an income tested care fee may be payable. The exact amount of income tested care fee payable, if any, is not necessarily required)
☐	Other financial information relevant to the care and services provided to the consumer
☐	An explanation that a consumer is entitled to request a statement of the home care service's financial position, including a copy of the most recent version of the home care provider's audited financial accounts. This must be provided within seven days of the request

The Home Care Agreement may be varied as required. Changes agreed between the consumer and the home care provider should be documented.

[10] Section 23 of the *User Rights Principles 2014.*

For packages being delivered on a CDC basis, home care providers must provide an individualised budget and regular statement of the consumer's Home Care Package income and expenditure.

2.3 Cases where the consumer does not want to sign the Home Care Agreement

While the home care provider must always offer and be prepared to enter into a Home Care Agreement, the consumer may choose not to sign a Home Care Agreement.

In such cases, the home care provider is still required by legislation to observe its responsibilities to negotiate and deliver the level and type of care and services the consumer needs.

It is important that the home care provider documents the reasons for not having a signed Home Care Agreement and the basis on which agreed care will be delivered.

The home care provider should always be ready to provide evidence that an "in-principle" agreement is in place. Documentation may include a copy of the agreement as offered to the consumer, a file note of the discussion with the consumer about the terms of the agreement (including the date that the discussion took place) and evidence that the consumer is receiving a Home Care Package as described in the Home Care Agreement.

2.4 When can the home care subsidy be claimed?

The home care subsidy can only be paid once the Home Care Agreement has been entered into. The subsidy cannot be claimed for discussions/meetings with the consumer (or carers and family members), or any services provided to the consumer, before the Home Care Agreement is entered into.

The date that the Home Care Agreement is entered into is the date that the consumer and the home care provider agree on the terms of the Home Care Agreement, as evidenced either by the signature of both parties, or a file note as described in Section 2.3 in this Part.

3. Packages delivered on a CDC basis

3.1 Care planning

3.1.1 Overview

A key feature of a package being delivered on a CDC basis is that the consumer must have ownership of decision making. This requires the provider to ensure an independent empowering decision making framework, which supports the consumer

to make decisions about their needs and goals and determine the amount of control they want to exercise in relation to their package.

The care planning process must be driven by the consumer, in partnership with the home care provider. Throughout the process, there should also be an emphasis on:

- consumer choice and control;
- support for consumer decision-making;
- being responsive to the consumer's customs, beliefs and background, including their relationship with carers and family members;
- wellness and re-ablement; and
- maintenance of independence and continuation of participation in the community (if this is what the consumer wants).

3.1.2 Goal setting

Before determining what services are to be provided, it will be important for the consumer to be asked what they would like to achieve through their Home Care Package. In other words, what their goals are, what is most important to the consumer?

The objectives of the Programme – to assist people to remain living at home and to enable consumers to have choice and flexibility in the way that aged care services and support is provided at home – establish an overall framework for goal setting.

A purpose statement that outlines why the package is being provided to the consumer (e.g. "to maintain me at home as independently as possible") could be developed to provide a clear understanding of the consumer's goals.

Individual goals will be shaped by the consumer's own circumstances, including the amount of support available from family, friends and carers, the consumer's level of health and well-being, and cultural and personal values. This requires effective communication between the consumer and home care provider.

3.1.3 Level of consumer control over the management of the package

As part of the care planning process, the consumer must be asked about, and given the option of, exercising different levels of control over the management of the package.

This could range from a high level of involvement, particularly in areas such as care co-ordination and administration, to very little or no active involvement in the management of the package.

The level of consumer involvement and control that has been agreed must be documented in the consumer's care plan. This may vary over time as the consumer's

needs change. Any changes to the level of consumer involvement and control must also be documented in the care plan.

The consumer's involvement in managing their package could include, but is not limited to, choosing the services they require, making contact with service providers, negotiating fees, scheduling appointments to provide services required by the consumer, and monitoring the quality of services provided.

3.1.4 Determining who has authority to make decisions

The determination of who has the authority to make decisions (e.g. the individual consumer, a family member or carer, a guardian, or (in some states) a person with power of attorney) will be a crucial part of the care planning process. The home care provider will need to determine who has the legal authority to make decisions. There should be shared decision-making between the consumer (to the extent that they are able to participate in decision-making), their appointed representative (if they have one) and the home care provider. This will be particularly important in situations where the consumer has some degree of cognitive impairment.

3.1.5 Case management

In the context of the Home Care Packages, case management refers to advisory and support services associated with:

- the initial assessment by the home care provider;
- identification of the consumer's goals;
- development of the Home Care Agreement, care plan and individualised budget;
- service coordination and referrals;
- ongoing monitoring and informal reviews of the consumer;
- formal re-assessment of the consumer's needs, and adjustment of the Home Care Agreement, care plan and individualised budget; and
- referral to an ACAT (e.g. if a reassessment is needed to move to a higher broad-banded level of package).

It is not expected that a consumer would take on the functions of a case manager, although the consumer may choose to have an active role in the management of the package. Ongoing monitoring, reviews and re-assessment must be undertaken by the home care provider, not by the consumer.

The case management role should not generally be sub-contracted to another provider, although this may be necessary in some cases (particularly for special needs groups or in rural and remote locations).

In some cases, a consumer may wish to have a specific person as a case manager. This can be negotiated between the consumer and the home care provider. If agreed, the home care provider will need to establish a contractual or employment

relationship with the case manager suggested by the consumer. The case manager should have appropriate skills and qualifications to perform this role.

3.1.6 Choosing care and services

Once a consumer's goals and the level of involvement in the management of the package have been identified, the consumer and the provider will determine what care and services are needed to support the consumer's goals – including what will be provided, by whom, the timing and frequency of services, and the cost. See Care and Services at Part E.

In a CDC environment, the consumer should not be limited by a "standard" menu of services or service providers. Providers and consumers should be thinking about innovative ways to meet the consumer's goals and care needs. This may involve the use of sub-contracted or brokered services if the home care provider is unable to provide the service/s itself or where the consumer would prefer the service be delivered by a particular worker. Sometimes this may involve additional costs of setting up sub-contracting or brokerage arrangements and these costs should be made clear to the consumer.

Whatever is agreed must be affordable within the total budget available for the package.

3.1.7 Care plan

Care plan development needs to be driven by the consumer, in consultation with the home care provider. The care plan should clearly spell out the following:

- the consumer's goals – what it is the consumer would like to achieve through their package;
- the care and services to be provided to support the consumer's assessed care needs and any identified goals;
- who will provide the care and services;
- when care and services will be provided, including the frequency of services and days/times when regular services are expected to be provided;
- the level of involvement and control the consumer will exercise over the management of the package;
- case management arrangements, including how ongoing monitoring and informal reviews will be managed; and
- the frequency of formal reassessments (which must be undertaken at least every 12 months).

The care plan must be supported by an individualised budget for the consumer.

Care planning discussions may also cover end of life planning such as advance care directives.

3.1.8 Giving effect to the consumer's choices and preferences

In a CDC environment, the provider must always encourage and support the consumer to make informed choices about the type of services to be provided through the package to meet the consumer's goals, including how the services are delivered and by whom.

Wherever possible, the home care provider should try to accommodate the consumer's goals and preferences. In some cases, this may require the home care provider to purchase (sub-contract or broker) services from another service provider.

The home care provider should always inform the consumer of any risks or additional costs of purchasing services from another source.

In some circumstances, the home care provider may not be able to accommodate the consumer's preferences. This will need to be considered on a case-by-case basis, based on what is reasonable in the circumstances.

The following list provides a guide to home care providers as to when it might be reasonable to decline a request from a consumer.

- The proposed service may cause harm or pose a threat to the health and/or safety of the consumer or staff.
- The proposed service is outside the scope of the Home Care Packages Programme (see Part E, Section 3.6).
- The home care provider would not be able to comply with its responsibilities under aged care legislation or other Commonwealth or state/territory laws.
- The consumer's choice of service provider is outside the home care provider's preferred list of service providers and all reasonable effort has been made to broker an acceptable sub-contracting arrangement.
- The requested service provider will not enter into a contract with the home care provider.
- There have been previous difficulties or negative experiences with the consumer's suggested service provider.
- Situations in which a consumer may want to go without necessary clinical services (resulting in a possible compromise of their health and/or wellbeing) in order to "save" for a more expensive non-clinical service.
- The cost of the service/item is beyond the scope of the available funds for the package.

Where the home care provider is not able to give effect to the consumer's preferences or request for services, the reasons must be clearly explained to the consumer and documented.

3.1.9 Sub-contracted or brokered services

Services may be provided directly by the home care provider, sub-contracted to another service provider (individual or organisation), or brokered through another organisation.

Regardless of how services are delivered and by whom, the home care provider remains responsible for service quality and meeting all regulatory responsibilities.

Home care providers are encouraged to develop a list of "preferred service providers" to support consumers' needs and choices.

Home care providers should also endeavour to build relationships with other organisations that specialise in providing services to people from special needs groups. Some consumers may request or prefer service providers that work with, or are from, the same special needs group.

It is possible that, even where there are extensive sub-contracting or brokerage arrangements in place, some consumers may still request a different service provider.

The home care provider should meet any reasonable request, noting that establishing a new service agreement (with an organisation not on the home care provider's preferred service provider list) may result in a delay in providing services and/or lead to additional costs. This should be disclosed to the consumer and be made clear in the individualised budget.

3.1.10 Requests for services to be provided by particular individuals or service providers

The consumer can request that services be provided by a particular individual or service provider, for example, someone who has previously provided services to the consumer.

In such cases, the home care provider is still responsible for ensuring that the police check requirements are met, and for ensuring that the worker is appropriately qualified and trained for the service being provided. Police check requirements are set out in Part F, Section 4.

3.1.11 Contracting to informal carers, family members or friends

Contracting service provision to informal carers, family members or friends is not encouraged under the Home Care Packages Programme.

However, it is recognised that in some areas, for example, remote parts of Australia, this may already occur and may continue to do so where there is no other workable alternative.

The following factors need to be considered by the home care provider in considering whether to contract service provision to informal carers, family members or friends of the consumer:

- elder abuse safeguards;
- the home care provider's responsibility for service quality, including the need to include the person providing the service in the provider's employee, volunteer or sub-contractor systems;
- legal responsibilities, including ensuring that police check requirements are met;
- industrial implications;
- insurance requirements;
- workplace health and safety; and
- qualifications and training required to provide certain types of care.

Carers may be eligible for support and assistance from the Australian Government through programmes such as the Carer Allowance or Carer Payment. These programmes are administered by the Department of Human Services and are not part of the Home Care Packages Programme. Further information is available at the Department of Human Services' carers webpage.

3.2 Individualised budget

3.2.1 Overview

The government subsidy for a Home Care Package is paid to the home care provider, not directly to the consumer.

The home care provider is the fund holder and will administer the budget in a transparent manner, meeting quality and accountability requirements[11].

All packages that are delivered on a CDC basis must have an individualised budget, and the consumer must be provided with a monthly statement of income and expenditure, including the balance of funds.

All information must be provided in a format that is simple for consumers to understand. Where required, the provider must arrange for the individualised budget and/or regular statements to be made available to the consumer in a language other than English.

As explained in Section 2.1 of this Part, home care providers are able to use the national Translating and Interpreting Service (TIS) to provide interpreting services to assist home care consumers to understand their Home Care Package, including the Home Care Agreement, the individualised budget and monthly statements.

[11] Part 3, Divisions 1 and 2, and Schedules 3 and 4 of the *Quality of Care Principles 2014*.

3.2.2 What is an individualised budget?

An individualised budget is a proposed budget for the consumer's package (broken down by income and planned expenditure) that is prepared as part of the care planning process.

The budget should be developed in partnership between the consumer (or their representative) and the home care provider, and be based on the agreed care plan. The budget must also be in a format that is simple to understand for the consumer.

The time period covered by the individualised budget should be agreed between the home care provider and the consumer. It could be prepared on a weekly, monthly, quarterly or annual basis.

Income

The budget should clearly identify the total funds available under the package, which would comprise:

- the government subsidy for the package level as indicated on the Department of Social Services website (including relevant supplements[12], e.g. Dementia and Cognition, Veterans', Oxygen, Enteral Feeding and Top-up Supplements (where applicable);
- any consumer contribution/care fee; and
- any unexpended funds carried over from the prior periods.

For a consumer who commences their package on or after 1 July 2014, the minimum funds available will not vary irrespective of whether the income tested care fee is paid. The minimum funds will still be the amount of the government subsidy for the package level and the relevant supplements, e.g. Dementia and Cognition, Veterans', Oxygen, Enteral Feeding and Top-up supplements (where applicable).

In this way, the minimum funds available to a consumer who cannot be asked to pay an income tested care fee, will be the same as those of a consumer who could be asked to pay an income tested care fee.

It should be noted that the Department of Human Services only ever advises the maximum fees payable, however, the approved provider and the consumer are able to negotiate lower fees should they choose. Also providers cannot use the government subsidy to meet the consumer's income tested care fee. That is, the provider and consumer cannot select a lower level of care and services to match the value of the government subsidy paid.

If all or part of the basic daily care fee is paid, the budget should clearly identify these funds as included under the package.

[12] Funding paid to the approved provider through the Viability Supplement (if applicable) does not have to be included in the individualised budget.

Planned expenditure

The expenditure plan in the budget should be grouped into three broad categories, although other sub-groups under these categories can also be used:

- administration costs;
- core advisory and case management services; and
- service and support provision and/or purchasing.

These categories are explained below.

- **Administration costs** – reflect establishment costs for the organisation and would also include the costs of meeting government quality and accountability requirements. Administration costs may include expenses associated with:
  - insurance and government reporting
  - organisational overheads
  - capital costs
  - ongoing research and service improvement
  - CDC administrative overheads including staff and IT
  - developing statements and other consumer communication
  - establishing contracts with sub-contracted providers
  - setting up and cancelling appointments.

- **Core advisory and case management services** – this category will include the costs associated with:
  - care planning
  - set up costs for new consumers
  - periodic reviews or re-assessments
  - case co-ordination or case management
  - provision of support to consumers who elect to manage their package themselves.

- **Service and support provision and/or purchasing** – this category will include the costs of direct service provision. This part of the budget should confirm the decisions made in the care plan about what services have been chosen to be delivered or purchased (e.g. nursing, domestic assistance), the individual cost of those services and any additional surcharges applied.

Balance remaining

The balance between Income and planned expenditure should be clearly demonstrated as funds may need to be carried over to a new period.

The budget should describe and quantify what tangible services will be provided to the consumer, e.g. costs are based on personal and phone contact of X hours per week at $Y per hour (or appropriate service unit).

3.2.3 Contingency

The budget may also include a small "contingency" to make provision for emergencies, unplanned events or increased care needs in the future, but this is not a requirement. Contingency amounts cannot be pooled across consumers.

If a contingency is set aside, it should be no more than 10 per cent of the total annual budget for the package. The contingency amount must be clearly identified in the individualised budget and in the monthly statement of income and expenditure provided to the consumer.

Contingency funds must be used before accessing additional home support programme services.

3.2.4 Income and expenditure statement to the consumer

The home care provider must provide the consumer with a monthly statement clearly showing the income and expenditure of the package, in a format that enables the consumer to understand where funds have been expended, as well as the balance of available funds (or unexpended funds).

Any unexpended package funds, including contingency funds, must carry over from month to month, and from year to year, for as long as the consumer continues to receive care under the package.

The format of the statement must be clear and easy to understand, should clearly state any unexpended or contingency funds, and should be consistent with the individualised budget. The means by which the statement is provided to the consumer, e.g. hardcopy, email or web-based, can be negotiated between the home care provider and the consumer.

3.2.5 Unspent funds when a consumer leaves a package

When a consumer leaves a package, there may be unspent funds in the budget from the contingency or any other funds not expended. It will depend on the circumstances as to how these unspent funds are used.

- If the consumer continues to receive a package from the home care provider (at a different package level), any unspent funds from the previous package must continue to be available under the consumer's new package.

- If the consumer moves to a different home care provider (e.g. to take up a package with another home care provider) or to enter residential care, any

unspent funds can be retained by the previous home care provider to support service delivery for other consumers, or for infrastructure purposes.

  - However, if the consumer returns to a package within 28 days, there is discretion for the home care provider to make available the unspent funds in a future package offered to the consumer.

  - There is also the discretion for a home care provider to agree to transfer unspent funds to another home care provider to support the ongoing care needs of the consumer. This would need to be negotiated and agreed between the relevant providers, in consultation with the consumer.

- Any unspent funds remain with the home care provider on the cessation of the Home Care Package where the consumer is deceased. These funds should be used to support service delivery for other consumers, or for infrastructure purposes.

- Where the consumer has provided their own money to top-up or purchase additional services through the home care provider, or has paid any fees in advance, any unspent money provided by the consumer must be returned to the consumer when they leave the package, or to the consumer's estate if the consumer is deceased. See Section 5.

3.3 Monitoring, review and re-assessment

3.3.1 Ongoing monitoring and review by the home care provider

The home care provider is responsible for ensuring that the needs of the consumer are being met on an ongoing basis. This will require ongoing monitoring or review of the appropriateness of the package, including whether the consumer's goals and care needs are being met and whether the consumer is satisfied with the services being received.

Review is a continuous process between the home care provider and the consumer. This review is informed by observations and feedback from staff and service providers who are in contact with the consumer.

3.3.2 Re-assessment by the home care provider

Note – this Section refers to the formal review (re-assessment) of the consumer by the home care provider, not an assessment undertaken by the ACAT.

Re-assessment by the home care provider involves assessing the consumer's needs, goals and preferences in order to update their care plan and, if necessary, change services the consumer is receiving. This may also result in changes to the Home Care Agreement and the individualised budget.

There must be a formal re-assessment of the consumer by the home care provider at least every 12 months. The cost of the re-assessment should be included in the individualised budget.

The consumer should not be able to opt out of the formal re-assessment, although the scheduling and style of the re-assessment should match the consumer's preferences wherever possible.

A re-assessment can occur more frequently than 12 months. Reasons for an additional or earlier re-assessment may include:

- a request by the consumer;
- a request by a carer;
- a health crisis or episode;
- a change in care need that cannot be met within the budget available for the package;
- a change in living or carer arrangements;
- ongoing or increasing use of clinical services by a consumer; or
- the use of a large amount (or all) of the contingency funds.

The re-assessment should have a re-ablement and wellness focus that does not assume a decline in the consumer's health and functioning. The re-assessment should involve:

- a review of the consumer's assessed care needs and goals;
- an evaluation of the quality and success of the services and supports that have been provided;
- a renegotiation and update of the care plan and individualised budget; and
- support for the consumer to continue to make informed decisions, including whether the consumer wishes to change their level of involvement and decision-making in the management of the package.

The re-assessment should be done in person, wherever possible. Video technology or other remote monitoring digital technology may also be used, where clinically appropriate.

3.3.3 Support for consumer following re-assessment by home care provider and changes to care plan

Re-assessment of the consumer's care needs could lead to significant changes in the nature of support being provided to a consumer. The home care provider should support the consumer, as much as possible, in any changes resulting from the review of the care plan.

If the consumer's care needs have increased significantly so that the person potentially requires home care in a higher band (e.g. Level 3 or 4, rather than Level 1 or 2), or entry to residential care, the consumer will need another

assessment by an ACAT. The home care provider can assist in arranging the ACAT assessment, with the permission of the consumer.

4. Packages NOT being delivered on a CDC basis

4.1 Overview

Many of the requirements set out in this Part, which apply to CDC packages, are also relevant to packages that are not being delivered on a CDC basis. These include:

- being offered a package by a home care provider (see Section 1 in this Part);
- developing the Home Care Agreement (see Section 2 in this Part);
- most elements of the care planning process (see Section 3 in this Part) and the monitoring, review and re-assessment process (see Section 3.3 in this Part); and
- topping up services under a package (see Section 5 in this Part).

The main requirements of non-CDC packages are summarised below. Care and services are outlined in Part E.

- After the ACAT assessment and approval, the next step is for the consumer to be offered a package by a home care provider. The provider will determine whether they are able to offer a package suitable for the consumer.
- A Home Care Agreement must be offered to the consumer before the package commences.
- The consumer's care plan forms the basis of the Home Care Agreement.
- The care planning process should be about the consumer. The consumer should be asked about their goals in developing (and reviewing) the care plan – while this is an important element of care planning under a CDC approach, this should be undertaken in **all** packages.
- Throughout the care planning process, there should also be an emphasis on wellness and re-ablement, as well as maintenance of independence and control for as long as possible.
- There is flexibility for the consumer and the home care provider to negotiate a broad range of aged care and services under a package – see Part E.
- Services may be provided directly by the home care provider, sub-contracted to another service provider (individual or organisation), or brokered through another organisation.
- The home care provider is responsible for ensuring that the needs of the consumer are being met on an ongoing basis.
- The care plan (and if necessary, the Home Care Agreement) must be formally re-assessed by the home care provider at a minimum, every 12 months. However, this can occur more frequently as required or agreed between the consumer and the provider.

- A consumer may choose to "top up" their package by purchasing additional care and services (i.e. paid for by the consumer). This would need to be negotiated and agreed between the consumer and the home care provider.

4.2 Level of consumer control over the management of the package

While not a requirement of non-CDC packages, wherever possible, the consumer should be asked about, and given the option, of exercising different levels of control over the management of the package. Providers are encouraged to incorporate this element into existing packages and when offering a non-CDC package to a new consumer.

4.3 Giving effect to the consumer's choices and preferences

Wherever possible, the home care provider should encourage and support the consumer to make choices about the type of services to be provided through the package to meet the consumer's goals, including how the services are delivered and by whom.

4.4 Individualised budget

The individualised budget (as described in Section 3.2 in this Part) is an important element of packages being delivered on a CDC basis.

While there is no requirement for an individualised budget in a non-CDC package, all providers are expected to deliver all Home Care Packages in an open and transparent manner, so that the consumer is aware of the budget/funding available and how funds are being spent. An individualised budget (or elements of the budget) can be incorporated into an existing package at any time, even if the package is not formally being delivered on a CDC basis.

5. Topping-up services or additional services under a package (both CDC and non-CDC)

A consumer may choose to "top up" their package by purchasing additional care and services through their home care provider. This arrangement needs to be negotiated and agreed between the consumer and the provider.

Any additional monetary contribution from the consumer to the home care provider for top up services must be separately identified, either within the individualised budget (if the package is being delivered on a CDC basis) or in a separate account.

In such cases, the additional care and services would be organised by the home care provider under the same conditions, rights and responsibilities that underpin the delivery of the Home Care Package.

In some cases, the home care provider may not be able to provide or organise for care and services to be delivered as a top-up to the package. Where this is the case, the consumer (or their representative) is responsible for organising any additional care and services themselves. This would be a private matter between the consumer and a third party (another service provider) with no involvement of the home care provider.

Where the consumer has provided their own money to top-up or purchase additional services through the approved provider, any unspent money provided by the consumer must be returned to the consumer when they leave the package, or to the consumer's estate if the consumer is deceased.

6. Converting packages delivered on a non-CDC basis to a CDC basis

All Home Care Packages, including packages allocated before the 2012-13 ACAR[13], must be delivered on a CDC basis from 1 July 2015. The period leading up to this date is a transitional period for home care providers to introduce any changes in administration, systems and training that may be needed to deliver Home Care Packages on a CDC basis.

Home care providers do not have to wait until 1 July 2015, but can elect to convert existing packages to a CDC basis once they are ready to make the transition. For home care providers wishing to transition their current non CDC packages, this can be undertaken through an informal or formal process.

6.1 Informal transition

Home care providers can informally deliver their Home Care Packages on a CDC basis. There is nothing in the current conditions of allocation that prevent this. This can be done at the place, provider or the service level. This allows providers and consumers to begin the process of implementing CDC delivery within their service delivery operations and allow for a staged implementation in the lead up to 1 July 2015.

An informal conversion does not vary the conditions of allocation and does not in itself include any additional statutory protection around the CDC conditions of allocation.

6.2 Formal transition

Home care providers are also able to formally convert their Home Care Packages to a CDC basis of delivery. Under the *Aged Care Act 1997*, Division 17, section 17-2, a home care provider can seek to vary the conditions of allocations for their non CDC place. See Part I, Section 2.

[13] Packages allocated to providers before the 2012-13 ACAR were allocated as CACP, EACH or EACHD packages. These became Home Care Level 2 or 4 packages on 1 August 2013.

Part E – What Home Care Packages provide

Covered in this part

- Home care subsidy
- Previous EACHD consumers
- Care and services
  - Overview
  - Nursing, allied health and other clinical services
  - Telehealth and digital technology
  - Aids and equipment
  - List of care and services – inclusions
  - Excluded items
- Security of tenure
  - Responsibilities for the provider
  - Consumers moving locality
- Leave provisions
  - Overview
  - Suspension of home care agreement arrangements
  - Impact of suspension on consumer fees (care fees)
  - Impact of suspension on supplements
  - Subsidy and care fees during suspension periods (CDC packages)

1. Home care subsidy

The government subsidy paid in respect of a home care place (the "home care subsidy") is paid to the home care provider, not directly to the consumer.

The subsidy is paid to the home care provider monthly in advance through the Department of Human Services aged care payment system.

The subsidy is calculated on a daily basis where there is an approved care recipient (consumer) receiving care through a package.

The basic subsidy amounts for 2014-15 are set out below.[14] Other supplement amounts may also apply – see Part H of these Guidelines.

Details of subsidy and supplement amounts are also published on the Department of Social Services Aged Care Funding webpage. The information on the webpage is updated when subsidy and supplement amounts change.

[14] Changes to subsidy amounts usually take effect from 1 July each year. Providers are advised about changes in subsidy amounts by the Department of Social Services, usually through a mailstream or faxstream notice.

Level of Home Care Package	Basic home care subsidy in 2014-15 (per day)	Basic home care subsidy in 2014-15 (per annum[15])
Level 1	$21.43	$7,822
Level 2	$38.99	$14,231
Level 3	$85.73	$31,291
Level 4	$130.32	$47,567

2. Previous EACHD consumers

From 1 August 2013, the previous Extended Aged Care at Home Dementia (EACHD) package converted to a Home Care Level 4 with a Dementia and Cognition Supplement paid in addition to the basic home care subsidy amount (or the Veterans' Supplement if the consumer meets the eligibility criteria and agrees that their eligibility can be disclosed to the home care provider).

To ensure that existing EACHD consumers (i.e. those who were receiving an EACHD package on 31 July 2013) continue to receive the same level of funding plus indexation, there is a "Top-up" Supplement paid in respect of existing EACHD consumers. This applied from 1 August 2013.

The Top-up Supplement is paid automatically to the home care provider in respect of the eligible consumer.

Home care	Total funding available in 2014-15 (per day)	Total funding available in 2014-15 (per annum)
Existing EACHD consumers only	$145.93 (see note below)	$53,264

Total funding for previous existing EACHD consumers comprises the Home Care Level 4 basic subsidy ($130.32 per day), plus 10 per cent for the Dementia and Cognition Supplement or Veteran's Supplement ($13.03 per day), plus the Top-up Supplement ($2.58 per day).

If the consumer moves to a different home care provider after 1 August 2013, the Top-up Supplement can continue to be paid to the new provider in respect of the consumer, as long as the period between ceasing the former package and commencing the new package is not more than 28 days.

3. Care and services

3.1 Overview

There is flexibility in the way consumers can choose care and services under Home Care Packages, across all four levels.

[15] Annual subsidy amounts have been rounded to the nearest dollar.

There is a common (single) list of care and services across all four package levels. There is also a single list of excluded items that applies across all four package levels.

The list of care and services and the excluded items are set out in the following tables (Sections 3.5 and 3.6). These tables are based on the information contained in Schedule 3 to the *Quality of Care Principles 2014.*

The list of care and services is not an exhaustive list, nor is it expected that all of the care and services listed will be provided to an individual consumer through a Home Care Package.

The main difference between the home care levels is the amount of care and services that can be provided to the consumer, rather than the type of care at each package level. More care and services can be provided under Home Care Level 4, compared to the other home care levels, reflecting the higher subsidy amount that is paid for under the Level 4 package.

The consumer and the home care provider can also negotiate other care and services required to support the consumer to live at home where this will assist the consumer to achieve his/her goals, consistent with the consumer's care needs.[16] The home care provider must also be able to provide the care and services within the limits of the resources available for the package, and the care and services must not be an excluded item (i.e. outside the scope of the Home Care Packages Programme).

This increased flexibility applies to **all** Home Care Packages, whether delivered on a CDC basis or not.

The care and services must be provided by the home care provider in a way that meets the Home Care Common Standards.

3.2 Nursing, allied health and other clinical services

Where required, a consumer can access nursing, allied health or other clinical services (such as hearing or vision services) under any level of Home Care Package. This is a change from the former CACPs, which did not include these types of services.

While nursing, allied health or other clinical services may be provided as part of Home Care Level 1 and 2 packages, these packages are not intended to provide comprehensive clinical or health services. Home Care Level 3 and 4 packages have a greater emphasis on delivering complex care in the home, including more clinical care where required.

The home care provider is responsible for ensuring that all home care consumers receive quality care and services that are safe and appropriate to their assessed

[16] The consumer's goals and care needs should be identified in the consumer's care plan.

needs.[17] This includes putting in place appropriate systems to support consumers in an emergency situation, including access to a person or service who can give emergency assistance when needed. If a consumer has been assessed as requiring nursing services, the home care provider should consider whether there is a need to include in the Home Care Package 24-hour on-call access to care provided by, or under the supervision of, a registered nurse.

3.3 Telehealth and digital technology

The care and services in all package levels may also be used to support the use of:

- telehealth, video conferencing and digital technology (including remote monitoring) where appropriate, to increase access to timely and appropriate care; and
- assistive technology, such as aids and equipment (particularly those that assist a person to perform daily living tasks), as well as devices that assist mobility, communication and personal safety.

3.4 Aids and equipment

The Home Care Packages Programme is not intended to be an aids and equipment scheme. However, some aids and equipment, including custom made aids, can be provided to a consumer where this is identified in their care plan and the item/s can be provided within the limits of the resources available for the package.

The home care subsidy can be also used to assist a consumer who requires a motorised wheelchair (or motorised scooter). However, given the high cost of these items, in most cases, it is expected that these items would be hired or leased, rather than purchased for the consumer.

If the home care subsidy is used to purchase, or contribute towards the cost of purchasing, a motorised wheelchair or scooter for the consumer, there will need to be a clear understanding between the home care provider and the consumer as to who owns the item, what will happen to the item once the consumer ceases in the package, and who is responsible for ongoing maintenance and repair costs. The agreed position and the responsibilities of each party should be documented and preferably included in the Home Care Agreement between the home care provider and the consumer.

State and territory governments operate specialised aids and equipment schemes to assist people with disabilities, including older people. It is expected that consumers will continue to be able to access specialised aids and equipment schemes where there is a need for support.

[17] *Charter of Care Recipients' Rights and Responsibilities – Home Care.*

3.5 List of care and services

The range of care and services available at any level of Home Care Packages includes the following:

A. Care services	Care can include:
Personal services	Personal assistance, including individual attention, individual supervision and physical assistance, with: • bathing, showering including providing shower chairs if necessary, personal hygiene and grooming, dressing and undressing, and using dressing aids • toileting • dressing and undressing • mobility • transfer (including in and out of bed)
Activities of daily living	Personal assistance, including individual attention, individual supervision and physical assistance, with: • communication including assistance to address difficulties arising from impaired hearing, sight or speech, or lack of common language, assistance with the fitting of sensory communication aids, checking hearing aid batteries, cleaning spectacles and assistance in using the telephone
Nutrition, hydration, meal preparation and diet	Includes: • assistance with preparing meals • assistance with special diet for health, religious, cultural or other reasons • assistance with using eating utensils and eating aids and assistance with actual feeding if necessary • providing enteral feeding formula and equipment
Management of skin integrity	Includes: • providing bandages, dressings, and skin emollients
Continence management	Includes: • assessment for and, if required, providing disposable pads and absorbent aids, commode chairs, bedpans and urinals, catheter and urinary drainage appliances and enemas • assistance in using continence aids and appliances and managing continence
Mobility and dexterity	Includes: • providing crutches, quadruped walkers, walking frames, walking sticks and wheelchairs • providing mechanical devices for lifting, bed rails, slide sheets, sheepskins, tri-pillows, and pressure relieving mattresses • assistance in using the above aids

B. Support services	**Care can include:**
Support services	Includes: • cleaning • personal laundry services, including laundering of the consumer's clothing and bedding that can be machine-washed, and ironing • arranging for dry-cleaning of the consumer's clothing and bedding that cannot be machine washed • gardening • medication management • rehabilitative support, or helping to access rehabilitative support, to meet a professionally determined therapeutic need • emotional support including ongoing support in adjusting to a lifestyle involving increased dependency and assistance for the consumer and carer if appropriate • support for consumers with cognitive impairment, including individual therapy, activities and access to specific programmes designed to prevent or manage a particular condition or behaviour, enhance quality of life and provide ongoing support • providing 24-hour on-call access to emergency assistance including access to an emergency call system if the consumer is assessed as requiring it • transport and personal assistance to help the consumer shop, visit health practitioners or attend social activities • respite care • home maintenance, reasonably required to maintain the home and garden in a condition of functional safety and provide an adequate level of security • modifications to the home, such as easy access taps, shower hose or bath rails • assisting the consumer, and the homeowner if the home owner is not the consumer, to access technical advice on major home modifications • advising the consumer on areas of concern in their home that pose safety risks and ways to mitigate the risks • arranging social activities and providing or coordinating transport to social functions, entertainment activities and other out-of-home services • assistance to access support services to maintain personal affairs
Leisure, interests and activities	Includes: • encouragement to take part in social and community activities that promote and protect the consumer's lifestyle, interests and wellbeing

C. Clinical services	Can include:
Clinical care	Includes: • nursing, allied health and therapy services such as speech therapy, podiatry, occupational or physiotherapy services • other clinical services such as hearing and vision services
Access to other health and related services	Includes: • referral to health practitioners or other service providers

3.6 Excluded items

The following services or items are outside the scope of the Home Care Packages Programme and must not be included in a package (at any of the four levels of home care).[18]

Excluded items	Items:
Excluded items	• use of the package funds as a source of general income for the consumer • purchase of food, except as part of enteral feeding requirements* • payment for permanent accommodation, including assistance with home purchase, mortgage payments or rent • payment of home care fees • payment of fees or charges for other types of care funded or jointly funded by the Australian Government • home modifications or capital items that are not related to the consumer's care needs • travel and accommodation for holidays • cost of entertainment activities, such as club memberships and tickets to sporting events • payment for services and items covered by the Medicare Benefits Schedule or the Pharmaceutical Benefits Scheme • gambling activities • illegal activities

Clarification

***Meals** – The government subsidy for a Home Care Package can be used to pay for the preparation and delivery of meals. This could be through the consumer's home care provider, a HACC service provider (for example, under a sub-contracting arrangement with the home care provider) or by a private service provider. However, the consumer is expected to cover, or to make a contribution towards, the cost of the food. The amount of the contribution or fee may be negotiated between the home care provider, the meals service provider and the consumer.

[18] These items are excluded under Part 2 of Schedule 3 to the *Quality of Care Principles 2014.*

4. Security of tenure

4.1 Responsibilities for the provider

Under the legislation, home care providers are responsible for ensuring a consumer's security of tenure.[19]

The Home Care Agreement must specify how either party may terminate the Home Care Agreement[20] and must not contradict the security of tenure provisions set out in the *User Rights Principles 2014*.[21]

When a consumer commences a Home Care Package, the home care provider should explain that, at some time in the future, the consumer may no longer be able to continue on the package.

The home care provider may re-allocate the consumer's package to another person only if:

- the consumer cannot be cared for in the community with the resources[22] available to the home care provider;
- the consumer tells the home care provider, in writing, that they wish to move to a location where home care is not available through the home care provider;
- the consumer tells the home care provider, in writing, that they no longer wish to receive the care; or
- the consumer's condition changes so that:
  - they no longer need home care; or
  - the consumer's needs, as assessed by the ACAT, can be more appropriately met by other types of services or care.
- the consumer does not meet his/her responsibilities, as described in the 'Charter of Care Recipients' Rights and Responsibilities – Home Care', for a reason within the consumer's control, for example:
  - if a consumer does not pay the fees or negotiate an alternative with their provider, the provider may re-allocate the consumer's package to another person.

If a transfer to another type of care is necessary, the home care provider should work with the consumer and alternative providers to ensure a smooth transition. This may include arranging another ACAT assessment.

[19] Section 56-2 of the *Aged Care Act 1997*.
[20] Division 4, paragraph 23(2)(g) of the *User Rights Principles 2014.*
[21] Division 2, section 17 of the *User Rights Principles 2014.*
[22] Resources available to the provider can include informal care and support provided by the consumer's family and/or other supports paid for by the consumer, in addition to the supports provided by the packages.

4.2 Consumers moving locality

When a consumer moves to a different location (that is outside the home care provider's service delivery area), the consumer may have to change to another provider. The consumer's package does not transfer with them in these circumstances. In order to continue to receive services under a Home Care Package, the consumer will need to be offered a package from a home care provider in the new location.

The current home care provider should ensure continuity of service delivery during the transfer and assist where possible to arrange services in the new location.

Should a consumer move to another location, any unspent consumer contributions (e.g. advance monthly consumer payments and any top-up payments) paid by the consumer would have to be refunded. For information on the treatment of unexpended funds in the consumer's existing package, refer to Part D, Section 3.2.5.

5. Leave provisions

5.1 Overview

A consumer may choose or need to take temporary leave from their Home Care Package for various reasons – for a hospital stay which may sometimes be followed by transition care, to receive respite care, or for any other purpose, such as social leave. Previously there were different leave provisions between CACP and EACH/EACHD packages.

With the introduction of the new Home Care Packages Programme, leave arrangements will be the same across all four home care levels. There will also be more consistent rules across the different types of leave.

5.2 Suspension of home care agreement arrangements

Under section 46.2 of the *Aged Care Act 1997*, a home care recipient may suspend their home care agreement for any reason on a temporary basis. For this to occur, a home care provider must be informed in writing. The consumer must also advise the home care provider in writing of any extension to a planned episode of leave.

A consumer's tenure will not be affected while on leave (suspending services) as long as they advise the home care provider in writing they are taking leave. The provider continues to receive subsidy in respect of the consumer during a suspension period at a reduced rate after 28 days. Refer to the table below for the impact of suspension on subsidy payments.

A consumer may wish to temporarily suspend some or all of the care and services they receive under their package while they are on leave. The consumer must advise

the home care provider of the relevant dates for the proposed suspension of services.

Suspensions are calculated on a financial year basis from 1 July. If a consumer transfers to a different Home Care Package level, such as from Level 3 to Level 4, within the same financial year, the suspension subsidy balances are reset when the new package commences.

The following table provides information about how the subsidy is paid to providers in relation to suspending the home care agreement. This applies to all Home Care Package levels (1 to 4).

Types of suspension	**Impact on payment of subsidy to approved provider**
Hospital	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 **consecutive** days in a financial year, for each episode of hospitalisation. • After 28 consecutive days, the subsidy is payable at 25 per cent of the basic subsidy rate.
Transition care	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 **consecutive** days in a financial year, for each episode of transition care. • After 28 consecutive days, the subsidy is payable at 25 per cent of the basic subsidy rate.
Residential Respite care	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 **cumulative** days in a financial year. • After 28 cumulative days, the subsidy is payable at 25 per cent of the basic subsidy rate.
Social leave*	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 **cumulative** days in a financial year. • After 28 cumulative days, the subsidy is payable at 25 per cent of the basic subsidy rate.

*all other suspension types

5.3 Impact of suspension on consumer fees (care fees)

A consumer may be required to pay an ongoing care fee to the home care provider while the consumer is on leave from their package[23]. This amount must be no more than the usual fee agreed between the consumer and the home care provider.

[23] Division 46, section 46-2 of the *Aged Care Act 1997* and *Aged Care (Transitional Provisions) Act 1997*; Division 2, section 72 of the *Subsidy Principles 2014;* section 108 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*; and Division 5, Part 4, subsection 130(5) of the *Aged Care (Transitional Provisions) Principles 2014*.

5.3.1 Consumers on a Home Care Package on or before 30 June 2014

A consumer who was in receipt of a package on 30 June 2014, cannot be asked to pay a home care fee while the consumer's package has been suspended while the consumer is receiving transition care or residential respite care.[24]

5.3.2 Consumers on a Home Care Package on or after 1 July 2014

For consumers who entered into a Home Care Agreement on or after 1 July 2014, the income tested care fee payable (if any) will remain payable while their package is suspended. The full fee will be paid for up to 28 days (see above table), after which the consumer will pay whichever is the lesser of:

- their income tested care fee, as previously advised; or
- the amount of the reduced home care subsidy, plus the primary supplements payable.

The Department of Human Services will notify the provider and consumer in writing of the amount payable.

A consumer who suspends their package to go into residential respite or transition care can apply for the financial hardship subsidy for the period of suspension if payment of the income tested care fee will put them into financial hardship.

However, for consumers who entered into a Home Care Agreement on or after 1 July 2014, the basic daily care fee must not be charged by the home care provider when the consumer takes leave for transition care or residential respite care[25].

5.4 Impact of suspension on supplements

Where the home care provider is eligible to receive a supplement/s in relation to a home care consumer, the following supplement/s will continue to be paid when the consumer takes leave from their package, during the period where the home care subsidy is paid at the full basic subsidy rate:

- Dementia and Cognition Supplement and Veteran's Supplement
- Top-up Supplement
- Viability Supplement

However the following supplements will not be paid should the home care agreement be suspended:

- Enteral Feeding Supplement
- Oxygen Supplement

[24] Subsection 130(5) of the *Aged Care (Transitional Provisions) Principles 2014*.
[25] Section 108 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

When the home care subsidy is paid at the reduced rate (25 per cent) after 28 consecutive days of suspension, payment of all supplements will cease, with the exception of the Viability Supplement. The amount of the Viability Supplement remains unchanged while the consumer is on leave.

5.5 Subsidy and care fees during suspension periods in packages delivered on a CDC basis

For Home Care Packages being delivered on a CDC basis, any subsidy, relevant supplements[26] or care fees paid to the home care provider while the consumer is on leave must be included in the regular statement of income and expenditure provided to the consumer.

[26] Dementia and Cognition, Veterans, Oxygen, Enteral Feeding and Top-Up Supplements (where applicable).

Part F – Rights and responsibilities

Covered in this part

- Context
- Consumers
  - Rights and responsibilities
  - Advocacy
  - Complaints (including the Aged Care Complaints Scheme)
- Approved providers
  - Responsibilities
- Police check/certificate requirements
- Quality Reporting Programme
- Qualifications of staff and workers

1. Context

The information contained in this Part is an overview and a guide to assist approved providers and consumers understand their rights and responsibilities in home care, including resources and programmes relating to advocacy and complaints.

However, this information is not intended to be a legal resource for providers or consumers. In the case of any discrepancy between the information contained in the Guidelines and the legislation, the legislative provisions take precedence.

Note – In this Part, the term "approved provider" is used rather than "home care provider". This is because there are a number of legislative references to matters affecting approved providers in this Part.

2. Consumers

2.1 Rights and responsibilities

The rights and responsibilities of the consumer in relation to Home Care Packages are set out in the 'Charter of Care Recipients' Rights and Responsibilities – Home Care' (the Charter).[27]

The Charter is contained in Schedule 2 to the *User Rights Principles 2014*. The full Charter will be available on the Department's website.

The rights and responsibilities should be clearly explained to the consumer by the approved provider. A copy of the Charter must be provided to the consumer with the Home Care Agreement.

[27] The Charter was previously called the 'Charter of Rights and Responsibilities for Community Care'.

2.2 Advocacy

The consumer (either the care recipient or their representative) can request that another person assist them in dealings with the approved provider.

A consumer has the right to call on an advocate of their choice to represent them in managing their care. Services provided by an advocate may include:

- establishing or reviewing the Home Care Agreement and care plan;
- negotiating the fees the consumer may be asked to pay by the approved provider; and
- presenting any complaints the consumer may have.

The approved provider must allow an advocate acting for an authorised body access to the home care service if the consumer or their representative has requested the assistance of such a person.[28]

Approved providers must accept the consumer's choice of advocate.

Should the consumer not have an advocate one may be made available through the National Aged Care Advocacy Programme.

2.2.1 National Aged Care Advocacy Programme

The National Aged Care Advocacy Programme (NACAP) is funded by the Australian Government under the *Aged Care Act 1997* and provides free, confidential advocacy support and information to consumers or potential consumers of Australian Government subsidised Home Care Packages.

There are nine community-based NACAP organisations operating nationally, one in each state and territory, and two in the Northern Territory. NACAP organisations provide information and support to consumers or potential consumers of aged care services, their carers and families about their rights and responsibilities when accessing services.

NACAP services:

- support consumers or people who are looking to receive residential aged care services or Home Care Packages to be involved in decisions that affect their life and their care needs;
- provide consumers receiving, or who are going to receive, residential aged care services or Home Care Packages with information and advice about their rights and responsibilities;

[28] Division 2, section 18 of the *User Rights Principles 2014.*

- assist consumers of residential aged care services or Home Care Packages and/or their representatives to resolve problems or complaints in relation to aged care services, through the provision of advocacy; and
- promote the rights of consumers receiving residential aged care services or Home Care Packages to aged care service providers.

To contact a NACAP provider in your area please call the National Aged Care Advocacy line on **1800 700 600**.

2.3 Complaints

If consumers are concerned about any aspect of service delivery, they should, in the first place, approach the approved provider. In most cases, the approved provider is best placed to resolve complaints and alleviate the consumer's concerns. Approved providers must accept a complaint regardless of whether it is made orally, in writing or anonymously.

Approved providers must have appropriate processes in place to receive, record and resolve complaints.[29] These processes are to include consideration of people with special needs such as people with vision or hearing impairments and people from culturally and linguistically diverse backgrounds. Approved providers are required to inform consumers about these mechanisms and they must be identified in the Home Care Agreement.

Approved providers must not discontinue provision of goods or services, refuse access or otherwise take recrimination against any person because they have made a complaint. Approved providers must handle and address any complaints fairly, promptly and confidentially.

Approved providers are to record, monitor, collate and analyse trends in complaints so that this information can be used to improve services.

Consumers should be actively encouraged to provide feedback about the services they receive. Approved providers must also make available information about the Aged Care Complaints Scheme, including information about how to make contact with the Complaints Scheme.

2.4 Aged Care Complaints Scheme

The Complaints Scheme is a free service for people to raise their concerns about the quality of care or services being delivered to people receiving aged care services that are subsidised by the Australian Government.

The Complaints Scheme can be contacted on **1800 550 552**. Complaints can also be made to the Scheme in writing and via the Scheme webpage (see link below).

[29] Section 56-4 of the *Aged Care Act 1997.*

When someone lodges a complaint with the Aged Care Complaints Scheme, the Complaints Scheme will explain the process, options for resolution and what can be achieved through those options. Options for resolution open to the Complaints Scheme include:

- asking the service provider to resolve concerns directly with the complainant and report back to the Complaints Scheme on the outcomes;
- conciliating an outcome between the provider and the complainant; and
- investigating the concerns.

The processes of the Complaints Scheme, including options for resolution, are governed by the *Complaints Principles 2014* under the Act.

The Complaints Scheme assesses quality of care and services in line with a provider's responsibilities under the Act including those outlined in:

- the 'Charter of Care Recipients' Rights and Responsibilities – Home Care'; and
- the Home Care Standards.

The Complaints Scheme has the capacity to require a provider to take action where they are not meeting these responsibilities.

More information can be found on the Aged Care Complaints Scheme webpage.

3. Approved providers

3.1 Responsibilities

Approved providers have a number of responsibilities under the *Aged Care Act 1997*. These responsibilities relate to:

- quality of care – Part 4.1 of the Act;
- user rights (i.e. the rights of the consumer) – Part 4.2 of the Act; and
- accountability for the care that is provided, including the suitability of their key personnel – Part 4.3 of the Act.

For those approved providers who do not meet their responsibilities, compliance action, including sanctions, under Part 4.4 of the Act may be taken.

3.1.1 Quality of care

Division 54 of the Act outlines the responsibilities of approved providers in relation to the quality of care.

This includes providing care and services in accordance with the *Quality of Care Principles 2014* and complying with the Home Care Standards.

Through the Quality Reporting Programme, the Australian Aged Care Quality Agency undertakes reviews of approved providers against the Home Care Standards. The Quality Reporting Programme is explained below in Section 5 in this Part.

Approved providers must also maintain an adequate number of appropriately skilled staff to ensure that the needs of consumers are met (see Section 6 in this Part).

3.1.2 User rights

Division 56 of the Act outlines the general responsibilities of approved providers in relation to consumers (users and proposed users) of Home Care Packages. These responsibilities are described in further detail in Part 4.2 of the Act and in the *User Rights Principles 2014.*

In summary, the responsibilities of approved providers include:

- charging fees in accordance with the Act;
- providing security of tenure;
- entering (or offering to enter) into a Home Care Agreement;
- protecting personal information;
- resolving complaints;
- the provision of information;
- access to home care service by advocates; and
- complying with any rights and responsibilities of consumers that are specified in the *Users Rights Principles 2014*.

As explained in the consumer rights and responsibilities (earlier in this Part of the Guidelines), the approved provider must also allow an advocate acting for an authorised body access to the home care service if the consumer or their representative has requested the assistance of such a person.

3.1.3 Accountability

Division 63 of the Act deals with the accountability requirements for approved providers, including:

- record keeping;
- complying with powers being exercised by authorised officers;
- complying with conditions of allocation;
- complying with responsibilities specified in the *Accountability Principles 2014* (includes police check/certificate requirements); and
- obligations in relation to key personnel.

4. Police check/certificate requirements

4.1 Overview

Approved providers are required to ensure that police certificates, not more than three years old, are held by:

- all staff members who are reasonably likely to have access to care recipients; and
- volunteers who have , or are likely to have, unsupervised access to care recipients,

The approved provider must be satisfied that the police certificate does not record that the person has been:

- convicted of murder or sexual assault; or
- convicted of, and sentenced to imprisonment for, any other form of assault.

Any person with a conviction for such offences listed above must not be allowed to provide any care or ancillary duties.

Volunteers provided by the Community Visitors Scheme (CVS) have a police certificate and have been assessed as meeting the requirement.

4.2 Staff member

A staff member is defined in section 4 of the *Accountability Principles 2014* as a person who:

- is at least 16 years old; and
- is employed, hired, retained or contracted by the approved provider (whether directly or through an employment or recruitment agency) to provide care or other services under the control of the approved provider; and
- has, or is reasonably likely to have, access to care recipients.

4.3 Volunteer

Under Part 1, section 4 of the *Accountability Principles 2014*, a volunteer is defined as a person who:

- is not a staff member of the approved provider; and
- offers his or her services to the approved provider; and
- provides care or other services on the invitation of the approved provider and not solely on the express or implied invitation of a care recipient; and
- has, or is reasonably likely to have, unsupervised access to care recipients; and

- is at least 16 years old or, if the person is a full-time student, has turned 18 old.

4.4 Key personnel

Additional conditions apply to key personnel. Part 2 of the *Sanctions Principles 2014* outlines the reasonable steps to be taken by an approved provider to ensure none of its key personnel is a disqualified individual. Approved providers are required to obtain a signed statutory declaration from its key personnel stating whether he or she has been convicted of an indictable offence or is an insolvent under administration.

The approved provider must:

- seek (with the person's permission) a report from the Australian Federal Police about a person's criminal conviction record;
- conduct a search of bankruptcy records;
- conduct previous employment and referee checks;
- ensure the person understands the obligations of the Act in relation to disqualified individuals;
- be satisfied the person is mentally capable of performing the duties as key personnel; and
- ensure a disqualified individual ceases to be one of the approved provider's key personnel.

Part 6 of the *Accountability Principles 2014* and section 9 of the *Records Principles 2014* outline the responsibilities of approved providers in relation to police checks or police certificates (the names are used interchangeably) for staff members, contractors and volunteers.

4.5 Contractors

Where an approved provider has a contract with an agency that provides staff who work under the control of the approved provider, the contracted individuals may be considered staff members under the Act. Sub-contractors who work under the control of the approved provider may also be considered as staff members under the Act.

The contract between the agency and the approved provider should state that any staff provided that are considered staff members under the Act must have a current police certificate, which does not preclude them from working in aged care.

4.6 Independent contractors

Police check requirements are not intended to extend to people engaged on an ad hoc basis. For example, trades people engaged as independent contractors

generally do not require police checks. The policy intention is to allow for reasonable judgments to be made.

Regardless of how services are delivered and by whom, the home care provider remains responsible for service quality and meeting all regulatory responsibilities.

Services that are also provided to the public at large, such as a gym, would generally be regarded as services provided by independent contractors. If a home care consumer is attending a gym as part of his/her package, the approved provider is not required to ensure that staff or employees of the gym have undergone a police check (unless the person is also a staff member of the approved provider).

Visiting medical practitioners, pharmacists and other health professionals who have been requested by, or on behalf of, a consumer but are not under contract to the approved provider also do not require police checks.

Approved providers have an overarching responsibility to protect the health, safety and wellbeing of consumers, and independent contractors and health professionals should be subject to appropriate supervision.

Approved providers can use the following indicators as a guide to establish whether a person is an independent contractor:

- the contractor has an ABN;
- the contractor advertises his or her services;
- the contractor has clients other than the approved provider;
- the approved provider does not determine the working hours and wages of the contractor;
- the approved provider does not make superannuation payments on behalf of the contractor; and
- the approved provider does not pay the contractor holiday pay or sick leave.

The difference between a contractor and an independent contractor is generally decided on the basis of the degree of control that is exercised over the person's work. A precise determination of whether a contractor is under the control of an approved provider can be difficult, and whether someone is a staff member or an independent contractor is a matter that might ultimately be determined by the courts.

To assist employers to determine whether an individual is a staff member or an independent contractor, a Contractor Decision Tool is available at the business.gov.au website.

Further information about police checks is available:

- by phone: **1800 200 422**
- in writing to:
  - the Department's inbox agedcare.police.checks@dss.gov.au
  - Aged Care Police Checks
    Aged Care Quality and Compliance Group
    Department of Social Services
    PO Box 7576
    CANBERRA BUSINESS CENTRE ACT 2610
- online: at the Police Certificate Guidelines for Aged Care Providers webpage.

5. Quality Reporting Programme

The Home Care Standards apply to the delivery of Home Care Packages. The Standards are contained in Part 3, Division 2 of the *Quality of Care Principles 2014*.

The Home Care Standards set the standards for the quality of care and services for the provision of home care to older Australians. They serve to ensure that a service provider:

- demonstrates it has effective management processes based on a continuous improvement approach;
- ensures all consumers (current and prospective) have access to care and services that are appropriate to their assessed needs; and
- ensures all consumers (current and prospective) are provided with information that enable them to make choices about the care they receive, are consulted about the care to be provided and are given information about their rights and responsibilities.

A copy of the Home Care Standards will be available on the Department's website.

All approved providers are required to undertake a quality review once during each three-year cycle. These reviews encourage service providers to improve the quality of their service delivery within a continuous improvement model and show how they are addressing the Home Care Standards.

The quality review process has been managed by the Department of Social Services. From 1 July 2014, this became one of the responsibilities of the Australian Aged Care Quality Agency.

Further information about the Home Care Standards and Quality Reporting arrangements will be available on the Department's website.

6. Qualifications of staff and workers

The Department does not set specific levels of qualifications or training for case managers or workers involved in the delivery of Home Care Packages. However, it is expected that case managers, care co-ordinators and care workers will have the appropriate level of skills and training in order to provide quality care to consumers, and for the approved provider to meet its responsibilities.

The approved provider should regularly monitor roles and tasks of case managers, co-ordinators, staff and sub-contractors to ensure that all staff and workers are adequately trained, supported and supervised where required.

With the introduction of CDC in new Home Care Packages from August 2013, and in all packages from July 2015, it is important for all staff and workers to understand what CDC means, including how care and services should be delivered on a CDC basis. In many cases, this will require additional training and support for staff and workers.

Part G – Consumer care fees

Covered in this part

- Overview
  - Arrangements from 1 August 2013
  - Arrangements from 1 July 2014
- Determining care fees
- Payment of care fees in advance

1. Overview

1.1 Arrangements from 1 August 2013

Under the former CACP, EACH and EACHD packages, an approved provider could charge a care recipient contribution (also known as a care recipient fee, care fee or consumer fee) in certain circumstances.

These arrangements will continue to apply from 1 August 2013 under the Home Care Packages Programme – as set out in this Part, Sections 2 and 3 below.

1.2 Arrangements from 1 July 2014

As part of the aged care reforms, from 1 July 2014, new arrangements will apply to the way that the home care subsidy is calculated.

The Department of Human Services advises the home care provider and the consumer on the maximum fees payable. However, the home care provider and the consumer are able to negotiate lower fees should they choose. It is important to note that the government subsidy cannot be used to meet the consumer's income tested care fee. That is, the provider and consumer cannot select a lower level of care and services to match the value of the government subsidy paid.

Consumers entering home care on or after 1 July 2014 may be asked to make a contribution towards their care, based on their income, with additional safeguards of annual and lifetime caps and financial hardship provisions. Under the new arrangements, the subsidy payable by the Government will be reduced according to the income tested care fee payable. The income testing arrangements and the care subsidy reduction will be administered by the Department of Human Services.

Further information about these changes is available from the My Aged Care website at www.myagedcare.gov.au or the national contact centre on **1800 200 422**.

2. Determining care fees

2.1 Existing Home Care Package consumers at 30 June 2014

Where consumers are already receiving a Home Care Package before 1 July 2014, the changes to the income tested care fee that start on 1 July 2014 will not apply to them. These consumers may continue to be asked to pay a basic daily care fee and any fees calculated on income they receive above the basic pension. They will continue to receive the same package of care after 1 July 2014 and will not be affected by the new fee arrangements if they move between package levels.

If the consumer terminates their Home Care Agreement for more than 28 days, the new fee arrangements commencing on 1 July 2014 will apply if the consumer commences a new package.

The maximum fee that a consumer can be asked to pay in a care recipient contribution (referred to in these Guidelines as a basic daily care fee) is determined by the legislation.[30] For an existing Home Care Package consumer before 1 July 2014, their care fee will be calculated as follows:

If the consumer's income is …	**Then …**
the basic rate of the single pension	the maximum fee is 17.5 per cent of the basic rate of the single pension; this applies to both single and married consumers
more than the basic rate of the single pension	the maximum fee is 17.5 per cent of the person's income to the level of the basic pension plus up to 50 per cent of income above the basic pension

Example: Where a consumer receives the single pension, for example $766.00 per fortnight, the maximum fee they would pay is $133.98 per fortnight. This example is based on the pension rates as at 20 March 2014. Pension rates are updated twice a year in March and September.

If a consumer is a member of a couple, the calculation is made based on the basic rate of the single pension.

The maximum amount that a service provider can charge depends on the consumer's income but the provider must also consider other expenses such as high pharmaceutical bills, rent, utilities and other living expenses.

Where two consumers live together and both are receiving packages, they may elect to pool their resources by sharing costs of the services across their individualised budgets.

[30] Division 60 of the *Aged Care (Transitional Provisions) Act 1997* and Part 4, section 130 of the *Aged Care (Transitional Provisions) Principles 2014.*

A consumer's access to a Home Care Package must not be affected by their ability to pay fees, but should be based on the need for care, and the capacity of the home care provider to meet that need.

However, a home care provider can ultimately withdraw the service for non-payment of fees, as detailed in the *User Rights Principles 2014*.[31] A consumer's responsibilities include paying the fees specified in the agreement. If a consumer does not pay the fees or negotiate an alternative with their provider, the provider may re-allocate the consumer's package to another person.

The legislation also requires that information about fees, including how fees are calculated and the fees payable, is included in the Home Care Agreement between the consumer and the home care provider.[32]

2.1.1 What constitutes income?

Income is defined as income after income tax and the Medicare levy. When home care providers are calculating income for the purpose of determining ongoing fees, they will exclude:

- any pharmaceutical allowance, rent assistance or telephone allowance received by the consumer;
- the pension supplement;
- the Clean Energy Supplement; and
- in the case of a pension payable under the Veterans' Entitlements Act 1986 (except a service pension), an amount equal to four per cent of the amount of the pension.

2.1.2 Review of care fees

A review of fees must be conducted at least annually, or more often if requested by the consumer. The consumer should be encouraged to seek such a review if their financial circumstances change.

The maximum fee may need to be varied when new rates for the aged pension are announced each March and September. Home care providers may need to discuss the impact of these changes on fees with the consumer.

[31] Paragraph 17(2)(e) of the *User Rights Principles 2014* and clause 2(5) of the *Charter of Care Recipient's Rights and Responsibilities – Home Care*
[32] Section 23 of the *User Rights Principles 2014.*

2.2 New income testing arrangements from 1 July 2014

New consumers of home care services from 1 July 2014 can be asked to pay one or both of the following:

- a basic daily care fee, equivalent to 17.5 per cent of the single basic age pension; and
- an income tested care fee if their income is over a certain amount.

The Australian Government will reduce the amount of subsidy it pays a service provider, based on the amount the consumer can be asked to pay as an income tested care fee.

The basic daily care fee does not impact the amount of government subsidy payable.

2.2.1 Basic daily care fee

Every consumer taking up a Home Care Package can be asked by their service provider to pay the basic daily care fee.

The maximum basic daily care fee is 17.5 per cent of the single person rate of the basic age pension. This is $133.98 per person, per fortnight (from 20 March 2014 to 19 September 2014).

This rate increases on 20 March and 20 September each year in line with changes to the age pension. This applies to each person receiving a Home Care package, even if they are a member of a couple.

2.2.2 Income tested care fee

Depending on a consumer's income, they may be asked by their service provider to contribute more to the cost of their care. This extra amount is known as an 'income tested care fee'.

A consumer **cannot** be asked to pay an income tested care fee if they have a yearly income below the maximum income for a full age pensioner. The maximum income amount for a full age pensioner at July 2014 rates is:

- individual person – $24,835.20;
- member of a couple but now separated due to illness (individual income) – $24,367.20; or
- member of a couple living together (combined income) – $38,552.80.

Consumers who are not currently in receipt of a means tested income support payment will need to complete and lodge an income assessment form. If the consumer is asked to complete and lodge this form but fails to do so, they can be asked to pay the maximum income tested care fee.

The Department of Human Services or the Department of Veterans' Affairs will work out the maximum income tested care fee payable based on an assessment of the consumer's income information, including the income deemed from their financial assets. The assessment does not include the value of the family home or any other assets.

More information on the income tested care fee is available on the My Aged Care website.

2.2.3 Caps on care fees

There is a limit to how much a consumer has to pay in income tested care fees. For part pensioners, this is **$5,000** per year. For self-funded retirees, this is **$10,000** per year. Once a consumer has reached this cap, the Australian Government will pay the consumer's share of the income tested care fee to the provider until the next anniversary of their start date into aged care.

There is a lifetime limit on income tested care fees (in home care) and means-tested care fees (in residential care) of **$60,000**. Once a consumer has reached this cap, they will not have to pay any further income or means tested care fees during their lifetime.

The annual and lifetime caps are indexed biannually. The current value of the caps is included in the 'Schedule of Fees and Charges for Residential and Home Care: From 1 July 2014', which is available on the Department of Social Services website.

2.2.4 How does a consumer work out what costs they may be asked to pay?

A consumer who is in receipt of a means tested income support payment does not need to complete the income assessment form. The Department of Human Services or Department of Veterans' Affairs will have the information needed to calculate the income tested care fee payable, if any. Once the Department of Human Services is notified that a consumer has commenced a package, the consumer and provider will be sent a letter from the Department of Human Services advising of the maximum fees payable.

However, a consumer in receipt of a means tested income support payment can seek fee advice from the Department of Human Services before commencing care. To do this the consumer can either call the Department of Human Services on **1800 227 475** or complete their contact details and sign the income assessment form.

In all cases a self-funded retiree will need to complete the income assessment form. This can be done either before or shortly after commencing a package. The Department of Human Services will send the consumer and provider a letter advising of the maximum fees payable.

Where an assessment is done prior to the consumer commencing care, the fee advice will be valid for 120 days unless there is a significant change in the consumer's circumstances.

If a consumer is simply seeking an indication of the fees that may be payable they can use the Fee Estimator available on the My Aged Care website. If the consumer does not have access to a computer they can call the national contact centre on **1800 200 422**. The contact centre will use the same fee estimator that is available on line to estimate the consumer's fees and charges.

The actual fees the consumer will pay will depend on the assessment undertaken by the Department of Human Services or the Department of Veterans' Affairs.

2.2.5 What constitutes income?

Income for aged care purposes is assessed in the same way as it is for the age pension. Unlike taxable income, income from superannuation and government income support payments is included in determining overall income.

For a member of a couple, it is half of the couple's combined income which is attributed to each member of the couple and considered against the applicable income threshold. This applies no matter who earned the income.

2.2.6 Review of fees

Once a consumer has commenced a Home Care Package the basic daily care fee and income tested care fee may change as a result of changes to the age pension, and in the case of the income tested care fee, the consumer's income.

Changes to the age pension will affect the basic daily care fee and the income free area and income thresholds which are used to determine the income tested fee.

The income tested care fee may also change if the care recipient's financial circumstances, marital status or home ownership change.

The basic daily care fee increases in March and September each year in line with age pension increases.

Income tested fees are generally set for four periods per year and reviewed in March, July, September and November/December each year. However, fees can also be reviewed and adjusted at other times including upon the request of a consumer or by the Department of Human Services where there has been a significant change to a consumer's circumstances.

The consumer and provider will be notified by letter if there is a change in the income tested care fee. Providers should refer to the 'Schedule of Fees and Charges

for Residential and Home Care: From 1 July 2014' for changes in the rate of the basic daily care fee, available on the Department of Social Service's website.

2.3 Financial advice

Consumers may want to consult with a financial adviser about their finances. There are various government services and resources that can help consumers obtain appropriate financial advice. It is suggested consumers do some research to see what options work best for them.

2.4 Provisions for financial hardship

A consumer commencing a Home Care Package under the new fee arrangements, after 1 July 2014, is eligible to seek financial hardship assistance with their home care fees.

Financial hardship assistance is available for the basic daily care fee and/or income tested care fee.

For Home Care Packages, the value of the consumer's assets will be taken into account as part of the assessment process for financial hardship assistance.

During periods of residential respite or transition care, consumers who pay an income tested care fee can also apply for the Hardship Supplement if payment of the income tested care fee will put them into financial hardship.

The basic daily care fee cannot be charged when a consumer takes leave for transition care or residential respite care.

The consumer, their representative or the provider may apply for financial hardship assistance in respect of the fees payable by the consumer. To apply for financial hardship assistance, the consumer or their representative will need to complete an application for financial hardship assistance and submit the form to the Department of Human Services. To obtain a copy of the application form a consumer should call the Department of Human Services on **1800 227 475** or the provider can call the Department of Human Services on **1800 195 206**.

If financial hardship is granted, the Government will pay a hardship supplement of an amount determined in each individual case. The home care fees payable will be reduced by the amount of hardship supplement.

3. Payment of care fees in advance

Home care providers may ask for fees to be paid up to one month in advance. If a consumer leaves the programme, any payment in advance beyond the date of leaving must be refunded to the consumer or their representative within 30 days of ceasing the package.

Part H – Supplements

Covered in this part

- Eligibility for supplements
  - Dementia and Cognition Supplement and Veterans' Supplement
  - Oxygen Supplement
  - Enteral Feeding Supplement
  - Viability Supplement
  - Top-up Supplement
  - Hardship Supplement

1. Eligibility for Supplements

In addition to the base level of subsidy for a Home Care Package, consumers may be eligible for one or more supplements.

Supplements are paid to a home care provider in recognition of the additional costs associated with certain care and service requirements for the consumer. The range of supplements is described below along with the eligibility criteria for each.

1.1 Dementia and Cognition Supplement and Veterans' Supplement

From 1 August 2013, a new Dementia and Cognition Supplement is available to all home care consumers who meet the eligibility criteria for the supplement (across any of the four levels of Home Care Packages). The Dementia and Cognition Supplement will provide an extra 10 per cent funding on top of the basic subsidy amount for the relevant Home Care Package.

There will also be a new funding supplement for veterans with an accepted mental health condition. Like the Dementia and Cognition Supplement, the Veterans' Supplement will provide an extra 10 per cent funding on top of the basic subsidy amount for the relevant Home Care Package level for eligible consumers. A home care provider can receive either the Dementia and Cognition Supplement *or* the Veterans' Supplement in respect of an eligible consumer, but not both supplements.

The purpose of these supplements is to provide additional financial assistance to home care providers in recognition of the additional costs associated with dementia and mental health care.

Guidelines for these supplements are available on the Department of Social Services webpage.

Supplements amounts for 2014-15 are outlined in the following table.

Home Care Package	Level 1	Level 2	Level 3	Level 4
Home Care Package basic subsidy	$21.43	$38.99	$85.73	$130.32
Dementia and Cognition Supplement (10 per cent)	$2.14	$3.90	$8.57	$13.03
Veterans' Supplement (10 per cent)	$2.14	$3.90	$8.57	$13.03

1.2 Oxygen Supplement

The Oxygen Supplement is available to consumers at any Home Care Package level, who have a clinical need (i.e. meet the eligibility criteria). Previously, it was only available to consumers receiving an EACH or EACHD package.

The Oxygen Supplement is paid to the home care provider for a consumer who has an ongoing medical need. The oxygen supplement covers the cost of oxygen, oxygen equipment and other costs associated with the administration of continual oxygen therapy. There is no supplement available for episodic or short-term illnesses such as bronchitis.

The need for consumers will normally be met by an oxygen concentrator. The standard supplement allows for some cylinder oxygen for the consumer's outings. A higher supplement may be approved if an oxygen concentrator does not meet the medical requirements.

A higher supplement is not available unless the costs incurred are at least 25 per cent above the standard supplement. This higher supplement will not be approved where higher costs are due to a more expensive source of supply than is required, for instance, a higher level supplement cannot be approved where cylinder oxygen is used in circumstances where concentrator oxygen would meet the consumer's needs.

The general practice for oxygen usage is that, subject to the various conditions, the home care provider must manage the package (and the supplement) to provide the best result for the consumer. If the consumer chooses to use more expensive options, then the provider would have to negotiate on the services or the consumer could pay the extra cost themselves.

An application form seeking the supplement for consumers receiving eligible oxygen treatment, titled, 'Application for Eligible Oxygen Treatment and/or Enteral Feeding Supplement' must be submitted (with a medical certificate by a doctor stating the particular requirements) to the relevant state or territory Department of Human Services office in which the service is located. This form can be downloaded from the Department of Human Services Aged Care Forms webpage.

Once approved, any change in circumstances relating to the eligibility for the supplement must be notified to the relevant Department of Human Services state office with the monthly subsidy claim.

The rates for the Oxygen Supplement are the same as the Residential Aged Care Supplements (Care Related) rates. The rates are available on the Department of Social Services aged care funding webpage.

1.3 Enteral Feeding Supplement

The Enteral Feeding Supplement is available to consumers at any Home Care Package level, who have a clinical need (i.e. meet the eligibility criteria). Previously, it was only available to consumers receiving an EACH or EACHD package.

The Enteral Feeding Supplement is paid to the home care provider for a consumer who requires enteral feeding on an ongoing basis. To be eligible for an enteral feeding supplement, the consumer must be receiving a complete food formula by means of a nasogastric, gastrostomy or jejunostomy tube. Enteral Feeding Supplements are not provided if formula is taken orally.

A higher supplement may be approved when, for example:

- a consumer requires greater than the standard volume of 1892 mls per day;
- a more expensive formula is required to meet special medical needs (for example diabetes or rehabilitation/weight gain required); and/or
- a mechanical pump may be required for the formula to be delivered over time or if a thicker formula is required. (An additional flexitainer is also usually required in these circumstances.)

There are two levels of the supplement, one for bolus and another for non-bolus feeding. A higher supplement may only be approved where a medical certificate is provided and the costs incurred are at least 25 per cent above the standard supplement. A higher-level supplement cannot be approved if the higher costs are due to a more expensive source of supply for the formula or equipment.

An application form seeking the supplement for consumers receiving eligible enteral feeding titled, 'Application for Eligible Oxygen Treatment and/or Enteral Feeding Supplement' must be submitted (with a medical certificate by a doctor or dietician stating the particular requirements) to the relevant state or territory Department of Human Services office in which the service is located. This form can be downloaded from the Department of Human Services aged care forms webpage.

Once approved, any change in circumstances relating to the eligibility for the supplement must be notified to the relevant Department of Human Services state office with the monthly subsidy claim.

The rates for the Enteral Feeding Supplements are the same as the Residential Aged Care Supplements (Care Related) rates. The rates are available on the Department of Social Services aged care funding webpage.

1.4 Viability Supplement

The Viability Supplement is available across all Home Care Package levels and recognises the higher costs associated with attracting and retaining staff as well as other resource implications faced in providing home care services in rural and remote areas.

The Viability Supplement is dependent on the consumer's location according to their Accessibility Remoteness Index of Australia (ARIA) value. The amount of the supplement varies depending on the remoteness of the consumer's location. ARIA values for geographical locations in Australia can be found on the Department of Human Services useful links and information webpage.

The home care provider is automatically paid the supplement through the Department of Human Services payment system, when the Home Care Package subsidy claim form is submitted, and where the location of the consumer receiving the Home Care Package has been provided.

Information about the Viability Supplement including the subsidy rates is available on the Department of Social Services Aged Care Funding webpage.

1.5 Top-up Supplement (for continuing EACHD consumers)

The Top-up Supplement provides an additional payment to the home care provider, on top of the basic subsidy amount, in respect of a consumer receiving care under an EACHD package on 31 July 2013. The Top-up Supplement is explained in Part E, Section 2.

1.6 Hardship Supplement

A consumer commencing a Home Care Package under the new fee arrangements on or after 1 July 2014, is eligible to seek financial hardship assistance with their home care fees. The Hardship Supplement is paid to the home care provider for consumers who have been granted financial hardship assistance as a result of experiencing difficulty in paying fees and charges for Home Care Packages. Provisions for financial hardship assistance are outlined in Part G, Section 2.4.

Further information on financial hardship assistance is also available on the My Aged Care website.

Part I – Administrative arrangements for approved providers

Covered in this part

- Conditions of allocations to replace agreements
  - Conditions of allocation
  - Commencement of places
- Variations, transfer and surrender or relinquishment of places (packages)
  - Variations of places
  - Transfer of places
  - Surrender or relinquishment of places
- Financial reporting to the Department
- Reporting of new consumers
- Claims process
  - Home care subsidy payments
  - Home care subsidy is GST free
  - Other taxation requirements

Note – In this Part, the term "approved provider" is used rather than "home care provider". This is because there are a number of legislative references to matters affecting approved providers in this Part.

1. Conditions of allocation to replace agreements

From 1 August 2013, there is no requirement for approved providers to enter into an agreement with the Commonwealth in respect of allocations of new home care places. This came into effect when Schedule 1 to the *Aged Care (Living Longer Living Better) Act 2013* and the transitional provisions in the *Allocation Principles 1997* commenced.

For all places, including those allocated to providers in the 2012-13 ACAR, the conditions of allocation will include a requirement that the places must be delivered on a CDC basis.

For those existing home care packages delivering on a non CDC basis, the transition to CDC will not come into effect until 1 July 2015.

1.1 Conditions of allocation

The conditions of allocation for home care places form part of the Notice of Allocation issued to the approved provider under section 14-8 of the *Aged Care Act 1997*.

Approved providers are required to comply with all conditions of allocation. The conditions may cover matters such as:

- the number of home care places (packages) for which the home care subsidy is payable;
- the aged care planning region, including, as necessary, specific locations in a planning region, in which the places must be provided;
- the minimum number or proportion of places to be provided to people from special needs groups;
- specific undertakings made by the approved providers in any application for new or in respect of existing places, and approved by the Secretary of the Department as a condition of allocation;
- delivering the place on a CDC basis;
- participating in an evaluation of the Home Care Packages Programme, including the CDC arrangements;
- financial reporting obligations;
- other conditions as appropriate.

Additional conditions of allocation may be issued from time to time under section 14-6 of the *Aged Care Act 1997*.

1.2 Commencement of places

An allocation of places to an approved provider takes effect when the Secretary of the Department (or delegate) determines that the approved provider is in a position to provide care in respect of those places. The approved provider will be advised of this through a Notice of Allocation from the Department issued under section 14-8 of the *Aged Care Act 1997*.

Places may be allocated with immediate effect (from a specified date), or on a provisional basis (if the approved provider is not ready to commence the place immediately).

If the place has been allocated on a provisional basis, the approved provider must advise the Department in writing when they are able to commence providing services. An approved provider must apply in writing to the Secretary using the form titled 'Application for a Determination that an Approved Provider is in a Position to Provide Care – Home Care'. This application form will be available on the Department's website.

Once this information has been considered by the Department, the delegate will make a determination under section 15-1 of the *Aged Care Act 1997*, and once approved, this will enable the approved provider to commence claiming a subsidy for the place. Such determinations cannot be backdated.

2. Variations, transfers and surrender or relinquishment of places

2.1 Variations of places

An approved provider can apply to the Secretary of the Department to vary an allocation of places (Home Care Packages) in certain circumstances, for example, to change conditions of allocation relating to geographic locations or special needs groups. This process can also be used to add a condition of allocation to deliver packages on a CDC basis. See Part D Section 6.

There are separate application forms for the variation of places that have taken effect (operational places) and places that are yet to take effect (provisionally allocated places). These forms will be available on the Department's website from mid 2014.

A variation cannot take effect unless it has been approved by the Secretary.

An application for a variation of places should not be made in the following circumstances:

- Where an approved provider is seeking to change the name of a service, the approved provider should advise the Department in writing. However, this does not have to be done via an application form.
- There is no capacity under the legislation to approve a variation in the level of the home care place that has been allocated to an approved provider, for example, from a Level 1 or 2 place to a Level 3 or 4 place. Providers seeking to obtain places at a different level should apply through the Aged Care Approvals Round.

2.2 Transfer of places

An approved provider may apply in writing to the Secretary of the Department to transfer operational places under sections 16-1 and 16-2 of the *Aged Care Act 1997*.

Further information, including an application form, will be available on the Department's website.

The application form must be completed by both the approved provider holding the allocation of places (the transferor) and the party seeking the places (the transferee). If the places proposed to be transferred are to be allocated to more than one service, a separate application form must be submitted in respect of each service.

A transfer of a place cannot take effect unless it has been approved by the Secretary. An application to transfer places can only be considered in respect of operational places, not provisionally allocated places.

2.3 Surrender or relinquishment of places

While an approved provider would not normally surrender or relinquish an allocation of places, there is capacity to do this under the Act.

In these circumstances, the approved provider should contact the relevant state or territory office of the Department.

3. Financial reporting to the Department

The *Accountability Principles 2014*[33] outline the financial reporting responsibilities of home care providers.

For the 2013-14 financial year, the Financial Accountability Report process will continue to apply. There will be a requirement for a non-audited statement stating the information given is a true account. This will need to be signed by the CFO or CEO of the home care provider.

The Financial Accountability Report for the reporting period 1 July 2013 to 30 June 2014, must be provided to the Department no later than **31 October 2014**.

The Aged Care Financing Authority (ACFA) has been asked to provide advice to the Assistant Minister for Social Services by 30 September 2014 on cost effective options for improving the collection of appropriate financial data from aged care providers.

Any new requirements are likely to apply from July 2015 for the 2015-16 financial year.

4. Reporting of new consumers

Providers need to lodge an Aged Care Entry Record (ACER) with the Department of Human Services for every client who commences a new Home Care Package from 1 July 2014.

The ACER is required to be completed within 28 days of home care commencing.

The ACER form can be downloaded from the Department of Human Services website, or accessed at the Medicare forms webpage.

[33] Part 4, Division 4 of the *Accountability Principles 2014*.

The completed ACER can be submitted to the Department of Human Services via the Aged Care Online Claiming webpage. Alternatively a paper form can be scanned and either:

- emailed to: aged.care.liaison@humanservices.gov.au; or
- mailed to:
  - Department of Human Services
    Aged Care Payments
    GPO Box 9923
    SYDNEY NSW 2001

5. Claims process

5.1 Home care subsidy payments

Subsidy payments for Home Care Packages are paid to an approved provider based on the number of consumers for whom a claim is made, up to the maximum number of places allocated to that approved provider.

There is information on the subsidy amounts for the Home Care Packages at Part E, Section 1 and on the Department of Social Services aged care funding webpage.

Subsidy payments are made by the Department of Human Services on behalf of the Department of Social Services. An approved provider's initial payment claim form covers the payment period from the date when the home care places become operational.

The initial payment of the subsidy to a new provider is usually based on the provider's estimated number of consumers in the first month of operation. This is up to the maximum number of home care places allocated to the provider.

To enable initial payments, or to change bank details to enable ongoing payments, approved providers must supply their aged care service's bank details to the Department of Human Services via a form. The form is available on the Department of Human Services aged care forms webpage. The form is titled 'Add or Change Approved Aged Care Service's Bank Details'.

An 'Aged Care Approved Provider Statement', signed by key personnel of an approved provider to advise that appropriate business and security controls are in place, is also required every three years. It ensures all aged care forms, claims and other relevant documentation to claim payments of subsidy under the Act are appropriately authorised. The provider statement only needs to be completed if the approved provider with services is not registered for Aged Care Online Claiming.

The current provider statement is valid for the period 1 July 2014 to 30 June 2017. The next statement is due 30 June 2017 and will be sent to providers with services

not registered for Aged Care Online Claiming from the Department of Human Services in April 2017.

After the initial payment period, future monthly payments are adjusted according to the actual number of consumers in the preceding payment periods.

Home care subsidies are paid monthly in advance, based on the number of home care places occupied in the second last preceding payment period. For example, a payment to an approved provider for March is based on occupied places claimed for in January. Monthly payments may include an adjustment to account for any over or under-payment in the previous month.

Approved providers are also able to access the Aged Care Online Claiming (ACOC) website, to view a consumers electronic Aged Care Client Record (eACCR) online.

To register to use the ACOC website to view eACCRs, approved providers need to complete a registration form. The registration form is available on the Department of Human Services aged care forms webpage.

The form is titled 'Register or Amend Access for Aged Care Online Claiming Viewing electronic Aged Care Client Records'. Further information about claiming for Home Care Packages is available at the Department of Human Services aged care webpage.

Additionally, information about online claiming is available at the Department of Human Services online claiming webpage.

All aged care services (regardless of their location) can contact the Department of Human Services at the Aged Care enquiries line on **1800 195 206** (charges apply from mobile and pay phones).

5.2 Home care subsidy is GST free

Home care subsidies are considered to be "GST free" under section 38-30 of the *A New Tax System (Goods and Services Tax) Act 1999*.

5.3 Other taxation matters

An approved provider must be able to quote its ABN in any Goods and Services Tax (GST) dealings with the ATO or other government departments and agencies, including the Department of Social Services and Department of Human Services. If an approved provider does not have an ABN, the provider cannot be registered for GST, cannot charge GST and does not have any entitlement to input tax credits.

Approved providers should give their ABN to the Department of Social Services and Department of Human Services so they can process and report payments correctly. Approved providers who do not supply their ABN may be subject to withholding tax.

Part J – Interface with other programmes

Covered in this part

- Interface with other programmes
- Commonwealth Home Support Programme (from July 2015)
- Home and Community Care
- National Respite for Carers Programme
- Residential respite
- Day Therapy Centres Programme
- Transition Care Programme
- Community Visitors Scheme
- Disability programmes
- Continence Aids Payment Scheme
- Palliative care
- Hospital in the Home
- Department of Veterans' Affairs Programmes
  - Veterans' Home Care
  - Coordinated Veterans' Care
  - Community Nursing
  - Repatriation Appliance Programme
  - Veterans' transport for Treatment
  - Consumer Fees – former Prisoners of War and Victoria Cross recipients

1. Interface with other programmes

It may be possible for a consumer to access care and services through a range of other programmes, where these are not provided as part of the consumer's Home Care Package.

This Part provides a short overview of these programmes, including the nature of the interface between each programme and the Home Care Packages Programme.

More detailed information about the individual programmes is available on the My Aged Care website at www.myagedcare.gov.au or the national contact centre on **1800 200 422**.

2. Commonwealth Home Support Programme

2.1 Overview of programme

As part of the aged care reforms, the Australian Government has announced that a new Commonwealth Home Support Programme will commence from 1 July 2015.

The Home Support Programme will incorporate the existing Commonwealth HACC Programme, the National Respite for Carers Programme (NRCP) and the Day Therapy Centres (DTC) Programme. The Assistance with Care and Housing for the Aged

(ACHA) Programme is being considered for inclusion in the Home Support Programme.

2.2 Interface with the Home Care Packages Programme

The future interface between the Home Care Packages Programme and the Commonwealth Home Support Programme will be developed in consultation with stakeholders. Further information will be available prior to the commencement of the Commonwealth Home Support Programme.

3. Home and Community Care (HACC)

3.1 Overview of programme

The Commonwealth HACC Programme provides funding for basic maintenance, care and support services for older people and their carers, who live in the community and whose capacity for independent living is at risk, or who are at risk of premature or inappropriate admission to long term residential care. Older people are people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.

The Commonwealth HACC Programme currently does not apply in Western Australia and Victoria. In these states, HACC services for consumers of all ages continue to be delivered via a jointly funded Commonwealth/State programme which is administered by state governments. Providers in these states should refer to the relevant HACC programme guidelines, which should be broadly consistent with guidance in the Commonwealth HACC Programme Manual. The transition of responsibility for delivering HACC to older people in Victoria will occur from 1 July 2015.

Note – The information below relates to both the Commonwealth HACC Programme and the HACC Programme in Victoria and Western Australia.

The HACC Programme provides services such as domestic assistance, personal care as well as goods and equipment, transport, meals, home modifications and maintenance, and counselling, information and advocacy.

3.2 Interface with the Home Care Packages Programme

Generally, if a person is receiving a Home Care Package, the package will be the primary source of government funding for care and services to the home care consumer. A home care provider can sub-contract to a HACC service provider to provide services as part of a Home Care Package (see Section 3.2.1 below). Additional HACC services can also be provided to a home care consumer, as part of the HACC Programme, in limited circumstances (see Section 3.2.2 below).

3.2.1 Sub-contracting services from HACC service providers as part of a Home Care Package

Can a home care provider sub-contract services to a HACC service provider?

- Yes, a home care provider can sub-contract to a HACC service provider to provide services to a home care consumer, for example, personal care, meals, community transport, nursing or allied health services, social activities, or respite care. In these cases, the full cost for providing the service will be paid out of the budget for the Home Care Package.

3.2.2 Accessing HACC services in addition to a Home Care Package

Can a home care consumer access HACC services in addition to their Home Care Package?

- As much as possible, a home care consumer's care needs should be addressed through their Home Care Package. A consumer may, however, access additional HACC services (funded by the HACC Programme rather than out of the budget for the Home Care Package) in an emergency, or when a carer is not able to maintain their caring role. These instances should be time limited, monitored and reviewed.

- A home care consumer receiving a Level 1 or 2 package may also access additional nursing or allied health services funded through the HACC Programme, where the budget for the Home Care Package has been fully allocated for care needs identified in the consumer's care plan and additional nursing or allied health services are required to support the consumer to remain living at home.

- When a HACC service provider is assessing a home care consumer's eligibility for services under the HACC Programme, the service provider must consider any other services that the consumer is already receiving. Priority for HACC services may be given to people who are not receiving any other services.

Can a home care consumer be asked to pay a consumer fee for a HACC service?

- Yes, where a home care consumer is accessing additional services through the HACC Programme, the consumer would be expected to pay any consumer fees charged for the HACC service (as applicable).

- The home care subsidy cannot be used to pay consumer fees charged for the HACC service.

4. National Respite for Carers Programme (NRCP)

4.1 Overview of programme

The Australian Government funds a range of home support services and programmes for carers of frail older people. The National Respite for Carers Programme (NRCP) is designed to contribute to the support and maintenance of caring relationships between carers and their dependent family members. The NRCP respite services provide community based respite care in a variety of settings, including in carers' homes, day centres, host families and overnight cottages.

4.2 Interface with the Home Care Packages Programme

When assessing a carer's eligibility for NRCP services, service providers must consider any other carer support services the carer is receiving. Priority for NRCP services should be given to carers who are not receiving any carer support services.

The home care subsidy cannot to be used to pay for consumer fees/contributions for NRCP services.

5. Residential respite

5.1 Overview of programme

Residential respite care provides short-term care in a residential aged care facility for people who are in temporary need of residential care but who intend to return home.

Residential respite care may be used on a planned or emergency basis to provide a break from normal care arrangements, for example, to help with carer stress, illness, holidays, or when the carer is unavailable for any reason.

5.2 Interface with the Home Care Packages Programme

A home care consumer can access residential respite care if they have been assessed as eligible for residential respite care by an ACAT, and a respite place is available. A residential respite subsidy will be paid to the respite facility to support this care and the consumer may be asked to pay a contribution to the cost of the respite care.

The home care subsidy cannot be used to pay the consumer contribution for residential respite care. If the consumer is unable to afford the respite care contribution, this should be negotiated with the respite facility. Hardship assistance is available for those who cannot afford to contribute to the cost of their care. There are criteria which need to be met in order to receive financial hardship assistance and these are assessed on an individual basis.

Under the legislation, a basic daily care fee must not be charged by the home care provider where the consumer takes leave for residential respite care.[34]

6. Day Therapy Centres programme

6.1 Overview of programme

The aim of the Day Therapy Centre (DTC) Programme is to provide a wide range of therapy and services to frail aged people living in the community and to low-care residents of Commonwealth funded residential aged care facilities. It assists them to regain or maintain physical and cognitive abilities which support them to either maintain or recover a level of independence, allowing them to remain either in the community or in low-care* residential aged care.

* From 1 July 2014, the distinction between "low care" and "high care" in permanent residential aged care has been removed. The DTC Programme has replaced "low care" with equivalent Aged Care Funding Instrument (ACFI) classification ranges in the programme's eligibility criteria.

6.1.1 Therapy and services

The main types of therapy and services provided by DTCs are:

- physiotherapy;
- podiatry;
- occupational therapy;
- diversional therapy;
- nursing services;
- speech therapy;
- social work;
- preventative therapies;
- personal services;
- transport to and from the DTC; and
- food services provided in conjunction with therapies.

Other therapy and services may be provided with the prior written agreement of the Commonwealth, through the Department. The therapy and services listed are not exclusive and not all DTCs are expected to cater for all types. There is no single model of service provision for DTCs and they may operate across a range of therapy types, intensity and services.

[34] Section 130 of the *Aged Care (Transitional Provisions) Principles 2014* and section 108 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014.*

6.2 Interface with the Home Care Packages Programme

As much as possible, it is expected that consumers' care needs will be addressed through their Home Care Package. Where day therapy services have been identified in the home care consumer's care plan, the funding or budget for the Home Care Package may be used to access these services. However, the home care subsidy cannot be used to pay consumer fees/contributions charged by DTCs.

7. Transition Care Programme

7.1 Overview of programme

The Transition Care Programme is a jointly funded initiative between the Australian Government and all states and territories.

Transition care provides short-term care that seeks to optimise the functioning and independence of older people after a hospital stay. Transition care is goal-oriented, time-limited and therapy-focussed. It provides older people with a package of services that includes low intensity therapy such as physiotherapy and occupational therapy, as well as social work, nursing support or personal care. It seeks to enable older people to return home after a hospital stay rather than enter residential care prematurely.

To access the Transition Care Programme, a person must be assessed as eligible for transition care by an ACAT **and** the person can only enter transition care directly following a hospital stay.

7.2 Interface with the Home Care Packages Programme

A home care consumer can receive transition care if they meet the eligibility criteria for the Transition Care Programme. The consumer is able to take leave from their Home Care Package while receiving transition care.

Under the legislation, a home care fee must not be charged by the home care provider where the consumer takes leave for transition care.[35]

8. Community Visitors Scheme

8.1 Overview of programme

The Community Visitors Scheme (CVS) is a national programme that provides companionship to socially or culturally isolated people living in Australian Government-subsidised aged care homes or receiving home care.

[35] Section 130 of the *Aged Care (Transitional Provisions) Principles 2014* and section 108 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014.*

The CVS funds community-based organisations (known as CVS auspices) to work with aged care providers in matching suitable volunteers with aged care recipients who have been identified by their aged care providers as being socially isolated, or at risk of becoming socially isolated due to lack of family contact, cultural reasons or disability. The CVS has a specific focus on targeting individuals who identify as being from one of the special needs groups under the *Aged Care Act 1997*.

The relationship between the CVS auspice and aged care providers is critical in ensuring those that would benefit from social contact are identified and matched appropriately.

The CVS auspices carry out the tasks of:

- recruiting, training and supporting volunteer community visitors;
- matching volunteers to aged care recipients; and
- supporting visitor-care recipient relationships.

The CVS is funded by the Australian Government and operates in every state and territory. To locate a CVS auspice operating in your area, contact My Aged Care on **1800 200 422**.

8.2 Interface with the Home Care Packages Programme

From 1 August 2013, the CVS was expanded to home care. Consumers receiving a Home Care Package can access the CVS, but they must not be charged fees for visits provided through the CVS.

9. Disability programmes

9.1 Overview of programme

Under the National Health Reform Agreement, the provision of specialist disability services, including accommodation, respite, community support and community access services is the responsibility of state and territory governments.

The Australian Government provides funding for these services for people who are aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) to access specialist disability services provided by state and territory governments. This enables older people who have been receiving state and territory disability services to choose whether they wish to continue to access these disability services, or receive aged care services instead, in order to receive care most appropriate to their needs.

These arrangements came into place on 1 July 2012.

9.2 National Disability Insurance Scheme Australia

From 1 July 2013, the National Disability Insurance Scheme (NDIS) commenced in South Australia, Tasmania, the Hunter region in New South Wales, and the Barwon region in Victoria. The Australian Capital Territory, the Perth Hills region of Western Australia and the Barkly region of the Northern Territory joined the NDIS on 1 July 2014. Additionally, Queensland will begin to roll-out the scheme from July 2016.

The NDIS is expected to be fully rolled out nationally by 2019-20.

Further information about the NDIS is available at the National Disability Insurance Scheme website.

The NDIS will provide reasonable and necessary supports to participants as per section 34 of the *National Disability Insurance Scheme Act 2013*. To become a participant of the NDIS, a person must meet:

- age requirements;
- residence requirements; and
- disability or early intervention requirements.

Each of these requirements is specified in the *National Disability Insurance Scheme Act 2013* and the 'National Disability Insurance Scheme Rules'.

9.3 Interface with the Home Care Packages Programme

In general, a person will not be a participant of the NDIS or receive disability services at the same time as they receive Australian Government funded aged care services, including a Home Care Package.

A person accessing a Home Care Package would generally relinquish that package upon becoming a participant of the NDIS. However, they may continue to receive services outside of the Home Care Package Programme from the same service provider if that provider is also registered as a provider with the NDIS.

A participant of the NDIS who first receives services through the Home Care Packages Programme after the person turns 65 years of age ceases to be a participant of the NDIS.

Younger people with a disability (including those with younger onset dementia) can receive care and services under a Home Care Package, if they are assessed by the ACAT as eligible.

The final decision to offer a Home Care Package to a young person is made by the home care provider. The provider will need to consider the appropriateness of their

service, including what can be offered under a Home Care Package at the level available, to meet the care needs of the younger person.

10. Continence Aids Payment Scheme

10.1 Overview of programme

The Continence Aids Payment Scheme (CAPS) is an Australian Government Scheme that provides a payment to assist eligible people who have permanent and severe incontinence to meet some of the costs of their incontinence products.

Further information about the Scheme, including who is eligible to apply for a payment, is available on the Department of Social Service's bladderbowel website.

10.2 Interface with the Home Care Packages Programme

A person receiving a Home Care Package may be able to receive a payment under the Continence Aids Payment Scheme. However, if the provision of continence aids is identified in the home care consumer's care plan, they will not be eligible for the Scheme.

11. Palliative care

11.1 Overview of palliative care

The Australian Government provides:

- funding for national palliative care projects primarily focusing on education, training, quality improvement and advance care planning;
- financial support to state and territory governments to operate palliative care services, a form of subacute care, as part of their health and community service provision responsibilities. (State and territory governments are responsible for determining their palliative care funding priorities and required mix of services within their jurisdictions); and
- subsidies for palliative care medicines under the PBS and palliative care consultations under the MBS.

As part of the aged care reform package, the Government is also providing access to specialist palliative care and advance care planning expertise for aged care providers and GPs caring for recipients of aged care services, through innovative advisory services. The Government has also funded the development of an online education and training package to assist health workers, including general practitioners, nurses and care workers to implement the principles of the 'Guidelines for a Palliative Approach for Aged Care in the Community Setting'. The online training is available on the Palliative Care Online website.

These projects align with the 'National Palliative Care Strategy', which aims to raise awareness of and information about palliative care and its benefits, and help build a skilled workforce across the health system to deliver quality palliative care, and will help aged care recipients to remain in familiar surroundings as their care needs change.

11.2 Interface with the Home Care Packages Programme

The Home Care Packages Programme provides support for the ongoing symptoms of ageing and is not specifically designed to provide palliative care associated with medical conditions or diseases that cause a life limiting illness.

Home care consumers are able to receive palliative care services in addition to their package, but this needs to be arranged by the person's GP or treating hospital.

As with any palliative care arrangement, the palliative care team would coordinate the skills and disciplines of many service providers to ensure appropriate care services. This would include working with the consumer's home care provider.

12. Hospital in the Home

12.1 Overview of programme

States and Territories may choose to deliver Hospital in the Home (HITH) as an alternative delivery of acute and post-acute care in the patient's home. HITH care is provided by clinicians from many specialties, e.g. infectious diseases, gerontology, general practice, emergency medicine, orthopaedics, cardiology, paediatrics, rehabilitation, respiratory, surgery and haematology. Access to HITH varies in each state and territory. Further information can be obtained from the local hospital service.

12.2 Interface with the Home Care Packages Programme

A person can continue to access services under a Home Care Package while an inpatient on the HITH programme. Where particular clinical services such as nursing or allied health services are required by the person, these services can be provided either under the person's Home Care Package or through the HITH Programme.

To ensure services are not duplicated, people in receipt of a Home Care Package, who are also receiving treatment on, or being referred to, the HITH Programme, should have their care plan reviewed (preferably prior to commencement of HITH services). Where the care plan includes provision of clinical services and support, it may be necessary for the home care provider to amend the plan to ensure the plan does not include the same services.

13. Department of Veterans' Affairs Programmes

The Department of Veterans' Affairs (DVA) offers a range of programmes to assist veterans and war widows/widowers with their health and wellbeing and who wish to continue living independently in their own home, but who need some assistance to do so.

Through DVA, eligible veterans and war widows/widowers may also access a range of other services, for example the Coordinated Veterans' Care Programme, Veterans' Home Care, community nursing, allied health services such as physiotherapy and podiatry, counseling services and transport for health care. For further information on these programmes, refer to the Department of Veterans' Affairs website.

Veterans and war widows/widowers are considered a special needs group under the Act and have the same right of access to Home Care Packages as any other member of the community. Specifically, veterans and war widows/widowers should not be discriminated against when accessing Home Care Package services on an assumption that DVA will provide for their overall care needs. Moreover, it is important to note that some services provided by DVA to veterans complement Home Care Packages, as long as duplication can be avoided.

13.1 Veterans' Home Care programme

13.1.1 Overview of programme

The Veterans' Home Care (VHC) programme is administered through DVA, and provides a range of low-level home care services to veterans and war widows/widowers. The VHC programme enhances the independence and health outcomes of veterans by reducing the risk of avoidable illness and injury and assisting them to remain independent in their own homes as long as possible.

VHC services include domestic assistance, personal care, safety-related home and garden services, respite (in-home and emergency respite care and approval for residential respite care) and social assistance services as part of the Coordinated Veterans' Care Programme. Eligibility to access the VHC programme is determined by DVA. DVA has criteria for access to VHC, as set out in the DVA Fact Sheets available on the Department of Veterans' Affairs website.

13.1.2 Interface with the Home Care Packages Programme

Where a veteran or war widow/widower has increasingly complex care needs and has been identified as requiring a higher level of services than those being received under the VHC programme, the veteran or war widow/widower should be referred for an ACAT assessment. The veteran or war widow/widower will then follow the pathway for accessing a Home Care Package outlined in Part C of these Guidelines.

Once a veteran or war widow/widower has been approved by an ACAT as eligible for a Home Care Package and been offered a package by a home care provider, that package becomes the **primary** source of care for the veteran or war widow/widower and generally VHC services will no longer be required.

The veteran or war widow/widower should not be accessing the same service tasks simultaneously from VHC and the Home Care Package, e.g. showering. In some instances, however, the veteran or war widow/widower may supplement the care provided under a Home Care Package with some VHC services, such as additional respite care, if the Home Care Package is not sufficient to meet the veteran's or war widow/widower's needs. As the Home Care Package remains the primary source of care, the selection of services under the Home Care Package utilising CDC should be focused on meeting the primary care needs from within the Home Care Package. It should not be expected that VHC will be able to provide additional services.

DVA may also provide, where appropriate, non-VHC services to the veteran or war widow/widower, such as DVA-contracted community nursing, rehabilitation aids and appliances, allied health and transport to medical appointments, which may not be part of the Home Care Agreement and care plan.

Any approval for additional services through the VHC programme must be negotiated between the veteran or war widow/widower, the VHC Assessment Agency and the home care provider.

There will be situations where a consumer of a Home Care Package lives with a person who is a veteran or war widow/widower. In these circumstances, the veteran or war widow/widower should continue to access the full range of services available from VHC, provided there is no duplication of service tasks within the household.

13.2 Coordinated Veterans' Care Programme

13.2.1 Overview of programme

The Coordinated Veterans' Care (CVC) Programme provides ongoing, planned and coordinated primary and community care, led by a general practitioner (GP) with a nurse coordinator (either a practice nurse or DVA community nurse) to eligible veterans and war widow/widowers. To be eligible, veteran participants must be Gold Card holders who have targeted chronic conditions, complex care needs and are at risk of unplanned hospitalisation.

An additional enhancement to the CVC Programme is the In-Home Telemonitoring for Veterans trial. Under the trial, participants in selected sites can have vital signs related to their chronic conditions monitored, using telemonitoring equipment, by health professionals, without being required to leave their home. Participants in the CVC programme, including those in the telemonitoring trial, will also be encouraged to participate in the national Personally Controlled Electronic Health Record System.

GPs are paid to enrol participants in the CVC Programme and provide ongoing quarterly periods of coordinated care. The amounts paid are in addition to all existing items, including all chronic disease management items GPs are currently eligible for. Eligibility for the CVC Programme is determined by the GP.

Gold Card holders are ineligible for the CVC Programme if they live in a Residential Aged Care Facility or choose to participate instead in a similar Commonwealth programme, such as a Home Care Package Level 3 or 4, or Diabetes Care Project.

Veteran and war widow/widowers participation is voluntary and the services provided are at no cost to the veteran.

13.2.2 Interface with the Home Care Packages Programme

Services offered under Home Care Levels 1 and 2 generally do not duplicate services provided by the CVC Programme. Home Care Package services complement the CVC Programme and provide greater support at home for the veteran or war widow/ widower. Therefore, there would be no exclusion in participating in both the CVC Programme and the low 'broadband' levels of Home Care Packages (Levels 1 and 2).

Where the veteran or war widow/widower has been approved by an ACAT as eligible for a Home Care Package in the higher broadband of Level 3 and 4, and has asked to be transferred to a Home Care Package at this level, that package becomes the primary source of care for the veteran or war widow/widower and generally CVC Programme services will no longer be required.

In some instances, the veteran or war widow/widower may supplement the care provided under a Home Care Package with other DVA services (see Section 13.1 of this Part – Veterans' Home Care Programme).

13.3 Department of Veterans' Affairs Community Nursing Programme

13.3.1 Overview of programme

DVA provides entitled veterans and war widows/widowers with access to community nursing services, through the DVA Community Nursing programme, to meet their assessed clinical and/or personal care needs in their own home.

Community nursing services are delivered by DVA-contracted community nursing providers. Prior to delivering services, the provider must first receive a referral from one of the following authorised referral sources:

- general practitioner;
- treating doctor in a hospital;
- hospital discharge planner;
- nurse practitioner specializing in a relevant field; or
- Veterans' Home Care (VHC) Assessment Agency.

DVA has criteria for access to community nursing services, as set out in the DVA Fact Sheets available on the Department of Veterans' Affairs website.

13.3.2 Interface with the Home Care Packages Programme

Although not intended to provide comprehensive clinical services, some nursing and allied health services may be provided as part of Home Care Level 1 and 2 packages. Where there is an assessed clinical need, and these services are not being provided under a Home Care Level 1 or 2 package, a DVA-contracted community nursing provider may deliver clinical nursing services.

Where a veteran or war widow/widower is in receipt of a Home Care Package, the home care provider must ensure that there is no duplication of services where a veteran or war widow/widower is also receiving DVA community nursing services.

As Home Care Level 3 and 4 will generally provide all assessed clinical and/or personal care needs for a veteran or war widow/widower, DVA community nursing services should not be delivered to a veteran or war widow/widower in receipt of these types of packages. It should not be expected that the DVA Community Nursing Programme will provide additional services.

13.4 Department of Veterans' Affairs Rehabilitation Appliances Programme

13.4.1 Overview of programme

Under the Rehabilitation Appliances Programme (RAP) the Repatriation Commission and the Military Rehabilitation and Compensation Commission (the Commissions) assist entitled veterans, ex-service personnel, their spouses/partners and dependants (entitled persons) to be as independent and self-reliant as possible in their own home. Health care assessment and the subsequent provision of aids and appliances are intended to minimise the impact of disabilities, enhance quality of life and maximise independence in daily life.

The programme provides aids and appliances:

- according to assessed clinical need;
- in a timely manner; and
- as part of the overall management of an individual's health care.

The equipment should be:

- appropriate for its purpose;
- safe for the entitled person; and
- designed for persons with an illness or disability, and not widely used by persons without an illness or disability.

13.4.2 Interface with the Home Care Packages Programme

In general, entitled persons receiving a Home Care Package may be able to access RAP aids and appliances where the service provider is not legally required to supply them under the terms of the Home Care Package.

Also, an entitled person who has previously been issued RAP aids and appliances may retain them subsequent to receiving a Home Care Package, and the Commissions may maintain responsibility for the repair, maintenance and, if necessary, replacement of such aids and appliances.

13.5 Veterans' Transport for Treatment

13.5.1 Overview of programme

The Repatriation Transport Scheme (RTS) provides eligible veterans and war widows/widowers (entitled persons) assistance with transport when they attend a health provider for medical treatment and travel by:

- private vehicle;
- public transport;
- community transport;
- taxi/hire car; or
- air travel.

The RTS is governed by sections 84 and 110 of the *Veterans' Entitlements Act 1986* (VEA).

The intention of the Scheme is to provide eligible persons with assistance with the cost of transport, meals and accommodation. The Scheme does not necessarily reimburse the entire cost incurred. Entitled persons can access transport assistance when travelling for treatment in Australia, in the following ways:

Reimbursement (D800) – Eligible persons can arrange and pay for their own transport and seek reimbursement from DVA. Travel, meals and accommodation may be payable for the entitled person and their attendant (if medically required). Entitled persons are able to arrange taxi travel themselves by contacting their local taxi company.

Reimbursement of a taxi fare will only be approved if the age criterion or any one of the medical criteria is met or public, community or private transport are unavailable. To receive the maximum allowable assistance with travelling expenses, eligible persons need to attend the closest practical health provider to their permanent or temporary residence at the time of treatment.

Booked Car With Driver (BCWD) – DVA may arrange for the provision of a Booked Car with Driver (BCWD) service for travel to approved treatment locations. Eligible persons may travel by a DVA arranged taxi or hire car for treatment purposes if:

- they are aged 80 years or older;
- public, community or private transport are not available
- they have any of the following **medical conditions**:
  - legal blindness;
  - dementia;
  - psychosis;
  - hemiplegia;
  - ataxia;
  - respiratory insufficiency severely limiting independent activity;
  - cardiac failure severely limiting independence;
  - recent coronary occlusion severely limiting independence;
  - peripheral vascular disease severely limiting independence;
  - amputation severely limiting independence;
  - arthritis severely limiting independence;
  - recent surgery severely affecting your capacity to use public transport;
  - conditions that would cause you to be gravely embarrassed or that are unacceptable to other passengers on public transport e.g. incontinence of bladder or bowel, severe deformity or disfigurement;
  - significant trauma; or
  - frailty that severely limits your independence.

The following treatment locations are approved BCWD locations for entitled persons **aged** 80 years and older, or legally blind or suffering from dementia:

- Local Medical Officers and general practitioners;
- dental providers;
- allied health services (other than those mentioned above);
- optical dispensers;
- VVCS – Veterans and Veterans Families Counselling Services;
- former Repatriation General Hospitals;
- public and approved private hospitals;
- providers of prosthetics, surgical footwear and orthotics;
- Office of Hearing Services accredited providers;
- medical specialist rooms; or
- radiology, imaging and pathology services.

BCWD locations for entitled persons aged 79 years or younger, not legally blind or not suffering from dementia are limited to:

- former Repatriation General Hospitals;
- public and approved private hospitals;
- providers of prosthetics, surgical footwear and orthotics;

- Office of Hearing Services accredited providers;
- medical specialist rooms; or
- radiology, imaging and pathology services.

Ambulance – Gold Card holders are eligible for ambulance services for the treatment of all health conditions, subject to their clinical need. White Card holders are eligible for ambulance services for the treatment of an injury or disease which has been accepted by DVA as war or service related, subject to their clinical need.

DVA will normally pay for a non-emergency ambulance trip if one of the following criteria is met, subject to treatment eligibility:

- require transport on a stretcher; or
- require treatment while in the ambulance; or
- are severely disfigured; or
- are incontinent to a degree that precludes the use of other forms of transport.

13.5.2 Interface with the Home Care Packages Programme

RTS can only be accessed and utilised by eligible persons and only in the context of travelling related to DVA approved treatment and to the closest practical health provider. RTS does not provide travel for shopping or personal needs, nor as a means of preventing social isolation. When travelling interstate for personal reasons, or on holidays, veterans are strongly encouraged to take out travel insurance as travel assistance may be provided based on the temporary residence only, i.e. DVA funded transport back to the permanent residence will not normally be provided.

13.6 Consumer fees – former Prisoners of War and Victoria Cross recipients

Former Prisoners of War (POW) and Victoria Cross (VC) recipients, who have been assessed as eligible for a Home Care Package by an ACAT, are entitled to have their consumer fees paid for by DVA on receipt of a package. Once eligibility has been established, DVA will pay:

- the basic consumer fee; and
- any income tested service fees, if the former POW or VC recipient has additional income that incurs an income tested fee.

The former POW or VC recipient should not be asked to make any payments to the approved provider within the scope of the package.

Where a former POW or VC recipient is already paying consumer fees for a Home Care Package, DVA can reimburse the consumer for fees paid on and after 21 August 2009. Consumers in these circumstances should contact DVA on **133 254**.

Part K – Appendices

Appendix A – Glossary of terms

Term	Meaning
ACAR	Aged Care Approvals Round
ACAT	Aged Care Assessment Team. ACATs are known as Aged Care Assessment Services (ACAS) in Victoria
ACFA	Aged Care Financing Authority
Act	*Aged Care Act 1997*
CACP	Community Aged Care Package
basic daily care fee (or home care fee)	Refers to the contribution that a consumer may be asked to pay by a home care provider under a Home Care Package (separate to the government subsidy). Also known as a care recipient contribution, care recipient fee or consumer fee
consumer (or home care consumer)	A person who is receiving care and services under a Home Care Package funded by the Australian Government. In the *Aged Care Act 1997*, this person is described as a "care recipient" In these Guidelines, references to the consumer include other people who are authorized to act on behalf of the consumer.
claim form	The Department of Human Services form used by home care providers to claim home care subsidy payments
Commonwealth HACC Programme	This programme provides home and community care services for frail older people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over. The Commonwealth HACC programme does not currently apply in Victoria and Western Australia
CDC	Consumer Directed Care
Department	Department of Social Services
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home package
EACHD	Extended Aged Care at Home Dementia package
home care	A type of aged care for which a home care subsidy is payable under Part 3.2 of the *Aged*

Term	Meaning
	Care Act 1997 and *Aged Care (Transitional Provisions) Act 1997*
home care consumer (or consumer)	A person who is receiving care and services under a Home Care Package funded by the Australian Government. In the *Aged Care Act 1997*, this person is referred to as a "care recipient"
home care provider (or approved provider)	An organisation approved by the Department of Social Services under Part 2.1 of the Act as suitable to provide home care. In the *Aged Care Act 1997*, this person or body is referred to as an "approved provider"
Home Care Agreement	An agreement entered into by a consumer and a home care provider outlining rights and responsibilities and what services will be provided to the consumer under the Home Care Package
Home Care Standards	The Home Care Standards means the 'Home Care Common Standards', as set out in Schedule 4 to the *Quality of Care Principles 2014*
Home Care Packages Programme	The Australian Government programme that provides funding for Home Care Packages aimed at supporting people to remain living at home
home care subsidy	The subsidy payable to a home care provider by the Australian Government under Part 3.2 of the *Aged Care Act 1997* and *Aged Care (Transitional Provisions) Act 1997*
income tested care fee	Refers to the fee a consumer may be asked to pay for their home care, based on an income assessment.
NACAP	The National Aged Care Advocacy Programme is funded by the Australian Government and provides advocacy support and promotes the rights of people who are seeking or are receiving Australian Government funded aged care services
NRCP	National Respite for Carers Programme is one of several initiatives designed to support and assist relatives and friends caring at home for people who are unable to care for themselves because of disability or frailty.
Principles	Aged Care Principles made under section 96-1 of the *Aged Care Act 1997* and *Aged Care*

Term	Meaning
	(Transitional Provisions) Act 1997
re-ablement	The use of timely assessment and targeted interventions to assist people to maximise their independence, choice and quality of life and minimise support required – to enable people to actively participate and remain engaged in their communities
suspension	Term used when a consumer takes a period of leave from their Home Care Package, and some or all services are suspended.
VHC	Veterans' Home Care

Australian Government
Department of Health

HOME CARE PACKAGES PROGRAMME

Operational Manual

A guide for home care providers

Updated December 2015

Operational Manual

Home Care Packages Programme: A guide for approved home care providers

Contents

1. Foreword

This Operational Manual (the Manual) provides guidance to support the delivery and management of the Home Care Packages Programme on a Consumer Directed Care (CDC) basis.

The Manual is primarily for use by home care providers (providers), although it has also been written with a broader audience in mind. The Manual replaces the Home Care Packages Programme Guidelines 2014 (the Guidelines). Key changes from the Guidelines include:

- Updated information on fees and charges;
- Expanded information for providers on the care planning process; and
- Detailed information for providers when establishing individualised budgets and monthly statements with their consumers.
    - whilst the Manual outlines what information these documents should contain, the Australian Government (the Government) does not regulate how the individualised budget is presented. This approach provides flexibility for providers to determine how they will satisfy the new requirements.

Although the Manual refers to elements of the legislative framework, **it is not intended to be a source of legal advice**. The Manual provides reference points to source documents that providers should refer to for further information. As the Government continues to embed CDC into the Home Care Packages Programme, the Operational Manual will be updated as required.

A range of complementary resources for consumers and providers can be found through the My Aged Care website at www.MyAgedCare.gov.au and the Home Care Packages Programme pages on the Department's website at www.dss.gov.au/homecarepackages

1.1 My Aged Care

My Aged Care is a website and contact centre set up by the Government to help providers and consumers navigate the aged care system.

The My Aged Care provider and assessor helpline, answers enquiries relating to the My Aged Care system and provides technical support.

Providers can contact the helpline on 1800 836 799, Monday to Friday, 8am to 8pm (closed on national public holidays) and on Saturdays, 10am to 2pm, local time across Australia.

Consumers can call the My Aged Care contact centre on 1800 200 422, Monday to Friday, 8am to 8pm (closed on national public holidays) and on Saturdays, 10am to 2pm, local time across Australia.

If you are deaf or have a hearing or speech impairment, we can help through the National Relay Service (NRS). Call 1800 555 677 and ask for 1800 836 799 (providers) or 1800 200 422 (consumers). Alternatively, you can visit the NRS website at www.relayservice.gov.au and choose your preferred access point.

Information is current from 1 July 2015 until January 2017.

2. Home Care Packages Programme

The Home Care Packages Programme is part of the Government's continuum of care for older Australians.

The Home Care Packages Programme is for people who have complex needs that can only be met by a coordinated package of care.

The objectives of the Programme are:

- to assist people to remain living at home; and
- to enable consumers to have choice and flexibility in the way that the consumer's aged care and support is provided at home.

2.1 Package levels

There are four levels of home care packages:

Home Care Level 1: Supports people with basic care needs.
Home Care Level 2: Supports people with low level care needs.
Home Care Level 3: Supports people with intermediate care needs.
Home Care Level 4: Supports people with high care needs.

2.2 Home care subsidy

The Government home care subsidy is paid to a provider in respect of a home care place occupied by a consumer. It is not paid directly to the consumer.

Details of subsidy and supplement amounts are published on the Department's Aged Care Funding webpage.

2.3 Supplements

In addition to the base level of subsidy for a home care package, consumers across all levels of home care packages may be eligible for one or more of the following supplements:

- Dementia and Cognition Supplement and Veteran's Supplement;
- Oxygen Supplement;
- Enteral Feeding Supplement;
- Viability Supplement;
- Top-up Supplement (EACHD consumers); and
- Hardship Supplement.

Supplements are paid to a home care provider, in respect to a consumer, in recognition of the additional costs associated with the consumer's particular care and service requirements.

For more information on supplements, refer to Section 4.4.3 'What is the Amount of the Home Care Subsidy?' of the Guide to Aged Care Law or the Aged Care Subsidies and Supplements page on the Department's website.

More detail on the Top-up Supplement can also be found in 4.2 Existing consumers at 30 June 2014 of the Manual.

2.4 Legal framework

The legal framework for the Home Care Packages Programme is underpinned by:

- the *Aged Care Act 1997*
- Principles made under the Acts, including:
  - *Accountability Principles 2014*
  - *Allocation Principles 2014*
  - *Fees and Payments Principles 2014 (No. 2)*
  - *Quality of Care Principles 2014*
  - *User Rights Principles 2014*
  - *Approval of Care Recipients Principles 2014*
  - *Complaints Principles 2014*
  - *Records Principles 2014*
  - *Sanctions Principles 2014*
  - *Subsidy Principles 2014*
- Determinations made under the Acts (for example, setting relevant subsidy and supplement levels).

For more information on the treatment of fees for consumers who entered into a home care package on or before 30 June 2014, see:

- *Aged Care (Transitional Provisions) Act 1997*; and
- *Aged Care (Transitional Provisions) Principles 2014.*

For more information on the legal framework that underpins the Home Care Packages Programme, refer to the Guide to Aged Care Law or go to www.comlaw.gov.au

The Department does not comment on business practices, nor is the Department in a position to offer legal advice. Providers may wish to seek independent legal advice about business arrangements and how they align with the legislation.

2.5 Target population

Although there is no minimum age requirement for a home care package, the Home Care Packages Programme has been developed to assist frailer older Australians to remain in their homes.

In some cases, younger people with disabilities, dementia or special care needs may be able to access a home care package. This should only occur where there are no other care facilities or care services more appropriate to meet their needs. The *National Guiding Principles for the Referral and Assessment of Younger People with Disability* provides further information on this.

There are no citizenship or residency restrictions on accessing a home care package. However, the packages are not intended for visitors to Australia or people requiring temporary or short-term care.

Special needs groups

All providers are expected to have policies and practices in place to ensure services are accessible by people with special needs.

Under the *Aged Care Act 1997*, people with special needs include those who identify with or belong to one or more of the following groups:

- people from Aboriginal and Torres Strait Islander communities;
- people from culturally and linguistically diverse backgrounds;
- people who live in rural and remote areas;
- people who are financially or socially disadvantaged;
- veterans;
- people who are homeless or at risk of becoming homeless;
- people who identify as lesbian, gay, bisexual, transgender or intersex;
- people who are care leavers; and
- parents separated from their children by forced adoption or removal.

Providers should have regard for consumer diversity, taking into account a consumer's individual interests, customs, beliefs and backgrounds. Providers should also work collaboratively with advocacy services, particularly the National Aged Care Advocacy Programme (NACAP) services, and specialist service providers for people from special needs' groups, where appropriate.

While not a separate special needs group under the legislation, all providers should also have policies and practices that address the provision of care for people with dementia.

In December 2012, the Government released national strategies for two of these special needs' groups:

- *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*; and
- *National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy*.

3. Pathway for the consumer

The consumer pathway involves a series of steps, from being assessed and finding information about home care packages through to being offered a package, service delivery and finally exiting the Programme.

The Manual has been written in conjunction with the Five steps to accessing a Home Care Package booklet (https://www.dss.gov.au/ageing-and-aged-care/programs-services/home-care/five-steps-to-accessing-home-care-packages) for consumers. It describes what is involved at each step and what providers are expected to do to support the consumer.

Step 1: Accessing a home care package

A person seeking Commonwealth funded aged care services will contact My Aged Care. If their care needs indicate they may need a home care package, they will be referred for an assessment to determine if they are eligible.

An Aged Care Assessment Team (ACAT), or Aged Care Assessment Service (ACAS) in Victoria, then assesses the person.

Please refer to 5. Accessing a Home Care Package of the Manual.

Step 2: Offering a home care package

The consumer meets with a provider and discusses whether a suitable package is available. This determines whether a consumer can be offered a package by the provider.

Please refer to 6. Offering a home care package to a consumer of the Manual.

Step 3: Determining a consumer's fees and charges

The Government pays for the bulk of aged care in Australia, but as with all aged care services, consumers may be asked to contribute towards the cost of their care if they can afford to do so.

Please refer to 7. Determining a consumer's fees and charges of the Manual.

Step 4: Home Care Agreement and care planning

The provider and the consumer enter into a *Home Care Agreement*. The provider will also work in partnership to develop a care plan, which describes the care and services to be provided, and an individualised budget, which shows what funds are available and planned expenditure.

As part of the care planning process, the consumer outlines their goals and the level of control they wish to exercise over their package.

Please refer to 8. Home Care Agreement and care planning of the Manual.

Step 5: Service delivery, monitoring and re-assessment

Services are delivered according to the agreed care plan, with flexibility to make changes to meet the consumer's needs. The provider will provide ongoing monitoring of the package.

Once services commence, the home care provider sends monthly statements to the consumer to show how their package budget is being spent.

Please refer to 9. Commencement of services of the Manual.

Moving or exiting

This may occur if the consumer's needs have changed significantly over time. Where this is the case, a new ACAT assessment may be required to assess eligibility for a package within a higher band (e.g. Level 3 or 4) or residential care.

Please refer to 9.4 When consumers leave a Home Care Package of the Manual.

4. Summary of changes to home care packages

When	Change	Impact
1 August 2013	Commenced the transition to Home Care Packages Programme	Where consumers were receiving an EACHD package, they were moved to a Level 4 home care package, with 'Top-Up' and 'Dementia and Cognition' supplements.
1 July 2014	Commencement of the *Aged Care (Transitional Provisions) Act 1997* and the *Aged Care (Transitional Provisions) Principles 2014*	Where consumers were receiving a home care package before 1 July 2014, they continue to be asked to pay the basic daily fee and any fees calculated on income they receive above the basic pension.
1 July 2014	Commencement of the *Fees and Payments Principles 2014* (Part 3A. 1 of *Aged Care Act 1997)*	For all consumers entering into a home care package from 1 July 2014, they will be asked to pay the basic daily fee, and an income-tested care fee **only** if their income is over the maximum income for a full pensioner.
1 July 2015	Commencement of the *Transitional provisions relating to the User Rights Amendment (Consumer Directed Care) Principles 2015*	*Home Care Agreements* entered into before 1 July 2015 do not need to be amended to comply with the requirements relating to the new CDC-related matters. Existing individualised budgets provided to consumers before 1 July 2015 are taken to have complied with subsections 21A(1), (2) and (3) in relation to the consumer. However, if there is a change to the care and services to be provided, or if the costs of providing care change, or if the consumer requests a revision to the budget, obligations to review and revise the budget and provide a copy of the revised budget to the consumer apply even if the original budget was provided before 1 July 2015.
1 July 2015	Commencement of the *User Rights Amendment (Consumer Directed Care) Principles 2015*	**All** home care packages **must** be delivered on a CDC basis. The key elements of CDC have been embedded in the principles and any CDC conditions of allocation have been revoked and replaced by these principles. All consumers entering into a home care package from 1 July 2015 must receive a *Home Care Agreement* that reflects CDC: ○ choice and flexibility; ○ care and services; and ○ an individualised budget and monthly statement.

4.1 Existing Extended Aged Care at Home - Dementia (EACHD) consumers at 31 July 2013

From 1 August 2013, the EACHD package converted to a Home Care Level 4 package with a Dementia and Cognition Supplement (or the Veterans' Supplement, if eligible) and a 'Top-up' Supplement to ensure that existing EACHD consumers (i.e. those receiving an EACHD package on 31 July 2013) continued to receive the same level of funding, plus indexation.

Note: If the consumer terminates their *Home Care Agreement* for more than 28 days, they will no longer receive the Top-up Supplement and the new fee arrangements that commenced on 1 July 2014 will apply if they commence a new package.

If a consumer moves to a new provider, the Top-up Supplement can continue to be paid to the new provider as long as the period between ceasing the former package and commencing the new package is not more than 28 days.

4.2 Existing consumers at 30 June 2014

The changes to the income-tested care fee that started on 1 July 2014 will not apply to consumers who were receiving a home care package on or before 30 June 2014.

These consumers can continue to be asked to pay a basic daily fee. Providers can also charge these consumers an income-tested fee under the arrangements that existed for income-tested fees pre-1 July 2014 but the post-1 July 2014 income-tested care fees do not apply to these consumers. They will continue to receive the same package of care after 1 July 2014 and will not be affected by the new fee arrangements if they move between package levels.

Note: If the consumer leaves their current care arrangements and enters into a home care agreement with a new home care service within 28 days, they have the option of choosing to have their fees calculated under the new arrangements that commenced on 1 July 2014. Where the consumer chooses to be covered by the new arrangements, they cannot revert back to their previous fee and payment arrangements.

If the consumer terminates their *Home Care Agreement* for more than 28 days, the new fee arrangements that commenced on 1 July 2014 will apply if the consumer commences a new package.

The maximum home care fee that these consumers can be asked to pay is determined by the *Aged Care (Transitional Provisions) Act 1997* and the *Aged Care (Transitional Provisions) Principles 2014*, Chapter 4, Part 4 - Home care fees.

For more information on the calculation of fees for these consumers, see 7.1 Existing consumers at 30 June 2014 of the Manual.

4.3 New consumers entering from 1 July 2014

Where consumers take up a home care package after 1 July 2014, they may be asked to pay:

- a basic daily fee; and
- an income-tested care fee, **only** if their income is over the maximum income for a full pensioner.

Note: A full pensioner can only be asked to pay the basic daily fee.

The maximum fee that a consumer can be asked to pay in a basic daily fee is determined by Part 3A.1, Division 52D – Home Care fees of the *Aged Care Act 1997* and Part 3 – Home care fees of the *Fee and Payments Principles 2014* for information on treatment of fees for consumers who entered into a home care agreement from 1 July 2014.

For further information on the calculation of fees for these for these consumers, see 7. Determining a consumer's fees and charges of the Manual.

4.4 Existing consumers at 30 June 2015

Transitional provisions relating to the *User Rights Amendment (Consumer Directed Care) Principles 2015* apply to existing consumers at 30 June 2015.

Individualised budgets

New subsections 25(1) and (2) provide that if a provider has given a consumer an individualised budget before 1 July 2015, they are taken to have complied with subsections 21A(1), (2) and (3) in relation to the consumer. This means the provider is not required to give the consumer another individualised budget after 1 July 2015.

However, subsection 25(3) clarifies that if there is a change to the care and services to be provided, or if the costs of providing care change, or if the consumer requests a revision to the budget, then obligations to review and revise the budget and provide a copy of the revised budget to the consumer apply even if the original budget was provided before 1 July 2015.

Subsections 25(4) and (5) apply where an approved provider has provided care to a consumer before 1 July 2015 and continues to provide care to the consumer after 1 July 2015, but has not given the consumer an individualised budget before 1 July 2015. In these circumstances, the provider must give the consumer an individualised budget, as soon as practical after 1 July 2015 after obtaining the necessary information to complete the budget.

Home Care Agreements

Section 26 provides that amendments to subsection 23(2) (made by items 2, 3 and 4 of the Amending Principles) only apply to *Home Care Agreements* entered into on or after 1 July 2015. This means existing *Home Care Agreements* entered into before 1 July 2015 do not need to be amended to comply with the requirements relating to the new CDC-related matters. However, providers must comply with the requirements of CDC.

4.5 All home care packages from 1 July 2015

From 2013, the Government progressively introduced CDC into the Home Care Packages Programme. From 1 July 2015, it applied to all home care packages.

The *User Rights Amendment (Consumer Directed Care) Principles 2015* (the Amending Principle) amends the User Rights Principles to require all providers to deliver home care packages on a CDC basis.

CDC was first piloted as a model of service delivery within the former Commonwealth funded Community Packaged Care Programme in 2010-11. Following the success of the pilot, the decision to implement CDC in home care packages was announced on 20 April 2012 as part of the *Living Longer, Living Better* reforms to aged care. From 1 August 2013, all newly released home care packages were required to be delivered on a CDC basis.

CDC is both a philosophy and an orientation to service delivery. It is a way of delivering aged care services that gives consumers greater flexibility by allowing them to make choices about the types of care and services they access and how those services are delivered.

The Manual has been written with the CDC model of service delivery built into it.

Key elements of consumer directed care

Since 1 July 2015, the *User Rights Principles 2014* and the *Charter of care recipients' rights and responsibilities-homecare* (the Charter), which recognise the rights and responsibilities of consumers and providers, explicitly acknowledge the key elements of CDC, emphasising the right of consumers to exercise choices in relation to the care provided to them.

Choice and flexibility

The Charter specifies consumers' right to:

- be supported by the provider to set goals, determine the level of ongoing involvement that they wish to have, and make decisions relating to their own care and to maintain their independence as far as possible;
- choose the care and services that best meet their goals, preferences and assessed needs, within the limits of the resources available;
- have choice and flexibility in the way the care and services are provided at home;
- participate in making decisions that affect them; and
- have their representative participate in decisions relating to their care.

Care and services

Consumers have the right to:

- receive care and services which are appropriate to meeting their goals, preferences and assessed needs;
- be given a written plan of the care and services that they expect to receive;
- receive care and services that take into account their preferences; and
- ongoing review of the care and services they receive, as required.

Individualised budget and monthly statements

An individualised budget must be developed in partnership between the consumer and the provider. It must list the amount of subsidy the Government is paying (including any

supplements), the maximum amount of home care fees payable by the consumer and the cost of the agreed care and services.

Consumers are to receive an individualised budget as soon as practical after the provider has all the necessary information to complete the budget.

The consumer is to also receive a monthly statement of available funds and expenditure for the care and services delivered in a particular period.

Both of these documents must be in an agreed format that is easy to read and understandable by the consumer.

For further information on the changes to the Charter, go to the *User Rights Amendment (Consumer Directed Care) Principles 2015* or Section 4.5 (home care packages) of the Guide to Aged Care Law.

5. Accessing a home care package

A person seeking information on Commonwealth funded aged care services can contact My Aged Care. If their care needs indicate that they may need a home care package, My Aged Care will refer them for an assessment to determine their eligibility.

An ACAT (or ACAS) is able to assess and approve a person's eligibility to receive Government subsidised care such as residential aged care, residential respite care, home care and transition care. Prior to the assessment, the person will be asked to sign an Application for Care under the *Aged Care Act 1997* form.

ACATs cover all of Australia and are based in hospitals or in the local community. People can find their local ACAT (or ACAS) through My Aged Care at www.myagedcare.gov.au/ or by calling 1800 200 422. People are able to contact an ACAT (or ACAS) directly until their state or territory fully transitions to the My Aged Care system (see Section 5.3).

5.1 Eligibility for a home care package

Eligibility requirements for home care packages are set out in the *Aged Care Act* 1997 and the *Approval of Care Recipients Principles 2014*. ACATs are required to assess people in accordance with these criteria and approve only those who are assessed as eligible for this type of care.

For information on age requirements and citizenship or residency restrictions, see 2.5 Target population of the Manual.

5.2 Assessment by an ACAT

In order to access a home care package, a person needs to first be assessed and approved as eligible by an ACAT (or ACAS).

ACAT assessments are comprehensive and holistic, independent, multi-disciplinary and multi-dimensional and client-focused. As part of the process, a person's physical, medical, psychological, cultural, social and restorative care needs are assessed to determine the type of services and supports that would be most appropriate to meet the person's needs.

The ACAT also considers the client's usual and community support systems and any other relevant matters. The needs of the carer or advocate are also taken into account.

The assessment should take into account any relevant information available from the person's medical practitioner and other specialist reports. The ACAT will conduct a face-to-face comprehensive assessment, if possible, to determine whether the person can be approved as eligible to receive a home care package.

The ACAT may also refer a person to a medical or health practitioner/service for more specialised assessment of needs, such as those associated with vision impairment or blindness, hearing loss, other disabilities or nutrition. These assessments could form part of the overall assessment.

Note: ACAT approvals for home care are 'broad-banded' to two categories – home care level 1 or 2 (low-level care) and home care level 3 or 4 (high-level care).

The ACAT does not determine whether a person's care needs are at a particular level within each band.

If a person has been assessed as eligible for a particular level of package, but none is available, the person can be offered a lower level package, as an interim measure, until a higher level package is available.

The decision to offer an eligible person a package, including at what level the package is offered (within scope of the approval) is made by the provider in partnership with the consumer.

Information about the ACAT decision

The consumer will be advised in writing of the outcome of the ACAT assessment and receive contact details for further advice, if required. The ACAT delegate must provide sufficient information in writing to allow a person to understand why a decision has been made and the evidence on which it was based.

An ACAT approval to receive a home care package does not lapse, unless given on a time limited basis, and takes effect from the day the approval is given.

Referral from an ACAT to a provider or other services

Once a person is approved as eligible for a home care package, they will need to find a provider in their local area. Their ACAT representative can help them do this.

If a person wants to find their own provider, they can contact My Aged Care on 1800 200 422 or use the Service Finder on the My Aged Care website, which provides an overview of providers in the local area and their website details so the person can get a better understanding about what they offer. The consumer can also get their provider's contact details so that they can arrange a time to visit.

If a person is not found to be eligible for a home care package, an ACAT representative may refer a consumer to other care services that do not require an ACAT approval, such as the CHSP or the Veterans' Home Care Programme. In some instances, if the ACAT determines that an ACAT assessment is not appropriate for that person, they may refer the person to the My Aged Care Regional Assessment Service for a home support assessment.

5.3 Changes to My Aged Care in 2015

On 1 July 2015, My Aged Care was expanded. The changes included:

- a central client record to facilitate the collection and sharing of client information between the client and their representatives, assessors and service providers;
- the introduction of the My Aged Care Regional Assessment Service (RAS) to conduct face-to-face assessments of people seeking entry level support at home, provided under the CHSP;
- My Aged Care contact centre staff and assessors using the National Screening and Assessment Form (NSAF) to ensure a nationally consistent and holistic screening and assessment process;
- an electronic matching and referral capability;
- web-based My Aged Care portals for clients, assessors and service providers;
- clients using the client portal to view their client record;
- assessors using the assessor portal to manage referrals, use the NSAF and update the client record with assessment information; and
- service providers using the provider portal to maintain information about the services they deliver, manage referrals and update the client record.

From September to December 2015, ACATs will transition to full use of the My Aged Care system to undertake assessments, with the NSAF to approve care types under the Act and to match and refer clients to services. From full transition, people will be required to access an ACAT through the My Aged Care contact centre on 1800 200 222.

More information on My Aged Care can be found on https://www.dss.gov.au/my-aged-care

6. Offering a home care package to a consumer

Once a person is approved as eligible for a home care package by an ACAT, they will approach a provider to deliver care and services to them.

Note: The responsibility is on the provider to check that a person has a valid assessment approval. A home care subsidy will not be paid without this approval.

A provider can offer a person a package at either level within the relevant band they have been approved for by the ACAT (e.g. Level 1 or 2 package, or Level 3 or 4 package). The person is then able to choose whether or not to accept the package.

Note: A provider can only offer a level of home care package that it has an allocation for and has readily available.

Providers should always review the prospective consumer's ACAT Aged Care Client Record (ACCR). This provides important information about their characteristics, needs and circumstances. It should be considered together with other information provided by the consumer, including any relevant information from their medical practitioner, in determining whether a package can be offered and, if so, at what level (within the ACAT approved band).

A consumer can commence a home care package even when the income assessment is not complete. For consumers in receipt of a means-tested income support payment, they will not need to complete the income assessment as the Department of Human Services (DHS) will have sufficient information to determine the consumer's income-tested care fee. For consumers who are not in receipt of a means-tested income support payment, the Government will fully meet the consumer's costs of care during the time that their information is being sought and the consumer will need to pay the basic daily fee.

The provider may choose to charge an interim fee while the consumer's fees are being determined by DHS. However, the Government does not set an amount of interim fee. Once DHS has advised of the fees payable by the consumer, any overpayments would need to be refunded. Similarly, regarding underpayments, the provider will need to seek any amounts owing from the consumer.

An indication of the consumer's fees payable can be obtained from the Home Care Fee Estimator on the My Aged Care website.

For more information on the income-tested fee, see 7.3 Paying fees of the Manual.

6.1 Waiting lists

There may be waiting lists for packages in some areas. Providers manage their own waiting lists, giving access and priority according to each individual's need and the provider's capacity to meet that need.

People on a waiting list do not necessarily access care purely on a 'first come, first served' basis. Providers are encouraged to assess each individual's care needs relative to others also waiting for home care. They must also take into account any conditions of allocation for the package, including priority of access for people from special needs groups.

People can be added to as many waiting lists as they want and providers cannot charge them a fee to be added to their waiting list.

6.2 Moving between package levels or bands

A consumer does not have to be reassessed by an ACAT to move from one package level to another **within the broad-banded levels approved by the ACAT**. This means that a provider can offer a higher level package when a consumer's needs require a higher level of care – from Level 1 to 2, or from Level 3 to 4 – without the need for another ACAT assessment.

A new assessment and approval from an ACAT is required before the consumer can be offered a package **in a higher band**, i.e. moving from a Level 1 or 2 package to a Level 3 or 4 package – except where the consumer already has an ACAT approval at the higher band.

7. Determining a consumer's fees and charges

The Government pays for the bulk of aged care in Australia by paying subsidies and supplements for care to providers. However, consumers may be asked to contribute towards the cost of their care if they can afford to do so.

Providers must discuss and agree upon any fees with the consumer before any services begin. The maximum fees payable must be recorded in the *Home Care Agreement* see 8. Home Care Agreement and care planning of the Manual.

A consumer's access to a home care package must not be affected by their ability to pay fees; however, a consumer's responsibilities include paying the fees specified in the *Home Care Agreement*. If a consumer does not pay the fees, or negotiate an alternative with their provider, providers are able to withdraw the service for non-payment of fees and re-allocate the package, as detailed in the *User Rights Principles 2014*.

Note: People who entered into a *Home Care Agreement* on or before 30 June 2014 will have their fees determined differently to those who commenced a home care package from 1 July 2014.

7.1 Existing consumers at 30 June 2014

These consumers can continue to be asked to pay a basic daily fee. Providers can also charge these consumers an income-tested fee under the arrangements that existed for income-tested fees pre-1 July 2014 but the post-1 July 2014 income-tested care fees do not apply to these consumers. The consumer will continue to receive the same package of care after 1 July 2014 and will not be affected by the new fee arrangements if they move between package levels.

For these consumers, fees are calculated as follows:

If the consumer's income is…	then…
up to the basic rate of the single Age Pension	the maximum fee is 17.5 per cent of the basic rate of the single Age Pension.
more than the basic rate of the single Age Pension	the maximum fee is 17.5 per cent of the basic rate of the single Age Pension **plus** up to 50 per cent of income above the basic rate of the single Age Pension.

7.2 Pooling of Resources

Where two consumers live together and both are receiving packages, they may elect to pool their resources by sharing costs of the services across their individualised budgets.

Providers are required to include information about fees payable in the *Home Care Agreement*. However, the calculated fee amount will be recorded in the consumer's individualised budget.

7.3 What constitutes a consumer's income?

Income is defined as income after income tax and the Medicare levy. When calculating income for the purpose of determining ongoing fees, the following are excluded:

- any Pharmaceutical Allowance, Rent Assistance or Telephone Allowance;
- the Pension Supplement;
- the Clean Energy Supplement; and
- in the case of a pension payable under the *Veterans' Entitlements Act 1986* (except a Service Pension), an amount equal to four per cent of the amount of the pension.

Please see Division 60 of the *Aged Care (Transitional Provisions) Act 1997* or section 130 of the *Aged Care (Transitional Provisions) Principles 2014* for more information.

7.4 Consumers entering from 1 July 2014

New consumers from 1 July 2014 may be asked to contribute towards the cost of their care, based on their income.

Providers can ask these consumers to pay:

- a basic daily fee (full pensioners can be asked to pay only this fee); and
- an income-tested care fee, **only** if their income is over the maximum income for a full pensioner.

Please see Part 3A.1 – Resident and Home Care fees of the *Aged Care Act 1997* for more information.

Basic daily fee

Providers can ask everyone taking up a home care package to pay the basic daily fee, irrespective of the consumer's income and whether or not they are a member of a couple (the basic daily fee has not changed with the introduction of CDC).

The basic daily fee is 17.5 per cent of the single basic Age Pension. The rate is readjusted on 20 March and 20 September each year in line with changes to the Age Pension.

Income-tested care fee

DHS calculates an income-tested care fee based on an assessment of the consumer's financial information. This assessment does not include the value of their home or any other assets.

Consumers can only be asked to pay an income-tested care fee if their yearly income is above the set thresholds, which takes into account personal characteristics.

If the consumer is a member of a couple, half of their combined income is considered in determining their income-tested care fee, regardless of which partner earns the income.

Following the assessment, DHS will advise the provider and the consumer on the maximum fees payable. These are the maximum fees and the provider can determine a lower amount but the full value of the package must still be provided as though these fees were paid in full.

Note: The amount of subsidy and primary supplements that the Government would normally pay to a provider on behalf of the consumer is reduced by the maximum amount of income-tested care fee that the consumer can be charged. The care subsidy reduction will be administered by DHS.

There are annual and lifetime caps that apply to the income-tested care fee. Once these caps are reached, the consumer cannot be asked to pay any more income-tested care fees for the relevant period. DHS will keep track of the caps, and notify the provider and consumer shortly after the cap has been reached. The Government will pay the remaining income-tested care fees for the consumer by way of increased subsidy to the provider after these caps have been reached. The annual and lifetime caps can be found on the Schedule of Fees and Charges for Residential and Home Care.

Note: Full pensioners do not pay an income-tested care fee.

How a consumer's income-tested care fee is assessed

If the consumer receives a means-tested income support payment
If they receive a payment, such as the Age Pension (full or part), Disability Support Pension or Service Pension, they can call DHS on 1800 227 475 or the Department of Veterans' Affairs (DVA) on 1800 555 254 and request a fee advice for home care.

DHS (or DVA) will have enough information to calculate the maximum fees payable. These consumers do not have to complete an assessment form, unless they want to receive fee advice before they start a home care package.

Once the provider has notified DHS that the consumer has entered their service through the Aged Care Entry Record, DHS will notify the provider and the consumer of the maximum fees payable based on the information it already holds.

If the consumer is a self-funded retiree or not in receipt of a means tested income support payment
These consumers will need to seek an income assessment from DHS.

To seek an income assessment, the consumer will need to fill out an Aged Care Fees Income Assessment form (SA456), which is available on the DHS website or by calling 1800 227 475.

Receiving a response from Department of Human Services

The results of the income assessment will be sent to the provider and the consumer via letter.

If a consumer has not received the results of their income assessment, the consumer should contact DHS on 1800 227 475.

If a provider has a home care package available for a consumer, and has not received a letter from DHS, they can charge an interim fee. The Home Care Fee Estimator can be used for this purpose. The amount the consumer pays can be adjusted if necessary when advice is received from DHS.

What if the consumer is unhappy with the results of their income assessment?

If a person does not think the assessment of their income is correct, they can ask DHS (or DVA if relevant) to review its decision.

The contact details to seek this review will be included in the fee advice letter they receive from DHS.

Determining fees before entering a home care package

Consumers can ask for fee advice from DHS before they enter a home care package.

The fee advice they receive before they start their package will be valid for 120 days, unless there is a significant change in their circumstances. If there is a change, the consumer will need to notify DHS, who will reissue their fee advice letter.

If a consumer seeks an assessment before commencing their package, only the consumer will receive the letter. The provider will receive a letter once they advise the DHS that the consumer has commenced a package with them.

My Aged Care Home Care Fee Estimator

In addition to providing information about fees, My Aged Care can give consumers an estimate of their likely fees. The fee estimator is available on the Home Care Fee Estimator page of the My Aged Care website or by calling the My Aged Care contact centre on **1800 200 422**.

Note: DHS is responsible for formally working out the maximum fees payable based on an assessment of the consumer's financial information and will notify both the provider and the consumer.

7.5 Paying fees

Providers cannot ask consumers to pay any fees before their home care package begins.

The fees and the contribution made by the Government go towards the overall value of the package and contribute to the provision of services the consumer receives.

Once the *Home Care Agreement* has been agreed, providers can ask the consumer to pay fees up to one month in advance. Any fees paid in advance must be refunded to the consumer if they leave the home care package, or move to another provider.

The fees that DHS advises are payable, and calculated daily, even on days a consumer does not receive a service. The Government subsidy and supplements are payable, or calculated, in the same way.

It is the responsibility of consumers to pay their agreed fees under the Charter of care recipients' rights and responsibilities – Home Care.

Review of fees

Existing consumers at 30 June 2014

A review of fees must be conducted periodically (or whenever the consumer requests a review). The consumer should be encouraged to seek a review if their financial circumstances change.

The maximum fees may need to be varied when new rates for the Age Pension are announced each March and September. Providers may need to discuss the impact of these changes on fees with the consumer and update their individual budget accordingly.

Consumers receiving a home care package on or after 1 July 2014

A quarterly review of income-tested care fees (or whenever the consumer requests a review) is conducted by DHS. The consumer should be encouraged to contact DHS or DVA to seek a review if their financial circumstances change.

The basic daily fee increases in March and September each year in line with Age Pension increases.

What if the consumer cannot afford the fees?

If the consumer thinks they will face financial hardship when paying the required fees, they can ask to be considered for financial hardship assistance. Each case is considered on an individual basis.

Note: Consumers who commenced a home care package before 1 July 2014 are not eligible for financial hardship assistance.

Depending on their situation, they may apply for financial assistance with:

- basic daily fee; and/or
- income-tested care fee.

If a care recipient is granted financial hardship assistance, an amount will be paid to the provider on their behalf by the Government by way of a Hardship Supplement. It may cover some, or all, of the consumer's basic and/or income tested fees. The consumer will be responsible for paying any portion of their fees that are not covered by the Hardship Supplement.

For a financial hardship application to be considered, a person must:

- have assets less than 1.5 times the annual Age Pension (plus supplements) as calculated under paragraph 60(2)(b) of the *Subsidy Principles 2014*;
- not have gifted more than $10,000 in the previous 12 months or $30,000 in the previous five years; and
- have had their income assessed in accordance with the *Aged Care Act 1997*.

To apply for financial hardship assistance, the consumer needs to fill out an application form and submit the completed form to DHS. The form is available on the Financial Hardship Assistance – Home Care and Respite Care form page on the DHS website or by calling 1800 227 475.

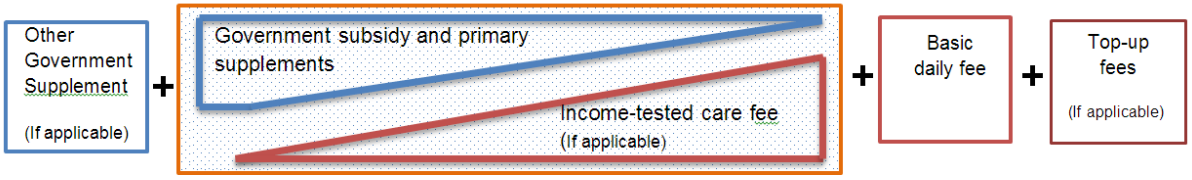
Level of services to be provided under a home care package when the full fees are not charged

For a consumer who started receiving a home care package on or after 1 July 2014, the subsidy and primary supplements payable by the Government are reduced by the maximum income-tested care fee payable by the consumer. The overall value of the package remains the same; what varies is the source of the funds.

Note: The Government subsidy is reduced whether or not the income-tested care fee is charged.

Part 2 of Schedule 3 to the *Quality of Care Principles 2014* lists the items which must not be included in the package of care and services. Payment of home care fees is listed as an excluded item.

The interaction between the Government subsidy/supplements paid and the income-tested care fee can be seen in the following diagram.



The subsidy and primary supplements will be reduced by the maximum income-tested care fee payable by the consumer so the overall value of the package remains the same. What varies is the source of the funds.

Example 1 – Adam

The Government subsidy and primary supplements of Adam's home care package is valued at $30,000 (in addition to the basic daily fee) and Adam has been assessed by DHS as being able to contribute $10,000 towards his income-tested care fee. The Government subsidy payable for Adam's care to his provider is the value of the home care package less Adam's income-tested care fee (that is, $30,000 - $10,000 = $20,000).

Adam's provider asks Adam to pay the income-tested care fee as advised by DHS. Adam's provider must provide him with services reflecting the full package valued at $30,000.

If Adam's home care provider does not collect the full income-tested care fee (regardless of the reason) the home care provider is still required to provide Adam with services as if the fee had been paid in full. That is, the home care provider and Adam cannot select a lower level of care and services to match the reduced value of the Australian Government subsidy paid.

The amount of basic daily fee charged has no impact on the amount of Government subsidy and primary supplements that are paid.

If Adam fails to meet his responsibilities, including the payment of fees, as described in Schedule 2 - Charter of care recipients' rights and responsibilities – home care of the *User Rights Principles 2014,* his home care provider may cease to provide home care to him under the security of tenure provisions in subsection 17–2(e) of the *User Rights Principles 2014*. Adam's Home Care Agreement must contain information such as the maximum fees payable by him and the conditions under which either party may terminate the provision of home care.

Example 2 – Emily

The Government subsidy and primary supplements of Emily's home care package is valued at $20,000 (in addition to the basic daily fee) and Emily has been assessed by DHS as being able to contribute $5,000 towards her income-tested care fee. The amount of Government subsidy payable for Emily's care to her provider is the value of the home care package less Emily's income-tested care fee (that is, $20,000 - $5,000 = $15,000).

If Emily does not pay the income-tested care fee or Emily's provider does not collect an income-tested care fee, Emily's provider must still provide her with services reflecting the full package valued at $20,000 and not services reflecting the amount of Government subsidy paid ($15,000).

8. *Home Care Agreement* and care planning

The Home Care Agreement is an agreement between the provider and the consumer that sets out a number of key elements about how the package will be delivered. It specifies the requirements set out in sections 22 and 23 of the *User Rights Principles 2014*.

For all home care packages, it is a legal requirement that a *Home Care Agreement* must be offered to the consumer before the package commences. A subsidy is not payable to a provider until the consumer has been offered and accepted a package by a home care provider and the *Home Care Agreement* is entered into.

For information on *Home Care Agreements*, refer to Division 61 – What are the requirements for *Home Care Agreements*? of the *Aged Care Act 1997* and Division 4 – *Home Care Agreements* of the *User Rights Principles 2014*.

Once the *Home Care Agreement* is entered into, care and services can formally commence under the package and the provider is able to commence claiming the Government subsidy for the package.

A *Home Care Agreement* recognises the consumer's rights and may spell out the consumer's responsibilities and cannot exclude any rights the consumer has under Commonwealth or State/Territory law.

The *Home Care Agreement* must also specify how either party may terminate the *Home Care Agreement*. For more information, refer to 10.2 Rights and responsibilities of a consumer of the Manual.

The *Home Care Agreement* should be written in plain language, be easily understood and, at a minimum, contain the consumer's care plan and individualised budget, which are often attachments or schedules to the Agreement.

Given the importance of the *Home Care Agreement*, the provider should ensure that the consumer and/or their authorised representative understand the terms of the agreement. The consumer can ask for an advocate to represent them during this process. Advocacy services are further explained in Advocacy section of the Manual.

Where required, the provider should arrange for the *Home Care Agreement*, including the care plan, to be made available to the consumer in a language other than English. Any additional costs associated with the translation must be clearly explained to the consumer.

There should be enough time for the consumer to look at the Agreement, and to seek independent legal advice, if they wish, before they sign it.

The signed *Home Care Agreement* must be provided to the consumer for their records.

What if the consumer is unable to sign the Home Care Agreement?

If the consumer is unable to sign a *Home Care Agreement* because of any physical incapacity or mental impairment, another person representing them may sign the Agreement on the consumer's behalf. See the Advocacy section of the Manual.

Cases where the consumer does not want to sign the *Home Care Agreement*

Providers must always offer and be prepared to enter into a *Home Care Agreement*; however, the consumer may choose not to sign a *Home Care Agreement*.

In such cases, providers are still required by legislation to observe their responsibilities to negotiate and deliver the level and type of care and services the consumer needs.

It is important that the provider documents the reasons the consumer has decided to not sign the *Home Care Agreement* and the basis on which agreed care will be delivered.

The provider should have an 'in-principle' *Agreement* in place and ensure it is readily available. This documentation may include a copy of the *Home Care Agreement* as offered to the consumer, a file note of the discussion with the consumer about the terms of the *Agreement* (including the date that the discussion took place) and evidence that the consumer is receiving a home care package as described in the *Home Care Agreement*.

8.1 Home Care Agreement – Transitional arrangements

Home Care Agreements, entered into on or after 1 July 2015, must include that the home care will be delivered on a CDC basis and specify that the provider will give an individualised budget and a monthly statement to the consumer.

From 1 July 2015, *Home Care Agreements* must also include a statement that the consumer is not entitled to a refund of unspent home care fees if they cease to receive care from their provider. The only amounts of home care fees that are refundable are fees that have been overpaid by the consumer and any fees paid in advance of the date from which the services cease.

Existing *Home Care Agreements* before 1 July 2015 do not need to be amended to reflect the new requirements relating to CDC; however, providers and consumers must comply with the new arrangements.

Providers will be able to achieve this through the co-design of the consumer's new care plan and individualised budget. The provider will also need to provide their consumers with a monthly statement so that they can see how their budget is being spent.

8.2 Developing a care plan

The home care provider will already have some information about the consumer available to them from the consumer's ACCR, which holds up-to-date information on the person's needs, the results of any assessments, and any services they receive, and their ACAT/ACAS assessment. This will help the provider work in partnership with the consumer to develop their care plan and individualised budget.

The consumer should drive the development of the care plan, in consultation with the provider.

The care plan should include:

- the consumer's goals – what it is they would like to achieve through their package;
- identified care needs;

- the level of involvement and control the consumer will have in managing and coordinating their home care package;
- the exact care and services to be provided to support the consumer's assessed care needs and any identified goals;
- who will provide those services;
- when the services are to be delivered, including the frequency of services and days/times when regular services are expected to be provided;
- case management arrangements, including how ongoing monitoring and informal reviews will be managed;
- the frequency of formal reassessments; and
- the individualised budget.

See 8.5 What home care packages provide of the Manual for information on the possible care and services that can be delivered within the Home Care Packages Programme.

During the care planning process, the provider should take into account any supports the consumer already has in place, such as carers, family members, local community and other services. A home care package is intended to meet needs that are not already being met by these other supports.

The care plan must be supported by the consumer's individualised (package) budget.

Care planning discussions may also cover end of life planning such as advance care directives.

Goal setting and identifying care needs

Identifying goals and care needs will help consumers choose the care and services that best support them.

Before determining what services are to be provided, it is important to talk to the consumer about what they would like to achieve through their home care package – their goals.
A goal could be something like maintaining a healthy lifestyle or achieving independence in mobility.

Their goals will be shaped by their circumstances, including their health and wellbeing, cultural and personal values, and the amount of support available from family, friends and carers.

It is also important to identify a consumer's care needs, which are the areas of a consumer's life where they have been assessed as needing extra care and support. Care needs may be identified when the consumer is assessed by the ACAT and/or through their discussions with their provider during the care planning process.

Consumer involvement and control over the management of their package

Providers need to talk to their consumers about how involved they would like to be in managing and coordinating their home care package.

This could range from a high level of involvement, particularly in areas such as care co-ordination, to very little or no active involvement.

The consumer's involvement in managing their package could include, but is not limited to, choosing the services they require, making contact with service providers, negotiating fees, scheduling appointments to provide services required by the consumer and monitoring the quality of services provided.

The level of consumer involvement and control that has been agreed must be documented in the consumer's care plan. This may vary over time as the consumer's needs change. Any changes to the level of consumer involvement and control must also be documented in the care plan.

Determining who has authority to make decisions

It is important to determine who has the authority to make decisions (e.g. the individual consumer, a family member or carer, a guardian, or (in some states) a person with power of attorney). Providers need to determine who has the legal authority to make decisions.

There should be shared decision-making between the provider, the consumer (to the extent that they are able to participate) and their appointed representative (if they have one).

This will be particularly important in situations where the consumer has some degree of cognitive impairment.

8.3 Individualised budget

Section 21A of the *User Rights Principles 2014* requires that all providers give a written individualised budget to each consumer.

The provider should develop the budget in partnership with the consumer (or their representative), based on the agreed care plan.

An individualised budget must be prepared having regard to:

- the consumer's goals, assessed needs and preferences;
- the resources available to the provider to provide the home care services (that is, the value of the home care package). The value of the package consists of the subsidies and supplements paid by the Government, any fees the consumer is charged, and, for consumers who enter from 1 July 2014, the maximum income-tested care fee calculated by the Government; and
- the services selected by the consumer and set out in the care plan.

The individualised budget should be amended whenever the care plan or costs change.

The individualised budget should clearly identify the total funds available to the consumer, which is made up of:

- the Government subsidy (and eligible supplements);
- the basic daily fee, which all consumers receiving a home care package can be asked to pay;
- the income-tested care fee, payable depending on the consumer's assessable income; and
- any other amount the consumer has agreed to with their provider.

The Government does not regulate how the individualised budget must look. This provides flexibility for providers to determine how they will satisfy the requirements

Providers can continue to utilise systems or processes they may have already established to comply with the previous requirements (that were set out in conditions of allocation and the Home Care Packages Programme Guidelines). Alternatively, they can use different approaches, such as including administration costs in their unit pricing. This is a matter for the provider to determine taking into account what will be most meaningful and useful for their consumers and their business model.

Planned expenditure

This includes all costs associated with the delivery of the home care package, including the provider's costs and the cost of care and services.

Regulation of administration costs

Providers are able to charge administrative costs to cover a range of overhead or operational costs, such as insurance, workers compensation, care co-ordination and travel costs.

The Department does not set a limit on administrative costs, but expects costs to be kept to a minimum so that consumers can receive the support they need.

Review of individualised budget

Providers must review and, if necessary, revise the individualised budget for the consumer if:

- a change to the care and services to be provided to the consumer through the home care package is proposed;
- the costs of providing the care and services change; and
- the consumer requests them to do so.

8.4 Monthly statement

Once care and services commence, providers must provide the consumer with a monthly statement that clearly shows their available funds, how those funds have been spent and the balance of any unspent funds. This must be delivered to the consumer as soon as practical, after the provider has all the necessary information to complete it.

A monthly statement must specify the following:

- the amount of home care subsidy paid or payable to the provider (including eligible supplements);
- the total amount of home care fees paid or payable by the consumer;
- the total amount paid or payable by the provider in respect of the home care provided;
- an itemised list of the care and services provided to the consumer and the total amount for each kind of care or service;
- the total of any unspent funds received from any previous month; and
- that any amount of home care fees paid by the consumer to the provider that has not been spent, and that is not refundable will not be refunded to the consumer if the provider ceases to provide home care to the consumer.

The Government does not regulate how the statement must look. The provider and the consumer need to agree on the level of detail in, and the format of, the statement.

The means by which the statement is provided to the consumer, e.g. hardcopy, email or web-based, can be negotiated between the provider and the consumer.

For more information on the monthly statement, please refer to Division 3 – Responsibilities of approved providers of home care – provision of information of the *User Rights Principles 2014*.

Topping up services or additional services under a package

A consumer may choose to "top-up" their package by purchasing additional care and services through their provider. This arrangement needs to be negotiated and agreed between the consumer and the provider.

Any additional monetary contribution from the consumer to the provider for top-up services must be separately identified, either within the individualised budget or in a separate account.

In such cases, the additional care and services would be organised by the provider under the same conditions, rights and responsibilities that underpin the delivery of the home care package.

In some cases, the provider may not be able to provide or organise for care and services to be delivered as a top-up to the package. Where this is the case, the consumer (or their representative) is responsible for organising any additional care and services themselves. This would be a private matter between the consumer and a third party (another service provider) with no involvement of the provider.

8.5 What home care packages provide

Once a consumer's goals and level of involvement in the management of the package have been identified, the provider will work in partnership with them to determine what care and services are needed to support their goals and meet their care needs.

This will include who the care and services are delivered by, the timing and frequency of services, and the costs.

When a consumer is deciding what care and services they are after, they should not be limited to a list – they have a right to make choices about the types of care and services they access and how those services are delivered.

For example, a consumer may have a particular service, care worker or home care provider they would like to use. Any additional costs that may arise through setting up new arrangements must be made clear to the consumer and included in the individualised budget and monthly statement.

Whatever is agreed must be affordable within the total budget available for the package.

Care and services

For a list of care, support and services that may be provided under a home care package. Please see Schedule 3 – Care and services for home care services, Part 1 – Care and services of the *Quality of Care Principles 2014*.

This list of care and services is not an exhaustive list, and other care and services can be provided to consumers if they meet the consumer's identified care needs and goals, as identified in the care plan.

However, Schedule 3, Part 2 of the Quality of Care Principles 2014 specifies items that must not be included as part of a consumer's care plan. Refer to Excluded items in this section of the Manual.

In the delivery of care and services, all providers must meet the requirements set out in Schedule 3 – Care and services for home care services, Part 3 – Home Care Services, Division 1 – Responsibilities of approved providers, section 13 of the *Quality of Care Principles 2014*.

When a provider agrees to use the home care package to fund items that do not clearly fall in either the inclusions or exclusions lists as identified in Schedule 3 of the *Quality of Care Principles 2014,* the agreed position and the responsibilities of each party should be documented and preferably included in the Home Care Agreement between the home care provider and the consumer.

Innovative and digital technology, aids and equipment

Where safe, effective and clinically appropriate, providers are encouraged to offer innovative and digital delivery options to provide services to consumers. Home care packages may also be used to support the use of:

- **telehealth, video conferencing and digital technology** (including remote monitoring) to increase access to timely and appropriate care; and
- **assistive technology, such as aids and equipment** (particularly those that assist a person to perform daily living tasks), as well as devices that assist mobility, communication and personal safety.

Aids and equipment

The Home Care Packages Programme is not intended to be an aids and equipment scheme. However, some aids and equipment, including custom made aids, can be provided to a consumer where this is identified in their care plan and the item/s can be provided within the individual (package) budget.

An example of this is a motorised wheelchair (or motorised scooter). Given the high cost of these items, these items would be hired or leased, rather than purchased for the consumer.

The *Home Care Agreement* needs to specify whether it is leased or who owns the item and who is responsible for ongoing maintenance and repair costs, as well as what will happen to the item once the consumer leaves the package. The agreed position and the responsibilities of each party should be documented.

Excluded items

Schedule 3 – Care and services for home care services, Part 2 – Excluded items of the *Quality of Care Principles 2014* specifies the items that must not be included in a home care package. These items include:

- items that would normally be purchased out of general income;
- purchase of food, except as part of enteral feeding requirements;
- payment for permanent accommodation, including assistance with home purchase, mortgage payments or rent;
- payment of home care fees;
- payment of fees or charges for other types of care funded or jointly funded by the Government;
- home modifications or capital items that are not related to a consumer's care needs
- travel and accommodation for holidays;
- cost of entertainment activities, such as club memberships and tickets to sporting events;
- gambling activities; and
- payment for services and items covered by the Medicare Benefits Schedule or the Pharmaceutical Benefits Scheme.

Declining a consumer's request

The following list provides a guide to providers as to when it might be reasonable to decline a request from a consumer:

- The proposed service may cause harm or pose a threat to the health and/or safety of the consumer or staff;
- The proposed service is outside the scope of Schedule 3 of the *Quality of Care Principles 2014*;
- The provider would not be able to comply with its responsibilities under aged care legislation or other Commonwealth or State/Territory laws;
- The consumer's choice of service provider is outside the provider's preferred list of service providers and all reasonable effort has been made to broker an acceptable sub-contracting arrangement;
- The requested service provider will not enter into a contract with the provider;
- There have been previous difficulties or negative experiences with the consumer's suggested service provider; or
- The cost of the service/item is beyond the scope of the available funds for the package.

Where a provider is unable to give effect to the consumer's preferences or request for services, the reasons must be clearly explained to the consumer and documented.

8.6 Community Visitors Scheme (CVS)

The CVS is a national scheme that provides friendship and companionship to consumers who are socially isolated or at risk of social isolation. The CVS assists in supporting consumers to maintain their wellbeing and quality of life through social interaction.

The CVS works with providers to match volunteers with consumers. The volunteers provide friendship and companionship through one-on-one contact by visiting the consumer in their home on a regular basis.

Note: Volunteer visits accessed through the CVS are not charged to a consumer's home care package budget. Therefore, offering this scheme is an innovative way to provide the social support a consumer may need in addition to the care and services they receive as part of their care plan.

The CVS is funded by the Government and operates in every state and territory.
To locate a CVS auspice operating in your area, contact **My Aged Care** on 1800 200 422.

8.7 What if a consumer needs an interpreter?

To ensure that everyone can participate fully in the development of their care plan, home care providers are able to access free interpreting services through the Government's National Translating and Interpreting Service (TIS National) to support them in the delivery of aged care services to people from non-English speaking backgrounds.

Under this arrangement, TIS National provides on-site and phone interpreting services to the Government's subsidised home care, home support and residential aged care providers. This subsidised arrangement is a provider entitlement that is not directly linked to individual consumers.

Providers are able to access TIS National as part of their operational requirements under the Home Care Packages Programme. They can, free of charge, use TIS National to negotiate the *Home Care Agreement*, co-design the care plan and individualised budget, as well as to discuss the consumer's monthly statement.

Note: TIS National first becomes available to providers when they are working with their consumers on the *Home Care Agreement*.

Providers access services through a non-transferable TIS National code issued to the individual provider. The Department is subsequently billed for those services by TIS National.

Existing providers will already have been allocated a code and advised of this in writing. If a provider is unsure of their code, they should contact TIS National directly. New providers can register for their unique code via the TIS National website.

Interpreters outside the operational requirements of the programme

For providers who require an interpreter for their consumer outside of the operational requirements of the programme (for example, when consumers are receiving personal care and services as part of their care plan) all costs incurred should be paid for by the consumer's available funds.

These additional costs should be made clear to the consumer prior to the *Home Care Agreement* being entered into. Whatever is agreed must be affordable within the total budget available for the consumer's package.

9. Commencement of services

Once a consumer has signed their *Home Care Agreement*, their care and services can begin. Their package starts on the day the *Home Care Agreement* is signed, not from the day that care is first delivered.

Care and services will be delivered according to the care plan, as co-produced by the provider and the consumer.

9.1 How long does a consumer stay in a home care package?

A consumer can stay in the home care package for as long as they need to, as long as the provider is delivering services as agreed and the consumer is meeting their obligations, such as paying their fees. This is called 'security of tenure'.

The *Home Care Agreement* must specify how either party may terminate the *Home Care Agreement* and must not contradict the security of tenure provisions set out in the *User Rights Principles 2014*.

9.2 Monitoring, review and re-assessment

Providers are responsible for ensuring that the needs of their consumers are being met on an ongoing basis. This requires ongoing monitoring or review of the appropriateness of the package, including whether the consumer's goals and care needs are being met and whether the consumer is satisfied with the services being received.

Review is a continuous process between the provider and the consumer. This review is informed by observations and feedback from staff and service providers who are in contact with the consumer.

Note: Although a consumer may choose to have an active role in the management of their package, they should not take on the functions of a case manager. Ongoing monitoring, reviews and re-assessment must be undertaken by the provider, not by the consumer.

The case management role should not generally be sub-contracted to another provider, although this may be necessary in some cases (particularly for special needs groups or in rural and remote locations).

Re-assessment by the home care provider

Note: This section refers to the formal review (re-assessment) of the consumer by the home care provider, not an assessment undertaken by the ACAT.

If a consumer's care needs change, and they require different care and services to meet them, the provider may need to review the consumer's care plan and individualised budget. This needs to be done in partnership with the consumer.

Reasons for a re-assessment may include:

- a request by the consumer;
- a request by a carer;
- a health crisis or episode;

- a change in care need that cannot be met within the budget available for the package;
- a change in living or carer arrangements;
- ongoing or increasing use of clinical services by a consumer; and
- a change in the costs of providing the care and services.

When reviewing the consumer's care plan, the provider must consider the consumer's needs, goals and preferences.

Note: A provider cannot change a consumer's care plan without their agreement.

The consumer should not be able to opt out of the formal re-assessment, although the scheduling and style of the re-assessment should match the consumer's preferences, wherever possible.

Support for consumer following re-assessment by home care provider

A re-assessment of a consumer's care needs could lead to significant changes in the types of support they receive. The provider should support the consumer, as much as possible, in any changes resulting from the review of their care plan.

What happens if a consumer's care needs have increased?

A consumer's care needs may increase significantly so that the person potentially requires home care in a higher band (e.g. Level 3 or 4, rather than Level 1 or 2), or entry to residential care. In these circumstances, the consumer will need another assessment by an ACAT. Providers can assist in arranging the ACAT assessment, with the permission of the consumer.

If the consumer is already in receipt of a Level 4 package, they may need to consider other options including:

- reviewing their care plan to identify alternatives and priorities (for example, reducing higher cost services, such as support on weekends, and replacing with informal supports)
- purchasing additional services
- the benefits of residential care, either as short-term respite to complement their package or as a long-term option.

The consumer will still have security of tenure of their package, and must continue to receive care and services as agreed, until they notify the provider in writing that they wish to terminate their *Home Care Agreement*, if they wish to do so.

9.3 Leave provisions

Under section 46.2 of the *Aged Care Act 1997*, a consumer may take temporary leave from their home care package for any reason, such as for a hospital stay that may be followed by transition care, to receive respite care, or social leave.

For this to occur, the consumer must request the provider to suspend their home care package and specify the commencement date.

Note: A consumer's security of tenure is not affected while they are on leave.

Leave arrangements are the same across all four home care package levels.

Impact of suspension on the home care subsidy

The following table provides information about how the subsidy is paid to providers in relation to suspending the *Home Care Agreement*:

Type of suspension	Impact on payment of subsidy to provider
Hospital **Transition care**	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 **consecutive** days in a financial year, for each episode of hospitalisation or transition care at a particular package level. • After 28 **consecutive** days, the subsidy is payable at 25 per cent of the basic subsidy rate.
Residential respite care **Social leave (all other suspension types)**	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 **cumulative** days in a financial year at a particular package level. • After 28 **cumulative** days, the subsidy is payable at 25 per cent of the basic subsidy rate.

Impact of suspension on consumer fees (care fees)

A consumer may be required to pay an ongoing care fee to the provider while the consumer is on leave from their package. This amount must be no more than the usual fee agreed between the consumer and the provider.

For information on the impact of suspension on consumer fees, please refer to:

- Division 46, section 46-2 of the *Aged Care Act 1997* and *Aged Care (Transitional Provisions) Act 1997*;
- Division 2, section 72 of the *Subsidy Principles 2014;*
- Section 108 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014;*
- Division 5, Part 4, subsection 130(5) of the *Aged Care (Transitional Provisions) Principles 2014*.

Existing consumers at 30 June 2014

Consumers who were receiving a home care package on or before 30 June 2014 cannot be asked to pay home care fees while the consumer's package has been suspended and the consumer is receiving transition care or residential respite care.

Consumers on a home care package on or after 1 July 2014

These consumers can continue to be asked to pay the income-tested care fee (if any) while their package is suspended.

The full fee must be paid for up to 28 days (see above table), after which the consumer will pay whichever is the lesser of:

- their income-tested care fee, as previously advised; and

- the amount of the reduced home care subsidy, plus the primary supplements payable.

Note: Providers cannot charge consumers who entered into a *Home Care Agreement* on or after 1 July 2014 the basic daily fee when the consumer takes leave for **residential respite or transition care**.

Impact of suspension on monthly statements

Any subsidy, relevant supplements or care fees paid to the provider while the consumer is on leave must be included in the consumer's monthly statement.

9.4 When consumers leave a home care package

If a consumer decides to leave a home care package, they will need to advise their provider in writing.

When a consumer moves to a location outside their provider's area

As home care packages are allocated to providers, the consumer's package does not transfer with them in these circumstances.

Consumers who move to a new location that is not within a service provider's area (as outlined in their conditions of allocation) will need to find a new provider with an available suitable home care package in the new location.

The consumer may ask the provider to assist with their transition to a new provider. The provider should ensure continuity of service delivery during the transfer and assist, where possible, to arrange services in the new location.

Once the consumer finds a new provider, they will need to enter into a new *Home Care Agreement* and develop a new care plan with them. They will not need to be reassessed by an ACAT/ACAS unless their care needs have changed significantly.

Unspent funds when a consumer leaves a package

When a consumer leaves a package, there may be unspent funds in the budget. It depends on the circumstances as to how these unspent funds are used.

If a consumer moves to a higher level package with the same provider, any unspent funds must be available for them to use in their higher level package.

A consumer is not entitled to a refund of unspent home care fees if they cease to receive care from their provider. The only amounts of home care fees that are refundable are fees that have been overpaid by the consumer and any fees paid in advance of the date from which the services cease.

10. Rights and responsibilities

10.1 Rights and responsibilities of an approved provider

Approved providers have a number of responsibilities under the *Aged Care Act 1997*. These responsibilities relate to:

- *Quality of Care Principles 2014* – Part 4.1 of the Act; which relate to the care and services that a provider of home care is to provide and the Home Care Standards that a home care provider is expected to meet as a part of quality review;
- *User Rights Principles 2014* – Part 4.2 of the Act, which covers the rights of the consumer; and,
- *Accountability Principles 2014* – Part 4.3 of the Act, which covers accountability for the care that is provided, including the suitability of their key personnel.

For those approved providers who do not meet their responsibilities, compliance action, including sanctions, under Part 4.4 of the Act may be taken.

For more information on the rights and responsibilities of approved providers, refer to Section 2.2 Responsibilities & Obligations of the Guide to Aged Care Law.

Qualifications of staff and workers

The Department does not set specific levels of qualifications or training for case managers or workers involved in the delivery of home care packages. However, it is expected that case managers, care co-ordinators and care workers will have the appropriate level of skills and training to provide quality care to consumers and to ensure the provider meets its responsibilities.

Providers should regularly monitor roles and tasks of case managers, co-ordinators, staff and sub-contractors to ensure that all staff and workers are adequately trained, supported and supervised, where required.

The Home Care Standards apply to the delivery of home care packages. They are contained in Part 3, Division 2 of the *Quality of Care Principles 2014*.

Sub-contracted or brokered services

Providers should, wherever possible, facilitate services being delivered by the person chosen by the consumer. Where this is not possible, providers should explain this to consumers in a manner they understand.

Services may be provided directly by the provider, sub-contracted to another service provider (individual or organisation), or brokered through another organisation.

Regardless of how services are delivered and by whom, the provider remains responsible for service quality and meeting all regulatory responsibilities.

The provider should always inform the consumer of any risks or additional costs of purchasing services from another source. These costs should not be unreasonable.

Providers are encouraged to develop a list of 'preferred service providers' to support consumers' needs and choices and to build relationships with other organisations that specialise in providing services to people from special needs groups.

When consumers request that services be provided by particular individuals or service providers

The consumer can request that services be provided by a particular individual or service provider, for example, someone who has previously provided services to the consumer.

In such cases, the provider is still responsible for ensuring that the police check requirements are met, and for ensuring that the worker is appropriately qualified and trained for the service being provided.

Contracting to informal carers, family members or friends

Contracting service provision to informal carers, family members or friends is not encouraged under the Home Care Packages Programme. However, it is recognised there may be no workable alternative in some areas (for example, remote parts of Australia).

Providers should consider the following factors when considering whether to contract service provision to informal carers, family members or friends of the consumer:

- elder abuse safeguards;
- their responsibility for service quality, including the need to include the person providing the service in the provider's employee, volunteer or sub-contractor systems;
- legal responsibilities, including ensuring that police check requirements are met;
- industrial implications;
- insurance requirements;
- workplace health and safety; and
- qualifications and training required to provide certain types of care.

Carers may be eligible for support and assistance from the Government through programmes such as the Carer Allowance or Carer Payment. These programmes are administered by DHS and are not part of the Home Care Packages Programme. Further information is available at the DHS' Carers webpage.

Duty of care and dignity of risk

The following information has been developed through the *Home Care Today* Legal Issues project and may assist you with working through your duty of care while providing your consumer with dignity of risk.

Duty of care is the obligation of a person to exercise reasonable care in the conduct of an activity. Breach of that duty which causes damage or loss to another may give rise to a claim for damages. Workers have a responsibility to their clients to **reduce** or **limit** the amount of harm or injury they may experience. This responsibility is known as 'duty of care' and it can sometimes seem overwhelming. For example, our responsibility to one party (for example, our employer) might conflict deeply with our responsibility to our clients. It helps to remember that duty of care is a balancing act.

There are several aspects to duty of care:

- **Legal** - What does the law suggest we do?
- **Professional/ethical** - What do other workers expect us to do?
- **Organisational** - What does our organisation, and its funding body, say we should do?
- **Community** - What do the family members of our clients and other community members expect us to do?
- **Personal** - What do our own beliefs and values suggest we do?

The following steps provide a guide for a process that can be used to work through issues that have legal or ethical implications.

1. Discover: Discover the person's identity and preferences, and reasons for seeking assistance. Identify their support networks and if they wish to nominate a representative to act on their behalf.

2. Discern and Dream: Explore the person's goals and creative options to support health, wellbeing, maintaining roles and independence.

3. Duty of Care: Act with due care and skill, providing relevant information to enable the person to make informed choices.

4. Dignity of Risk: Respect the person's autonomy and self-determination to make choices for themselves and take calculated risks.

5. Discuss: Work through the options and choices, outlining the consequences and any potential limits to the choices available. Work together to discern the best response to the person's needs within the resources available, balancing duty of care and dignity of risk.

6. Do: Work with the person's choices and think about how their requests can be fulfilled safely.

7. Decline: You can decline a request if the service is outside of the scope of home care packages or you have good reason to believe that the person's choices may cause harm or pose a threat to the safety of the person or staff, volunteers or contractors.

8. Document: Document your discussions, the information you have provided and the choices that the person has made to demonstrate that you have met your duty of care.

9. Disclaimer: Where a person has chosen a course of action that may involve a risk, the provider may ask the person or their representative to sign an indemnity form.

10. Disagreement: Working through this process should lead to agreement but if this is not possible then the person should be made aware of the complaints process, their right to access the National Aged Care Advocacy Line and the Aged Care Complaints Service.

For more information, please refer to the 'Practice Guidance on the legal issues in consumer directed care' document which has been developed through the *Home Care Today* Legal Issues project.

Quality Reporting Programme

All providers are required to undertake a quality review by the Australian Aged Care Quality Agency (AACQA) during each three-year cycle.

These reviews encourage providers to improve the quality of their service delivery within a continuous improvement model and show how they are addressing the Home Care Standards.

The Home Care Standards set the standards for the quality of care and services for the provision of home care to older Australians. The standards require:

- service providers to demonstrate effective management processes based on a continuous improvement approach to service management, planning and delivery
- the standards also require each consumer (current and prospective):
    - has access to services and consumers receive appropriate services that are planned, delivered and evaluated in partnership with themselves and/or their representative
    - is provided with information to assist them to make service choices and has the right (and responsibility) to be consulted and respected.
    - have access to complaints and advocacy information and processes and their privacy and confidentiality and right to independence is respected.
- each provider to demonstrate it has effective management processes based on a continuous improvement approach and ensure all consumers (current and prospective).

The Home Care Standards apply to the delivery of home care packages. They are contained in Part 3, Division 2 of the *Quality of Care Principles 2014*.

Further information about the Home Care Standards and Quality Reporting arrangements is available on the Department's website.

For more information on the AACQA, go to their website.

Police checks and certificate requirements

Providers are required under Part 6, Section 47 of the *Accountability Principles 2014* to ensure that police certificates, not more than three years old, are held by:

- all staff members who are reasonably likely to have access to consumers
- volunteers who have, or are likely to have, unsupervised access to consumers.

The provider must be satisfied that the police certificate does not record that the person has been:

- convicted of murder or sexual assault
- convicted of, and sentenced to imprisonment for, any other form of assault.

Any person with a conviction for such offences listed above must not be allowed to provide any care or ancillary duties.

Volunteers provided by the CVS have a police certificate and have been assessed as meeting the requirement.

Staff member

A staff member is defined in Part 1, Section 4 of the *Accountability Principles 2014* as a person who:

- is at least 16 years old; and
- is employed, hired, retained or contracted by the provider (whether directly or through an employment or recruitment agency) to provide care or other services under the control of the provider; and
- has, or is reasonably likely to have, access to consumers.

Volunteer

Under Part 1, Section 4 of the *Accountability Principles 2014*, a volunteer is defined as a person who:

- is not a staff member of the provider; and
- offers his or her services to the provider; and
- provides care or other services on the invitation of the provider and not solely on the express or implied invitation of a consumer; and
- has, or is reasonably likely to have, unsupervised access to consumers; and
- is at least 16 years old or, if the person is a full-time student, is at least 18 years old.

Key Personnel

Additional conditions apply to key personnel. Part 2 of the *Sanctions Principles 2014* outlines the reasonable steps to be taken by an approved provider to ensure none of its key personnel is a disqualified individual.

The provider must:

- obtain (with the person's written consent) a police certificate for the person;
- conduct a search of bankruptcy records;
- conduct previous employment and referee checks;
- ensure the person understands the obligations of the Act in relation to disqualified individuals;
- be satisfied the person is mentally capable of performing the duties as key personnel or make arrangements for the person to be examined by a registered medical practitioner; and
- ensure a disqualified individual ceases to be one of the provider's key personnel.

Part 6 of the *Accountability Principles 2014* and Section 9 of the *Records Principles 2014* outline the responsibilities of providers in relation to police checks or police certificates (the names are used interchangeably) for staff members, contractors and volunteers.

Contractors

Where a provider has a contract with an agency that provides staff who work under the control of the provider, the contracted individuals may be considered staff members under Section 4 of the *Accountability Principles 2014*. Sub-contractors who work under the control of the provider may also be considered as staff members under the Act.

The contract between the agency and the provider should state that staff must have a current police certificate, which does not preclude them from working in aged care.

Independent contractors

Police check requirements are not intended to extend to people engaged on an ad hoc basis. For example, trades people engaged as independent contractors generally do not require police checks. The policy intention is to allow for reasonable judgments to be made.

Regardless of how services are delivered and by whom, the provider remains responsible for service quality and meeting all regulatory responsibilities.

Services that are also provided to the public at large, such as a gym, would generally be regarded as services provided by independent contractors. If a home care consumer is attending a gym as part of his/her package, the provider is not required to ensure that staff or employees of the gym have undergone a police check (unless the person is also a staff member of the approved provider).

Visiting medical practitioners, pharmacists and other health professionals who have been requested by, or on behalf of, a consumer but are not under contract to the provider also do not require police checks.

Providers have an overarching responsibility to protect the health, safety and wellbeing of consumers, and independent contractors and health professionals should be subject to appropriate supervision.

Providers can use the following indicators as a guide to establish whether a person is an independent contractor:

- the contractor has an ABN;
- the contractor advertises his or her services;
- the contractor has clients other than the provider;
- the provider does not determine the working hours and wages of the contractor;
- the provider does not make superannuation payments on behalf of the contractor; and
- the provider does not pay the contractor holiday pay or sick leave.

The difference between a contractor and an independent contractor is generally decided on the basis of the degree of control that is exercised over the person's work. A precise determination of whether a contractor is under the control of an approved provider can be difficult, and whether someone is a staff member or an independent contractor is a matter that might ultimately be determined by the courts.

To assist employers to determine whether an individual is a staff member or an independent contractor, a Contractor Decision Tool is available at the business.gov.au website.

Further information about police checks is available:

- online: at the Police Certificate Guidelines for Aged Care Providers webpage
- by phone: 1800 200 422
- in writing to:
  - the Department's inbox agedcare.police.checks@dss.gov.au

- Aged Care Police Checks
  Aged Care Quality and Compliance Group
  Department of Social Services
  PO Box 7576
  CANBERRA BUSINESS CENTRE ACT 2610.

10.2 Rights and responsibilities of a consumer

The rights and responsibilities of consumers are set out in the *Charter of care recipients' rights and responsibilities – Home Care* (the Charter). The Charter is contained in Schedule 2 to the *User Rights Principles 2014*.

Providers should clearly explain a consumer's rights and responsibilities to them and provide a copy of the Charter to them with their *Home Care Agreement*.

For more information on the rights and responsibilities of consumers, refer to the Charter on the Department's website.

Advocacy

Consumers can request that another person of their choice assist and/or represent them in managing their care, such as:

- establishing or reviewing the *Home Care Agreement* and care plan;
- negotiating the fees the consumer may be asked to pay by the provider; and
- presenting any complaints the consumer may have.

Providers must accept the consumer's choice to be supported by an advocate and allow an advocate acting for an authorised body access to the home care service if the consumer or their representative has requested the assistance of such a person.

National Aged Care Advocacy Programme (NACAP)

Should the consumer require advocacy support, they can access advocacy services through the Government funded NACAP.

Under the *Aged Care Act 1997*, NACAP services look after people who are, or are going to, receive a home care package or residential aged care services.

NACAP organisations provide free, confidential and independent advocacy support and information to consumers (or potential consumers) and their families and carers about their rights and responsibilities when accessing aged care services.

NACAP services:

- support consumers to be involved in decisions that affect their life and care needs;
- provide consumers with information and advice about their rights and responsibilities;
- assist consumers to resolve problems or complaints in relation to aged care services, through the provision of advocacy; and
- promote the rights of consumers to aged care service providers.

Consumers can contact a NACAP provider in their area on 1800 700 600 or visit the Department's website for further information.

Complaints

If consumers are concerned about any aspect of service delivery, they are encouraged to approach the provider, in the first instance. In most cases, they will be best placed to resolve any complaints and alleviate the consumer's concerns.

The provider needs to accept a complaint regardless of whether it is made orally, in writing or anonymously. The provider must also have appropriate processes in place to receive, record and resolve complaints. The provider should inform their consumers about how they can access these processes and they should be identified in the *Home Care Agreement*.

These processes should take into consideration people with special needs, such as people with vision or hearing impairments and people from culturally and linguistically diverse backgrounds.

Note: Providers must not discontinue care or services, refuse access or otherwise take action against any person because they have made a complaint. Providers must also handle and address any complaints fairly, promptly and confidentially.

It is important that home care providers record, monitor, collate and analyse trends in complaints so that this information can be used to improve services.

Providers should also actively encourage consumers to provide feedback about the services they receive.

Aged Care Complaints Scheme

The Aged Care Complaints Scheme (the Complaints Scheme) is a free service for people to raise their concerns about the quality of care or services being delivered to people receiving Government subsidised aged care services.

Providers must make information available about the Complaints Scheme, including contact information.

The Complaints Scheme can be contacted on 1800 550 552. Complaints can also be made in writing via the Complaints Scheme webpage.

When a complaint is made, a staff member from the Complaints Scheme will explain the process to the complainant, including options for resolution and what can be achieved through those options.

Options for resolution open to the Complaints Scheme include:

- asking the provider to resolve concerns directly with the complainant and report back to the Complaints Scheme on the outcomes;
- conciliating an outcome between the provider and the complainant; or
- investigating the concerns.

The Complaints Scheme assesses quality of care and services in line with a provider's responsibilities under the Act including those outlined in:

- the 'Charter of care recipients' rights and responsibilities – home care'
- the Home Care Standards.

The Complaints Scheme has the capacity to require a provider to take action where they are not meeting these responsibilities.

More information can be found on the Complaints Scheme webpage.

The processes of the Complaints Scheme, including options for resolution, are governed by the *Complaints Principles 2014* under the Act.

For more information on the *Complaints Principles 2014*, go to the Guide to Aged Care Law.

11. Reporting and administrative responsibilities

11.1 Conditions of allocation to replace agreements

Since 1 August 2013, there has been no requirement for providers to enter into an agreement with the Commonwealth in respect of allocations of new home care places. This came into effect when Schedule 1 to the *Aged Care (Living Longer Living Better) Act 2013* and the transitional provisions in the *Allocation Principles 1997* commenced.

Conditions of allocation

The conditions of allocation for home care places form part of the Notice of Allocation issued to the provider under section 14-8 of the *Aged Care Act 1997*.

11.2 Commencement of places

An allocation of places to an approved provider takes effect when the Secretary of the Department (or delegate) determines that the provider is in a position to provide care in respect of those places. The provider will be advised of this through a Notice of Allocation from the Department issued under section 14-8 of the *Aged Care Act 1997*.

Places may be allocated with immediate effect (from a specified date), or on a provisional basis (if the approved provider is not ready to commence the place immediately).

If the place has been allocated on a provisional basis, the provider must advise the Department in writing when they are able to commence providing services. A provider must apply in writing to the Secretary using the form titled 'Application for a Determination that an Approved Provider is in a Position to Provide Care – Home Care'. This application form is available on the Management of Places Forms for Approved Providers page of the Department's website.

Once this information has been considered by the Department, the delegate will make a determination under section 15-1 of the *Aged Care Act 1997*, and once approved, this will enable the provider to commence claiming a subsidy for the place. Such determinations cannot be backdated.

11.3 Variations, transfers and surrender or relinquishment of places

Variations of places

A provider can apply to the Secretary of the Department to vary an allocation of places (home care packages) in certain circumstances, for example, to change conditions of allocation relating to geographic locations or special needs groups.

The application form 'Application to vary conditions of allocation' is available on the Management of Places Forms for Approved Providers page of the Department's website.

A variation cannot take effect unless it has been approved by the Secretary.

An application for a variation of places should not be made in the following circumstances:

- Where a provider is seeking to change the name of a service as this does not have to be done via an application form. However, the provider should advise the Department in writing.
- To approve a variation in the level of the home care package that has been allocated to a provider, for example, from a Level 1 or 2 place to a Level 3 or 4 place. There is no capacity under the legislation. Providers seeking to obtain places at a different level should apply through the Aged Care Approvals Round.

Transfer of places

The provider may apply in writing to the Secretary of the Department to transfer operational places under sections 16-1 and 16-2 of the *Aged Care Act 1997*.

The 'Application form to transfer aged care places to another provider' is available on the Management of Places Forms for Approved Providers page of the Department's website. The application form must be completed by both the provider holding the allocation of places (the transferor) and the party seeking the places (the transferee). If the places proposed to be transferred are to be allocated to more than one service, a separate application form must be submitted in respect of each service.

A transfer of a place cannot take effect unless it has been approved by the Secretary. An application to transfer places can only be considered in respect of operational places, not provisionally allocated places.

Surrender or relinquishment of places

While a provider would not normally surrender or relinquish an allocation of places, there is capacity to do this under the Act.

In these circumstances, the provider should contact the relevant state or territory office of the Department.

11.4 Home care subsidy payments

Home care subsidies are calculated on a daily basis where there is a consumer receiving care through a package.

They are paid monthly in advance, based on the number of home care places occupied in the second last preceding payment period. For example, a payment to a provider for March is based on occupied places claimed for in January.

Monthly payments may include an adjustment to account for any over or under-payment in the previous month.

Subsidy payments are made through the DHS aged care payment system, on behalf of the Department.

The home care subsidy can only be paid once the *Home Care Agreement* has been entered into. The subsidy cannot be claimed for discussions/meetings with the consumer (or carers and family members) or any services provided to the consumer before the *Home Care Agreement* is entered into.

Initial payments

A provider's initial payment claim form covers the payment period from the date when the home care places become operational.

The initial payment of the subsidy to a new provider is usually based on the provider's estimated number of consumers in the first month of operation. This is up to the maximum number of home care places allocated to the provider.

After the initial payment period, future monthly payments are adjusted according to the actual number of consumers in the preceding payment periods.

For more information about the home care subsidy, refer to the *Aged Care Act 1997*, the *Subsidy Principles 2014*, or the Guide to Aged Care Law.

11.5 Financial reporting to the Department

Division 4 – Responsibilities of approved providers for home care services of the *Accountability Principles 2014*, sets out a provider's financial reporting responsibilities to the Department.

Taxation matters

Goods and Services Tax (GST)

Home care subsidies are considered to be "GST free" under section 38-30 of the *A New Tax System (Goods and Services Tax) Act 1999*.

The introduction of monthly statements has highlighted the treatment of GST and whether or not the GST should be passed onto the consumer. Although the Department advises that providers need to seek their own financial and taxation advice when applying commonwealth tax law, home care providers may like to refer to the next section of the manual 'A new tax system (Goods and Services Tax) Act 1999 – Sect 38.30'

A new tax system (Goods and Services Tax) Act 1999 – Sect 38.30

(1) A supply of * home care is GST-free if home care subsidy is payable under Part 3.2 of the *Aged Care Act 1997* or Part 3.2 of the *Aged Care (Transitional Provisions) Act 1997* to the supplier for the care.

(2) A supply of care is GST-free if the supplier receives funding under the Home and Community Care Act 1985 in connection with the supply.

(3) A supply of * home care is GST-free if the supply is of services:

(a) that are provided to one or more aged or disabled people

(b) that are of a kind covered by item 2.1 (daily living activities assistance) of Part 2 of Schedule 1 to the * Quality of Care Principles.

(4) A supply of care is GST-free if:

(a) the supplier receives funding from the Commonwealth, a State or a Territory in connection with the supply

(b) the supply of the care is of a kind determined in writing by the * Aged Care Minister to be similar to a supply that is GST-free because of subsection (2).

Other taxation matters

A provider must be able to quote its ABN in any GST dealings with the ATO or other government departments and agencies, including the Department and DHS.

If a provider does not have an ABN, it cannot be registered for GST, cannot charge GST and does not have any entitlement to input tax credits.

Providers should give their ABN to the Department and DHS so they can process and report payments correctly. Providers who do not supply their ABN may be subject to withholding tax.

New home care providers

To enable initial payments, or to change bank details to enable ongoing payments, providers must supply their aged care service's bank details to DHS via a form. The form is available on the DHS aged care forms webpage. The form is titled 'Add or Change Approved Aged Care Service's Bank Details'.

Aged Care Approved Provider Statement

An 'Aged Care Approved Provider Statement', signed by key personnel of an approved provider to advise that appropriate business and security controls are in place, is required every three years. It ensures all aged care forms, claims and other relevant documentation to claim payments of subsidy under the *Aged Care Act 1997* are appropriately authorised. The provider statement only needs to be completed if the provider with services is not registered for Aged Care Online Claiming.

The current provider statement is valid for the period 1 July 2014 to 30 June 2017. The next statement is due 30 June 2017 and will be sent to providers with services not registered for Aged Care Online Claiming from DHS in April 2017.

For more information about claiming the home care subsidy, refer to the DHS claiming page.

12. Interface with other programmes and schemes

The Home Care Packages Programme does not have policies that restrict access to other programmes and schemes. Therefore, it may be possible for a consumer to receive care and services through a range of other programmes and schemes that they cannot receive as part of a home care package.

These programmes and schemes include:

- Transition Care Programme;
- Community Visitors Scheme;
- Disability Programmes;
- Continence Aids Payment Scheme;
- Palliative Care; and
- Department of Veteran's Affairs Programmes

More detailed information about the individual programmes is available on the My Aged Care website or the national contact centre on 1800 200 422.

For information about how other programmes or schemes interact with the Home Care Packages Programme, please refer to information on the programme or scheme you are interested in.

Commonwealth Home Support Programme (CHSP)

In certain circumstances, consumers are able to receive care and services through the CHSP on a time limited basis when they are in a home care package (that is, the additional CHSP services will not be charged to the consumer's individualised budget).

These circumstances include:

- Where a Level 1 or 2 home care package consumer's budget is already fully allocated, they can access additional, short-term or episodic Allied Health and Therapy services or Nursing services from CHSP
- Where the consumer's budget is already fully allocated, and a carer requires it, a consumer can access additional planned respite services under CHSP
- In an emergency (such as when a carer is not able to maintain their caring role), where a consumer's budget is already fully allocated, additional services under the broader CHSP can be obtained on an emergency or short term basis.

These instances should be time limited, monitored and reviewed.

Please see the CHSP Programme Manual for more information.

13. Glossary of terms

Term	Meaning
ACAR	Aged Care Approvals Round
ACAT	Aged Care Assessment Team. ACATs are known as Aged Care Assessment Services (ACAS) in Victoria
ACFA	Aged Care Financing Authority
Act	*Aged Care Act 1997*
basic daily fee	Refers to the contribution that a consumer may be asked to pay by a home care provider under a home care package (separate to the Government subsidy). Also known as a care recipient contribution, care recipient fee or consumer fee
CDC	Consumer directed care
claim form	The DHS form used by home care providers to claim home care subsidy payments
Consumer	A person who is receiving care and services under a home care package funded by the Australian Government. In the *Aged Care Act 1997*, this person is described as a "care recipient" In these Guidelines, references to the consumer include other people who are authorised to act on behalf of the consumer
Commonwealth Home Support Programme	This programme provides home and community care services for frail older people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over. The Commonwealth Home Support Programme does not currently apply in Victoria and Western Australia
Department	Department of Health
DHS	Department of Human Services
DVA	Department of Veterans' Affairs
EACHD	Extended Aged Care at Home Dementia package
home care	A type of aged care for which a home care subsidy is payable under Part 3.2 of the *Aged Care Act 1997* and *Aged Care (Transitional Provisions) Act 1997*
home care consumer (or consumer)	A person who is receiving care and services under a home care package funded by the Australian Government. In the *Aged Care Act 1997*, this person is referred to as a "care recipient"
home care provider (or approved provider)	An organisation approved by the Department of Health under Part 2.1 of the Act as suitable to provide home care. In the *Aged Care Act 1997*, this person or body is referred to as an "approved provider"

Term	Meaning
Home Care Agreement	An agreement entered into by a consumer and a home care provider outlining rights and responsibilities and what services will be provided to the consumer under the home care package
Home Care Packages Programme	The Australian Government programme that provides funding for home care packages aimed at supporting people to remain living at home
Home Care Standards	The Home Care Standards means the 'Home Care Common Standards', as set out in Schedule 4 to the *Quality of Care Principles 2014*
home care subsidy	The subsidy payable to a home care provider by the Australian Government under Part 3.2 of the *Aged Care Act 1997* and *Aged Care (Transitional Provisions) Act 1997*
Income-tested care fee	Refers to the fee a consumer may be asked to pay for their home care, based on an income assessment
NACAP	The National Aged Care Advocacy Programme is funded by the Australian Government and provides advocacy support and promotes the rights of people who are seeking or are receiving Australian Government funded aged care services
Principles	Aged Care Principles made under section 96-1 of the *Aged Care Act 1997* and *Aged Care (Transitional Provisions) Act 1997*
suspension	Term used when a consumer takes a period of leave from their home care package, and some or all services are suspended

Australian Government
Department of Health

Home Care Packages Program

Operational Manual for Home Care Package consumers

Version 1 – March 2020

Contents

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1 Introduction

1.1 Helping you stay at home

The Australian Government funds a range of aged care services delivered in the community to support senior Australians to live independently in their own home for as long as possible. These are:

- entry level home support – ongoing or short-term entry level services provided under the **Commonwealth Home Support Programme**;
- more coordinated support at home - coordinated support packages that address your care needs and goals through the **Home Care Packages Program**. There are four levels of packages ranging from low care needs to high care needs.

You can plan for your future by thinking about your aged care needs and personal goals early. Planning ahead improves your ability to live independently and to have your wishes respected when the time comes to access aged care services. Having these conversations with your family, doctor and other support people will ensure you are better prepared for the future.

My Aged Care has further information on how to start planning for your future aged care needs. The My Aged Care website is www.myagedcare.gov.au.

1.2 What does the manual contain?

This manual is for the Home Care Packages Program, which enables coordinated support at home. The manual is a part of a suite of information resources including:

- 'Your pathway to accessing a home care package' brochure;
- 'Your guide to Home Care Package services' booklet; and
- fact sheets and other information that may be of interest.

You can find all of these resources by going to www.myagedcare.gov.au, scrolling to the bottom of the homepage and selecting "Resources" under "Further Information".

This manual has the most detailed information on the Home Care Packages Program. It takes you through the Home Care Packages Program from how to access a Home Care Package, what costs are involved and the care and support you can receive. You can also speak to your provider for more information.

This manual contains 1800 numbers you can contact for further assistance. Calls to 1800 numbers are generally free when made from a landline. All calls made from mobile phones are charged at the rates applicable to each telephone provider.

1.3 Who has a role in providing home care?

This manual refers to a number of stakeholders that have a role in the aged care system in Australia. It is important to understand the role everybody plays.

Stakeholder	Role
Consumer	A consumer is a recipient of a Home Care Package.
Carer	A carer is a family member, friend or other person who provides ongoing care and support to you.
Nominated representative	A nominated representative is someone who you have given permission to: • give information on your behalf; and • receive information on your behalf. They may be a family member, friend, carer or other person. Your representative can be: 1. regular or 2. authorised. If you are able to give someone consent to speak and act for you, they can be set up as a regular representative. A regular representative can speak and act for you, but they must: • get your permission before discussing your personal My Aged Care information with anyone; and • consult you on all decisions and actions they make on your behalf. If you are not physically or medically able to give consent to someone to speak on your behalf, you can set up an authorised representative.

Stakeholder	Role
	An authorised representative can speak and act for you, but they must: • ensure that decisions and actions made on your behalf are in your best interest; and • keep your personal My Aged Care information confidential. They must not disclose your information to any unauthorised persons. You do not have to have a representative if you do not want to.
My Aged Care	My Aged Care is both a website and a contact centre and the main entry point to the aged care system in Australia. My Aged Care aims to make it easier for senior Australians, their families, and carers to: • access information on ageing and aged care; • have their needs assessed; and • be supported to find and access services.
Aged Care Assessment Team	Aged Care Assessment Teams (ACAT) are teams of medical, nursing and allied health professionals. They assess your care needs and help you to access appropriate levels of support. ACATs conduct comprehensive aged care assessments. ACAT are called Aged Care Assessment Services (ACAS) in Victoria.
Approved providers	Approved providers deliver aged care in Australia. This is the organisation that you will interact with the most in managing your Home Care Package. Throughout this manual, approved providers are frequently referred to as providers.
Department of Health	The Australian Government Department of Health is responsible for the policy, funding and administration of the aged care system. The Department of Health sets policy for the aged care system and provides information to both yourself and providers in relation to each aged care program.

Stakeholder	Role
Services Australia (formerly Department of Human Services)	The Australian Government Services Australia provides income assessment services to senior Australians. This is an important step in understanding how much home care services will cost you. It also administers the payment system for Home Care Packages. This includes paying approved providers a subsidy on behalf of the Department of Health.
Department of Veterans' Affairs	The Australian Government Department of Veterans Affairs (DVA) conducts aged care income assessments for eligible veterans, their partners and war widow(er)s who receive a relevant entitlement. Once the level of assessable income for aged care is assessed by DVA, this information is provided to the Services Australia who will advise you of the outcome of the assessment and the home care fees you may be asked to pay. DVA also provides home care services to eligible veterans and their families.
Aged Care Quality and Safety Commission	The role of the Aged Care Quality and Safety Commission (Commission) is to protect and enhance the safety, health, well-being and quality of life of people receiving aged care. The Commission independently accredits, assesses and monitors aged care services subsidised by the Australian Government. The Commission also responds to feedback and complaints received about approved providers. For more information on making a complaint, you can read Section 8.2 of this manual.

1.4 How will this manual be updated?

The Department of Health will use their best endeavours to keep this manual up to date and accurate.

Please use the online version of the manual located on the My Aged Care website. You can find this manual by visiting this link: https://www.myagedcare.gov.au/publications/home-care-packages-manual-pdf.

1.5 Do you have further questions?

If you have further questions you can call the My Aged Care contact centre on **1800 200 422**.

2 The Home Care Packages Program

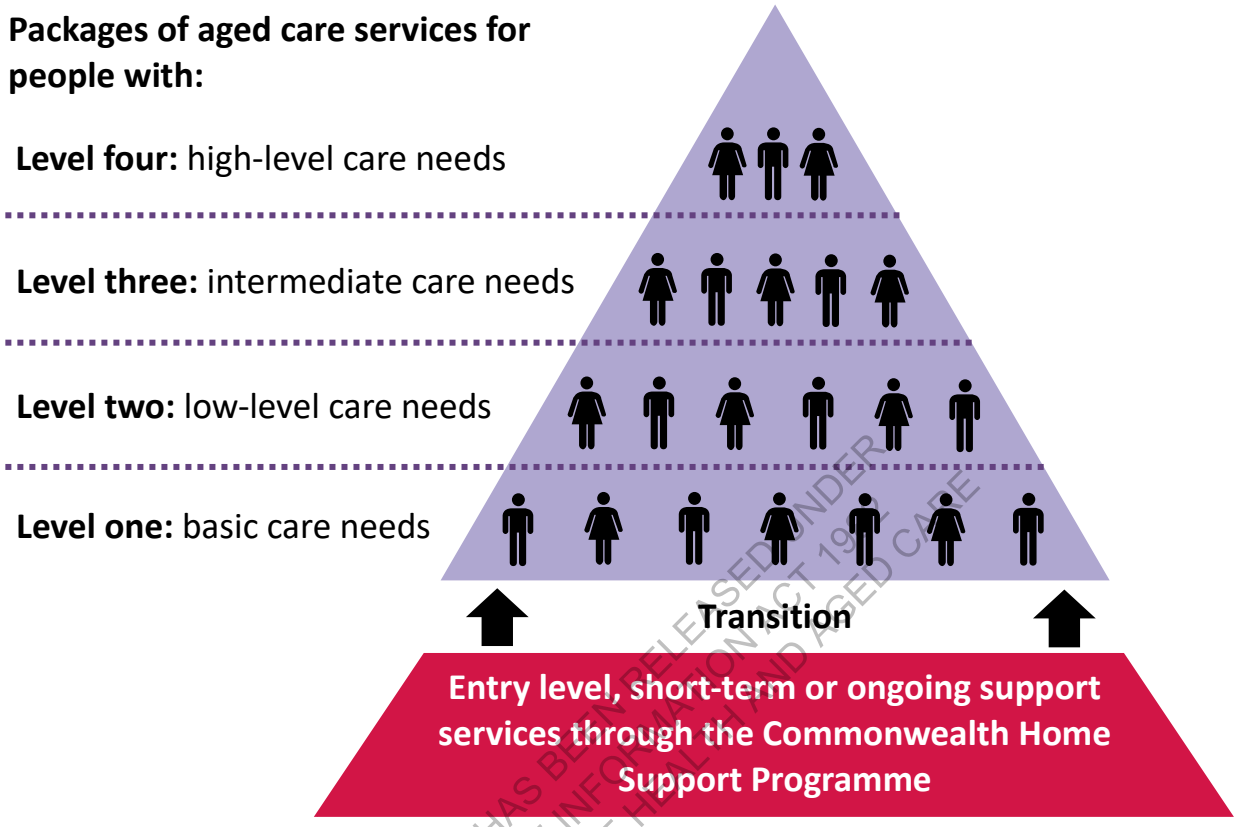
This section describes a Home Care Package, Consumer Directed Care (CDC) and the national priority system. It also helps you understand how the Home Care Packages Program relates to other aged care programs, and what to do if you have hearing or speech difficulties, or need a translator.

2.1 What is a Home Care Package?

A Home Care Package is a coordinated package of care and services to help you to live independently in your own home for as long as you can. After you are assessed as needing a Home Care Package you will be placed in the national priority system. Once you are assigned a package, you need to find a home care provider who will work with you to:

- choose care and services that best meet your assessed needs and personal goals; and
- allow you to self-manage your care and services (if you choose to).

There are four levels of Home Care Packages to help meet the different levels of care needs:



To get a Home Care Package, you need a comprehensive aged care assessment. This is done by an Aged Care Assessment Team (ACAT). During your assessment, your assessor will discuss your current care needs and supports. They will decide the best level of Home Care Package for you.

2.2 What is the intent of Home Care?

The intent of the Home Care Packages Program is to provide coordinated care and services that help senior Australians to live safely and independently in their own home for as long as you can. In the Home Care Packages Program, you will work together with your provider to design a package of aged care services that is best and most appropriate for you as an individual. 'Dignity of risk' is at the centre of home care, and means that you have freedom to make choices for yourself and to guide your care, if you would like to.

A Home Care Package is not extra income that can be used for everyday items and costs. The money is intended to help meet your assessed care needs so you can continue to live independently in your home for as long as it is safe

and appropriate. You are encouraged to work with your provider to determine how the money is spent.

2.3 What is the scope of Home Care?

The main categories of care and services you can get from a Home Care Package are:

Category	Services
Services to keep you well and independent	• Personal care. • Nursing. • Allied health and therapy services. • Meal preparation and diet. • Specialised support.
Services to keep you safe in your home	• Nursing assistance. • Home maintenance. • Minor home modifications. • Goods, equipment and assistive technology.
Services to keep you connected to your community	• Transport. • Social support.

These care and services do not replace other health programs that you might be eligible for. You should continue to access these if and when you need through your general practitioner (GP) and hospitals. A Home Care Package should not be used for care and services that can be accessed through other health programs. Other health programs include the Medical Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS).

There is more information on what can and cannot be included in a Home Care Package at Section 4 of this manual.

2.4 What is Consumer Directed Care?

Through your Home Care Package, you have flexibility and choice in the delivery of your care and services. This means you (and your carer, if appropriate) have more choice and control over what, when and where services are delivered. Your Home Care provider must work in partnership

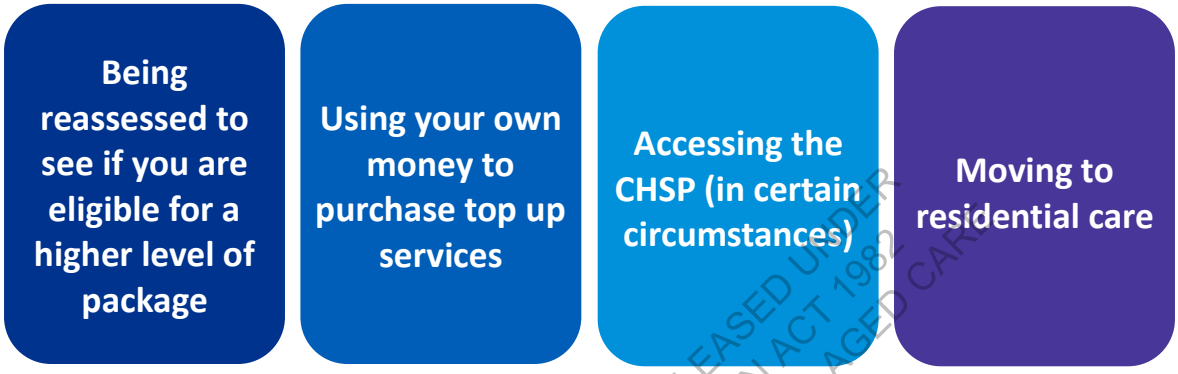
with you to design and deliver services that meet your assessed needs and personal care goals.

Consumer Directed Care means:

You and your provider will agree on:

- how much you want to be involved in managing your Home Care Package;
- the Home Care Package budget available to provide your care and services; and
- the costs of care and services under your current care plan.

If your needs cannot be met using your Home Care Package budget, then you may need to look at other options, including:



For more information on where CHSP might be available, see Section 6.3. You will need to complete the process of looking into other options in partnership with your provider.

2.5 How does the Government contribute to the cost of my Home Care Package?

The Australian Government pays a different subsidy amount for each level of Home Care Package. They will also pay supplements for specific additional care needs. These amounts are paid to the home care provider you choose.

The total amount of a Home Care Package is made up of what:

- the Australian Government pays (the subsidy and supplements); and
- you may need to pay (your home care fees).

For more information about government contributions and how to work out the costs you may need to pay, see Section 5.

2.6 What is the national priority system?

There will be a wait time between when you are approved for care and when you are assigned a Home Care Package. Wait times change. You can find these at this link or by searching "Assessment decision: Home Care Packages" at www.myagedcare.gov.au.

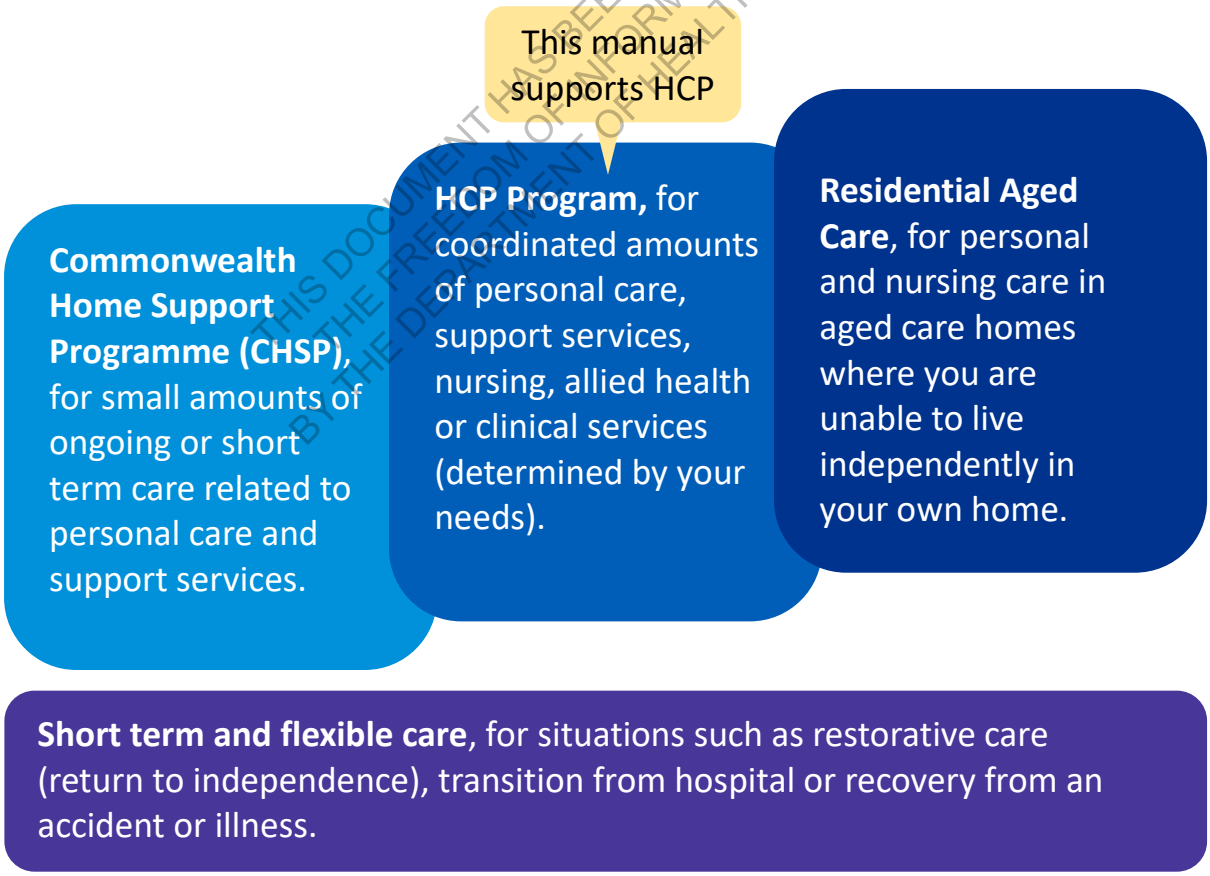
The national priority system assigns packages to consumers equitably based on their individual needs, regardless of where they live. Once you are approved for a Home Care Package, you are placed in the national priority system to be assigned a Home Care Package. Your place in the national priority system depends only on:

- when you were approved for home care; and
- the priority that was assigned to you by the ACAT during your comprehensive aged care assessment.

How the national priority system impacts on your access to a Home Care Package is discussed in Section 3.5.1 of this manual.

2.7 How does the Home Care Packages Program interact with other programs?

The Home Care Packages Program is part of the Australian Government's commitment to care for seniors Australians from entry level care to high need residential care. The diagram below outlines where the Home Care Packages Program is situated within the continuum.



Access to each of the above programs is determined by a comprehensive aged care assessment by an ACAT or Regional Assessment Service (RAS). My Aged Care will connect you to an assessment service for your needs. You may receive services through another program, and then move to a Home Care Package, or you may start Australian Government-supported aged care with a Home Care Package.

You do not need to receive other aged care services, such as CHSP or flexible care, before you are eligible for a Home Care Package.

For more information on how the Home Care Packages Program interacts with other programs, see Section 6.3 of this manual.

2.8 For more information

2.8.1 My Aged Care

For more information about home care, visit the My Aged Care website at www.myagedcare.gov.au. You can also call the My Aged Care contact centre on **1800 200 422** (Monday to Friday 8 am to 8 pm and Saturday 10 am to 2 pm AEST). If you are calling from overseas, dial **+61 2 6289 1555** (Monday to Friday 9am to 5pm) and ask for the My Aged Care contact centre. There may be a charge associated with this call.

2.8.2 What if I have hearing or speech difficulties?

Contact My Aged Care through the National Relay Service (NRS). For more information, visit the NRS website at communications.gov.au/accesshub/nrs to choose your preferred access point. You can also call the NRS Helpdesk on **1800 555 660**.

2.8.3 What if I need help with interpreting?

If you speak a language other than English, the Translating and Interpreting Service (TIS National) is available for the cost of a local call on **131 450**. TIS National offers telephone or on-site interpreting services in over 100 languages.

TIS National can be used free of charge when you:

- are working with your provider to develop your Home Care Agreement, package budget and care plan;
- need help to understand your package budget and monthly statements; or
- would like to make a complaint to the Aged Care Quality and Safety Commission.

When you start to receive care and services under your Home Care Package, the cost of interpreting will be charged to your package budget.

TIS does not provide Aboriginal language translation services. Your State or Territory may have a translation program that you can use. These include:

- the Northern Territory Aboriginal Interpreter Service; and
- Aboriginal Interpreting Western Australia.

You can find more information on the NT Aboriginal Interpreter Service at this link. You can also contact the Service by calling **(08) 8999 5511**.

You can find more information on Aboriginal Interpreting WA at this link. You can also contact the Service by calling **1800 330 331**.

The My Aged Care contact centre uses the NT Aboriginal Interpreter Service for their services and at no cost to the caller.

2.8.4 What if I am a veteran?

If you're a veteran or a war widow/widower, you may be able to get services from the Department of Veterans Affairs (DVA) and Australian Government aged care programs at the same time, as long as you don't get the same service from both.

For more information on services and payments you may be eligible for as a veteran or war widow/widower, call DVA on **1800 555 254** or visit www.dva.gov.au.

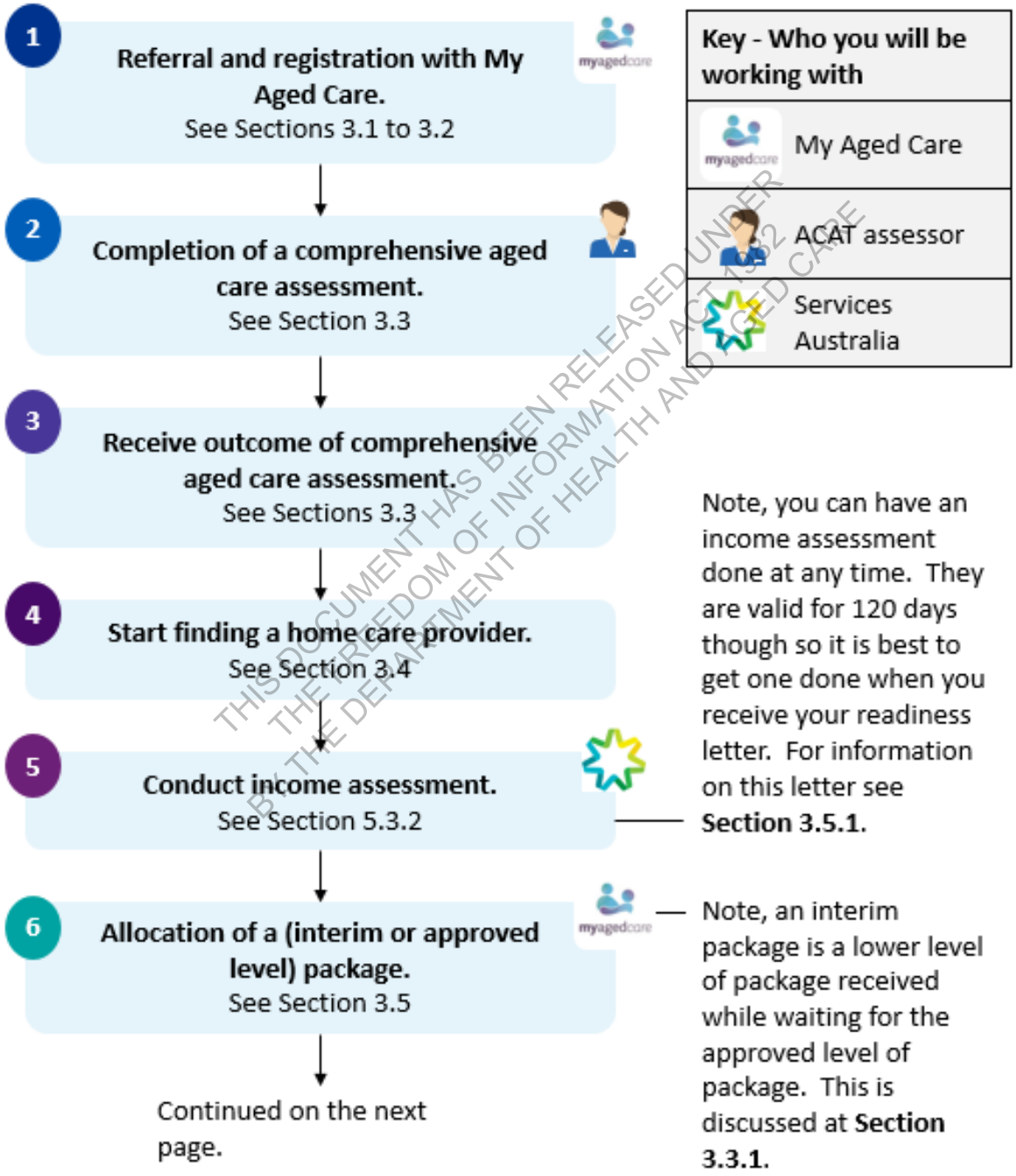
✓ Key points to remember

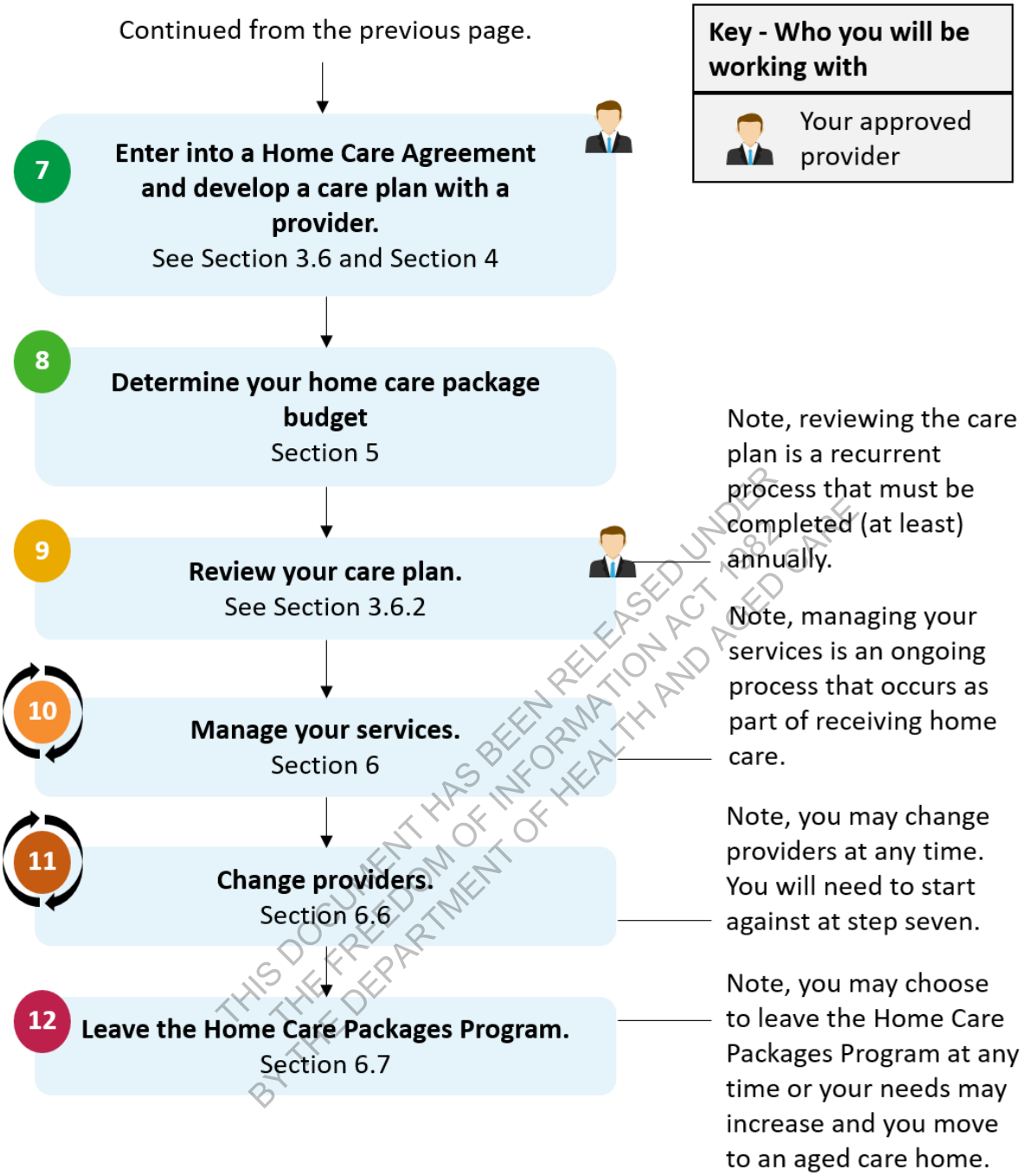
- A Home Care Package is a coordinated package of care and services to help you to live independently and safely in your own home for as long as you can.
- It provides more intensive care than CHSP (where you get small amounts of personal care and support services), but is less intensive than Residential Aged Care (where your care is provided in an aged care home).
- Your package is assigned by the national priority system based on when you were approved and the priority assigned to you. This system ensures packages are assigned fairly across the country.
- If you have a Home Care Package, you will work together with your chosen provider to design your care plan based on assessed need.

- Services are available to help you navigate your Home Care Package. You can call the My Aged Care contact centre on **1800 200 422**.

3 Your pathway to a Home Care Package

This section tells you the steps you need to take to get a Home Care Package. These are outlined in the diagram below. Each step refers to a part of this section for further detail if you need it.





3.1 Can I get a Home Care Package?

You may be eligible for a Home Care Package if you are:

- a senior Australian who needs coordinated services to help you to stay in your home; or
- a younger person with a disability, dementia or other special care needs that are not met through other specialist services.

In this context, 'senior Australian' includes residents of Australia.

You may have discussed your care needs with your GP or other health professionals, including during a hospital stay. These health professionals may have referred you to My Aged Care for screening and assessment and to consider your eligibility for a Home Care Package. **You do not need to be referred to My Aged Care by a health professional – you or your representative can call My Aged Care on 1800 200 422.**

Home Care Packages are not assigned to people who need short-term care.

If you are a younger person with a disability, you can find more information at this link. You can also search "Younger people in aged care" at www.health.gov.au.

3.2 Registering with My Aged Care

Your first step to a Home Care Package is registering with My Aged Care. You, your carer or your nominated representative need to call My Aged Care on **1800 200 422**. The contact centre staff will undertake a screening process and ask you questions that will help them understand your needs and personal situation. This will include any help you get from family, friends and other programs or services.

They will also ask your permission to create a personalised client record on the My Aged Care system. Your record will hold up-to-date information on your needs, the results of any assessments and any services that you receive. The client record will reduce the need for you to retell your story.

After you have registered with My Aged Care the contact centre staff may then:

- provide you with aged care information and details on services that may assist you;
- arrange a face-to-face assessment of your needs that takes place in your own home by a trained assessor;

- refer you for aged care services, reflecting any preferences you have for particular providers.

You can also nominate a family member or friend as your representative/s. They will then be able to:

Only one person is able to get mail relating to your Home Care Package. You can see who is receiving this mail by logging into the My Aged Care system at this link. You can also find the My Aged Care system by searching "View your My Aged Care client record" at www.myagedcare.gov.au. Or you can call My Aged Care on **1800 200 422**.

You can also see electronic versions of your letters in the My Aged Care system. You can find the system at the links above.

3.3 How do I get a comprehensive aged care assessment?

3.3.1 Assessing your needs

The My Aged Care contact centre will discuss your needs with you. If your care needs suggest you might need a Home Care Package, you will be referred to an Aged Care Assessment Team (ACAT). They are trained to conduct a comprehensive aged care assessment and will identify the aged care services that will best meet your needs. This assessment is free.

An ACAT assessor will visit your home and talk to you about your current situation. They will assess your needs against the ACAT Guidance Framework. You can find the Framework at this link. You can also search "ACAT Guidance Framework for Home Care Package Level" at www.health.gov.au.

The ACAT assessor will make a recommendation to a representative of the Department of Health on whether you are eligible to get Australian Government-subsidised aged care services. You are welcome to have someone else - a friend, family member or your carer - come to your assessment with you for extra support.

The ACAT assessor may ask your permission to talk to your doctor about your medical history before or after they meet with you. If you agree, they will record your consent in your personal client record. All your information will be treated confidentially.

To prepare for your assessment you may wish to have key information ready, like:

- your Medicare number;
- a copy of any referrals from your doctor;
- any information provided to you that you may want to discuss with the assessor;
- your GP or other health professional contact details; or
- information on any current support you receive.

Read more about preparing for your assessment at this link. You can also search "Prepare for your assessment" at www.myagedcare.gov.au.

The assessor may also ask for your permission to talk to people who support you, such as a family member or carer. They will ask you to complete an "**Application for Care form"**. You can find the form at this link. You can also find the form by searching "Application for care form" at www.health.gov.au.

The assessor will ask questions about:

The ACAT assessor will develop a support plan that records your strengths, challenges, care goals and preferences for services. They can also:

- consider other types of services that help meet your needs;
- give you information about providers that may offer the care you need in your area;
- discuss if you might need more support so you can live in your own home, or other options such as an aged care home.

Your preferences will always be considered, and you do not need to make any decisions about your future assessed needs during your assessment.

Interim packages

You may choose to accept a lower level Home Care Package than you have been approved for. This means you can access care and services while you wait for your approved level package. This is called an 'interim package'. For example, if you have been approved to get a level four Home Care Package, you may get a letter assigning you a level two package. This means you can access care and services to the value of a level two package, while you wait for a level four package. This helps you connect to care more quickly. A level two package will be available before a level three or four package.

You must let your assessor know that you would like to be assigned an interim package if one is available. You can tell My Aged Care or your assessor the minimum level package you are willing to accept. You may be offered a lower level package to enable you to start receiving care and services as soon as possible. Accessing an interim package ensures you get care sooner and does not affect your wait time for your approved level package.

3.3.2 The outcome of the assessment

After your assessment a formal decision about your eligibility for a Home Care Package will be made. This decision is based on the recommendations made by your assessor. They will recommend whether you can get a Home Care Package and, if you can, what level of Home Care Package will meet your needs.

If you are assessed as eligible for a Home Care Package, you will:

- Get an approval letter from My Aged Care that sets out the level of Home Care Package you are approved to receive and your priority for care. This letter is not your approval to start receiving care.

- Be placed in the national priority system for your approved Home Care Package level. The national priority system is explained further in Section 3.5.1.

If you are found not eligible to receive a Home Care Package, you will get a letter setting out why and who to contact for more help. You may be eligible for other aged care services. If so, this information will be included with your letter.

If your care needs change at any time, you can ask for a new ACAT assessment by contacting My Aged Care.

If you do not get an approval letter explaining your assessment outcome, telephone your ACAT assessor. Your ACAT assessor will have provided you with their contact details during your assessment.

3.3.3 What if I have concerns about the ACAT assessment?

You have the right to raise any concerns about your ACAT assessment or the decisions in your approval letter. Your letter will include further information about how you can make a complaint or appeal the decision.

ACATs are employed by state and territory governments, so each team is covered by their government's complaints procedures.

Every ACAT must follow the procedures in place to work through any concerns. First, call your ACAT assessor to talk these through and request their help. They are there to help you and will listen.

If after you have spoken to your ACAT assessor, you still do not agree with your assessment outcome, you can write to the Secretary of the Department of Health outlining why you think it should be changed. You **must** write within **28 days** of receiving your letter.

The address to write to is:

The Secretary

Department of Health

Attn: Aged Care Assessment Program Reconsiderations

GPO Box 9848

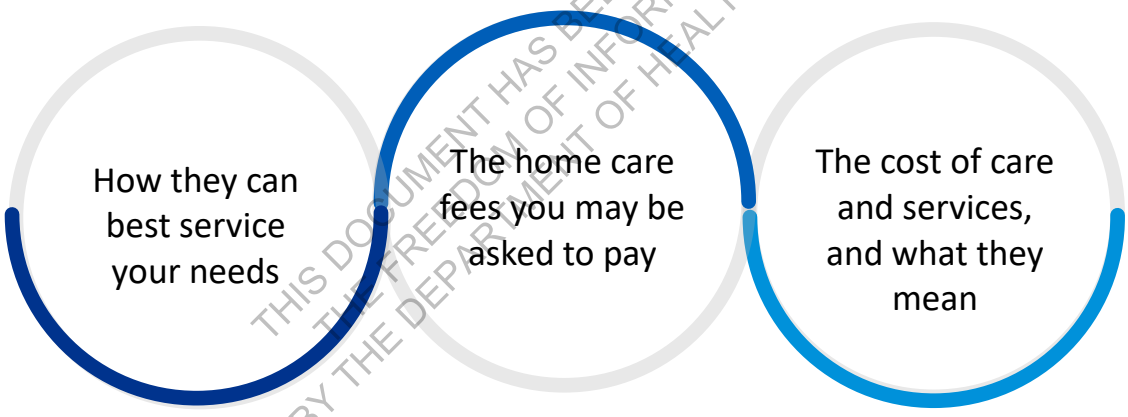
Adelaide SA 5001

A decision is usually made within 90 days and you will be advised of the outcome in a letter. There is no charge to request this review. If you do not agree with the review outcome by the Secretary, you can request a further review by the Administrative Appeals Tribunal. You will be charged for this process.

3.4 How do I find a home care provider?

You are likely to have to wait between the time you are approved for care and the time you are assigned a Home Care Package. You can find out your wait time by calling My Aged Care on **1800 200 422** or by accessing your client record using myGov. You may already have a set up a myGov account if you applied for the Age Pension. You can find advice on how to set up a myGov account and link it to My Aged Care is described at Section 14.

After receiving your approval, you should look for approved home care providers in your local area, or that providers you think will best suit your needs. Each provider is different, so meeting them will help you understand what you can expect. You will also be able to see what types of care, services and activities they offer. It is important that you find out:



There is a checklist at the end of this manual to help you prepare for questions you might want to ask potential providers.

To find providers near you, use the 'Find a Provider' tool on the My Aged Care website or you can telephone My Aged Care on **1800 200 422**. You can find the tool at this link. You can also find the tool if you search "Find a Provider" at www.myagedcare.gov.au.

Just because you meet with a provider does not mean you have to choose them as your provider. It is important to take time to think about which provider is best for you. No provider should pressure you to choose them.

3.5 How will I be assigned a Home Care Package?

3.5.1 How does the national priority system work?

Once you are approved for a Home Care Package, you are placed in the national priority system to be assigned a Home Care Package. The national priority system assigns packages equitably based on individual need, regardless of where someone lives.

Your place in the national priority system is based only on:

- when you were approved for home care;
- your priority for service determined by the ACAT during your assessment.

There will be a wait time between the time you enter the national priority system and the time you are assigned a Home Care Package. The Department of Health releases Home Care Packages weekly. The number of packages released at each level takes into account the:

- number of new packages that are available;
- number of packages that other consumers no longer need;
- packages that have not been accepted by consumers in previous releases.

The Department of Health carefully manages and monitors the release of packages. This means that packages are released weekly for all four package levels at both medium and high priority levels. Consumers who are assessed as being a high priority by the ACAT are assigned packages more quickly. This does not mean that a consumer with a lower priority at the same level must wait until high priority packages have been assigned.

You will get a 'readiness letter' approximately three months before the national priority system expects to assign you a package. This letter tells you that you should expect to be assigned a Home Care Package within three months and you may want to start looking for a provider.

When a Home Care Package becomes available, My Aged Care will write to you to let you know that you have been assigned a package.

This letter will include:

- what level of Home Care Package has been assigned to you;
- a unique referral code that you give to your chosen provider.

Once you get this letter, you can then start negotiating the details of your Home Care Agreement with your preferred provider. Once you have entered into a Home Care Agreement, you can start receiving services.

3.5.2 What do I do with this letter?

When you get your letter advising that you have been assigned a package, you have **56 calendar days** from the date on the letter to find a provider and enter into a Home Care Agreement. Whenever you meet with your preferred provider(s), you should bring a copy of this letter that has the unique referral code. Your provider can use the referral code to look at your My Aged Care record. This will help them better understand your ACAT assessment and care needs.

You can call My Aged Care on **1800 200 422** if you are having difficulty finding an approved provider in the **56 days**. You can also call them if you need some extra time to make a decision. My Aged Care can extend the time by a further **28 days**.

If you do not enter into a Home Care Agreement in the time agreed with My Aged Care, My Aged Care will send you a letter advising your Home Care Package has been withdrawn. If the offered package is a lower level package (see Section 3.5.3 below) you will stay in the national priority system to wait for your higher level package.

If the offered package is your higher level package, and it is withdrawn, you will be removed from the national priority system. If this happens but you do want to receive a package, you will need to call My Aged Care. You will need to tell them if you want to be placed back in the national priority system to get a Home Care Package. Your place in the national priority system will be determined by the date of your original home care approval and your assessed priority.

3.5.3 What happens if I am assigned a lower level package?

If you choose to accept a lower level package, this does not change your position in the national priority system for your approved level package. You will receive services while you wait through your interim package.

When a higher level package becomes available, you will be sent a letter telling you of your upgrade. You will be automatically upgraded to the higher level package by My Aged Care. You do not need to do anything to be upgraded to the higher level package. Your provider will also be informed and work with you to review your care plan and package budget.

3.5.4 What happens if I don't accept a lower level package?

If you chose not to accept a lower level package, you will not be disadvantaged. You will remain in the national priority system for your approved level package. You will be notified when one becomes available.

3.5.5 What happens if I do not want a package at my approved level?

If you do not want a package at your approved level you can opt out of the national priority system and will not be assigned a Home Care Package. You can change your status to "not seeking services' in the My Aged Care client portal. Or, call the My Aged Care Contact Centre to do this for you.

You can change at any time to 'seeking services' and you will be put back in the national priority system. You will be assigned a package based on when you were approved for home care and your priority level.

3.5.6 What are the expected wait times for a Home Care Package?

Wait times for all package levels change regularly. Current wait times for a Home Care Package can be accessed at this link. You can also search "Assessment decision: Home Care Packages" at www.myagedcare.gov.au. You can find out how long your wait is likely to be by:

- logging in to your client record using myGov; or
- calling the My Aged Care contact centre on **1800 200 422**.

Call My Aged Care if you need care while you are waiting to be assigned a Home Care Package, or your care needs change. You may be eligible for other care and services.

3.6 Your Home Care Agreement

Once you have chosen a home care provider they must provide you with a Home Care Agreement. Your Home Care Agreement is a legal agreement with your provider that sets out:

The details of what your package will provide

Who will provide the services

How much the services will cost

If any exit amount will be deducted from funds left in your package, if you chose to leave their care

Your provider must:

- Offer you a Home Care Agreement that records the terms under which your package is provided.
- Give you a copy of the Charter of Aged Care Rights, and talk you through what it means. These are discussed at Section 7**.**
- Work with you to develop a written care plan, designed to meet your goals and assessed care needs as determined by an ACAT. The care plan will set out the day-to-day services you will receive, who will provide the service and when. A copy of your care plan must be given to you before, or within 14 days of your care and services starting. This care plan is part of your Home Care Agreement.
- Include a copy of their full pricing schedule. You must be charged these prices unless you agree another amount with your provider.
- Develop a package budget that sets out the total funds available (including Government subsidies, supplements and any home care fees) and how they will be used. This should be done as soon as your provider has all of the information they need, and the care plan is in place.
- Give you a monthly statement outlining how your funds have been used during that month and the funds remaining in your Home Care Package.

Your Home Care Package is also covered by consumer law. More information is available in the *Home care – know your consumer rights* brochure. You can find the brochure at this link. You can also search "Home Care" at www.accc.gov.au.

You can follow the *Entering into a Home Care Agreement* checklist at the end of this manual. It has also been translated into 18 languages. You can find the translated versions at this link. You can also search "Entering into a Home Care Agreement" at www.myagedcare.gov.au.

If you need translation services to support you to negotiate your Home Care Agreement please see Section 2.8.3 of this manual.

3.6.1 Entering into a Home Care Agreement

It is important to remember that you and the provider enter into a Home Care Agreement as partners. There should be enough time for you to read and understand the Home Care Agreement and make choices you are comfortable with. You can also seek independent legal advice, if you wish, before you enter into the Home Care Agreement.

You must enter into a Home Care Agreement before your Home Care Package services start. You may not be able to enter into a Home Care Agreement because of physical or medical problems. Your nominated representative may enter the agreement on your behalf.

Your provider must always offer you a written Home Care Agreement. Wherever possible, both you and the provider should sign the Home Care Agreement. A written Home Care Agreement identifies your obligations to the provider and their obligations to you. It can be very helpful to have a written Agreement when working with your provider to discuss and receive your care services.

If you do not sign the written Home Care Agreement, you can still enter into the Home Care Agreement through your actions. The provider will still need to talk with you about how much involvement you would like to have in managing your Home Care Package. They are also required to help design the type of care and services you need.

The provider will need to record why you did not sign the Home Care Agreement, and what actions they took to enter into the Agreement instead. This may include:

- a copy of the Agreement being offered to you;
- a note of the discussion with you about the Agreement details (including the date the discussion took place); and/or
- proof that you are receiving the Home Care Package described in the Home Care Agreement.

3.6.2 Developing a care plan

Your care plan is an important part of your Home Care Agreement. Your home care provider will already have some information about your care needs recorded at your ACAT assessment.

Your provider must consider your personal preferences and work with you to develop your care plan. This includes considering the needs of your carer if you have one. When talking about your needs with your provider, think about what your goals are and what is most important to you.

As a guide, your care plan may include:

- the exact types of services you will receive;
- who will provide which services (including subcontracted services);

- how much involvement you will have in managing and coordinating your services;
- when your services are delivered (for example, which day of the week and time); and
- how much the care and services will cost.

A copy of your care plan must be given to you before, or within **14 days** of your care and services starting.

Identified care needs and personal goals

Identified care needs are the areas of your daily life where you need extra care and support. Care needs are identified during the following:

- your comprehensive aged care assessment with an ACAT;
- other health professional assessments (for example your GP); and
- the care planning process with your provider.

Personal goals are also an important part of your care plan. Knowing your goals will help you choose care and services that best support your needs. An example goal might be maintaining a healthy lifestyle, or achieving independence in mobility.

You might ask yourself the following questions:

- What sorts of things might improve my day-to-day life?
- What do I enjoy doing most?
- What support do I need to stay safe?
- Where and when do I want support?
- How does this fit in with the help I already have?

Your provider should consider any formal or informal support you already receive. This can include carers, family members, friends, local community and other services. This helps work out the best way to use your Home Care Package funds.

You can discuss the possible list of care and services further with your provider. If there is a type of service that you think would meet your care needs and can be funded from your Home Care Package, talk to your provider. Your provider is required to do what they can to help you access that care or service. This may include sub-contracting services from other providers (this may change the cost of each service).

Reviewing your care plan

Your care needs can change over time and your care plan can be amended to meet those changing needs. For example, your health and independence may improve so you would like to focus on a new goal. Or you may experience a setback and need different services.

Your provider is required to review your care plan:

- at least once every 12 months to make sure the care and services you receive through your Home Care Package still meet your needs; and
- if you have been receiving an interim package, and you get upgraded to a higher package level.

You can also review your care plan with your provider at any time. Reasons for an additional or earlier review may include:

- a health crisis or episode;
- a change in your care needs that cannot be met within your package budget;
- a change in your living or carer arrangements;
- a change in your personal goals; and/or
- an increase in your use of clinical services (such as nursing).

If your care needs have changed a lot, you may need to get a new assessment done by the ACAT. This has to happen if you need to move to a higher package (see Section 2.1 of this manual for information on the package levels) or if you need to receive other support services. If you are not sure, your provider can help you work out if you need a new assessment.

Your care plan, including the cost of care and services, cannot change without your agreement. Your provider must give you a copy of any agreed changes to the care plan for your records.

3.6.3 Can someone help me negotiate with my home care provider?

Yes. You can have another person, such as a family member, friend or carer with you while your care plan is being prepared.

The Australian Government also funds the Older Persons Advocacy Network (OPAN) to provide advocacy services under the National Aged Care Advocacy Program. Advocacy services provide information to consumers, their families and carers about their rights and responsibilities when accessing aged care services.

An advocate can help you by:

- participating in the discussion about your Home Care Agreement, care plan and package budget; and/or
- talking about any concerns you may have.

Advocacy services are free, confidential and independent. You can contact OPAN on free call **1800 700 600**.

✓ Key points to remember

- If you think you need home care services, the first thing to do is to register with My Aged Care by calling **1800 200 422**. They will ask you some 'screening questions' – this is normal.
- Your care needs will then be assessed. Your assessor will help explain the process to you as they do the assessment.
- You will get a letter about the outcome of your assessment. If you have been approved for a Home Care Package, this does not mean that you can receive one yet. Your approval will be placed in the national priority system which assigns packages equitably based on when you were approved for home care and your priority level.
- You will be assigned a package when one becomes available.
- While you are waiting for a package to be assigned, you should start looking for a provider. The My Aged Care 'Find a provider' tool is a good place to start. You can find it at this link, or you can search "Find a Provider" at www.myagedcare.gov.au.
- You will get a letter notifying you when you have been assigned a Home Care Package. You need to enter into a Home Care Agreement with an approved provider within 56 days of the date on that letter. A Home Care Agreement defines what services you will get from your provider, and the fees for those services.
- You will develop a care plan with your provider based on your assessed care needs and personal goals. The care plan includes the services you will get, when you will get them and who will provide them. Your care plan should be reviewed every 12 months or when your care needs change.

4 What can be included in a Home Care Package?

This section talks about what services can and cannot be paid for out of your Home Care Package. This is sometimes called 'inclusions and exclusions'.

Your Home Care Package funds should be used for care and services that meet your care. Your care needs are set out in your My Aged Care support plan and your care plan. You should discuss with your provider your care needs and goals when developing your care plan which forms part of your Home Care Agreement. Your care plan should:

- match services and supports to your care needs and personal goals;
- optimise your health and wellbeing; and
- help you to live safely and independently in your own home.

4.1 What can my Home Care Package be used for?

Your Home Care Package can be used to purchase care and services, including (but not limited to) the following:

Service types	Typical services
Personal services	Bathing, showering, toileting, dressing/undressing, getting in and out of bed, washing and drying hair, shaving, and reminding you to take your medication.
Nursing	Wound care and management, medication administration such as assisting you to take medication, general health and other assessments, certain medical tests.
Allied health and therapy services	This may include speech therapy, podiatry, occupational or physiotherapy services and other clinical services such as hearing and vision services.
Nutrition, hydration, meal preparation and diet	Assistance with preparing meals, including special diets for health, religious, cultural or other reasons, assistance with using eating utensils and assistance with feeding.

Service types	Typical services
Continence management	Assessment for, providing, and assistance in using continence aids and appliances such as disposable pads and absorbent aids, commode chairs, bedpans and urinals, catheter and urinary drainage appliances, and enemas.
Mobility and dexterity	Providing crutches, quadruped walkers, walking frames, walking sticks, mechanical devices for lifting, bed rails, slide sheets, sheepskins, tri-pillows, pressure-relieving mattresses and assistance using these aids.
Transport and personal assistance	Assistance with shopping, cleaning and household tasks, visiting health practitioners, emotional support, social support and attending social activities.
Management of skin integrity	Providing bandages, dressings and skin emollients.
Support for cognitive impairment	Individual therapy, activities and access to specific programs designed to prevent or manage a particular condition or behaviour, enhance quality of life and provide ongoing support
Cleaning and household tasks	Help with making beds, ironing, laundry, dusting, vacuuming, and mopping.
Home maintenance	Minor home maintenance, minor modifications to the home, assistance with accessing technical assistance for major modifications to the home and advising you of areas of concern regarding the safety of your home.
Light gardening	Light weeding, light pruning, lawn mowing, or minor garden maintenance.
In-home respite	A care worker supporting you in your home for a short period of time (for example, when your carer is away or unavailable).

Service types	Typical services
Care management	Administering your Home Care Package, reviewing your Home Care Agreement or care plan, preparing your monthly statements and managing your package funds.
Activities of daily living	Help with communication including assistance to address difficulties arising from impaired hearing, sight or speech, or lack of common language, assistance with the fitting of sensory communication aids, checking hearing aid batteries, cleaning spectacles and assistance in using the telephone.

A Home Care Package may also support the use of:

- **Telehealth:** video conferencing and digital technology (including remote monitoring) to increase access to timely and appropriate care.
- **Assistive technology:** such as devices that help with mobility, communication and personal safety.
- **Aids and equipment:** particularly those that assist a person to perform daily living tasks. Your Home Care Agreement needs to specify whether it is leased or who owns the item and who is responsible for ongoing maintenance and repair costs. For more information on including aids and equipment in your Home Care Package budget please see this link. You can also search "Home Care Packages" at www.myagedcare.gov.au.

4.2 What can't Home Care Package funds be used for?

There are care and services that you **must not use** Home Care Package funds for:

- items that would normally be purchased out of general income;
- buying food including groceries and take-away meals, except as part of enteral feeding requirements;
- payment for permanent accommodation, including assistance with home purchase, mortgage payments or rent;
- payment of home care fees owing to your chosen provider;
- payment of fees or charges for other types of care funded, or partly funded, by the Australian Government;
- home modifications or assets that are not related to your care needs;

- travel and accommodation for holidays;
- cost of entertainment activities, such as club memberships and tickets to sporting events;
- gambling activities; and
- payment for services and items covered by the Medicare Benefits Schedule (for example, visits to your GP) or the Pharmaceutical Benefits Scheme (for example, most medication you need a script for).

The examples show some of the types of items that cannot be included in your Home Care Package:

Excluded item	Example
Items that would normally be purchased out of general income	• Household bills such as electricity and gas. • Purchase of a car or petrol. • Funeral cover.
Payment for permanent accommodation, including assistance with home purchase, mortgage payments or rent	• Home ownership expenses such as rates. • Home and contents insurance.
Payment of home care fees	• Basic daily fee. • Income-tested care fee. • Additional fees.
Payment of fees or charges for other types of care funded or jointly funded by the Australian Government	• Transition Care fees. • Services that can be covered by the public health system.
Home modifications or assets that are not related to your care needs	• House renovations that add capital value to the property or exceed what is essential for safety.

4.3 What if I want care or services not listed above?

Sometimes a support may not fall neatly within the inclusions and exclusions list. This does not mean it cannot be included in your Home Care Package. It means that you will need to work in partnership with your provider to determine if the service, support or purchase:

- is directly linked to your identified care needs and goals;
- will optimise your health and wellbeing;
- is necessary for you to remain living safely and independently in your home;
- can be delivered within your package budget; and
- would be considered an acceptable use of Government funds.

Your provider will also consider whether they have the capacity and capability to deliver, or source, the proposed support.

The framework on the next page has been designed to support you and your provider to determine what can and cannot be included as part of your Home Care Package. It includes:

- understanding your care needs and goals;
- key questions and considerations that your provider will work through with you; and
- your provider keeping a record of these discussions and the decisions you make together.

Figure 1 Inclusions and Exclusions Framework

Your provider will work with you to understand your care needs and goals.

Your care needs and goals must be clearly understood by yourself and your provider. Care needs and goals can change over time. Information provided in your ACAT assessment, other care needs reviews and discussions with your provider will provide the basis for this step.

Answer key questions (on the next page) about each care and service.

These questions have been developed to help you and your provider determine if a type of care or service should be included as part of your Home Care Package. The questions have been grouped by category. It is important that all the considerations identified below are talked through with your provider. A decision can then be made, having thought about all the questions.

Document all discussions about the inclusion or exclusion.

Your provider will keep a record of the discussions they have with you about inclusions and exclusions of your Home Care Package. Care and services to be included in your package should be clearly documented in your care plan and budget. Where a provider is unable to meet your preferences or requests, the reasons must be clearly explained to you and documented.

Inclusions and exclusions framework – Step two questions

Mandatory criteria

Is the support specifically excluded under the Aged Care legislation?

See Section 4.2 of this manual for a summary of excluded items. If the support is on the list of excluded items it must not be included in a Home Care Package.

Consumers assessed needs

Does the support directly align with the intent and scope of the Home Care Packages Program?

See Sections 2.2 and 2.3 of this manual for information on the intent and scope of the HCP Program. This question helps you to think about whether the care or service is an appropriate and acceptable use of the package budget. If it does not align with the intent and scope of the HCP Program it should not be included in your Home Care Package.

How does the support assist you to achieve your assessed care needs and goals, now and in the short-medium term? Is it necessary to meet your care needs and goals?

This question helps you think about the appropriateness of the care or service for your circumstances. When answering this question your provider should consider the immediate impacts of the care or service on your package budget. You should also think about how it impacts on whether your budget will still meet your care needs and goals in the short to medium term.

How does the support match your care needs in your ACAT assessment, your provider's assessment or an assessment by a health care professional?

This question helps you think about your care needs identified by other health professionals such as GPs and physiotherapists etc. Your care needs may have changed from the original ACAT assessment, while waiting to be assigned a Home Care Package. It is important to consider all assessments relevant to your current care needs and goals.

Inclusions and exclusions framework – Step two questions

Have you considered the evidence-base for the support in addressing the particular care needs?

This question helps you think about whether the care or service is the right treatment to meet your care needs and goals. In some circumstances there may be no supporting clinical evidence. You will need to talk to your provider about whether it will help you meet your care needs and goals.

Quality and safety

Does the support pose a risk to your health and safety?

This question asks you to consider the risks associated with the care or service. You can then make an informed conclusion with your provider about the impact on your safety.

You do have a dignity of risk regarding your choices, however, your provider has a responsibility to provide safe care and services to you. If your provider believes the support poses an unacceptable risk to your safety, then it should be not be included in your package.

Does the support pose a risk to the health and safety to the people providing your care and your community?

This question asks you to consider whether the care or service can be delivered to you in a safe way by the staff providing your care. It also asks you to think about any broader implications for your community. This might include, for example, the safety of providing a mobility scooter to you if it may pose a risk to the public whilst travelling on footpaths.

Does a support require maintenance to ensure its safe use that represents a significant portion of your package budget? Is it difficult to provide the maintenance required?

This question asks you to consider the costs of maintaining the item purchased in the short-term and into the future.

Inclusions and exclusions framework – Step two questions

Financial

Is there an opportunity cost associated with the support?

This question asks you to think about the other care and services you cannot get if you would like to include a support, or purchase, in your package budget. Your request may be at the expense of receiving other care and services that would better meet your assessed care needs and personal goals.

Will you miss out on the care you need if the support is included in your package budget?

This question asks you to focus on whether your budget can afford the support as well as the care and services that you need to keep you safe in your home.

Does the support represent value for money to meet your assessed care needs?

This question asks you to consider costs and benefits of the support. It is important to remember, that while you have a say about the care and services you receive, the bulk of the package budget is a government subsidy funded by taxpayers to be used appropriately. For example, if you needed kitchen modifications (e.g. easy access taps) to assist in the preparation of meals, a kitchen refurbishment (beyond minor modifications) is not an appropriate use of government funding and is not permitted.

Other

Can the support be provided in your community?

This question asks you to think about whether the care or service can be provided for free in your community. This might include, for example, considering whether you can use transport that is free from your local club to access the club, rather than paying for transport from your package budget.

Inclusions and exclusions framework – Step two questions

Does the support directly benefit you, or does it have significant benefits for others?

This question helps you think about who the care or service would benefit the most. This question is not designed to exclude respite care, which provides benefit to your carer and helps them continue to support you to live in your own home.

✓ Key points to remember

- Your Home Care Package funds can be used to meet your assessed care needs, as set out in your care plan. Your care plan should match care and services to your care needs and personal goals, optimise your health and wellbeing and help you to live safely and independently in your own home.
- Your Home Care Package cannot be used for things you would need to buy anyway (like food) or for recreational activities (like holidays or going to sports games).
- If you are not sure whether you can use your Home Care Package funds for something you want, you can use the questions in the 'framework' above to guide you. You can also use these questions to discuss what services you can receive with your provider.

5 What is my Home Care Package budget?

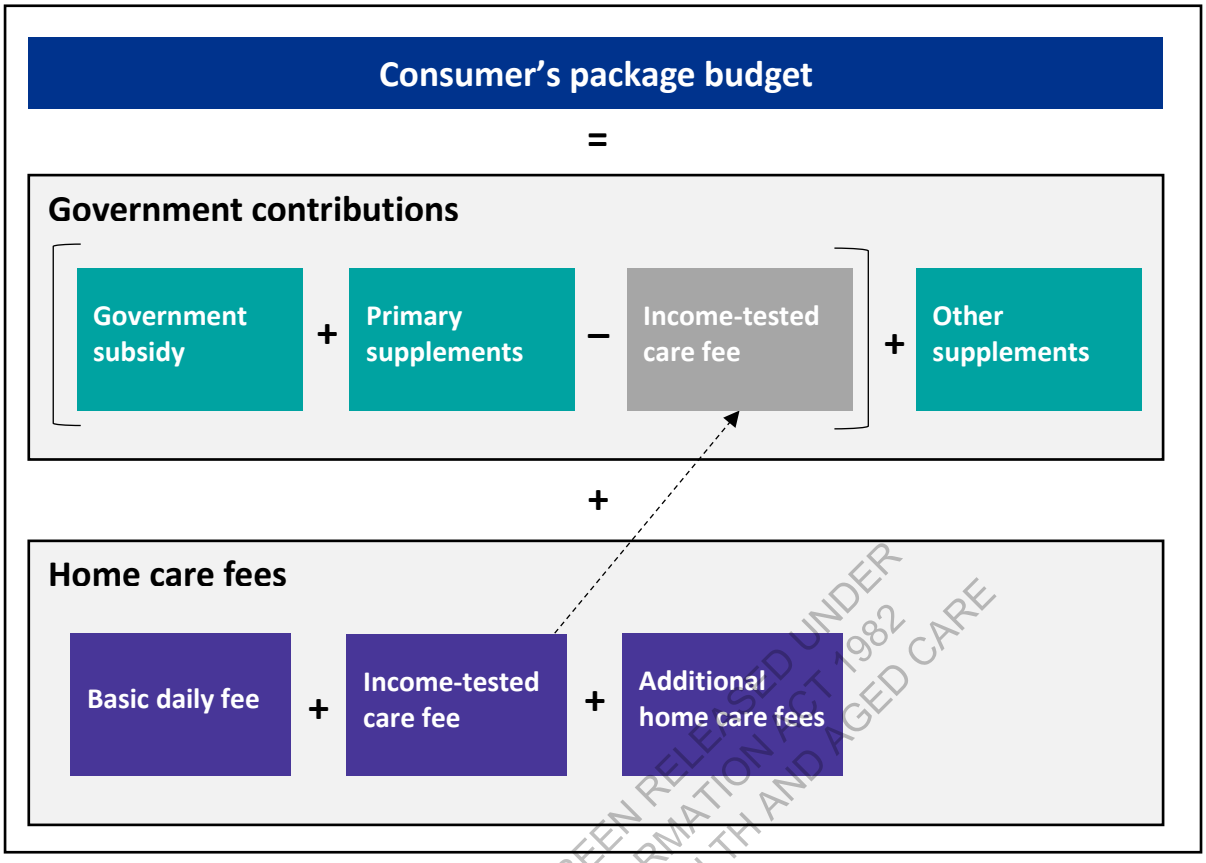
This section tells you what the Australian Government pays towards your Home Care Package budget (package budget), and what home care fees you may be asked to pay. This information explains the different parts of your budget. They may not all apply to you.

5.1 Your Home Care Package budget

The care and services you get must be paid for using your Home Care Package budget. The total amount of your budget is made up of what the Australian Government pays (subsidies and supplements) and what you may be asked to pay (your home care fees).

Your package budget shows what funds are available in your budget. It is important to remember the care and services you get must fit within your package budget. You can make additional contributions to top up your budget if you need to. Your provider cannot require or insist that you make additional contributions.

If you entered into care after 1 July 2014, the picture below shows the different parts that your package budget may include.



Your provider will discuss the package budget available to you and how it can be used. Your provider looks after the Home Care Package funds on your behalf.

If you entered into care before 1 July 2014, please look at Section 10 for an explanation of what home care fees you may be asked to pay.

5.2 What Government subsidies and supplements are available?

5.2.1 Government subsidy

The Government home care subsidy is paid to your provider. It is based on the level of your Home Care Package. The subsidy cannot be paid directly to you. The current amount paid by the Government for each package level can be seen at this link. You can also search "Schedule of Subsidies and Supplements" at www.health.gov.au.

Services Australia manage these payments for the Department of Health.

5.2.2 Supplements

If you have additional care needs, you may be entitled to more government funding through supplements. You may be eligible for a supplement if you meet the criteria for that supplement. This may involve an assessment. In most cases, your provider should lodge the application with Services Australia and follow up to check if your supplement has been paid. All supplements you receive will be added to your package budget. Ask your provider if you have any questions about whether you can apply for a supplement.

The different supplements are listed below:

Supplement	Description	Administration
Dementia and Cognition Supplement	To help with the costs of caring for someone with dementia and other conditions.	You must meet certain criteria to get this supplement. The assessment requires a GP or other health professional to do an assessment. Your provider must apply for this supplement. This supplement will automatically go with you if you change providers.
Veterans' Supplement	To help with the costs of caring for veterans with a mental health condition. The condition must be related to their service.	Your provider must apply for this supplement. This supplement will automatically go with you if you change providers. If you are eligible for both the Veterans' and the Dementia and Cognition Supplements, you will only get the Veterans' Supplement.

Supplement	Description	Administration
Oxygen Supplement	To help with the costs of caring for someone with medical need to use oxygen. This does not apply for short–term illnesses such as bronchitis.	Your provider must apply for this supplement. This supplement will not automatically go with you if you change providers. Your new provider will need to re-apply for this supplement.
Enteral Feeding Supplement	To help with the costs of caring for people who need to be fed by a tube on an ongoing basis.	Your provider must apply for this supplement. This supplement will not automatically go with you if you change providers. Your new provider will need to re-apply for this supplement.
Viability Supplement for Home Care	To help with the costs of caring for people who live in rural or remote areas.	Your provider must supply postcode details for this supplement to be paid. They can do this when they apply to Services Australia for the supplement. This supplement will not automatically go with you if you change providers.
Top-up Supplement	A payment for the provider if you held an Extended Aged Care at Home – Dementia (EACH-D) Package prior to 1 August 2013.	You do not need to apply for this supplement. It will be automatically allocated.

Supplement	Description	Administration
Hardship Supplement	Available to you, if you are in genuine financial hardship. This means you cannot pay the costs of aged care due to circumstances beyond your control.	You need to apply for this supplement (see Section 5.3.7 for more information). Enquiries about this supplement can be made on the Services Australia customer line on **1800 227 475**.

5.3 What home care fees will I need to pay?

You could be asked to contribute towards the cost of your care if you can afford to do so. Your contribution is made up of three types of fees:

- a basic daily fee;
- an income-tested care fee (if applicable);
- an amount for additional care and services.

Any fees that you agree to pay will be discussed and agreed between you and your provider. These fees form part of your package budget and must be included in your Home Care Agreement.

5.3.1 The basic daily fee

The basic daily fee is set by the Government. Providers can ask everyone to pay a basic daily fee. It is based on your Home Care Package level as follows:

Package level	Per cent of the single person rate of the basic age pension
1	**15.68%**
2	**16.68%**
3	**17.05%**
4	**17.50%**

The basic daily fee amounts are reviewed in March and September each year in line with changes to the Age Pension.

The current rates are available in the schedule of fees and charges for residential and home care. The schedule can be found at this link. You can also search 'Charging fees for aged care services' at www.health.gov.au.

You may be asked to pay the basic daily fee for every day you are receiving a Home Care Package unless you are on certain types of leave. This includes days where you are in a Home Care Package, even if you don't get a home care service on that day. An example of this is below:

Worked example

Jenny starts receiving services on Wednesday 3 July 2019. She gets nursing services on Mondays, Wednesdays and Saturdays.

In the first week, Jenny will need to pay her basic daily fee for five days, Wednesday-Sunday.

For every week after that, until she stops getting home care services or if she goes on some types of leave from her package*, she will need to pay her basic daily fee for seven days, Monday-Sunday. This is because she is receiving a Home Care Package, even on the days where she doesn't get services.

* You can find information on leave at Section 6.4 of this manual.

The basic daily fee is generally paid to your provider fortnightly or monthly. Your provider can ask you to pay fees up to one month in advance. The basic daily fee adds to your package budget.

If you are a former Prisoner of War (POW) or Victoria Cross (VC) recipient, the Department of Veterans' Affairs (DVA) will pay the basic daily fee on your behalf. You also do not have to pay an income-tested care fee.

For more information, contact DVA on **133 254** or **1800 555 254** (for regional callers).

5.3.2 The income-tested care fee

You may also be asked to make a further contribution to the cost of your care based on your financial situation. This is known as the 'income-tested care fee' and is in addition to the basic daily fee.

If you are asked to pay an income-tested care fee, the government subsidy is reduced by the amount of income-tested care fee you need to pay. Your provider must deliver services reflecting the full value of your Home Care Package. The only thing that changes is the source of funds.

My Aged Care can give you an estimate of your likely fees. To get an estimate you can:

- use the My Aged Care Fee Estimator at this link, or search "Fee Estimator" at www.myagedcare.gov.au; or
- call My Aged Care on **1800 200 422**.

How do I arrange an income assessment?

If you get a means tested payment from Centrelink or Department of Veterans' Affairs (DVA), and your pension assessment has been updated in the last two years, you do not need to complete an income assessment. You can call Services Australia on **1800 227 475** or DVA on **1800 555 254** and ask for a pre commencement letter for home care. Services Australia (or DVA) will have sufficient information to calculate your maximum home care fees payable.

For self-funded retirees the easiest way to complete an income assessment is to use form SA486, at this link, or by searching "SA486" at www.servicesaustralia.gov.au. This is a dynamic form and will present different questions based on the answers provided.

You can request a hardcopy copy of the Home Care Package Calculation of your costs of care form (SA456) to be sent to you by calling Services Australia on **1800 227 475**. You can also download a copy of the form from the Services Australia website at this link or by searching "SA456" at www.servicesaustralia.gov.au.

If you do not complete the income assessment, you may be asked to pay the maximum income-tested care fee.

How will I be advised of the fees?

Services Australia works out your income-tested care fee and will send you and your provider a letter with this information.

If you seek an assessment before commencing your package, only you will get a letter to tell you about the maximum fees you can be asked to pay. This letter will be valid for 120 days, unless there is a significant change in your circumstances. If there is a change in your situation, you will need to notify Services Australia who will reissue your fee advice letter.

You should take this letter with you to any discussions that you have with potential providers. This will help you understand the home care fees providers may charge you. Your provider will get a letter once they advise Services Australia that you have started a package with them.

What if I haven't received a response from Services Australia?

If you have not received the results of your income assessment, you should contact Services Australia on **1800 227 475** for an update on the status of your assessment.

Annual and lifetime caps

If you entered care after 1 July 2014, there are limits on the amount of income-tested care fees providers can ask you to pay. Services Australia will let you and your provider know when you reach annual or lifetime caps.

Your provider can still ask you to pay the basic daily fee and any other fees outlined in your agreement, even when you reach your annual or lifetime cap as these sit outside of the cap.

You can find out more about the current rates at this link. You can also search "Fees for people entering Home Care Packages" at www.health.gov.au.

Things to note about the income-tested care fee:

- If you get the full pension, you will pay no income-tested care fees. You can be asked to pay a basic daily fee.
- Your family home is not included in the assessment of your income.
- If you are part of a couple, the income-tested care fee payable is determined by halving your combined income, regardless of who earned the income.
- You will not be asked to pay an income-tested care fee if your yearly income is below the full pensioners' maximum income amount.
- Your income-tested care fee can change over time if your income changes. You can read more on why fees change over time at this link. You can also search "Changes to aged care fees, annual and lifetime caps" at www.myagedcare.gov.au.

5.3.3 Additional fees

Additional fees are any other amount you have agreed to pay for extra care and services. This extra care and services wouldn't otherwise be covered by your package budget.

5.3.4 Calculating your Home Care Package budget

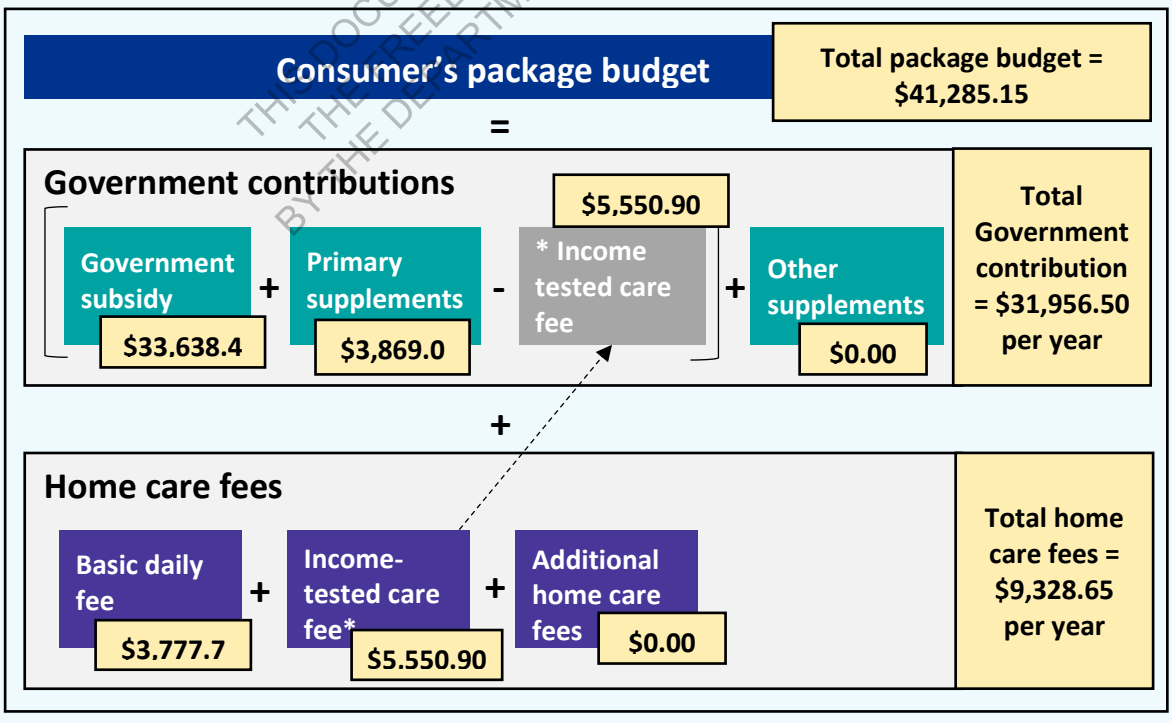
How do we calculate Adam's package budget?

Fact scenario

- Adam lives at home with his partner David.
- Adam has been assigned a level three package. The value of his daily package subsidy is $92.16 per day (as at 20 September 2019). This equates to $33,638.40 per year.
- Adam is also eligible for the dementia and cognition supplement. The value of the supplement at his package level is $10.60 per day. This equates to $3,869.00 per year.
- Adam is not eligible for any other supplements.
- The basic daily fee for Adam's package level is $10.35 per day. This equates to $3,777.75 per year.
- Adam has completed his income assessment, and has been assessed by Services Australia as being able to pay an additional $15.24 per day or $5,550.90 per year in income-tested care fees.
- Adam did not agree to pay any additional fees in his Home Care Agreement.

Calculation of package budget

The diagram below outlines how Adam's home care budget is calculated:



How do we calculate Adam's package budget?

The Government subsidy and supplements of Adam's Home Care Package is valued at $37,507.40 ($33,638.40 + $3,869.00) per year.

The amount of basic daily fee charged adds to Adam's package budget. It has no impact on the amount of Government subsidy and supplements that are paid.

Adam, however, has been assessed by Services Australia as being able to contribute $5,550.90 per year towards his income-tested care fee. The Government subsidy and primary supplement payable for Adam's care to his provider is reduced by Adam's income-tested care fee. That is, $33,638.40 + 3,869.00 - $5,550.90 = $31,956.50.

If Adam's home care provider does not collect the full income-tested care fee, the home care provider is still required to provide Adam with services as if the fee had been paid in full. The home care provider and Adam cannot select a lower level of care and services to match the reduced value of the Australian Government subsidy paid (in this example $31,956.50).

If Adam fails to meet his responsibilities, including the payment of fees, as described in section 17 of the *User Rights Principles 2014*, his home care provider may cease to provide home care to him under the security of tenure provisions. Adam's Home Care Agreement must contain a statement setting out which home care fees (if any) are payable by him and the conditions under which either party may terminate the provision of home care.

5.3.5 When do I start paying fees?

You do not have to pay any home care fees before your Home Care Package starts.

Once you have entered into a Home Care Agreement with a provider, however, you can be asked to pay home care fees up to one month in advance. Any fees you have paid in advance will be refunded it you choose to exit your Home Care Package.

5.3.6 When are my fees reviewed?

Services Australia conducts a quarterly review of income-tested care fees in January, March, July and September. They can also conduct a review if you ask

for one in exceptional circumstances. You should contact Services Australia or DVA to seek a review if your financial situation changes.

Rates for the basic daily fee are reviewed in March and September each year in line with changes to the age pension.

For consumers in the pre-1 July 2014 arrangements, see Section 10.

5.3.7 What if I cannot afford the fees?

If you are having difficulty paying your home care fees, you can ask to be considered for financial hardship assistance with your basic daily fee and income-tested care fee. Each case is considered on an individual basis. You may be granted assistance with one or both.

For a financial hardship application to be considered, you must:

- have assets less than 1.5 times the annual age pension (plus pension supplement and the clean energy supplement);
- not have gifted more than $10,000 in the last year or $30,000 in the last five years; and
- have had your income assessed in accordance with the *Aged Care Act 1997* (see Section 5.3.2).

To apply for financial hardship assistance, you or your representative need to complete an application form and submit it to Services Australia. You can get a copy of the form at this link. You can also search "SA462" at www.servicesaustralia.gov.au, or by calling **1800 227 475**.

For more information on eligibility criteria and assessments for financial hardship go to this link. You can also search 'Financial hardship assistance' at www.myagedcare.gov.au.

5.3.8 Where can I get information on managing my finances?

You can get basic information about managing your finances from the Services Australia free Financial Information Service. This is a confidential service. It can help you make informed decisions about investment and financial issues for your current and future needs.

For more information about the Financial Information Service, call Services Australia on **132 300** and say "Financial Information Service" when prompted.

5.4 What costs can be charged by a provider to my package budget?

Each provider will have different costs associated with providing care and services.

From 1 July 2019, providers must publish their pricing information for the services they provide on My Aged Care. The standardised Home Care Pricing Schedule is available on the 'Find a provider' tool. It will help you compare providers.

The pricing information that needs to be included in the Home Care Pricing Schedule includes the:

- basic daily fee amount (this is the amount the provider will charge you);
- care management costs and the approximate number of hours provided;
- prices for common services provided under a Home Care Package;
- staff travel costs to visit you;
- package management costs;
- maximum exit amount; and
- if there is a separate cost when you want to get services from a different provider.

If providers do not charge for these items, the price will show as $0 or N/A on the schedule.

Providers cannot charge separately for business-related administration costs. These costs, such as office rent, insurance and marketing, must be included in the price for individual care and services. Providers also cannot charge for entry or establishment costs.

All providers must also make a full pricing list of all the home care services they offer available on My Aged Care. They should provide a copy to you before you enter into a Home Care Agreement.

If you enter the Home Care Packages Program from 1 July 2019, your provider must include a copy of their Home Care Pricing Schedule in your Home Care Agreement. They must charge you the prices in the schedule, unless you agree otherwise.

Providers charge different prices for their services for a variety of reasons. As part of setting up your Home Care Agreement with your provider, you may be able to negotiate a different price to what is in their Schedule. Your provider must document any different prices, and the reason for the variation.

Your provider cannot charge you a price you have not agreed to for your care and services.

If you entered the Program before 1 July 2019, your provider will contact you about these changes by 1 July 2020. Again, they cannot make any changes to your Home Care Agreement without your agreement. This includes the prices they charge your package.

5.4.1 Care management

Care management ensures you get the right level of support in a way that meets your current and future care needs. Care management can be provided by your care manager. Some providers may call this staff member by a different title. Examples include care coordinator, care facilitator or case manager.

Care management may include:

- ensuring you get safe and effective personal care and/or clinical care;
- reviewing your Home Care Agreement and care plan;
- organising the delivery of your services;
- ensuring your care is aligned with other supports;
- providing a point-of-contact for you, your carer or your family;
- ensuring the care you get is respectful of your culture and identity; and
- ensuring the supports you get keep you safe.

Your care plan should outline your provider's approach to care management. Care management may be provided in different ways including face-to-face or via phone or email.

Some providers offer the option for you to be involved in the management of your Home Care Package. Your provider will discuss these options with you and the care plan will outline the level of involvement you choose. This level can range from fully managed by your provider to fully self-managed.

Self-management means you will have more control over choosing how your package budget is spent and the staff delivering your care and services.

Your provider will always need to take on some care management activities. For example, providing your monthly statement and doing an annual review of your Home Care Agreement and care plan. You will need to pay for these care management activities from your package budget.

If you choose to self-manage, your provider is still held accountable by the Australian Government for how your package budget is spent and meeting all legal requirements. For more information, speak with your provider.

5.4.2 Prices for common services

Providers must include their hourly prices for personal care, nursing, cleaning and household tasks, light gardening and in-home respite. Standard work hours are considered to be Monday to Friday 6am to 6pm. Your care and services may be delivered by the provider's staff or other contracted staff.

- **Personal care services** – may include: bathing; showering; toileting; dressing/undressing; getting in and out of bed; washing and drying hair; shaving; and reminding you to take your medication.
- **Nursing -** may include: wound care and management; medication administration such as assisting you to take medication; general health and other assessments; certain medical tests including blood pressure; and support with dementia. This does not include the price for goods such as bandages, dressings and continence aids where required – these may be charged separately to your Home Care Package. The costs shown are for nursing services delivered by a Registered Nurse. The provider may offer to deliver nursing services by other levels of nurses (e.g. an Enrolled Nurse), which may have a different cost per hour.
- **Cleaning and household tasks -** may include: help with making beds; ironing; laundry; dusting; vacuuming; and mopping.
- **Light gardening** - may include help with light weeding; watering; light pruning; lawn mowing; or minor garden maintenance.
- **In-home respite -** A care worker supporting you in your home for a short period of time, for example when your carer is away or unavailable.

5.4.3 Staff travel costs to visit you

Staff travel costs is the price per kilometre for a care worker to travel (without you) to visit your location. Some providers may not charge this if you are within a certain distance from their location. This is different from costs for providers to travel with you, where you are receiving a transport service as part of your Home Care Package.

5.4.4 Package management

Package management is the organisation of your Home Care Package. It may include the costs for: preparing monthly statements; managing your package

funds; and compliance and quality assurance activities required for Home Care Packages.

Package management does not include:

- costs that are unrelated to supporting your care;
- costs of running the provider's business such as marketing, office rent and insurance; or
- costs incurred before you enter into a Home Care Agreement with them (providers cannot charge for these).

Providers will include costs of running the business in the hourly price for their home care services.

5.4.5 Maximum exit amounts

Your provider will be able to tell you if they charge an exit amount. An exit amount applies if you decide to change providers or leave home care.

5.4.6 Separate cost when you want to get services from a different provider

You can get services from another provider if you choose to. Your provider must tell you if they charge a separate cost when you want to get services from a different provider. Your provider must also say how it is charged. For example whether it is charged as a separate cost or included in the service price.

5.5 What is an exit amount?

Home care providers can deduct an exit amount from any unspent package funds. An exit amount only applies if you decide to move to another home care provider or you choose to end the agreement. The exit amount helps providers cover the administrative costs related to you leaving their service.

Providers do not have to charge an exit amount. If a provider wants to charge an exit amount they must:

- display their maximum amount on My Aged Care;
- discuss this amount with you; and
- if you agree, include it in your Home Care Agreement.

You can negotiate a lower exit amount than the amount displayed on My Aged Care.

5.5.1 Deducting exit amounts

If you change providers or leave home care, the exit amount deducted from your unspent home care amount cannot be more than:

- the provider's maximum exit amount (as displayed on My Aged Care at the time you entered into your Home Care Agreement);
- the exit amount stated in your Home Care Agreement; or
- your unspent home care amount.

If you have spent all your package budget when you leave care, a provider cannot charge an exit amount. This is the case even if you agreed to an amount in your Home Care Agreement. Your provider cannot require you to accrue unspent funds so that they know they can deduct an exit fee.

Your Home Care Agreement will also include information on conditions like minimum contract periods or notice periods. It is important that you understand any exit amount and conditions before you enter into your Home Care Agreement.

Example of deducting an exit amount

Anton has a level two Home Care Package and is with a provider that has a published exit amount of $500 on My Aged Care. Anton negotiates with his provider to include a lesser exit amount of $250 in his Home Care Agreement.

When Anton leaves home care, his provider calculates the unspent home care amount as $150 (before the exit amount is applied). The maximum exit amount that can be deducted by Anton's provider is $150.

5.6 Your monthly statement

Your provider must supply monthly statements that show what has been spent from your package budget. This will include any additional charges you have agreed to. You can get your monthly statement via post, email or in a web-based format. If you are not receiving a monthly statement, talk to your provider first. You can complain to the Aged Care Quality and Safety Commission on **1800 951 822** if this does not help.

The monthly statement must show:

- what the Government has paid into your individualised package budget;
- the home care fees you have agreed with your provider;

- a detailed list of the care and services that have been provided under your Home Care Package for that month;
- the price for each of those care and services; and
- any unspent funds.

Any unspent funds must carry over from month to month, and from year to year, for as long as you continue to get a Home Care Package. For more information on unspent funds see Section 6.7.

✓ Key points to remember

- The Government pays money towards your Home Care Package. This will be the 'subsidy' and any supplements that you are eligible for (if you are eligible for any).
- There are three types of fees your provider may ask you to pay:
  - a basic daily fee;
  - an income-tested care fee (if applicable);
  - an amount for additional care and services.
- If you are experiencing financial hardship you will need to fill out a form. You can find the form at this link, by searching "SA462" at www.servicesaustralia.gov.au, or by calling **1800 227 475**.
- For information on what home care fees apply to you, you can use the My Aged Care Fee Estimator which can be found at this link, or by searching "Fee Estimator" at www.myagedcare.gov.au, or by calling My Aged Care on **1800 200 422.**
- Providers must include a copy of their full pricing list in your Home Care Agreement.
- Your provider must charge the prices you have agreed to.
- Your provider must give you a monthly statement that tells you what your Home Care Package has been spent on. You should use this to understand what costs your provider charges to you.

6 Managing your services

When you have a Home Care Agreement, a care plan and package budget, your agreed care and services can begin. Your Home Care Package starts on the day you enter into a Home Care Agreement, not from the day you start receiving care and services.

When you start to get the care and services in your agreed care plan, you have the right to:

- receive care and services in line with your agreed care plan;
- have ongoing conversations with your provider about your care needs and goals;
- work with your provider to update your care plan if your care needs change;
- have your monthly statements explained to you;
- be involved in managing your Home Care Package, if you would like to; and
- be formally reassessed, if you wish, to ensure that your care and services continue to meet your needs.

The remainder of this section tells you what to do to manage your services if:

- your Home Care Package budget is fully allocated, but you need more services;
- you need to take leave from your Home Care Package (if, for example, you go on holiday or are in hospital); or
- you want to change providers.

6.1 Package upgrades

If you have been receiving an interim package whilst waiting for your approved package, My Aged Care will automatically upgrade you to the higher level package when one is available. My Aged Care will notify you and your provider when your package has been upgraded. As soon as you are notified, you should review your care plan and package budget with your provider. This will help you make best use of the new higher package level and funds.

Once your package is upgraded to a higher level it cannot be downgraded.

If your current package level is meeting your needs, and/or you have unspent funds, you should remain on your current package level. If you want to do this, let My Aged Care know by calling **1800 200 422** to opt out of the national priority system. This will let another person in need take up the available package.

If you later change your mind and would like your higher level package, call My Aged Care at any time and opt back in to the national priority system. There will be no disadvantage to you. Your place in the national priority system is based on when you were first approved for care and your priority.

6.2 What happens if my package isn't meeting my needs?

Your care needs may change over time. If this happens, you can arrange your services to better suit you. If you notice that your care needs change, talk to your provider in the first instance and ask for a review of your care plan. Your provider must discuss with you any changes to the costs charged to your Home Care Package. You can redesign the care plan with your provider or pay for the services privately.

If your provider cannot help, call My Aged Care as you may need to be reassessed for a higher level Home Care Package or other support services.

6.3 What other programs can I access at the same time as my Home Care Package?

It may be possible for you to get care and services through other programs that can complement your Home Care Package. These programs include:

You cannot access Short-term Restorative Care if you are also receiving a Home Care Package.

You may be able to access other State and Territory funded programs. Your provider will be able to help you identify any that are relevant to you.

6.3.1 Commonwealth Home Support Programme

In certain circumstances and on a short-term basis, you can get care and services through the CHSP when you are receiving a Home Care Package. This means your package budget will not be charged for the CHSP services. These circumstances include:

- if you have a level one or two Home Care Package, you can access additional, short-term or once-off allied health and therapy services or nursing services from CHSP, where your budget has been used;
- you can access additional planned respite services under CHSP, if your carer requires it and your package budget has been used; or
- where your budget has been fully used, you can get extra services under CHSP on an emergency or short term basis. These instances should be time limited, monitored and reviewed.

For more information, please refer to the factsheet at this link. You can also search "CHSP interaction with Home Care Packages" at www.health.gov.au.

6.3.2 Veterans' Home Care

If you are an eligible Department of Veteran's Affairs (DVA) client, Veterans' Home Care is designed to assist you with small amounts of practical help. This help is designed to keep you living independently in your own home. Services include:

- domestic assistance;
- personal care;
- respite care; and
- safety-related home and garden maintenance.

Veterans' Home Care is not designed to meet complex or high-level care needs, like that of a Home Care Package.

You can access both a Home Care Package and Veterans' Home Care if there is no duplication of services. For example, if you already access garden maintenance in your Home Care Package, you cannot access garden maintenance through Veterans' Home Care.

For more information please access the Veterans' Home Care factsheet at this link. You can also search "Factsheet HCS01 – Veterans' Home Care" at www.dva.gov.au.

6.3.3 National Dementia Support Program

If you are living with dementia, the National Dementia Support Program (NDSP) provides education, resources, and support to you and your family and carers. The NDSP aims to improve awareness and understanding about dementia.

The NDSP offers a website and national helpline, where professional counselling can be scheduled. These can be group or individual sessions. These can help you and your family and carers, with support strategies to cope with dementia. They can also provide advice on what to expect once a diagnosis of dementia is received.

The NDSP also offers education and training to family members and carers of people living with dementia to help you remain in your own home for longer.

You can contact the NDSP provider on **1800 100 500** to discuss any concerns. You can also visit www.dementia.org.au to access information about memory loss or dementia.

6.3.4 Community Visitors Scheme

The Community Visitors Scheme (CVS) supports volunteers to make regular visits to you if you are lonely or socially isolated. CVS provides friendship and companionship by matching you with volunteer visitors. You can access the CVS program without any impact on services received through your Home Care Package.

For more information about the CVS, including frequently asked questions, you can use this link. You can also search "Community Visitors Scheme" at www.health.gov.au.

6.3.5 National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) funds supports and services for people living with a disability. If you are accepted to the NDIS and received a Home Care Package before turning 65 years old you should move from your package as soon as possible. Until you can move, you may be able to receive different services under both programs.

You should talk to your provider about accessing the NDIS and whether you meet the eligibility criteria.

6.3.6 Continence Aids Payment Scheme

If you have permanent and severe incontinence confirmed by a health professional, you are eligible to access the Continence Aids Payment Scheme, through Services Australia. You cannot also be receiving continence support through your Home Care Package.

You should discuss your eligibility for these programs with your provider. They will be able to assist you in accessing the best supports for your care needs.

6.4 What happens if I take leave from my Home Care Package?

You should talk to your provider if you take leave from your Home Care Package for:

- a hospital stay;
- transition care (following a hospital stay);
- residential respite care; or
- social reasons (package suspended for any other reason).

You need to let your provider know the date that your leave starts. This does not have to be in writing, but your provider must record the dates.

Your provider must:

- not deliver services during the period you have taken leave but must start them again when you return; and
- tell you about any changes to your home care fees and the costs charged to your Home Care Package.

6.4.1 Impact on fees you pay

You may need to pay ongoing home care fees to your provider while you are on leave from your package. The table below explains what home care fees you may need to pay for the different types of leave and when you would need to pay them.

Leave type	Basic daily fee	Income-tested care fee
Hospital	Yes	Yes - payable at the full rate for 28 **consecutive** days, after which you can be asked to pay the lesser of your income-tested care fee or 25% of the basic subsidy rate for your package level.
Transition Care	No	Yes - payable at the full rate for 28 **consecutive** days, after which you can be asked to pay the lesser of your income-tested care fee or 25% of the basic subsidy rate for your package level.
Residential respite	No	Yes - payable at the full rate for 28 **cumulative** days, after which you can be asked to pay the lesser of your income-tested care fee or 25% of the basic subsidy rate for your package level.
Social leave (package suspended for any other reason)	Yes	Yes - payable at the full rate for 28 **cumulative** days, after which you can be asked to pay the lesser of your income-tested care fee or 25% of the basic subsidy rate for your package level.

Your leave balance resets each year on 1 July and if your package level changes at any time. If you change providers, your leave balance transfers with you.

6.5 What other programs can I access if I take leave from my Home Care Package?

It may be possible for you to get care and services through other programs if you take leave from your Home Care Package. These programs include:

- Transition Care; and
- Residential respite care.

6.5.1 Transition Care

Transition Care helps you recover after a hospital stay. It provides short-term specialised care and support to help you regain your independence and confidence sooner. It is designed to avoid the need for longer term care and support services.

You can access Transition Care after a stay in hospital if you take leave from your Home Care Package. You need to be assessed and approved for Transition Care by an ACAT. This assessment needs to happen while you are in the hospital.

For more information on Transition Care you can go to this link or search "Transition care" at www.myagedcare.gov.au.

6.5.2 Residential respite care

You can access residential respite care provided by the Department of Health if you take leave from your Home Care Package. You must be assessed and approved for residential respite by an ACAT.

You can access up to 63 days of subsidised care in a financial year. This includes both planned and emergency residential respite care. It is possible to extend this by 21 days at a time, with further approval from your aged care assessor. This may be required due to your care needs, carer stress, or the absence of your carer.

For more information on residential respite you can go to this link or search "Respite care" at www.myagedcare.gov.au.

6.6 Can I change providers?

You can change providers at any time, whether you are moving to a different location or are looking for a better fit. Your current provider must support you to move to another provider. Check your Home Care Agreement so you know about any conditions such as notification periods and any exit amount that may apply.

For your own peace of mind and to limit any interruption to your services, you should find a new provider before agreeing on an end date with your current provider.

You can find a new home care provider by using the 'Find a provider' tool on the My Aged Care website at www.myagedcare.gov.au. You can also phone My Aged Care on **1800 200 422** and they will help you find a new provider.

It is important to discuss and agree with your current provider the date you want your care and services to end.

6.7 How do I change providers?

Once you have found a new provider, you will need to contact My Aged Care on **1800 200 422** to re-activate your referral code. You need to give this referral code to your new provider before you can start receiving their services.

When that referral code is accepted by your new provider, your current provider will be notified through My Aged Care that you are looking to change providers.

This is not your official notice to them. You should have a discussion with your current provider to formally agree an end date for your services with them.

Once you have agreed an end date with your current provider, you have **56 days** from the end date to enter into a Home Care Agreement with a new provider.

If you do not enter into an Agreement by this time, your Home Care Package will be withdrawn. If you need more time to make a decision, you can call My Aged Care to request an extension of a further 28 days.

The start date with your new provider **must be on or after** the end date you have agreed with your old provider.

If you entered care before 1 July 2014 and would like to change providers, please see Section 10.

6.8 What are unspent funds?

When the funds paid to your provider (by the Australian Government and yourself) are more than the funds used for providing your care this creates unspent funds.

The budget for your package should meet your **current** care needs. You should work with your provider to ensure you benefit from the full use of your package budget. Talk to your provider about the funds available and how you are going to spend them to support your needs. You should develop a care plan and package budget with your provider that fully meets your assessed care needs and personal goals. Your assessed care needs will be included in your Home Care Agreement.

Unspent funds are called 'available funds' while you are getting a Home Care Package. They become unspent funds when you leave the Home Care Packages Program or change your provider.

The unspent home care amount will be calculated from the date you started receiving home care services from your provider, until the agreed end date of your home care services. If you started receiving home care before 1 July 2015, this will be the start date used to calculate your unspent home care amount.

6.8.1 Changing providers

If there are any unspent funds in your package (after all expenses and charges for care and services have been paid) these will follow you to your new provider.

The unspent home care amount is calculated for the period between:

- 1 July 2015, or the date on which you started receiving home care with your provider (whichever is later); and
- the date on which your provider stopped providing home care to you (end date).

Your current provider has 56 days from the end date you have agreed with them to issue you with a notice that will include:

- confirmation of the end date of home care services you have both agreed to;
- the exit amount that will be deducted (if one is applicable); and
- the balance of any unspent funds in your Home Care Package.

You need to notify your old provider within 56 days after your agreed end date with them of the details of your new provider. They will then transfer any unspent funds to them. If you have given this information to your old provider then they must complete this transfer as soon as possible and within 70 days of your agreed end date.

A checklist for changing providers is included at the end of this manual.

6.8.2 Ceasing care

If you move into permanent residential care, pass away or cease your Home Care Package, then you are ceasing care. The following table shows you what happens to your package budget when you cease care.

You will receive:	The Government will receive:
• A refund of any home care fees you paid in advance. • A letter that tells you your unspent funds amount. Your provider should send you this within 56 days of the day you stop receiving home care services. Any home care fees you paid in advance will not be included in the calculation of the unspent funds.	• A refund of any contributions the Government has made towards your Home Care Package that have not been spent yet. These contributions are the subsidy and any supplements you are entitled to.

✓ Key points to remember

- When you have a Home Care Agreement and a care plan your agreed care and services can begin. Your Home Care Package starts on the day you enter into a Home Care Agreement, not from the day you start receiving care and services.
- Your package budget should be prepared as soon as your provider has all the information they need.
- If you have been receiving an interim package, you will be automatically upgraded to a higher level package when one is available. My Aged Care will notify you and your provider when your package has been upgraded. You will need to work with your provider to review your care plan and package budget.
- Your care needs may change over time. If this happens, talk to your provider about reviewing your care plan. If you change your care and services your package budget will need to reflect these changes.
- You can take a break from receiving your home care services if you need. This is called leave. You may need to still pay your home care fees while you are on leave depending on why you are taking leave and for how long. You must tell your provider you are taking leave before you do so, or as soon as possible if the leave is unexpected.

- You may be able to access other government funded aged care programs whilst you are on a Home Care Package. Some programs will complement the services you get through your Home Care Package. Some programs require you to take leave from your Home Care Package. You should talk to your provider.
- You can change providers at any time. They may charge an exit amount to your Home Care Package (this will have been agreed in your Home Care Agreement).
- If you have unspent funds in your package your old provider should give you a letter telling you what the amount is within 56 days, and must transfer them to your new provider within 70 days of the day you tell them you are changing providers.

7 Your rights and responsibilities

This section tells you about your rights and responsibilities as a consumer of Home Care Packages. It is important to remember that you and your provider are entering into a Home Care Agreement as partners. Mutual respect is key to good aged care outcomes.

Your provider must comply with the Charter of Aged Care Rights and the *Aged Care Act 1997*. This includes all of the principles made under the *Aged Care Act 1997*. Everybody involved in delivering your care must respect your rights.

Your provider must also deliver your care following the *Aged Care Quality Standards*. These are discussed at Section 8.2.

7.1 Charter of Aged Care Rights

The Charter of Aged Care Rights (the Charter) sets out your rights as a person receiving Home Care Package services. The Charter provides the same rights to all people receiving aged care regardless of the type of Government funded aged care they get. The Charter makes it easier for you and your family and carers to understand what to expect from an aged care service.

The Charter is extracted on the next page.

I have the right to:

- safe and high quality care and services
- be treated with dignity and respect
- have my identity, culture and diversity valued and supported
- live without abuse and neglect
- be informed about my care and services in a way I understand
- access all information about myself, including information about my rights, care and services
- have control over and make choices about my care, and personal and social life, including where the choices involve personal risk
- have control over, and make decisions about, the personal aspects of my daily life, financial affairs and possessions
- my independence
- be listened to and understood
- have a person of my choice, including an aged care advocate, support me or speak on my behalf
- complain free from reprisal, and to have my complaints dealt with fairly and promptly
- personal privacy and to have my personal information protected
- exercise my rights without it adversely affecting the way I am treated.

7.2 Signing the Charter

Your provider is required to help you to understand the Charter of Aged Care Rights. Providers must give you a signed copy of the Charter and explain your rights. They must also give you or your representative the opportunity to sign the Charter.

By signing the Charter you are acknowledging that you have received the Charter, your provider helped you to understand it and that you understand your rights. Your aged care services will not be affected if you choose to not sign the Charter.

More information about the Charter including a booklet to help you understand your rights is available on the My Aged Care website at www.myagedcare.gov.au/rights-and-responsibilities. You can also call My Aged Care on **1800 200 422** and ask for a copy of the booklet to be sent to you.

The Older Persons Advocacy Network (OPAN) is also available to help you understand your rights. You can visit their website for more information at www.opan.com.au or call them on **1800 700 600**.

Your aged care rights co-exist with other rights. For example you also have rights under the Australian Consumer Law. Further information about these rights is available from the Australian Competition and Consumer Commission (ACCC) at this link. You can also find this information by searching "Home care – a guide to your consumer rights" at www.accc.gov.au. You can also call the ACCC on **1300 302 502**.

7.3 Your Responsibilities

You also have responsibilities to your home care provider. These include providing a safe place for them to work, giving them information to help deliver your care and paying your home care fees as agreed with your provider.

You will need to:

Responsibility	What this means
Treat others with respect	All people involved in aged care, including consumers, their family, carers and visitors are expected to be respectful and considerate. They should make sure that their behaviour does not adversely affect others. Any kind of violence, harassment or abuse towards staff or others is not acceptable.
Respect the rights of staff to work in a safe environment	You are expected to maintain a safe environment for staff members and others. For example, if your provider is delivering services in your home, keep pets away from staff members and do not smoke near staff.
Assist your provider by giving relevant information	It is important that you share information about yourself that will help providers deliver you safe and quality care. This may include: • up to date information and • any problems you have with the provider's care or services.
Pay agreed home care fees on time	You are expected to pay any agreed fees on time. If you are unable to pay your fees, talk to your provider to find a solution.

If you do not do some of these things your provider may end your Home Care Agreement and stop providing your services. Your provider may end your Home Care Agreement if you have:

- not paid your home care fees, as agreed in your Home Care Agreement, for a reason within your control, and have not negotiated for an alternative payment arrangement with your provider;
- no longer a need for home care or, as assessed by an aged care assessment team, can be more appropriately met by other types of services or care;
- intentionally caused serious injury to a staff member of your provider; or
- intentionally infringed the right of a staff member of the approved provider to work in a safe environment.

Your provider may also ask you to agree to more responsibilities in the Home Care Agreement. You need to make sure you are aware of these extra responsibilities.

✓ Key points to remember

- You have rights, and your provider must talk to you about them.
- You can sign the Charter of Aged Care Rights if you want. This shows that you know and understand your rights.
- You also have responsibilities to providers. These are things like being respectful, providing a safe place to work, being open to changes in your package if your health requires it, and paying your home care fees as agreed with your provider.

8 Quality in aged care

This section is about the requirements the Australian Government has set up to try to make sure you get quality aged care. It also tells you what you can do if you do not think you are getting quality aged care.

8.1 What can I expect in aged care?

Most people know what good care feels like. The staff are friendly and respectful, and they respond to your individual needs. The organisation providing your care and services is well-run and you are well cared for by people who know their jobs. You have people to talk to about the things that matter to you.

Every person receiving care has a right to be treated with dignity and respect, and to have their personal and clinical needs met. This is regardless of who you are, where you live, your life experience, identify, beliefs or culture. Raising concerns isn't 'being difficult', it's a normal part of service delivery.

8.2 The Aged Care Quality Standards

The Australian Government has set Aged Care Quality Standards (the Standards) that clearly define what good care should look like. The Standards make it easier to check that people get good care. Good care is not about your provider 'ticking boxes'. It's about them caring for you and your individual needs.

Each Standard says what you, the consumer, can expect. Your aged care provider has to meet an "outcome" for you and they have to demonstrate how they are meeting that outcome.

There are eight Standards, and each one is about an aspect of care that contributes to your safety, health and wellbeing:

Standard	Description
1. Consumer dignity and choice	This means your provider knows you and respects your identity, culture and the choices you make.
2. Ongoing assessment and planning with consumers	This means your provider works with you when planning your care and if your care needs change.

Standard	Description
3. Personal care and clinical care	This means your provider gives you the personal and/or clinical care that is safe and right for you.
3. Services and supports for daily living	This means your provider must ensure your services and supports meet your everyday needs for living at home independently.
5. Organisation's service environment	An organisation's service environment refers to their physical environment through which care and services are delivered, for example, at a Respite Centre. It does not include your home through which in-home services are provided.
6. Feedback and complaints	This means your provider encourages and supports you to give feedback and make complaints. This may include using advocates and language services. The provider must engage with you during the process of addressing your feedback.
7. Human resources	This means the staff who provide your care must be kind, caring and respectful and have the right qualifications and skills to deliver your care.
8. Organisational governance	This means the provider's business must be well run and ensures the delivery of safe and quality care.

The Aged Care Quality and Safety Commission (the Commission) has useful information to help you understand the Standards and quality of care you should get. This can be found at this link. You can also search "Quality Standards consumer resources" at www.agedcarequality.gov.au. You can also contact the Commission on **1800 951 822**.

8.3 What can I do if I have feedback about a provider?

If you are comfortable to do so, you should talk to your provider about your feedback. This gives them the opportunity to make changes to respond to the feedback. If the provider will make changes, this will help you get the outcome you want faster.

After that, or if you are not comfortable talking to your provider, you can contact the Commission. You can give the Commission feedback about the quality of care and services you have received. This is different to making a complaint. This information helps the Commission in accrediting, assessing and monitoring services against the quality standards. To provide feedback, please call the Commission on **1800 951 822** or email at Audit.Feedback@agedcarequality.gov.au.

8.4 What can I do if I have a concern about the care I am receiving?

If you have a concern about the care you or someone else is receiving, it is important that you talk about it. It is often best to talk to your provider about your concerns first to see if they can help. They are there to support you. They are also responsible for resolving any concerns you might have about subcontractors who are providing your services.

If you want, you can have a family member, friend, carer or an aged care advocate with you when you meet with your provider. Whether you make your complaint in person, in writing or anonymously, the provider must deal with your complaint.

Making a complaint is not 'being difficult'. Most aged care providers do their best to provide quality care and services for senior Australians. Issues can occur, so we need to ensure that people can raise their concerns in a useful and safe way. Raising your concerns is an opportunity for providers to understand issues, find solutions and improve their care.

Sometimes, complaints cannot be resolved by the service provider. Or you might not feel comfortable raising your concern with them. When this happens, you can contact the Commission.

You have the right to complain anonymously or confidentially. This means that the Commission will be able to keep you up to date and provide you with information. The Commission will explain the difference between open, anonymous and confidential complaints when you contact them.

Complaints can be lodged by phone, in writing or online using the following contact details.

By phone

You can contact the Commission via phone - Free call **1800 951 822** between 9am and 5pm weekdays, or leave a phone message.

Online

You can submit a complaint through the Commission's online complaints form. You can find the form at this link or by searching **"Online Complaints Form"** at www.agedcarequality.gov.au. The Commission will respond to you during business hours; within 24 to 48 hours after receiving your complaint.

In writing

You can write a letter to the Commission and send to:

Aged Care Quality and Safety Commission
GPO Box 9819, in your capital city

It's important the letter includes:

- your name, address and telephone number;
- the date you are lodging your complaint;
- details of your complaint, including specific dates of events and relevant comments;
- the name of the aged care home or service and the state/territory in which it is located; and
- the name of the person receiving aged care that your complaint relates to.

For further information about lodging a complaint please visit this link or search "Making a complaint" at www.agedcarequality.gov.au.

8.4.1 Support making a complaint

If you are not sure about raising an issue, you can speak with an advocate. They can help you work out what your rights are and what your options may be. You can speak to an advocate by calling **1800 700 600** or visiting the Older Person Advocacy Network (OPAN) website at opan.com.au.

Interpreting services are also available. These services are free. You can find out more at this link or by searching "Translation and other support" at www.agedcarequality.gov.au. You can also call the Australian Government Translating and Interpreting Service on **131 450**.

✓ Key points to remember

- All Australian Government funded aged care providers are required to meet the Aged Care Quality Standards. If you don't think your provider is meeting these, the first thing you should do is talk to your provider.

- If you don't feel like your complaint has been addressed properly by your provider you can provide feedback to the Commission. You can call the Commission on **1800 951 822** or email at Audit.Feedback@agedcarequality.gov.au.
- If your complaint is still not resolved you can make a formal complaint online or in writing. This manual tells you how to do that in Section 8.4.

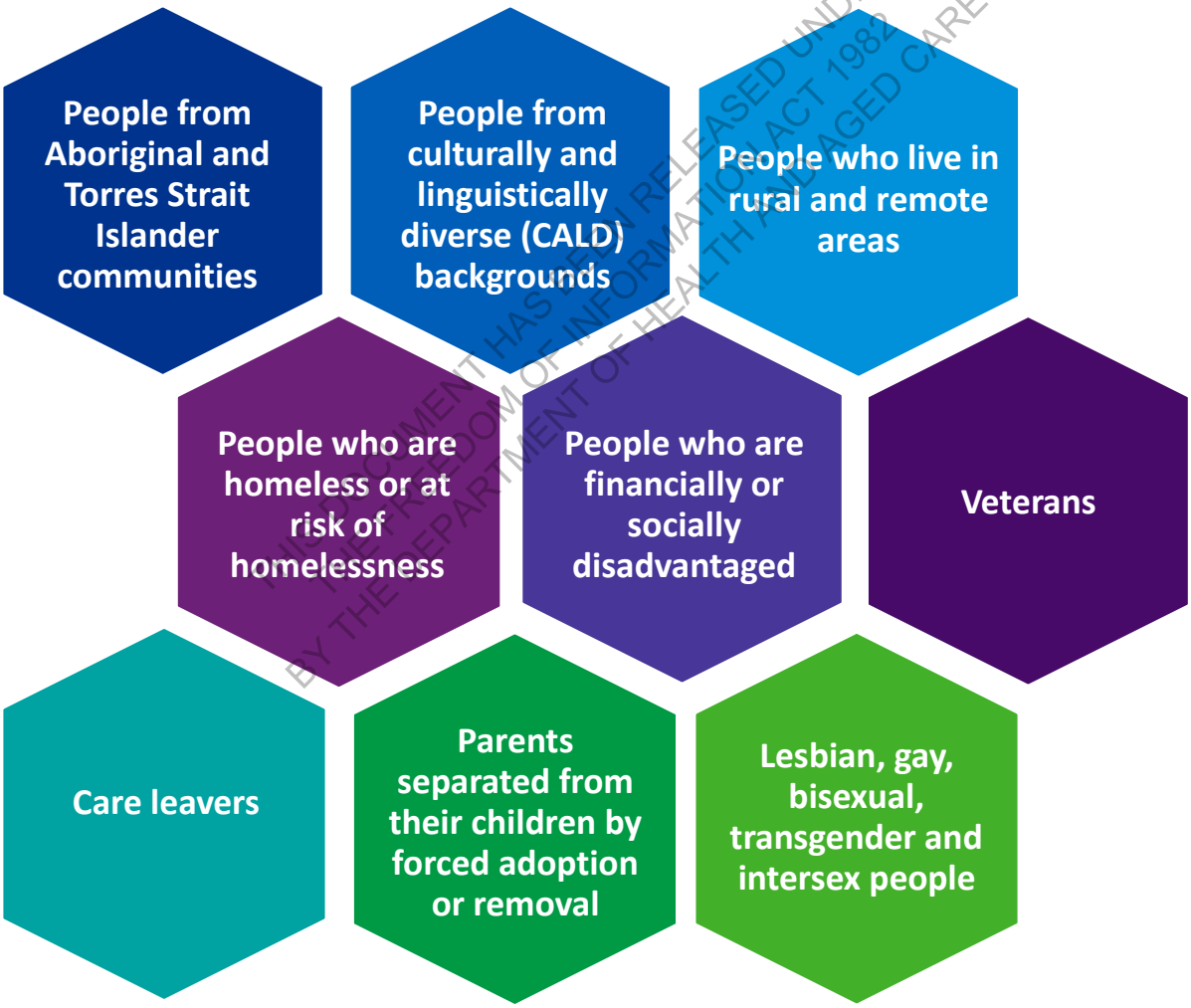
9 Further assistance

This section tells you about extra help that you can get to navigate your Home Care Package and support your care needs.

9.1 What help is available for people with diverse needs?

The aged care system is designed to meet the aged care needs of all senior Australians. It is important that any specific needs and requirements are taken into account when planning a Home Care Package.

The *Aged Care Act 1997* gives particular consideration of the needs of senior Australians who identify with or belong to one or more of the following groups:



Links are included below to the My Aged Care resources for each of the identified groups. You can also call My Aged Care on **1800 200 422** to discuss the supports that may be available to you.

Group	Link	Search terms
Aboriginal and/or Torres Strait Islander people	This link	Search "Support for Aboriginal and Torres Strait Islander people" at www.myagedcare.gov.au
People from culturally and linguistically diverse (CALD) backgrounds	This link	Search "Support for people from culturally and linguistically diverse backgrounds" at www.myagedcare.gov.au
People who live in rural and remote areas	This link	Search "Support for people living in rural and remote areas" at www.myagedcare.gov.au
People who are financially and socially disadvantaged	This link	Search "Support for financially disadvantaged people" at www.myagedcare.gov.au
Veterans	This link	Search "Support for veterans" at www.myagedcare.gov.au
People who are homeless or at risk of homelessness	This link	Search "Support for people facing homelessness" at www.myagedcare.gov.au
Care leavers	This link	Search "Support for care leavers" at www.myagedcare.gov.au
Parents separated from their children by forced adoption or removal	This link	Search "Support for care leavers" at www.myagedcare.gov.au
Lesbian, gay, bisexual, transgender and intersex people	This link	Search "Support for lesbian, gay, bisexual, transgender and intersex people" at www.myagedcare.gov.au

Providers need to be respectful of your needs. They need to ensure that they treat people with dignity and that they support choices that people make when choosing their care and services. For example, you may want to meet with LGBTI social groups or need translation services.

The Aged Care Diversity Framework and action plans can help providers deliver care and support that meets your individual needs. The action plans include documents for you, the consumer, to help express your needs when speaking with providers. You can find more information at this link. You can also search "Aged Care Diversity Framework action plans" at www.health.gov.au.

9.2 What assistance is available for my carer(s)?

Your Home Care Package is intended to meet your specific care needs. If you have a carer, they may need support to help care for you. If your carer is in need of additional support, contact the Carer Gateway on **1800 422 737** or go to the website at www.carergateway.gov.au to find out more.

The Dementia Behaviour Management Advisory Services (DBMAS) provides advice to individuals caring for people living with dementia. This service is provided where behavioural and psychological symptoms of dementia are impacting on their care and quality of life. Access is through the 24 hour helpline **1800 699 799** or the DBMAS website (www.dementia.com.au).

9.3 What other support services are available?

9.3.1 Older Persons Advocacy Network

Older Persons Advocacy Network (OPAN) provides free and confidential services to support senior Australians and their representatives. They assist with issues related to Government funded aged care services. OPAN aims to provide a national voice for aged care advocacy. They promote excellence and national consistency in the delivery of advocacy services under the Program.

For more information, visit the OPAN at opan.com.au. You can also call **1800 700 600** to connect with the aged care advocacy organisation in your state or territory.

9.3.2 Other services

Further information about the support services available from the Australian Government can be found on the My Aged Care website at www.myagedcare.gov.au. There are also a variety of programs that are run by States and Territories, which you may be eligible for. You can find out more about these by consulting with your State or Territory department for health as well as through your usual GP.

The aged care system does not replace the broader health system. You should continue to access health services such as GP, specialist and hospital services for your health needs.

If your carer needs support they can contact the Carer Gateway on **1800 422 737** or go to the website at www.carergateway.gov.au.

✓ Key points to remember

- If you have diverse needs your provider needs to be respectful of those. The Aged Care Diversity Framework will help. You can find it at this link. You can search "Aged Care Diversity Framework action plans" at www.health.gov.au.
- The Older Person Advocacy Network on **1800 700 600** can support you if you have a problem with your care.
- If your carer needs support they can contact the Carer Gateway on **1800 422 737** or go to the website at www.carergateway.gov.au.

10 What happens if I started my Home Care Package before 1 July 2014?

On 1 July 2014, the way home care fees for Home Care Packages are calculated changed. If you received a Home Care Package on or before 1 July 2014, these changes do not apply to you. This means your provider can continue to ask you to pay your current home care fees.

10.1 How are my home care fees calculated?

The home care fees that your provider may ask you to pay are explained below. Your provider will be responsible for calculating your fees. You do not need a Services Australia income assessment if you entered care before 1 July 2014.

10.1.1 Basic daily fee

Providers may charge you a basic daily fee. The rates are included below:

Package level	Per cent of the basic rate of the single age pension (maximum fee)
1	15.68%
2	16.68%
3	17.05%
4	17.50%

Rates for the basic daily fee are reviewed in March and September each year in line with changes to the Age Pension. The current rates are available in the schedule of fees and charges for residential and home care. The schedule can be found at this link. You can also search 'Charging fees for aged care services' at www.health.gov.au.

10.1.2 Income tested fee

If your income is above the basic rate of pension, providers may charge an additional amount of up to 50 per cent of income above the single age

pension. This amount will vary when new rates for the Age Pension are announced each March and September.

10.1.3 When do my fees change?

Your provider should review your fees regularly. You can also ask them to do a review at any time, if your financial circumstances change.

10.1.4 How does leave work?

If you entered cared before 1 July 2014, you are entitled to leave in the same circumstances as consumers in the post-1 July 2014 arrangements. The home care fees that will be payable, however, differs. The table below outlines when home care fees will be payable:

Leave type	Home care fees
Hospital	Yes
Transition Care	No
Residential respite care	No
Social leave (package suspended for any other reason)	Yes

10.1.5 Financial hardship

Your provider must not charge you the maximum amounts if doing so would cause you financial hardship. Your maximum fees depend on your income but your home care provider must also have regard to unavoidable expenses such as high pharmaceutical bills, rent, utilities and other living expenses. This means that you can negotiate a lower basic daily fee and/or income tested fee directly with your home care provider, if you are experiencing financial hardship.

10.1.6 Annual and lifetime caps

If you received a Home Care Package before 1 July 2014, or you have transferred to a new home care provider but have decided to stay on your existing fee arrangements, the annual and lifetime caps do not apply to your income tested fees.

10.2 What happens if I intend to move to a new service provider?

If you were receiving a Home Care Package on or before 30 June 2014 and move to a new approved provider you may be able to opt in to the new fee arrangements.

Information to help you decide is available at this link. You can also search for 'Aged care costs if you entered care before 1 July 2014' at www.myagedcare.gov.au.

If you choose the new fee arrangements, you will need to complete and sign the '**Continuing Care Recipient opting into the New Aged Care Arrangements from 1 July 2014 (AC022)** form' within 28 days of transferring to a new provider. Form AC022 is at this link or by searching "AC022" at www.servicesaustralia.gov.au. You will need to submit this form to your new provider **before** you start with them. This completed and signed form is sent with the Aged Care Entry Record (ACER) to Services Australia by your new provider.

Your new provider will also need to give you the 'New Arrangements for Aged Care from 1 July 2014 – Home Care' publication. You can find this publication at this link or by searching "New Arrangements for Aged Care from 1 July 2014" at www.health.gov.au.

If you do not give the completed form to your new provider before you start with them, you will automatically be classed as a 'continuing care recipient'. This means you will stay on your pre-1 July 2014 fee arrangements. This is not a reviewable decision and must be done correctly so you can opt in to the post-1 July 2014 fee arrangements.

10.3 What does my Home Care Agreement need if I entered care before 1 July 2014?

In addition to the parts of a Home Care Agreement outlined at Section 3.6 of this manual, a pre-1 July 2014 consumer's Home Care Agreement will need to include the following:

- A statement that the provider may charge the consumer home care fees in accordance with Division 6 of the *Aged Care (Transitional Provisions) Act 1997*;

- A statement setting out which fee (if any), as determined in accordance with section 130 of the *Aged Care (Transitional Provisions) Principles 2014*, the provider will charge; and
- If the provider is charging the consumer a daily amount of home care fees in accordance with Division 60 of the *Aged Care (Transitional Provisions) Act 1997* that is different from the daily amount of home care fees mentioned in the pricing Schedule, the different amount and the reason for the different amount.

✓ Key points to remember

- If you received a Home Care Package before 1 July 2014, and have not moved to the post-1 July 2014 arrangements, you have a different home care fee arrangement.
- If you entered care before 1 July 2014, your provider is responsible for calculating your fees. You do not have to get a Services Australia income assessment.
- Your Home Care Agreement must include additional provisions if you entered care before 1 July 2014.

Researching Home Care Providers – Considerations and checklist

What to consider	Why?
What services are important to me?	You will need to research providers and find out if they offer services that are important to you, particularly if you have special requirements. For example, some providers specialise in services such as a specific language or dementia support. You may also want to consider where the provider is located as this can reduce travel times and in some cases, reduce the costs associated with travel. You can find providers in your local area by using the 'Find a provider' tool on the My Aged Care website or by calling My Aged Care on **1800 200 422**.
Can I choose who is going to provide certain services for me?	You have a say in the types of care and services delivered to you as part of your Home Care Package, as well as who delivers those services. Discuss any preferences you have with potential providers to understand how they can best support you.
How does the provider ensure quality of service?	You can ask each provider about their screening process and what checks they do before they employ care workers. You can also ask whether they have a training program and what qualifications they expect of their care workers before they are able to work with clients. Providers are required to offer care and services in a way that meets the Aged Care Quality Standards. If you want to know what these Standards are and how they work, talk to the provider. You can also ask how they obtain and use your feedback.
How much will each service cost?	Knowing how much each service costs and what type of services you can get lets you get the most out of your package.

What to consider	Why?
	Each provider must publish their full price list on the My Aged Care website. This includes prices for common services and care management costs. You can view and compare this information on the 'Find a provider' tool on the My Aged Care website. Services can include general support such as cleaning and household tasks, light gardening, and personal care such as bathing, showering and dressing. It may also include nursing services, in-home respite, social support or transport services. Take a copy of your Home Care Package approval letter and support plan as well as your income assessment outcome (if you have it) to potential providers, as this will help your discussions.
How much will I have to pay in home care fees (post 1 July 2014)	If you can afford to, you are expected to help with the cost of your care. Your contribution may be made up of three types of fees: • a basic daily fee • an income-tested care fee (if your income is over the maximum income for a full pensioner, you may be asked to pay this fee) • an amount for additional care and services you have agreed to pay for extra care and services that wouldn't otherwise be covered by your Home Care Package. To get an estimate of the fees you may be asked to pay, use the home care fee estimator on www.myagedcare.gov.au, which you can locate by searching for 'Fee Estimator'. If you're receiving a pension that is not means tested e.g. blind rate service pension or war widow pension, or you're not receiving a means tested income support payment, you should call Services Australia on

What to consider	Why?
	1800 227 475 (or DVA on **1800 555 254**) and ask if you need a formal income assessment.
What other costs can the provider charge?	The only costs a provider can charge, that are not directly related to delivering your care and services, are outlined in the 'other costs' section of the Schedule, published on the My Aged Care website. This must also be included in your Home Care Agreement. This includes package management, which is the cost for the ongoing administration and organisation activities associated with ensuring the smooth delivery of your Home Care Package, maximum exit amount, staff travel costs to visit you and separate costs when you want to get services from a different provider. Providers cannot charge separately for any other costs that are unrelated to supporting your care or costs associated with the running of their business. You should also be clear on what these costs are and the impact to your available Home Care Package funds. You should also ask if they charge exit amounts if you decide to change providers at a later stage.
What processes does the provider have for managing complaints?	Ask the provider what process they have to request a change of care worker, any notice periods and/or cost implications and if there is a complaints process. You direct your own care and have control over who delivers your care, and where and when they deliver it.
Can I bring a family member or carer to my discussion with providers?	There can be a lot of information discussed at your meeting with a provider so bringing a family member, friend or carer with you can be helpful. Ask how your family can be included in your decision making and how the provider will include your family member/carer in your care plan.

Checklist

- ☐ Consider what is important to you and how potential providers can deliver the services you need and want, to help you manage at home.
- ☐ Create a shortlist of providers you want to speak to:
  - use the 'Find a provider' tool on the My Aged Care website www.myagedcare.gov.au
  - compare providers including their prices for some common services you may receive through your Home Care Package as well as other cost
  - call My Aged Care on **1800 200 422** if you need help.
- ☐ Prepare questions you would like to ask potential providers – use the considerations in the table above as guidance.

Next steps

- ☐ If you have not already done so, work out what you may be asked to contribute the cost of your care. Use the Fee Estimator at this link, or by searching "Fee Estimator" at www.myagedcare.gov.au
- ☐ Wait for a letter from My Aged Care advising you of the assignment of your Home Care Package. This will include a referral code for you to provide to your preferred provider.

  You can then negotiate and enter into a Home Care Agreement and start receiving services under your Home Care Package.

Entering into a Home Care Agreement – Considerations and checklist

What to consider	Why?
What is included in my Home Care Agreement?	Your Home Care Agreement sets out how your services will be provided, who will provide them, and how much they will cost. Your Agreement will include: • a care plan – outlining the services you will receive under your package taking into consideration your individual goals and preferences • an individual budget – outlining the funds available in your package, and how those funds will be spent. If your care needs change over time, your care plan and budget should be updated to reflect care plan or cost changes.
Your individual (Home Care Package) budget	Discuss your Home Care Package budget with the provider to see what services you can afford. Your Home Care Package budget is made up of: • The government subsidy (and eligible supplements). • The basic daily fee, which all people receiving a Home Care Package may be asked to pay. The basic daily fee varies depending on your package level. • Your income-tested care fee (if applicable). You may need to pay this depending on your income assessment (if you entered into a Home Care Agreement after 1 July 2014) • Your income tested fee (if you entered into a home care agreement pre 1 July 2014) • An amount for additional care and services (if agreed).
How much will the provider charge for care and services?	All providers must publish their prices for common services and costs on the My Aged Care website. You can find this information using the 'Find a provider' tool.

What to consider	Why?
	The provider must include a copy of their published pricing schedule in your Home Care Agreement. They must then charge you the price outlined in your Home Care Agreement, unless you agree and document otherwise.
What other costs can the provider charge?	The only extra costs a provider can charge that are not direct care and services are published on the My Aged Care website. This includes package management which is the ongoing administration and organisational activities associated with ensuring the smooth delivery and management of your Home Care Package. It may include the cost for preparing monthly statements, managing your package funds, and compliance and quality assurance activities required for Home Care Packages. Providers are unable to charge you a different amount, unless you agree otherwise. This different price, and the reason, must then be documented in your Home Care Agreement. Providers are also unable to charge you separately for any business-related administration costs such as marketing, office rent, insurance or activities completed before a person enters into a Home Care Agreement. Where necessary, a provider can include any other administration costs within the price for home care services. This is to ensure that you can see the all-inclusive cost of delivering the service.
If I change providers, will I need to pay a fee?	Providers are able to charge an exit amount to cover any administration costs they may incur. Clarify what (if any) exit amount they will charge you if you decide to change providers and any minimum notice period that may apply. Your provider must disclose the exit amount in your Home Care Agreement. Providers are also required to display their maximum exit amount in the 'Find a provider' tool on the My Aged Care website.

What to consider	Why?
What information will be covered in my statement?	You will receive monthly statements that show how your Home Care Package budget is being spent. Your statement will show you the income and expenditure for your package, and any unspent home care amount so you can keep track of your spending. Any unspent home care amount will carry over from month to month, and from year to year, for as long as you continue to receive care under the package. If you want more information about how you will receive the statement, discuss this with the provider.
What if I need an interpreter to help with my Home Care Agreement?	If you need an interpreter to help you develop your Home Care Agreement, budget and care plan, ask your provider to arrange time with the Translating and Interpreting Service (TIS National). You can contact TIS National on **131 450**. TIS offers telephone or on-site interpreting services in over 100 languages. It can be used free of charge when you are working with your provider to develop or change details of your Home Care Agreement.
Do I understand the terms of my Home Care Agreement?	Your provider has a responsibility to help you understand the terms of your Home Care Agreement. It is important that you are happy and agree with the information included in your Agreement. Read it carefully. Create a list of questions and concerns and consider discussing them with a friend, family member, carer or advocate before discussing these with your provider. You can also seek independent legal advice, if you wish. Once you are happy with the content, you can enter into the Agreement. This will be your contract to start receiving services.
Can I change my Home Care Agreement?	It is <u>your</u> Home Care Agreement so you can talk with your provider about changes at any time. Any changes to the terms of your Agreement are subject to mutual consent

What to consider	Why?
	with your provider. Talk to your provider about this process.

Checklist

- ☐ Confirm who will deliver your services, how often and where they will deliver the services.
- ☐ Provide your support plan and outcome from your income assessment to your provider.
- ☐ Clarify the costs associated with the delivery of your care and services. These should align with those published on My Aged Care, unless you discuss and agree a different amount with your provider.
- ☐ Work with your provider to design a care plan that meets your needs and care requirements.
- ☐ Review your Home Care Agreement with a family member, carer, friend or advocate. If you want to, you can also seek independent legal advice.
- ☐ Enter into your Home Care Agreement and start receiving services.

Changing Providers – Considerations and Checklist

What to consider	Why?
Am I able to change home care providers?	You can change providers at any time, if you are moving to a different location or are looking for a better fit. Check your Home Care Agreement so you know of any conditions such as notice periods and exit amounts that may apply.
Do I need to find a new provider before I leave my current provider?	For your own peace of mind and to minimise any interruption to your services, you should start researching providers before agreeing on an end date with your current provider. Use the 'Find a provider' tool on the My Aged Care website to check if another provider is able to deliver the care and services you need and how much it may cost. You can also call My Aged Care on **1800 200 422**. Providers must publish their pricing information in a standardised schedule, as well as their full price list, on the My Aged Care website. Using the compare function, you can select providers and compare their common services and other costs. This will allow you to make a more informed decision about which provider is best suited to deliver your care. Under the *Charter of Aged Care Rights*, you have a responsibility to tell your provider of the day you intend to stop receiving home care services.
How do I change providers?	Call My Aged Care on **1800 200 422** to re-activate your referral code. You need this referral code to give to your new provider before you can start receiving their services. When the re-activated referral code is accepted by your new provider, a notification will be sent to your current provider to let them know you are looking to change

What to consider	Why?
	providers. This is not your official notice to them and you should have a discussion with your existing provider to formally agree an end date for your current services.
How long do I have to enter into a Home Care Agreement with a new provider?	Once you have agreed an end date with your current provider, you have **56 days** from the end date to enter into an Agreement with a new provider. If you need more time then you can call My Aged Care and request a **28 day** extension. If you do not enter into an Agreement by this time, your Home Care Package will be withdrawn. The start date with your new provider must be after the end date you have agreed with your old provider and the dates cannot overlap.
Will I need to pay an exit amount?	Exit amounts may be charged by a provider if agreed to in your Home Care Agreement, when you move to another home care provider or exit home care. You should review your Home Care Agreement to check if you need to pay an exit amount. The exit amount (if applicable) will be deducted from any unspent funds in your package. The exit amount cannot be more than your unspent funds, or what is listed in your Home Care Agreement.
What happens to any unspent funds?	If there are any unspent funds in your package (after all other payments and fees have been paid) this will follow you to your new provider. For this to happen, you must notify your old provider within 56 days of ending your services with them, of the details of your new provider. Your old provider must give you a statement outlining any unspent funds within 56 days of your agreed end date with them and then transfer any unspent funds to your new provider within 70 days of your agreed end date.

What to consider	Why?
If I was receiving home care prior to 1 July 2014, will my fee arrangements be affected if I change providers?	You must enter into a Home Care Agreement with a new provider within 28 days to continue with the old home care fee arrangements. If you take more than 28 days to enter into a new Home Care Agreement, the new fee arrangements that started on 1 July 2014 will apply to you.

Checklist

- ☐ Review the terms and conditions of your current Home Care Agreement so you are aware of any costs and notice periods when you change provider.
- ☐ Create a shortlist of providers in your local area:
  - use the 'Find a provider' tool on the My Aged Care website myagedcare.gov.au
  - compare providers including their prices for some common services you may receive through your Home Care Package as well as other costs
  - call My Aged Care on **1800 200 422** if you need help.
- ☐ Decide on a suitable provider and check they are able to provide you with the care and services you need.
- ☐ Agree on an end date of services with your old provider. Remember; you have 56 days (or 84 days if you requested an extension) from this end date to enter into a Home Care Agreement with a new provider.
- ☐ Call My Aged Care on **1800 200 422** and ask to re-activate your referral code. Your new provider will need this referral code before they can start delivering services to you.
- ☐ Work with your new provider to develop or review your care plan.

- ☐ Review the terms and conditions of your current Home Care Agreement so you are aware of any costs and notice periods when you change provider.
- ☐ Agree on a start date for services with the new provider and enter into a Home Care Agreement. Remember; the start date must be on or after the end date with your old provider.
- ☐ Notify your old provider within 56 days of ending your services with them, of the details of your new provider so that any unspent funds can follow you.
- ☐ Check that any unspent funds have been transferred from your old provider to your new provider within 70 days of your agreed end date of services.

Setting up a myGov account

You can use myGov to access Medicare, Centrelink and My Aged Care online accounts, all in one place. This shows you how to create a myGov account.

Step	Instructions
1. Create an account	Go to my.gov.au and select **Create an account** on the homepage.
2. Agree to terms of use	Read the **Terms of use**. If you agree to the terms, select **I agree.**
3. Enter an email address	Each myGov account must have a unique email address. You can't use the same email for two myGov accounts. If you share an email address with someone, only one of you can use it to create a myGov account. Enter your **Email address**, then select **Next.** myGov will send a code to your email address. Check your email enter the **Code** I and then select **Next.**
4. Enter your mobile number	Enter your **Mobile number**, and then select **Next**. If you don't have access to a mobile phone or mobile reception, select **Skip this step**.
5. Create a password	Enter a **Password** and then **Re-enter password**. You can then select **Next**. Your password must have at least 7 characters and include at least 1 number.
6. Create secret questions	Secret questions and answers help keep your account secure. myGov will ask you to create 3 questions and answers that only you can answer. Choose a question from the list or create your own question. Make sure your answers are easy for you to remember. Select **Next** after you enter your answer. Repeat this step to create questions 2 and 3.

Step	Instructions
7. Use your myGov account	You've created a myGov account. You'll see your myGov username on screen and it will also be emailed to you. You can use your username or email address to sign in to myGov. Select **Continue to myGov**.
8. Link your My Aged Care online account	Once logged in to myGov, click the **Services** button on your myGov home page. Then click the **Link** icon next to My Aged Care. You will now be redirected to a Department of Social Services login screen. Enter your **email address**. This must be the same email address you provided My Aged Care when they registered you and created your client record. Then select **Continue**. You will be emailed an activation code to the email address you entered. Enter this **Activation Code** and select **Confirm**. Your My Aged Care online account is now linked. My Aged Care will now appear in your linked services on your myGov homepage.

Australian Government
Department of Health

Home Care Packages Program

Operational Manual

A guide for home care providers

Version 1.1 – February 2021

Contents

Reviews

Date	Summary of changes
March 2020	Manual (v1.0) first issued
February 2021	Manual revised (v1.1). Includes content about Improved Payment Arrangements, the Aged Care Provider Portal, addressing people receiving care and services under a package funded by the Australian Government as care recipients, updated web links and minor updates to wording.

Disclaimer

The Home Care Packages Program is governed by the applicable legislation, not this Manual. Home care providers are responsible for understanding and complying with all legislation that is relevant to delivering home care. This Manual is not a substitute for, and is not intended to replace independent legal advice on providers' legal obligations, or provide any interpretation of the legislation.

Home care providers should consider the need to obtain their own appropriate legal advice relevant to their particular circumstances.

In addition to the legislation referred to in this Manual, each State and Territory may have its own separate legislation that is relevant to providers' operations as a home care provider. It is the provider's responsibility to understand and meet their obligations as they relate to all applicable legislation.

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In addition to this Manual, there are information resources that may further help providers understand their responsibilities and obligations as an approved provider. These Australian Government resources are available from:

- The Department of Health www.health.gov.au
- My Aged Care www.myagedcare.gov.au
- The Aged Care Quality and Safety Commission www.agedcarequality.gov.au
- Services Australia www.servicesaustralia.gov.au
- The Australian Competition and Consumer Commission www.accc.gov.au

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1 Introduction

This section discusses management of the Home Care Packages (HCP) Program Provider Manual (this manual) including how it will be updated, and how to provide feedback on the manual.

1.1 What does this manual contain?

This manual provides guidance on the Australian Government's policy context and operational requirements for the HCP Program for approved home care providers.

A HCP Program consumer manual has also been developed and is available at www.health.gov.au and www.myagedcare.gov.au. Both manuals are detailed, however, if you are looking for a high-level summary of the program, you can find information at:

- This link or by searching "Home Care Packages Program" at www.health.gov.au; or
- This link or by searching "Home Care Packages" at www.myagedcare.gov.au.

1.2 How will the manual be updated?

The Home Care Packages Program and the broader aged care system continue to operate in an environment of change.

The Department of Health ('the Department') will update the manual, as required, to ensure its currency and accuracy. The table at page five of this manual outlines the revisions that have been made since its release.

Please refer to the online version of the manual at www.health.gov.au to ensure that you have the most recent version. The footer of each page includes the issue date of the manual.

1.3 If I want to talk to someone about my questions, who can I contact?

To answer any questions you have, the My Aged Care contact centre is open Monday to Friday 8am-8pm and Saturday 10am-2pm. You can call the My Aged Care provider and assessor helpline on **1800 836 799**.

The My Aged Care contact centre is closed on Sundays and public holidays.

1.4 Who may I get additional assistance from?

The following peak bodies may be a further source of information and support for delivering aged care services generally:

Peak body	Website	Phone number
Aged & Community Services Australia (ACSA)	www.acsa.asn.au	**1300 877 855**
COTA Australia	www.cota.org.au	**(02) 6154 9740**
Federation of Ethnic Communities Councils of Australia (FECCA)	fecca.org.au/	**(02) 6282 5755**
Leading Age Services Australia (LASA)	www.lasa.asn.au	**1300 111 636**
National Aboriginal Communities Controlled Health Organisation (NACCHO) Affiliates	www.naccho.org.au	**(02) 6246 9300**
National Seniors	nationalseniors.com.au/	**(07) 3233 9198**
Older Persons' Advisory Network (OPAN)	opan.com.au/	**1800 700 600**

✓ Key points to remember

- If you are reading a printed copy of this manual, please make sure it is the most up to date version. You can find the most current version of the manual by going to https://www.health.gov.au/resources/publications/home-care-packages-program-operational-manual-a-guide-for-home-care-providers.

2 The Home Care Packages Program

This section provides an overview of the HCP Program, including the underlying philosophy and intent of the Program.

2.1 What is the philosophy underpinning Home Care?

The Department and the Australian Government seek to meet to the needs and preferences of senior Australians by placing them at the centre of aged care services. Australians are living longer and healthier lives. It is important that, as people age, they have choice about their care. Reviews into aged care have found that senior Australians do not want to be passive recipients of services.

Rather they want the opportunity to play an active role in where they live, which provider they choose to deliver their care and the ways in which services are provided. Feedback has also consistently shown that senior Australians wish to remain living independently in their own homes for as long as possible. In response, the Government has progressively implemented a number of reforms to the aged care sector in order to deliver a consumer directed care (CDC) approach to aged care services.

The Australian Government funds a range of aged care services from entry level home support to residential care for high needs.

Three principles underpin these programs:

2.2 What is the intent of the Home Care Packages Program?

The HCP Program supports senior Australians with complex care needs to live independently in their own homes, using a consumer-directed care approach to ensure the support suits a person's needs and goals. Home care packages ('packages') deliver co-ordinated packages of care and services to meet people's assessed care needs within the limits of their individual home care budget and the scope of the Program. How care and services are identified and delivered should reflect and respect the individual, their care needs, personal situation and preferences.

All packages are delivered using a CDC model. The aim of this approach to planning and managing care and services is to give care recipients choice and flexibility in the supports they access, based on need, and how they are delivered.

The Aged Care Quality Standards require providers to deliver safe and effective services and supports for daily living that optimise the person's independence, health, well-being and quality of life. Services and supports for daily living include, but are not limited to, food services, domestic assistance, home maintenance, transport and recreational and social activities.

These may include services and supports to keep people:

- well and independent – including personal care, nursing services, allied health
- safe in their home – including cleaning, home maintenance and modifications, assistive technology
- connected to their community – including transport, social support services.

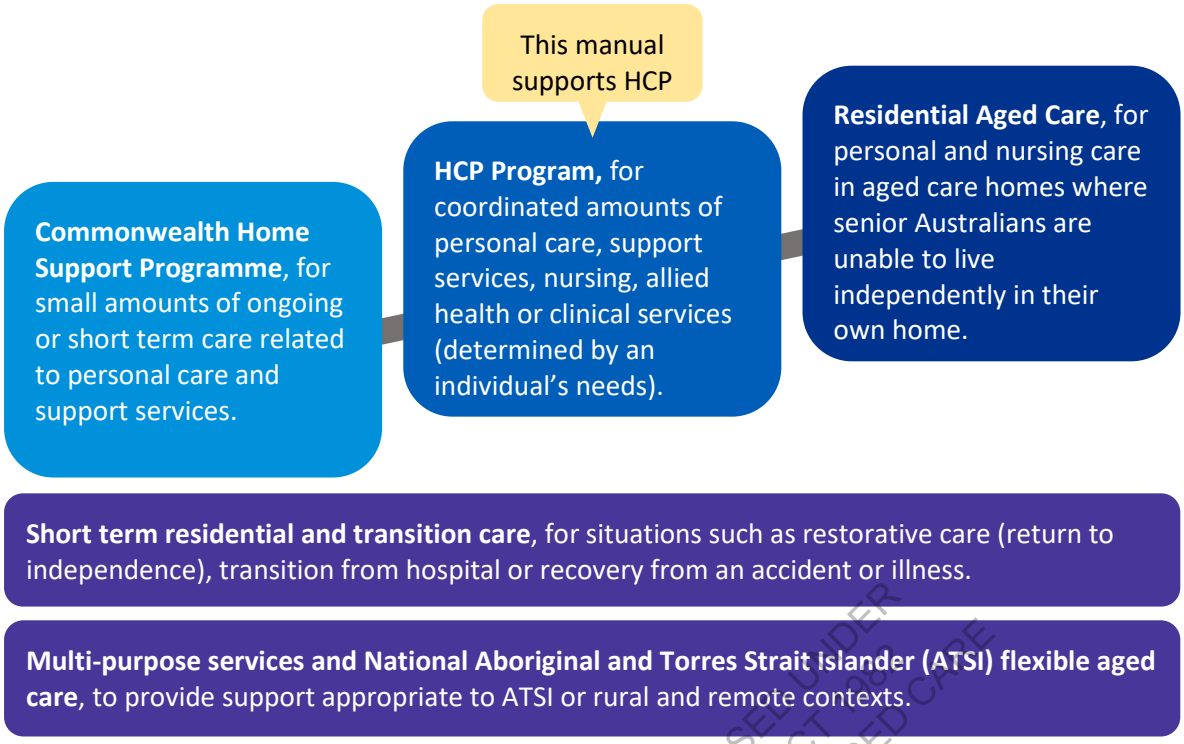
Care recipients should be actively involved in deciding how their package funds are spent. A package, however, is not a source of income that people can use completely at their own discretion. Providers need to work in partnership with care recipients to ensure that funding is used appropriately. This includes due consideration of the legislated exclusions from a package (discussed at Section 9).

Different people, and their support networks, will want different levels of involvement in planning and managing their package, including self-management. At every level, providers will need to work with care recipients to balance their duty of care with an individual's right to make choices that take reasonable risks. This right is known as 'dignity of risk' and is discussed further at Section 9.

Notwithstanding the above, an approved provider is responsible for the compliance and quality of all care and services provided under a package.

2.3 What is the scope of the Home Care Packages Program?

The HCP Program is part of the Australian Government's continuum of care for senior Australians. It addresses the level of need between the Commonwealth Home Support Programme (which offers a relatively small amount of care and support services) and Residential Aged Care (a high level of care in a residential aged care home). The following diagram outlines where the HCP Program sits within the continuum:



Access to care at home programs is determined by an independent assessment by an Aged Care Assessment Team (ACAT) or a Regional Assessment Service (RAS). My Aged Care will connect individuals to the correct assessment service for their needs (see Section 6).

Some people will receive services through flexible care or Commonwealth Home Support Programme and will then be assessed for the HCP Program; others will start their Government-supported aged care with the HCP Program. There is no requirement that anyone participates in programs earlier in the continuum of care to be eligible for the HCP Program. Further information on the interaction of these and other aged care programs is included at Section 16.

The HCP Program provides a subsidy and supplements (where an individual is eligible) towards a co-ordinated package of care, services and care management to meet each person's assessed care needs, care goals and preferences. There are four levels of packages to reflect the different levels of assessed care needs to support people to safely remain living at home.

The types of care and services that can be subsidised by the Government under the HCP Program should keep people well and independent, safe in their home and/or connected to their community. Primary categories of in-scope supports are set out in the table below:

Services to keep people well and independent	Services to keep people safe in their home	Services to keep people connected to their community
• Personal care • Nursing • Allied health and therapy services • Meal preparation and diet • Specialised support	• Domestic assistance • Home maintenance • Minor home modifications • Goods equipment and assistive technology • Respite	• Transport • Social support

The HCP Program cannot be used to purchase types of care that are funded, or jointly funded, by the Australian Government through other initiatives such as the Medicare Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS). Nor can it be used toward purchasing care or services the care recipient already accesses or plans to access through another program or scheme, including those funded by State/Territory Governments. For example, aids and equipment schemes, patient transport and accommodation schemes, and sensory impairment support schemes.

Further guidance on how to decide what can be included under a package is included at Section 9**.**

2.4 How are a care recipient's care needs and goals established?

When a person enters the HCP Program, their provider should ensure they understand that person's assessed care needs and help them to establish goals for their care. The documentation from their ACAT assessment will record assessed care needs at the time of assessment, and providers will need to discuss these with them. In the time between the assessment and assignment of a package, assessed care needs may have changed. Providers are well placed to identify how these needs have changed and can be met within the framework of the existing ACAT assessment. This can be done when discussing which care and services to provide under a package.

As part of this conversation, providers and care recipients should consider any supports already in place or accessible through a carer, family members, friends, local community and other services should be considered. The package can be used to access complementary care and services, maximising the supports available.

Each individual's package should equally be directed by their personal goals. A wellness approach should be taken to delivering all care and services. Where possible and clinically appropriate, care and service should also align with reablement.

Wellness is an approach that involves the assessment, planning and delivery of supports that build on an individual's strengths, capacity and goals. This includes encouraging actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home.

Wellness as a philosophy is based on the premise that, even with frailty, chronic illness or disability, people generally have the desire and capacity to make gains in their physical, social and emotional wellbeing to live autonomously and as independently as possible.

Reablement involves short-term or time-limited interventions that are targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities. Like wellness, reablement aims to assist people to reach their goals and maximise their independence and autonomy. Supports could include training in a new skill or re-learning a lost skill, minor modification to a person's home environment or having access to equipment or assistive technology.

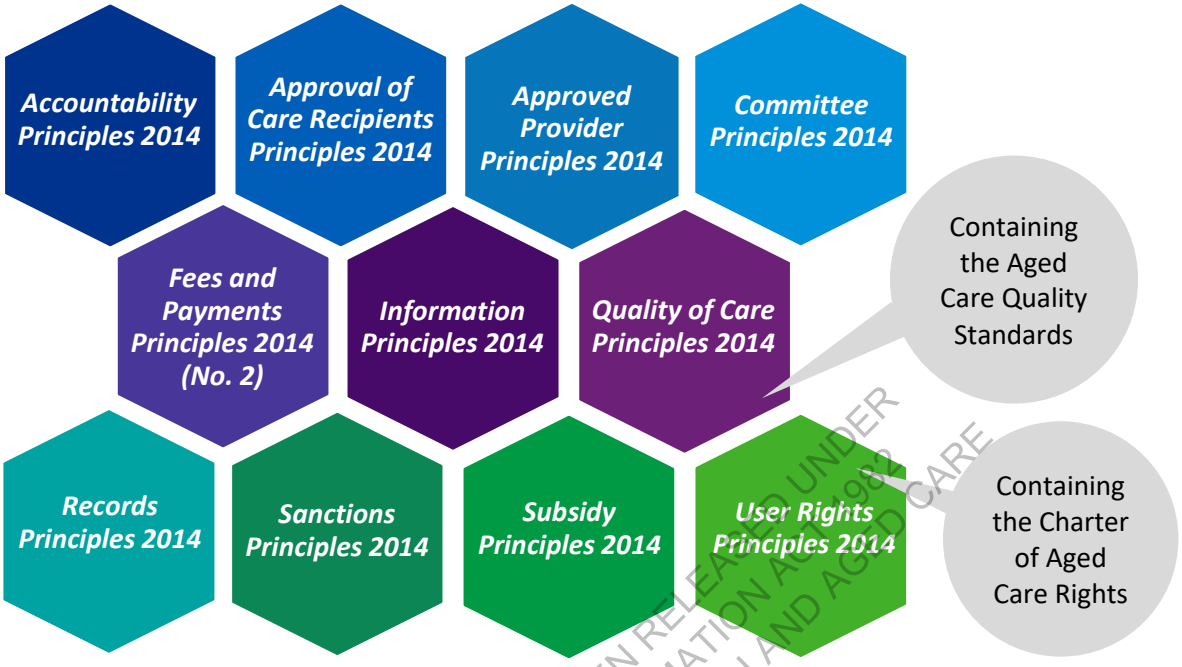
More information about wellness and reablement is at Section 7.3 of this manual.

2.5 What governs the Home Care Packages Program?

There are three tiers of laws that govern the HCP Program. These are:

- **Principal legislation.** This is the overarching law enacted by Parliament.
- **Legislative instruments.** These are subordinate legislation made with powers provided by the principal legislation. These instruments provide more details on how the HCP Program operates.
- **Determinations.** These are instruments that the legislation enables, if needed, to set out or clarify specific facts and details about the HCP Program.

For people who entered the HCP Program after 1 July 2014, the *Aged Care Act 1997* governs the HCP Program. A number of legislative instruments, titled 'Principles', have been made to support that legislation. Eleven of these Principles are relevant to the HCP Program and have been cited throughout this manual. 'The Principles' (relevant to post-1 July 2014 care recipients in the HCP Program) are listed below for reference:



One determination is relevant for post-1 July 2014 care recipients: the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

In addition to the above law, transitional provisions have been established for people who entered the HCP Program before 1 July 2014 (pre-1 July 2014 care recipients). These are established by the following legislation, instrument and determination:

- *Aged Care (Transitional Provisions) Act 1997*
- *Aged Care (Transitional Provisions) Principles 2014*
- *Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014*.

Information regarding these pre-1 July 2014 provisions is at **Appendix A** of this manual.

Finally, provider compliance and the quality of aged care is governed by the following legislation and instrument:

- *Aged Care Quality and Safety Commission Act 2018*
- *Aged Care Quality and Safety Commission Rules 2018.*

The Federal Register of Legislation is frequently updated. As a result, this manual does not include links to the legislation. You will be able to find the most recent version by searching the title of the instrument you are looking for at www.legislation.gov.au[1].

The Department does not provide advice on whether a provider's business operations are consistent with the requirements of the Act.

The Department funds the Business Advisory Service to provide accounting and business advisory services to approved providers to maximise business performance and service viability. This involves reviewing and assessing the organisation then providing advice and business management and

[1] If you are not sure if you have the most recent version, you can check by looking at the top left corner of the web page. If you have the right version the words 'In force- latest version' will be marked in green above the heading 'View Series'. If it is not the current version, it will say 'In force – Superseded version' in red text.

financial strategies. For more information go to this link or visit the website at www.pwc.com.au/health/aged-care-advisory.html.

✓ Key points to remember

- The HCP Program supports senior Australians with complex care needs to live independently in their own homes, using a consumer-directed care approach to ensure the support suits a person's needs and goals.
- The HCP Program is designed to provide more co-ordinated care and services than the Commonwealth Home Support Programme, but less intensive care than Residential Aged Care.
- The HCP Program operates using a CDC model to provide more choice and flexibility to care recipients. Providers remain responsible for ensuring the delivery of quality and appropriate care.
- The HCP Program is governed by the *Aged Care Act 1997* and a number of other laws (including the Principles) all of which must guide providers in delivering packages.

3 Rights and responsibilities

This section outlines rights and responsibilities that should underpin delivery of the Home Care Packages Program.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 54-1, 56-2, and 56-4 of the *Aged Care Act 1997*
- *User Rights Principles 2014*
- *Quality of Care Principles 2014*
- *Aged Care Quality and Safety Commission Rules 2018.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

3.1 Charter of Aged Care Rights

The *User Rights Principles 2014*, made under the *Aged Care Act 1997*, contains the Charter of Aged Care Rights. The Charter came into effect from 1 July 2019 and applies to all Australian Government funded aged care recipients of the HCP Program. The Charter consists of 14 individual consumer rights and is extracted below:

Charter of Aged Care Rights

I have the right to:

1. safe and high quality care and services
2. be treated with dignity and respect
3. have my identity, culture and diversity valued and supported
4. live without abuse and neglect
5. be informed about my care and services in a way I understand
6. access all information about myself, including information about my rights, care and services
7. have control over and make choices about my care, and personal and social life, including where the choices involve personal risk
8. have control over, and make decisions about, the personal aspects of my daily life, financial affairs and possessions
9. my independence
10. be listened to and understood
11. have a person of my choice, including an aged care advocate, support me or speak on my behalf
12. complain free from reprisal, and to have my complaints dealt with fairly and promptly
13. personal privacy and to have my personal information protected
14. exercise my rights without it adversely affecting the way I am treated.

3.2 What responsibilities do I (as an approved provider) have in relation to the Charter of Aged Care Rights?

Approved providers must not act in a way that is inconsistent with the Charter of Aged Care Rights. Providers also have responsibilities, in relation to the Charter to:

- Give consumers a copy of the Charter signed by a staff member of the provider.
- Give the consumer information about their rights under the Charter.
- Assist the consumer to understand their rights under the Charter.
- Ensure the consumer, or their authorised person, is given a reasonable opportunity to sign a copy of the Charter.
- Keep a record of the Charter given to the consumer, which includes the:
  - signature of a staff member of the provider;
  - date on which the provider gave the consumer a copy of the Charter;
  - date on which the provider gave the consumer (or their authorised person) a reasonable opportunity to sign the Charter;
  - consumer (or authorised persons)'s signature (if they choose to sign); and
  - full name of the consumer (and authorised person, if applicable).

Providers must offer all consumers the choice to sign the Charter of Aged Care Rights. They are not required to sign and can receive care and services if they choose not to sign.

Asking the consumer to sign provides them with an opportunity to acknowledge that their provider has given them a copy of the Charter, has assisted them to understand it and that they understand their rights. Providers must meet all the consumer rights in the Charter of Aged Care Rights whether they sign their copy or not.

Resources to support the sector's understanding of the Charter, including a booklet, are available on the Department's website at this link, or by searching "Charter of Aged Care Rights" at www.agedcarequality.gov.au.

3.3 What responsibilities do aged care consumers have in relation to the Charter of Aged Care Rights?

All people involved in aged care – care recipients, their families, carers, visitors and the aged care workforce – must respect and be considerate of each other. Quality aged care outcomes are more likely to be achieved in an environment of mutual respect. Aged care consumers are expected to:

- give providers the information they need to properly deliver care and services;
- comply with the conditions of their Home Care Agreement and pay fees outlined in the agreement on time; and
- respect the rights of aged care workers to work in a safe environment. Any kind of violence, harassment or abuse towards staff or others is not acceptable.

Home Care Agreements have terms and conditions that set out the rights and responsibilities of the parties who have entered into the agreement. Home Care Agreements are discussed in detail at Section 6.

3.4 What responsibilities do I have as an approved provider?

Approved providers must understand and comply with a range of provider responsibilities under the law. For information on responsibilities under the aged care legislation, see **Appendix D**.

Security of tenure

As part of responsibilities outlined in **Appendix D** providers are bound by security of tenure. Security of tenure means providers must deliver the agreed care and services for as long as the care recipient needs those services. Providers may only stop delivering home care where the requirements under the *User Rights Principles 2014* are met. Section 17 of the *User Rights Principles 2014* provides:

Exceptions to security of tenure

(1) For paragraph 56-2(f) of the Act, this section specifies the security of tenure that an approved provider of home care must provide to a care recipient to who the approved provider provides, or is to provide, home care.

(2) The approved provider may cease to provide home care to the care recipient only if:

(a) the care recipient cannot be cared for in the community with the resources available to the approved provider; or

(b) the care recipient notifies the approved provider, in writing, that they wish to move to a location where home care is not provided by the provider; or

(c) the care recipient notifies the approved provider, in writing, that they no longer wishes to receive the home care; or

(d) the care recipient's condition changes to the extent that:

(i) the care recipient no longer needs home care; or

(ii) the care recipient's needs, as assessed by an aged care assessment team, can be more appropriately met by other types of services or care; or

(e) the care recipient:

(i) has not paid to the approved provider, for a reason within the care recipient's control, any home care fee specified in the Home Care Agreement between the care recipient and the approved provider; and

(ii) has not negotiated an alternative arrangement with the approved provider for payment of the home care fee; or

(f) the care recipient has:

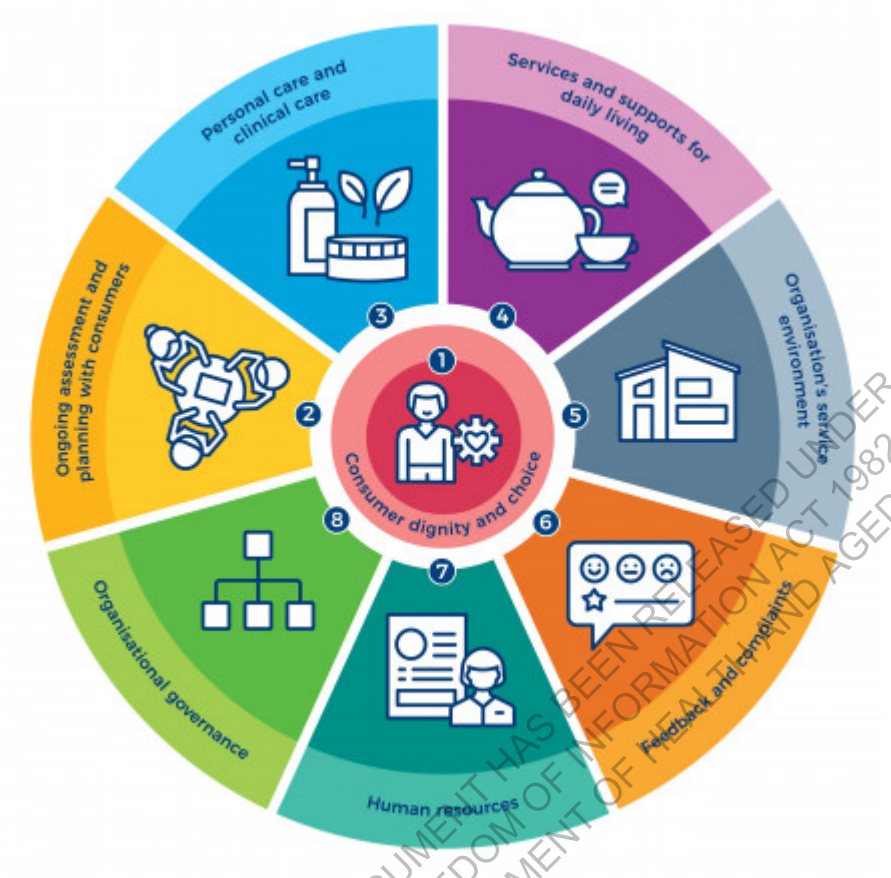
(i) intentionally caused serious injury to a staff member (as defined in section 63-1AA of the Act) of the approved provider; or

(ii) intentionally infringed the right of a staff member (as defined in section 63-1AA of the Act) of the approved provider to work in a safe environment.

Note: an approved provider of aged care is an organisation that has been approved to provide residential care, home and/or flexible care under the *Aged Care Act 1997.* For more information on becoming an approved provider see Section 4.

3.4.2 Aged Care Quality Standards

Providers are also responsible for delivering quality care and services in a way that complies with the Aged Care Quality Standards ('the Standards'). All approved providers will be assessed against these standards and they must be able to provide evidence of their compliance with, and performance against, all the Standards.



The Standards focus on outcomes for consumers and reflect the level of care and services the community can expect from organisations that provide Australian Government funded aged care services. The Standards are made up of eight individual standards, outlined in the following diagram:

Source: Aged Care Quality and Safety Commission

The Standards are at this link, or can be found by searching "Download the Aged Care Quality Standards images" at www.agedcarequality.gov.au.

The Aged Care Quality and Safety Commission (the Commission) has developed the *Guidance and Resources for providers to support the Aged Care Quality Standards* (Guidance and Resources). It describes the Commission's expectations and provides supporting information, suggested practices, examples and evidence required to ensure compliance. It also indicates any matters that quality assessors will consider in evaluating compliance. It is available at this link or by searching "Quality Standards" at www.agedcarequality.gov.au and clicking on 'Quality Standards'.

3.5 How is compliance with the Aged Care Quality Standards assessed?

The Commission conducts quality reviews to assess whether approved providers deliver care and services in accordance with the Quality Standards. It also monitors quality through assessment contacts.

The Commission's quality assessors assess provider performance against the Quality Standards by collecting evidence and arriving at findings based on this evidence. Quality assessors collect evidence through:

- interviewing consumers or representatives;
- interviewing staff and management;
- sampling consumer records;
- reviewing documents such as policies, procedures, agreements and registers; and/or
- observing the environment, activities in progress and any interaction with consumers or representatives.

These assessment and monitoring processes are undertaken in accordance with the *Aged Care Quality and Safety Commission Rules 2018,* established under the *Aged Care Quality and Safety Commission Act 2018*. The rules can be located by searching "Aged Care Quality and Safety Commission Rules" at www.legislation.gov.au.

Through engagement and education work the Commission aims to build confidence and trust in aged care, empower consumers, support providers to comply with quality standards, and promote best practice service provision. Further information about the Commission's functions are available at this link, or by searching "Providers" at www.agedcarequality.gov.au/.

Further information regarding the Commission's assessment and monitoring process is available on the Commission's website at www.agedcarequality.gov.au/.

✓ Key points to remember

- The Charter of Aged Care Rights provides the same rights to all consumers, regardless of the type of Australian Government funded aged care and services they receive, including the HCP Program. Quality aged care outcomes are best achieved in an environment of mutual respect.
- All supports provided as a part of a home care package need to be delivered in a way that is cognisant of and compliant with the Aged Care Quality Standards.
- All approved providers are responsible for understanding and complying with all relevant responsibilities under the law.

4 Becoming an approved provider

To deliver care under the HCP Program, an organisation must become an approved provider. An approved provider of aged care is an organisation that has been approved to provide residential care, home and/or flexible care under the *Aged Care Quality and Safety Commission Act 2018* (the Act). Approved providers must comply with their responsibilities under the *Aged Care Act 1997.*

This section explains who can become an approved provider, how to complete the application process to become an approved provider, and what steps an organisation needs to take (if it gets approval as an approved provider) in order to provide services.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 54-1 and 63-1 of the *Aged Care Act 1997*
- *Aged Care Quality and Safety Commission Act 2018.*
- *Quality of Care Principles 2014*
- *Accountability Principles 2014*
- *Sanctions Principles 2014*.

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

4.1 What considerations do I need to satisfy to become an approved provider of Home Care Packages?

To be approved as a provider of aged care under the Act, providers must satisfy the matters established in Part 7A of the *Aged Care Quality and Safety Commission Act 2018*. Further information about becoming an approved provider is available at this link or by searching "Becoming an approved aged care provider" at www.agedcarequality.gov.au. To be approved, applicants must satisfy the following considerations:

Consideration 1.	Consideration 2.	Consideration 3.	Consideration 4.
The applicant must make the application in writing using the approved form.	The applicant's organisation must be incorporated.	The applicant must be suitable to provide aged care.	The applicant must not have any disqualified individuals as key personnel.

4.1.1 Application process

To become an approved provider, an applicant needs to apply in writing. Corporations must apply using whichever of the forms is most applicable to their circumstances. You can access all

application forms at this link, or by searching "Becoming an approved aged care provider" at www.agedcarequality.gov.au.

The table below outlines the forms that can be used to apply, and the circumstances in which an applicant should use each form.

1. New applicant	2. Existing service provider	3. Government organisation
This form is for organisations that are not currently approved to provide any type of care under the Act. **Note**: if the applicant is an approved provider of Commonwealth Home Support Programme only, and wants to provide home care, they must apply as a new applicant.	This form is for an existing approved provider that wants to provide another care type. Because existing approved providers have already had their suitability to provide aged care approved through a previous assessment process, the application form seeks specific detail to assess suitability to provide home care.	States, Territories, authorities of a State or Territory and local government authorities are taken to be approved in respect of all types of aged care. A simplified form has been developed for these Government organisations to enable the creation of a Departmental record and payment of subsidies to the organisation.

If you need further guidance, please see this link, or search "Guidance for applicants seeking to provide aged care" at www.agedcarequality.gov.au.

4.1.2 Incorporated organisations

Only organisations that are incorporated are eligible to become an approved provider of home care, residential care or flexible care. This means that if the applicant is a sole trader, partnership or other unincorporated entity, they cannot be approved as a provider of aged care under the Act and the application cannot be accepted. Definitions of each of these organisation structures can be found at www.business.gov.au.

States, Territories and local governments are automatically approved to provide aged care.

4.1.3 Suitability to provide aged care

Part 7A of the *Aged Care Quality and Safety Commission Act 2018* lists the areas each applicant must be assessed against. These are:

1. Experience in providing aged care or other relevant forms of care
2. Understanding of approved provider responsibilities
3. Systems it has, or will have, in place to meet these responsibilities
4. Record of financial management and the methods used, or proposed to ensure sound financial management
5. Conduct as a provider (including compliance with responsibilities as a provider) and obligations arising from the receipt of any payments from the Australian Government for providing aged care (if the applicant has been a provider of aged care).

It is up to the applicant to effectively demonstrate how and why their organisation meets these suitability considerations.

4.1.4 Key personnel

Identifying key personnel is a critical component of becoming an approved provider. Applicants must ensure they understand the meaning of key personnel and establish who within the organisation meet this definition. Key personnel are:

- People responsible for the executive decisions of the applicant (this includes directors and board members), whether or not the person is employed by the applicant;
- People having authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the applicant, whether or not the person is employed by the applicant;
- Any person responsible for nursing services provided, or to be provided, by the applicant, whether or not the person is employed by the applicant; and
- Any person who is, or is likely to be, responsible for the day-to-day operation of an aged care service conducted, or proposed to be conducted, by the applicant, whether or not the person is employed by the applicant.

There are specific requirements about who can/cannot be key personnel. Key personnel cannot be a disqualified individual. A disqualified individual is someone who has been convicted of an indictable offence, is insolvent or under administration, or is of unsound mind. Each State and Territory law identifies different types of offences as being indictable. These typically include serious offences such as murder, manslaughter, the intentional or unlawful administration of drugs or poisons, or committing fraudulent or dishonest activities. The applicant must also be certain that none of their key personnel are disqualified.

Under the *Sanctions Principles 2014*, all approved providers, including those providing home care, have ongoing responsibilities to continue to ensure key personnel meet the requirements about who can/cannot be key personnel as outlined in the Act. They also have reporting obligations if changes to key personnel materially affect their suitability to provider care, including if they become disqualified, or if changes to key personnel affects the organisation's contact details. This is discussed at Section 15 of this manual.

4.2 How do I know if I have been approved to provide packages?

Applicants must be notified if they have or have not been approved as a provider of aged care within 90 days of receiving a complete application. Applications cannot be assessed unless all the required documents have been provided. Applicants may be asked to provide additional information resulting in delays assessing their application.

Alternatively, applications may not be accepted and will be returned. In these cases, applicants will be informed of the reason the application was not accepted. If an applicant is required to provide further information, they will have 28 days to submit this. Once the information is received, a further 90 day timeframe for decision applies. Once an application is deemed complete, the applicant will receive written confirmation and advice that the application has progressed to assessment.

If the applicant is approved to provide aged care, they will receive a letter which includes the National Approved Provider System (NAPS) ID. You can find more information on NAPS at Section 5 of this manual.

4.2.1 Appeals pathways (if you are dissatisfied with the outcome of the assessment)

If the applicant would like reconsideration of the assessment of their application, they should submit a notice in writing within 14 days of receiving the decision letter. The request must detail the reasons for making the request and should take into account the reasons that the application was not approved. Reconsideration requests can be submitted by emailing approvedproviderapplications@agedcarequality.gov.au.

A different decision maker then reconsiders the decision, and decides whether to confirm, vary, or set the decision aside and substitute a new decision.

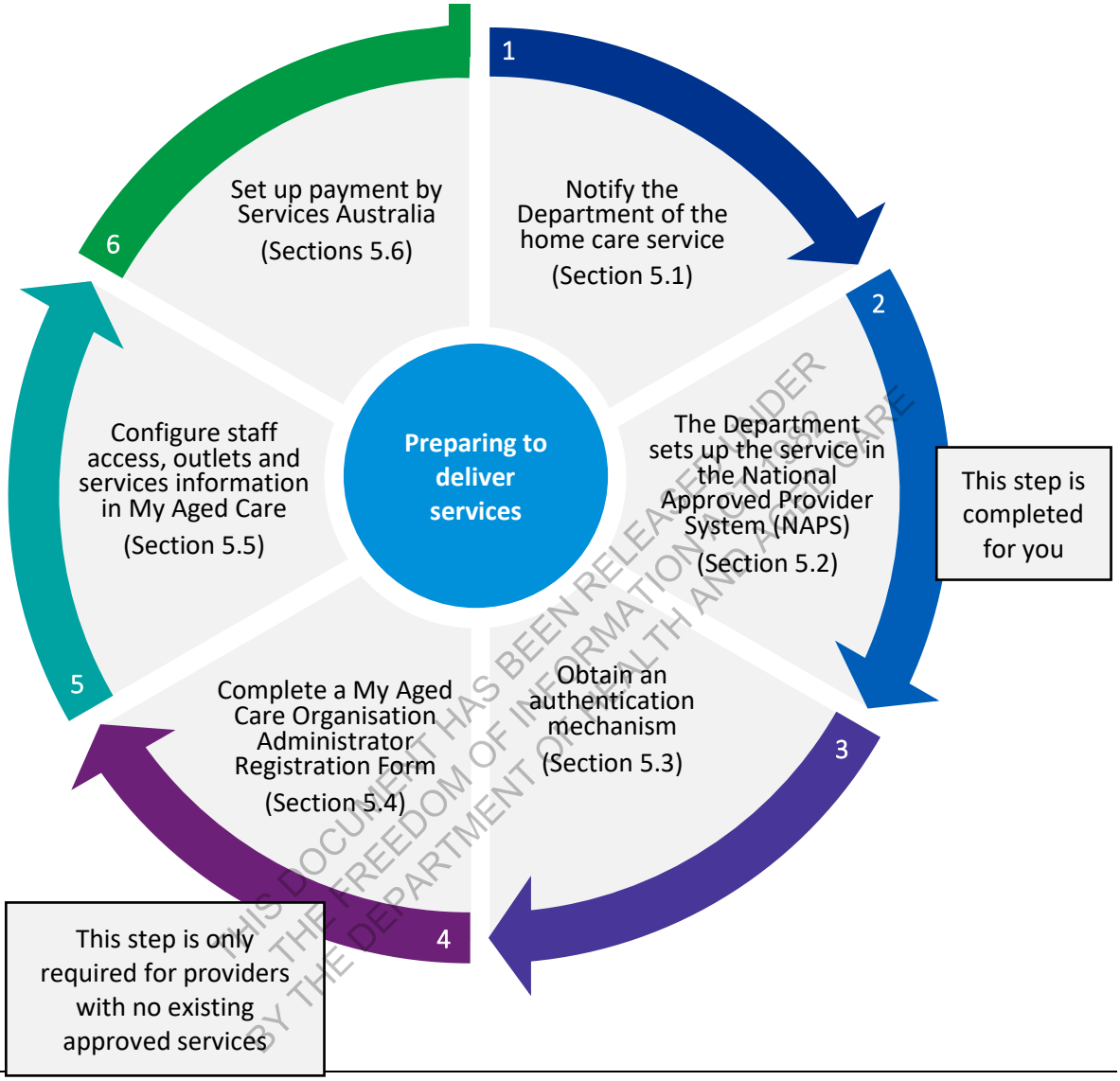
If the applicant wishes to appeal the outcome of the reconsideration they can make an application to the Administrative Appeals Tribunal (AAT).

You can find information on making an application to the AAT at www.aat.gov.au/.

✓ Key points to remember

- In order to provide Government-subsidised home care under the HCP Program, an organisation must be an approved provider.
- To become an approved provider, an organisation must be a corporation, and must show that they can meet the suitability matters and have the ability to provide quality aged care services.
- Organisations will need to apply to the Aged Care Quality and Safety Commission to become an approved provider.

5 Preparing to deliver services as an approved provider



This section provides information on each of the activities providers need to complete before they can deliver services as an approved provider. It includes processes, requirements and systems. These steps may be completed in a different order to suit provider needs. The diagram below outlines an order that may be helpful for providers.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 9-1A and 63-1 of the *Aged Care Act 1997.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

5.1 How do I notify the Department of my home care service?

Providers who have been approved will receive a confirmation approval letter from the Aged Care Quality and Safety Commission advising of their approved provider status and National Approved Provider System (NAPS) ID. This is also known as the Provider NAPS ID. Providers then need to notify the Department of the home care services that they will provide. This can be done by completing the **"Home Care Service Notification form"**. The form can be found at this link or by searching "Notification of changes for Home Care Packages" at www.health.gov.au.

A separate form must be submitted for each home care service from which providers intend to provide home care. This form must be lodged before starting to provide care through that service. Providers must do this to be able to claim and receive subsidies for home care services.

Once the **"Home Care Service Notification form"** has been submitted, the provider will receive an email with a tracking ID and a PDF of the completed form.

There are specific processes for moving home care services to another approved provider, merging home care services and combining home care services. Information on these is in Section 13.5.

5.2 How does NAPS registration work?

The Department will directly submit **"Home Care Service Notification forms"** to the most relevant State or Territory office for processing.

The state-based team will enter the details into the NAPS system. The provider will be notified by email once the information has been processed (new services or changes to existing services) and will receive a Service ID for any new services. It is important to note that it can take up to 48 hours for a new service to appear in My Aged Care.

The provider can use this Service ID to submit claims to the Services Australia.

5.3 How do I obtain authentication mechanism?

New providers will need an authentication mechanism to securely access and use the My Aged Care system.

From late March 2020, My Aged Care will support the following login methods:

- VANguard Federated Authentication Service (FAS); and
- myGovID and Relationship Authorisation Manager (RAM).

VANguard FAS

VANguard FAS integrates with an organisation's local network, allowing individuals to reuse their username and password to access external agencies without sharing the user's credentials. Staff authenticate once with their My Aged Care portal with subsequent authentications being transparent to the user.

VANguard FAS provides:

- Users with an improved login experience – allowing users to Single Sign On to My Aged Care using their own organisation credentials;
- Organisations with a single place to manage their authorisations – user access is controlled through an organisation's existing on-boarding and off-boarding procedures.

VANguard FAS is delivered by the Department of Industry, Innovation and Science (DIIS) and is suitable for any organisation with corporate network infrastructure that includes a Single Sign-On System (e.g. Active Directory Federation Server). There are no fees payable to DIIS for using FAS.

To find out more or get started with FAS, organisations can email the VANguard service desk at VANguard.Customer@industry.gov.au with their contact details and organisation name, phone number and email address.

myGovID and RAM

The Australian Taxation Office has introduced a flexible and secure way to access government online services. These are:

- myGovID – an authentication service that allows you to prove who you are online. It is different to your myGov account.
- Relationship Authorisation Manager – an authorisation service that allows you to act on behalf of an organisation online when linked with your myGovID.

Together, myGovID and RAM offer a secure login experience:

- Users log in by authenticating with their myGovID app each time they access My Aged Care, protecting their digital identity.
- Organisations use RAM to control user access to government online services from a single place.

myGovID and RAM form a whole-of-government solution that can be used to access many other government online services.

5.4 How do I complete the My Aged Care Administrator Form?

Providers with no existing Provider Portal administrators will need to nominate an Organisation Administrator by completing and submitting the **"My Aged Care Organisation Administrator Registration Form"** located at this link or by searching "My Aged Care – Organisation Administrator Registration Form" at www.health.gov.au. The Department will email this form to providers at the appropriate time.

This allows the Department to set up the initial administrator for a provider organisation, to allow access to the Provider Portal. Once the Organisation Administrator registration form has been processed, the Department will contact the Organisation Administrator via email regarding next steps.

The nominated Organisation Administrator will be the first person from a provider organisation to log into the portal. They will be responsible for setting up staff access and managing the organisation's information and portal structure. The My Aged Care Assessor Portal – Organisation Administrator User Guide is available at this link or by searching "Organisation Administrator User Guide" at www.health.gov.au. Additionally, the My Aged Care – Provider Portal User Guide: Part 1 Administrator Functions is available at this link or by searching "My Aged Care – Provider Portal User Guide Part 1" at www.health.gov.au.

Established users can then set up 'Outlets' and 'Services' in the portal and add the organisation's service information. Once the service item is 'Operational' and the outlet is 'Active', referrals can be received from My Aged Care. The My Aged Care – Provider Portal User Guide: Part 2 is available at this link or by searching "My Aged Care - Provider Portal User Guide Part 2" at www.health.gov.au.

Note: the Department recommends the initial administrator sets up other staff in a provider organisation as Organisation Administrators to allow for back up access.

Providers can find the My Aged Care Provider Portal at this link or by searching "For service providers" at www.myagedcare.gov.au.

5.5 How do I configure my information in the My Aged Care Provider Portal?

The My Aged Care Provider Portal is a web-based platform that allows providers to self-manage information about the services they provide. This information is displayed on the public 'find a provider' tool on the My Aged Care website, and is used by care recipients and their carers to search and compare potential home care providers that can best meet their assessed care needs in their preferred location. It is also used by My Aged Care contact centre staff and assessors to refer people to service(s). It allows providers to accept and reject referrals.

It is essential that providers ensure all of their information on this platform is current, correct and complete. It should be written for care recipients in plain English with enough detail to support their decision-making. A Quick Reference Guide on the procedures for creating and maintaining information about service delivery outlets is available at this link, or by searching "My Aged Care Process Overviews – Home Care Packages" at www.health.gov.au.

As an approved provider, details of services are automatically listed within the 'find a provider' tool. Providers, however, will need to ensure that these details are complete.

Providers can set up 'Outlets' and 'Services' in the portal and add the organisation's service information. Once the service item is 'Operational' and the outlet is 'Active', referrals can be received from My Aged Care.

At a minimum, this must include pricing information. New pricing requirements were introduced on 1 July 2019 to improve transparency for senior Australians, to enable direct comparisons between providers, and to curb problematic charging practices by some providers. Information on providers' pricing obligations are at **Appendix B**. Providers can also list other information on the 'find a provider' tool, which can help promote their services. This could include:

- cultural specialisations;
- religious specialisations;
- languages other than English that carers speak;
- specialised services; and/or
- ability to provide services to individuals with diverse needs.

Guidance on completing the 'specialisations' section of the provider portal is available from this link or by searching "My Aged Care Provider Portal User Guide" on www.health.gov.au.

Providers can configure this information, and their financial information, at an organisation and/or outlet level. This means that a larger provider can set up information for all the outlets they have, and then let the outlets provide further information, or amend the provided information, as required. A smaller provider can set all their information up at one time.

The Department expect providers' service information to meet their requirements for managing service information in the 'find a provider' tool on My Aged Care. The Department can choose to remove organisations who do not comply. The requirements include:

- the same service, with the same NAPS Service ID, must only be listed once per location i.e. the service must only appear once in the search results for that location;
- outlet and service item names must not include phone numbers or marketing slogans; and
- service delivery areas must reflect only those locations where the provider can deliver service.

Further information on these requirements is available at this link, or by searching "Managing your home care service information" at www.health.gov.au.

5.6 How do I set up payment of subsidies with Services Australia?

Services Australia administers payments for aged care subsidies and supplements (where relevant) on behalf of the Department. Providers will need to set up their organisation with Services Australia to make claims for services and receive payments. They will need to complete and return the following forms to Services Australia:

- **"Aged Care approved provider statement form"** (AC003). AC003 is at this link, or can be found by searching "AC003" at www.servicesaustralia.gov.au.
- **"Register, amend or remove users for Aged Care Provider Portal form"** (AC004). AC004 is at this link, or can be found by searching "AC004" at www.servicesaustralia.gov.au.
- **"Application to add or change approved care service's bank details form"** (AC015). AC015 is at this link, or can be found by searching "AC015" at www.servicesaustralia.gov.au.

For more general Services Australia information, see this link or search "Aged care providers" at www.servicesaustralia.gov.au.

✓ Key points to remember

- If an organisation is approved as an approved provider, there are six administrative tasks that need to be completed before they can provide services to care recipients. These are outlined in the diagram at the start of this section, but can be summarised as:

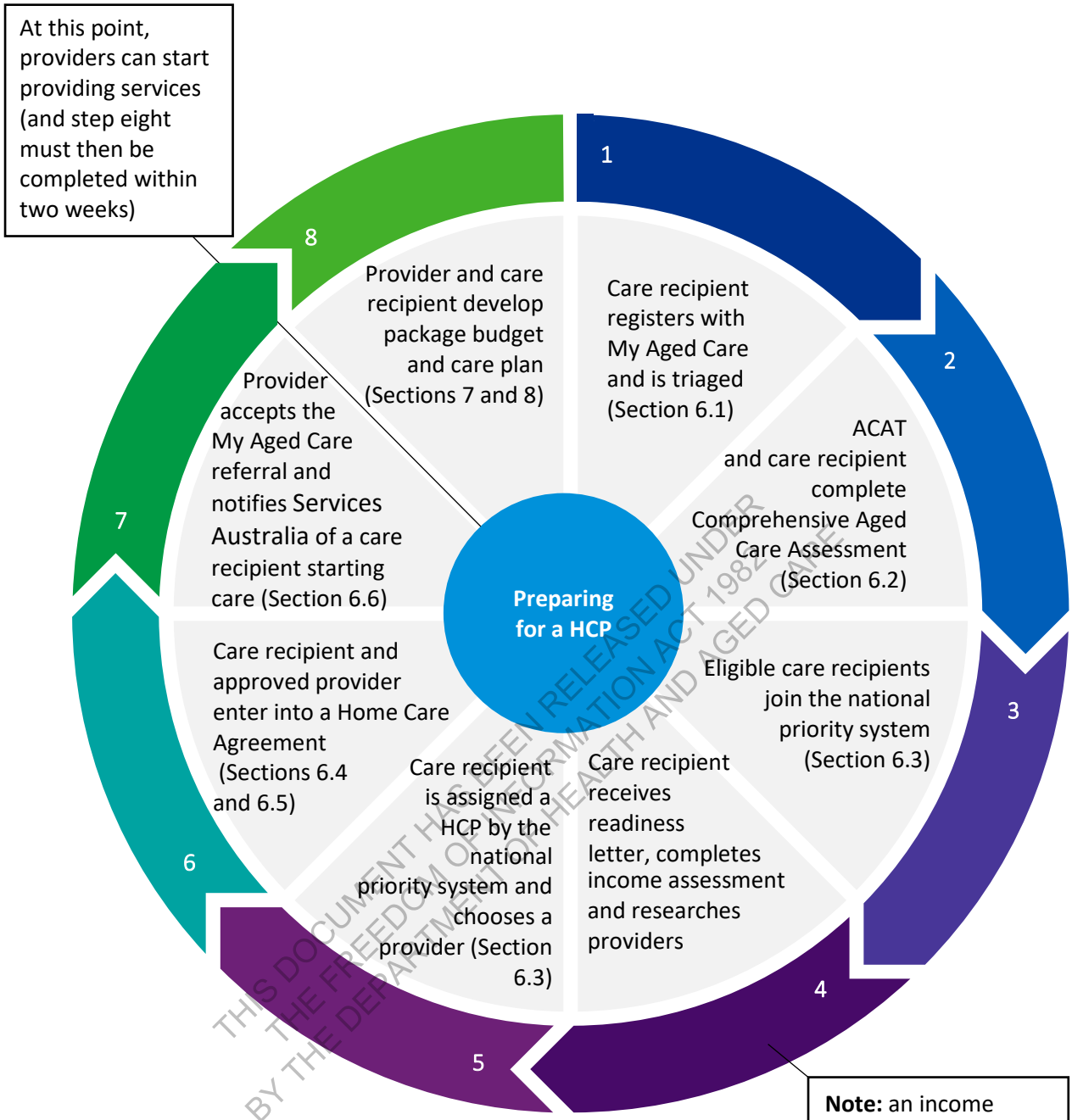
  1. Notify the Department of the Home Care service
  2. The Department sets up the service in the National Approved Provider System (NAPS)
  3. Obtain an authentication mechanism
  4. Complete a My Aged Care Organisation Administrator Form
  5. Configure staff access, outlets and services information in My Aged Care
  6. Set up payment by Services Australia.

  Providers can complete these steps in a different order if they would like. If providers follow the above order, this process may run more smoothly.

6 Eligibility for care recipients to receive Australian Government-funded packages

This section sets out the steps that people need to take to receive services under a package. This information has been provided to support providers to help care recipients navigate this process, if needed. This section also sets out the steps that providers need to take after an individual has been assigned a package, but before they can start providing Government-subsidised home care services to that individual.

Note: care plans need to be reviewed regularly during the course of delivering a home care package. This review process is discussed at Section 10.3.



Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 56-2 and 63-1 of the *Aged Care Act 1997*
- *Accountability Principles 2014*
- *User Rights Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

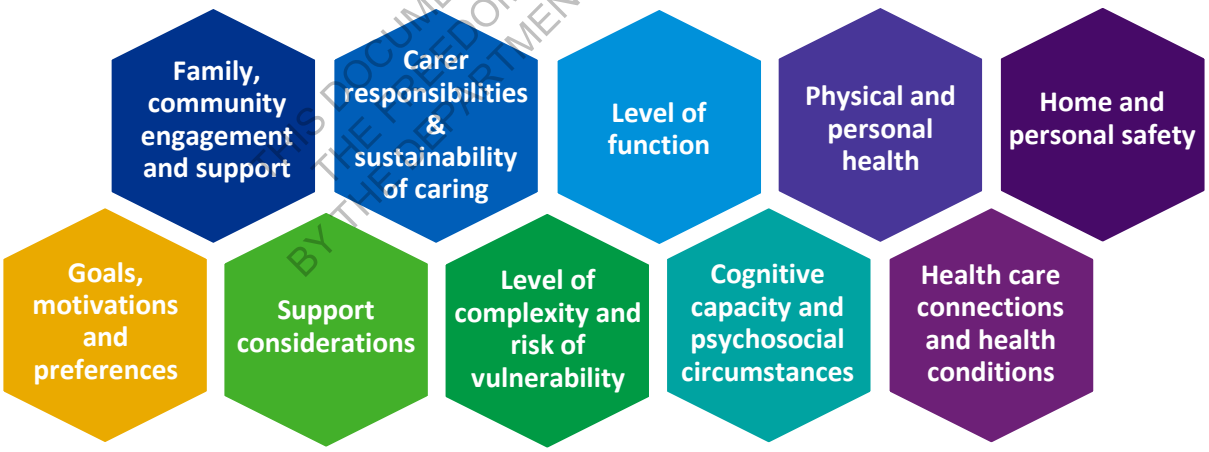
See **Appendix D** for further detail on specific provider responsibilities.

6.1 How do care recipients start the process to get a package?

Care recipients and/or their representative complete screening with My Aged Care to determine their pathway to aged care services. They can do this by calling the My Aged Care contact centre on **1800 200 422** which will generate a reference for a face-to-face assessment based on the information given at the screening. If this information indicates a comprehensive assessment is required, the My Aged Care contact centre will refer them to an ACAT to conduct the assessment.

6.2 What is a comprehensive aged care assessment and how does it work?

Eligibility for the HCP Program is assessed by an ACAT. The comprehensive assessment will consider:



The assessment identifies an individual's strengths and areas of difficulties across these factors, which will be considered as the assessor works with them to develop a support plan. In some instances, it may be appropriate to use a supplementary assessment tool clarify their individual needs further.

The assessor will make recommendations based on the person's care needs at that time. After conducting a comprehensive assessment, an ACAT will send their assessment findings and recommendations to the ACAT delegate to determine eligibility for aged care services under the Act. Information on how to prepare for an assessment and what to expect has been provided in the HCP Program Consumer Manual.

Everyone assessed will receive the outcome of their assessment by mail. The letter will contain the assessment decision confirming eligibility for a package, the level of package approved (if eligible), the reasons and evidence supporting the decision and a copy of their support plan developed during their assessment.

6.3 What is the national priority system?

The national priority system is the system that assigns packages. Once a person is assessed as eligible, they will be placed in the national priority system, where they will wait for the assignment of a package. They will not be able to access Australian Government subsidised home care services under the HCP Program until they have been assigned a package.

The national priority system ensures the equitable assignment of packages based on a person's assessed care needs and circumstances; not where they live. The system only takes into account:

- priority for home care services as determined by the ACAT during the comprehensive assessment; and
- the date of approval for home care at that level.

People who were actively seeking care at the time of their approval will be automatically placed in the national priority system and set as 'seeking services'. They will receive a package as soon as one is available based only on the above two factors.

Those who are not actively seeking care at the time of their approval should inform their assessor. They will then be set as 'not seeking services', and will not be assigned a package until they are advised otherwise. If someone who was 'not seeking services' wishes to be assigned a package, they will need to indicate that they are actively seeking care. Following this, they will be assigned a package as soon as one is available.

A person can request to be set as 'seeking services' or 'not seeking services' at any point. This can be done by calling the My Aged Care contact centre on **1800 200 422**, or by using the My Aged Care Client Portal at this link, or by searching "View your My Aged Care client record" at www.myagedcare.gov.au.

The Department releases packages regularly, generally weekly, as indicated by the national priority system. The number of packages released at each level takes into account the number of new packages that are available, as well as the number of packages that other people have left or not accepted in previous weeks. Projected wait times for a package are available in time-bands in the client portal.

6.4 What does a person need to do to be assigned a package (after they have been assessed as eligible)?

Eligible home care recipients will receive a letter notifying them that they have been assigned a package.

After being assigned a package, people have 56 calendar days from the date their package is assigned to find an approved provider and enter into a Home Care Agreement that best meets their needs. If someone wants more time to find a suitable provider, they can contact the My Aged Care Contact Centre and request a 28 day extension, giving them a total of 84 calendar days to enter into a Home Care Agreement.

If the person has not entered into a Home Care Agreement within 56 calendar days (or 84 calendar days with the extension), the package is withdrawn. This means the package is no longer assigned to them, and approved providers are not able to claim a subsidy.

If a person is assigned an interim package and it is withdrawn they will stay on the national priority system to wait for their approved level of package. Interim packages are discussed further at Section 6.4.1.

If a person is assigned their approved level of package and it is withdrawn, they will be removed from the national priority system. If they later decide they want to receive services through a package, they need to re-join the national priority system by calling My Aged Care. People who re-join the national priority system will have their date of entry recorded as the date they were originally approved for home care at that specific package level.

Providers may receive a referral in the provider portal through one of two ways:

- a system generated referral – created either by the My Aged Care contact centre or by a member of an ACAT; or
- a direct referral – direct receipt of a person's referral code e.g. an eligible person has presented their package assignment letter and requested that the provider deliver their services.

From the referral record providers can view the referral summary and a person's record. This will help them make an informed decision about whether they can deliver the services required by the person and when they need services to start.

Detailed information on managing referral care recipients' records on My Aged Care is available at this link or by searching "My Aged Care for service providers" on www.health.gov.au.

6.4.1 Interim package

People eligible for a home care package have the option of receiving a package at a lower level than they are approved for, as an interim arrangement while waiting. There may still be a wait for an interim package, however this wait would be less. An ACAT will help determine if an interim package is appropriate.

No one will be disadvantaged if they receive an interim package, and they will not wait longer to receive a package at their approved level. An interim level package simply allows them to connect with care and services while they wait for their approved package level. For clarity, either accepting or not accepting an interim package will have no impact on the wait time for the approved package level.

People can call My Aged Care on **1800 200 422** at any time to indicate that they are willing to accept a package at a lower level as an interim arrangement.

Anyone on an interim package will automatically be assigned a higher level package (up to their approved level) when one is available.

The person will receive a letter advising them of the change and their provider will receive a notification of the new package level in the Provider Portal. It is important to keep people's contact details current in their My Aged Care client record so they get their notification letter.

Payment at the higher level will commence immediately. The provider must review the assessed care needs with the care recipient when a higher level package is assigned to ensure best use of the funds to meet their needs.

Care recipients who decide they are happy with an interim package, and their assessed care needs are being met by the package, should indicate that they are 'not seeking services' by calling the My Aged Care contact centre. This will ensure they are not automatically assigned a higher level package. They must do this before they are assigned a higher level package as, it cannot be declined after it is assigned. If a person on an interim package does this, they can opt in to 'seeking services' at a later date if their needs increase to access their approved level package.

6.5 What should I include in a Home Care Agreement?

When someone chooses an organisation as their approved provider, the provider should enter into a Home Care Agreement with them before starting to deliver services. Providers cannot charge people for entry to services.

The Home Care Agreement sets out the terms and conditions by which a provider will deliver care and services to a care recipient. It is the legal contract between a provider and a care recipient and captures each parties' responsibilities. It is critical that providers seek legal advice and assistance in drafting agreements.

The Act and Principles set out strict conditions by which the Home Care Agreement must comply. It is essential that providers understand the requirements under the Act.

A Home Care Agreement for people who started receiving services after 1 July 2014 must be written in plain English that is readily accessible. It must not contain any provision that would have the effect of the care recipient being treated less favourably in relation to any matter than they would otherwise be treated under any law of the Commonwealth in relation to the matter. Finally, it must include the following:

6.5.1 Relationship with the care recipient

#	Requirement	Legislation citation
1	A statement specifying that home care will be delivered on a CDC basis. CDC has been discussed at Section 2.1 of this manual.	Section 23(2)(b)(i) of the *User Rights Principles 2014*
2	A statement specifying the care recipient's rights in relation to decisions about the care and services that are to be provided. CDC has been discussed at Section 2.1 of this manual. **Note**: any changes to the Home Care Agreement must be agreed through informed, mutual consent of the provider and the care recipient. Variation of the Home Care Agreement is discussed at Section 6.5.5.	Section 23(2)(b)(iv) of the *User Rights Principles 2014*
3	A statement outlining: • that a care recipient is entitled to make a complaint about the provision of their care and services without fear of reprisal; and • the complaints mechanism the provider has in place. For more information on designing a complaints mechanism see Section 10.	Section 61-1(1)(f) of the *Aged Care Act 1997* Section 23(4) of the *User Rights Principles 2014*
4	A statement outlining any responsibilities of the care recipient as a recipient of home care from the service.	Section 61-1(1)(g) of the *Aged Care Act 1997*

6.5.2 Care and services

#	Requirement	Legislation citation
5	The date the provider will start to provide home care to the care recipient. If they are transferring from another provider, please see Section 13 of this manual.	Section 23(2)(a) of the *User Rights Principles 2014*
6	A statement specifying the level of home care to be provided. This will be the package level that the care recipient has been assigned. This process has been discussed at Section 6 of this manual.	Section 23(2)(b)(iii) of the *User Rights Principles 2014*
7	A statement specifying the care and services that the care recipient will receive. This will also need to be outlined in the care plan, as discussed in Section 7 of this manual.	Section 23(2)(b)(ii) of the *User Rights Principles 2014*
8	A statement specifying that the provider will give the care recipient copies of their care plan and package budget, including any updated copies if the provider and the care recipient make any changes to the care plan and package budget. Home Care Agreements entered into before 1 July 2015 do not need to be updated to include this provision. In practice, however, providers must provide their care recipients with these documents.	Section 23(2)(b)(v) of the *User Rights Principles 2014*
9	A statement that the care recipient may suspend, on a temporary basis, the provision of home care (known as taking leave) if the provider is notified. Leave has been discussed more generally at Section 11 of this manual.	Section 23(2)(f) of the *User Rights Principles 2014*
10	The amounts that the care recipient will be liable to pay to the approved provider for any period of suspension. Fees payable during suspension (leave) are discussion at Section 11 of this manual.	Section 61-1(1)(e) of the *Aged Care Act 1997*

6.5.3 Pricing and budget

#	Requirement	Legislation citation
11	A statement of home care fees that the provider will charge to the care recipient. **Note**: the discussion at Item 13 of this table, below.	Section 23(2)(c)(i) of the *User Rights Principles 2014*
12	A statement of the policies and practices that the provider will follow in setting the fees that the care recipient will be liable to pay to the approved provider for the provision of the care and services. Fees are discussed at Section 8 of this manual.	Section 61-1(1)(c) of the *Aged Care Act 1997*

#	Requirement	Legislation citation
13	A copy of the provider's Schedule as published on My Aged Care. This is discussed further in **Appendix B** of this manual. In short, all agreements entered into after 1 July 2019 must comply with the new pricing requirements. All prior agreements must be updated to become compliant by 1 July 2020. The prices under the Agreement must be the same as those in the pricing schedule unless the provider and care recipient discuss and agree to a variation in pricing. If the provider and care recipient reach agreement on a variation, this must be documented within the Home Care Agreement. If the care recipient is to be charged an amount of the basic daily fee (discussed in Section 8 of this manual) that is different from the amount of the fee in the schedule, the provider and care recipient must also reach agreement on a variation, and this must be documented within the Home Care Agreement.	Sections 23(2)(ba)-(bc) of the *User Rights Principles 2014* Section 23(2)(c)(ii) of the *User Rights Principles 2014*
14	A statement specifying that the provider will give the care recipient a statement of the available funds and expenditure in respect of each month for the care and services provided to the care recipient during the month (a monthly statement). Monthly statements have been discussed further at Section 10.	Section 23(2)(cb) of the *User Rights Principles 2014*
15	A statement specifying that any care recipient portion or transfer portion of the care recipient's unspent home care amount will be paid in accordance with Part 3 Division 3A of the *User Rights Principles 2014*. For more information on how to action this please see Sections 13 and 14.	Section 23(2)(cc) of the *User Rights Principles 2014*
16	If the provider intends to deduct an exit amount when they cease providing home care to the care recipient, a statement of the maximum exit amount that they will deduct. An exit amount is a charge that providers can deduct from funds that are left in a care recipient's package (unspent home care amount) when they leave their care (to change providers or to leave home care). The exit amount is intended to allow providers to recover administrative costs associated with determining and making payment of unspent home care amounts. It is not mandatory to charge an exit amount. Providers will need to decide whether they would like to charge an exit amount and agree the value of the amount with the care recipient when they execute the Home Care Agreement. Information on how providers must disclose their exit amounts is at **Appendix B** of this manual. Information on how and when providers can deduct the exit amount is at Sections 13 and 14 of this manual.	Section 23(2)(cba) of the *User Rights Principles 2014*

#	Requirement	Legislation citation
17	Provision for financial information to be given to the care recipient about the home care that the care recipient will receive, including a statement that the approved provider must, within seven days after a request by the care recipient, give the care recipient: • A clear and simple presentation of the financial position of the home care service, including the costs of home care that explains any ongoing fees payable by the care recipient. • A copy of the most recent statement of the audited accounts of the home care service or, if the home care service is operated as part of a broader organisation, the most recent statement of the audited accounts of the organisation's aged care component (that includes the home care service).	Section 23(2)(d) of the *User Rights Principles 2014*

6.5.4 Administration

#	Requirement	Legislation citation
18	A guarantee that the provider will take all reasonable steps to protect the confidentiality, as far as legally permissible, of information provided by the care recipient. Details of the use of information that is to be made by the provider and each person or entity to who the provider discloses the information.	Section 23(2)(e) of the *User Rights Principles 2014*
19	A statement specifying the home care service through which the approved provider will provide care to the care recipient.	Section 61-1(1)(a) of the *Aged Care Act 1997*
20	A statement specifying the levels of care and services that the provider has the capacity to provide to the care recipient while they are being provided with care through the home care outlet. **Note**: while an approved provider must be able to deliver all levels of packages, they are not required to be able to do so at all services.	Section 61-1(1)(b) of the *Aged Care Act 1997*
21	If the care recipient is not to be provided with the home care service on a permanent basis – the period for which the care and services will be provided.	Section 61-1(1)(d) of the *Aged Care Act 1997*

6.5.5 Variation or termination

#	Requirement	Legislation citation
22	A statement that the agreement may be varied by the approved provider if the variation is necessary to implement the *A New Tax System (Goods and Services Tax) Act 1999,* but that the agreement must not be varied pursuant to the above unless the provider has given reasonable notice of the variation, in writing, to the care recipient.	Sections 23(3)(a)(i) and 23(3)(b() of the *User Rights Principles 2014*

#	Requirement	Legislation citation
23	A statement that, in any case other than that discussed at Item 22 above, the Home Care Agreement can only be varied by mutual consent, following adequate consultation of the care recipient and the provider.	Section 23(3)(b) of the *User Rights Principles 2014*
24	A statement that the agreement must not be varied in a way that is inconsistent with *A New Tax System (Goods and Services Tax) Act 1999*, the *Aged Care Act 1997* or the *Extra Service Principles 2014*. **Note**: in their current form, the *Extra Services Principles 2014* contemplate residential care services only. They have not been considered further.	Section 23(3)(c) of the *User Rights Principles 2014*
25	The conditions under which either party may terminate the provision of home care, noting that providers may only terminate the provision of home care were security of tenure allows it. Security of tenure has been discussed at Section 3.4 of this manual.	Section 23(2)(g) of the *User Rights Principles 2014*

Home Care Agreements with care recipients who are in the pre-1 July 2014 arrangements must include different items. These are outlined in **Appendix A**.

6.6 What should I consider when entering into a Home Care Agreement with a care recipient?

In addition to obligations under the *Aged Care Act 1997*, outlined in **Appendix D**, providers have obligations under consumer and competition law. When negotiating with someone for the delivery of care and services and drafting the Home Care Agreement providers should also have regard to all these obligations.

The Australian Competition & Consumer Commission (ACCC) has developed guidelines for consumers and providers that outline consumer and business rights and obligations under the competition and consumer law (as they relate to the HCP Program).

The provider guide is at this link, or can be found by searching "Home care services – your business rights & obligations" at www.accc.gov.au. The consumer guide is at this link, or can be found by searching "Home care – a guide to your consumer rights" at www.accc.gov.au.

Approved providers should confirm with the consumer or their family who has been authorised to enter into the Agreement. In some circumstances, other arrangements may be in place for an authorised representative to act on their behalf.

The Department cannot provide individual advice on business practices, nor is the Department in a position to offer legal advice. Providers may wish to seek independent legal advice about business arrangements and how they align with the legislation.

6.7 What do I do if a care recipient won't sign a Home Care Agreement?

Wherever possible, both the care recipient and the provider should sign the Home Care Agreement. The care recipient should be given a copy of the signed Home Care Agreement.

A care recipient, however, does not necessarily need to sign the Home Care Agreement for it to be in place. As long as there is mutual agreement between them (or their authorised representative) and

the provider regarding the care and services to be delivered as part of the package, the agreement is considered 'in place'.

In the event that a care recipient does not sign the agreement, providers should keep detailed records of reasons why the agreement is not signed. This is because they must always be able to provide proof that an agreement is in place. Proof may include:

- a copy of the Home Care Agreement document the provider offered to the care recipient
- a file note of the discussion with the care recipient about the basis of the agreement (including the date the discussion took place); and/or
- proof that the provider is providing a package as described in the agreement.

6.8 I don't speak the same language as my care recipient. How can I arrange interpreting services?

For home care recipients who speak a language other than English as their first language, the Department of Home Affairs provides free interpreting services through the Translating and Interpreting Service (TIS National). Providers must register online for a TIS National Code. You can find information on this at this link or by searching "Interpreting support for Home Care Package service providers" at www.health.gov.au.

The intention of TIS National is primarily to assist care recipients to understand their package, including the Home Care Agreement, the package budget and monthly statements. When TIS National is used for this purpose including if required to discuss the monthly budget, there is no cost to the provider and there should not be any charges made to the care recipient's package budget.

TIS National is available 24 hours a day, seven days a week and provides both telephone and onsite services. Bookings can be made online via www.tisnational.gov.au. Alternatively, providers can call 131 450 for immediate telephone interpreting or 1300 655 082 for on-site bookings.

When accessing TIS National, providers will need to quote their service's unique code. If a provider is unsure of their care recipient's client code, they can contact TIS National on 1300 655 820.

Note: if providers are unable to provide aged care workers that can communicate in the required language they may negotiate with the care recipient to include any costs for an interpreter in the care plan. If there are costs associated with translation services and the package funds are used to purchase, or contribute towards the costs for a translator, it would be appropriate for the provider and the care recipient to discuss how this service would impact the package budget and the ability to deliver other care and services.

The agreed position and the responsibilities of the provider, care recipient and interpreter should be documented and included in the Home Care Agreement. Further information about the Translating and Interpreting Services charges for non-English speakers is available at www.tisnational.gov.au.

6.9 How and why do I notify Services Australia of a care recipient starting care with my service?

Providers need to declare care recipient entry information to Services Australia within 28 calendar days of when they commenced their home care services. Providers will first need to accept the referral in the My Aged Care Provider Portal, and then complete the paperwork to notify Services Australia. This paperwork can be completed through the Aged Care Provider Portal or through the submission of an Aged Care Entry Record (ACER).

The Aged Care Provider Portal can be found at this link, or by searching "Aged Care Provider Portal" at www.servicesaustralia.gov.au. An ACER can be completed using paper form AC021 at this link or by searching "AC021" at www.servicesaustralia.gov.au.

Entry information must be provided to Services Australia as early as possible and before the care recipient's package take up deadline to ensure their package is not withdrawn. If providers do not advise Services Australia of entry information, or if they do not have a Home Care Agreement in place, they will not be paid any applicable subsidy or supplements.

At this time, providers should also inform the Department if a care recipient has commenced a package and also receives a compensation entitlement. This is discussed at **Appendix C**.

✓ Key points to remember

- Before someone can receive services under the HCP Program, they need to register with My Aged Care, be assessed by an ACAT as eligible for the program, and be assigned a package through the national priority system.
- Once they have been assigned a package, they need to enter into a Home Care Agreement with a provider within 56 days (or 84 days with an extension).
- If providers are entering into a Home Care Agreement with a care recipient, they are bound by the obligations of consumer law. Providers can find out more in the ACCC provider guide at this link, or by searching "Home care services – your business rights & obligations" at www.accc.gov.au.
- If providers do not advise Services Australia of entry information they will not be paid any applicable subsidy or supplements.
- A free interpreting service is available to help providers negotiate the Home Care Agreement, develop the care plan with the care recipient and advise on the monthly budget. If the provider cannot provide aged care workers who speak the required language, they can negotiate with the care recipient to charge translation fees to their package budget.

7 Care planning

This section defines what a care plan is and outlines some strategies providers may use to complete care planning with care recipients.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 54-1 and 56-2 of the *Aged Care Act 1997*
- *User Rights Principles 2014*
- *Quality of Care Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

7.1 What is a care plan?

A care plan is a document that defines the package of care and services that a care recipient will fund using their package budget. The package budget is discussed at Section 8. Providers will need to undertake assessment and planning for care and services in partnership with the person within 14 calendar days of starting to provide care services. The assessment and planning has a focus on optimising health and well-being in accordance with the assessed care needs, goals and preferences. Providers must undertake initial and ongoing assessment and planning to meet Standard 2 of the Aged Care Quality Standards (see Section 3).

During the care planning process, providers will need to take into account any supports the person already has in place, such as carers, family members, local community and other services. For each care recipient, providers need to be able to demonstrate assessment and planning that:

- includes consideration of risks to the care recipient's health and well-being to inform the delivery of safe and effective care and services;
- identifies and addresses the care recipient's current assessed care needs, goals and preferences, including advance care planning and end of life planning if the care recipient wishes;
- is based on ongoing partnership with the care recipient and others that the care recipient wishes to involve in assessment, planning and review of the care recipient's care and services; and
- includes other organisations, and individuals and providers of other care and services that are involved in the care of the care recipient.

The care planning document should provide a detailed outline of services to be delivered, including when and where. This information should be specific, for example 2-3pm Tuesdays, rather than 'Tuesday'. Once the care plan and package budget (as discussed at Section 8) have been agreed, providers must give a copy to the care recipient for their records.

Information on approaches to care planning is set out at Section 7.3. Information on what services can (or cannot) be included in a care plan is set out at Section 9.

7.2 How do I work with a care recipient to develop their care plan?

Because the HCP Program uses a CDC model, as discussed at Section 2.2, providers will need to work with a care recipient to develop their care plan. This is an opportunity to manage their expectations and to outline an appropriate scope for the package. The provider's role in the care planning process is to help care recipients understand what care or services they can lawfully charge to the package and make choices between those. To do this, providers will need to understand what the potential inclusions and exclusions are for each individual home care package. Guidance on how to do this is set out at Section 9.

Providers will also need to help care recipients understand what care, services, and/or purchases they can afford within their package budget. They should prepare for care plan conversations by developing an understanding of the likely components of each individualised package. The information found at Section 8 of this manual will help providers to do this.

Please note, if charges have been levied against a package for excluded items the provider will, at a minimum, be required to repay any amounts that have been unlawfully charged against the budget back into the package.

7.3 What approaches can I employ to work with a care recipient to develop their care plan?

When working with a care recipient to develop goals, providers may consider whether reablement or wellness approaches to providing care might help them meet their goals. Giving consideration to these two contemporary approaches supports providers to ensure that the care and services they deliver align with the core principles of the HCP Program. These concepts underpin a number of aged care services, and are outlined, at a high level, below.

No matter which approach to care planning providers choose to take, it is important to remember that care planning is a collaborative process, between the provider and the care recipient.

7.3.1 Wellness approach

Wellness is an approach that involves assessment, planning and delivery of supports that build on an individuals' strengths, capacity and goals, and encourages actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home. Wellness as a philosophy is based on the premise that, even with frailty, chronic illness or disability, senior Australians generally have the desire and capacity to make gains in their physical, social and emotional wellbeing and to live autonomously and as independently as possible.

This approach supports senior Australians to undertake a task or activity themselves, or with limited assistance, and to increase satisfaction with any achievements. It underpins all assessment and service provision, whether the need for assistance is episodic, fluctuates in intensity or type over time, or is of an ongoing nature.

The case study on the next page outlines how a wellness approach can make a difference.

Case study: Jing

Jing likes to keep busy and tries to do as many jobs around the house as possible. Lately, she has been unable to hang up some of her heavier clothing items on the line. The traditional approach would involve support workers coming into Jing's home once a week to hang out the clothes for her. The wellness approach would encourage the support worker to work with Jing to hang out her bigger, heavier items and encourage her to hang her smaller items by using a laundry trolley and an easy-to-reach drying rack. In this way, Jing can continue to do things for herself and can act independently to do all her washing except for those items she needs some support to lift.

Source: Silverchain

7.3.2 Reablement approach

Reablement involves time-limited interventions that are targeted toward a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities. Like wellness, reablement aims to assist people to reach their goals and maximise their independence and autonomy. Supports could include training in a new skill or re-learning a lost skill, minor modification to a person's home environment or having access to equipment or assistive technology.

In practice, reablement can mean different things for different people – it all depends on their individual situation. For example, it might mean working with the care recipient to:

- practice daily activities, such as cooking and bathing, to help the them regain skills and get their confidence back;
- find new ways to do some things so that they feel safer and more confident;
- look at what else might help (for example, support to go out, personal alarms, home adaptations or other equipment, such as bath rails); and/or
- involve their relatives and/or carers in helping them to live more independently – and discuss any support they might need.

The kind of supports reablement might draw on vary, but could include the following:

- equipment and technology to help a care recipient live more independently at home;
- skills for independent living provided through intensive, short-term support; and/or
- outreach - help with transport and getting out and about.

7.4 If two people live together, can they have one care plan that contains information for both of them?

People who live together must undergo individual assessments by an ACAT. These assessments will generate individual support plans. Each care recipient must be assigned a package and have their own care plan.

They may, however, elect to pool their resources to fund joint care or services across both of their package budgets. For example, if both have been assessed as requiring cleaning services once a week, they may pool resources to share the cost of the cleaner between the two packages. Providers are required to include information about their respective home care fees payable in the Home Care Agreement, and the calculated home care fee amount being recorded in their respective package budgets.

7.5 What do I do if a care recipient wants services my company doesn't deliver?

Providers can deliver home care directly, or can engage other organisations or individuals to deliver care and services. This can occur in a number of ways, including sub-contracting.

Approved providers should, where possible, facilitate services being delivered by the person chosen by the care recipient. With CDC, if someone prefers a particular care worker to deliver their services, they can ask the provider to engage that care worker. Providers must indicate in their home care pricing schedule whether they charge an additional amount for any services they sub-contract from another service provider. Providers must also discuss this cost with the care recipient before the care plan is agreed. It is good practice to document this conversation for records.

Regardless of how the services are delivered, providers remain responsible for ensuring services are delivered in a way that meets the requirements of the Act and the Aged Care Quality Standards. Providers must also ensure services are delivered in line with the agreed care plan. The care plan will need to be revised periodically to ensure that the sub-contracted services continue to meet the care recipient's assessed care needs.

Approved providers also need to remember that they, not the sub-contracted service provider, remain responsible for meeting all of the regulatory responsibilities. These regulatory responsibilities include ensuring that all police checks and key personnel suitability requirements are met, as well as all obligations under the legislation. **Note**: a list of provider responsibilities is extracted at **Appendix D**.

If the sub-contracting arrangements materially affect approved provider suitability they will need to be disclosed to the Commission. When and how to do this is discussed at Section 15.

7.6 Are there any other models of care delivery which I should be aware of?

The Australian Government is supportive of innovative delivery of services under the HCP Program, to the extent that they are compliant with the intent and scope of the Program.

Home care support must still be offered on a CDC basis. This means the Home Care Agreement must be developed in partnership with the care recipient and the supports delivered must meet individual assessed care needs, personal care goals and the care plan.

Charging for services that are not provided is likely to lead to sanctions. Providers must also continue to meet all their obligations under the Act and Principles.

7.7 Can I decline a care recipient's request to sub-contract services?

In some circumstances, providers may not be able to accommodate the care recipient's preferences. This will need to be considered on a case-by-case basis, based on what is reasonable in the circumstances.

The following list provides a guide to home care providers as to when a request to use a particular service provider might be declined.

- The proposed service may cause harm or pose a threat to the health and/or safety of the care recipient or staff.

- The proposed service is outside the scope of the HCP Program.
- The home care provider would not be able to comply with its responsibilities under aged care legislation or other Australian Government or State/Territory laws.
- The requested service provider will not enter into a contract with the home care provider.
- There have been previous difficulties or negative experiences with the requested service provider.
- The cost of the service/item is beyond the scope of the available funds for the package.

Where the provider is not able to give effect to the care recipient's preferences or request for services, the reasons must be clearly explained to them and documented.

7.8 What do I need to provide to the care recipient at the end of their first care planning process?

Providers will need to give the care recipient a copy of their care plan within 14 calendar days of commencing service delivery and the package budget as soon as practicable. The package budget must identify what the budget is made up of (that is, the Government contributions and the home care fees) and how those budget funds have been allocated to care and services under the care plan.

Providers will need to consider pricing obligations when developing the budget. The budget is discussed at Section 8. Pricing obligations are discussed at **Appendix B**.

✓ Key points to remember

- Providers need to complete a care plan for all new care recipients within 14 calendar days of them starting services.
- Providers will need to collaborate with the care recipient to develop their care plan. When thinking about how to approach the care planning process, providers should consider taking a wellness or reablement approach.
- Providers' role in the care planning process is to help care recipients understand what care, services, or purchases they can choose to get from their package based on assessed need, and to enable them to make choices between those care and services.

8 A care recipient's package budget

As discussed at Section 7, providers need to work with each new care recipient to develop a care plan within 14 calendar days of the day the Home Care Agreement is completed. The individualised package budget needs to be done as soon as providers have all the information needed and the care plan is place. This section explains what makes up a package budget and how to calculate each component. All the financial aspects of the HCP Program are defined by the legislation. Providers should refer to the legislation for more information.

This section provides information relevant to people who entered the HCP Program after 1 July 2014, or who have opted into the post-1 July 2014 arrangements. For information on the pre-1 July 2014 arrangements, see **Appendix A**.

✓ **Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section**
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

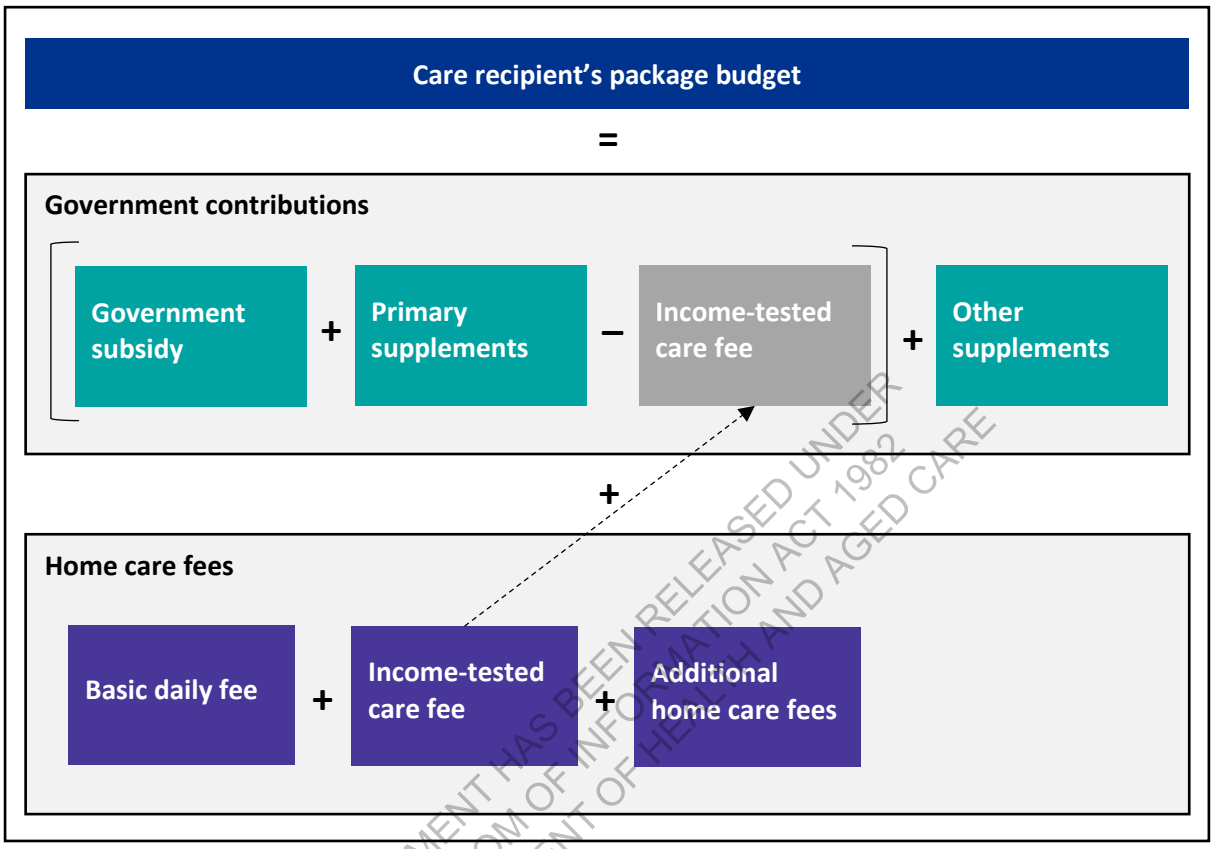
- Sections 52D-1 and 56-2 of the *Aged Care Act 1997*
- *User Rights Principles 2014*
- *Fees and Payments Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

8.1 What makes up a care recipient's package budget?

Each individualised package budget is made up of contributions from the Australian Government and, where applicable, the home care fees payable by the care recipient. The components of a post-1 July 2014 package budget may include:



Note: It should be noted that a care recipient's package budget will be affected if they have received a compensable payment amount. These are discussed in **Appendix C**.

8.2 How do I determine the amount of Government contribution to a care recipient's budget?

The Government contribution is calculated as follows:

1. The basic subsidy amount
2. Plus any primary supplements (oxygen supplement, enteral feeding supplement, dementia and cognition supplement, veterans' supplement)
3. Less any reductions in subsidy and primary supplements (income-tested care fee)
4. Plus any other supplement (hardship supplement, viability supplement).

The Government subsidy and supplements are payable, and calculated daily, even on days a care recipient does not receive a service.

8.2.1 Basic subsidy

The subsidy is paid in accordance with the level of package the care recipient has been assigned. There are four package levels, outlined in the table below:

Package	Needs
Level one	Basic care
Level two	Low level care
Level three	Intermediate care
Level four	High level care

The current amount that can be paid by the Government can be accessed at this link or by searching "Home care packages subsidy" at www.health.gov.au.

8.2.2 Supplements

If care recipients are eligible, providers can also claim for supplements that will be added to the subsidy amount. An authorised signatory of the approved provider must sign the dementia, oxygen and enteral feeding claim forms. Once a form is completed, the form and supporting evidence can be emailed to Services Australia via aged.care.liaison@servicesaustralia.gov.au. Providers should keep copies of all supplement forms and supporting evidence in the associated care recipient's records.

Any supplements providers claim for a care recipient must be added to their total package budget. Although they will be eligible for supplements if they require particular types of supports, the supplement funds do not have to be used to provide that specific support. Supplements are an acknowledgement of additional needs, and the supplement funds can be used in the same ways as any other component of a package budget.

Providers can claim supplements for eligible care recipients on any package level; whether they are on a level one, two, three of four package.

The table below identifies and describes each of the supplements, and outlines the administration requirements.

Primary supplements

Supplement	Description	Application process and payment	What happens if the care recipient changes providers?
The Dementia and Cognition Supplement in Home Care	The dementia and cognition supplement provides additional funding in recognition of the extra costs of caring for people with cognitive impairment associated with dementia and other conditions. For further information go to this link, or search "Dementia and cognition supplement for home care" at www.health.gov.au.	Assessment using one of the prescribed tools by an approved assessor. The approved provider is responsible for lodging an application with Services Australia.	Supplement automatically transfers to new provider. The new provider must obtain a copy of the record of assessment undertaken by the care recipient.

Supplement	Description	Application process and payment	What happens if the care recipient changes providers?
The Veterans' Supplement in Home Care	The veterans' supplement in home care provides additional funding for veterans with a mental health condition accepted by the Department of Veterans' Affairs (DVA) as related to their service. For further information go to this link, or search "Veterans' supplement for aged care" www.health.gov.au.	DVA determines eligibility and advises Services Australia. No action required by provider.	Supplement automatically transfers to new provider.
Oxygen Supplement	The oxygen supplement is for care recipients with a specified medical need for the continual administration of oxygen. For further information go to this link, or search "Oxygen supplement" www.health.gov.au.	Paid to provider to help pay for specialised products and equipment. The approved provider is responsible for completing the application form available on the Services Australia website. Once the form is completed, the form and supporting evidence can be returned to Services Australia.	Supplement does not automatically transfer. The new provider needs to submit a new application to Services Australia, including medical evidence.
Enteral Feeding Supplement	The enteral feeding supplement is for care recipients with a specified medical need for enteral feeding. For further information go to this link, or search "Enteral feeding supplement" at www.health.gov.au.	Paid to provider to help pay for specialised products and equipment. The approved provider is responsible for completing the application form available on the Services Australia website. Once the form is completed, the form and supporting evidence can be returned to Services Australia.	Supplement does not automatically transfer. The new provider needs to submit a new form to Services Australia, including medical evidence.

Other supplements

Supplement	Description	Application process and payment	What happens if the care recipients changes providers?
Viability Supplement in Home Care	The viability supplement is paid to providers on behalf of recipients of home care in rural and remote areas in recognition of the higher costs of delivering care and services in these areas. For further information go to this link, or search "Viability supplement for aged care" at www.health.gov.au.	Provide location details (suburb and postcode) to Services Australia through entry event and location event screen in the Aged Care Provider Portal.	Supplement automatically transfers to the new provider if a care recipients remains at the same location. The new provider must enter the same postcode and suburb on the Aged Care Provider Portal. A care recipient who relocates will automatically be reassessed for viability supplement based on their new location.
Hardship Supplement	The hardship supplement is available to recipients of home care in genuine financial hardship who do not have income to pay their costs of aged care due to circumstances beyond their control. Care recipients who have commenced receiving a package on or after 1 July 2014 need to apply to Services Australia for financial hardship assistance. For further information go to this link, or search "Financial hardship assistance" at www.health.gov.au.	Paid to provider as a hardship supplement in lieu of the basic daily fee and/or income-tested care fee. Care recipients (or their representative) applies and submits form to Services Australia.	Supplement automatically transfers to new provider, if a valid approval exists. As this supplement is time-limited, the new provider should confirm if the care recipient is receiving a hardship supplement and the validity period.

The schedule of aged care subsidies and supplements contains the current daily rate for HCP Program subsidies and supplements. The schedule can be found at this link or by searching "Schedule of subsidies and supplements" at www.health.gov.au.

8.3 How do I determine the amount of a care recipient's home care fees?

There are three types of legislated fees a provider may ask a care recipient to pay:

- the basic daily fee;
- an income-tested care fee; and
- any other amounts they have agreed to pay for additional care and services.

If a care recipient wishes to purchase additional services over and above those they could otherwise afford under the package, their provider can agree with them a further amount for additional care and services to increase the value of the package.

These fees are part of the individualised package budget and must be included in the Home Care Agreement as a statement of fees that may be payable. Providers must discuss any fees to be paid by the care recipient before they commence services.

If the care recipient is on leave there may be changes to the subsidy, supplements and home care fees payable. Please see Section 11 of this manual.

8.3.1 Basic daily fee

Providers can ask everyone to pay the basic daily fee. It is set by the Government at:

- Level one - the maximum fee is 15.68 per cent of the single person rate of the basic age pension.
- Level two - the maximum fee is 16.58 per cent of the single person rate of the basic age pension.
- Level three - the maximum fee is 17.05 per cent of the single person rate of the basic age pension.
- Level four - the maximum fee is 17.50 per cent of the single person rate of the basic age pension.

Rates for the basic daily fee are reviewed in March and September each year in line with changes to the Age Pension. The current rates are available in the schedule of fees and charges for residential and home care. The schedule can be found at this link or by searching "Charging fees for aged care services" at www.health.gov.au.

As the maximum basic daily fee is linked to the package level, an increase in package level may result in an increase to the basic daily fee.

Home care fees are payable, and calculated daily, even on days a care recipient does not receive a service. The Government subsidy and supplements are payable, and calculated, in the same way.

8.3.2 Income-tested care fee

Under the post 1 July 2014 income testing arrangements, the amount of Government subsidy is reduced by the amount of the income-tested care fee. **Providers are still required to provide services to the full value of the package should they choose not to charge this fee (or charge a lesser fee).**

The income-tested care fee is a contribution that care recipients may be asked to pay if they can afford to do so, and is in addition to the basic daily fee. The income-tested care fee is determined through an income assessment, which is conducted by Services Australia or DVA as applicable. It is the responsibility of the provider to put in place the business processes to collect and manage income-tested care fees from the care recipient.

The care recipient has been assigned a package level based on their needs. They cannot decide with the provider to select a lower level of care and services by agreeing not to pay the income-tested care fee or pay a lesser amount.

8.3.3 Income assessment

The easiest way for a care recipient to complete an income assessment is to use form SS313, at this link, or by searching **"Authorising a person or organisation to enquire or act on your behalf form (SS313)"** at www.servicesaustralia.gov.au. This is a dynamic form and will present different questions based on the answers provided.

If the care recipient prefers to complete a hardcopy form, they can download a copy of the **"Authorising a person or organisation to enquire or act on your behalf form (SS313)"** from the Services Australia website at this link or by searching "SS313" at www.servicesaustralia.gov.au. Or call Services Australia on **1800 227 475** to ask a copy be sent to them. If the care recipient receives a means tested income support payment, they can call Services Australia on **1800 227 475** or DVA on **1800 555 254** and request a pre commencement letter for home care. Services Australia (or DVA) will have sufficient information to calculate their maximum home care fees payable.

If they do not complete the income assessment, they may be asked to pay the maximum income-tested care fee.

For an estimate of home care fees for the person, My Aged Care has a home care fee estimator at this link, or can be found by searching "Fee estimator" at www.myagedcare.gov.au.

8.3.4 Annual and lifetime caps

There are annual and lifetime caps that apply to the income-tested care fee. The current caps are at this link or can be found by searching "Schedule of Fees and Charges for Residential and Home Care" at www.health.gov.au. Once the annual cap is reached, the care recipient cannot be asked to pay any more income-tested or means-tested care fees until the next anniversary of when they first started receiving aged care. Providers can still ask for payment of the basic daily fee.

Services Australia will notify the provider and care recipient once the cap has been reached. The Government will pay the remaining income-tested care fees by way of increased subsidy to the provider after these caps have been reached.

8.3.5 Worked example

How do we calculate Adam's package budget?

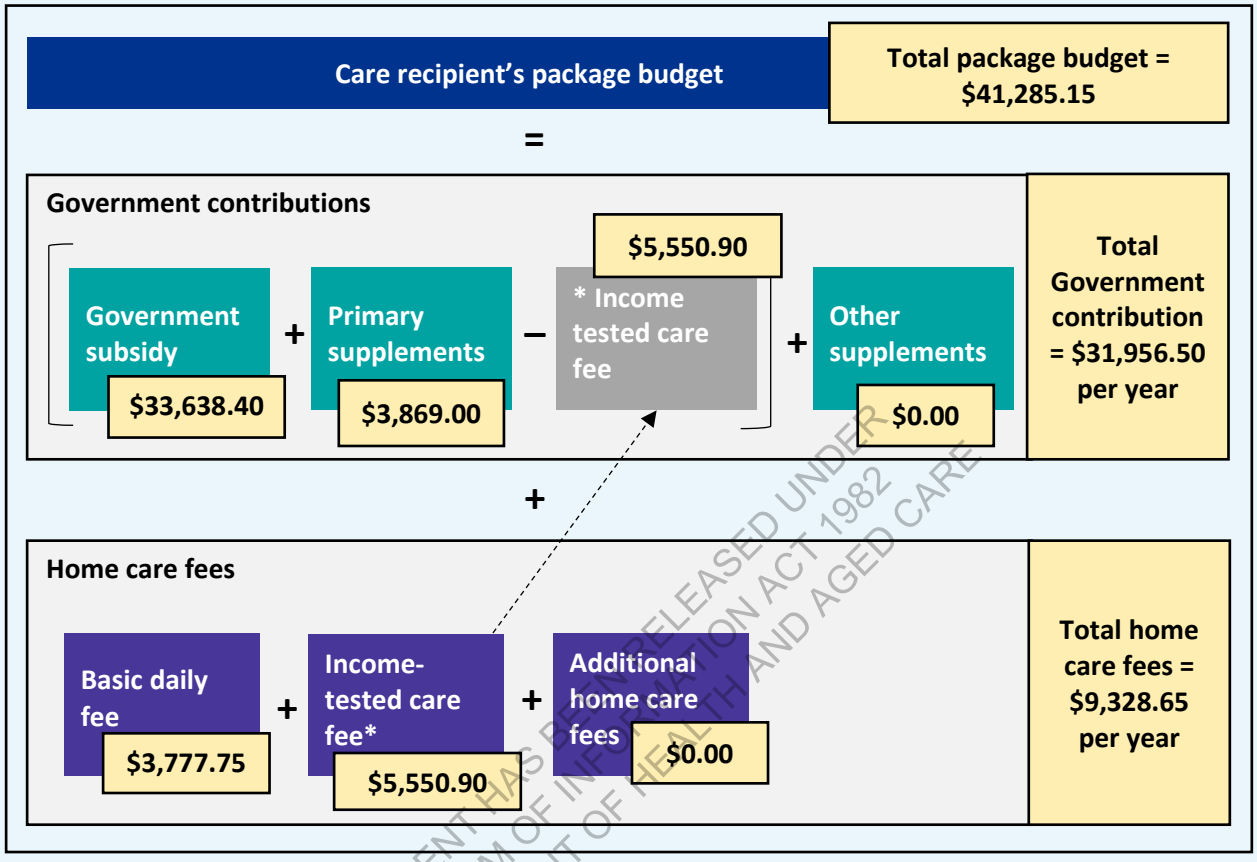
Fact scenario

- Adam lives at home with his partner David.
- Adam has been assigned a level three package. The value of his daily package subsidy is $92.16 per day (as at 20 September 2019). This equates to $33,638.40 per year.
- Adam is also eligible for the dementia and cognition supplement. The value of the supplement at his package level is $10.60 per day. This equates to $3,869.00 per year.
- Adam is not eligible for any other supplements.
- The basic daily fee for Adam's package level is $10.35 per day. This equates to $3,777.75 per year.
- Adam has completed his income assessment, and has been assessed by Services Australia as being able to pay an additional $15.24 per day or $5,550.90 per year in income-tested care fees.
- Adam did not agree to pay any additional fees in his Home Care Agreement.

How do we calculate Adam's package budget?

Calculation of package budget

The diagram below outlines how Adam's home care budget is calculated:



The Government subsidy and supplements of Adam's Home Care Package is valued at $37,507.40 ($33,638.40 + $3,869.00) per year.

The amount of basic daily fee charged adds to Adam's package budget. It has no impact on the amount of Government subsidy and supplements that are paid.

Adam, however, has been assessed by Services Australia as being able to contribute $5,550.90 per year towards his income-tested care fee. The Government subsidy and primary supplement payable for Adam's care to his provider is reduced by Adam's income-tested care fee. That is, $33,638.40 + 3,869.00 - $5,550.90 = $31,956.50.

If Adam's home care provider does not collect the full income-tested care fee (regardless of the reason), the home care provider is still required to provide Adam with services as if the fee had been paid in full. The home care provider and Adam cannot select a lower level of care and services to match the reduced value of the Australian Government subsidy paid (in this example $31,956.50).

If Adam fails to meet his responsibilities, including the payment of fees, as described in section 17 of the *User Rights Principles 2014*, his home care provider may cease to provide home care to him under the security of tenure provisions. Adam's Home Care Agreement must contain a statement setting out which home care fees (if any) are payable by him and the conditions under which either party may terminate the provision of home care.

8.4 What do I do if a care recipient is facing financial hardship?

If someone thinks they will face financial hardship when paying their aged care fees, they can apply to Services Australia for financial hardship assistance. Each case is considered on an individual basis. Depending on their situation, they may apply for financial assistance with the:

- basic daily fee; and/or
- income-tested care fee.

Care recipients experiencing financial hardship may be granted assistance with one, both or neither of these fees. If financial hardship assistance is granted, a hardship supplement will be paid to the provider in lieu of the basic daily fee and/or income-tested care fee.

For more information on eligibility criteria and assessments for financial hardship go to this link, or by searching "Hardship supplement for aged care" at www.health.gov.au.

✓ Key points to remember

- A package budget is made up of Government subsidies and supplements, and home care fees.
- A care recipient's home care fees will depend on their circumstances. All care recipients may be asked to pay a basic daily fee. Some may also be asked to pay an income-tested care fee.
- Government subsidy and supplements are payable, and calculated daily, even on days a care recipient does not receive a service. Home care fees are also payable, and calculated daily.
- It is a business decision for the provider if they choose to collect the basic daily fee. Collecting this fee adds to the package budget and provides access to more care and services.
- It is a business decision for the provider if they collect the income-tested care fee (or a lower income-tested care fee). Providers must deliver care to the full value of the package budget, regardless of whether they collect the income-tested care fee from the care recipient. The provider and the care recipient cannot select a lower level of care and services by agreeing not to pay the income-tested care fee.

9 Inclusions and exclusions

This section outlines the care and services that can and cannot be included in a Home Care Agreement. It gives providers information and tools to use when working in partnership with care recipients to develop a care plan that optimises health and wellbeing in accordance with their assessed care needs, care goals and preferences, and helps them live safely and independently at home.

Under a CDC service delivery model, people have choice over the types of care and services they access and how these are delivered. Decisions on what is included or excluded in the care plan need to reflect that they have a 'dignity of risk' (under the Charter of Aged Care Rights) to accept the personal risks associated with making these choices. Providers need to balance this with their ongoing accountability for what each package budget is being spent on, and for delivering quality of care. This is necessary to ensure providers are compliant with the Aged Care Quality Standards and any relevant Australian Government or State and Territory laws.

To meet these obligations, providers may need to have challenging conversations with care recipients and their carers about whether a type of care or service or item can be included. A framework of considerations is included in Section 9.1 to support these discussions. It is also important that providers document and retain records of the reasons why a service or item is included or excluded.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Section 54-1 of the *Aged Care Act 1997*
- *Quality of Care Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them. See **Appendix D** for further detail on specific provider responsibilities.

Providers will need to act in compliance with all relevant State, Territory and Australian Government laws. A list of relevant Australian Government laws can be found at this link, or by searching "Legislation" at www.agedcarequality.gov.au/. The Aged Care Quality Standards can be found at this link or by searching "Quality Standards" at www.agedcarequality.gov.au/. Please consult your State or Territory register of legislation for information on relevant State or Territory laws.

9.1 How do I work out what services can be included in a care recipient's care plan?

The HCP Program is designed to provide a mix of services and supports that are customised to meet the individual care needs and goals of each eligible person. As discussed at Section 7, that mix is determined through care planning. Care planning involves:

- partnering with the care recipient to discuss their assessed care needs and care goals;
- deciding which care and service types will best assist them to meet these needs and goals; and
- detailing these care and services types in the care plan.

When working with each person to clarify their assessed care needs and care goals, providers should encourage them to think about what supports will optimise their health and wellbeing. Their

priorities and preferences are a key part of the discussion to co-produce their care plan. Care and services included in the care plan that will be purchased using the package budget should be drawn, for the most part, from the legislated inclusions, and must not include any legislated exclusions (see Section 9.2).

Sometimes a care recipient will seek a care or service type that is not specified as an inclusion or exclusion in the legislation. This means that you will need to work in partnership with care recipients to determine if the service, support or purchase:

- is directly linked to their identified care needs and goals;
- supports for daily living that is important for the care recipient's health and wellbeing;
- is necessary for them to support functional safety in their home;
- can be delivered within their package budget; and
- would be considered an acceptable use of Government funds.

You will also need to consider whether you have the capacity and capability to deliver, or source, the proposed support.

The framework supports providers to take a flexible and responsive approach to working with care recipients on whether to provide proposed care and services that are not identified in the legislated inclusions. It allows providers to take a person-centred approach to care planning that supports a balance between assessed care needs, care goals and individual preferences, and considers individual circumstances such as financial and social position, cultural diversity and location.

The following framework has been designed to support decision making when it comes to determining what can and cannot be included as part of a package:

Consider and understand the care recipient's care needs and care goals to support them in living independently in their own home (in the short and medium term).

The care recipient's care needs and care goals must be clearly understood by both the provider and the care recipient, noting that these care needs and care goals can change over time. Information provided in the ACAT assessment and discussions with the care recipient will provide the basis for understanding this.

For each care and service type the questions on the next page will need to be considered.

These questions have been developed to help providers determine with care recipients if a care or service type should be included as part of their package. The questions have been grouped by category. To draw a conclusion, it is important that all the questions are considered on balance of each other.

Document all discussions about the inclusion or exclusion.

All discussions surrounding inclusions and exclusions for each care recipient should be clearly documented. Care and services to be included in the package should be clearly documented in the care plan and package budget. Where a provider is unable to give effect to the care recipient's preferences or request for services, the reasons must be clearly explained to the care recipient and documented. Documenting these discussions provides justification for the decisions regarding inclusions and exclusions of a package. Providers may be required to produce this documentation as evidence for the Aged Care Quality and Safety Commission or the Department.

Inclusions and exclusions framework – Step two questions
Mandatory criterion
Is the support specifically excluded under the Aged Care legislation? See Section 9.2 of this manual for an extract of excluded items. This question prompts providers and care recipients to think about whether the care or service is prohibited by the legislation. If the care or service is on the list of excluded items, it must not be included in a package.
Care recipient's assessed care needs
Does the support directly align with the intent and scope of the HCP Program? See Sections 2.2 and 2.3 of this manual for information on the intent and scope of the HCP Program. This question helps providers and care recipients to think about whether the care or service is an appropriate and acceptable use of the package budget. If the care or service does not align with the intent and scope of the HCP Program, it should not be funded from the package budget.
How does the support align with the assessed care needs as documented in the ACAT assessment, the providers' own assessment of the care recipient's needs or an assessment by a health care professional?

Inclusions and exclusions framework – Step two questions
This question helps providers and care recipients think about other clinicians' and allied health practitioners' assessment of their care needs. The care needs may have changed between the time of the original ACAT assessment and the assignment of the package. It is important to consider all assessments relevant to the care recipient's current care needs and goals.
How does the support assist the care recipient to achieve their care goals, now and in the short to medium term? Is the support necessary to meet the care recipient's assessed care needs and care goals? This question helps providers and care recipients think about the appropriateness of the care or service for the individual care recipient. When answering this question, consider the immediate impacts of the care or service on the package budget. Providers and care recipients should also think about how the care or service impacts on whether the package budget will still meet their assessed care needs and care goals in the short to medium term.
Has the evidence-base for the use of the support in addressing the particular assessed care need been considered? This question helps providers and care recipients think about the clinical appropriateness of a care or service to meet the care recipient's assessed care needs or care goals. While many variations of care and service types can help meet these, in some circumstances, there may be no supporting clinical evidence. In these instances, providers can use the clinical skills and expertise available to them to determine whether the care or service is appropriate to meeting the care recipient's care needs and goals.
Quality and safety
Does the support pose a risk to the health and safety of the care recipient? This question asks providers and care recipients to consider the risks associated with the care or service. Providers can then make an informed conclusion about its safety for the care recipient. While people have the right to dignity of risk regarding their choices, the provider's team (those supporting the care recipient), and the approved provider, have professional obligations to provide safe services and supports to care recipients. If providers form the view that the care or service poses an unacceptable risk to their safety, then the item should be excluded from the package.
Does the support pose a risk to the health and safety of staff and the community? This question asks providers to consider whether they believe the care or service can safely be delivered by their staff (or other persons who they engage to deliver the package). It also asks providers and care recipients to think about any broader implications of the care or service on the community. This might include, for example, the safety of providing a mobility scooter to a particular care recipient if they may pose a risk to the public whilst travelling on footpaths.

Inclusions and exclusions framework – Step two questions

Does the support require maintenance to ensure the safe use of the item that represents a significant portion of the budget? Is it difficult to provide the maintenance required?

This question asks providers to consider the financial feasibility of maintaining the item purchased in the short-term and into the future. It is closely linked to the assessment of the opportunity cost associated with the care or service, which is considered in the next question.

Financial

Is there an opportunity cost associated with the support?

This question asks providers and care recipients to think about the trade-offs the care recipient will be making if they would like to include a care or service in their package. Given a package provides a set amount of funding, the request may be at the expense of receiving other care and services that would better meet the assessed care needs and care goals to keep them living independently in their home.

Will the care recipient miss out on a support identified in their assessment if package funding is used for a large purchase?

This question is a more detailed consideration of the question above, however, this question focusses on assessed care needs only. It requires providers to think about whether they will be able to deliver safe and clinically necessary care with the remaining funds in the package budget, if a large purchase is funded. If the provider cannot deliver the required care with the remaining package budget, this is a strong indicator that the purchase should not be made.

Does the support represent value for money to meet the care recipient's assessed care needs?

This question asks providers to consider the appropriateness of the expenditure, noting the cost of the care or service, and the expected benefits. When making this assessment it is useful to remember that, although a package is for use by the care recipient, the bulk of the home care budget is a Government subsidy funded by taxpayers to be used appropriately. For example, where a care recipient needs kitchen modifications (e.g. easy access taps) to assist in the preparation of meals, a full kitchen refurbishment (beyond minor modifications) is not an appropriate use of Government funding.

Other

Can the support be provided informally through the community?

This question asks providers and care recipients to think about whether there are alternate, feasible ways the care recipient could get the same benefits without using their package budget. This might include, for example, considering whether the care recipient can use transport that is free from their local club to access the club, rather than paying for transport from their package.

Does the support directly support the care recipient, or does it have significant benefits for others that do not directly benefit the care recipient?

This question helps providers and care recipients to think about who the care or service would benefit the most. If something can be related back to the care recipient's care goals, but primarily

benefits someone other than the care recipient without directly benefiting them, it should not be included under a package, particularly if there is a direct or implied monetary benefit. For example purchasing a car for a family member so they can transport the care recipient.

Respite care is an acceptable and important support, as it directly benefits the care recipient by ensuring their carer is capable to continue supporting them to live in their own home.

9.2 Is the proposed care or service specifically included or excluded under the Aged Care legislation?

As outlined in the above framework, the legislation provides guidance about specific items that can be included or must be excluded. It is worth remembering, however, that the care or service is only included when it meets assessed care needs and care goals.

This guidance is outlined in the *Quality of Care Principles 2014*.

The inclusions have been extracted below:

9.2.1 Care services

Service inclusions	Content
Personal services	Personal assistance, including individual attention, supervision and physical assistance, with: • Bathing, showering including providing shower chairs if necessary, personal hygiene and grooming, dressing and undressing, and using dressing aids • Toileting • Mobility • Transfer (including in and out of bed).
Activities of daily living	Personal assistance, including individual attention, individual supervision and physical assistance, with communication including assistance to address difficulties arising from impaired hearing, sight or speech, or lack of common language, assistance with the fitting of sensory communication aids, checking hearing aid batteries, cleaning spectacles and assistance using the telephone.
Nutrition, hydration, meal preparation and diet	Includes: • Assistance with preparing meals • Assistance with special diet for health, religious, cultural or other reasons • Assistance with using eating utensils and eating aids and assistance with actual feeding, if necessary • Providing enteral feeding formula and equipment.
Management of skin integrity	Includes providing bandages, dressings, and skin emollients.

Service inclusions	Content
Continence management	Includes: • Assessment for and, if required, providing disposable pads and absorbent aids, commode chairs, bedpans and urinals, catheter and urinary drainage appliances and enemas • Assistance in using continence aids and appliances and managing continence.
Mobility and dexterity	Includes: • Providing crutches, quadruped walkers, walking frames, walking sticks and wheelchairs • Providing mechanical devices for lifting, bed rails, slide sheets, sheepskins, tri-pillows, and pressure relieving mattresses • Assistance in using the above aids.

9.2.2 Support services

Service inclusions	Content
Support services	Includes: • Cleaning • Personal laundry services, including laundering of care recipient's clothing and bedding that can be machine-washed, and ironing • Arranging for dry-cleaning of care recipient's clothing and bedding that cannot be machine-washed • Gardening • Medication management • Rehabilitative support, or helping to access rehabilitative support, to meet a professionally determined therapeutic need • Emotional support including ongoing support in adjusting to a lifestyle involving increased dependency and assistance for the care recipient and carer, if appropriate • Support for care recipients with cognitive impairment, including individual therapy, activities and access to specific programs designed to prevent or manage a particular condition or behaviour, enhance quality of life and provide ongoing support • Providing 24-hour on-call access to emergency assistance including access to an emergency call system if the care recipient is assessed as requiring it • Transport and personal assistance to help the care recipient shop, visit health practitioners or attend social activities • Respite care • Home maintenance, reasonably required to maintain the home and garden in a condition of functional safety and provide an adequate level of security, such as cleaning gutters • Modifications to the home, such as easy access taps, shower hose or bath rails • Assisting the care recipient, and the homeowner if the home owner is not the care recipient, to access technical advice on major home modifications • Advising the care recipient on areas of concern in their home that pose safety risks and ways to mitigate the risks • Arranging social activities and providing or co-ordinating transport to social functions, entertainment activities and other out of home services • Assistance to access support services to maintain personal affairs.
Leisure, interests and activities	Includes encouragement to take part in social and community activities that promote and protect the care recipient's lifestyle, interests and wellbeing.
Care management	Includes reviewing the care recipient's Home Care Agreement and care plan, co-ordinating and scheduling care and services, ensuring care and services are aligned with other supports, liaising with the care recipient and the care recipient's representatives, ensuring that care and services are culturally appropriate, and identifying and addressing risks to the care recipient's safety.

9.2.3 Clinical services

Service inclusions	Content
Clinical care	Includes: • Nursing, allied health and therapy services such as speech therapy, podiatry, occupational or physiotherapy services • Other clinical services such as hearing and vision services.
Access to other health and related services	Includes referral to health practitioners or other related service providers.

The *Quality of Care Principles 2014* have also established a number of services that must not be included in the package. These are always excluded; even if they may advance the care recipient's assessed care needs and care goals, they are not aligned to the intent and scope of the HCP Program. Specified exclusions are extracted below:

Specified exclusions

The following items must not be included in the package of care and services under the HCP Program:

- Use of the package funds as a source of general income for the care recipient
- Purchase of food, except as part of enteral feeding requirements
- Payment for permanent accommodation, including assistance with home purchase, mortgage payments or rent
- Payment of home care fees
- Payment of fees or charges for other types of care funded or jointly funded by the Australian Government
- Home modifications or capital items that are not related to the care recipient's care needs
- Travel and accommodation for holidays
- Cost of entertainment activities, such as club memberships and tickets to sporting events
- Gambling activities
- Payment for services and items covered by the Medicare Benefits Schedule or the Pharmaceutical Benefits Scheme.

In relation to meal services and whether food can be included in a HCP:

- preparation and delivery of meals can be included
- the raw food component of those meals cannot be included, except in the case of enteral feeding.

The Department has not mandated a standard split/ratio for the raw food component. This is a business decision for the company providing the meal services to calculate how much the raw food component is. Home care providers should discuss with the care recipient the amount of the raw food contribution, as well as how and who it is paid to, as part of the negotiation with the meals provider and the care recipient.

Food referred to as 'takeaway' is also an excluded item. 'Takeaway' food is generally defined as food you would buy from a restaurant or food outlet.

The following table provides examples of care and services that fall within the most commonly excluded categories outlined in the legislation.

Excluded item (category)	Example of excluded item
Use of the package funds as a source of general income for the care recipient	Household bills, the purchase of a car or petrol, funeral cover, household furniture, solar panels, servicing gas heaters, phone and/or internet plans, or entertainment activities such as streaming subscriptions
Payment for permanent accommodation, including assistance with home purchase, mortgage payments or rent	Rates, home and contents insurance
Payment of home care fees	Basic daily fee, income-tested care fee and additional fees
Payment of fees or charges for other types of care funded or jointly funded by the Australian Government	Services that can be covered under the public health system, such as hearing aids, dentures
Home modifications or capital items that are not related to the care recipient's care needs	House renovations that exceed what is necessary for functional safety, independence, wellness and reablement, such as household security alarms, replacing gutters

The following list provides a guide to providers on when it might be reasonable to decline a request from a care recipient:

- The proposed service may cause harm or pose a risk to the health and/or safety of the care recipient or staff.
- The proposed service is outside the scope of the *Quality of Care Principles 2014*.
- The provider would not be able to comply with its responsibilities under aged care legislation or other Australian Government or State/Territory laws.
- The care recipient's choice of service provider is outside the provider's preferred list of service providers and all reasonable effort has been made to establish an acceptable sub-contracting arrangement.
- The requested service provider will not enter into a contract with the provider.
- There have been previous difficulties or negative experiences with the suggested service provider.
- The cost of the service/item is beyond the scope of the available funds for the package.

The following is a case study of when an item might be clinically necessary, but is excluded:

Case study: Yashwant

Yashwant is in his 80s and on a level three package. He has accrued approximately $5,000 in unspent funds. Yashwant needs a new set of hearing aids. He can get these devices fully subsidised under the Australian Government Hearing Services Program. He has decided, however, that he would like to use his unspent funds to get different hearing aids that are partially subsidised or not available through the Hearing Services program.

Yashwant's care manager meets with him to discuss his unspent funds. Yashwant notifies her that he would like to use $3,000 of his package towards a new pair of hearing aids. He thinks the more expensive ones look better, and his neighbour has told him that because they are more expensive, they will last longer than the ones that are funded through the Hearing Services program.

Yashwant's case manager explains to him that unfortunately, his package cannot be used for care, services or purchases that are already available through publicly funded programs. She then explains to Yashwant why the hearing aids from the Hearing Services program are appropriate to meet his needs.

9.3 What are unspent funds and how do they affect choices about inclusions and exclusions?

Unspent funds are the total amount of home care subsidy, supplements (if applicable) and home care fees paid to a provider that have not been spent or committed on a person's care. Unspent funds typically accumulate over time where the care recipient's package funds have not been fully allocated within their package budget. Strategies for managing build-up of unspent funds are discussed at Section 10 of this Manual.

When thinking about how unspent funds affect inclusions and exclusions, providers need to work with care recipients who have a large build-up of unspent funds to prioritise ongoing care and services to ensure that their assessed care needs and care goals are being met. Accumulation of unspent funds does not mean that large purchases of goods can automatically be made. All inclusions under a package should be considered in line with the framework outlined above. They should be considered both reasonable and necessary in the context of individual circumstances and an appropriate use of taxpayer funded Government subsidy.

✓ Key points to remember

- The legislation prescribes care, services and purchases that can and cannot be included in a package. All inclusions must also link to identified assessed care needs and care goals.
- There will be care and services that care recipients request, or may need, that are not listed in the legislation. Providers and care recipients can use the inclusions and exclusions framework in this manual to help make an informed decision.
- Providers need to document their reasons and the discussions they have with the care recipient about the inclusion/exclusions. They may need to produce these documents for the Commission, or to prove they have been compliant with any Australian Government or State and Territory laws.
- The Commission website can provide further guidance, at www.agedcarequality.gov.au/.

10 Delivering care under a package

Once a provider has started providing services to a care recipient (in line with their care plan and package budget), they will need to manage their care. This section outlines the ordinary administrative things providers need to do to make sure care recipients are getting the best outcomes possible from their package.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 56-2 and 56-4 of the *Aged Care Act 1997*
- *User Rights Principles 2014*.

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

10.1 Commencing services

Once a person is assigned a package and has entered into their Home Care Agreement, their care and services can begin. The date care is first delivered should be specified in their Agreement. Their package starts on the day the Home Care Agreement is entered into, not from the day that care is first delivered. Therefore, the commencement date on the ACER form may be the same or earlier than the date that care is first delivered. The commencement date on the ACER has to be within the package take up timeframe.

Care and services should then be delivered according to the care plan that the provider and the care recipient have developed in partnership.

10.1.1 Client summary tab

A 'client summary tab' is available in the My Aged Care client record. This is also known as the 'Client journey dashboard'. This tab provides key information about the care recipient in one place, which may include:

- assessment information;
- approvals;
- service recommendations;
- service delivery information;
- goals and reablement; and
- any periods of linking support.

Information will only be displayed where it is applicable to that individual person.

More information is available at this link or by searching "My Aged Care - Client summary tab" at www.health.gov.au.

10.2 How do I claim the Government subsidy for services I provide?

Providers can only claim the home care subsidy for people who have been assigned a package from the national priority system and have a Home Care Agreement in place. This means that providers can only claim the Government subsidy from the date they entered into the Home Care Agreement, not the date they start negotiating with the care recipient or completing pre-service delivery care planning.

Services Australia will know the date a provider commences delivering services to a care recipient through the submission of the ACER. This must be completed within 28 days of when they entered home care.

The Services Australia payment system checks provider claims against the My Aged Care listing of care for people with an assigned package. Services Australia cannot process a claim for a care recipient if they do not have a package that is assigned and active.

The home care subsidy can only be paid once the Home Care Agreement has been entered into. The subsidy cannot be claimed for discussions and meetings with the care recipient (or carers and family members), or any services provided to them **before** the Home Care Agreement is entered into.

10.2.1 Improved Payment Arrangements

In December 2020, the Australian Government passed Bill 1 *Aged Care Legislation Amendment (Improved Home Care Payment Administration No. 1) Bill 2020.*

Legislation will support the commencement of Phase 1 of the Improved Payment Arrangements measure announced by the Government in the 2019-20 Budget. Instead of receiving a full subsidy payment against each care recipient at the beginning of each month, legislation requires providers to be paid monthly **in arrears**. This measure will reduce the prudential risk in home care over time and improve protections for care recipients' HCP funds.

Phase 1 (in place)

- From 1 February 2021, providers will be funded in arrears rather than in advance.
- Payments for each month will be claimed in the next month, for the full subsidy, based on the number of care recipients in care during February 2021.
- Fact sheets containing information about Phase 1 changes for providers and care recipients have been released on the Department of Health's website.

Phase 2 (Bill 2)

On 2 February 2021, the Australian Government passed Bill 2 *Aged Care Legislation Amendment (Improved Home Care Payment Administration No. 2) Bill 2020*.

- From 1 September 2021, providers will be paid in arrears, based on actual care and services delivered.
- The Government will collect and hold the Commonwealth portion of unspent funds, in each care recipient's home care account, until needed by the care recipient.

More information about the Improved Payment Arrangements, including the fact sheets for providers and care recipients, is available at this link or by searching "Improved Payment Arrangements for Home Care" at www.health.gov.au.

Claiming payments

In Phase 1, providers will continue to claim through Services Australia as they do now, but the claim will be for the number of care recipients in care from the **previous** month. The usual compliance processes apply. Services Australia's payment system enables the introduction of Phase 1.

The subsidy is calculated by adding together the daily amounts (subsidy plus supplement less the subsidy reduction) for each day a care recipient is in a Home Care Agreement with that provider from the previous month. This is based on information provided in the monthly claim form submitted to Services Australia through the Aged Care Provider Portal, at this link. Online claiming can be found by searching "Aged Care Provider Portal" at www.servicesaustralia.gov.au.

Monthly payments may include an adjustment to account for any over or under-payment in the previous month/s. Subsidy payments are made through the Services Australia Aged Care Provider Portal, on behalf of the Department.

10.3 How should I manage my care recipients' package services?

A care recipient should be allocated a care manager by a provider. The care manager is responsible for enabling the steps discussed at Sections 6, 7 and 8 (initial assessment, care planning and establishing the Home Care Agreement), as well as:

- reviewing the Home Care Agreement and care plan;
- co-ordinating and scheduling care and services;
- ensuring care and services are aligned with other supports;
- liaising with the care recipient and the care recipient's representatives, ensuring that care and services are culturally appropriate, and identifying and addressing risks to the care recipient's safety;
- referral to an ACAT (e.g. if their needs change); and
- supporting timely and appropriate referral to individuals, other organisations and/or providers of other care and services.

10.4 What happens if a care recipient wants to self-manage their package?

Self-management means that a care recipient is involved in designing and directing their care, taking a lead role in making decisions to manage their package. This includes choosing preferred workers, and scheduling and co-ordinating their care and services. Care recipients can ask to do this because the HCP Program operates under a CDC model. Providers who offer this option should ensure that what is involved is fully understood.

It is important that both the provider and the care recipient understand that the approved provider is ultimately responsible for compliance with the legislation (see Section 2), Aged Care Quality Standards (see Section 3), and scope and intent of the HCP Program (see Section 2). Providers will still need to have oversight over what self-managing care recipients spend their package budget on. Providers will also continue to undertake some required activities such as reviewing the care plan.

This may incur some costs and staff effort, so providers can charge a care management fee proportionate to the work incurred to oversee the care recipient's self-management.

10.5 How often does the care plan need to be reviewed?

The care manager must review a care recipient's care plan:

- regularly and at least once every 12 months, to make sure the care and services received through the package still meet the care recipient's needs;
- at any time when requested by the care recipient's or their carer;
- if the care recipient has been receiving services through a lower level package than their approved level, and they get upgraded to a higher package level; and/or
- if there has been a change in the care recipient's package budget.

Reviews may also occur more frequently than every 12 months. Reasons for an additional or earlier review may include:

- a health crisis or episode;
- a change in care need that cannot be met within the package budget available for the package;
- a change in living or carer arrangements;
- ongoing or increasing use of clinical services; or
- the use of a large amount (or all) of the remaining funds.

When thinking about how often to review the care plan, providers should be aware of compliance with Standards 2 and 3 of the Aged Care Quality Standards. For more information on the standards see Section 3 of this manual.

The review should have a reablement and wellness focus that does not assume a decline in the care recipient's health and functioning. It should involve:

- a review of current care needs, care goals and preferences;
- an evaluation of the quality and success of the services and supports that have been provided;
- a renegotiation and update of the care plan and individualised package budget; and
- support for the care recipient to continue to make informed choices about their care and services, and the life they choose to live, including whether they wish to change their level of involvement and decision-making in the management of the package.

Wellness and reablement are discussed further at Section 7.3.

The review should be done in person, wherever possible. Phone and video technology or other remote monitoring digital technology may also be used, where clinically appropriate.

Review of the care recipient's care needs may lead to significant changes in the nature of the support provided to them. The provider should support the care recipient (and anyone else they choose to involve, such as family or advocates), as much as possible, in any changes resulting from the review of the care plan.

Another ACAT assessment may be required if the care recipient's care needs have increased significantly so that they potentially require more support in order to remain in their home, or entry to residential care or residential respite. Some care recipients may already have suitable approvals. To determine if an approval is already in place, providers can review their My Aged Care client record. If they do need a new ACAT assessment, the provider can assist to arrange this, with their permission.

As discussed at Section 7, providers need to undertake initial and ongoing assessment and planning for care and services in partnership with each person they enter into a Home Care Agreement with. Providers cannot change a care plan without mutual consent from the care recipient.

Review of the care plan is an included service, paid for out of the care management cost (if any), as agreed in the Home Care Agreement. Providers cannot charge additional costs to the care recipient's package budget for each time they request a review of their care plan or Home Care Agreement.

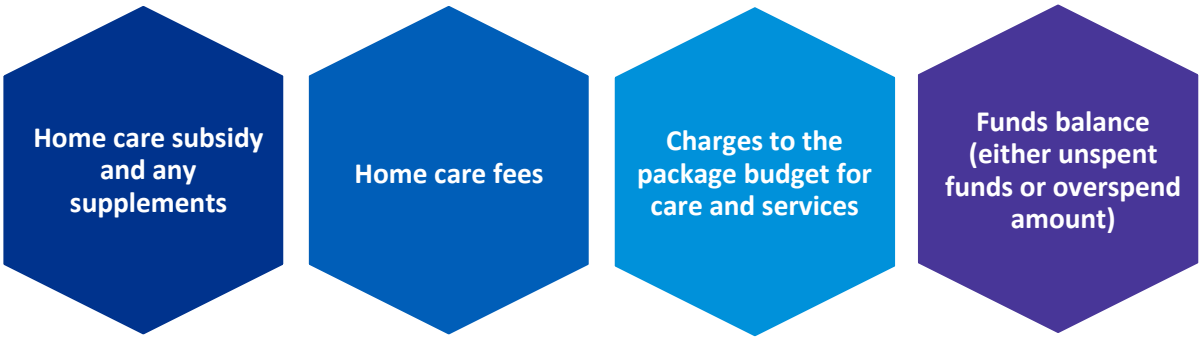
While the care plan should be reviewed regularly for effectiveness, if someone is asking for recurrent reviews of their care plan where their circumstances have not changed, providers should discuss why they are requesting reviews of the care plan, and what can be done to help. Providers should document records of these conversations taking place.

Note: where there is a change to the care recipient's care plan, the package budget will also need to be updated.

10.6 What is a monthly statement and what does it need to have in it?

Providers are required by the *User Rights Principles 2014* to issue care recipients with monthly statements that show the package budget funds available to them and what has been spent from their budget. Providers may also include any agreed additional charges. A monthly statement should clearly show services delivered so that the care recipient and/or their carers can easily understand how the service provider is charging for the package.

The following amounts must be itemised and included in the monthly statement:



Any unspent funds amount must carry over from month to month, and from year to year, for as long as that person continues to receive a package.

10.7 When can I charge home care fees?

Once the Home Care Agreement has been entered into, providers may ask the care recipient to pay home care fees up to one month in advance. Providers cannot ask for payment of any home care fees before their package begins.

Any fees paid in advance must be refunded to the care recipient, or their estate, if they exit the HCP Program or move to another provider. See Section 13 for more information on refunds when transferring services.

10.8 When should I review a care recipient's home care fees?

Rates for the basic daily fee are reviewed and changes announced in March and September each year in line with new rates for the Age Pension. Providers may need to discuss the impact of these fees changes with the care recipient and update their package budget accordingly.

Services Australia conducts a quarterly review of income-tested care fees in January, March, July and September. If a care recipient's financial circumstances change the care recipient can request a review with Services Australia or DVA.

For care recipients in the pre-1 July 2014 arrangements, see **Appendix A**.

10.9 How can I work with my care recipients to manage unspent amounts?

Providers should work with care recipients to ensure they are able to benefit from the full use of their package and budget. However, there are several reasons why unspent funds may accumulate in a package budget – key examples are listed below:

Reason	Information
Consumer choice	The package budget for a care recipient's assessed level of care should be used to meet their current care needs. However, they may actively choose to set aside a small proportion of their package budget for future events, such as leave of a carer.
Automated package upgrades	Care recipients receiving services through a lower level package than they are approved for are automatically upgraded when a package is available at a higher level. If their care needs are being met by the lower level package the provider should discuss opting out of the national priority system for a period of time. The care recipient can re-enter the national priority system, in future and still be in the position they would have been in if they had not withdrawn. Automatic upgrades may lead to a build-up of unspent funds if the level of services are not reviewed to reflect the full value of their upgraded package, or the level of funding/service is not required.
Temporary leave	Care recipients can temporarily suspend their package if they take leave. Depending on the reason, the full rate of home care subsidy is payable for up to 28 cumulative or consecutive days (depending on the leave type) in a financial year and they may continue to be asked to pay their home care fees. After this, the subsidy is payable at a rate of 25 per cent. Further information

	on leave arrangements for subsidy, supplements and home care fees is at Section 11.

Providers have a legal obligation to transfer any unspent funds if someone changes provider, or return unspent funds if they leave home care. This is discussed further at Sections 13 and 14. The Department uses information about the returned Australian Government portion of unspent funds as an input to determine the number of packages to be released to people on the national priority system.

The table below outlines two strategies providers may use to help manage any unspent funds:

Strategy	Information
Revise the care plan and package budget	Providers should work together with their care recipients to develop a plan that meets their assessed care needs. This includes talking about the funds available and how to spend those funds, through the package budget. This may include an agreement, based on the care recipient's choice, to set aside a small part of their package budget for future care needs. It is important to be able to save for future events, such as a carer going on holiday or needing respite.
Actively manage packages	Providers also play an important role in managing their care recipient's package. This can minimise the accumulation of unspent funds. Providers will receive a notification if their care recipient's package is upgraded. The provider should talk to their care recipient about their assessed care needs and make updates to the care plan, Home Care Agreement and package budget as soon as possible, so that more essential services can be arranged. Doing this quickly will prevent unspent funds accumulating from the date of the automatic package upgrade.

10.10 What happens when a care recipient's care needs have increased?

A care recipient's care needs may increase significantly so that they potentially require home care at a higher level or entry to residential care. In these circumstances, they may need another assessment by an ACAT. With the care recipient's prior consent providers can assist in arranging the ACAT assessment. Providers can do this by submitting a Support Plan Review (SPR) request via the My Aged Care provider portal. More information is available at this link or by searching "request a Support Plan Review" at www.health.gov.au.

Care recipients can request a SPR themselves by calling My Aged Care.

If it is determined that another assessment is necessary, the provider should attach supporting documentation about the care recipient's care arrangements. For example, a package budget or care plan. These attachments are required to be attached to the SPR requests for people who are receiving a package. The My Aged Care contact centre will also request this information when submitting SPR requests on behalf of service providers.

If someone is already in receipt of a Level Four package, they may need to consider other options including:

- reviewing their care plan to identify alternatives and priorities (for example, reducing higher cost services, such as support on weekends, and replacing with informal supports);

- purchasing additional care and services from their own funds if an option; or
- the benefits of residential care, either as short-term respite to complement their package or as a long-term option.

10.10.1 Respite

Respite can be provided in the home or in a residential setting. Respite in the home may take the form of additional services for a short time period, where the carer would otherwise provide those services. This could include providing a break during the day for the carer or overnight respite to allow the carer to rest.

Residential respite provides short-term care in an aged care home. The primary purpose of residential respite is to support and maintain the care relationship between carers and care recipients through providing good quality respite care for the care recipient so their carer may take a break from their usual care arrangements. Residential respite may be used on a planned or emergency basis. An ACAT approval is required to access this care.

A package can be suspended when a home care package recipient is receiving residential respite. For information on taking 'leave', see Section 11. In this case, the services delivered under the package would be put on hold. Providers are unable to collect the basic daily fee from the care recipient, however, the income-tested care fee may remain payable. If this occurs, it is important for the home care provider to engage with the residential respite provider to ensure continuity of care and allow the care recipient to be supported in their continuing care goals. This may be facilitated by sharing their home care plan with the residential respite provider. This will allow the respite provider to consider any wellness or reablement approaches that remain relevant within the residential setting.

It is also important that the residential respite provider enters their payment claim correctly in the Services Australia payments system. If they enter a claim for permanent residential care this will result in the withdrawal of an active package.

Alternatively, a care recipient may choose to receive residential respite and their home care package services at the same time. This may be an appropriate option where some of their assessed care needs can continue to be met by the home care provider outside the aged care home. For example maintaining a safe environment for their return.

In this situation, it is vital that the home care provider engages with the residential respite provider to share the care plan and ensure there is no duplication of services. Again, it is important to consider wellness, reablement and continuing care goals. A care recipient must also be made aware of the impact this will have on their fee arrangements (see **Section 11**).

If a carer would like to arrange for respite services, whether in the home or residential facilities, they may wish to contact the Commonwealth Respite and Carelink Centre on **1800 052 222**. The Centre can book short-term and emergency respite in residential facilities and help carers access a range of other respite options, including in-home and centre-based respite.

The Carers Gateway provides practical information and support, accessed via www.carergateway.gov.au.

10.11 What if I can't meet the care recipient's needs?

Once providers enter into a Home Care Agreement, they are required to continue to deliver the agreed care and services for as long as the care recipient needs those services. As discussed at Section 3.4, this is called security of tenure.

There are exceptions to security of tenure, such as when the care recipient can no longer be cared for safely in their home. These exceptions are extracted in full at Section 3.4.

If providers do not think they can meet the care recipient's needs, but none of the exceptions to security of tenure apply, they should consider sub-contracted arrangements to help fulfil obligations under security of tenure. Sub-contracting is discussed at Section 7.

10.12 What do I do if I think someone is being subjected to elder abuse?

The World Health Organization defines elder abuse as 'a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person'. It can take various forms, such as physical, psychological or emotional, sexual and financial abuse. It can also be the result of intentional or unintentional neglect.

If providers would like to talk to someone about potential or actual elder abuse they can call the national **1800 ELDERHelp** (**1800 353 374**) line. This service provides information on how to get help, support and referrals to assist with potential or actual elder abuse.

Providers may have obligations in relation to elder abuse under State or Territory laws in the jurisdictions in which they operate. Each State and Territory provides information about abuse and abuse prevention, as well as useful contacts and options for getting help:

State/Territory	Organisation or resource	Contact
Australian Capital Territory	Older Persons Abuse Prevention Referral and Information Line (APRIL)	**02 6205 3535**
New South Wales	NSW Elder Abuse Helpline	**1800 628 221**
Northern Territory	Elder Abuse Information Line	**1800 037 072**
Queensland	Elder Abuse Prevention Unit	**1300 651 192**
South Australia	Aged Rights Advocacy Service Elder Abuse Phoneline	**08 8232 5377** **1800 700 600**
Tasmania	Tasmanian Elder Abuse Helpline	**1800 441 169**
Victoria	Seniors Rights Victoria	**1300 368 821**
Western Australia	Elder Abuse Helpline	**1300 724 679**

Providers can find a case study that provides an example of financial elder abuse at this link or by searching "case studies" at www.agedcarequality.gov.au.

10.13 What do I need to do to manage complaints?

The Aged Care Quality Standards require providers to have a complaints management function in place. The purpose of this function should be:

- **For the consumer to:** feel safe, encouraged and supported to give feedback and make complaints; feel engaged in processes to address feedback and complaints; and feel comfortable that appropriate action has been taken.

- **For the provider to:** regularly seek input and feedback from consumers, carers, the workforce and others; and use the input and feedback to inform continuous improvements for individual and the whole organisation.

The complaints function must be outlined in every Home Care Agreement. If it is appropriate, providers may want to refer a consumer to the Commission material on making a complaint at this link or by searching "making a complaint" at www.agedcarequality.gov.au/.

If a complaint arises, the provider must:

a. use their complaints resolution mechanism to address the complaint; and

b. advise the complainant of any other mechanisms that are available to address complaints, such as the Commission.

It is important that providers view complaints as an opportunity to further develop their customer service by gaining insights into the needs and wants of consumers. If staff are open to complaints and educated on how to manage them, complaints can be an opportunity to address minor issues before they become significant, and to build positive relationships with consumers, their families, friends and representatives.

The Commission 'Better Practice Guide to Complaint Handling in Aged Care Services' provides information on how to design a complaints function. It is at this link, or by searching "Better Practice Guide to Complaint Handling in Aged Care Services" at www.agedcarequality.gov.au/.

The Commission also has case studies that outline some strategies providers might use to resolve complaints. These can be found at this link or by searching "Case studies" at www.agedcarequality.gov.au/.

✓ Key points to remember

- Providers are required to review each care recipient's care plan regularly, at least once per year, and if their care needs change or they request it.
- Changes to a care recipient's care plan will result in changes to their package budget.
- Providers are required to give care recipient's monthly statements. This is a financial document and shows them what makes up their package budget and how it is being spent.
- If someone is gathering a large amount of 'unspent funds', providers should work with them to better allocate their package budget. Opting out of future package upgrades could be required.
- Approved providers and all of their employees need to be aware of elder abuse, including obligations in regards to reporting and response to elder abuse, which vary by State or Territory.
- Providers need to have a complaints management function in place, and they must use it to manage complaints they receive.

11 Leave

This section outlines what providers need to do if someone wants to take leave from receiving services under their package (also known as suspension) and how that affects their budget.

This section provides information relevant to care recipients who entered the HCP Program after 1 July 2014, or who have opted into the post-1 July 2014 arrangements. For information on the pre-1 July 2014 arrangements, see **Appendix A**.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

The *Fees and Payments Principles 2014 (No.2)* and the *Subsidies Principles 2014* outline how leave operates within the HCP Program. As providers of services under the program, providers are expected to comply with those laws.

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

11.1 When can a care recipient take leave?

Care recipients are allowed to temporarily suspend their package for any reason. Leave may be taken:

- for a hospital stay;
- for transition care following a hospital stay;
- to receive residential respite care; and/or
- other reasons (such as social leave).

A care recipient's security of tenure is not affected by the choice to take leave. They must, however, notify their provider that they are choosing to take leave from their package and specify the date that leave commences, or they will be liable for services delivered. This notification is not required to be in writing, but providers need to record the leave dates, and how and who informed them of the leave.

Providers must include information in each Home Care Agreement, explaining how the care recipient can notify them if they are planning to take leave. If they choose to take leave, the provider should work with them to update their care plan accordingly.

11.2 What is the impact of leave on the home care subsidy and supplements?

The amount of home care subsidy paid to the provider is dependent on the type of leave the care recipient takes from their package, as set out in the table on the next page:

Type of leave	Impact on payment of subsidy or eligible supplements to provider
• **Hospital** • **Transition Care**	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 consecutive days in a financial year, for each episode of hospitalisation or transition care at each particular package level. • After 28 consecutive days, the subsidy is payable at 25% of the basic subsidy rate. • After 28 consecutive days, primary supplements* are not payable.
• **Residential respite care** • **Social leave****	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 cumulative days in a financial year at each particular package level. • After 28 cumulative days, the subsidy is payable at 25% of the basic subsidy rate. • After 28 cumulative days, primary supplements* are not payable.

* Primary supplements are oxygen, enteral feeding, dementia and cognition, and veterans. Other eligible supplements (such as the viability and hardship supplements) continue to be paid during periods of leave. Supplements are discussed at **Section 8.2.2**.

** Package suspension for any other reason.

11.3 What is the impact of leave on home care fees?

A care recipient may be required to pay ongoing home care fees to the provider while they are on leave from their package. The amount and type of fee that can be charged while a care recipient is on leave from their package is set out below:

Leave type	Basic daily fee	Income-tested care fee
Hospital	Yes	Yes - payable at the full rate for 28 **consecutive** days, after which the care recipient can be asked to pay the lesser of their income-tested care fee or 25% of the basic subsidy rate for their package level.
Transition care	No	Yes - payable (at the full rate for 28 **consecutive** days, after which the care recipient can be asked to pay the lesser of their income-tested care fee or 25% of the basic subsidy rate for their package level.
Residential respite	No	Yes - payable at the full rate for 28 **cumulative** days, after which the care recipient can be asked to pay the lesser of their income-tested care fee or 25% of the basic subsidy rate for their package level.
Social leave	Yes	Yes - payable at the full rate for 28 **cumulative** days, after which the care recipient can be asked to pay the lesser of their income-tested care fee or 25% of the basic subsidy rate for their package level.

11.4 What is the impact of leave on monthly statements?

Any subsidy, relevant supplements or home care fees paid or payable to the provider while the care recipient is on leave must be included in their monthly statement.

11.5 How do leave balances work?

A care recipient's leave balance resets on 1 July each year or if their package level changes at any time. Leave balances are specific to each person receiving a home care package and will transfer with them, for example, if they change providers.

Worked examples:

A care recipient has been in hospital for more than 28 consecutive days, and because they advised their provider to suspend their package, the basic subsidy has stepped down to 25% after the 28th day. The care recipient then moves into transition care for a period. How is the rate of subsidy calculated and how should the home care fees be calculated?
Hospital leave and transition care leave are two different types of leave. Each time a care recipient accesses either hospital leave or transition care leave, their provider receives the full subsidy amount for up to 28 consecutive days, after which the subsidy reduces to 25% of the basic subsidy rate. The leave will also impact on their basic daily fee and income-tested care fee (if applicable). Hospital leave: the care recipient's provider would receive the full home care subsidy for up to 28 consecutive days for each episode of hospital leave. During this period, the provider can continue to charge them the basic daily fee and the income-tested care fee. After 28 consecutive days, the subsidy will be reduced to 25% of the basic subsidy rate. The basic daily fee remains payable, however, the income-tested care fee may change (if the new subsidy rate is less than the income-tested care fee). Services Australia will notify the provider and care recipient of any adjustments through the quarterly review process. If the care recipient is admitted to transition care immediately after being discharged from hospital, the provider will recommence receiving the full subsidy for up to 28 consecutive days of transition care leave. During this period, the provider cannot charge the basic daily fee but may continue to charge the income-tested care fee. After 28 consecutive days, the subsidy reduces to 25% of the basic subsidy rate. The income-tested care fee remains payable but may change if the new subsidy rate is lower than the income-tested care fee. Services Australia will notify the provider and care recipient of any adjustments through the quarterly review process. **Note 1**, the income-tested care fee will be reduced to the lesser of the income-tested care fee or the reduced subsidy. This means that for some care recipients the Government will stop paying the subsidy and primary supplements. **Note 2**, this worked example assumes that the care recipient chooses to take leave while they are in hospital. If they do not take leave from their package and want to continue receiving some services (for part or all of the leave period), they may be asked to pay the basic daily fee and the income-tested fee.

A care recipient is on leave in hospital but needs minor modifications to the home before they can be released from the hospital to go home. Do I need to do these minor modifications for the care recipient while they are on leave?

In situations such as a hospital stay, it is usually expected that the care recipient is provided with a full range of care and services in the hospital setting. They can, however, choose not to suspend their package and discuss with the provider what services should continue during the period of the hospital stay and have that reflected in their care plan. This might include minor home modifications if there are sufficient funds available in the package to fund the required work.

Therefore, if the care recipient wants minor home modifications to be done within their package, they will need to return from leave in order for these to be done. If they will not agree to return from leave to have the modifications done then the provider does not have to provide for any care, services, or purchases under their package until they return from leave.

A care recipient is going on a three month holiday. Their home needs household maintenance services (such as mowing) in order to make the home safe while they are away ready for their return home. Can I charge to the package budget while they are on leave?

If the care recipient requires care, services, or purchases to be actioned during a period of planned leave then they cannot take leave from their package.

Providers can amend their care plan so that the care and services they will not use are not scheduled during the period they are away. The funds typically used to pay for these will accrue as unspent funds in their package budget. These funds should be used for care and services that will advance their care goals when the care recipient returns from leave.

✓ Key points to remember

- People can take a break from receiving services under their package. This is known as taking leave, and does not affect their entitlement to receive home care services when they want to come back from leave.
- The Government may still pay the Home Care subsidy to that care recipient's budget while they are on leave. This will depend on the reason the care recipient is taking leave, and how much leave they have already taken in the financial year.
- Depending on the type of leave and how much leave, the care recipient may be asked to pay their basic daily fee and income-tested care fee.

12 Responding to special needs and changing cognition in home care package delivery

As discussed at Section 2.1, the HCP Program is underpinned by a CDC model. This means that aged care services should be designed in partnership with the care recipient and adapted to their individual needs and care goals. An individual's needs may include special needs or changes to their cognitive function.

Approved providers need to be ready and able to respectfully and safely provide aged care services to people with special needs and changing cognition. They have a right to have their special needs and/or changing cognition respected. Any services must treat each care recipient with dignity and respect, enable them to maintain their identity, and account for and cater to any special needs and/or changing cognition if they would like them to, or if it is necessary for them to remain living safely in their home.

This section defines the terms 'special needs' and 'changing cognition', and outlines strategies providers may employ to support care recipients with special needs and/or changing cognition.

✓ **Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section**
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

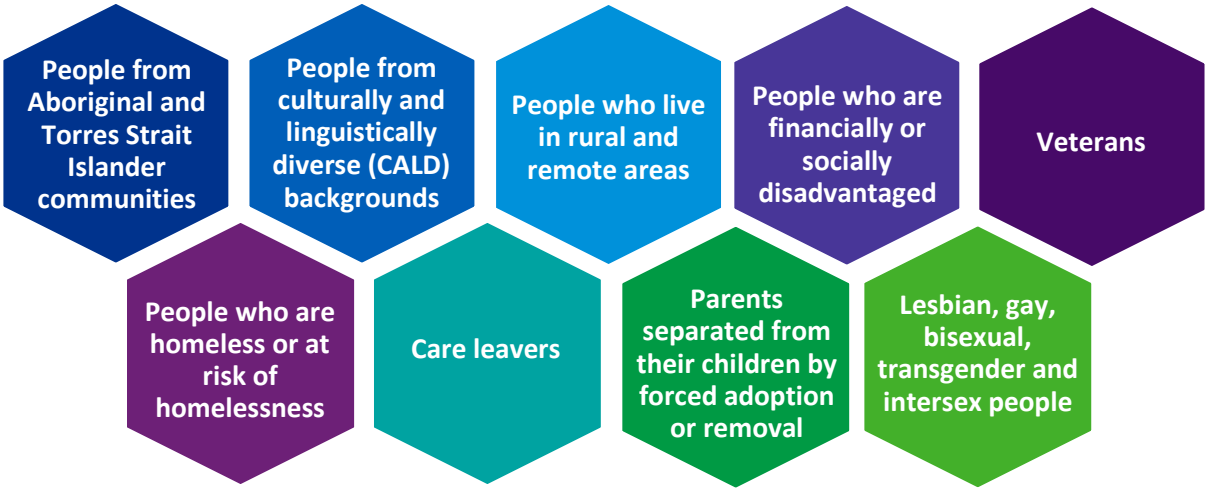
- Section 56-2 of the *Aged Care Act 1997*
- *User Rights Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

12.1 What are special needs?

The *Aged Care Act 1997* defines nine types of special needs, as outlined in the figure below:



When thinking about whether a person has any of the above special needs, providers should not focus on what they look like or whether they show certain physical characteristics. Instead, they should think about how the care recipient sees themselves, and their circumstances.

This manual does not provide specific guidance on what providers should do when providing services to people with each type of special need. This is because the HCP Program is based on a CDC model, which focusses on the needs of the individual. Each person will view their special needs differently and their needs will have different impacts on their lives. Approved providers should be open and respectful, and work together with them to design a program of care and services that is adapted to their particular circumstances.

When working with people with special needs, it is worth remembering that they may have had negative experiences of discrimination, or other adverse actions, in the past. The best way to approach this is to work in partnership with them and have open and respectful conversations about their care needs and goals.

The Commission provides several examples on meeting the care needs of aged care recipients with special needs at this link. Or you can search "case studies" at www.agedcarequality.gov.au/.

The Aged Care Diversity Framework and action plans also helps providers consider how their services may be appropriately tailored to care recipients with diverse characteristics and life experiences. These can be found at this link, or by searching "Aged Care Diversity Framework action plans" at www.health.gov.au.

12.2 What is changing cognition?

Changing cognition is not defined by legislation; it is a broad term used to describe dementia or other changes in care recipient capacity and memory.

12.2.1 Early warning signs of dementia

Early symptoms of dementia often vary a great deal, which can make it hard to identify. Providers' clinicians or other service providers may have regular contact with care recipients. This means they are well placed to help identify when someone may be in the early stages of dementia.

Dementia Australia provides guidance on early warning signs of dementia, which may be helpful to the provider and their team members in identifying whether one of their care recipients may be living with dementia. It can be found at this link or by searching "Warning signs of dementia" at www.dementia.org.au.

12.2.2 Determining capacity

If a provider's staff member, or a care recipient's family and/or friends are concerned about signs of dementia or other changes in cognition, providers will need to determine whether the person still has 'capacity' to make a choice for themselves. 'Capacity' is a legal term, and as a starting point, must always be assumed (even if the care recipient has been diagnosed with dementia or another type of cognitive impairment). It is also decision-specific. Just because someone has not had capacity in the past that does not mean that they will not have capacity to make future or less complex choices.

The individual's right to make their own choices, decisions, mistakes and take risks must be respected. Providers are obliged to support and encourage care recipient autonomy and self-direction, whilst also being mindful of indicators of incapacity and potential abuse of their care recipients.

Capacity means being able to:

It is also important that the care recipient can apply their personal values to the decision, and that there is some stability and consistency to the decision-making over time. Another way of checking capacity is to ask them to explain the decision in their own words, including why the decision is made. Capacity is not an all or nothing concept. It is decision-specific and can also fluctuate over time. A person may lack capacity in one area (such as making complex financial decisions) but may be able to make decisions about other areas of life (such as the type of supports they need and who they would like to provide them).

The case study below provides guidance on what a provider could do to manage care planning with a care recipient who has dementia but still retains capacity to make choices about their care. It is important to remember that anyone who retains capacity has a right to their own dignity of risk.

Case study: Olga

Olga has been receiving home care services for several years. She has dementia and her needs have gradually increased, but she is capable of living semi-independently for now. Her two children live nearby and at least one of them visits daily. Olga gets on well with the care staff and makes it clear to them that she wants to keep doing as much of her own housework and personal care as she can.

Her children, however, express concern to the provider that she is no longer capable of making decisions that best meet her needs. They ask the provider to add laundry, ironing and bed-making to their duties, tasks that Olga has been doing herself until now without mishap. The care staff who look after her directly tell the service co-ordinator they think this change is unnecessary and risks making Olga unhappy and affecting her confidence. The provider has to balance the wishes of Olga's family with Olga's own preferences.

The main priorities are Olga's safety, her well-being, and respecting her wish to keep doing her daily tasks. There are certainly safety and hygiene issues to consider. So far, these have not arisen but may as Olga's dementia progresses. A care co-ordinator with experience in dementia meets with Olga to talk about these issues. Olga understands the concerns being raised by her children and decides that the risks discussed with her are outweighed by the importance of the benefits she get from doing her own laundry and ironing. She agrees to a small increase in staff supervision for these activities, and that the bed-making service can start. In explaining the plan to Olga's children, the co-ordinator emphasises how important it is for their mother to maintain a sense of independence, self-worth and purpose. The co-ordinator also makes it clear that the provider has carefully discussed the health and safety risks with their mother and will continue to monitor them from day to day.

12.2.3 Dementia Training Program

The Dementia Training Program is a program for providers that offers a national approach to accredited education, up-skilling, and professional development in dementia care. Services include:

- accredited dementia care vocational level training courses - free to eligible care workers in residential, respite, community care or the wider health services;
- an online training portal allowing staff to undertake web-based training; and
- tailored onsite training to aged care providers who request assistance, including a dementia skills and environment audit, followed by a tailored training package.

The Dementia Training Program website is at www.dementiatrainingaustralia.com.au.

12.2.4 Dementia Behaviour Management Advisory Services

The Dementia Behaviour Management Advisory Services (DBMAS) provides advice to providers and individuals caring for people living with dementia where behavioural and psychological symptoms of dementia (BPSD) are impacting on their care and quality of life. Access is through the 24 hour helpline, on **1800 699 799**, or the DBMAS website at www.dementia.com.au.

12.3 How do I manage issues related to changing cognition?

CDC encourages people receiving a package to continue to make choices and direct the support that they need. Some individuals, however, may have more difficulty engaging with CDC and making choices about their care goals and services. If they would like or need it, there are different ways in which they can be supported in their decision-making and in expressing their views about their service arrangements:

Strategy	Description
Representative	A person may appoint a representative to assist with their decision making or be authorised to make decisions on their behalf. This may take various forms, such as an informal arrangement with a friend, family member or ally, someone with a formal power of attorney or a legal guardian.
Supported decision-making	Supported decision-making is a model that has mainly been used for supporting people with disabilities, often cognitive disabilities, to make significant decisions and exercise their legal capacity. Specific decisions are addressed, weighed and concluded by the person with the disability, while drawing on the support of a network of people or an individual. Potential supporters may be friends, family, volunteers, community members or any other trusted person. These unpaid supporters may help the person with disability to gather, understand and consider relevant information about the decision in question, assist them to weigh pros and cons, predict likely outcomes and consequences or evaluate the available options. With this support, the person then makes the decision themselves. This process can be formally facilitated, for instance by creating written supported decision-making agreements. It often occurs informally, however, within the community, both to support people with impaired decision-making capacity and to support anyone in making a challenging decision. This model of support aims to build and extend the decision-making skills of those using it, developing the ability of people to make and communicate decisions with more independence and confidence. Source: Disability Advocacy Network Australia

Strategy	Description
Power of Attorney	Powers of attorney are legal documents that let a person choose someone they trust to make decisions for them. An enduring financial or medical power of attorney, or enduring guardianship, are a way a competent person can appoint others to make decisions and manage their affairs in the event they are unable to make decisions for themselves. Arrangements may differ in each State or Territory. Contact your Office of the Public Advocate in your State or Territory for further information.
Guardianship	Guardianship is the appointment of a person (a 'guardian') to make decisions for an adult with a disability (the 'represented care recipient) when they are unable to do so. All adults over the age of 18 years, regardless of disability, are entitled to make their own decisions when they are able to do so. Australian guardianship law is the key regulatory mechanism for protecting the health of young persons, adults with disabilities and the elderly. Australia has eight different guardianship regimes, which vary widely in their forms of regulation. See www.austguardianshiplaw.org for more information.
Care planning	All care recipient care plans should include a contingency plan, which is reviewed each year and provides clear guidance around what to do in the event that their capacity to make decisions regarding their care declines.
Advance care planning	Advance care planning provides an opportunity for people to think, discuss and plan for the medical treatment they would prefer if they became too ill in the future to express their wishes. An Advance Care Directive is a written document that records the medical treatment wishes of a person, which can then be used if they are unable to speak for themselves due to illness or injury. The document may also appoint a substitute decision maker and include non-medical wishes for end of life, such as spiritual care. You can find information about advance care planning at this link or on www.health.gov.au by searching “advance care planning”. Information, guidance, and resources are available from the End of Life Directions for Aged Care website at this link or at www.eldac.com.au. Advance Care Planning Australia has information about contacts in each State and Territory. For more information see www.advancecareplanning.org.au.

The case study on the next page outlines how advance care planning can help provide the care recipient, their families and the approved provider with comfort through end of life planning.

Case study: Ricardo and Alicia

Ricardo and Alicia had been living in their own unit for three years when Ricardo, aged 70, was diagnosed with a rapid form of dementia. They contacted their provider to discuss extra services they expected to need as the illness progressed. Recognising how important it was for Ricardo's final months to be comfortable and dignified and to reflect his wishes, even when he could no longer express them, the provider encouraged them to make a formal advance care plan.

A staff member trained in developing advance care plans helped Ricardo identify his values and treatment preferences. What mattered to Ricardo most was staying in his home with his wife and dog, taking daily walks and looking after the unit's small garden. He did not want treatment that might extend his life while its quality deteriorated. Following the provider's protocol for end of life planning, the staff member worked with Ricardo and Alicia to document a detailed advance care plan. Ricardo was pleased everyone knew his clinical, cultural and spiritual preferences.

For more information on supported decision making in aged care please go to this link or search "Supported decision-making" at cdpc.sydney.edu.au/.

12.4 What do I do if care recipients need additional support in exercising their choice?

Advocacy has an important role in supporting care recipients in exercising choice and directing their services. An advocate can help them understand their rights and choices within their package, and supports them through decision-making processes. Advocacy can be particularly useful for people who are experiencing changing cognition.

The care recipient (either the care recipient or their representative) can request that another person assist them in dealings with their approved provider. An advocate is not the same as a representative, in that they may be present to support decision-making or negotiations with the provider, but are not necessarily authorised to make decisions for the individual.

Providers must allow the advocate of the care recipient's (or their representative's) choice access to the home care service.

An advocate may be made available through the National Aged Care Advocacy Program (NACAP). The NACAP is delivered on the behalf of the Australian Government by the Older Persons Advocacy Network (OPAN). It provides free, confidential and independent advocacy support to senior Australians receiving or looking to access Government-funded aged care services.

An advocate's support can help with the following:

For more information on advocacy services go to opan.com.au.

Key points to remember

- Providers need to be ready and able to provide care and services to people with special needs and/or changing cognition. Care and services must be considerate of and appropriate to special needs and/or changing cognition.
- The Aged Care Diversity Framework and action plans can help providers consider how services may be appropriately tailored to people with diverse characteristics and life experiences. These can be found at this link, or by searching "Aged Care Diversity Framework action plans" at www.health.gov.au.
- Capacity can be difficult to navigate with a senior Australian and their family. This section outlines legal and advocacy strategies that providers can use to help with this.
- OPAN provides free, independent advocacy services. If care recipients need support making decisions, but can still make decisions for themselves, providers can connect them to this service.

13 Changing home care providers

This section outlines the obligations of a provider if one of their care recipients chooses to change home care providers. This includes details on how to calculate and transfer their unspent funds.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Section 56-2 of the *Aged Care Act 1997*
- *User Rights Principles 2014*
- *Accountability Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

13.1 When can a care recipient change home care providers?

Once receiving a package, a care recipient can change providers if they are looking for a better fit, or for any other reason. If they decide to make a change, their unspent Home Care funds (less any exit amount as agreed in the Home Care Agreement) will move with them to their new provider.

When someone transfers to a new provider, they must notify their existing provider that they no longer wish to receive care and agree on the date that services from the existing provider will cease. They should also advise their existing provider of who their new provider will be.

13.1.1 Agreeing on a cessation day

A care recipient may tell their existing provider they wish to change providers directly, or they may reactivate their referral code in My Aged Care, triggering a notification to the existing provider through the Provider Portal. The existing provider should discuss the care recipient's needs and the timing of their move once they become aware of their intent to change providers.

This includes agreeing on a cessation day for the existing home care services that takes into consideration the care recipient's situation, the terms of the Home Care Agreement, and legislative requirements of home care. As per the *Records Principles 2014*, the existing provider will need to document the agreed cessation day.

The existing provider must continue providing care up until the agreed cessation day.

13.2 How does this affect the claims for that care recipient's home care subsidy?

Reaching an agreed cessation day with the care recipient is important to know the period for which the existing provider can claim home care subsidy. It also allows the existing provider to accurately reconcile the balance of package funds and calculate any unspent funds.

The start date for the new provider must be on or after the cessation day of the existing provider. When someone changes providers and there is no gap in care, the start day for the new provider should be the same date as the cessation day for the existing provider. This ensures there is no gap in payment of home care subsidy.

When a care recipient changes home care provider, the existing provider is not paid a home care subsidy for the cessation day, while the new provider is paid home care subsidy for the start day. An example of how subsidies are paid to the existing provider and new provider when there is no gap in services to the care recipient is outlined in the table below:

Recipient	26 June	27 June	28 June	29 June	30 June
Existing provider	Subsidy paid	Last day of services, Subsidy paid	Cessation day		
New provider			Start date, Subsidy paid	Subsidy paid	Subsidy paid

Before providing home care services, the new approved provider should confirm the cessation day with both the care recipient and the existing provider to ensure there are no overlapping claims for home care subsidy. Where two or more approved providers claim subsidy for the same person on the same day, payment will be made to the provider that first entered into a Home Care Agreement with them. When the start day and the cessation day are the same date, this does not represent an overlapping claim as home care subsidy is not paid for the cessation day.

13.2.1 Notifying the cessation day and start date

The new provider must accept the care recipient's referral in My Aged Care and submit the ACER within 28 calendar days of the cessation day. They have 56 calendar days from their agreed cessation day to enter into a new Home Care Agreement with their new provider before their package is withdrawn.

The existing provider must notify the Australian Government that they have ceased providing services to a care recipient within 31 calendar days of their cessation day. This must be done by submitting the care recipient's name and their cessation day through the Aged Care Provider Portal. The Aged Care Provider Portal is at this link, or can be found by searching "Aged Care Provider Portal" at www.servicesaustralia.gov.au.

Note: For continuing care recipients if they wish to retain their pre-1 July 2014 fee arrangements they must enter care with the new provider within 28 days. For more information see **Appendix A**.

13.3 What are the obligations on providers?

13.3.1 Obligations for the existing approved provider

The diagram below outlines the obligations for the existing approved provider:

1. Provide cessation information to Services Australia	2. Notify care recipient of unspent amount/arrange payment	3. Retain records
Once a cessation day is agreed with the care recipient, the existing provider must notify Services Australia within 31 calendar days of care ceasing. It is important to remember that a home care subsidy is not paid for the cessation day.	Three steps must be taken: a. Calculate the unspent home care amount b. Provide written notice of the unspent home care amount c. Make payment of the unspent home care amount.	The existing provider must retain: • Written notice of the care recipient's unspent home care amount • Records relating to the payment of the unspent home care amount to the new provider.

Further information on the steps necessary to notify the care recipient of the unspent amount and arrange payment is outlined below:

a. Calculate the unspent home care amount

The steps and requirements for calculating a care recipient's unspent home care amount are detailed in the *User Rights Principles 2014*. Before completing the final reconciliation, the provider must make sure claims for the care recipient are up-to-date; that home care fees have been received; and all expenses have been identified, including any outstanding invoices from sub-contracted or brokered services.

Note: The calculation of unspent home care amount should not include:

- any home care fees paid in advance, as these should be must be separately refunded to the care recipient by the provider; or
- home care subsidy for the cessation day, as home care subsidy is not paid for the care recipient on that day.

Worked examples of how to calculate the unspent home care amount are set out at **Appendix E.**

b. Provide written notice of the unspent home care amount

Within 56 calendar days after the cessation day, the existing service provider must give the care recipient (or their representative) a written notice about their unspent home care amount. The written notice must include the:

- Cessation day for care and services.
- Exit amount that has been deducted (if applicable).
- Unspent home care amount, which is the balance of any unspent funds (less any exit amount) in the package budget, broken down into the following portions:
  - the care recipient portion, which is the unspent amount attributed to home care fees paid to the provider by the care recipient, less any unpaid home care fees owed by the care recipient;
  - the Australian Government portion, which is the unspent amount attributed to home care subsidy and supplements paid to the provider for a care recipient;
  - the transfer portion, which is the unspent amount that must be transferred to another provider when a care recipient changes home care providers.

- Any unpaid home care fees which have been deducted (if applicable).

The home care subsidy cannot be used to account for unpaid home care fees. Where a care recipient has unpaid home care fees, this is a matter for the approved provider to manage with them directly under the terms of the Home Care Agreement. The written notice must explain how the unspent home care amount will be paid, so they (or their estate) understands the process and the timeframes involved.

c. Make payment of unspent home care amount

The care recipient must notify their existing provider within 56 calendar days after the cessation day of the new provider who they have entered into a Home Care Agreement with. This is to allow their existing provider to arrange payment of the transfer portion of the unspent home care amount to the new provider. If the existing provider is not notified within this period, the existing provider must treat any unspent home care amount as if the care recipient has left home care. This is discussed at Section 14**.**

The existing provider is required to make payment to the new provider as soon as possible, but within 70 calendar days, after the cessation day. The existing provider must also provide a copy of the written notice of the unspent home care amount to the new provider at the time the payment is made. This allows the new provider to identify the transferred amount for the care recipient.

13.3.2 Obligations for the new approved provider

The diagram below outlines the obligations for the new approved provider:

1. Accept the care recipient referral in My Aged Care	2. Develop a Home Care Agreement with the care recipient.	3. Provide care recipient entry information to Services Australia.
Providers must accept the care recipient's referral in the Provider Portal before submitting entry information to Services Australia.	The new provider should work in partnership with their new care recipient to develop a Home Care Agreement, care plan and package budget based on their assessed care needs.	The new provider must notify Services Australia within 28 calendar days of the care recipient starting care by submitting an ACER.

Once the new provider receives the unspent funds amount they must separately identify the transfer portion of the unspent home care amount in the care recipient's monthly statement.

13.4 When can I charge the exit amount?

The existing provider can charge the exit amount after the care recipient's cessation date, but before the transfer of the unspent funds (as outlined above).

If the value of their unspent funds is less than the value of the exit amount (as agreed in the Home Care Agreement), the existing provider can only charge the exit amount up to the value of the available unspent funds. If the care recipient has no unspent funds then they cannot charge any exit amount.

13.5 My organisation has undergone a merger or acquisition. How do I transfer my care recipients?

When a provider has undergone a merger or acquisition, their care recipients will need to be exited from their service and transferred to the new provider. Further guidance on obligations if a provider is subject to a merger or acquisition can be found at this link, or by searching "Transferring home care services to another approved provider" at www.health.gov.au.

Note that if a provider is looking to move care recipients from one of their home care services to another within their control, they can do this via a self-service process in the My Aged Care Provider Portal. Providers can find support with technology and guidance on how to use the My Aged Care Provider Portal at this link. They can also search "My Aged Care for service providers" at www.health.gov.au.

More information on administrative responsibilities is at Section 15 of this manual.

✓ Key points to remember

- Care recipients can change home care providers at any time.
- If someone receiving home care services chooses to change providers, it is important that they and their existing provider agree a cessation date. This affects the way the providers claim the care recipient's package subsidy and when the existing provider will need to transfer the care recipient's unspent funds.
- The existing provider must transfer the care recipient's unspent funds to their new provider as soon as possible, but within 70 calendar days, of the cessation date.
- If a provider has a transferring care recipient who entered care before 1 July 2014 and they want to opt into the post-1 July 2014 fee arrangements, they must complete the **"Continuing Care Recipient opting into the New Aged Care Arrangements from 1 July 2014 (AC022)"** form. The care recipient must submit this form to their new provider. The new provider must give them a copy of the *New Arrangements for Aged Care from 1 July 2014 – Home Care* publication before they transfer to the new service.

14 Leaving the HCP Program

This section tells providers the steps they need to take if a care recipient leaves the HCP Program.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 52D-1 and 56-2 of the *Aged Care Act 1997*
- *Fees and Payments Principles 2014 (No.2)*
- *User Rights Principles 2014*
- *Accountability Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

14.1 What administrative tasks do I need to complete?

14.1.1 Notify Services Australia of a care recipient ceasing care

Within 31 calendar days of a care recipient ceasing services, the provider must notify Services Australia through the Aged Care Provider Portal of their name, cessation date, and the reason for their departure (for example, moving to residential aged care or passing away). The Aged Care Provider Portal is at this link, or can be found by searching "Aged Care Provider Portal" at www.servicesaustralia.gov.au.

If a care recipient moves into permanent residential aged care, their start date with their residential aged care provider will be the date their home care provider ceases receiving payment of subsidies. It is important that the home care provider agrees with the individual and their residential aged care provider the cessation date for their package and the start date for residential care, to ensure the home care provider is eligible to receive all subsidies they are expecting to receive.

If a person passes away, in addition to making the necessary changes on the Provider Portal, providers should call My Aged Care on **1800 200 422** so they can update their record. This is important, as it will ensure future communications with family members are mindful of this fact, and do not cause further distress. Alternatively, providers can advise the care recipient's representative to call My Aged Care.

14.1.2 Complete hand over (if relevant)

It is important that aged care recipients have continuity of care. As a part of care management, providers should do a hand over with relevant parties when needed, to ensure each person's care needs are understood. Providers should seek the care recipient's permission to share their information and documentation about their care. This will ensure any new providers of aged care will have as much information as possible to inform the care they provide.

This should occur before the care recipient's cessation date. If it occurs after the cessation date, the provider will not be able to charge the care management to them.

This will not be required if the care recipient has passed away.

14.1.3 Make payment of unspent home care amount

If a care recipient leaves home care or passes away, their provider must undertake the following with respect to unspent funds:

- Notify the Australian Government of the Australian Government portion (including nil amounts) within 70 calendar days through the claims process managed by Services Australia
- Transfer the care recipient portion to the person or their estate. If they are leaving the HCP Program, this must be completed within 70 days after the cessation date. If they have passed away, this must be completed within 14 days of being shown the probate of the Will or letters of administration.

The Australian Government portion will be recovered through deductions in future home care subsidy payments made to the approved provider. Worked examples of unspent funds are at **Appendix E** of this manual.

14.2 When can I charge the exit amount?

Providers can charge the exit amount after the care recipient's cessation date, but before the transfer of the unspent funds (as outlined above).

If the value of their unspent funds are less than the value of the exit amount (as agreed in the Home Care Agreement), the provider can only charge the exit amount up to the value of the available unspent funds. If the care recipient has no unspent funds then the provider cannot charge any exit amount.

✓ Key points to remember

- Providers should support care recipients through their transition to other aged care programs.
- Providers must notify Services Australia when a care recipient leaves the HCP Program.
- Providers can charge the exit amount after the care recipient has ceased receiving services from them, but before they transfer the unspent funds. Providers should then make payment of their unspent home care amount in the appropriate portions to the Australian Government and to the care recipient (or their estate).

15 Providers' reporting and administrative responsibilities

Once providers are set up to provide services under the HCP Program they need to continue to comply with their disclosure and reporting obligations.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 9-1A, 9-2, 9-3, 9-3B, and 63-1 of the *Aged Care Act 1997*
- *Accountability Principles 2014*
- *Records Principles 2014*
- *Sanctions Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

15.1 My organisation's circumstances have changed. What do I need to do?

There are two types of changes that providers need to notify either the Department or the Commission about:

15.1.1 Changes to the home care service

Changes to the home care service includes things like changes of name, address or contact details. In short, if the change affects who or how the Department can contact the approved provider they must notify the Department.

This can be done by completing the form at this link. You can also find the form by searching "Notification of changes for Home Care Packages" at www.health.gov.au.

15.1.2 Material changes to suitability

Approved providers have an ongoing responsibility to ensure they are ready and able to provide legislatively compliant, high quality and safe home care services at all times. For more information on this, see Sections 2, 3 and 4 of this manual.

Provider suitability is assessed against the following five considerations:

1. Experience in providing aged care or other relevant forms of care
2. Understanding of approved provider responsibilities
3. Systems it has, or will have, in place to meet these responsibilities
4. Record of financial management and the methods used, or proposed to ensure sound financial management
5. Conduct as a provider (including compliance with responsibilities as a provider) and obligations arising from the receipt of any payments from the Australian Government for providing that aged care or any other relevant form of care.

If anything changes that materially affects these criteria, providers are required to disclose this information to the Commission. This information must be disclosed using the **"Notification of Material Change"** form. The form is at this link or can also be found by searching "Notification of a Material Change" at www.agedcarequality.gov.au.

All notifications must be made within 28 days of the change occurring. Penalties may be applied if a provider does not notify the Commission within this timeframe.

The **"Notification of Material Change Form"** (discussed above) can also be used by an approved provider to update information about its organisation which may include key personnel responsible for the overall governance of the organisation or the authorised contacts or address information.

15.2 My key personnel have changed. What do I need to do?

Providers are responsible for knowing who in their organisation meets the definition of key personnel as outlined in Section 8B of the *Aged Care Quality and Safety Commission Act 2018* and ensuring their key personnel are not a disqualified individual. Providers will be liable for any sanctions if it is determined that key personnel are disqualified individuals.

As discussed at Section 4, a disqualified individual is someone who has been convicted of an indictable offence, is insolvent or under administration, or is certified by a medical practitioner that they have a mental incapacity to perform their duties as key personnel. Each State and Territory law identifies different types of offences as being indictable. These typically include serious offences such as murder, manslaughter, the intentional or unlawful administration of drugs or poisons, or committing fraudulent or dishonest activities.

Providers must take reasonable steps to ensure none of their key personnel are a disqualified individual. The following steps are taken by the legislation to constitute 'reasonable steps'.

For each of a provider's existing key personnel:

- Ensure that the person understands the obligations of key personnel and of approved providers under the Act in relation to disqualified individuals
- If the provider reasonably believes that the person may be mentally incapable of performing his or her duties as one of their key personnel, make arrangements for the person to be examined by a registered medical practitioner
- If the provider reasonably believes that the person may be a disqualified individual, take the steps outlined below
- If the provider has ascertained that the person is a disqualified individual, ensure that the person ceases to be one of their key personnel.

For any person who proposes to become, or becomes, one of a provider's key personnel:

- Obtain a police certification for the person (this requires their written consent);
- Conduct a search of bankruptcy records; and
- Conduct previous employment and referee checks.

If a provider fails to take reasonable steps to ensure their key personnel are not disqualified individuals, they may be liable to pay a fine, face revocation of their approved provider status or, in certain circumstances, face a prison sentence.

Providers need to keep documentation, such as police checks, confirming the suitability of their key personnel. These obligations arise under the *Records Principles 2014* and have been outlined at **Appendix D** of this manual.

15.3 What are my financial disclosure obligations?

Approved providers must complete an Aged Care Financial Report (ACFR) annually, four months after the end of the financial year. All financial reporting requirements for residential aged care, HCP Program and short-term restorative care are reflected in the ACFR template so providers can report on all the aged care services they provide in one report to the Department.

15.3.1 Home Care financial reporting

To support all aged care providers to meet their legal obligation to complete the ACFR annually, the Department sends each provider an ACFR User Guide. This guide is sent out during August, and a customised cover letter explains which sections of the ACFR are relevant to the recipient's organisation.

Home care providers will be prompted to complete the Home Care Financial Report (HCFR) section of the ACFR. The HCFR is to be completed at a Planning Region level, with a home care service defined as an approved provider's home care operation within an aged care planning region. While some providers will have their Home Care Service IDs at the planning region level, others will have their Service IDs at the package level (i.e. Level two packages). Where Service IDs are at the package level, providers may be required to aggregate their financial information in order to complete the Financial Report.

15.3.2 Lodgement

Providers must lodge all required sections of the ACFR with the Department, via the online ACFR portal. The portal can be found at health.formsadministration.com.au. The ACFR portal can only be accessed through VANguard or myGovID login. You can continue to use your existing AUSKey to access Health services until the end of March 2020. For more information about the removal of AUSkey from My Aged Care, please see this link. Providers must complete and lodge their ACFR by 31 October for the previous financial year ending 30 June.

There are no provisions within the legislation to grant extensions. Providers must lodge their ACFRs early to provide adequate time to address any issues and finalise all components of the ACFR as it relates to their organisation. The Department may take compliance action if providers fail to comply with these requirements. A range of sanctions can be imposed on an approved provider including revoking or suspending approval as a provider of aged care services and restricting approval to provide aged care services. The type of sanctions imposed on an approved provider will depend on the nature of the non-compliance.

ACFRs cannot be lodged until all the required sections are completed and correct, and all necessary documents have been uploaded at the ACFR portal. The customised cover letter sent directly to all providers with each financial year's ACFR user guide will outline all sections relevant to providers delivering the HCP Program.

15.3.3 Pricing review

Providers must also review their full price list and do one of the following:

- Report to the Department that they have done so. This can be done by entering 'Confirm review of pricing information' in the My Aged Care Provider Portal.
- Update their price list. This will cause the 'last updated date' to update in the Department's systems, and will be sufficient evidence that the provider has reviewed their price list.

More information on obligations related to pricing is at **Appendix B**.

15.4 What happens if I am not compliant with my obligations or responsibilities?

The consequences of identified non-compliance by aged care providers depends on the risks posed by the non-compliance and the provider's response to the Commission's concerns. The Commission's primary concern is the risks to the health, welfare or interests of current and/or future recipients of aged care services.

Reflecting this, compliance can include things like education, repayments, issuing a non-compliance notice or sanctions. If there is a recurring non-compliance, continued unwillingness or inability by the provider to address the non-compliance, the Commission may revoke their approval to provide aged care. In some instances non-compliance could also result in a criminal charges for the most serious breaches.

Please note, other penalties or sanctions may also arise under other legislation, such as the consumer law.

✓ Key points to remember

- Providers must notify the Department of changes to their circumstances.
- Providers have annual obligations to report financial information to the Department. They can complete reporting for all aged care services they provide in one form.
- Providers must notify the Commission of material changes to suitability.
- Providers are responsible for ensuring that key personnel are not disqualified individuals.
- Providers also have an annual obligation to review their price list annually.
- If providers have a financial year that ends on 30 June, they must report their financial information by 31 October.
- On 1 January 2020 the Commission took on compliance functions, previously the responsibility of the Department of Health. The regulatory management of this matter now rests entirely with the Commission.

15.5 Reporting issues

Aged care providers must spend package funds appropriately.

15.5.1 Reporting suspected non compliance with provider requirements

The Commission has processes for people to raise a concern or make a complaint about the quality of care or services provided to people receiving Australian Government funded aged care. More information is available at this link or by searching for 'complaint' at www.aged carequality.gov.au.

The consequences of identified non-compliance by aged care providers depends on the risks posed.

When resolving complaints in relation to the care and services, if the Commission finds a provider used package funds inappropriately then it can initiate compliance action, including at a minimum, repayment of any amounts that have been incorrectly charged.

15.5.2 Reporting suspected fraud

The Department does not tolerate fraudulent use of HCP funding. If funding is used for purposes stipulated in the 'Specified Exclusions' table at 9.2.3 or for other items deemed not part of services or care to be funded by a HCP, the Department may initiate a fraud investigation and take action accordingly.

The Department has the power to investigate allegations of fraud against health funding and programs and is actively engaged in intelligence gathering with external agencies.

IF YOU SEE SOMETHING, SAY SOMETHING BECAUSE FRAUD IS A CRIMINAL OFFENCE.

If you suspect that an approved provider, including a competitor, is engaging in fraud, or you have concerns about the financial management of HCP funding, please contact the Department via email at fraudsection@health.gov.au. Alternatively, you can call the Health Fraud Hotline on **1800 829 403**, between 9am to 5pm Australian Eastern Standard Time, Monday to Friday. You can report suspected fraud anonymously.

If an approved provider wants to self-report a concern, they should contact the Department.

16 Interface with other Programs and Schemes

This section provides information on what programs can be accessed at the same time as the HCP Program. It focusses on the Commonwealth Home Support Programme, because it is related to the HCP Program within the Australian Government continuum of care for senior Australians, but also discusses a broad range of other programs.

✓ **Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section**
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

No specific obligations arise. The *Aged Care Act 1997*, however, governs how the HCP Program interacts with other programs. As providers of services under the program, providers are expected to comply with those laws.

16.1 How does the HCP Program interface with other programs?

As outlined at Section 2, the HCP Program is a part of the Australian Government's continuum of care for senior Australians. The table below outlines what other services can or cannot be received at the same time as the HCP Program:

Services that may be received while receiving HCP Program services	Services that cannot be received while receiving HCP Program services
Commonwealth Home Support Programme^ Community Visitors Scheme Continence Aids Payment Scheme DVA Programs Residential Respite Care* Dementia Behaviour Management Advisory Services (DBMAS) Palliative Care National Dementia Support Program National Disability Insurance Scheme (NDIS)^	Permanent Residential Aged Care Short Term Restorative Care Transition Care Programme Multi-Purpose Services Program National Aboriginal and Torres Strait Islander Flexible Aged Care Program

^Under limited circumstances

* Unless the care recipient has taken leave from their package.

16.2 What is the Commonwealth Home Support Programme?

The Commonwealth Home Support Programme (CHSP) represents the entry tier of the Australian Government aged care system. Investment in entry-level support that focuses on keeping people independent and safe in their own homes can delay the need to move to more intensive forms of care. This benefits frail senior Australians through increasing their independence and quality of life as well as reducing Australian Government outlays for other forms of care, such as residential aged care.

Assessment for eligibility to access the CHSP is completed by the Regional Assessment Service (RAS). An ACAT may also approve eligibility.

The CHSP provides funding for a broad range of entry-level support services to assist frail senior Australians aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) and who have functional limitations (including cognitive), to remain living independently at home and in their community[2].

CHSP subsidised services are delivered on a short-term, episodic or ongoing basis, with a strong focus on activities that support independence and social connectedness and taking into account each person's individual goals, preferences and choices. As with the HCP Program, people receiving services through the CHSP may need to contribute funds towards their services[3].

As an 'entry-level' program, the CHSP is designed to provide relatively low intensity (small amounts) of a single service or a few services to a large number of frail senior Australians. These services are designed for senior Australians who need only a small amount of assistance or support to enable them to maintain their independence, continue living safely in their homes and participate in their communities.

The CHSP is not designed for senior Australians with more intensive, multiple or complex aged care needs, and does not replace or fund support services already provided for other programs or schemes, including the health care system. People with higher needs are supported through other aged care programs.

16.3 How does the HCP Program interact with Commonwealth Home Support Programme?

The HCP Program is designed to support senior Australians living in the community whose care needs exceed the level of support that can be provided through the CHSP.

CHSP service providers should only supply additional CHSP services to a person receiving a home care package where they have the capacity to do so without disadvantaging the CHSP target population. People who need CHSP subsidised services, but do not have access to other relevant support services, should be prioritised over people who are already receiving a home care package.

There are defined circumstances in which care recipients are able to receive specific CHSP subsidised services on a time-limited basis when they are in a package (that is, the additional CHSP services will

[2] **Note**: the eligible ages for the Assistance with Care and Housing (ACH) Sub-Program differ from those for the core Commonwealth Home Support Programme. Further detail on the sub-program can be found in the Commonwealth Home Support Programme Manual. The manual is at this link, or can be found by searching "Commonwealth Home Support Programme (CHSP) Manual" at www.health.gov.au/.

[3] This occurs through the 'Client Contribution Framework'. Further detail can be found at Chapter 5 of the Commonwealth Home Support Programme Manual (at the link above).

not be charged to their package budget). These circumstances are limited, to ensure the CHSP continues to, in the main, deliver entry-level services.

They include:

- For care recipients on a Level one or two package: where the care recipient's package budget is already fully allocated, they can access additional, short-term or episodic Allied Health and Therapy services or Nursing services from the CHSP, where these specific services may assist the care recipient to regain functionality after a setback (such as a fall).
- For care recipients on a Level one to four package: where the care recipient's package budget is already fully allocated and a carer requires it, they can access additional planned respite services under the CHSP (on a short-term basis).
- For care recipients on a Level one to four package: in an emergency (such as when a carer is not able to maintain their caring role), where the care recipient's package budget is already fully allocated, additional services under the broader CHSP can be obtained on an emergency or short-term basis. These instances must be time limited, monitored and reviewed.
- For care recipients on an interim Level one or two package who are waiting for a Level three or four package; where the care recipient's package budget is already fully allocated, they can access additional minor home modifications from the CHSP.
- For care recipients on a Level one to four package: care recipients who have transitioned from the CHSP may continue to access their existing CHSP social support group on an ongoing basis to allow the continuity of social relationships. This only applies to care recipients attending a pre-existing CHSP social support group service.

These instances should be time limited, monitored and reviewed. During these times, the package is not suspended; both the HCP Program and the CHSP will be received concurrently.

More information is available in the Commonwealth Home Support Programme Manual. The manual is at this link, or can be found by searching "Commonwealth Home Support Programme (CHSP) Manual 2020-2022" at www.health.gov.au.

You can also refer to the factsheet at this link for more information on how the HCP Program interacts with the Commonwealth Home Support Programme. You can also find the factsheet by searching "Commonwealth Home Support Programme interaction with Home Care Packages" at www.health.gov.au.

16.4 How does the HCP Program interact with other programs and schemes?

It may be possible for a person to receive care and services through a range of other programs and schemes that they cannot receive as part of a home care package. Key programs and schemes are outlined below. Providers should work with their care recipients to identify additional services that they may need, and to explore the best available combination of health and aged care services.

More detailed information about the individual programs is available on the My Aged Care website, at www.myagedcare.gov.au. You can also call the My Aged Care contact centre on **1800 200 422**. For information on how other programs or schemes interact with the HCP Program, please refer to information on the program or scheme of interest.

16.4.1 Residential Aged Care

Under the *Aged Care Act 1997*, an entry into permanent residential care will result in the withdrawal of an active home care package. If a care recipient is receiving HCP Program services and needs to

permanently move to a residential aged care facility, their home care provider is responsible for discussing this move with them and mutually agreeing a cessation date.

16.4.2 Transition Care

Transition Care provides time-limited, goal-oriented and therapy-focused packages of services to senior Australians after a hospital stay.

People receiving HCP Program services are able to access transition care after a hospital stay if they are assessed and approved as eligible by an ACAT and take appropriate leave from their package. Information on leave can be found at Section 11.

This program is jointly funded by the Commonwealth and State or Territory governments.

16.4.3 Short Term Restorative Care

Short Term Restorative Care (STRC) provides a time-limited, goal-oriented, multi-disciplinary and co-ordinated package of services. STRC aims to reverse and/or slow 'functional decline' in senior Australians and improve their wellbeing.

A care recipient cannot receive STRC if they are also receiving a package. They may choose to end their STRC even if they have not yet met their physical and cognitive goals in order to enter the HCP Program. In this circumstance, the home care provider should ensure the care plan incorporates strategies to assist the care recipient to achieve these physical and cognitive goals.

16.4.4 Community Visitors Scheme

The Community Visitors Scheme (CVS) supports volunteers to make regular visits to senior Australians who are socially isolated or are at risk of social isolation or loneliness. CVS provides friendship and companionship by matching individuals with volunteer visitors.

The CVS is available to recipients of Australian Government subsidised residential aged care services or home care.

Further information about the CVS, including frequently asked questions, can be found at this link, or by searching "Community Visitors Scheme" at www.health.gov.au.

Any eligible care recipient whose quality of life could be improved by the companionship of a regular community visitor can be referred to the CVS. A CVS State Network Member can assist to find a CVS service provider in your area. The CVS State Network Member contact list is available from the CVS webpage at this link, or by searching "CVS State and Territory network members" at www.health.gov.au.

As part of the Lesbian Gay Bisexual Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy, the CVS was expanded to include services that specifically cater for the needs of LGBTI people.

Home care consumers who are socially isolated and whose quality of life would be improved by friendship and companionship may access the CVS program without any impact on services received through their package.

16.4.5 Continence Aids Payment Scheme

HCP Program care recipients are eligible to access the Continence Aids Payment Scheme, through Services Australia, as long as their care plan does not already include continence support.

16.4.6 DVA Programs

Senior veterans or a war widow/widower may be able to get aged care services from the DVA and the Department at the same time, as long as the same services are not accessed for both.

For example, a care recipient may access low-level domestic assistance and personal care through the Veterans' Home Care Program, and receive social assistance and respite through the home care package.

16.4.7 Residential Respite Care

People receiving HCP Program services are able to access residential respite if they are assessed and approved as eligible by an ACAT. Respite is standard practice to give carers a break, and needs to be accounted for in care planning with care recipients. This is discussed further at Section 10 of this manual.

Care recipients can receive respite at the same time as a package, provided that they are not receiving the same services from both. For example, they may have a period of residential respite care but choose not to take leave from their package if they need gardening or other services about the home to keep it safe and secure. Leave is discussed at Section 11.

16.4.8 Palliative Care

Palliative care may be beneficial to any person with a life-limiting illness, regardless of their age.

The aim of palliative care is to improve the quality of life for a person with a life-limiting illness, and to help them live well for as long as possible. People who have chronic or terminal health conditions may be supported by state and territory health palliative care specific services and housing systems, as well as the aged care system, to provide basic daily living support and care, such as assistance with daily chores, personal care, providing meals, transport assistance, respite care, home modifications and social support.

16.4.9 National Dementia Support Program

The National Dementia Support Program (NDSP) provides education, resources, and counselling and support to people living with dementia and their families and carers to improve awareness and understanding about the disease.

The NDSP offers a website and national helpline, where professional counselling or group and individual support sessions can be scheduled. These resources can help care recipients, including people living with dementia and their families and carers, with support strategies to cope with dementia, and provide advice on what to expect once a diagnosis of dementia is received. The NDSP also offers education and training to family members and carers of people living with dementia to help them remain in their own homes for longer, where appropriate, and help ensure they are aware of the requirements of people living with dementia.

People living with dementia, their families and carers and health professionals can contact the National Dementia Helpline on **1800 100 500** (free call). People can also go to www.dementia.org.au to discuss any concerns or access information about memory loss or dementia.

16.4.10 National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) funds reasonable and necessary supports that are not provided from other formal and informal sources. Care recipients cannot receive NDIS support and the HCP Program at the same time if they were over 65 years of age when they entered the HCP Program. If a person has been admitted to the HCP Program before turning the age of 65 years and has been determined eligible for the NDIS they are expected to move from their home care package as soon as possible. Until then, they may access both programs, as long as are not receiving the same care and services under both.

Providers can find more information on the NDIS at this link, or by searching "Provider toolkit" at www.nds.org.au.

The webpage at this link provides information that may be useful for providers who deliver home care to younger people who may also be eligible for the NDIS. You can also find the webpage by searching "providing aged care services to younger people" at www.health.gov.au.

✓ Key points to remember

- Generally, care recipients cannot receive CHSP and HCP Program services at the same time. In limited circumstances they may be able to receive small amounts of top up CHSP at the same time as they receive HCP Program services.
- Care recipients can receive support from some other programs where needed. Some of these programs are listed at **Section 16.4**.
- The HCP Program cannot be received at the same time as STRC, transition care, or permanent residential aged care.

Appendix A: Pre-1 July 2014 arrangements

On 1 July 2014, the way home care fees are calculated changed. For people that received a package before 1 July 2014, these changes do not apply and they may continue to be asked to pay their current home care fees.

This manual has outlined the way the HCP Program currently operates, under the post-1 July 2014 arrangements. Care recipients who were in the program before 1 July 2014 however, are entitled to continue to receive home care on the basis of the pre-1 July 2014 arrangements.

If a person was receiving a package on or before 30 June 2014 and they move to a new home care service (and do not spend more than 28 days outside of care, other than on approved leave), they can opt into the fee arrangements that started on 1 July 2014.

To make this choice, they will need to complete and sign the **"Continuing Care Recipient opting into the New Aged Care Arrangements from 1 July 2014 (AC022)"** form and submit this form to the new provider before they transfer to the new service. Form AC022 is at this link or by searching "AC022" at www.servicesaustralia.gov.au. The new provider must submit this form with the ACER to Services Australia through the Services Australia Provider Portal. The new provider also needs to give the care recipient the *New Arrangements for Aged Care from 1 July 2014 – Home Care* publication available at this link or by searching for the form at www.health.gov.au.

If the care recipient does not complete this form and have it submitted to Services Australia before they transfer providers, they will automatically be classed as a 'continuing care recipient' and will remain on their pre-1 July 2014 fee arrangements. This is not a reviewable decision and must be done correctly in order to opt in to the post-1 July 2014 fee arrangements.

This section outlines how the package budget and leave work for pre-1 July 2014 care recipients, and provides a checklist of components that must be included in a Home Care Agreement with a pre-1 July 2014 care recipient. Unless indicated in this appendix, the HCP Program operates in the same manner for people receiving a home care package, regardless of when they entered the HCP Program.

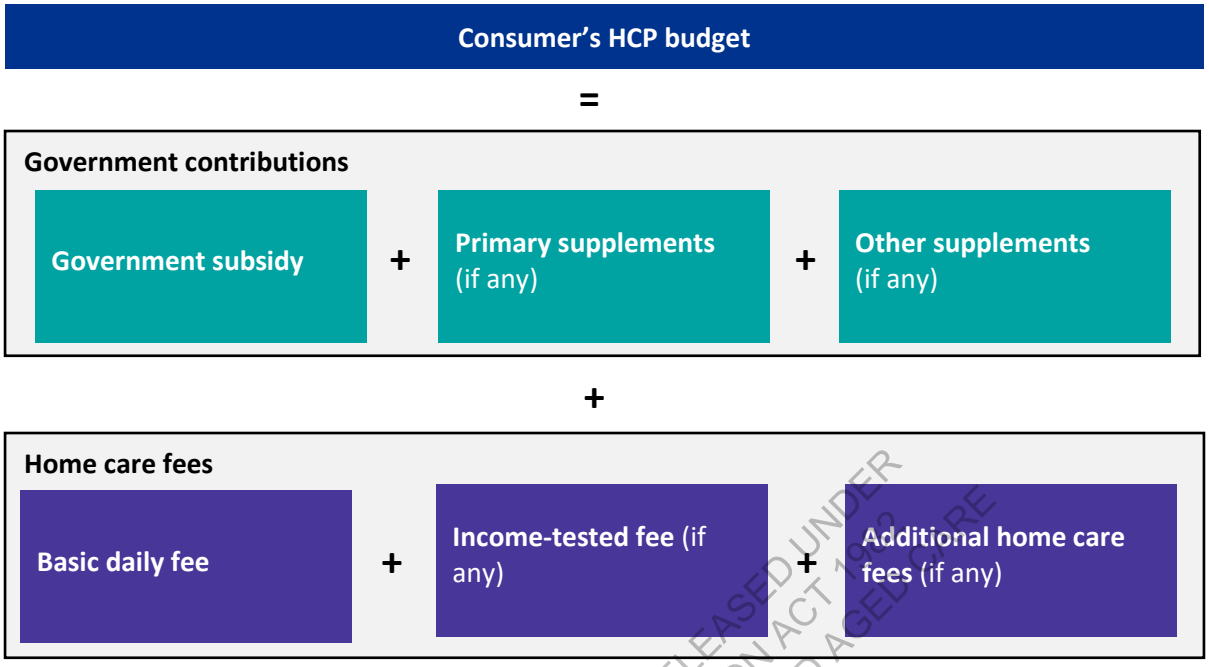
Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Section 56-2 of the *Aged Care Act 1997*
- Sections 60-1 and 60-2 of the *Aged Care (Transitional Provisions) Act 1997*
- *Aged Care (Transitional Provisions) Principles 2014*
- *User Rights Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations pursuant to them.

See **Appendix D** for further detail on specific provider responsibilities.

A.1 What makes up the package budget for care recipients in the pre-1 July 2014 arrangements?



A.2 How do I work out the Government contribution for pre-1 July 2014 care recipients?

The Government contribution can be determined by adding together the Government subsidy, plus any primary and other supplements for which the care recipient is eligible. This is outlined in the diagram at Section A.1 of this Appendix.

In home care, prior to 1 July 2014, there was no reduction in subsidy and primary supplements paid by Government if the provider did not charge the income tested fee. If collected, any fee would be additional to the value of the package. In setting these fees, providers need to consider if they would cause the care recipient financial hardship and reduce the level of fees as necessary.

The same subsidy and supplement rates will apply for people receiving a home care package, regardless of when they entered the HCP Program.

Pre-1 August 2013 care recipients who were receiving an Extended Aged Care at Home – Dementia (EACH-D) package are eligible for the dementia and cognition supplement plus the top up supplement. This supplement is automatically applied by Services Australia, and will automatically transfer to the new provider if the individual changes providers.

A.3 How do I work out the home care fees for pre-1 July 2014 care recipients?

Providers are responsible for working out the home care fees that they will charge to care recipients in the pre-1 July 2014 arrangements. The Services Australia income assessment that people who

entered the HCP Program after 1 July 2014 complete does not consider the pre-1 July 2014 fee structure.

A.3.1. Basic daily fee

- Level 1 - the maximum fee 15.68 per cent of the basic rate of the single age pension.
- Level 2 - the maximum fee 16.58 per cent of the basic rate of the single age pension.
- Level 3 - the maximum fee 17.05 per cent of the basic rate of the single age pension.
- Level 4 - the maximum fee 17.50 per cent of the basic rate of the single age pension.

A.3.2. Income tested fee

For care recipients with income above the basic rate of pension, providers can charge an additional amount of up to 50 per cent of income above the single Age Pension.

Calculating income

Income is defined as income after income tax and the Medicare levy. When calculating income for the purpose of determining ongoing fees, the following are excluded:

- any Pharmaceutical Allowance, Rent Assistance or Telephone Allowance;
- the Pension Supplement;
- the Clean Energy Supplement; and
- in the case of a Disability Pension payable under the *Veterans' Entitlements Act 1986* an amount equal to four per cent of the amount of the pension.

Please see Division 60 of the *Aged Care (Transitional Provisions) Act 1997* or section 130 of the *Aged Care (Transitional Provisions) Principles 2014* for more information.

A.3.3. Financial hardship

Home care recipients who began a home care package before 1 July 2014 are not eligible for the hardship supplement. Rather, these home care recipients are able to negotiate lower fees with their provider. The Aged Care (Transitional Provisions) Act 1997 allow providers to consider care recipients' other expenses such as high pharmaceutical bills, utilities and other living expenses when setting fees.

A.3.4. Review of fees

A review of fees should be conducted periodically (or whenever the care recipient requests a review). The care recipient should be encouraged to seek a review if their financial circumstances change.

The maximum fees may need to be varied when new rates for the Age Pension are announced each March and September. Providers may need to discuss the impact of these changes on fees with the care recipient and update their budget accordingly.

A.4 How does leave work for a care recipient in the pre-1 July 2014 arrangements?

Care recipients in the pre-1 July 2014 arrangements are entitled to take leave in the same circumstances as care recipients in the post-1 July 2014 arrangements, although the home care fees that will be payable differ. The table below outlines when home care fees will be payable:

Leave type	Home care fees
Hospital	Yes
Transition care	No
Residential respite care	No
Other leave	Yes

A.5 What do I need to include in a Home Care Agreement for a care recipient in the pre-1 July 2014 arrangements?

In addition to the components of a Home Care Agreement outlined at **Section 6.5** of this manual, a pre-1 July 2014 care recipient's Home Care Agreement will need to include the following:

- ☐ A statement that the provider may charge the care recipient home care fees in accordance with Division 6 of the *Aged Care (Transitional Provisions) Act 1997*
- ☐ A statement setting out which fee (if any), as determined in accordance with section 130 of the *Aged Care (Transitional Provisions) Principles 2014*, the provider will charge
- ☐ If the provider is charging the care recipient a daily amount of home care fees in accordance with Division 60 of the *Aged Care (Transitional Provisions) Act 1997* that is different from the daily amount of home care fees mentioned in their Schedule, the different amount and the reason for the different amount.

✓ Key points to remember

- Care recipients who entered the HCP Program before 1 July 2014, and who have not moved to the post-1 July 2014 arrangements, have different home care fee arrangements.
- Providers are responsible for calculating home care fees for pre-1 July 2014 care recipients.
- Providers will also need to ensure any Home Care Agreement entered into with a pre-1 July 2014 care recipient reflects the provisions that apply to them.

Appendix B: 1 July 2019 changes to pricing

New pricing requirements were introduced on 1 July 2019 to improve transparency for senior Australians. These requirements enable direct comparisons between home care providers, and are intended to curb problematic charging practices by some providers.

Key legislation, instruments and determinations underpinning this section
Note, this section is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Section 56-2 of the *Aged Care Act 1997*
- *User Rights Principles 2014*.

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with their obligations pursuant to them.

See **Appendix D** for further detail on specific provider responsibilities.

B.1 What is the pricing Schedule and what do providers need to do with it?

All home care providers are required to publish their pricing information in a new standardised pricing comparability Schedule (the Schedule) on the My Aged Care Service Finder. The Schedule has been designed to:

- encourage senior Australians to consider other factors in addition to the price of the service when choosing an approved provider
- provide clear and unambiguous pricing information on the common home care package services
- achieve price comparability across common home care package services
- limit any impact on the ability of providers to innovate by catering for different business models
- ensure equity in the requirements across providers and allowing dedicated areas to promote their value statement and point of difference.

The Schedule includes five common home care services:

- personal care
- nursing
- cleaning and household tasks
- light gardening
- in-home respite.

The Schedule also displays information on maximum exit amounts. Providers will also be able to indicate if they charge a per kilometre cost for a care worker to travel to the care recipient's location; or if they charge an extra amount if a care recipient wishes to sub-contract, and receive services through a different provider. Providers will need to explain their approach to any separate cost, for example, if it is charged separately or included in the service price.

Within the Schedule, providers will need to nominate a single price (the most common) for each common home care service within the Schedule. Where providers offer genuine care recipient choice of different prices for a service, they will also be able to enter the minimum and maximum price points. This may be where an approved provider arranges services via sub-contracting arrangements and therefore can offer their care recipients different prices for a service.

Providers will be able to complete a different pricing Schedule where required, for example to account for regional variability in pricing.

Providers must review, and if required, update their pricing Schedule on My Aged Care annually. This will ensure accurate pricing information is published. Current pricing information must also be included within each individual Home Care Agreement. As discussed at Section 15 providers are required to complete one of the following, to show that they have reviewed their Schedule:

- Report to the Department that they have done so. Providers can do this by entering 'Confirm review of pricing information' in the My Aged Care Provider Portal.
- Update their price list. This will cause the 'last updated date' to update in the Department's systems, and will be sufficient evidence that the provider has reviewed their price list.

B.1.1. Relationship between published and contracted price

The price published in the Schedule will be the default price charged.

A copy of the Schedule must be included within a care recipient's Home Care Agreement. This ensures the published price is a meaningful and accurate indication of the costs charged under a home care package.

There are situations where the contracted price will need to differ from the published price. For example, where the care recipient has a particular request. In these instances, the home care provider will need to negotiate and agree a price with their care recipient. This difference in price and accompanying reason will need to be clearly outlined within the Home Care Agreement and package budget. It is expected this would be an exception. In most instances, the price published will be the price charged.

B.1.2. Obligations through transition

For care recipients already in the program at 1 July 2019, providers have until 1 July 2020 to:

- review their Home Care Agreement and include a copy of the pricing schedule
- charge them the prices in that schedule, unless otherwise agreed — any different prices and the reason must be included in their Home Care Agreement
- roll any separate business-related administration costs they are retaining into service prices
- make sure any administration costs are reasonable.

B.1.3. Compliance

These pricing changes apply to all home care providers. This is to ensure consistency across the sector and allow all senior Australians to benefit.

Providers' compliance with these requirements is actively monitored. Compliance action may be taken, consistent with the compliance policy and procedures, as discussed throughout this manual.

B.2 How do the pricing changes affect care management?

Care management, often called case management or care coordination, is a key component of every home care package. The introduction of the Schedule provides an opportunity to better define care management, and educate senior Australians.

Providers need to indicate the cost for care management services and outline their approach to care management in the Schedule. Care management may include:

- ensuring each consumer gets safe and effective personal care and/or clinical care
- reviewing the Home Care Agreement and care plan
- coordination and scheduling of services
- ensuring the care is aligned with other supports
- providing a point of contact for the home care consumer or their support network
- ensuring care is culturally appropriate
- identifying and addressing risks to the home care consumer's safety.

Care management should ensure there is no overlap, over-servicing or mismanagement of services. These services may be provided in different ways including face-to-face or via phone or email.

B.3 How do the pricing changes affect the way administration costs can be charged?

There are different components to administration costs; package management costs, and other administration costs. Providers are able to include their fortnightly package management costs across each home care package level in the Schedule.

Package management is the ongoing organisational activities associated with ensuring the smooth delivery and management of a home care package. It may include the costs for preparing monthly statements; managing package funds; and compliance and quality assurance activities required for home care.

It does not include costs that are unrelated to supporting a care recipient's care or costs associated with running any business, such as marketing, office rent, insurance, or activities completed before a person enters into a Home Care Agreement.

Any other administrative costs that need to be recouped from a home care package, apart from package management, will need to be included in the unit price for specific care services. This will ensure people can see the all inclusive cost of delivering the service. Providers cannot charge more than a reasonable amount for any administration-related costs.

For more information on the 1 July 2019 changes to pricing please see this link or search "Price transparency for Home Care Packages" at www.health.gov.au.

Appendix C: Compensation payments

If a person receives a compensation entitlement under a judgment, a settlement, or a reimbursement arrangement, their home care package budget is amended slightly to account for this. A compensation entitlement includes things like a permanent impairment or incapacity payment to a veteran, a workplace insurance claim settlement, a motor vehicle accident claim settlement, or some types of common law settlements (such as, potentially, an award for personal injury caused by negligence).

The provider is responsible for asking the care recipient if they have a compensation entitlement and, if so, notifying the Department of that entitlement. Providers can notify the Department when they complete the form to notify a new care recipient starting in their care, discussed at Section 6, or at any other time by completing an ACER. An ACER can be completed using paper **"Aged care entry record form AC021"** at this link or by searching "AC021" at www.servicesaustralia.gov.au.

If a claim has not been settled, subsidies will continue to be paid on the care recipient's behalf up until the date liability has been accepted. Once the compensation insurer has agreed to pay or to contribute to the care costs, payment of subsidies will cease with the date of effect from the date of liability or settlement. Providers should notify the Department as soon as they become aware of a care recipient's compensations claims.

If a provider does not advise the Department that a care recipient is entitled to compensation and the Department later becomes aware of this, the Department will need to recover funds in arrears.

C.1 Package budget with compensation entitlement

If a provider has entered into a Home Care Agreement with a care recipient who has a compensation entitlement, and they have notified the Department, the Department will advise both parties of the amount of the compensation reduction amount. The provider will then be able to invoice the care recipient for the total amount of the compensation payment reduction and home care fees (if applicable). The amount is deducted from the Government's contribution and added to the care recipient's contribution.

Below is an example of a budget, including a compensation entitlement:

How do we calculate Sonali's package budget?

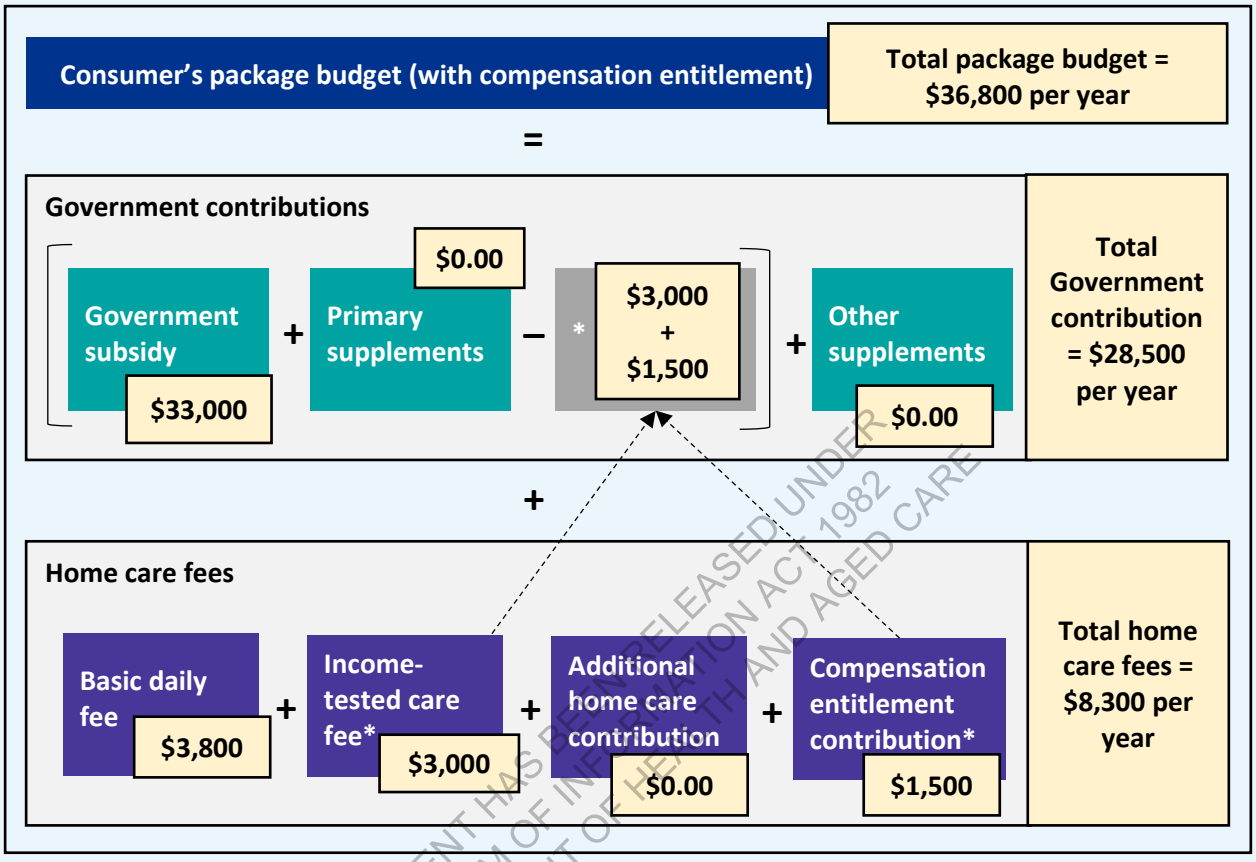
Fact scenario

- Sonali has been assigned a Level 3 package. The value of her package is approximately $33,000 per year.
- Sonali is not eligible for any primary or other supplements.
- The basic daily fee for Sonali's package level is $3,800 per year.
- Sonali has completed her income assessment, and has been assessed by Services Australia as being able to pay an additional $3,000 per year in income tested care fees.
- Sonali received a workplace injury settlement. Her provider notified Services Australia of the value of the settlement, and Sonali was told she would need to contribute an additional $1,500 per year in compensable entitlement contributions.
- Sonali did not agree to pay any additional fees in her Home Care Agreement.

How do we calculate Sonali's package budget?

Calculation of package budget

The diagram below outlines how Sonali's home care budget is calculated:



Appendix D: Responsibilities of approved providers

Approved providers must deliver aged care that aligns with the responsibilities and standards that are specified in the *Aged Care Act 1997* (the Act) and associated legislation. This information is designed to assist approved providers to meet their obligations as providers of aged care.

Quality of care – Part 4.1 in the *Aged Care Act 1997*

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Quality of care	Approved providers must comply with the Aged Care Quality Standards.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 3
Quality of care	Providers must maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 4
Care and services	An approved provider of a home care service must provide a package of care and services selected from those specified in Part 1 of Schedule 3 of the Quality of Care Principles. Extracted at section 9.2 of this manual.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 9
Care and services	Part 2 of Schedule 3 of the Quality of Care Principles specify excluded items that must not be included in the package of care and services provided under section 13 of the Quality of Care Principles. Extracted at section 9.3 of this manual.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 9
Care and services	Care and services provided to the care recipient must be consistent with the care recipient's care plan.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 7

Rights of care recipients – Part 4.2 in the *Aged Care Act 1997*

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Budgets, fees and pricing	An approved provider of home care must not charge for the care recipient's entry to the service through which the care is, or is to be, provided.	Section 56-2(a) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 6
Budgets, fees and pricing	If the care recipient is a post-1 July 2014 care recipient, providers must not charge more than the maximum daily amount. The maximum daily amount depends on the care recipient and will need to be worked out using the home care fee calculator. The home care fee calculator is at section 52D-2 of the *Aged Care Act 1997.*	Sections 52D-1, 52D-2 and 56-2(b) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Budgets, fees and pricing	If a care recipient who is a post-1 July 2014 care recipient leaves the HCP Program, any fees paid in advance in respect of a period occurring after the care recipient's death, or the cessation of home care, must be refunded to the care recipient.	Sections 52D-1 and 56-2(b) of the *Aged Care Act 1997*	*Fees and Payments Principles 2014 (No.2)* *User Rights Principles 2014*	Section 14
Budgets, fees and pricing	If the care recipient is a pre-1 July 2014 care recipient, providers must charge no more for provision of the care and services then the amount permitted by the *Aged Care (Transitional Provisions) Principles.* This is outlined in Appendix A Section 3 of this manual.	Section 56-2(c) of the *Aged Care Act 1997* Sections 60-1(a) and 60-2 of the *Aged Care (Transitional Provisions) Act 1997*	*Aged Care (Transitional Provisions) Principles 2014* *User Rights Principles 2014*	Appendix A
Budgets, fees and pricing	Care recipients must not be required to pay home care fees more than one month in advance.	Section 52D-1 of the *Aged Care Act 1997* Section 60-1(b) of the *Aged Care (Transitional Provisions) Act 1997*	*User Rights Principles 2014*	Appendix A

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Budgets, fees and pricing	Providers must not charge home care fees for any period prior to the time the care recipient was being provided with home care.	Sections 56-2(b), 56-2(c) and 52D-1 of the *Aged Care Act 1997* Section 60-1(c) of the *Aged Care (Transitional Provisions) Act 1997*	*User Rights Principles 2014*	Appendix A
Fees and payments	If a care recipient who is a pre-1 July 2014 care recipient leaves the HCP Program, any fees paid in advance in respect of a period occurring after the care recipient's death, or the cessation of home care, must be refunded as soon as practicable to the care recipient or a person authorised to receive the refund for the care recipient's estate.	Section 60-1(d) of the *Aged Care (Transitional Provisions) Act 1997*	*Aged Care (Transitional Provisions) Principles 2014*	Appendix A
Agreements with care recipients	Providers must provide such other care and services as agreed in the Home Care Agreement between the approved provider and the care recipient.	Section 56-2(e) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Fees and payments	Providers must charge no more for any other care or services than an amount agreed beforehand with the care recipient.	Section 56-2(d) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Budgets, fees and pricing	Providers must give the care recipient an itemised account of any other care or services.	Section 56-2(d) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Stability of approved provider	Providers must provide security of tenure to care recipients. The approved provider may cease to provide home care to the care recipient only if: • the care recipient cannot be cared for in the community with the resources available to the approved provider; or	Section 56-2(f) and 63-1AA of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	• the care recipient notifies the approved provider, in writing, that they wish to move to a location where home care is not provided by the provider; or • the care recipient notifies the approved provider, in writing, that they no longer wishes to receive the home care; or • the care recipient's condition changes to the extent that the care recipient no longer needs home care, or the care recipient's needs, as assessed by an aged care assessment team, can be more appropriately met by other types of services or care; or • the care recipient: has not paid to the approved provider, for a reason within the care recipient's control, any home care fee specified in the home care agreement between the care recipient and the approved provider; and has not negotiated an alternative arrangement with the approved provider for payment of the home care fee; or • the care recipient has: intentionally caused serious injury to or infringed the right of a staff member (to work in a safe environment) of the approved provider.			
Agreements with care recipients	Providers must offer to enter into a Home Care Agreement with the care recipient, and, if the care recipient wishes, to enter into such an agreement.	Section 56-2(g) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 6
Agreements with care recipients	The Home Care Agreement must include specified provisions. These are extracted at Section 6 of this manual.	Section 61-1 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 6
Monitoring, compliance	Providers must allow people acting for bodies that have been paid advocacy grants under Part 5.5 to	Section 56-2(j) of the	*User Rights Principles 2014*	Section 12

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
and other access	have access to each home care service through which they provide home care.	*Aged Care Act 1997*		
Rights of care recipients	Providers must not act in a way which is inconsistent with the legal and consumer rights of a care recipient.	Sections 54-1(1)(d) and 56-2(k) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 3 and 6
Rights of care recipients	Providers must give a prospective care recipient a copy of the Charter of Aged Care Rights ('the Charter'). The copy of the Charter that is provided must: • be signed by a staff member of the provider; • include the signature of the care recipient or their authorised person, if they have signed it; • include the date on which the care recipient or their authorised person was given reasonable opportunity to sign the Charter, if they have not signed it, • set out the full name of the care recipient, • set out the full name of an authorised person who was present at the time the copy of the Charter was given to the care recipient, if relevant, and • set out the date on which the copy of the Charter was given to the care recipient. This must be done before the care recipient enters into a home care agreement with the provider the provider's home care service, or by 1 December 2019 for care recipients who were already receiving home care services from the provider on 1 July 2019.	Sections 56-2(k) and 56-2(l) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3
Rights of care recipients	Providers must give a prospective care recipient information about their rights and responsibilities (including in relation to the payment	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	of home care fees), and the rights and responsibilities of their provider. This must be done before the care recipient enters into a home care agreement with the provider.			
Rights of care recipients	Providers must assist prospective care recipients to understand information provided to them, including the Charter of Aged Care Rights.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3
Rights of care recipients	Providers must ensure that the care recipient, or an authorised person of the care recipient, has been given reasonable opportunity to sign a copy of the Charter of Aged Care Rights (after it has been provided to them).	Section 56-2of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3
Rights of care recipients	Providers must take reasonable steps to prevent the provider, or a person employed or otherwise engaged by the provider, from causing damage to a care recipient's home and other property in the course of providing the home care.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	-
Rights of care recipients	Providers must provide such information as is reasonably necessary to assist a care recipient to choose the care and services that best meet his or her goals and assessed needs and preferences, within the limits of the resources available.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 8
Care and services	Providers must give care recipients a written plan of the care and services that they will receive before the care recipient receives home care or within 14 days of the date on which they commence receiving home care.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 8
Budgets, fees and pricing	Providers must give care recipients invoices that are clear and in a format that is understandable.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10
Budgets, fees and pricing	Providers must periodically review the home care fees that each care recipient is liable to pay, including if requested to do so by a care recipient	Section 56-2 of the *Aged*	*User Rights Principles 2014*	Section 7

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	on the grounds that the care recipient's financial circumstances have changed.	*Care Act 1997*		
Budgets, fees and pricing	Providers must provide notice of their pricing Schedule to the Secretary before offering to enter into a Home Care Agreement with a care recipient.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B
Budgets, fees and pricing	Providers must review their pricing Schedule and price list at least every 12 months, and: • if there is to be a change, provide the Secretary with an updated notice, or • if there is not to be a change, provide the Secretary with a written notice that they have reviewed the information.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B
Care recipients changing providers/ leaving	If a pre-1 July 2014 care recipient intends to move to another home care service, the provider that is to provide the new service must give the care recipient written notice of the following: • If the care recipient moves to the new service within 28 days of leaving the old service, they may make a written choice to be covered by the post-1 July 2014 arrangements in relation to the new service. That choice cannot be made after they have already moved to the new service. If they do not make a choice before entering the new service they will be covered by the pre-1 July 2014 arrangements. • If the care recipient moves to the new service 28 days or more after leaving the old service, they will automatically be covered by the post-1 July 2014 arrangements. • If the care recipient is covered by the post-1 July 2014	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix A

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	arrangements that may result in a change to their fees payable. • If the care recipient moves from the pre-1 July 2014 arrangements to the post-1 July 2014 arrangements, they cannot make a choice to return to the pre-1 July 2014 arrangements.			
Care recipients changing providers/ leaving	If a pre-1 July 2014 care recipient intends to move to another home care service, the provider that is to provide the new service must give the care recipient a copy of the document titled 'New Arrangements for Aged Care – for 1 July 2014', published by the Department, as it exists on 1 July 2014.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix A
Budgets, fees and pricing	Providers must give every care recipient to whom they provide, or are to provide, home care, a written individualised budget which sets out a budget for the care and services detailed in the care recipient's care plan. The budget must be provided as soon as practicable after the provider has all the necessary information to complete it. The budget must state the amount of home care subsidy payable to the provider for the care recipient in respect of the period agreed between the care recipient and provider, and the maximum amount of home care fees payable by the care recipient in respect of that period.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Budgets, fees and pricing	Providers must prepare a care recipient's individualised budget: • in partnership with the care recipient, and • considering the care recipient's goals, assessed needs, preferences, resources available, and the services selected by the care recipient.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Budgets, fees and pricing	Providers must review and, if necessary, revise the individualised budget of the care recipient if: • a change to the care and services to be provided through the home care service is proposed, or • the costs or providing the care and services change, or • the care recipient requests the provider to do so. If the care recipient requests the review, the review must be completed within 14 days of the request.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10
Budgets, fees and pricing	If the provider reviews the individualised budget they must give the care recipient of a copy of the revised individualised budget and help them to understand it.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10
Budgets, fees and pricing	Providers must give all care recipients a written monthly statement of the available funds and the expenditure in respect of the home care provided to the care recipient during the month. The statement must be provided as soon as practicable after the provider has all the necessary information to complete it. The monthly statement must specify: • the amount of home care subsidy paid or payable to the provider for the care recipient in respect of the month; • the total amount of home care fees paid or payable by the care recipient in respect of the month; • the total amount paid or payable by the provider in respect of the home care provided to the care recipient during the month; • an itemised list of the care and services provided to the care recipient during the month and the total amount paid or payable in relation to each kind of care or service;	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	• the total amount (if any) of the funds received or to be received in respect of any previous month for the provision of home care to the care recipient that have not been spent; • if, during the month, the transfer portion of the care recipient's unspent home care amount was received by the approved provider—the amount that was received.			
Budgets, fees and pricing	Providers must help care recipients to understand their monthly statements.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10
Care recipients changing providers/ leaving	Provider must give notice to care recipients or, if the care recipient has passed away, their legal personal representative, of care recipients ceasing to receive care from their service within 56 days of the cessation day. The notice must specify: • the cessation day, • the care recipient's total unspent home care amount and amounts broken into the Commonwealth portion, the care recipient portion and the transfer portion, • the exit amount deducted (if relevant), • the unpaid home care fee amount deducted (if relevant). The notice must also explain how unspent funds will be transferred.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 14
Care recipients changing providers/ leaving	Providers must pay the care recipient and transfer portion of unspent funds as specified in the *User Rights Principles*. The relevant tables have been extracted at Sections 13 and 14 of this manual.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 13 and 14
Care recipients changing	Providers who are making payment of a transfer amount to a care recipient's new provider must give the new provider the notice issued to	Section 56-2 of the *Aged*	*User Rights Principles 2014*	Section 13

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
providers/ leaving	the care recipient on their cessation at the time they pay the transfer portion to the new provider.	*Care Act 1997*		
Care recipients changing providers/ leaving	Providers must give written notice to the Secretary, in an approved form, within 70 days after a care recipient's cessation day that specifies if there is a Commonwealth portion of the care recipient's unspent home care amount, or if the Commonwealth portion of the care recipient's unspent home care amount is nil.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 13 and 14
Care recipients changing providers/ leaving	Providers must not deduct an exit amount for a care recipient leaving their care from a care recipient's unspent funds unless the exit amount was agreed in the Home Care Agreement, and the provider's standard exit amount was notified to the Secretary in the pricing Schedule before that Home Care Agreement was executed.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 13 and 14
Care recipients changing providers/ leaving	Providers must not charge an exit amount greater than the maximum exit amount specified in their pricing Schedule as published before the Home Care Agreement was executed.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 13 and 14
Care recipients changing providers/ leaving	Providers must not charge an exit amount greater than the value of the care recipient's unspent funds.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 13 and 14
Budgets, fees and pricing	Providers must not charge care recipients for costs (however described) that are business costs as a separate charge.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B
Budgets, fees and pricing	Providers must not charge care recipients more than a reasonable amount for travel, sub-contracting arrangements and package management.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B
Budgets, fees and pricing	Providers must not charge care recipients more than a reasonable amount for business costs that are	Section 56-2 of the *Aged*	*User Rights Principles 2014*	Appendix B

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	part of the price charges for providing care and services.	*Care Act 1997*		
Budgets, fees and pricing	Providers must charge care recipients the fees and/or prices listed in their pricing Schedule (as it applies on the relevant day the service was provided) unless the Home Care Agreement specifies a different fee and/or price and the reason for the different amount. **Note:** this does not apply to care recipients who were receiving home care services from the provider prior to 1 July 2019. This obligation will come into effect for those care recipients on 1 July 2020.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B
Rights of care recipients	Provider must establish a complaints resolution mechanism for their aged care service.	Section 56-4(1) of the *Aged Care Act 1997*	-	Section 10
Rights of care recipients	Providers must use their complaints resolution mechanism to address any complaints made by or on behalf of a care recipient to whom care is provided through the service. The complaints resolution mechanism must be the complaints resolution mechanism provided for in the Home Care Agreement entered into between the provider and the care recipient.	Section 56-4(1) of the *Aged Care Act 1997*	-	Section 10
Rights of care recipients	Providers must advise a complainant of any other mechanisms that are available to address complaints, and provide such assistance as the care recipient requires to use those mechanisms.	Section 56-4(1) of the *Aged Care Act 1997*	-	Section 10
Rights of care recipients	Providers must comply with any requirement made of the provider in relation to a direction made by the Aged Care Quality and Safety Commissioner.	Section 56-4(1) of the *Aged Care Act 1997* Section 21(2) of the *Aged Care Quality and Safety*	*Aged Care Quality and Safety Commission Rules 2018*	Section 3

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
		Commission Act		
Information and record keeping	Personal information must not be used other than: • for a purpose connected with the provision of aged care to the person by the approved provider; or • for a purpose for which the personal information was given by or on behalf of the person to the approved provider.	Sections 56-2(h) and 62-1 of the *Aged Care Act 1997*	-	-
Information and record keeping	Except with the written consent of the person, personal information must not be disclosed to any other person other than: • for a purpose connected with the provision of aged care to the care recipient by the approved provider; or • for a purpose connected with the provision of aged care to the care recipient by another approved provider; or • for a purpose for which the personal information was given by or on behalf of the care recipient; or • for the purpose of complying with an obligation under the *Aged Care Act 1997*, the *Aged Care (Transitional Provisions) Act 1997* or any of the principles.	Section 56-2(h) and 62-1(b) of the *Aged Care Act 1997*	-	-
Information and record keeping	Personal information must be protected with security safeguards that it is reasonable in the circumstances to take against the loss or misuse of the information.	Section 61-1(c) of the *Aged Care Act 1997*	-	-

Accountability – Part 4.3 in the *Aged Care Act 1997*

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Record keeping	Providers must keep the following kinds of records about care recipients: • assessments of care recipients; • individual care plans; • medical records, progress notes and other clinical records; • schedules of fees and charges; • Home Care Agreements; • accounts of care recipients; • records relating to care recipients' entry, discharge and leave arrangements, including death certificates where appropriate; • records relating to a determination that a care recipient is a care recipient with financial hardship; • in relation to a continuing home care recipient of care to whom the approved provider starts to provide home care through a home care service on or after 1 July 2014—a record of whether the care recipient made a written choice regarding whether they would be covered by the pre or post-1 July 2014 arrangements; • up-to-date records of: the name and contact details of at least one representative of each care recipient; and the name and contact details of any other representative of a care recipient; • copies of unspent funds notices; • records relating to the payment of the care recipient portion or transfer portion of care recipients' unspent home care amounts; • copies of notices of published exit amounts;	Sections 63-1(1)(a) and 87-2 of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	*Records Principles 2014*	-

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	• records required by the National Aged Care Mandatory Quality Indicator Program Manual to be kept.			
Record keeping	Providers must keep all required records for care recipients for three years after the 30 June of the year in which they ceased to provide care to the care recipient.	Section 63-1(2) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	*Records Principles 2014*	-
Record keeping	Providers must keep records relating to each copy of the Charter of Aged Care Rights given a care recipient. **Note:** this requirement does not apply if the care recipient does not enter the provider's home care service.	Sections 63-1(1)(a) and 87-2 of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	*Records Principles 2014*	-
Record keeping	Providers must keep records that enable them to demonstrate that: • they have police certificates for all staff members or volunteers that are not more than three years old; • for any period where a staff member or volunteer was without a police certification, an application for a police certificate had been made, and • any statutory declaration required to be made by a staff member or volunteer has been made. Police certificates must be kept in compliance with the *Privacy Act 1988*.	Sections 63-1(1)(a) and 87-2 of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	*Records Principles 2014*	-
Record keeping	Providers must keep records (in written or electronic form) that enable claims for payments of	Section 63-1 of the *Aged Care Act*	-	-

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	subsidy to be properly verified. These records must be kept for three years after 30 June of the year in which the record was made.	*1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*		
Record keeping	Providers must keep records (in written or electronic form) that enable proper assessments to be made of whether the approved provider had complied, or is complying, with its responsibilities. These records must be kept for three years after the 30 June of the year in which the record was made.	Section 63-1(1) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	-	-
Monitoring, compliance and other access	Providers must co-operate with any person who is exercising powers under Part 6.4 in relation to the service and comply with Part 6.4 in relation to the person's exercise of those powers. Part 6.4 of the *Aged Care Act 1997* makes provisions for authorised officers to exercise monitoring and questioning powers. The following obligations arise in relation to exercise of those powers: • a person at any premises entered into under a warrant must provide reasonable assistance to an authorised officer; • a person whom the Secretary has requested to give evidence pursuant to section 93-1 must attend at a time and place specified in the notice, take any oath or affirmation requirement, and answer any questions put by an officer or produce any documents (or copies or documents) as are referred to in the notice. (They may refuse any requests that lead to self-incrimination, or do not relate to:	Sections 63-1(1)(b) and 90-1 to 94-2 of the *Aged Care Act 1997*	-	-

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	a) the affairs of a corporation that is/has been an approved provider or b) the payment of a subsidy).			
Monitoring, compliance and other access	Providers must co-operate with any person who is exercising powers under Part 8 of the *Aged Care Quality and Safety Commission Act 2018* in relation to the services. Part 8 of the *Aged Care Quality and Safety Commission Act 2018* currently enables authorised officers and regulatory officials to enter and search premises.	Section 63-1(1)(ba) of the *Aged Care Act 1997* Part 8 of the *Aged Care Quality and Safety Commission Act 2018*	-	-
Reporting and disclosure	Providers must notify the Secretary of the name and address of the service in relation to each home care service, in the form approved by the Secretary, before providing home care through the service.	Sections 9-1A and 63-1(1)(c) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	-	Sections 5 and 15
Reporting and disclosure	Providers must notify the Secretary of any changes to the name and address of the service within 28 days of the change.	Sections 9-1A and 63-1(1)(c) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	-	Section 15
Reporting and disclosure	Providers must notify the Aged Care Quality and Safety Commissioner (the Commissioner) of any change of circumstances that materially affects the approved provider's suitability to be a provider of aged care within 28 days of the change. Commonwealth for providing that aged care.	Sections 9-1 and 63-1(1)(c) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety*	-	Section 15

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	If that change in circumstances relates, wholly or partly, to key personnel becoming a disqualified individual, the approved provider must notify the Secretary of the reason why they are, or are about to become, a disqualified individual.	*Commission Act 2018*		
Reporting and disclosure	Providers must respond to a written request from the Commissioner for information relating to: • the provider's suitability to be a provider of aged care, • payments made under the *Aged Care Act 1997* or *Aged Care (Transitional Provisions) Act 1997*, • the provider's financial situation, within 28 days after the request was made, or within any shorter period as is specified in the notice, or (if a periodic request is made with respect to financial information) before the time or times worked out in accordance with the request.	Sections 9-2, 9-3, 9-3B and 63-1(1)(c) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	-	Section 15
Monitoring, compliance and other access	Providers must allow RAS assessors, ACAT assessors, or other people authorised by the Secretary to assess the care needs of any care recipient, access to the service.	Section 63-1(1)(g) of the *Aged Care Act 1997*	-	-
Monitoring, compliance and other access	Providers to comply with any agreement they make in lieu of revocation of approved provider status, and with any undertaking they give to respond to notice to remedy non-compliance.	Sections 66-2(1)(b), 63-1(1)(k) and 67-4 of the *Aged Care Act 1997*	-	-
Reporting and disclosure	Providers must notify the Secretary, in writing and in an approved form, of each care recipient who starts to be provided with home care through the service. Notice must be provided within 28 days of the date the care recipient starts to be provided with home care through the service.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles*	Section 6

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Reporting and disclosure	Providers must notify the Secretary, in writing and in an approved form, of each care recipient who ceases to be provided with home care through the service. Notice must be provided within 31 days of the date the care recipient ceases to be provided with home care through the service.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Sections 13 and 14
Reporting and disclosure	Providers must give the Secretary an aged care financial report each financial year, within four month of the end of the financial year. The report must be signed by one of the providers' key personnel (who is authorised by the provider to sign the report).	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Section 15
Reporting and disclosure	If a provider of an aged care service receives an aged care workforce census form sent by or on behalf of the Department, the approved provider must complete the form and return it to the Department by the date specified in the form.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	-
Staff and volunteers	A provider must not allow a person to become a staff member or volunteer of the provider, unless satisfied that: • the person has a police certificate that is not more than three years old; or the person has applied for a police certificate, will be supervised when with care recipients, and has completed a statutory declaration stated that they have not been convicted murder or sexual assault, or convicted or imprisoned for any other form of assault; and • the police certificate does not record that the person has been convicted of murder or sexual assault, or convicted or imprisoned for any other form of assault; and • if the person has been, at any time after turning 16, a citizen or permanent resident of a country	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Section 4

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	other than Australia—the person has made a statutory declaration stating that the person has never been convicted of murder or sexual assault, or convicted or imprisoned for any other form of assault.			
Staff and volunteers	Providers must continue to satisfy the above requirements related to police certificates and suitability of staff members or volunteers. Providers must ensure that each person who is a staff member or volunteer is not allowed to continue to be a staff member or volunteer unless the above is satisfied.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Section 15
Staff and volunteers	Providers must take reasonable measures to require each person who is a staff member or volunteer to notify them if they are convicted of murder or sexual assault, or convicted or imprisoned for any other form of assault.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Sections 4 and 15
Monitoring, compliance and other access	Providers must do the following in relation to each of their key personnel: • ensure that the person understands the obligations of key personnel and of approved providers under the Act in relation to disqualified individuals; and • if the provider reasonably believes that the person may be mentally incapable of performing his or her duties as one of the approved provider's key personnel—make arrangements for the person to be examined by a registered medical practitioner; and • if the provider has ascertained that the person is a disqualified individual—ensure that the person ceases to be one of the	Section 63-1A of the *Aged Care Act 1997*	*Sanctions Principles 2014*	Sections 4 and 15

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	approved provider's key personnel.			
Monitoring, compliance and other access	Providers must do the following in relation to each person who proposes to become, or becomes, one of their key personnel: • obtain (with the person's written consent) a police certificate for the person; and • conduct a search of bankruptcy records; and • conduct previous employment and referee checks.	Section 63-1A of the *Aged Care Act 1997*	*Sanctions Principles 2014*	Sections 4 and 15
Monitoring, compliance and other access	If the Secretary requests it, providers must provide information related to the steps the provider has taken to ensure that a person who is a key personnel is not a disqualified individual.	Section 63-1A of the *Aged Care Act 1997*	*Sanctions Principles 2014*	-
Monitoring, compliance and other access	An approved provider of home care must do all things reasonably practicable to ensure that there is no change to circumstances materially affecting their suitability to provide aged care.	63-1C of the *Aged Care Act 1997*	-	-

Appendix E: Unspent funds – worked examples

Example 1: Mai transfers providers (Provider A to Provider B)

- On 1 November 2015, Mai commences a level two package with Provider A.
- On 17 January 2017, Mai consents to an exit amount of $200 to be included in her Home Care Agreement.
- After two years in care with Provider A, Mai decides to take her package to Provider B.
- Mai and Provider A agree on a cessation date of 31 October 2017.
- Mai has $137 in home care fees that are payable to Provider A but have not been paid.
- The 'period' for calculations in the table is: 1 November 2015 to 31 October 2017.

Note: *Percentages in the table have been rounded.*

Step	Activity	Calculation	Amount
	Calculate the unspent home care amount:		
1	Total the following amounts paid to Provider A in relation to the period for Mai: (a) home care subsidy (b) home care fees *(do not include home care fees paid in advance – these must be separately refunded)* (c) any amount paid to Provider A from another home care provider	$\$28{,}000 + \$6{,}500 + \$0 = \$34{,}500$	$\$34{,}500$
2	Total spent or committed during the period by Provider A on care and services for Mai.		$\$32{,}000$
3	Subtract amount at step 2 from amount at step 1. *If the result is negative, the amount is nil.*	$\$34{,}500 - \$32{,}000 = \$2{,}500$	$\$2{,}500$
4	If an exit amount may be deducted by Provider A, subtract the exit amount from the amount at step 3.	$\$2{,}500 - \$200 = \$2{,}300$	$\$2{,}300$
5	The amount (including a nil amount) worked out under step 3 or 4 is ***Mai's unspent home care amount***		$\$2{,}300$
	Calculate the Australian Government portion, care consumer portion and transfer portion:		
1	Total the following amounts paid to Provider A in relation to the period for Mai: (a) home care subsidy (b) the Australian Government portion of any amount paid to Provider A by another provider	$\$28{,}000 + \$0 = \$28{,}000$	$\$28{,}000$

Step	Activity	Calculation	Amount
2	Total the following amounts paid to Provider A in relation to the period for Mai: (a) home care fees *(do not include home care fees paid in advance – these must be separately refunded)* (b) the care consumer portion of any amount paid to Provider A by another provider	$\$6{,}500 + \$0 = \$6{,}500$	$6,500
3	Add the total amounts worked out under steps 1 and 2	$\$28{,}000 + \$6{,}500 = \$34{,}500$	$34,500
4	Work out the Australian Government percentage (amount at step 1 divided by amount at step 3)	$(\$28{,}000 \div \$34{,}500) \times 100 = 81\%$	81%
5	Work out the care consumer percentage (amount at step 2 divided by amount at step 3)	$(\$6{,}500 \div \$34{,}500) \times 100 = 19\%$	19%
6	Work out the ***Australian Government portion***: (Australian Government percentage of Mai's unspent home care amount)	$81\% \times \$2{,}300 = \$1{,}863$	$1,863
7	Work out the ***care consumer portion***: (a) the care consumer percentage of Mai's unspent home care amount; less (b) the amount of any home care fees that are payable by Mai to Provider A, but have not been paid.	$(19\% \times \$2{,}300) - \$137 = \$300$	$300
8	Work out the ***transfer portion***: (Total of the Australian Government portion and the care consumer portion)	$\$1{,}863 + \$300 = \$2{,}163$	$2,163

Provider A worked out the following amounts:

- ***Mai's unspent home care amount***: $2,300
- ***Australian Government portion*** of Mai's unspent home care amount: $1,863
- ***Care consumer portion*** of Mai's unspent home care amount: $300
- ***Transfer portion*** of Mai's unspent home care amount: $2,163

Note: *Percentages in the table have been rounded.*

- On 6 November 2017, Provider A is notified that Mai has entered into a Home Care Agreement with Provider B (i.e. within 56 days after the cessation date).

Provider A responsibilities	Reference
Within 31 days after the cessation date:	*Accountability Principles 2014*

Provider A responsibilities	Reference
• Provider A must notify Services Australia of Mai's cessation date through the Aged Care Provider Portal (the home care claim form or the Aged Care Provider Portal).	
Within 56 days after the cessation date: • Provider A must issue a notice of the unspent home care amount to Mai.	Section 21E of the *User Rights Principles 2014*
Within 70 days after the cessation date: • Provider A must make payment of the ***transfer portion*** of Mai's unspent home care amount ($2,163) to Provider B. • At the same time, Provider A must issue a copy of the notice of Mai's unspent home care amount to Provider B.	Subsections 21F(2) and 21G(2) of the *User Rights Principles 2014*
Provider A must retain: • a copy of the notice of Mai's unspent home care amount; • records relating to the payment of the transfer portion of Mai's unspent home care amount; and • copies of notices of published exit amounts.	*Records Principles 2014*
Provider B responsibilities	**Reference**
Within 28 days of the commencement of home care services to Mai: • Provider B is required to indicate the entry date for Mai via the submission of an Aged Care Entry Record to Services Australia.	*Accountability Principles 2014*
On receipt of the ***transfer portion*** of Mai's unspent home care amount ($2,163) from Provider A: • Provider B must separately identify that amount in the next monthly statement provided to Mai.	Paragraph 21B(2)(f) of the *User Rights Principles 2014*
Provider B must retain a copy of the notice of Mai's unspent home care amount. This will enable Provider B to include relevant amounts in its reconciliation of Mai's package when it ceases to provide home care to Mai.	*Records Principles 2014*

Example 2: Mai leaves home care (Provider B to permanent residential aged care)

- On 5 November 2017, Mai commences home care with Provider B (after transferring from Provider A).
- An agreement exit amount of $500 is explained to Mai by Provider B and disclosed in the Home Care Agreement.
- After 18 months in care, Mai's agrees on a cessation date with Provider B of 4 May 2019.
- On 5 May 2019, Mai transitions into permanent residential aged care.
- Mai has $122 in home care fees that are payable to Provider B but have not been paid.
- The 'period' for calculations in the table is: 5 November 2017 to 4 May 2019.

Note: *Percentages in the table have been rounded.*

Step	Activity	Calculation	Amount
	Calculate the unspent home care amount:		
1	Total the following amounts paid to Provider B in relation to the period for Mai: (a) home care subsidy (b) home care fees *(do not include home care fees paid in advance – these must be separately refunded)* (c) any amount paid to Provider B from Provider A	$\$56{,}000 + \$5{,}300 + \$2{,}163 = \$63{,}463$	$63,463
2	Total spent or committed during the period by Provider B on care and services for Mai.		$59,863
3	Subtract amount at step 2 from amount at step 1. *If the result is negative, the amount is nil.*	$\$63{,}463 - \$59{,}863 = \$3{,}600$	$3,600
4	If an exit amount may be deducted by Provider B, subtract the exit amount from the amount at step 3.	$\$3{,}600 - \$500 = \$3{,}100$	$3,100
5	The amount (including a nil amount) worked out under step 3 or 4 is ***Mai's unspent home care amount***.		$3,100
	Calculate the Australian Government portion, care consumer portion and transfer portion:		
1	Total the following amounts paid to Provider B in relation to the period for Mai: (a) home care subsidy (b) the Australian Government portion of any amount paid to Provider B by Provider A	$\$56{,}000 + \$1{,}863 = \$57{,}863$	$57,863
2	Total the following amounts paid to Provider B in relation to the period for Mai: (a) home care fees *(do not include home care fees paid in advance – these must be separately refunded)* (b) the care consumer portion of any amount paid to Provider B by Provider A	$\$5{,}300 + \$300 = \$5{,}600$	$5,600
3	Add the total amounts worked out under steps 1 and 2	$\$57{,}863 + \$5{,}600 = \$63{,}463$	$63,463
4	Work out the Australian Government percentage (amount at step 1 divided by amount at step 3)	$(\$57{,}863 \div \$63{,}463) \times 100 = 91\%$	91%

Step	Activity	Calculation	Amount
5	Work out the care consumer percentage (amount at step 2 divided by amount at step 3)	($5,600 ÷ $63,463) × 100 = 9%	9%
6	Work out the ***Australian Government portion***: (Australian Government percentage of Mai's unspent home care amount)	91% × $3,100 = $2,821	$2,821
7	Work out the ***care consumer portion***: (a) the care consumer percentage of Mai's unspent home care amount; less (b) the amount of any home care fees that are payable by Mai to Provider B, but have not been paid.	(9% × $3,100) – $122 = $157	$157
8	Work out the ***transfer portion***: (Total of the Australian Government portion and the care consumer portion)	$2,821 + $157 = $2,978	$2,978

Provider B worked out the following amounts:

- ***Mai's unspent home care amount***: $3,100
- ***Australian Government portion*** of Mai's unspent home care amount: $2,821
- ***Care consumer portion*** of Mai's unspent home care amount: $157
- ***Transfer portion*** of Mai's unspent home care amount: $2,978

Provider B responsibilities	Reference
Within 31 days after the cessation date: • Provider B must notify Services Australia of Mai's cessation date through the Aged Care Provider Portal (the home care claim form or the Aged Care Provider Portal).	*Accountability Principles 2014*
Within 56 days after the cessation date: • Provider B is required to issue a notice of the unspent home care amount to Mai.	Section 21E of the *User Rights Principles 2014*
Within 70 days after the cessation date: • Provider B must make payment of the ***care consumer portion*** of the unspent home care amount ($157) to Mai. • At the same time, Provider B must notify the Australian Government of the ***Australian Government portion*** ($2,821) through the Aged Care Provider Portal, for recovery either through deductions in future home care subsidy payments to Provider B, or through a debt notice.	Subsections 21F(2), 21F(3) and 21G(3) of the *User Rights Principles 2014*

Provider B responsibilities	Reference
Provider B must retain: • a copy of the notice of Mai's unspent home care amount; • records relating to the payment of the care consumer portion of the Mai's unspent home care amount; and • copies of notices of published exit amounts.	*Records Principles 2014*

Appendix F: Glossary

Term	Meaning
ACAT	Aged Care Assessment Team. ACATs are known as Aged Care Assessment Services (ACAS) in Victoria.
ACER	Aged Care Entry Record. ACERs are used to notify Services Australia of new care recipients entering care, or changes to existing care recipients' circumstances.
Australian Government	The Federal Government of Australia.
The Commission	The Aged Care Quality and Safety Commission. The Commission is a statutory body, responsible for overseeing the Aged Care Quality Standards across the aged care sector.
The Department	The Australian Government Department of Health
The Standards	The Aged Care Quality Standards. The Standards are established under the *Aged Care Act 1997*, and all approved providers of aged care are expected to be compliant.
Approved provider (or provider)	An approved provider of aged care is an organisation that has been approved to provide residential care, home and/or flexible care under the *Aged Care Act 1997*.
Basic daily fee	Refers to a home care fee that a care recipient may be asked to pay by a home care provider based on their package level (separate to the Government subsidy).
Care plan	A care plan is a document that defines the care, services and/or purchases that a care recipient is going to use their package budget to fund.
Care recipient	A person who is receiving care and services under a package funded by the Australian Government, under the *Aged Care Act 1997*
CDC	Consumer directed care.
Consumer	Includes other people who are authorised to act on behalf of the care recipient.
Commonwealth Home Support Programme	This program provides home and community care services for frail senior Australians aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.
Dignity of risk	An individual's right to make choices to take reasonable risks.
DVA	Department of Veterans' Affairs
Exclusions	Care, services or purchases that cannot be funded from a package budget.
FAS	VANguard Federated Authentication Service

Term	Meaning
Home care	A type of aged care for which a home care subsidy is payable under Part 3.2 of the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997*.
Home care consumer (or consumer)	A person who is receiving care and services under a package funded by the Australian Government. In the *Aged Care Act 1997*, this person is referred to as a "care recipient".
Home care provider (or approved provider)	An organisation approved by the Department of Health under Part 2.1 of the Act as suitable to provide home care. In the *Aged Care Act 1997*, this person or body is referred to as an "approved provider".
Home Care Agreement	An agreement entered into by a care recipient and a home care provider outlining rights and responsibilities and what services will be provided to the care recipient under the package.
Home Care Packages Program	The Australian Government program that provides funding for packages aimed at supporting people to remain living at home.
HCP	Home care package
Home care subsidy	The subsidy payable to a home care provider by the Australian Government under Part 3.2 of the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997*.
Inclusions	Care, services or purchases that can be funded from a package budget.
Income-tested care fee	Refers to a home care fee a care recipient may be asked to pay based on an income assessment.
Instrument	Primary legislation, delegated legislation, or a determination under legislation.
Key personnel	Key personnel are: • People responsible for the executive decisions of the applicant (this includes directors and board members), whether or not the person is employed by the applicant • People having authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the applicant, whether or not the person is employed by the applicant • Any person responsible for nursing services provided, or to be provided, by the applicant, whether or not the person is employed by the applicant • Any person who is, or is likely to be, responsible for the day-to-day operation of an aged care service conducted, or proposed to be conducted, by the applicant, whether or not the person is employed by the applicant.
Leave	A care recipient suspending care, services and purchases under their package for a specified period of time.
Monthly statement	A document provided to care recipients every month that shows the package budget funds available to that care recipient and what has been spent from the budget.

Term	Meaning
My Aged Care	My Aged Care is the starting point to access Australian Government-funded aged care services. The phone line and website can help senior Australians, their families and carers to get the help and support they need.
NAPS	National Approved Provider System
National priority system	The national priority system is a standardised process for prioritising assignment of packages.
Package budget	The funds available to be spent under a care recipient's package. A care recipient's package budget is made up of contributions from the Australian Government and, where applicable, home care fees paid by the care recipient themselves. If the income-tested care fee is not paid in full or is reduced, the package budget should reflect these fees as though they have been paid in full.
Pre-1 July 2014 care recipients	Care recipients who entered the HCP Program before 1 July 2014. Packages for pre-1 July 2014 care recipients have different home care fee arrangements.
Principles	Delegated legislation made under the *Aged Care Act 1997*.
Reablement	Reablement is an approach to aged care, involving time-limited interventions that are targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities.
Residential aged care	This program provides high-levels of care to people in a residential aged care home.
Security of tenure	Security of tenure means providers are required to continue to deliver the agreed care and services for as long as the care recipient needs those services.
Services Australia	Formerly known as Department of Human Services
Subsidy	An Australian Government contribution to all care recipient's package budgets, determined on the basis of the level of the package the care recipient has been allocated.
Supplement	An Australian Government contribution to a care recipient's package budget, where the care recipient satisfies the specific eligibility criteria for that contribution.
The Act	*Aged Care Act 1997.*

Term	Meaning
The Principles	• *Accountability Principles 2014* • *Approval of Care Recipients Principles 2014* • *Approved Provider Principles 2014* • *Committee Principles 2014* • *Fees and Payments Principles 2014 (No.2)* • *Information Principles 2014* • *Quality of Care Principles 2014* • *Records Principles 2014* • *Sanctions Principles 2014* • *Subsidy Principles 2014* • *User Rights Principles 2014*
Unspent funds	Any component of a care recipient's package budget that has not been spent.
Wellness	Wellness is an approach to aged care involving assessment, planning and delivery of supports that build on the strengths, capacity and goals of individuals, and encourage actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home.

Australian Government
Department of Health

Home Care Packages Program

Operational Manual

A guide for home care providers

Version 1.2 – September 2021

Contents

Reviews

Date	Summary of changes
March 2020	Manual (v1.0) first issued
February 2021	Manual revised (v1.1). Includes content about Improved Payment Arrangements, the Aged Care Provider Portal, addressing people receiving care and services under a package funded by the Australian Government as care recipients, updated web links and minor updates to wording.
September 2021	Manual revised (v1.2). Includes content about Improved Payment Arrangements.

Disclaimer

The Home Care Packages Program is governed by the applicable legislation, not this Manual. Home care providers are responsible for understanding and complying with all legislation that is relevant to delivering home care. This Manual is not a substitute for, and is not intended to replace independent legal advice on providers' legal obligations, or provide any interpretation of the legislation.

Home care providers should consider the need to obtain their own appropriate legal advice relevant to their particular circumstances.

In addition to the legislation referred to in this Manual, each State and Territory may have its own separate legislation that is relevant to providers' operations as a home care provider. It is the provider's responsibility to understand and meet their obligations as they relate to all applicable legislation.

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In addition to this Manual, there are information resources that may further help providers understand their responsibilities and obligations as an approved provider. These Australian Government resources are available from:

- The Department of Health www.health.gov.au
- My Aged Care www.myagedcare.gov.au
- The Aged Care Quality and Safety Commission www.agedcarequality.gov.au
- Services Australia www.servicesaustralia.gov.au
- The Australian Competition and Consumer Commission www.accc.gov.au

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1 Introduction

This section discusses management of the Home Care Packages (HCP) Program Provider Manual (this manual) including how it will be updated, and how to provide feedback on the manual.

1.1 What does this manual contain?

This manual provides guidance on the Australian Government's policy context and operational requirements for the HCP Program for approved home care providers.

A HCP Program consumer manual has also been developed and is available at www.health.gov.au and www.myagedcare.gov.au. Both manuals are detailed, however, if you are looking for a high-level summary of the program, you can find information at:

- This link or by searching "Home Care Packages Program" at www.health.gov.au; or
- This link or by searching "Home Care Packages" at www.myagedcare.gov.au.

1.2 How will the manual be updated?

The Home Care Packages Program and the broader aged care system continue to operate in an environment of change.

The Department of Health ('the Department') will update the manual, as required, to ensure its currency and accuracy. The table at page five of this manual outlines the revisions that have been made since its release.

Please refer to the online version of the manual at www.health.gov.au to ensure that you have the most recent version. The footer of each page includes the issue date of the manual.

1.3 If I want to talk to someone about my questions, who can I contact?

To answer any questions you have, the My Aged Care contact centre is open Monday to Friday 8am-8pm and Saturday 10am-2pm. You can call the My Aged Care provider and assessor helpline on **1800 836 799**.

The My Aged Care contact centre is closed on Sundays and public holidays.

1.4 Who may I get additional assistance from?

The following peak bodies may be a further source of information and support for delivering aged care services generally:

Peak body	Website	Phone number
Aged & Community Services Australia (ACSA)	www.acsa.asn.au	**1300 877 855**
COTA Australia	www.cota.org.au	**(02) 6154 9740**
Federation of Ethnic Communities Councils of Australia (FECCA)	fecca.org.au/	**(02) 6282 5755**
Leading Age Services Australia (LASA)	www.lasa.asn.au	**1300 111 636**
National Aboriginal Communities Controlled Health Organisation (NACCHO) Affiliates	www.naccho.org.au	**(02) 6246 9300**
National Seniors	nationalseniors.com.au/	**(07) 3233 9198**
Older Persons' Advisory Network (OPAN)	opan.com.au/	**1800 700 600**

✓ Key points to remember

- If you are reading a printed copy of this manual, please make sure it is the most up to date version. You can find the most current version of the manual by going to https://www.health.gov.au/resources/publications/home-care-packages-program-operational-manual-a-guide-for-home-care-providers.

2 The Home Care Packages Program

This section provides an overview of the HCP Program, including the underlying philosophy and intent of the Program.

2.1 What is the philosophy underpinning Home Care?

The Department and the Australian Government seek to meet to the needs and preferences of senior Australians by placing them at the centre of aged care services. Australians are living longer and healthier lives. It is important that, as people age, they have choice about their care. Reviews into aged care have found that senior Australians do not want to be passive recipients of services.

Rather they want the opportunity to play an active role in where they live, which provider they choose to deliver their care and the ways in which services are provided. Feedback has also consistently shown that senior Australians wish to remain living independently in their own homes for as long as possible. In response, the Australian Government has progressively implemented a number of reforms to the aged care sector in order to deliver a consumer directed care (CDC) approach to aged care services.

The Australian Government funds a range of aged care services from entry level home support to residential care for high needs.

Care recipients may also contribute to the cost of their Home Care Package depending on their financial situation and the provider they choose.

Three principles underpin these programs:

This is a diagram that lists the principles. The first is that senior Australians should have access to care and services that support them to live in their own homes for as long as they can and choose to. The second is that senior Australians can and should make decisions on the care and services they receive under Commonwealth Government subsidised aged care programs. The third is that the best care outcomes come from senior Australians and home care providers working in partnership.

2.2 What is the intent of the Home Care Packages Program?

The HCP Program supports senior Australians with complex care needs to live independently in their own homes, using a consumer-directed care approach to ensure the support suits a person's needs and goals. Home care packages ('packages') deliver co-ordinated packages of care and services to meet people's assessed care needs within the limits of their individual home care budget and the

scope of the Program. How care and services are identified and delivered should reflect and respect the individual, their care needs, personal situation and preferences.

All packages are delivered using a CDC model. The aim of this approach to planning and managing care and services is to give care recipients choice and flexibility in the supports they access, based on need, and how they are delivered.

The Aged Care Quality Standards require providers to deliver safe and effective services and supports for daily living that optimise the person's independence, health, well-being and quality of life. Services and supports for daily living include, but are not limited to, food services, domestic assistance, home maintenance, transport and recreational and social activities.

These may include services and supports to keep people:

- well and independent – including personal care, nursing services, allied health
- safe in their home – including cleaning, home maintenance and modifications, assistive technology
- connected to their community – including transport, social support services.

It is important to note that a Home Care Package is not a source of income that people can use completely at their own discretion.

Providers need to work in partnership with care recipients to ensure that funding is used appropriately and transparently. Care recipients should be actively involved in deciding how their package funds are spent. This includes due consideration of the legislated exclusions from a package (discussed at Section 9).

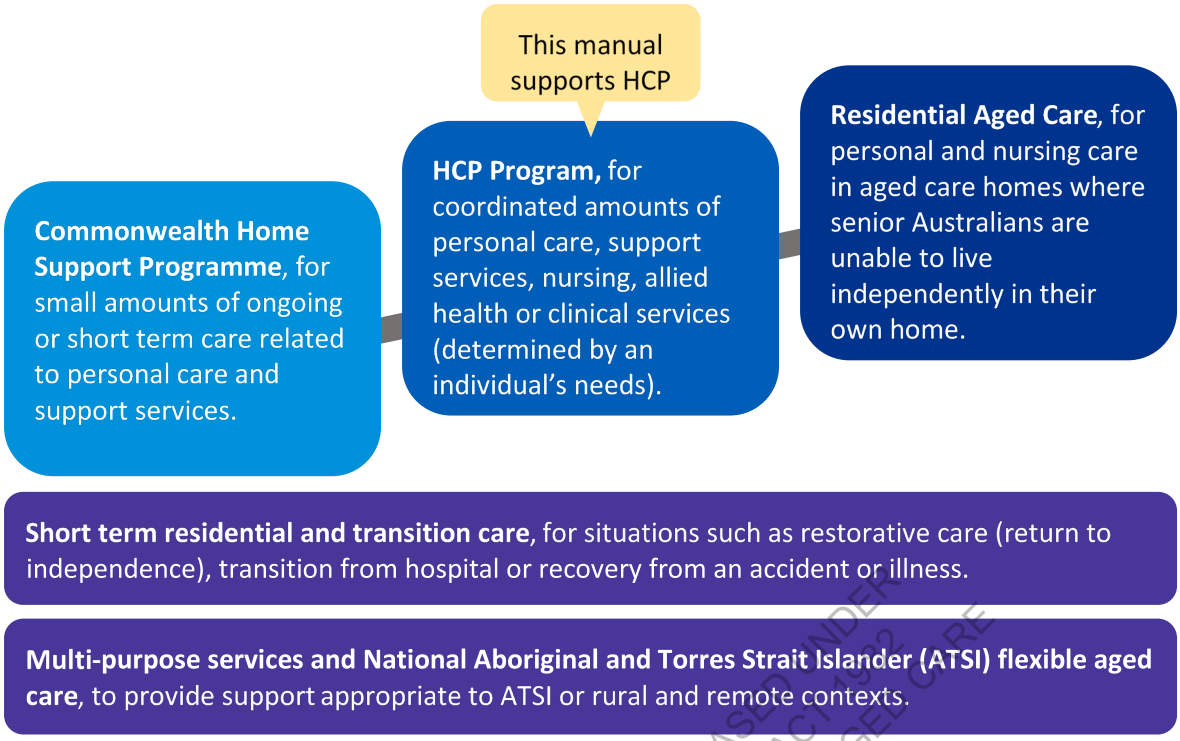
Recent changes introduced through the Improved Payment Arrangements for the Home Care Packages Program allow for greater transparency of unspent funds. These changes move the responsibility for holding the Commonwealth portion of unspent funds for care recipients from the provider to the Australian Government. This will reduce the prudential risk in home care over time and improve protections for care recipients' home care funds as the program grows. The changes also reinforce the focus on delivering services to meet consumers needs and choices. See Appendix E for more information on Improved Payment Arrangements.

Different people, and their support networks, will want different levels of involvement in planning and managing their package, including self-management. At every level, providers will need to work with care recipients to balance their duty of care with an individual's right to make choices that take reasonable risks. This right is known as 'dignity of risk' and is discussed further at Section 9.

Notwithstanding the above, an approved provider is responsible for the compliance and quality of all care and services provided under a package.

2.3 What is the scope of the Home Care Packages Program?

The HCP Program is part of the Australian Government's continuum of care for senior Australians. It addresses the level of need between the Commonwealth Home Support Programme (which offers a relatively small amount of care and support services) and Residential Aged Care (a high level of care in a residential aged care home). The following diagram outlines where the HCP Program sits within the continuum:



Access to care at home programs is determined by an independent assessment by an Aged Care Assessment Team (ACAT) or a Regional Assessment Service (RAS). My Aged Care will connect individuals to the correct assessment service for their needs (see Section 6).

Some people will receive services through flexible care or Commonwealth Home Support Programme and will then be assessed for the HCP Program; others will start their Government-supported aged care with the HCP Program. There is no requirement that anyone participates in programs earlier in the continuum of care to be eligible for the HCP Program. Further information on the interaction of these and other aged care programs is included at Section 16.

The HCP Program provides a subsidy and supplements (where an individual is eligible) towards a co-ordinated package of care, services and care management to meet each person's assessed care needs, care goals and preferences. There are four levels of packages to reflect the different levels of assessed care needs to support people to safely remain living at home.

The types of care and services that can be subsidised by the Australian Government under the HCP Program should keep people well and independent, safe in their home and/or connected to their community. Primary categories of in-scope supports are set out in the table below:

Services to keep people well and independent	Services to keep people safe in their home	Services to keep people connected to their community
• Personal care • Nursing • Allied health and therapy services • Meal preparation and diet • Specialised support	• Domestic assistance • Home maintenance • Minor home modifications • Goods equipment and assistive technology • Respite	• Transport • Social support

The HCP Program cannot be used to purchase types of care that are funded, or jointly funded, by the Australian Government through other initiatives such as the Medicare Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS). Nor can it be used toward purchasing care or services the care recipient already accesses or plans to access through another program or scheme, including those funded by State/Territory Governments. For example, aids and equipment schemes, patient transport and accommodation schemes, and sensory impairment support schemes.

Further guidance on how to decide what can be included under a package is included at Section 9**.**

2.4 How are a care recipient's care needs and goals established?

When a person enters the HCP Program, their provider should ensure they understand that person's assessed care needs and help them to establish goals for their care. The documentation from their ACAT assessment will record assessed care needs at the time of assessment, and providers will need to discuss these with them. In the time between the assessment and assignment of a package, assessed care needs may have changed. Providers are well placed to identify how these needs have changed and can be met within the framework of the existing ACAT assessment. This can be done when discussing which care and services to provide under a package.

As part of this conversation, providers and care recipients should consider any supports already in place or accessible through a carer, family members, friends, local community and other services should be considered. The package can be used to access complementary care and services, maximising the supports available.

Each individual's package should equally be directed by their personal goals. A wellness approach should be taken to delivering all care and services. Where possible and clinically appropriate, care and service should also align with reablement.

Wellness is an approach that involves the assessment, planning and delivery of supports that build on an individual's strengths, capacity and goals. This includes encouraging actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home.

Wellness as a philosophy is based on the premise that, even with frailty, chronic illness or disability, people generally have the desire and capacity to make gains in their physical, social and emotional wellbeing to live autonomously and as independently as possible.

Reablement involves short-term or time-limited interventions that are targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities. Like wellness, reablement aims to assist people to reach their goals and maximise their independence and autonomy. Supports could include training in a new skill or re-learning a lost skill, minor modification to a person's home environment or having access to equipment or assistive technology.

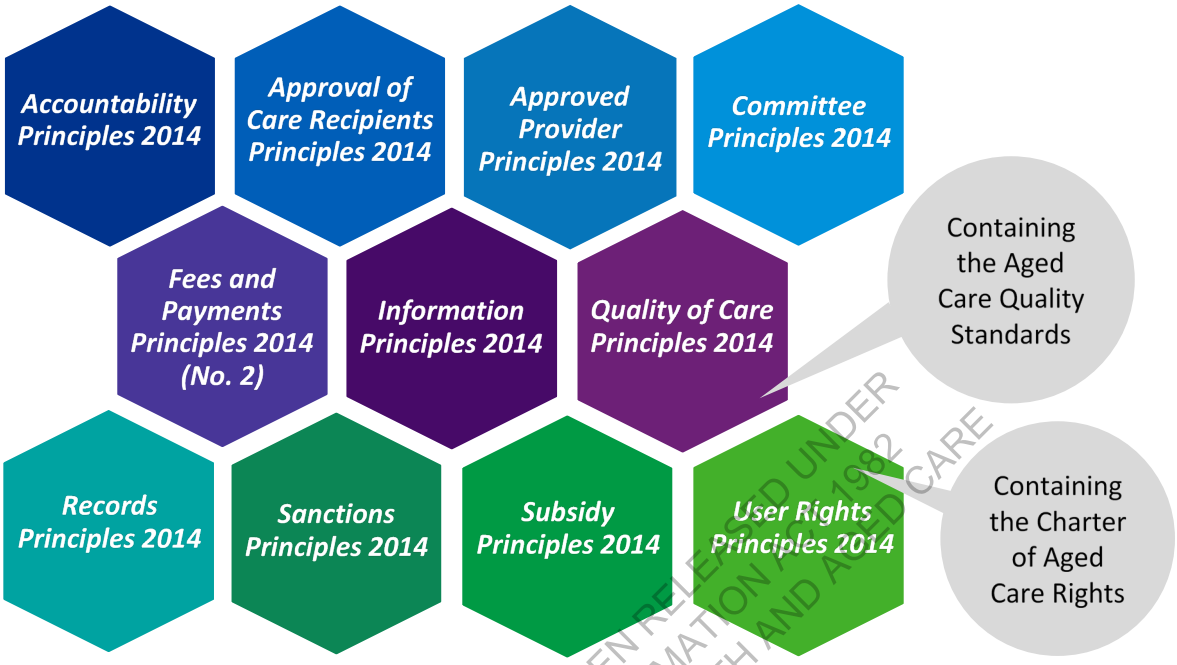
More information about wellness and reablement is at Section 7.3 of this manual.

2.5 What governs the Home Care Packages Program?

There are three tiers of laws that govern the HCP Program. These are:

- **Principal legislation.** This is the overarching law enacted by Parliament.
- **Legislative instruments.** These are subordinate legislation made with powers provided by the principal legislation. These instruments provide more details on how the HCP Program operates.
- **Determinations.** These are instruments that the legislation enables, if needed, to set out or clarify specific facts and details about the HCP Program.

For people who entered the HCP Program after 1 July 2014, the *Aged Care Act 1997* governs the HCP Program. A number of legislative instruments, titled 'Principles', have been made to support that legislation. Eleven of these Principles are relevant to the HCP Program and have been cited throughout this manual. 'The Principles' (relevant to post-1 July 2014 care recipients in the HCP Program) are listed below for reference:



One determination is relevant for post-1 July 2014 care recipients: the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

In addition to the above law, transitional provisions have been established for people who entered the HCP Program before 1 July 2014 (pre-1 July 2014 care recipients). These are established by the following legislation, instrument and determination:

- *Aged Care (Transitional Provisions) Act 1997*
- *Aged Care (Transitional Provisions) Principles 2014*
- *Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014*.

Information regarding these pre-1 July 2014 provisions is at **Appendix A** of this manual.

Finally, provider compliance and the quality of aged care is governed by the following legislation and instrument:

- *Aged Care Quality and Safety Commission Act 2018*
- *Aged Care Quality and Safety Commission Rules 2018.*

The Federal Register of Legislation is frequently updated. As a result, this manual does not include links to the legislation. You will be able to find the most recent version by searching the title of the instrument you are looking for at www.legislation.gov.au[1].

The Department does not provide advice on whether a provider's business operations are consistent with the requirements of the Act.

The Department funds the Business Advisory Service to provide accounting and business advisory services to approved providers to maximise business performance and service viability. This involves

[1] If you are not sure if you have the most recent version, you can check by looking at the top left corner of the web page. If you have the right version the words 'In force- latest version' will be marked in green above the heading 'View Series'. If it is not the current version, it will say 'In force – Superseded version' in red text.

reviewing and assessing the organisation then providing advice and business management and financial strategies. For more information go to this link or visit the website at www.pwc.com.au/health/aged-care-advisory.html.

✓ Key points to remember

- The HCP Program supports senior Australians with complex care needs to live independently in their own homes, using a consumer-directed care approach to ensure the support suits a person's needs and goals.
- The HCP Program is designed to provide more co-ordinated care and services than the Commonwealth Home Support Programme, but less intensive care than Residential Aged Care.
- The HCP Program operates using a CDC model to provide more choice and flexibility to care recipients. Providers remain responsible for ensuring the delivery of quality and appropriate care.
- The HCP Program is governed by the *Aged Care Act 1997* and a number of other laws (including the Principles) all of which must guide providers in delivering packages.

3 Rights and responsibilities

This section outlines rights and responsibilities that should underpin delivery of the Home Care Packages Program.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 54-1, 56-2, and 56-4 of the *Aged Care Act 1997*
- *User Rights Principles 2014*
- *Quality of Care Principles 2014*
- *Aged Care Quality and Safety Commission Rules 2018.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

3.1 Charter of Aged Care Rights

The *User Rights Principles 2014*, made under the *Aged Care Act 1997*, contains the Charter of Aged Care Rights. The Charter came into effect from 1 July 2019 and applies to all Australian Government funded aged care recipients of the HCP Program. The Charter consists of 14 individual consumer rights and is extracted below:

Charter of Aged Care Rights
I have the right to: 1. safe and high quality care and services 2. be treated with dignity and respect 3. have my identity, culture and diversity valued and supported 4. live without abuse and neglect 5. be informed about my care and services in a way I understand 6. access all information about myself, including information about my rights, care and services 7. have control over and make choices about my care, and personal and social life, including where the choices involve personal risk 8. have control over, and make decisions about, the personal aspects of my daily life, financial affairs and possessions 9. my independence 10. be listened to and understood 11. have a person of my choice, including an aged care advocate, support me or speak on my behalf 12. complain free from reprisal, and to have my complaints dealt with fairly and promptly 13. personal privacy and to have my personal information protected 14. exercise my rights without it adversely affecting the way I am treated.

3.2 What responsibilities do I (as an approved provider) have in relation to the Charter of Aged Care Rights?

Approved providers must not act in a way that is inconsistent with the Charter of Aged Care Rights. Providers also have responsibilities, in relation to the Charter to:

- Give consumers a copy of the Charter signed by a staff member of the provider.
- Give the consumer information about their rights under the Charter.
- Assist the consumer to understand their rights under the Charter.
- Ensure the consumer, or their authorised person, is given a reasonable opportunity to sign a copy of the Charter.
- Keep a record of the Charter given to the consumer, which includes the:
  - signature of a staff member of the provider;
  - date on which the provider gave the consumer a copy of the Charter;
  - date on which the provider gave the consumer (or their authorised person) a reasonable opportunity to sign the Charter;
  - consumer (or authorised persons)'s signature (if they choose to sign); and
  - full name of the consumer (and authorised person, if applicable).

Providers must offer all consumers the choice to sign the Charter of Aged Care Rights. They are not required to sign and can receive care and services if they choose not to sign.

Asking the consumer to sign provides them with an opportunity to acknowledge that their provider has given them a copy of the Charter, has assisted them to understand it and that they understand their rights. Providers must meet all the consumer rights in the Charter of Aged Care Rights whether they sign their copy or not.

Resources to support the sector's understanding of the Charter, including a booklet, are available on the Department's website at this link, or by searching "Charter of Aged Care Rights" at www.agedcarequality.gov.au.

3.3 What responsibilities do aged care consumers have in relation to the Charter of Aged Care Rights?

All people involved in aged care – care recipients, their families, carers, visitors and the aged care workforce – must respect and be considerate of each other. Quality aged care outcomes are more likely to be achieved in an environment of mutual respect. Aged care consumers are expected to:

- give providers the information they need to properly deliver care and services;
- comply with the conditions of their Home Care Agreement and pay fees outlined in the agreement on time; and
- respect the rights of aged care workers to work in a safe environment. Any kind of violence, harassment or abuse towards staff or others is not acceptable.

Home Care Agreements have terms and conditions that set out the rights and responsibilities of the parties who have entered into the agreement. Home Care Agreements are discussed in detail at Section 6.

3.4 What responsibilities do I have as an approved provider?

Approved providers must understand and comply with a range of provider responsibilities under the law. For information on responsibilities under the aged care legislation, see **Appendix D**.

Security of tenure

As part of responsibilities outlined in **Appendix D** providers are bound by security of tenure. Security of tenure means providers must deliver the agreed care and services for as long as the care recipient needs those services. Providers may only stop delivering home care where the requirements under the *User Rights Principles 2014* are met. Section 17 of the *User Rights Principles 2014* provides:

Exceptions to security of tenure

(1) For paragraph 56-2(f) of the Act, this section specifies the security of tenure that an approved provider of home care must provide to a care recipient to who the approved provider provides, or is to provide, home care.

(2) The approved provider may cease to provide home care to the care recipient only if:

(a) the care recipient cannot be cared for in the community with the resources available to the approved provider; or

(b) the care recipient notifies the approved provider, in writing, that they wish to move to a location where home care is not provided by the provider; or

(c) the care recipient notifies the approved provider, in writing, that they no longer wishes to receive the home care; or

(d) the care recipient's condition changes to the extent that:

(i) the care recipient no longer needs home care; or

(ii) the care recipient's needs, as assessed by an aged care assessment team, can be more appropriately met by other types of services or care; or

(e) the care recipient:

(i) has not paid to the approved provider, for a reason within the care recipient's control, any home care fee specified in the Home Care Agreement between the care recipient and the approved provider; and

(ii) has not negotiated an alternative arrangement with the approved provider for payment of the home care fee; or

(f) the care recipient has:

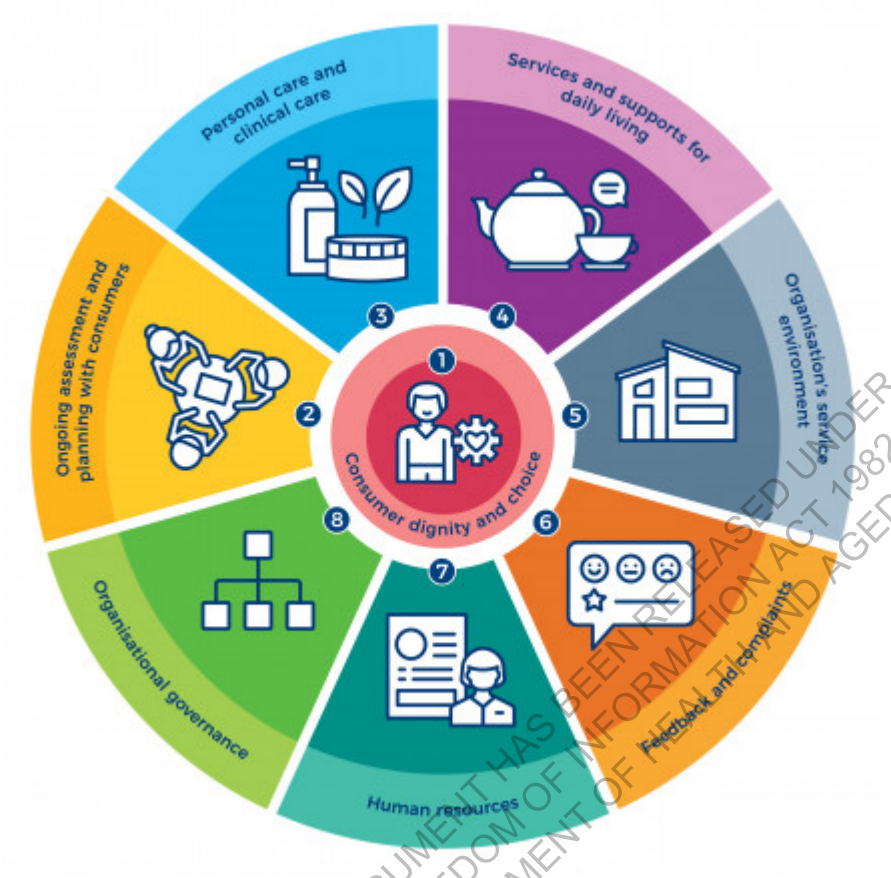
(i) intentionally caused serious injury to a staff member (as defined in section 63-1AA of the Act) of the approved provider; or

(ii) intentionally infringed the right of a staff member (as defined in section 63-1AA of the Act) of the approved provider to work in a safe environment.

Note: an approved provider of aged care is an organisation that has been approved to provide residential care, home and/or flexible care under the *Aged Care Act 1997.* For more information on becoming an approved provider see Section 4.

3.4.1 Aged Care Quality Standards

Providers are also responsible for delivering quality care and services in a way that complies with the Aged Care Quality Standards ('the Standards'). All approved providers will be assessed against these standards and they must be able to provide evidence of their compliance with, and performance against, all the Standards.



The Standards focus on outcomes for consumers and reflect the level of care and services the community can expect from organisations that provide Australian Government funded aged care services. The Standards are made up of eight individual standards, outlined in the following diagram:

Source: Aged Care Quality and Safety Commission

The Standards are at this link, or can be found by searching "Download the Aged Care Quality Standards images" at www.agedcarequality.gov.au.

The Aged Care Quality and Safety Commission (the Commission) has developed the *Guidance and Resources for providers to support the Aged Care Quality Standards* (Guidance and Resources). It describes the Commission's expectations and provides supporting information, suggested practices, examples and evidence required to ensure compliance. It also indicates any matters that quality assessors will consider in evaluating compliance. It is available at this link or by searching "Quality Standards" at www.agedcarequality.gov.au and clicking on 'Quality Standards'.

3.5 How is compliance with the Aged Care Quality Standards assessed?

The Commission conducts quality reviews to assess whether approved providers deliver care and services in accordance with the Quality Standards. It also monitors quality through assessment contacts.

The Commission's quality assessors assess provider performance against the Quality Standards by collecting evidence and arriving at findings based on this evidence. Quality assessors collect evidence through:

- interviewing consumers or representatives;
- interviewing staff and management;
- sampling consumer records;
- reviewing documents such as policies, procedures, agreements and registers; and/or
- observing the environment, activities in progress and any interaction with consumers or representatives.

These assessment and monitoring processes are undertaken in accordance with the *Aged Care Quality and Safety Commission Rules 2018,* established under the *Aged Care Quality and Safety Commission Act 2018*. The rules can be located by searching "Aged Care Quality and Safety Commission Rules" at www.legislation.gov.au.

Through engagement and education work the Commission aims to build confidence and trust in aged care, empower consumers, support providers to comply with quality standards, and promote best practice service provision. Further information about the Commission's functions are available at this link, or by searching "Providers" at www.agedcarequality.gov.au/.

Further information regarding the Commission's assessment and monitoring process is available on the Commission's website at www.agedcarequality.gov.au/.

✓ Key points to remember

- The Charter of Aged Care Rights provides the same rights to all consumers, regardless of the type of Australian Government funded aged care and services they receive, including the HCP Program. Quality aged care outcomes are best achieved in an environment of mutual respect.
- All supports provided as a part of a home care package need to be delivered in a way that is cognisant of and compliant with the Aged Care Quality Standards.
- All approved providers are responsible for understanding and complying with all relevant responsibilities under the law.

4 Becoming an approved provider

To deliver care under the HCP Program, an organisation must become an approved provider. An approved provider of aged care is an organisation that has been approved to provide residential care, home and/or flexible care under the *Aged Care Quality and Safety Commission Act 2018* (the Act). Approved providers must comply with their responsibilities under the *Aged Care Act 1997.*

This section explains who can become an approved provider, how to complete the application process to become an approved provider, and what steps an organisation needs to take (if it gets approval as an approved provider) in order to provide services.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 54-1 and 63-1 of the *Aged Care Act 1997*
- *Aged Care Quality and Safety Commission Act 2018.*
- *Quality of Care Principles 2014*
- *Accountability Principles 2014*
- *Sanctions Principles 2014*.

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

4.1 What considerations do I need to satisfy to become an approved provider of Home Care Packages?

To be approved as a provider of aged care under the Act, providers must satisfy the matters established in Part 7A of the *Aged Care Quality and Safety Commission Act 2018*. Further information about becoming an approved provider is available at this link or by searching "Becoming an approved aged care provider" at www.agedcarequality.gov.au. To be approved, applicants must satisfy the following considerations:

Consideration 1.	Consideration 2.	Consideration 3.	Consideration 4.
The applicant must make the application in writing using the approved form.	The applicant's organisation must be incorporated.	The applicant must be suitable to provide aged care.	The applicant must not have any disqualified individuals as key personnel.

4.1.1 Application process

To become an approved provider, an applicant needs to apply in writing. Corporations must apply using whichever of the forms is most applicable to their circumstances. You can access all application forms at this link, or by searching "Becoming an approved aged care provider" at www.agedcarequality.gov.au.

The table below outlines the forms that can be used to apply, and the circumstances in which an applicant should use each form.

1. New applicant	2. Existing service provider	3. Government organisation
This form is for organisations that are not currently approved to provide any type of care under the Act. **Note**: if the applicant is an approved provider of Commonwealth Home Support Programme only, and wants to provide home care, they must apply as a new applicant.	This form is for an existing approved provider that wants to provide another care type. Because existing approved providers have already had their suitability to provide aged care approved through a previous assessment process, the application form seeks specific detail to assess suitability to provide home care.	States, Territories, authorities of a State or Territory and local government authorities are taken to be approved in respect of all types of aged care. A simplified form has been developed for these Government organisations to enable the creation of a Departmental record and payment of subsidies to the organisation.

If you need further guidance, please see this link, or search "Guidance for applicants seeking to provide aged care" at www.agedcarequality.gov.au.

4.1.2 Incorporated organisations

Only organisations that are incorporated are eligible to become an approved provider of home care, residential care or flexible care. This means that if the applicant is a sole trader, partnership or other unincorporated entity, they cannot be approved as a provider of aged care under the Act and the application cannot be accepted. Definitions of each of these organisation structures can be found at www.business.gov.au.

States, Territories and local governments are automatically approved to provide aged care.

4.1.3 Suitability to provide aged care

Part 7A of the *Aged Care Quality and Safety Commission Act 2018* lists the areas each applicant must be assessed against. These are:

1. Experience in providing aged care or other relevant forms of care
2. Understanding of approved provider responsibilities
3. Systems it has, or will have, in place to meet these responsibilities
4. Record of financial management and the methods used, or proposed to ensure sound financial management
5. Conduct as a provider (including compliance with responsibilities as a provider) and obligations arising from the receipt of any payments from the Australian Government for providing aged care (if the applicant has been a provider of aged care).

It is up to the applicant to effectively demonstrate how and why their organisation meets these suitability considerations.

4.1.4 Key personnel

Identifying key personnel is a critical component of becoming an approved provider. Applicants must ensure they understand the meaning of key personnel and establish who within the organisation meet this definition. Key personnel are:

- People responsible for the executive decisions of the applicant (this includes directors and board members), whether or not the person is employed by the applicant;

- People having authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the applicant, whether or not the person is employed by the applicant;
- Any person responsible for nursing services provided, or to be provided, by the applicant, whether or not the person is employed by the applicant; and
- Any person who is, or is likely to be, responsible for the day-to-day operation of an aged care service conducted, or proposed to be conducted, by the applicant, whether or not the person is employed by the applicant.

There are specific requirements about who can/cannot be key personnel. Key personnel cannot be a disqualified individual. A disqualified individual is someone who has been convicted of an indictable offence, is insolvent or under administration, or is of unsound mind. Each State and Territory law identifies different types of offences as being indictable. These typically include serious offences such as murder, manslaughter, the intentional or unlawful administration of drugs or poisons, or committing fraudulent or dishonest activities. The applicant must also be certain that none of their key personnel are disqualified.

Under the *Sanctions Principles 2014*, all approved providers, including those providing home care, have ongoing responsibilities to continue to ensure key personnel meet the requirements about who can/cannot be key personnel as outlined in the Act. They also have reporting obligations if changes to key personnel materially affect their suitability to provider care, including if they become disqualified, or if changes to key personnel affects the organisation's contact details. This is discussed at Section 15 of this manual.

4.2 How do I know if I have been approved to provide packages?

Applicants must be notified if they have or have not been approved as a provider of aged care within 90 days of receiving a complete application. Applications cannot be assessed unless all the required documents have been provided. Applicants may be asked to provide additional information resulting in delays assessing their application.

Alternatively, applications may not be accepted and will be returned. In these cases, applicants will be informed of the reason the application was not accepted. If an applicant is required to provide further information, they will have 28 days to submit this. Once the information is received, a further 90 day timeframe for decision applies. Once an application is deemed complete, the applicant will receive written confirmation and advice that the application has progressed to assessment.

If the applicant is approved to provide aged care, they will receive a letter which includes the National Approved Provider System (NAPS) ID. You can find more information on NAPS at Section 5 of this manual.

4.2.1 Appeals pathways (if you are dissatisfied with the outcome of the assessment)

If the applicant would like reconsideration of the assessment of their application, they should submit a notice in writing within 14 days of receiving the decision letter. The request must detail the reasons for making the request and should take into account the reasons that the application was not approved. Reconsideration requests can be submitted by emailing approvedproviderapplications@agedcarequality.gov.au.

A different decision maker then reconsiders the decision, and decides whether to confirm, vary, or set the decision aside and substitute a new decision.

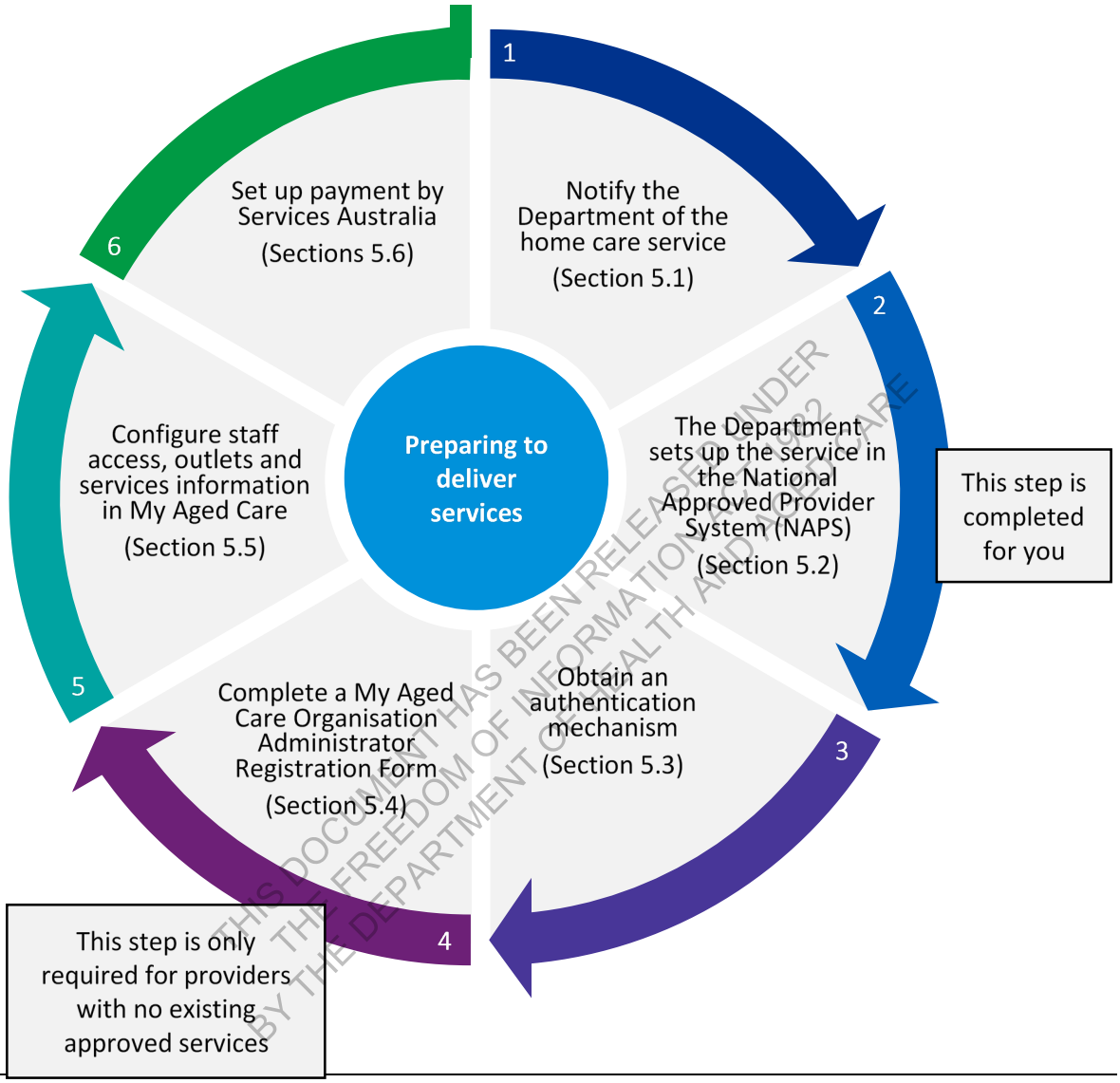
If the applicant wishes to appeal the outcome of the reconsideration they can make an application to the Administrative Appeals Tribunal (AAT).

You can find information on making an application to the AAT at www.aat.gov.au/.

✓ Key points to remember

- In order to provide Government-subsidised home care under the HCP Program, an organisation must be an approved provider.
- To become an approved provider, an organisation must be a corporation, and must show that they can meet the suitability matters and have the ability to provide quality aged care services.
- Organisations will need to apply to the Aged Care Quality and Safety Commission to become an approved provider.

5 Preparing to deliver services as an approved provider



This section provides information on each of the activities providers need to complete before they can deliver services as an approved provider. It includes processes, requirements and systems. These steps may be completed in a different order to suit provider needs. The diagram below outlines an order that may be helpful for providers.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 9-1A and 63-1 of the *Aged Care Act 1997.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

5.1 How do I notify the Department of my home care service?

Providers who have been approved will receive a confirmation approval letter from the Aged Care Quality and Safety Commission advising of their approved provider status and National Approved Provider System (NAPS) ID. This is also known as the Provider NAPS ID. Providers then need to notify the Department of the home care services that they will provide. This can be done by completing the **"Home Care Service Notification form"**. The form can be found at this link or by searching "Notification of changes for Home Care Packages" at www.health.gov.au.

A separate form must be submitted for each home care service from which providers intend to provide home care. This form must be lodged before starting to provide care through that service. Providers must do this to be able to claim and receive subsidies for home care services.

Once the **"Home Care Service Notification form"** has been submitted, the provider will receive an email with a tracking ID and a PDF of the completed form.

There are specific processes for moving home care services to another approved provider, merging home care services and combining home care services. Information on these is in Section 13.5.

5.2 How does NAPS registration work?

The Department will directly submit **"Home Care Service Notification forms"** to the most relevant State or Territory office for processing.

The state-based team will enter the details into the NAPS system. The provider will be notified by email once the information has been processed (new services or changes to existing services) and will receive a Service ID for any new services. It is important to note that it can take up to 48 hours for a new service to appear in My Aged Care.

The provider can use this Service ID to submit claims to the Services Australia.

5.3 How do I obtain authentication mechanism?

New providers will need an authentication mechanism to securely access and use the My Aged Care system.

From late March 2020, My Aged Care will support the following login methods:

- VANguard Federated Authentication Service (FAS); and
- myGovID and Relationship Authorisation Manager (RAM).

VANguard FAS

VANguard FAS integrates with an organisation's local network, allowing individuals to reuse their username and password to access external agencies without sharing the user's credentials. Staff authenticate once with their My Aged Care portal with subsequent authentications being transparent to the user.

VANguard FAS provides:

- Users with an improved login experience – allowing users to Single Sign On to My Aged Care using their own organisation credentials;
- Organisations with a single place to manage their authorisations – user access is controlled through an organisation's existing on-boarding and off-boarding procedures.

VANguard FAS is delivered by the Department of Industry, Innovation and Science (DIIS) and is suitable for any organisation with corporate network infrastructure that includes a Single Sign-On System (e.g. Active Directory Federation Server). There are no fees payable to DIIS for using FAS.

To find out more or get started with FAS, organisations can email the VANguard service desk at VANguard.Customer@industry.gov.au with their contact details and organisation name, phone number and email address.

myGovID and RAM

The Australian Taxation Office has introduced a flexible and secure way to access Government online services. These are:

- myGovID – an authentication service that allows you to prove who you are online. It is different to your myGov account.
- Relationship Authorisation Manager – an authorisation service that allows you to act on behalf of an organisation online when linked with your myGovID.

Together, myGovID and RAM offer a secure login experience:

- Users log in by authenticating with their myGovID app each time they access My Aged Care, protecting their digital identity.
- Organisations use RAM to control user access to Government online services from a single place.

myGovID and RAM form a whole-of-government solution that can be used to access many other Government online services.

5.4 How do I complete the My Aged Care Administrator Form?

Providers with no existing Provider Portal administrators will need to nominate an Organisation Administrator by completing and submitting the **"My Aged Care Organisation Administrator Registration Form"** located at this link or by searching "My Aged Care – Organisation Administrator Registration Form" at www.health.gov.au. The Department will email this form to providers at the appropriate time.

This allows the Department to set up the initial administrator for a provider organisation, to allow access to the Provider Portal. Once the Organisation Administrator registration form has been processed, the Department will contact the Organisation Administrator via email regarding next steps.

The nominated Organisation Administrator will be the first person from a provider organisation to log into the portal. They will be responsible for setting up staff access and managing the organisation's information and portal structure. The My Aged Care Assessor Portal – Organisation Administrator User Guide is available at this link or by searching "Organisation Administrator User Guide" at www.health.gov.au. Additionally, the My Aged Care – Provider Portal User Guide: Part 1 Administrator Functions is available at this link or by searching "My Aged Care – Provider Portal User Guide Part 1" at www.health.gov.au.

Established users can then set up 'Outlets' and 'Services' in the portal and add the organisation's service information. Once the service item is 'Operational' and the outlet is 'Active', referrals can be received from My Aged Care. The My Aged Care – Provider Portal User Guide: Part 2 is available at this link or by searching "My Aged Care - Provider Portal User Guide Part 2" at www.health.gov.au.

Note: the Department recommends the initial administrator sets up other staff in a provider organisation as Organisation Administrators to allow for back up access.

Providers can find the My Aged Care Provider Portal at this link or by searching "For service providers" at www.myagedcare.gov.au.

5.5 How do I configure my information in the My Aged Care Provider Portal?

The My Aged Care Provider Portal is a web-based platform that allows providers to self-manage information about the services they provide. This information is displayed on the public 'find a provider' tool on the My Aged Care website, and is used by care recipients and their carers to search and compare potential home care providers that can best meet their assessed care needs in their preferred location. It is also used by My Aged Care contact centre staff and assessors to refer people to service(s). It allows providers to accept and reject referrals.

It is essential that providers ensure all of their information on this platform is current, correct and complete. It should be written for care recipients in plain English with enough detail to support their decision-making. A Quick Reference Guide on the procedures for creating and maintaining information about service delivery outlets is available at this link, or by searching "My Aged Care Process Overviews – Home Care Packages" at www.health.gov.au.

As an approved provider, details of services are automatically listed within the 'find a provider' tool. Providers, however, will need to ensure that these details are complete.

Providers can set up 'Outlets' and 'Services' in the portal and add the organisation's service information. Once the service item is 'Operational' and the outlet is 'Active', referrals can be received from My Aged Care.

At a minimum, this must include pricing information. New pricing requirements were introduced on 1 July 2019 to improve transparency for senior Australians, to enable direct comparisons between providers, and to curb problematic charging practices by some providers. Information on providers' pricing obligations are at **Appendix B**. Providers can also list other information on the 'find a provider' tool, which can help promote their services. This could include:

- cultural specialisations;
- religious specialisations;
- languages other than English that carers speak;
- specialised services; and/or
- ability to provide services to individuals with diverse needs.

Guidance on completing the 'specialisations' section of the provider portal is available from this link or by searching "My Aged Care Provider Portal User Guide" on www.health.gov.au.

Providers can configure this information, and their financial information, at an organisation and/or outlet level. This means that a larger provider can set up information for all the outlets they have, and then let the outlets provide further information, or amend the provided information, as required. A smaller provider can set all their information up at one time.

The Department expect providers' service information to meet their requirements for managing service information in the 'find a provider' tool on My Aged Care. The Department can choose to remove organisations who do not comply. The requirements include:

- the same service, with the same NAPS Service ID, must only be listed once per location i.e. the service must only appear once in the search results for that location;
- outlet and service item names must not include phone numbers or marketing slogans; and
- service delivery areas must reflect only those locations where the provider can deliver service.

Further information on these requirements is available at this link, or by searching "Managing your home care service information" at www.health.gov.au.

5.6 How do I set up payment of subsidies with Services Australia?

Services Australia administers payments for aged care subsidies and supplements (where relevant) on behalf of the Department. Providers will need to set up their organisation with Services Australia to make claims for services and receive payments. They will need to complete and return the following forms to Services Australia:

- **"Aged Care approved provider statement form"** (AC003). AC003 is at this link, or can be found by searching "AC003" at www.servicesaustralia.gov.au.
- **"Register, amend or remove users for Aged Care Provider Portal form"** (AC004). AC004 is at this link, or can be found by searching "AC004" at www.servicesaustralia.gov.au.
- **"Application to add or change approved care service's bank details form"** (AC015). AC015 is at this link, or can be found by searching "AC015" at www.servicesaustralia.gov.au.

For more general Services Australia information, see this link or search "Aged care providers" at www.servicesaustralia.gov.au.

✓ Key points to remember

- If an organisation is approved as an approved provider, there are six administrative tasks that need to be completed before they can provide services to care recipients. These are outlined in the diagram at the start of this section, but can be summarised as:

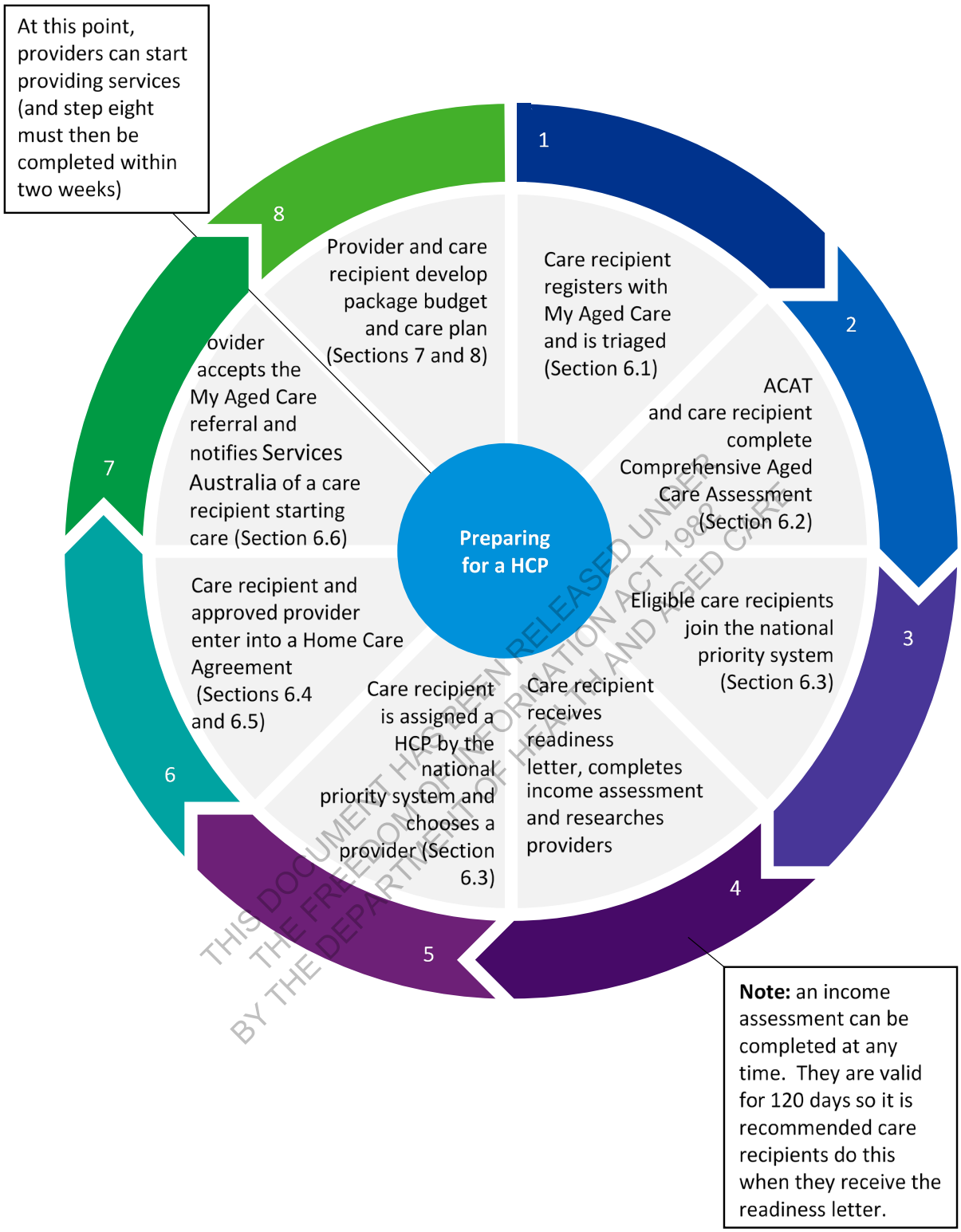
1. Notify the Department of the Home Care service
2. The Department sets up the service in the National Approved Provider System (NAPS)
3. Obtain an authentication mechanism
4. Complete a My Aged Care Organisation Administrator Form
5. Configure staff access, outlets and services information in My Aged Care
6. Set up payment by Services Australia.

Providers can complete these steps in a different order if they would like. If providers follow the above order, this process may run more smoothly.

6 Eligibility for care recipients to receive Australian Government-funded packages

This section sets out the steps that people need to take to receive services under a package. This information has been provided to support providers to help care recipients navigate this process, if needed. This section also sets out the steps that providers need to take after an individual has been assigned a package, but before they can start providing Government-subsidised home care services to that individual.

Note: care plans need to be reviewed regularly during the course of delivering a home care package. This review process is discussed at Section 10.3.



Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section

Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 56-2 and 63-1 of the *Aged Care Act 1997*
- *Accountability Principles 2014*

- *User Rights Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

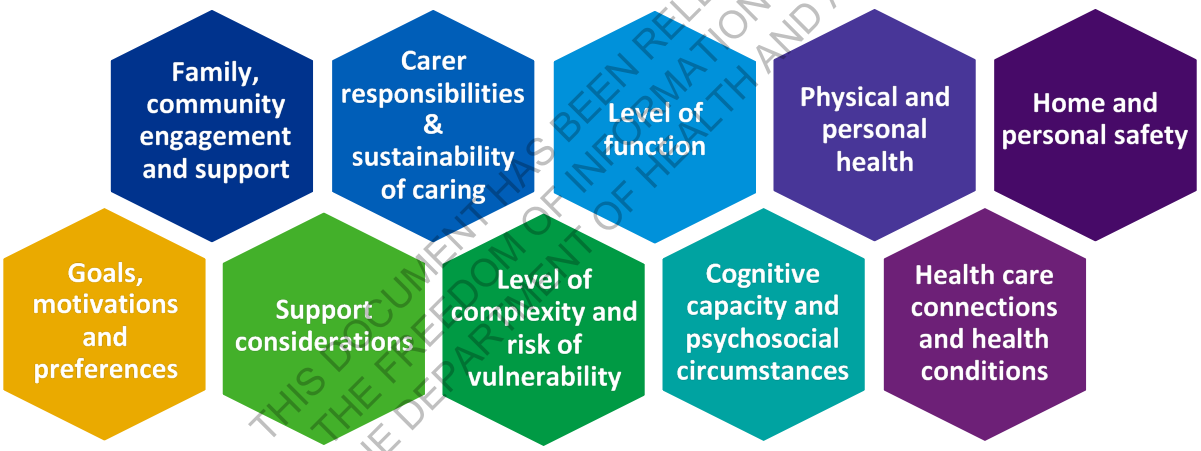
See **Appendix D** for further detail on specific provider responsibilities.

6.1 How do care recipients start the process to get a package?

Care recipients and/or their representative complete screening with My Aged Care to determine their pathway to aged care services. They can do this by calling the My Aged Care contact centre on **1800 200 422** which will generate a reference for a face-to-face assessment based on the information given at the screening. If this information indicates a comprehensive assessment is required, the My Aged Care contact centre will refer them to an ACAT to conduct the assessment.

6.2 What is a comprehensive aged care assessment and how does it work?

Eligibility for the HCP Program is assessed by an ACAT. The comprehensive assessment will consider:



The assessment identifies an individual's strengths and areas of difficulties across these factors, which will be considered as the assessor works with them to develop a support plan. In some instances, it may be appropriate to use a supplementary assessment tool clarify their individual needs further.

The assessor will make recommendations based on the person's care needs at that time. After conducting a comprehensive assessment, an ACAT will send their assessment findings and recommendations to the ACAT delegate to determine eligibility for aged care services under the Act. Information on how to prepare for an assessment and what to expect has been provided in the HCP Program Consumer Manual.

Everyone assessed will receive the outcome of their assessment by mail. The letter will contain the assessment decision confirming eligibility for a package, the level of package approved (if eligible), the reasons and evidence supporting the decision and a copy of their support plan developed during their assessment.

6.3 What is the national priority system?

The national priority system is the system that assigns packages. Once a person is assessed as eligible, they will be placed in the national priority system, where they will wait for the assignment of a package. They will not be able to access Australian Government subsidised home care services under the HCP Program until they have been assigned a package.

The national priority system ensures the equitable assignment of packages based on a person's assessed care needs and circumstances; not where they live. The system only takes into account:

- priority for home care services as determined by the ACAT during the comprehensive assessment; and
- the date of approval for home care at that level.

People who were actively seeking care at the time of their approval will be automatically placed in the national priority system and set as 'seeking services'. They will receive a package as soon as one is available based only on the above two factors.

Those who are not actively seeking care at the time of their approval should inform their assessor. They will then be set as 'not seeking services', and will not be assigned a package until they are advised otherwise. If someone who was 'not seeking services' wishes to be assigned a package, they will need to indicate that they are actively seeking care. Following this, they will be assigned a package as soon as one is available.

A person can request to be set as 'seeking services' or 'not seeking services' at any point. This can be done by calling the My Aged Care contact centre on **1800 200 422**, or by using the My Aged Care Client Portal at this link, or by searching "View your My Aged Care client record" at www.myagedcare.gov.au.

The Department releases packages regularly, generally weekly, as indicated by the national priority system. The number of packages released at each level takes into account the number of new packages that are available, as well as the number of packages that other people have left or not accepted in previous weeks. Projected wait times for a package are available in time-bands in the client portal.

6.4 What does a person need to do to be assigned a package (after they have been assessed as eligible)?

Eligible home care recipients will receive a letter notifying them that they have been assigned a package.

After being assigned a package, people have 56 calendar days from the date their package is assigned to find an approved provider and enter into a Home Care Agreement that best meets their needs. If someone wants more time to find a suitable provider, they can contact the My Aged Care Contact Centre and request a 28 day extension, giving them a total of 84 calendar days to enter into a Home Care Agreement.

If the person has not entered into a Home Care Agreement within 56 calendar days (or 84 calendar days with the extension), the package is withdrawn. This means the package is no longer assigned to them, and approved providers are not able to claim a subsidy.

If a person is assigned an interim package and it is withdrawn they will stay on the national priority system to wait for their approved level of package. Interim packages are discussed further at Section 6.4.1.

If a person is assigned their approved level of package and it is withdrawn, they will be removed from the national priority system. If they later decide they want to receive services through a package, they need to re-join the national priority system by calling My Aged Care. People who re-join the national priority system will have their date of entry recorded as the date they were originally approved for home care at that specific package level.

Providers may receive a referral in the provider portal through one of two ways:

- a system generated referral – created either by the My Aged Care contact centre or by a member of an ACAT; or
- a direct referral – direct receipt of a person's referral code e.g. an eligible person has presented their package assignment letter and requested that the provider deliver their services.

From the referral record providers can view the referral summary and a person's record. This will help them make an informed decision about whether they can deliver the services required by the person and when they need services to start.

Detailed information on managing referral care recipients' records on My Aged Care is available at this link or by searching "My Aged Care for service providers" on www.health.gov.au.

6.4.1 Interim package

People eligible for a home care package have the option of receiving a package at a lower level than they are approved for, as an interim arrangement while waiting. There may still be a wait for an interim package, however this wait would be less. An ACAT will help determine if an interim package is appropriate.

No one will be disadvantaged if they receive an interim package, and they will not wait longer to receive a package at their approved level. An interim level package simply allows them to connect with care and services while they wait for their approved package level. For clarity, either accepting or not accepting an interim package will have no impact on the wait time for the approved package level.

People can call My Aged Care on **1800 200 422** at any time to indicate that they are willing to accept a package at a lower level as an interim arrangement.

Anyone on an interim package will automatically be assigned a higher level package (up to their approved level) when one is available.

The person will receive a letter advising them of the change and their provider will receive a notification of the new package level in the Provider Portal. It is important to keep people's contact details current in their My Aged Care client record so they get their notification letter.

Payment at the higher level will commence immediately. The provider must review the assessed care needs with the care recipient when a higher level package is assigned to ensure best use of the funds to meet their needs.

Care recipients who decide they are happy with an interim package, and their assessed care needs are being met by the package, should indicate that they are 'not seeking services' by calling the My Aged Care contact centre. This will ensure they are not automatically assigned a higher level package. They must do this before they are assigned a higher level package as, it cannot be declined after it is assigned. If a person on an interim package does this, they can opt in to 'seeking services' at a later date if their needs increase to access their approved level package.

6.5 What should I include in a Home Care Agreement?

When someone chooses an organisation as their approved provider, the provider should enter into a Home Care Agreement with them before starting to deliver services. Providers cannot charge people for entry to services.

The Home Care Agreement sets out the terms and conditions by which a provider will deliver care and services to a care recipient. It is the legal contract between a provider and a care recipient and captures each parties' responsibilities. It is critical that providers seek legal advice and assistance in drafting agreements.

The Act and Principles set out strict conditions by which the Home Care Agreement must comply. It is essential that providers understand the requirements under the Act.

A Home Care Agreement for people who started receiving services after 1 July 2014 must be written in plain English that is readily accessible. It must not contain any provision that would have the effect of the care recipient being treated less favourably in relation to any matter than they would otherwise be treated under any law of the Commonwealth in relation to the matter. Finally, it must include the following:

6.5.1 Relationship with the care recipient

#	Requirement	Legislation citation
1	A statement specifying that home care will be delivered on a CDC basis. CDC has been discussed at Section 2.1 of this manual.	Section 23(2)(b)(i) of the *User Rights Principles 2014*
2	A statement specifying the care recipient's rights in relation to decisions about the care and services that are to be provided. CDC has been discussed at Section 2.1 of this manual. **Note**: any changes to the Home Care Agreement must be agreed through informed, mutual consent of the provider and the care recipient. Variation of the Home Care Agreement is discussed at Section 6.5.5.	Section 23(2)(b)(iv) of the *User Rights Principles 2014*
3	A statement outlining: • that a care recipient is entitled to make a complaint about the provision of their care and services without fear of reprisal; and • the complaints mechanism the provider has in place. For more information on designing a complaints mechanism see Section 10.	Section 61-1(1)(f) of the *Aged Care Act 1997* Section 23(4) of the *User Rights Principles 2014*
4	A statement outlining any responsibilities of the care recipient as a recipient of home care from the service.	Section 61-1(1)(g) of the *Aged Care Act 1997*

6.5.2 Care and services

#	Requirement	Legislation citation
5	The date the provider will start to provide home care to the care recipient. If they are transferring from another provider, please see Section 13 of this manual.	Section 23(2)(a) of the *User Rights Principles 2014*
6	A statement specifying the level of home care to be provided. This will be the package level that the care recipient has been assigned. This process has been discussed at Section 6 of this manual.	Section 23(2)(b)(iii) of the *User Rights Principles 2014*
7	A statement specifying the care and services that the care recipient will receive. This will also need to be outlined in the care plan, as discussed in Section 7 of this manual.	Section 23(2)(b)(ii) of the *User Rights Principles 2014*
8	A statement specifying that the provider will give the care recipient copies of their care plan and package budget, including any updated copies if the provider and the care recipient make any changes to the care plan and package budget. Home Care Agreements entered into before 1 July 2015 do not need to be updated to include this provision. In practice, however, providers must provide their care recipients with these documents.	Section 23(2)(b)(v) of the *User Rights Principles 2014*
9	A statement that the care recipient may suspend, on a temporary basis, the provision of home care (known as taking leave) if the provider is notified. Leave has been discussed more generally at Section 11 of this manual.	Section 23(2)(f) of the *User Rights Principles 2014*
10	The amounts that the care recipient will be liable to pay to the approved provider for any period of suspension. Fees payable during suspension (leave) are discussion at Section 11 of this manual.	Section 61-1(1)(e) of the *Aged Care Act 1997*

6.5.3 Pricing and budget

#	Requirement	Legislation citation
11	A statement of home care fees that the provider will charge to the care recipient. **Note**: the discussion at Item 13 of this table, below.	Section 23(2)(c)(i) of the *User Rights Principles 2014*
12	A statement of the policies and practices that the provider will follow in setting the fees that the care recipient will be liable to pay to the approved provider for the provision of the care and services. Fees are discussed at Section 8 of this manual.	Section 61-1(1)(c) of the *Aged Care Act 1997*

#	Requirement	Legislation citation
13	A copy of the provider's Schedule as published on My Aged Care. This is discussed further in **Appendix B** of this manual. In short, all agreements entered into after 1 July 2019 must comply with the new pricing requirements. All prior agreements must be updated to become compliant by 1 July 2020. The prices under the Agreement must be the same as those in the pricing schedule unless the provider and care recipient discuss and agree to a variation in pricing. If the provider and care recipient reach agreement on a variation, this must be documented within the Home Care Agreement. If the care recipient is to be charged an amount of the basic daily fee (discussed in Section 8 of this manual) that is different from the amount of the fee in the schedule, the provider and care recipient must also reach agreement on a variation, and this must be documented within the Home Care Agreement.	Sections 23(2)(ba)-(bc) of the *User Rights Principles 2014* Section 23(2)(c)(ii) of the *User Rights Principles 2014*
14	A statement specifying that the provider will give the care recipient a statement of the available funds and expenditure in respect of each month for the care and services provided to the care recipient during the month (a monthly statement). Monthly statements have been discussed further at Section 10.	Section 23(2)(cb) of the *User Rights Principles 2014*
15	A statement specifying that any care recipient portion or transfer portion of the care recipient's unspent home care amount will be paid in accordance with Part 3 Division 3A of the *User Rights Principles 2014*. For more information on how to action this please see Sections 13 and 14.	Section 23(2)(cc) of the *User Rights Principles 2014*
16	If the provider intends to deduct an exit amount when they cease providing home care to the care recipient, a statement of the maximum exit amount that they will deduct. An exit amount is a charge that providers can deduct from funds that are left in a care recipient's package (unspent home care amount) when they leave their care (to change providers or to leave home care). The exit amount is intended to allow providers to recover administrative costs associated with determining and making payment of unspent home care amounts. It is not mandatory to charge an exit amount. Providers will need to decide whether they would like to charge an exit amount and agree the value of the amount with the care recipient when they execute the Home Care Agreement. Information on how providers must disclose their exit amounts is at **Appendix B** of this manual. Information on how and when providers can deduct the exit amount is at Sections 13 and 14 of this manual.	Section 23(2)(cba) of the *User Rights Principles 2014*

#	Requirement	Legislation citation
17	Provision for financial information to be given to the care recipient about the home care that the care recipient will receive, including a statement that the approved provider must, within seven days after a request by the care recipient, give the care recipient: • A clear and simple presentation of the financial position of the home care service, including the costs of home care that explains any ongoing fees payable by the care recipient. • A copy of the most recent statement of the audited accounts of the home care service or, if the home care service is operated as part of a broader organisation, the most recent statement of the audited accounts of the organisation's aged care component (that includes the home care service).	Section 23(2)(d) of the *User Rights Principles 2014*

6.5.4 Administration

#	Requirement	Legislation citation
18	A guarantee that the provider will take all reasonable steps to protect the confidentiality, as far as legally permissible, of information provided by the care recipient. Details of the use of information that is to be made by the provider and each person or entity to who the provider discloses the information.	Section 23(2)(e) of the *User Rights Principles 2014*
19	A statement specifying the home care service through which the approved provider will provide care to the care recipient.	Section 61-1(1)(a) of the *Aged Care Act 1997*
20	A statement specifying the levels of care and services that the provider has the capacity to provide to the care recipient while they are being provided with care through the home care outlet. **Note**: while an approved provider must be able to deliver all levels of packages, they are not required to be able to do so at all services.	Section 61-1(1)(b) of the *Aged Care Act 1997*
21	If the care recipient is not to be provided with the home care service on a permanent basis – the period for which the care and services will be provided.	Section 61-1(1)(d) of the *Aged Care Act 1997*

6.5.5 Variation or termination

#	Requirement	Legislation citation
22	A statement that the agreement may be varied by the approved provider if the variation is necessary to implement the *A New Tax System (Goods and Services Tax) Act 1999,* but that the agreement must not be varied pursuant to the above unless the provider has given reasonable notice of the variation, in writing, to the care recipient.	Sections 23(3)(a)(i) and 23(3)(b() of the *User Rights Principles 2014*

#	Requirement	Legislation citation
23	A statement that, in any case other than that discussed at Item 22 above, the Home Care Agreement can only be varied by mutual consent, following adequate consultation of the care recipient and the provider.	Section 23(3)(b) of the *User Rights Principles 2014*
24	A statement that the agreement must not be varied in a way that is inconsistent with *A New Tax System (Goods and Services Tax) Act 1999*, the *Aged Care Act 1997* or the *Extra Service Principles 2014*. **Note**: in their current form, the *Extra Services Principles 2014* contemplate residential care services only. They have not been considered further.	Section 23(3)(c) of the *User Rights Principles 2014*
25	The conditions under which either party may terminate the provision of home care, noting that providers may only terminate the provision of home care were security of tenure allows it. Security of tenure has been discussed at Section 3.4 of this manual.	Section 23(2)(g) of the *User Rights Principles 2014*

Home Care Agreements with care recipients who are in the pre-1 July 2014 arrangements must include different items. These are outlined in **Appendix A**.

6.6 What should I consider when entering into a Home Care Agreement with a care recipient?

In addition to obligations under the *Aged Care Act 1997*, outlined in **Appendix D**, providers have obligations under consumer and competition law. When negotiating with someone for the delivery of care and services and drafting the Home Care Agreement providers should also have regard to all these obligations.

The Australian Competition & Consumer Commission (ACCC) has developed guidelines for consumers and providers that outline consumer and business rights and obligations under the competition and consumer law (as they relate to the HCP Program).

The provider guide is at this link, or can be found by searching "Home care services – your business rights & obligations" at www.accc.gov.au. The consumer guide is at this link, or can be found by searching "Home care – a guide to your consumer rights" at www.accc.gov.au.

Approved providers should confirm with the consumer or their family who has been authorised to enter into the Agreement. In some circumstances, other arrangements may be in place for an authorised representative to act on their behalf.

The Department cannot provide individual advice on business practices, nor is the Department in a position to offer legal advice. Providers may wish to seek independent legal advice about business arrangements and how they align with the legislation.

6.7 What do I do if a care recipient won't sign a Home Care Agreement?

Wherever possible, both the care recipient and the provider should sign the Home Care Agreement. The care recipient should be given a copy of the signed Home Care Agreement.

A care recipient, however, does not necessarily need to sign the Home Care Agreement for it to be in place. As long as there is mutual agreement between them (or their authorised representative) and

the provider regarding the care and services to be delivered as part of the package, the agreement is considered 'in place'.

In the event that a care recipient does not sign the agreement, providers should keep detailed records of reasons why the agreement is not signed. This is because they must always be able to provide proof that an agreement is in place. Proof may include:

- a copy of the Home Care Agreement document the provider offered to the care recipient
- a file note of the discussion with the care recipient about the basis of the agreement (including the date the discussion took place); and/or
- proof that the provider is providing a package as described in the agreement.

6.8 I don't speak the same language as my care recipient. How can I arrange interpreting services?

For home care recipients who speak a language other than English as their first language, the Department of Home Affairs provides free interpreting services through the Translating and Interpreting Service (TIS National). Providers must register online for a TIS National Code. You can find information on this at this link or by searching "Interpreting support for Home Care Package service providers" at www.health.gov.au.

The intention of TIS National is primarily to assist care recipients to understand their package, including the Home Care Agreement, the package budget and monthly statements. When TIS National is used for this purpose including if required to discuss the monthly budget, there is no cost to the provider and there should not be any charges made to the care recipient's package budget.

TIS National is available 24 hours a day, seven days a week and provides both telephone and onsite services. Bookings can be made online via www.tisnational.gov.au. Alternatively, providers can call 131 450 for immediate telephone interpreting or 1300 655 082 for on-site bookings.

When accessing TIS National, providers will need to quote their service's unique code. If a provider is unsure of their care recipient's client code, they can contact TIS National on 1300 655 820.

Note: if providers are unable to provide aged care workers that can communicate in the required language they may negotiate with the care recipient to include any costs for an interpreter in the care plan. If there are costs associated with translation services and the package funds are used to purchase, or contribute towards the costs for a translator, it would be appropriate for the provider and the care recipient to discuss how this service would impact the package budget and the ability to deliver other care and services.

The agreed position and the responsibilities of the provider, care recipient and interpreter should be documented and included in the Home Care Agreement. Further information about the Translating and Interpreting Services charges for non-English speakers is available at www.tisnational.gov.au.

6.9 How and why do I notify Services Australia of a care recipient starting care with my service?

Providers need to declare care recipient entry information to Services Australia within 28 calendar days of when they commenced their home care services. Providers will first need to accept the referral in the My Aged Care Provider Portal, and then complete the paperwork to notify Services Australia. This paperwork can be completed through the Aged Care Provider Portal or through the submission of an Aged Care Entry Record (ACER).

The Aged Care Provider Portal can be found at this link, or by searching "Aged Care Provider Portal" at www.servicesaustralia.gov.au. An ACER can be completed using paper form AC021 at this link or by searching "AC021" at www.servicesaustralia.gov.au.

Entry information must be provided to Services Australia as early as possible and before the care recipient's package take up deadline to ensure their package is not withdrawn. If providers do not advise Services Australia of entry information, or if they do not have a Home Care Agreement in place, they will not be paid any applicable subsidy or supplements.

At this time, providers should also inform the Department if a care recipient has commenced a package and also receives a compensation entitlement. This is discussed at **Appendix C**.

✓ Key points to remember

- Before someone can receive services under the HCP Program, they need to register with My Aged Care, be assessed by an ACAT as eligible for the program, and be assigned a package through the national priority system.
- Once they have been assigned a package, they need to enter into a Home Care Agreement with a provider within 56 days (or 84 days with an extension).
- If providers are entering into a Home Care Agreement with a care recipient, they are bound by the obligations of consumer law. Providers can find out more in the ACCC provider guide at this link, or by searching "Home care services – your business rights & obligations" at www.accc.gov.au.
- If providers do not advise Services Australia of entry information they will not be paid any applicable subsidy or supplements.
- A free interpreting service is available to help providers negotiate the Home Care Agreement, develop the care plan with the care recipient and advise on the monthly budget. If the provider cannot provide aged care workers who speak the required language, they can negotiate with the care recipient to charge translation fees to their package budget.

7 Care planning

This section defines what a care plan is and outlines some strategies providers may use to complete care planning with care recipients.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 54-1 and 56-2 of the *Aged Care Act 1997*
- *User Rights Principles 2014*
- *Quality of Care Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

7.1 What is a care plan?

A care plan is a document that defines the package of care and services that a care recipient will fund using their package budget. The package budget is discussed at Section 8. Providers will need to undertake assessment and planning for care and services in partnership with the person within 14 calendar days of starting to provide care services. The assessment and planning has a focus on optimising health and well-being in accordance with the assessed care needs, goals and preferences. Providers must undertake initial and ongoing assessment and planning to meet Standard 2 of the Aged Care Quality Standards (see Section 3).

During the care planning process, providers will need to take into account any supports the person already has in place, such as carers, family members, local community and other services. For each care recipient, providers need to be able to demonstrate assessment and planning that:

- includes consideration of risks to the care recipient's health and well-being to inform the delivery of safe and effective care and services;
- identifies and addresses the care recipient's current assessed care needs, goals and preferences, including advance care planning and end of life planning if the care recipient wishes;
- is based on ongoing partnership with the care recipient and others that the care recipient wishes to involve in assessment, planning and review of the care recipient's care and services; and
- includes other organisations, and individuals and providers of other care and services that are involved in the care of the care recipient.

The care planning document should provide a detailed outline of services to be delivered, including when and where. This information should be specific, for example 2-3pm Tuesdays, rather than 'Tuesday'. Once the care plan and package budget (as discussed at Section 8) have been agreed, providers must give a copy to the care recipient for their records.

Information on approaches to care planning is set out at Section 7.3. Information on what services can (or cannot) be included in a care plan is set out at Section 9.

7.2 How do I work with a care recipient to develop their care plan?

Because the HCP Program uses a CDC model, as discussed at Section 2.2, providers will need to work with a care recipient to develop their care plan. This is an opportunity to manage their expectations and to outline an appropriate scope for the package. The provider's role in the care planning process is to help care recipients understand what care or services they can lawfully charge to the package and make choices between those. To do this, providers will need to understand what the potential inclusions and exclusions are for each individual home care package. Guidance on how to do this is set out at Section 9.

Providers will also need to help care recipients understand what care, services, and/or purchases they can afford within their package budget. They should prepare for care plan conversations by developing an understanding of the likely components of each individualised package. The information found at Section 8 of this manual will help providers to do this.

Please note, if charges have been levied against a package for excluded items the provider will, at a minimum, be required to repay any amounts that have been unlawfully charged against the budget back into the package.

7.3 What approaches can I employ to work with a care recipient to develop their care plan?

When working with a care recipient to develop goals, providers may consider whether reablement or wellness approaches to providing care might help them meet their goals. Giving consideration to these two contemporary approaches supports providers to ensure that the care and services they deliver align with the core principles of the HCP Program. These concepts underpin a number of aged care services, and are outlined, at a high level, below.

No matter which approach to care planning providers choose to take, it is important to remember that care planning is a collaborative process, between the provider and the care recipient.

7.3.1 Wellness approach

Wellness is an approach that involves assessment, planning and delivery of supports that build on an individuals' strengths, capacity and goals, and encourages actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home. Wellness as a philosophy is based on the premise that, even with frailty, chronic illness or disability, senior Australians generally have the desire and capacity to make gains in their physical, social and emotional wellbeing and to live autonomously and as independently as possible.

This approach supports senior Australians to undertake a task or activity themselves, or with limited assistance, and to increase satisfaction with any achievements. It underpins all assessment and service provision, whether the need for assistance is episodic, fluctuates in intensity or type over time, or is of an ongoing nature.

The case study on the next page outlines how a wellness approach can make a difference.

Case study: Jing

Jing likes to keep busy and tries to do as many jobs around the house as possible. Lately, she has been unable to hang up some of her heavier clothing items on the line. The traditional approach would involve support workers coming into Jing's home once a week to hang out the clothes for her. The wellness approach would encourage the support worker to work with Jing to hang out her bigger, heavier items and encourage her to hang her smaller items by using a laundry trolley and an easy-to-reach drying rack. In this way, Jing can continue to do things for herself and can act independently to do all her washing except for those items she needs some support to lift.

Source: Silverchain

7.3.2 Reablement approach

Reablement involves time-limited interventions that are targeted toward a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities. Like wellness, reablement aims to assist people to reach their goals and maximise their independence and autonomy. Supports could include training in a new skill or re-learning a lost skill, minor modification to a person's home environment or having access to equipment or assistive technology.

In practice, reablement can mean different things for different people – it all depends on their individual situation. For example, it might mean working with the care recipient to:

- practice daily activities, such as cooking and bathing, to help the them regain skills and get their confidence back;
- find new ways to do some things so that they feel safer and more confident;
- look at what else might help (for example, support to go out, personal alarms, home adaptations or other equipment, such as bath rails); and/or
- involve their relatives and/or carers in helping them to live more independently – and discuss any support they might need.

The kind of supports reablement might draw on vary, but could include the following:

- equipment and technology to help a care recipient live more independently at home;
- skills for independent living provided through intensive, short-term support; and/or
- outreach - help with transport and getting out and about.

7.4 If two people live together, can they have one care plan that contains information for both of them?

People who live together must undergo individual assessments by an ACAT. These assessments will generate individual support plans. Each care recipient must be assigned a package and have their own care plan.

They may, however, elect to pool their resources to fund joint care or services across both of their package budgets. For example, if both have been assessed as requiring cleaning services once a week, they may pool resources to share the cost of the cleaner between the two packages. Providers are required to include information about their respective home care fees payable in the Home Care Agreement, and the calculated home care fee amount being recorded in their respective package budgets.

7.5 What do I do if a care recipient wants services my company doesn't deliver?

Providers can deliver home care directly, or can engage other organisations or individuals to deliver care and services. This can occur in a number of ways, including sub-contracting.

Approved providers should, where possible, facilitate services being delivered by the person chosen by the care recipient. With CDC, if someone prefers a particular care worker to deliver their services, they can ask the provider to engage that care worker. Providers must indicate in their home care pricing schedule whether they charge an additional amount for any services they sub-contract from another service provider. Providers must also discuss this cost with the care recipient before the care plan is agreed. It is good practice to document this conversation for records.

Regardless of how the services are delivered, providers remain responsible for ensuring services are delivered in a way that meets the requirements of the Act and the Aged Care Quality Standards. Providers must also ensure services are delivered in line with the agreed care plan. The care plan will need to be revised periodically to ensure that the sub-contracted services continue to meet the care recipient's assessed care needs.

Approved providers also need to remember that they, not the sub-contracted service provider, remain responsible for meeting all of the regulatory responsibilities. These regulatory responsibilities include ensuring that all police checks and key personnel suitability requirements are met, as well as all obligations under the legislation. **Note**: a list of provider responsibilities is extracted at **Appendix D**.

If the sub-contracting arrangements materially affect approved provider suitability they will need to be disclosed to the Commission. When and how to do this is discussed at Section 15.

7.6 Are there any other models of care delivery which I should be aware of?

The Australian Government is supportive of innovative delivery of services under the HCP Program, to the extent that they are compliant with the intent and scope of the Program.

Home care support must still be offered on a CDC basis. This means the Home Care Agreement must be developed in partnership with the care recipient and the supports delivered must meet individual assessed care needs, personal care goals and the care plan.

Charging for services that are not provided is likely to lead to sanctions. Providers must also continue to meet all their obligations under the Act and Principles.

7.7 Can I decline a care recipient's request to sub-contract services?

In some circumstances, providers may not be able to accommodate the care recipient's preferences. This will need to be considered on a case-by-case basis, based on what is reasonable in the circumstances.

The following list provides a guide to home care providers as to when a request to use a particular service provider might be declined.

- The proposed service may cause harm or pose a threat to the health and/or safety of the care recipient or staff.

- The proposed service is outside the scope of the HCP Program.
- The home care provider would not be able to comply with its responsibilities under aged care legislation or other Australian Government or State/Territory laws.
- The requested service provider will not enter into a contract with the home care provider.
- There have been previous difficulties or negative experiences with the requested service provider.
- The cost of the service/item is beyond the scope of the available funds for the package.

Where the provider is not able to give effect to the care recipient's preferences or request for services, the reasons must be clearly explained to them and documented.

7.8 What do I need to provide to the care recipient at the end of their first care planning process?

Providers will need to give the care recipient a copy of their care plan within 14 calendar days of commencing service delivery and the package budget as soon as practicable. The package budget must identify what the budget is made up of (that is, the Government contributions and the home care fees) and how those budget funds have been allocated to care and services under the care plan.

Providers will need to consider pricing obligations when developing the budget. The budget is discussed at Section 8. Pricing obligations are discussed at **Appendix B**.

✓ Key points to remember

- Providers need to complete a care plan for all new care recipients within 14 calendar days of them starting services.
- Providers will need to collaborate with the care recipient to develop their care plan. When thinking about how to approach the care planning process, providers should consider taking a wellness or reablement approach.
- Providers' role in the care planning process is to help care recipients understand what care, services, or purchases they can choose to get from their package based on assessed need, and to enable them to make choices between those care and services.

8 A care recipient's package budget

As discussed at Section 7, providers need to work with each new care recipient to develop a care plan within 14 calendar days of the day the Home Care Agreement is completed. The individualised package budget needs to be done as soon as providers have all the information needed and the care plan is place. This section explains what makes up a package budget and how to calculate each component. All the financial aspects of the HCP Program are defined by the legislation. Providers should refer to the legislation for more information.

This section provides information relevant to people who entered the HCP Program after 1 July 2014, or who have opted into the post-1 July 2014 arrangements. For information on the pre-1 July 2014 arrangements, see **Appendix A**.

✓ **Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section**
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

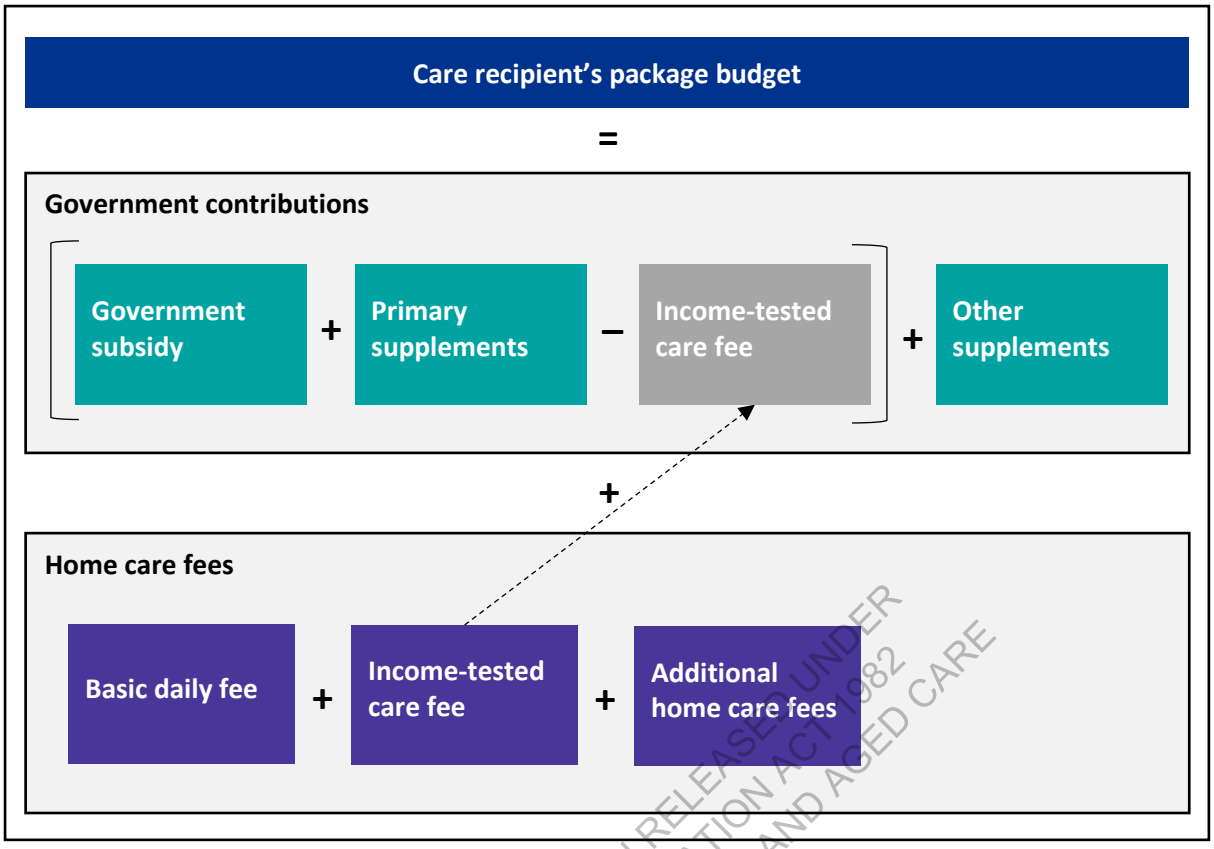
- Sections 47, 48, 52D-1, 56-2 and 96 of the *Aged Care Act 1997*
- *User Rights Principles 2014*
- *Fees and Payments Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

8.1 What makes up a care recipient's package budget?

Each individualised package budget is made up of contributions from the Australian Government and, where applicable, the home care fees payable by the care recipient. The components of a post-1 July 2014 package budget may include:



Note: It should be noted that a care recipient's package budget will be affected if they have received a compensable payment amount. These are discussed in **Appendix C**.

8.2 How do I determine the amount of Government contribution to a care recipient's budget?

The Government contribution is calculated as follows:

1. The basic subsidy amount
2. Plus any primary supplements (oxygen supplement, enteral feeding supplement, dementia and cognition supplement, veterans' supplement)
3. Less any reductions in subsidy and primary supplements (income-tested care fee)
4. Plus any other supplement (hardship supplement, viability supplement).

The Government subsidy and supplements are payable, and calculated daily, even on days a care recipient does not receive a service.

8.2.1 Basic subsidy

The subsidy is paid in accordance with the level of package the care recipient has been assigned. There are four package levels, outlined in the table below:

Package	Needs
Level one	Basic care
Level two	Low level care
Level three	Intermediate care
Level four	High level care

The current amount that can be paid by the Government can be accessed at this link or by searching "Home care packages subsidy" at www.health.gov.au.

8.2.2 Supplements

If care recipients are eligible, providers can also claim for supplements that will be added to the subsidy amount. An authorised signatory of the approved provider must sign the dementia, oxygen and enteral feeding claim forms. Once a form is completed, the form and supporting evidence can be emailed to Services Australia via aged.care.liaison@servicesaustralia.gov.au. Providers should keep copies of all supplement forms and supporting evidence in the associated care recipient's records.

Any supplements providers claim for a care recipient must be added to their total package budget. Although they will be eligible for supplements if they require particular types of supports, the supplement funds do not have to be used to provide that specific support. Supplements are an acknowledgement of additional needs, and the supplement funds can be used in the same ways as any other component of a package budget.

Providers can claim supplements for eligible care recipients on any package level; whether they are on a level one, two, three of four package.

The table below identifies and describes each of the supplements, and outlines the administration requirements.

Primary supplements

Supplement	Description	Application process and payment	What happens if the care recipient changes providers?
The Dementia and Cognition Supplement in Home Care	The dementia and cognition supplement provides additional funding in recognition of the extra costs of caring for people with cognitive impairment associated with dementia and other conditions. For further information go to this link, or search "Dementia and cognition supplement for home care" at www.health.gov.au.	Assessment using one of the prescribed tools by an approved assessor. The approved provider is responsible for lodging an application with Services Australia.	Supplement automatically transfers to new provider. The new provider must obtain a copy of the record of assessment undertaken by the care recipient.

Supplement	Description	Application process and payment	What happens if the care recipient changes providers?
The Veterans' Supplement in Home Care	The veterans' supplement in home care provides additional funding for veterans with a mental health condition accepted by the Department of Veterans' Affairs (DVA) as related to their service. For further information go to this link, or search "Veterans' supplement for aged care" www.health.gov.au.	DVA determines eligibility and advises Services Australia. No action required by provider.	Supplement automatically transfers to new provider.
Oxygen Supplement	The oxygen supplement is for care recipients with a specified medical need for the continual administration of oxygen. For further information go to this link, or search "Oxygen supplement" www.health.gov.au.	Paid to provider to help pay for specialised products and equipment. The approved provider is responsible for completing the application form available on the Services Australia website. Once the form is completed, the form and supporting evidence can be returned to Services Australia.	Supplement does not automatically transfer. The new provider needs to submit a new application to Services Australia, including medical evidence.
Enteral Feeding Supplement	The enteral feeding supplement is for care recipients with a specified medical need for enteral feeding. For further information go to this link, or search "Enteral feeding supplement" at www.health.gov.au.	Paid to provider to help pay for specialised products and equipment. The approved provider is responsible for completing the application form available on the Services Australia website. Once the form is completed, the form and supporting evidence can be returned to Services Australia.	Supplement does not automatically transfer. The new provider needs to submit a new form to Services Australia, including medical evidence.

Other supplements

Supplement	Description	Application process and payment	What happens if the care recipients changes providers?
Viability Supplement in Home Care	The viability supplement is paid to providers on behalf of recipients of home care in rural and remote areas in recognition of the higher costs of delivering care and services in these areas. For further information go to this link, or search "Viability supplement for aged care" at www.health.gov.au.	Provide location details (suburb and postcode) to Services Australia through entry event and location event screen in the Aged Care Provider Portal.	Supplement automatically transfers to the new provider if a care recipients remains at the same location. The new provider must enter the same postcode and suburb on the Aged Care Provider Portal. A care recipient who relocates will automatically be reassessed for viability supplement based on their new location.
Hardship Supplement	The hardship supplement is available to recipients of home care in genuine financial hardship who do not have income to pay their costs of aged care due to circumstances beyond their control. Care recipients who have commenced receiving a package on or after 1 July 2014 need to apply to Services Australia for financial hardship assistance. For further information go to this link, or search "Financial hardship assistance" at www.health.gov.au.	Paid to provider as a hardship supplement in lieu of the basic daily fee and/or income-tested care fee. Care recipients (or their representative) applies and submits form to Services Australia.	Supplement automatically transfers to new provider, if a valid approval exists. As this supplement is time-limited, the new provider should confirm if the care recipient is receiving a hardship supplement and the validity period.

The schedule of aged care subsidies and supplements contains the current daily rate for HCP Program subsidies and supplements. The schedule can be found at this link or by searching "Schedule of subsidies and supplements" at www.health.gov.au.

8.3 How do I determine the amount of a care recipient's home care fees?

There are three types of legislated fees a provider may ask a care recipient to pay:

- the basic daily fee;
- an income-tested care fee; and
- any other amounts they have agreed to pay for additional care and services.

If a care recipient wishes to purchase additional services over and above those they could otherwise afford under the package, their provider can agree with them a further amount for additional care and services to increase the value of the package.

These fees are part of the individualised package budget and must be included in the Home Care Agreement as a statement of fees that may be payable. Providers must discuss any fees to be paid by the care recipient before they commence services.

If the care recipient is on leave there may be changes to the subsidy, supplements and home care fees payable. Please see Section 11 of this manual.

8.3.1 Basic daily fee

Providers can ask everyone to pay the basic daily fee. It is set by the Australian Government at:

- Level one - the maximum fee is 15.68 per cent of the single person rate of the basic age pension.
- Level two - the maximum fee is 16.58 per cent of the single person rate of the basic age pension.
- Level three - the maximum fee is 17.05 per cent of the single person rate of the basic age pension.
- Level four - the maximum fee is 17.50 per cent of the single person rate of the basic age pension.

Rates for the basic daily fee are reviewed in March and September each year in line with changes to the Age Pension. The current rates are available in the schedule of fees and charges for residential and home care. The schedule can be found at this link or by searching "Charging fees for aged care services" at www.health.gov.au.

As the maximum basic daily fee is linked to the package level, an increase in package level may result in an increase to the basic daily fee.

Home care fees are payable, and calculated daily, even on days a care recipient does not receive a service. The Government subsidy and supplements are payable, and calculated, in the same way.

8.3.2 Income tested care fee

The income-tested care fee is a contribution that care recipients may be asked to pay if they can afford to do so, and is in addition to the basic daily fee. The income tested care fee is determined through an income assessment, which is conducted by Services Australia or DVA as applicable. It is the responsibility of the provider to put in place the business processes to collect and manage income-tested care fees from the care recipient.

If a care recipient has been assessed as needing to pay the income tested care fee, this will be deducted from the Government subsidy paid to the provider by Services Australia.

From 1 September 2021, if a care recipient's assessed income tested care fee is equal to or less than the price reported to Services Australia, no Government subsidy entitlement will be paid to the provider. Any unspent government subsidy will accrue in the care recipient's home care account for future care and services. See Appendix E for more information on Improved Payment Arrangements.

It is the responsibility of the provider to put in place the business processes to collect and manage income tested care fees from care recipients who have been assessed as needing to pay the fee.

Fees must be outlined in the Home Care Agreement and providers must discuss and agree these fees with the care recipient before they start services.

If a provider has been waiving all or part of a care recipient's income tested care fee because the care recipient is not using all of their package, providers can use any portion of the care recipient's unspent funds they are holding to cover care and services that the income tested care fee would have contributed towards. This can continue as long as the provider holds unspent funds on a care recipient's behalf. Once the unspent funds that the provider holds for the care recipient have been used, or if the care recipient has no unspent funds, providers will only be able to waive the income tested care fee by using retained earnings. If providers are not able to do this, the care recipient will need to start contributing their assessed income tested care fee.

This should not impact full pensioners as their means test is automatically matched by Services Australia through Government data and full pensioners do not pay the income tested care fee.

Providers cannot charge care recipients the income tested care fees that they have waived in the past.

8.3.3 Income assessment

The easiest way for a care recipient to complete an income assessment is to use form SS313, at this link, or by searching **"Authorising a person or organisation to enquire or act on your behalf form (SS313)"** at www.servicesaustralia.gov.au. This is a dynamic form and will present different questions based on the answers provided.

If the care recipient prefers to complete a hardcopy form, they can download a copy of the **"Authorising a person or organisation to enquire or act on your behalf form (SS313)"** from the Services Australia website at this link or by searching "SS313" at www.servicesaustralia.gov.au. Or call Services Australia on **1800 227 475** to ask a copy to be sent to them. If the care recipient receives a means tested income support payment, they can call Services Australia on **1800 227 475** or DVA on **1800 555 254** and request a pre commencement letter for home care. Services Australia (or DVA) will have sufficient information to calculate their maximum home care fees payable.

For an estimate of home care fees for the person, My Aged Care has a home care fee estimator at this link, or can be found by searching "Fee estimator" at www.myagedcare.gov.au.

Providers must continue to support care recipients to understand fees and their means assessment. This may also require providing information about how to request to Services Australia review of the assessment decision, or how to apply for financial hardship supports through Services Australia.

Delayed income assessment

A care recipient may begin to receive services prior to their means test being finalised. Services Australia assume no income tested care fee is payable and will pay the full monthly claim entitlement until the care recipient is assigned a 'means not disclosed status'.

If a care recipient is assigned a 'means not disclosed status' Services Australia assume the full income tested care fee is payable. This may result in a provider being paid less than the care recipient is entitled to.

Once a means test outcome is finalised, Services Australia will apply the correct income tested subsidy reduction backdated to the date the care recipient first entered the Home Care Packages Program. This means that:

- If a care recipient's means test outcome has resulted in an overpayment to the provider, Services Australia will deduct the overpayment from the next payment to the provider.
- If a care recipient paid income tested care fees in excess of what they were required to pay, the provider must repay these to the care recipient.

To manage risk for new care recipients, providers can apply the maximum income tested fee, the second daily cap in the Schedule of Fees and Charges, for any care recipients where they have not received their initial means testing advice. This should not impact pensioners as their means tests are automatically matched by Services Australia through Government data and full pensioners do not pay the income tested fee.

Providers should manage their cash-flow accordingly to cover any future liabilities arising from a late submitted means test.

Means testing adjustments

If a care recipient is paying an income tested care fee and receives a delayed income assessment which determines they should have been paying a lower contribution than the maximum income tested fee, or no fee, the provider must refund the difference to the care recipient once the care recipient fees are set.

If a care recipient receives a delayed income assessment which determines they should have been paying a higher income tested care fee, this is backdated to their date of entry. This means the income tested subsidy reduction is also backdated. An adjustment will be applied in the next claim, and the subsidy paid for that care recipient in the next claim would be reduced by the backdated adjustment amount.

If the adjustment amount was greater than the care recipient's payment determination for the current claim month, this would result in a negative payment amount for the care recipient for the month. This negative amount would be factored into the overall service payment. The provider may then claim the underpaid income tested care fee from the care recipient.

If an income tested care fee is refunded to a provider due to a quarterly review but the care recipient has already left care and their balances have been settled the following applies:

- If the care recipient has exited care to move to another provider, the refunded income tested care fee can be transferred from the previous provider to the new provider
- If the care recipient has exited care, due to entry into residential care or has passed away, then the income tested care fee can be refunded to the care recipient/or their estate.

If a care recipient does not agree with the outcome of their means test, they can request Services Australia to review this decision. If a care recipient is unable to pay their fees due to financial hardship, they can apply for financial hardship help from the Government.

8.3.4 Annual and lifetime caps

There are annual and lifetime caps that apply to the income-tested care fee. The current caps are at this link or can be found by searching "Schedule of Fees and Charges for Residential and Home Care" at www.health.gov.au. Once the annual cap is reached, the care recipient cannot be asked to pay any more income-tested or means-tested care fees until the next anniversary of when they first started receiving aged care. Providers can still ask for payment of the basic daily fee.

Services Australia will notify the provider and care recipient once the cap has been reached. The Government will pay the remaining income-tested care fees by way of increased subsidy to the provider after these caps have been reached.

8.3.5 Worked example

How do we calculate Adam's package budget?

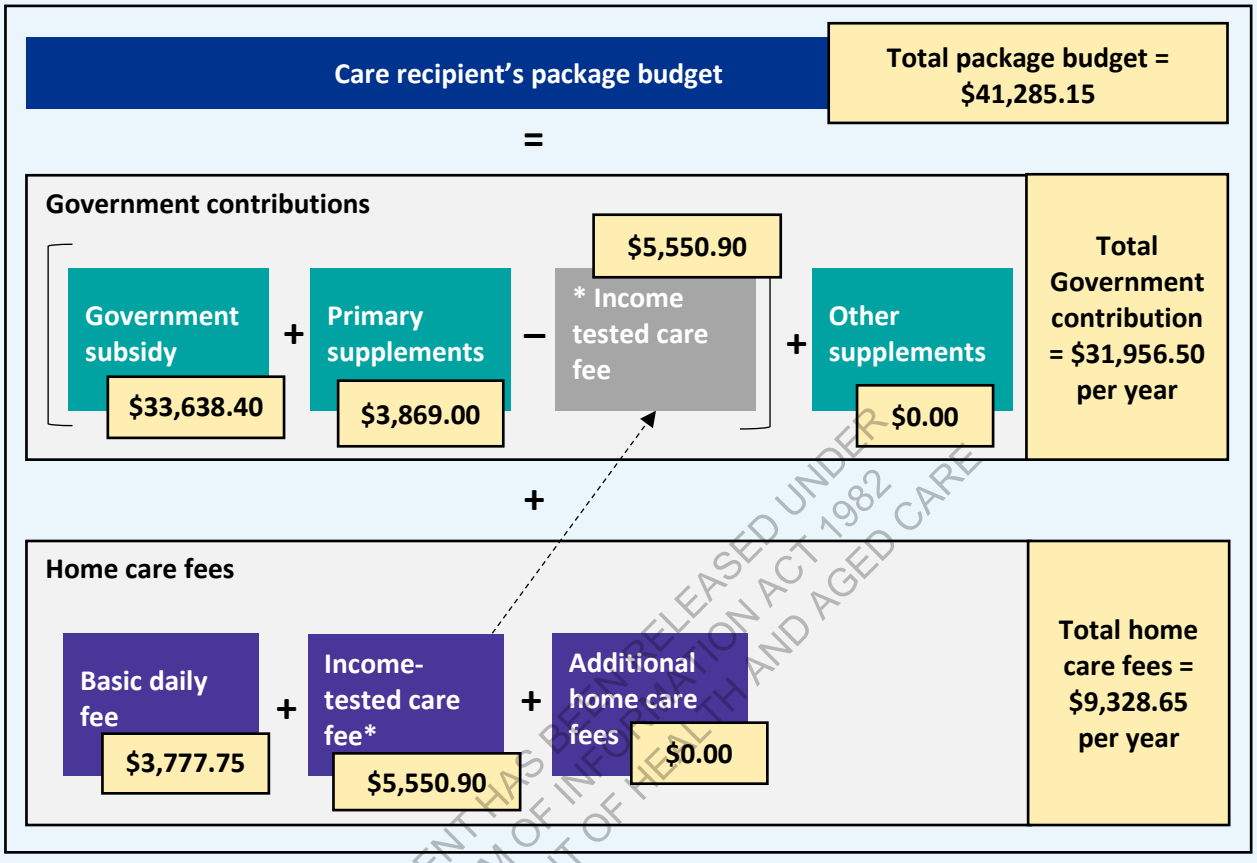
Fact scenario

- Adam lives at home with his partner David.
- Adam has been assigned a level three package. The value of his daily package subsidy is $92.16 per day (as at 20 September 2019). This equates to $33,638.40 per year.
- Adam is also eligible for the dementia and cognition supplement. The value of the supplement at his package level is $10.60 per day. This equates to $3,869.00 per year.
- Adam is not eligible for any other supplements.
- The basic daily fee for Adam's package level is $10.35 per day. This equates to $3,777.75 per year.
- Adam has completed his income assessment, and has been assessed by Services Australia as being able to pay an additional $15.24 per day or $5,550.90 per year in income-tested care fees.
- Adam did not agree to pay any additional fees in his Home Care Agreement.

How do we calculate Adam's package budget?

Calculation of package budget

The diagram below outlines how Adam's home care budget is calculated:



The Government subsidy and supplements of Adam's Home Care Package is valued at $37,507.40 ($33,638.40 + $3,869.00) per year.

The amount of basic daily fee charged adds to Adam's package budget. It has no impact on the amount of Government subsidy and supplements that are paid.

Adam, however, has been assessed by Services Australia as being able to contribute $5,550.90 per year towards his income tested care fee. The Government subsidy and primary supplement payable for Adam's care to his provider is reduced by Adam's income tested care fee. That is, $33,638.40 + 3,869.00 - $5,550.90 = $31,956.50.

If Adam fails to meet his responsibilities, including the payment of fees, as described in section 17 of the *User Rights Principles 2014*, his home care provider may cease to provide home care to him under the security of tenure provisions. Adam's Home Care Agreement must contain a statement setting out which home care fees are payable by him and the conditions under which either party may terminate the provision of home care.

8.4 What do I do if a care recipient is facing financial hardship?

If someone thinks they will face financial hardship when paying their aged care fees, they can apply to Services Australia for financial hardship assistance. Each case is considered on an individual basis. Depending on their situation, they may apply for financial assistance with the:

- basic daily fee; and/or
- income-tested care fee.

Care recipients experiencing financial hardship may be granted assistance with one, both or neither of these fees. If financial hardship assistance is granted, a hardship supplement will be paid to the provider in lieu of the basic daily fee and/or income tested care fee.

For more information on eligibility criteria and assessments for financial hardship go to this link, or by searching "Hardship supplement for aged care" at www.health.gov.au.

✓ Key points to remember

- A package budget is made up of Government subsidies and supplements, and home care fees.
- A care recipient's home care fees will depend on their circumstances. All care recipients may be asked to pay a basic daily fee. Some may also be asked to pay an income tested care fee.
- Government subsidy and supplements are payable, and calculated daily, even on days a care recipient does not receive a service. Home care fees are also payable, and calculated daily.
- It is a business decision for the provider if they choose to collect the basic daily fee. Collecting this fee adds to the package budget and provides access to more care and services.
- It is the responsibility of the provider to put in place the business processes to collect and manage income tested care fees from care recipients who have been assessed as needing to pay the fee. Providers should work with their care recipients to ensure they are receiving the level of care and services they require.

9 Inclusions and exclusions

This section outlines the care and services that can and cannot be included in a Home Care Agreement. It gives providers information and tools to use when working in partnership with care recipients to develop a care plan that optimises health and wellbeing in accordance with their assessed care needs, care goals and preferences, and helps them live safely and independently at home.

Under a CDC service delivery model, people have choice over the types of care and services they access and how these are delivered. Decisions on what is included or excluded in the care plan need to reflect that they have a 'dignity of risk' (under the Charter of Aged Care Rights) to accept the personal risks associated with making these choices. Providers need to balance this with their ongoing accountability for what each package budget is being spent on, and for delivering quality of care. This is necessary to ensure providers are compliant with the Aged Care Quality Standards and any relevant Australian Government or State and Territory laws.

To meet these obligations, providers may need to have challenging conversations with care recipients and their carers about whether a type of care or service or item can be included. A framework of considerations is included in Section 9.1 to support these discussions. It is also important that providers document and retain records of the reasons why a service or item is included or excluded.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Section 54-1 of the *Aged Care Act 1997*
- *Quality of Care Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them. See **Appendix D** for further detail on specific provider responsibilities.

Providers will need to act in compliance with all relevant State, Territory and Australian Government laws. A list of relevant Australian Government laws can be found at this link, or by searching "Legislation" at www.agedcarequality.gov.au/. The Aged Care Quality Standards can be found at this link or by searching "Quality Standards" at www.agedcarequality.gov.au/. Please consult your State or Territory register of legislation for information on relevant State or Territory laws.

9.1 How do I work out what services can be included in a care recipient's care plan?

The HCP Program is designed to provide a mix of services and supports that are customised to meet the individual care needs and goals of each eligible person. As discussed at Section 7, that mix is determined through care planning. Care planning involves:

- partnering with the care recipient to discuss their assessed care needs and care goals;
- deciding which care and service types will best assist them to meet these needs and goals; and
- detailing these care and services types in the care plan.

When working with each person to clarify their assessed care needs and care goals, providers should encourage them to think about what supports will optimise their health and wellbeing. Their

priorities and preferences are a key part of the discussion to co-produce their care plan. Care and services included in the care plan that will be purchased using the package budget should be drawn, for the most part, from the legislated inclusions, and must not include any legislated exclusions (see Section 9.2).

Sometimes a care recipient will seek a care or service type that is not specified as an inclusion or exclusion in the legislation. This means that you will need to work in partnership with care recipients to determine if the service, support or purchase:

- is directly linked to their identified care needs and goals;
- supports for daily living that is important for the care recipient's health and wellbeing;
- is necessary for them to support functional safety in their home;
- can be delivered within their available package budget; and
- would be considered an acceptable use of Government funds.

You will also need to consider whether you have the capacity and capability to deliver, or source, the proposed support.

The framework supports providers to take a flexible and responsive approach to working with care recipients on whether to provide proposed care and services that are not identified in the legislated inclusions. It allows providers to take a person-centred approach to care planning that supports a balance between assessed care needs, care goals and individual preferences, and considers individual circumstances such as financial and social position, cultural diversity and location.

The following framework has been designed to support decision making when it comes to determining what can and cannot be included as part of a package:

Consider and understand the care recipient's care needs and care goals to support them in living independently in their own home (in the short and medium term).

The care recipient's care needs and care goals must be clearly understood by both the provider and the care recipient, noting that these care needs and care goals can change over time. Information provided in the ACAT assessment and discussions with the care recipient will provide the basis for understanding this.

For each care and service type the questions on the next page will need to be considered.

These questions have been developed to help providers determine with care recipients if a care or service type should be included as part of their package. The questions have been grouped by category. To draw a conclusion, it is important that all the questions are considered on balance of each other.

Document all discussions about the inclusion or exclusion.

All discussions surrounding inclusions and exclusions for each care recipient should be clearly documented. Care and services to be included in the package should be clearly documented in the care plan and package budget. Where a provider is unable to give effect to the care recipient's preferences or request for services, the reasons must be clearly explained to the care recipient and documented. Documenting these discussions provides justification for the decisions regarding inclusions and exclusions of a package. Providers may be required to produce this documentation as evidence for the Aged Care Quality and Safety Commission or the Department.

Inclusions and exclusions framework – Step two questions
Mandatory criterion
Is the support specifically excluded under the Aged Care legislation? See Section 9.2 of this manual for an extract of excluded items. This question prompts providers and care recipients to think about whether the care or service is prohibited by the legislation. If the care or service is on the list of excluded items, it must not be included in a package.
Care recipient's assessed care needs
Does the support directly align with the intent and scope of the HCP Program? See Sections 2.2 and 2.3 of this manual for information on the intent and scope of the HCP Program. This question helps providers and care recipients to think about whether the care or service is an appropriate and acceptable use of the package budget. If the care or service does not align with the intent and scope of the HCP Program, it should not be funded from the package budget.
How does the support align with the assessed care needs as documented in the ACAT assessment, the providers' own assessment of the care recipient's needs or an assessment by a health care professional?

Inclusions and exclusions framework – Step two questions

This question helps providers and care recipients think about other clinicians' and allied health practitioners' assessment of their care needs. The care needs may have changed between the time of the original ACAT assessment and the assignment of the package. It is important to consider all assessments relevant to the care recipient's current care needs and goals.

How does the support assist the care recipient to achieve their care goals, now and in the short to medium term? Is the support necessary to meet the care recipient's assessed care needs and care goals?

This question helps providers and care recipients think about the appropriateness of the care or service for the individual care recipient. When answering this question, consider the immediate impacts of the care or service on the package budget. Providers and care recipients should also think about how the care or service impacts on whether the package budget will still meet their assessed care needs and care goals in the short to medium term.

Has the evidence-base for the use of the support in addressing the particular assessed care need been considered?

This question helps providers and care recipients think about the clinical appropriateness of a care or service to meet the care recipient's assessed care needs or care goals. While many variations of care and service types can help meet these, in some circumstances, there may be no supporting clinical evidence. In these instances, providers can use the clinical skills and expertise available to them to determine whether the care or service is appropriate to meeting the care recipient's care needs and goals.

Quality and safety

Does the support pose a risk to the health and safety of the care recipient?

This question asks providers and care recipients to consider the risks associated with the care or service. Providers can then make an informed conclusion about its safety for the care recipient.

While people have the right to dignity of risk regarding their choices, the provider's team (those supporting the care recipient), and the approved provider, have professional obligations to provide safe services and supports to care recipients. If providers form the view that the care or service poses an unacceptable risk to their safety, then the item should be excluded from the package.

Does the support pose a risk to the health and safety of staff and the community?

This question asks providers to consider whether they believe the care or service can safely be delivered by their staff (or other persons who they engage to deliver the package). It also asks providers and care recipients to think about any broader implications of the care or service on the community. This might include, for example, the safety of providing a mobility scooter to a particular care recipient if they may pose a risk to the public whilst travelling on footpaths.

Inclusions and exclusions framework – Step two questions
Does the support require maintenance to ensure the safe use of the item that represents a significant portion of the budget? Is it difficult to provide the maintenance required?
This question asks providers to consider the financial feasibility of maintaining the item purchased in the short-term and into the future. It is closely linked to the assessment of the opportunity cost associated with the care or service, which is considered in the next question.
Financial
Is there an opportunity cost associated with the support?
This question asks providers and care recipients to think about the trade-offs the care recipient will be making if they would like to include a care or service in their package. Given a package provides a set amount of funding, the request may be at the expense of receiving other care and services that would better meet the assessed care needs and care goals to keep them living independently in their home.
Will the care recipient miss out on a support identified in their assessment if package funding is used for a large purchase?
This question is a more detailed consideration of the question above, however, this question focusses on assessed care needs only. It requires providers to think about whether they will be able to deliver safe and clinically necessary care with the remaining funds in the package budget, if a large purchase is funded. If the provider cannot deliver the required care with the remaining package budget, this is a strong indicator that the purchase should not be made. See section 9.4 for further information on larger purchases.
Does the support represent value for money to meet the care recipient's assessed care needs?
This question asks providers to consider the appropriateness of the expenditure, noting the cost of the care or service, and the expected benefits. When making this assessment it is useful to remember that, although a package is for use by the care recipient, the bulk of the home care budget is a Government subsidy funded by taxpayers to be used appropriately. For example, where a care recipient needs kitchen modifications (e.g. easy access taps) to assist in the preparation of meals, a full kitchen refurbishment (beyond minor modifications) is not an appropriate use of Government funding.
Other
Can the support be provided informally through the community?
This question asks providers and care recipients to think about whether there are alternate, feasible ways the care recipient could get the same benefits without using their package budget. This might include, for example, considering whether the care recipient can use transport that is free from their local club to access the club, rather than paying for transport from their package.
Does the support directly support the care recipient, or does it have significant benefits for others that do not directly benefit the care recipient?

Inclusions and exclusions framework – Step two questions
This question helps providers and care recipients to think about who the care or service would benefit the most. If something can be related back to the care recipient's care goals, but primarily benefits someone other than the care recipient without directly benefiting them, it should not be included under a package, particularly if there is a direct or implied monetary benefit. For example purchasing a car for a family member so they can transport the care recipient. Respite care is an acceptable and important support, as it directly benefits the care recipient by ensuring their carer is capable to continue supporting them to live in their own home.

9.2 Is the proposed care or service specifically included or excluded under the Aged Care legislation?

As outlined in the above framework, the legislation provides guidance about specific items that can be included or must be excluded. It is worth remembering, however, that the care or service is only included when it meets assessed care needs and care goals.

This guidance is outlined in the *Quality of Care Principles 2014*.

The inclusions have been extracted below:

9.2.1 Care services

Service inclusions	Content
Personal services	Personal assistance, including individual attention, supervision and physical assistance, with: • Bathing, showering including providing shower chairs if necessary, personal hygiene and grooming, dressing and undressing, and using dressing aids • Toileting • Mobility • Transfer (including in and out of bed).
Activities of daily living	Personal assistance, including individual attention, individual supervision and physical assistance, with communication including assistance to address difficulties arising from impaired hearing, sight or speech, or lack of common language, assistance with the fitting of sensory communication aids, checking hearing aid batteries, cleaning spectacles and assistance using the telephone.
Nutrition, hydration, meal preparation and diet	Includes: • Assistance with preparing meals • Assistance with special diet for health, religious, cultural or other reasons • Assistance with using eating utensils and eating aids and assistance with actual feeding, if necessary • Providing enteral feeding formula and equipment.
Management of skin integrity	Includes providing bandages, dressings, and skin emollients.

Service inclusions	Content
Continence management	Includes: • Assessment for and, if required, providing disposable pads and absorbent aids, commode chairs, bedpans and urinals, catheter and urinary drainage appliances and enemas • Assistance in using continence aids and appliances and managing continence.
Mobility and dexterity	Includes: • Providing crutches, quadruped walkers, walking frames, walking sticks and wheelchairs • Providing mechanical devices for lifting, bed rails, slide sheets, sheepskins, tri-pillows, and pressure relieving mattresses • Assistance in using the above aids.

9.2.2 Support services

Service inclusions	Content
Support services	Includes: • Cleaning • Personal laundry services, including laundering of care recipient's clothing and bedding that can be machine-washed, and ironing • Arranging for drycleaning of care recipient's clothing and bedding that cannot be machine-washed • Gardening • Medication management • Rehabilitative support, or helping to access rehabilitative support, to meet a professionally determined therapeutic need • Emotional support including ongoing support in adjusting to a lifestyle involving increased dependency and assistance for the care recipient and carer, if appropriate • Support for care recipients with cognitive impairment, including individual therapy, activities and access to specific programs designed to prevent or manage a particular condition or behaviour, enhance quality of life and provide ongoing support • Providing 24-hour on-call access to emergency assistance including access to an emergency call system if the care recipient is assessed as requiring it • Transport and personal assistance to help the care recipient shop, visit health practitioners or attend social activities • Respite care • Home maintenance, reasonably required to maintain the home and garden in a condition of functional safety and provide an adequate level of security, such as cleaning gutters • Modifications to the home, such as easy access taps, shower hose or bath rails • Assisting the care recipient, and the homeowner if the home owner is not the care recipient, to access technical advice on major home modifications • Advising the care recipient on areas of concern in their home that pose safety risks and ways to mitigate the risks • Arranging social activities and providing or co-ordinating transport to social functions, entertainment activities and other out of home services • Assistance to access support services to maintain personal affairs.
Leisure, interests and activities	Includes encouragement to take part in social and community activities that promote and protect the care recipient's lifestyle, interests and wellbeing.
Care management	Includes reviewing the care recipient's Home Care Agreement and care plan, co-ordinating and scheduling care and services, ensuring care and services are aligned with other supports, liaising with the care recipient and the care recipient's representatives, ensuring that care and services are culturally appropriate, and identifying and addressing risks to the care recipient's safety.

9.2.3 Clinical services

Service inclusions	Content
Clinical care	Includes: • Nursing, allied health and therapy services such as speech therapy, podiatry, occupational or physiotherapy services • Other clinical services such as hearing and vision services.
Access to other health and related services	Includes referral to health practitioners or other related service providers.

The *Quality of Care Principles 2014* have also established a number of services that must not be included in the package. These are always excluded; even if they may advance the care recipient's assessed care needs and care goals, they are not aligned to the intent and scope of the HCP Program. Specified exclusions are extracted below:

Specified exclusions

The following items must not be included in the package of care and services under the HCP Program:

- Use of the package funds as a source of general income for the care recipient
- Purchase of food, except as part of enteral feeding requirements
- Payment for permanent accommodation, including assistance with home purchase, mortgage payments or rent
- Payment of home care fees
- Payment of fees or charges for other types of care funded or jointly funded by the Australian Government
- Home modifications or capital items that are not related to the care recipient's care needs
- Travel and accommodation for holidays
- Cost of entertainment activities, such as club memberships and tickets to sporting events
- Gambling activities
- Payment for services and items covered by the Medicare Benefits Schedule or the Pharmaceutical Benefits Scheme.

In relation to meal services and whether food can be included in a HCP:

- preparation and delivery of meals can be included
- the raw food component of those meals cannot be included, except in the case of enteral feeding.

The Department has not mandated a standard split/ratio for the raw food component. This is a business decision for the company providing the meal services to calculate how much the raw food component is. Home care providers should discuss with the care recipient the amount of the raw food contribution, as well as how and who it is paid to, as part of the negotiation with the meals provider and the care recipient.

Food referred to as 'takeaway' is also an excluded item. 'Takeaway' food is generally defined as food you would buy from a restaurant or food outlet.

The following table provides examples of care and services that fall within the most commonly excluded categories outlined in the legislation.

Excluded item (category)	Example of excluded item
Use of the package funds as a source of general income for the care recipient	Household bills, the purchase of a car or petrol, funeral cover, household furniture, solar panels, servicing gas heaters, phone and/or internet plans, or entertainment activities such as streaming subscriptions
Payment for permanent accommodation, including assistance with home purchase, mortgage payments or rent	Rates, home and contents insurance
Payment of home care fees	Basic daily fee, income-tested care fee and additional fees
Payment of fees or charges for other types of care funded or jointly funded by the Australian Government	Services that can be covered under the public health system, such as hearing aids, dentures
Home modifications or capital items that are not related to the care recipient's care needs	House renovations that exceed what is necessary for functional safety, independence, wellness and reablement, such as household security alarms, replacing gutters

The following list provides a guide to providers on when it might be reasonable to decline a request from a care recipient:

- The proposed service may cause harm or pose a risk to the health and/or safety of the care recipient or staff.
- The proposed service is outside the scope of the *Quality of Care Principles 2014*.
- The provider would not be able to comply with its responsibilities under aged care legislation or other Australian Government or State/Territory laws.
- The care recipient's choice of service provider is outside the provider's preferred list of service providers and all reasonable effort has been made to establish an acceptable sub-contracting arrangement.
- The requested service provider will not enter into a contract with the provider.
- There have been previous difficulties or negative experiences with the suggested service provider.
- The cost of the service/item is beyond the scope of the available funds for the package.

The following is a case study of when an item might be clinically necessary, but is excluded:

Case study: Yashwant

Yashwant is in his 80s and on a level three package. He has accrued approximately $5,000 in unspent funds. Yashwant needs a new set of hearing aids. He can get these devices fully subsidised under the Australian Government Hearing Services Program. He has decided, however, that he would like to use his unspent funds to get different hearing aids that are partially subsidised or not available through the Hearing Services program.

Yashwant's care manager meets with him to discuss his unspent funds. Yashwant notifies her that he would like to use $3,000 of his package towards a new pair of hearing aids. He thinks the more

Case study: Yashwant

expensive ones look better, and his neighbour has told him that because they are more expensive, they will last longer than the ones that are funded through the Hearing Services program.

Yashwant's case manager explains to him that unfortunately, his package cannot be used for care, services or purchases that are already available through publicly funded programs. She then explains to Yashwant why the hearing aids from the Hearing Services program are appropriate to meet his needs.

9.3 What are unspent funds and how can they be used for care and services?

Unspent funds are the total amount of home care subsidy, supplements (if applicable) and home care fees that have not been spent or committed on a person's care. Under the Improved Payment Arrangements Phase 2 changes (see Appendix E and Appendix F), providers will need to report the Commonwealth portion of unspent funds they hold for each care recipient to Services Australia by 31 December 2021. Unspent funds may be made up of the following:

- Provider-held Commonwealth portion of unspent funds
- Provider-held care recipient portion of unspent funds
- Services Australia held home care account balance

Unspent funds can only be used for eligible care and services in line (see sections 9.1 and 9.2).

9.4 How can providers make large purchases for their care recipients?

Any large purchases must be:

- related to the care recipient's care needs
- agreed within the care recipient's care plan
- within the available budget for the package level, with any fees mutually agreed with the care recipient through the Home Care Agreement before purchase.

Providers can access unspent funds to pay for large purchases. Where the cost exceeds available funds for care recipient, providers and their care recipients can:

- postpone the purchase until there are sufficient funds to cover the costs
- enter leasing arrangements where appropriate.

Providers must not split the cost over multiple claim months.

There are certain circumstances where a Home Care Package care recipient can access Commonwealth Home Support Programme (CHSP) services over and above the services provided through the home care package budget. See the Commonwealth Home Support Programme Manual for more information. This may be subject to the available capacity of CHSP providers and their available funding, given CHSP clients will be the priority. Consumer contributions may apply.

✓ Key points to remember

- The legislation prescribes care, services and purchases that can and cannot be included in a package. All inclusions must also link to identified assessed care needs and care goals.
- There will be care and services that care recipients request, or may need, that are not listed in the legislation. Providers and care recipients can use the inclusions and exclusions framework in this manual to help make an informed decision.
- Providers need to document their reasons and the discussions they have with the care recipient about the inclusion/exclusions. They may need to produce these documents for the Commission, or to prove they have been compliant with any Australian Government or State and Territory laws.
- The Commission website can provide further guidance, at www.agedcarequality.gov.au/.

10 Delivering care under a package

Once a provider has started providing services to a care recipient (in line with their care plan and package budget), they will need to manage their care. This section outlines the ordinary administrative things providers need to do to make sure care recipients are getting the best outcomes possible from their package.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 47, 48, 56-2, 56-4 and 96 of the *Aged Care Act 1997*
- *User Rights Principles 2014*.

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

10.1 Commencing services

Once a person is assigned a package and has entered into their Home Care Agreement, their care and services can begin. The date care is first delivered should be specified in their Agreement. Their package starts on the day the Home Care Agreement is entered into, not from the day that care is first delivered. Therefore, the commencement date on the ACER form may be the same or earlier than the date that care is first delivered. The commencement date on the ACER has to be within the package take up timeframe.

Care and services should then be delivered according to the care plan that the provider and the care recipient have developed in partnership.

On 1 September 2021, as part of the Improved Payment Arrangements changes, Services Australia created a home care account for each care recipient who was in care, with a balance of $0. All new care recipients commencing after 1 September 2021 will also have a home care account created for them.

From 1 September 2021, when a provider lodges their monthly claim the Government subsidy less any income tested care fees payable will be used to cover the price. If the Government subsidy is:

- More than the price, the difference will accrue in the home care account for future use.
- Less than the price, Services Australia will draw down on the home care account balance to cover the difference.

Care recipients will retain their full Government subsidy under these changes. Appendix E provides further detail on Improved Payment Arrangements.

10.1.1 Client summary tab

A ‘client summary tab’ is available in the My Aged Care client record. This is also known as the ‘Client journey dashboard’. This tab provides key information about the care recipient in one place, which may include:

- assessment information;
- approvals;

- service recommendations;
- service delivery information;
- goals and reablement; and
- any periods of linking support.

Information will only be displayed where it is applicable to that individual person.

More information is available at this link or by searching "My Aged Care - Client summary tab" at www.health.gov.au.

10.2 How do I claim the Government subsidy for services I provide?

Providers can only claim the home care subsidy for people who have been assigned a package from the national priority system and have a Home Care Agreement in place. This means that providers can only claim the Government subsidy from the date they entered into the Home Care Agreement, not the date they start negotiating with the care recipient or completing pre-service delivery care planning.

Services Australia will know the date a provider commences delivering services to a care recipient through the submission of the ACER. This must be completed within 28 days of when they entered home care.

The Services Australia payment system checks provider claims against the My Aged Care listing of care for people with an assigned package. Services Australia cannot process a claim for a care recipient if they do not have a package that is assigned and active.

The home care subsidy can only be paid once the Home Care Agreement has been entered into. The subsidy cannot be claimed for discussions and meetings with the care recipient (or carers and family members), or any services provided to them **before** the Home Care Agreement is entered into.

10.2.1 Improved Payment Arrangements

The Australian Government has changed the way Home Care Program providers are paid:

Phase 1 (implemented on 1 February 2021)

- Providers are funded in arrears rather than in advance.
- Payments for each month are claimed in the next month, for the full subsidy, based on the number of care recipients in care.

Phase 2 (implemented on 1 September 2021)

- Providers are paid in arrears, based on actual care and services delivered.
- The Government holds the Commonwealth portion of unspent funds, in each care recipient's home care account, until needed by the care recipient.

Legislation to support Phase 1 was passed by Parliament in December 2020, and for Phase 2 in February 2021. This measure reduces the financial and prudential risks of providers holding substantial amounts of unspent funds, as these will be held by the Government instead.

More information about the Improved Payment Arrangements can be found in Appendix E.

10.2.2 Claiming payments through Services Australia

For claims for months prior to September 2021

Providers will continue to claim through Services Australia and the claim will be for the number of care recipients in care from the previous month. The usual compliance processes apply. Services Australia's payment system enables the introduction of **Phase 1**. The subsidy is calculated by adding together the daily amounts (subsidy plus supplement less the subsidy reduction) for each day a care recipient is in a Home Care Agreement with that provider from the previous month. Providers claim through the Services Australia Aged Care Portal, Aged Care Web Services or through paper claims. Monthly payments may include an adjustment to account for any over or under-payment in the previous month/s. Subsidy payments are made through the Services Australia Aged Care Provider Portal, on behalf of the Department.

To help providers be ready for Phase 2, key actions include:

- Ensuring your claims and care recipients are up to date.
- Ensuring systems and processes that track the value of care and services delivered for each care recipient are in place.
- Reconcile the Commonwealth portion of unspent funds you are currently holding for each care recipient to support meeting the 31 December 2021 deadline for reporting.
- [If you do not intend to opt in to draw down unspent funds] Ensure systems and processes that track unspent funds you are holding for each care recipient are in place, and the balance of the Commonwealth portion of unspent funds can be extracted to support ongoing reporting to Services Australia.

For claims for months post September 2021 onwards

Providers will need to start submitting claims through Services Australia under the new model from the September 2021 claim period (from 1 October 2021). Providers claim through the Services Australia Aged Care Portal, Aged Care Web Services or through paper claims.

Providers only need to claim a total dollar amount for each care recipient in their monthly claim (this is referred to as the price or invoice amount). The price reported to Services Australia should incorporate the services delivered to care recipients minus any Basic Daily Fee or other care fees charged (not including the income tested care fee).

Package management fees and care management fees are considered services and can be included as part of the price. GST is not included in the claim.

Providers do not need to include an itemised list of fees, care and services delivered to the care recipient during the relevant month to Services Australia. However, this information must be provided to the care recipient as part of their detailed monthly statement.

Providers should be accurate in their claiming and claim the costs associated with the services delivered in the month even if they have exceeded the subsidy.

Providers should not split the cost over multiple claim months.

Providers will be paid the lesser of: The shortfall amount or the maximum contribution amount. The outstanding amount must be covered by the provider or by unspent funds held by the provider for the care recipient.

Services Australia will automatically deduct the income tested care fee payable from the payment made to providers, for care recipients who are assessed as needing to pay it.

Providers do not need to report supplements as part of the price to Services Australia in their claim. Supplements will automatically be applied by Services Australia if the home care recipient is eligible.

It will be included as part of the calculation completed by Services Australia of the subsidy available to the care recipient.

If the Government subsidy is more than the price, the difference will accrue in the home care account for future use. A care recipient's home care account balance will be available to their current service provider through the Aged Care Provider Portal and the payment statement Services Australia issues to providers.

Further information on the new model is available at Appendix E, with Attachment A to explain the claims process.

10.3 How should I manage my care recipients' package services?

A care recipient should be allocated a care manager by a provider. The care manager is responsible for enabling the steps discussed at Sections 6, 7 and 8 (initial assessment, care planning and establishing the Home Care Agreement), as well as:

- reviewing the Home Care Agreement and care plan;
- co-ordinating and scheduling care and services;
- ensuring care and services are aligned with other supports;
- liaising with the care recipient and the care recipient's representatives, ensuring that care and services are culturally appropriate, and identifying and addressing risks to the care recipient's safety;
- referral to an ACAT (e.g. if their needs change); and
- supporting timely and appropriate referral to individuals, other organisations and/or providers of other care and services.

10.4 What happens if a care recipient wants to self-manage their package?

Self-management means that a care recipient is involved in designing and directing their care, taking a lead role in making decisions to manage their package. This includes choosing preferred workers, and scheduling and co-ordinating their care and services. Care recipients can ask to do this because the HCP Program operates under a CDC model. Providers who offer this option should ensure that what is involved is fully understood.

It is important that both the provider and the care recipient understand that the approved provider is ultimately responsible for compliance with the legislation (see Section 2), Aged Care Quality Standards (see Section 3), and scope and intent of the HCP Program (see Section 2). Providers will still need to have oversight over what self-managing care recipients spend their package budget on. Providers will also continue to undertake some required activities such as reviewing the care plan.

This may incur some costs and staff effort, so providers can charge a care management fee proportionate to the work incurred to oversee the care recipient's self-management.

10.5 How often does the care plan need to be reviewed?

The care manager must review a care recipient's care plan:

- regularly and at least once every 12 months, to make sure the care and services received through the package still meet the care recipient's needs;

- at any time when requested by the care recipient's or their carer;
- if the care recipient has been receiving services through a lower level package than their approved level, and they get upgraded to a higher package level; and/or
- if there has been a change in the care recipient's package budget.

Reviews may also occur more frequently than every 12 months. Reasons for an additional or earlier review may include:

- a health crisis or episode;
- a change in care need that cannot be met within the package budget available for the package;
- a change in living or carer arrangements;
- ongoing or increasing use of clinical services; or
- the use of a large amount (or all) of the remaining funds.

When thinking about how often to review the care plan, providers should be aware of compliance with Standards 2 and 3 of the Aged Care Quality Standards. For more information on the standards see Section 3 of this manual.

The review should have a reablement and wellness focus that does not assume a decline in the care recipient's health and functioning. It should involve:

- a review of current care needs, care goals and preferences;
- an evaluation of the quality and success of the services and supports that have been provided;
- a renegotiation and update of the care plan and individualised package budget; and
- support for the care recipient to continue to make informed choices about their care and services, and the life they choose to live, including whether they wish to change their level of involvement and decision-making in the management of the package.

Wellness and reablement are discussed further at Section 7.3.

The review should be done in person, wherever possible. Phone and video technology or other remote monitoring digital technology may also be used, where clinically appropriate.

Review of the care recipient's care needs may lead to significant changes in the nature of the support provided to them. The provider should support the care recipient (and anyone else they choose to involve, such as family or advocates), as much as possible, in any changes resulting from the review of the care plan.

Another ACAT assessment may be required if the care recipient's care needs have increased significantly so that they potentially require more support in order to remain in their home, or entry to residential care or residential respite. Some care recipients may already have suitable approvals. To determine if an approval is already in place, providers can review their My Aged Care client record. If they do need a new ACAT assessment, the provider can assist to arrange this, with their permission.

As discussed at Section 7, providers need to undertake initial and ongoing assessment and planning for care and services in partnership with each person they enter into a Home Care Agreement with. Providers cannot change a care plan without mutual consent from the care recipient.

Review of the care plan is an included service, paid for out of the care management cost (if any), as agreed in the Home Care Agreement. Providers cannot charge additional costs to the care recipient's package budget for each time they request a review of their care plan or Home Care Agreement.

While the care plan should be reviewed regularly for effectiveness, if someone is asking for recurrent reviews of their care plan where their circumstances have not changed, providers should discuss why they are requesting reviews of the care plan, and what can be done to help. Providers should document records of these conversations taking place.

Note: where there is a change to the care recipient's care plan, the package budget will also need to be updated.

10.6 What is a monthly statement and what does it need to have in it?

Providers are required by the *User Rights Principles 2014* to issue care recipients with monthly statements that show the package budget funds available to them and what has been spent from their budget. Providers may also include any agreed additional charges. A monthly statement should clearly show services delivered so that the care recipient and/or their carers can easily understand how the service provider is charging for the package.

The following amounts must be itemised and included in the monthly statement:

- The amount of home care subsidy for the care recipient for the month
- The amount of home care fees (if any) paid or payable by the care recipient for the month, and any unpaid home care fees relating to previous months.
- An itemised list of:
    - The care and services provided to the care recipient during the month (including travel, subcontracting arrangements and package management) for which the care recipient was charged;
    - The price that the provider charged the care recipient for the month;
    - The total of those prices;
- The care recipient's unspent home care amount (provider-held unspent funds) in respect of: the previous month; and the current month;
- If, during the month, the provider received the care recipient portion of unspent funds from another provider – the amount that was received.

The monthly statement should align with the provider claim for care and services delivered during the month (the payment period). That is, both the claim and the statement should include care and services even if the payment for these services has not been finalised, for example as it was delivered by a sub-contractor and the invoice has not been received. Any adjustments can be reflected in subsequent months (in both the claim and statement).

Any unspent funds amount must carry over from month to month, and from year to year, for as long as that person continues to receive a package.

Providers must continue providing detailed monthly statements for all care recipients. Providers must provide the total amount of all unspent funds they hold, including the funds being held in the home care account (if any).

Statements do not need to break down the unspent funds balance into the provider-held care recipient portion, Commonwealth portions, or the home care account balance until providers are ready to include this information. The Department will review this early in 2022, to determine the date at which this reporting requirement becomes mandatory. Advance notice will be provided to the sector.

A non-mandatory better practice statement is currently being developed and providers should continue to strive to align with this.

Services Australia will expand the payment statement issued to providers to report the balance of Government subsidy held within each care recipient's home care account and any provider-held amounts returned.

10.7 When can I charge home care fees?

Once the Home Care Agreement has been entered into, providers may ask the care recipient to pay home care fees up to one month in advance. Providers cannot ask for payment of any home care fees before their package begins.

Any fees paid in advance must be refunded to the care recipient, or their estate, if they exit the HCP Program or move to another provider. See Section 13 for more information on refunds when transferring services.

10.8 When should I review a care recipient's home care fees?

Rates for the basic daily fee are reviewed and changes announced in March and September each year in line with new rates for the Age Pension. Providers may need to discuss the impact of these fees changes with the care recipient and update their package budget accordingly.

Services Australia conducts a quarterly review of income-tested care fees in January, March, July and September. If a care recipient's financial circumstances change the care recipient can request a review with Services Australia or DVA.

For care recipients in the pre-1 July 2014 arrangements, see **Appendix A**.

10.9 How can I work with my care recipients to manage unspent amounts?

Providers should work with care recipients to ensure they are able to benefit from the full use of their package and budget. However, there are several reasons why unspent funds may accumulate in a package budget – key examples are listed below:

Reason	Information
Consumer choice	The package budget for a care recipient's assessed level of care should be used to meet their current care needs. However, they may actively choose to set aside a small proportion of their package budget for future events, such as leave of a carer.
Automated package upgrades	Care recipients receiving services through a lower level package than they are approved for are automatically upgraded when a package is available at a higher level. If their care needs are being met by the lower level package the provider should discuss opting out of the national priority system for a period of time. The care recipient can re-enter the national priority system, in future and still be in the position they would have been in if they had not withdrawn. Automatic upgrades may lead to a build-up of unspent funds if the level of services are not reviewed to reflect the full value of their upgraded package, or the level of funding/service is not required.
Temporary leave	Care recipients can temporarily suspend their package if they take leave. Depending on the reason, the full rate of home care subsidy is payable for up to 28 cumulative or consecutive days (depending on the leave type) in a financial year and they may continue to be asked to pay their home care fees. After this, the subsidy is payable at a rate of 25 per cent. Further information

Reason	Information
	on leave arrangements for subsidy, supplements and home care fees is at Section 11.

If a care recipient transfers to a new service provider, the previous provider will need to transfer the care recipient portion of unspent funds to the new service.

If a care recipient exits the HCP Program, the provider must transfer the care recipient portion of unspent funds back to the care recipient or the care recipient's estate.

If a care recipient exits the HCP Program the Australian Government portion of unspent funds must be returned to the Government.

Providers have a legal obligation to transfer any unspent funds if someone changes provider, or return unspent funds if they leave home care.

This is discussed further at Sections 13 and 14. The Department uses information about the returned Australian Government portion of unspent funds as an input to determine the number of packages to be released to people on the national priority system.

Further information on the treatment of unspent funds under Improved Payment Arrangements is available at Appendix E and Appendix F.

The table below outlines two strategies providers may use to help manage any unspent funds they may hold for care recipients:

Strategy	Information
Revise the care plan and package budget	Providers should work together with their care recipients to develop a plan that meets their assessed care needs. This includes talking about the funds available and how to spend those funds, through the package budget. This may include an agreement, based on the care recipient's choice, to set aside a small part of their package budget for future care needs. It is important to be able to save for future events, such as a carer going on holiday or needing respite. Providers should also ensure record keeping regarding care recipients days in care are accurate and up to date (see section 11 for further information on leave).
Actively manage packages	Providers also play an important role in managing their care recipient's package. Providers will receive a notification if their care recipient's package is upgraded. The provider should talk to their care recipient about their assessed care needs and make updates to the care plan, Home Care Agreement and package budget as soon as possible, so that more essential services can be arranged. Doing this quickly will prevent unspent funds accumulating from the date of the automatic package upgrade.

10.10 What happens when a care recipient's care needs have increased?

A care recipient's care needs may increase significantly so that they potentially require home care at a higher level or entry to residential care. In these circumstances, they may need another assessment by an ACAT. With the care recipient's prior consent providers can assist in arranging the

ACAT assessment. Providers can do this by submitting a Support Plan Review (SPR) request via the My Aged Care provider portal. More information is available at this link or by searching "request a Support Plan Review" at www.health.gov.au.

Care recipients can request a SPR themselves by calling My Aged Care.

If it is determined that another assessment is necessary, the provider should attach supporting documentation about the care recipient's care arrangements. For example, a package budget or care plan. These attachments are required to be attached to the SPR requests for people who are receiving a package. The My Aged Care contact centre will also request this information when submitting SPR requests on behalf of service providers.

If someone is already in receipt of a Level Four package, they may need to consider other options including:

- reviewing their care plan to identify alternatives and priorities (for example, reducing higher cost services, such as support on weekends, and replacing with informal supports);
- purchasing additional care and services from their own funds if an option; or
- the benefits of residential care, either as short-term respite to complement their package or as a long-term option.

10.10.1 Respite

Respite can be provided in the home or in a residential setting. Respite in the home may take the form of additional services for a short time period, where the carer would otherwise provide those services. This could include providing a break during the day for the carer or overnight respite to allow the carer to rest.

Residential respite provides short-term care in an aged care home. The primary purpose of residential respite is to support and maintain the care relationship between carers and care recipients through providing good quality respite care for the care recipient so their carer may take a break from their usual care arrangements. Residential respite may be used on a planned or emergency basis. An ACAT approval is required to access this care.

A package can be suspended when a home care package recipient is receiving residential respite. For information on taking 'leave', see **Section 11**. In this case, the services delivered under the package would be put on hold. Providers are unable to collect the basic daily fee from the care recipient, however, the income-tested care fee may remain payable. If this occurs, it is important for the home care provider to engage with the residential respite provider to ensure continuity of care and allow the care recipient to be supported in their continuing care goals. This may be facilitated by sharing their home care plan with the residential respite provider. This will allow the respite provider to consider any wellness or reablement approaches that remain relevant within the residential setting.

It is also important that the residential respite provider enters their payment claim correctly in the Services Australia payments system. If they enter a claim for permanent residential care this will result in the withdrawal of an active package.

Alternatively, a care recipient may choose to receive residential respite and their home care package services at the same time. This may be an appropriate option where some of their assessed care needs can continue to be met by the home care provider outside the aged care home. For example maintaining a safe environment for their return.

In this situation, it is vital that the home care provider engages with the residential respite provider to share the care plan and ensure there is no duplication of services. Again, it is important to consider wellness, reablement and continuing care goals. A care recipient must also be made aware of the impact this will have on their fee arrangements (see **Section 11**).

If a carer would like to arrange for respite services, whether in the home or residential facilities, they may wish to contact the Commonwealth Respite and Carelink Centre on **1800 052 222**. The Centre can book short-term and emergency respite in residential facilities and help carers access a range of other respite options, including in-home and centre-based respite.

The Carers Gateway provides practical information and support, accessed via www.carergateway.gov.au.

10.11 What if I can't meet the care recipient's needs?

Once providers enter into a Home Care Agreement, they are required to continue to deliver the agreed care and services for as long as the care recipient needs those services. As discussed at Section 3.4, this is called security of tenure.

There are exceptions to security of tenure, such as when the care recipient can no longer be cared for safely in their home. These exceptions are extracted in full at Section 3.4.

If providers do not think they can meet the care recipient's needs, but none of the exceptions to security of tenure apply, they should consider sub-contracted arrangements to help fulfil obligations under security of tenure. Sub-contracting is discussed at Section 7.

10.12 What do I do if I think someone is being subjected to elder abuse?

The World Health Organization defines elder abuse as 'a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person'. It can take various forms, such as physical, psychological or emotional, sexual and financial abuse. It can also be the result of intentional or unintentional neglect.

If providers would like to talk to someone about potential or actual elder abuse they can call the national **1800 ELDERHelp** (**1800 353 374**) line. This service provides information on how to get help, support and referrals to assist with potential or actual elder abuse.

Providers may have obligations in relation to elder abuse under State or Territory laws in the jurisdictions in which they operate. Each State and Territory provides information about abuse and abuse prevention, as well as useful contacts and options for getting help:

State/Territory	Organisation or resource	Contact
Australian Capital Territory	Older Persons Abuse Prevention Referral and Information Line (APRIL)	**02 6205 3535**
New South Wales	NSW Elder Abuse Helpline	**1800 628 221**
Northern Territory	Elder Abuse Information Line	**1800 037 072**
Queensland	Elder Abuse Prevention Unit	**1300 651 192**
South Australia	Aged Rights Advocacy Service Elder Abuse Phoneline	**08 8232 5377** **1800 700 600**
Tasmania	Tasmanian Elder Abuse Helpline	**1800 441 169**

State/Territory	Organisation or resource	Contact
Victoria	Seniors Rights Victoria	**1300 368 821**
Western Australia	Elder Abuse Helpline	**1300 724 679**

Providers can find a case study that provides an example of financial elder abuse at this link or by searching "case studies" at www.agedcarequality.gov.au.

10.13 What do I need to do to manage complaints?

The Aged Care Quality Standards require providers to have a complaints management function in place. The purpose of this function should be:

- **For the consumer to:** feel safe, encouraged and supported to give feedback and make complaints; feel engaged in processes to address feedback and complaints; and feel comfortable that appropriate action has been taken.
- **For the provider to:** regularly seek input and feedback from consumers, carers, the workforce and others; and use the input and feedback to inform continuous improvements for individual and the whole organisation.

The complaints function must be outlined in every Home Care Agreement. If it is appropriate, providers may want to refer a consumer to the Commission material on making a complaint at this link or by searching "making a complaint" at www.agedcarequality.gov.au/.

If a complaint arises, the provider must:

a. use their complaints resolution mechanism to address the complaint; and
b. advise the complainant of any other mechanisms that are available to address complaints, such as the Commission.

It is important that providers view complaints as an opportunity to further develop their customer service by gaining insights into the needs and wants of consumers. If staff are open to complaints and educated on how to manage them, complaints can be an opportunity to address minor issues before they become significant, and to build positive relationships with consumers, their families, friends and representatives.

The Commission 'Better Practice Guide to Complaint Handling in Aged Care Services' provides information on how to design a complaints function. It is at this link, or by searching "Better Practice Guide to Complaint Handling in Aged Care Services" at www.agedcarequality.gov.au/.

The Commission also has case studies that outline some strategies providers might use to resolve complaints. These can be found at this link or by searching "Case studies" at www.agedcarequality.gov.au/.

✓ Key points to remember

- Providers are required to review each care recipient's care plan regularly, at least once per year, and if their care needs change or they request it.
- Changes to a care recipient's care plan will result in changes to their package budget.
- Providers are required to give care recipient's monthly statements. This is a financial document and shows them what makes up their package budget and how it is being spent.
- Approved providers and all of their employees need to be aware of elder abuse, including obligations in regards to reporting and response to elder abuse, which vary by State or Territory.

- Providers need to have a complaints management function in place, and they must use it to manage complaints they receive.
- From 1 September 2021, providers receive funding based on the actual services delivered to care recipients in the previous month. This aligns home care with other Government-funded programs like the National Disability Insurance Scheme, as well as modern business practices. These changes will not affect care recipients' subsidy entitlements.

11 Leave

This section outlines what providers need to do if someone wants to take leave from receiving services under their package (also known as suspension) and how that affects their budget.

This section provides information relevant to care recipients who entered the HCP Program after 1 July 2014, or who have opted into the post-1 July 2014 arrangements. For information on the pre-1 July 2014 arrangements, see **Appendix A**.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

The *Fees and Payments Principles 2014 (No.2)* and the *Subsidies Principles 2014* outline how leave operates within the HCP Program. As providers of services under the program, providers are expected to comply with those laws.

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

11.1 When can a care recipient take leave?

Care recipients are allowed to temporarily suspend their package for any reason. Leave may be taken:

- for a hospital stay;
- for transition care following a hospital stay;
- to receive residential respite care; and/or
- other reasons (such as social leave).

A care recipient's security of tenure is not affected by the choice to take leave. They must, however, notify their provider that they are choosing to take leave from their package and specify the date that leave commences, or they will be liable for services delivered. This notification is not required to be in writing, but providers need to record the leave dates, and how and who informed them of the leave.

Providers must include information in each Home Care Agreement, explaining how the care recipient can notify them if they are planning to take leave. If they choose to take leave, the provider should work with them to update their care plan accordingly.

11.2 What is the impact of leave on the home care subsidy and supplements?

The amount of home care subsidy paid to the provider is dependent on the type of leave the care recipient takes from their package, as set out in the table on the next page:

Type of leave	Impact on payment of subsidy or eligible supplements to provider
• **Hospital** • **Transition Care**	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 consecutive days in a financial year, for each episode of hospitalisation or transition care at each particular package level. • After 28 consecutive days, the subsidy is payable at 25% of the basic subsidy rate. • After 28 consecutive days, primary supplements* are not payable.
• **Residential respite care** • **Social leave****	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 cumulative days in a financial year at each particular package level. • After 28 cumulative days, the subsidy is payable at 25% of the basic subsidy rate. • After 28 cumulative days, primary supplements* are not payable.

* Primary supplements are oxygen, enteral feeding, dementia and cognition, and veterans. Other eligible supplements (such as the viability and hardship supplements) continue to be paid during periods of leave. Supplements are discussed at **Section 8.2.2**.

** Package suspension for any other reason.

11.3 What is the impact of leave on home care fees?

A care recipient may be required to pay ongoing home care fees to the provider while they are on leave from their package. The amount and type of fee that can be charged while a care recipient is on leave from their package is set out below:

Leave type	Basic daily fee	Income-tested care fee
Hospital	Yes	Yes - payable at the full rate for 28 **consecutive** days, after which the care recipient can be asked to pay the lesser of their income-tested care fee or 25% of the basic subsidy rate for their package level.
Transition care	No	Yes - payable (at the full rate for 28 **consecutive** days, after which the care recipient can be asked to pay the lesser of their income-tested care fee or 25% of the basic subsidy rate for their package level.
Residential respite	No	Yes - payable at the full rate for 28 **cumulative** days, after which the care recipient can be asked to pay the lesser of their income-tested care fee or 25% of the basic subsidy rate for their package level.
Social leave	Yes	Yes - payable at the full rate for 28 **cumulative** days, after which the care recipient can be asked to pay the lesser of their income-tested care fee or 25% of the basic subsidy rate for their package level.

11.4 What is the impact of leave on monthly statements?

Any subsidy, relevant supplements or home care fees paid or payable to the provider while the care recipient is on leave must be included in their monthly statement.

11.5 How do leave balances work?

A care recipient's leave balance resets on 1 July each year or if their package level changes at any time. Leave balances are specific to each person receiving a home care package and will transfer with them, for example, if they change providers.

Worked examples:

A care recipient has been in hospital for more than 28 consecutive days, and because they advised their provider to suspend their package, the basic subsidy has stepped down to 25% after the 28th day. The care recipient then moves into transition care for a period. How is the rate of subsidy calculated and how should the home care fees be calculated?

Hospital leave and transition care leave are two different types of leave. Each time a care recipient accesses either hospital leave or transition care leave, their provider receives the full subsidy amount for up to 28 consecutive days, after which the subsidy reduces to 25% of the basic subsidy rate. The leave will also impact on their basic daily fee and income-tested care fee (if applicable).

Hospital leave: the care recipient's provider would receive the full home care subsidy for up to 28 consecutive days for each episode of hospital leave. During this period, the provider can continue to charge them the basic daily fee and the income-tested care fee.

After 28 consecutive days, the subsidy will be reduced to 25% of the basic subsidy rate. The basic daily fee remains payable, however, the income-tested care fee may change (if the new subsidy rate is less than the income-tested care fee). Services Australia will notify the provider and care recipient of any adjustments through the quarterly review process.

If the care recipient is admitted to transition care immediately after being discharged from hospital, the provider will recommence receiving the full subsidy for up to 28 consecutive days of transition care leave. During this period, the provider cannot charge the basic daily fee but may continue to charge the income-tested care fee. After 28 consecutive days, the subsidy reduces to 25% of the basic subsidy rate. The income-tested care fee remains payable but may change if the new subsidy rate is lower than the income-tested care fee. Services Australia will notify the provider and care recipient of any adjustments through the quarterly review process.

Note 1, the income-tested care fee will be reduced to the lesser of the income-tested care fee or the reduced subsidy. This means that for some care recipients the Government will stop paying the subsidy and primary supplements.

Note 2, this worked example assumes that the care recipient chooses to take leave while they are in hospital. If they do not take leave from their package and want to continue receiving some services (for part or all of the leave period), they may be asked to pay the basic daily fee and the income-tested fee.

A care recipient is on leave in hospital but needs minor modifications to the home before they can be released from the hospital to go home. Do I need to do these minor modifications for the care recipient while they are on leave?

In situations such as a hospital stay, it is usually expected that the care recipient is provided with a full range of care and services in the hospital setting. They can, however, choose not to suspend their package and discuss with the provider what services should continue during the period of the hospital stay and have that reflected in their care plan. This might include minor home modifications if there are sufficient funds available in the package to fund the required work.

Therefore, if the care recipient wants minor home modifications to be done within their package, they will need to return from leave in order for these to be done. If they will not agree to return from leave to have the modifications done then the provider does not have to provide for any care, services, or purchases under their package until they return from leave.

A care recipient is going on a three month holiday. Their home needs household maintenance services (such as mowing) in order to make the home safe while they are away ready for their return home. Can I charge to the package budget while they are on leave?

If the care recipient requires care, services, or purchases to be actioned during a period of planned leave then they cannot take leave from their package.

Providers can amend their care plan so that the care and services they will not use are not scheduled during the period they are away. The funds typically used to pay for these will accrue as unspent funds in their package budget. These funds should be used for care and services that will advance their care goals when the care recipient returns from leave.

✓ Key points to remember

- People can take a break from receiving services under their package. This is known as taking leave, and does not affect their entitlement to receive home care services when they want to come back from leave.
- The Government may still pay the Home Care subsidy to that care recipient's home care account while they are on leave. This will depend on the reason the care recipient is taking leave, and how much leave they have already taken in the financial year.
- Depending on the type of leave and how much leave, the care recipient may be asked to pay their basic daily fee and income tested care fee.

12 Responding to special needs and changing cognition in home care package delivery

As discussed at Section 2.1, the HCP Program is underpinned by a CDC model. This means that aged care services should be designed in partnership with the care recipient and adapted to their individual needs and care goals. An individual's needs may include special needs or changes to their cognitive function.

Approved providers need to be ready and able to respectfully and safely provide aged care services to people with special needs and changing cognition. They have a right to have their special needs and/or changing cognition respected. Any services must treat each care recipient with dignity and respect, enable them to maintain their identity, and account for and cater to any special needs and/or changing cognition if they would like them to, or if it is necessary for them to remain living safely in their home.

This section defines the terms 'special needs' and 'changing cognition', and outlines strategies providers may employ to support care recipients with special needs and/or changing cognition.

✓ **Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section**
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

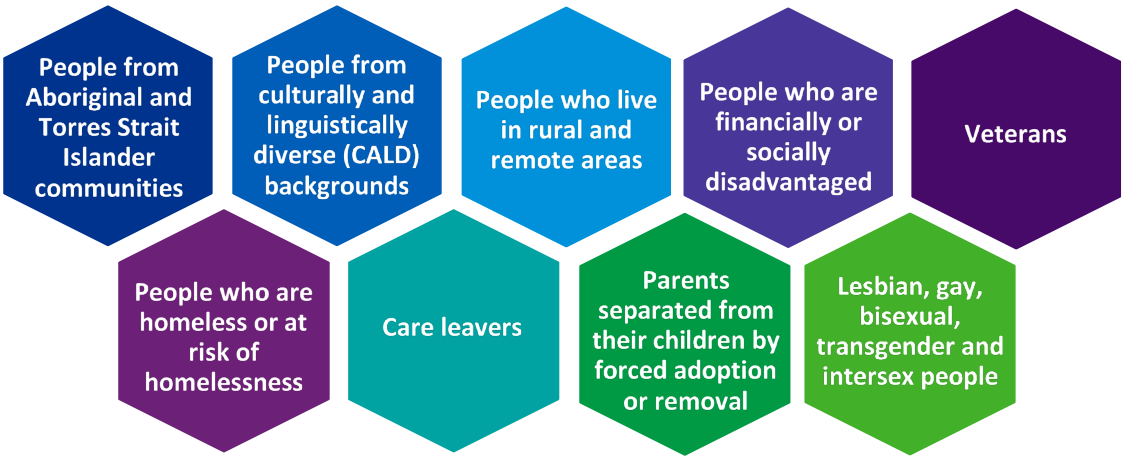
- Section 56-2 of the *Aged Care Act 1997*
- *User Rights Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

12.1 What are special needs?

The *Aged Care Act 1997* defines nine types of special needs, as outlined in the figure below:



When thinking about whether a person has any of the above special needs, providers should not focus on what they look like or whether they show certain physical characteristics. Instead, they should think about how the care recipient sees themselves, and their circumstances.

This manual does not provide specific guidance on what providers should do when providing services to people with each type of special need. This is because the HCP Program is based on a CDC model, which focusses on the needs of the individual. Each person will view their special needs differently and their needs will have different impacts on their lives. Approved providers should be open and respectful, and work together with them to design a program of care and services that is adapted to their particular circumstances.

When working with people with special needs, it is worth remembering that they may have had negative experiences of discrimination, or other adverse actions, in the past. The best way to approach this is to work in partnership with them and have open and respectful conversations about their care needs and goals.

The Commission provides several examples on meeting the care needs of aged care recipients with special needs at this link. Or you can search "case studies" at www.agedcarequality.gov.au/.

The Aged Care Diversity Framework and action plans also helps providers consider how their services may be appropriately tailored to care recipients with diverse characteristics and life experiences. These can be found at this link, or by searching "Aged Care Diversity Framework action plans" at www.health.gov.au.

12.2 What is changing cognition?

Changing cognition is not defined by legislation; it is a broad term used to describe dementia or other changes in care recipient capacity and memory.

12.2.1 Early warning signs of dementia

Early symptoms of dementia often vary a great deal, which can make it hard to identify. Providers' clinicians or other service providers may have regular contact with care recipients. This means they are well placed to help identify when someone may be in the early stages of dementia.

Dementia Australia provides guidance on early warning signs of dementia, which may be helpful to the provider and their team members in identifying whether one of their care recipients may be living with dementia. It can be found at this link or by searching "Warning signs of dementia" at www.dementia.org.au.

12.2.2 Determining capacity

If a provider's staff member, or a care recipient's family and/or friends are concerned about signs of dementia or other changes in cognition, providers will need to determine whether the person still has 'capacity' to make a choice for themselves. 'Capacity' is a legal term, and as a starting point, must always be assumed (even if the care recipient has been diagnosed with dementia or another type of cognitive impairment). It is also decision-specific. Just because someone has not had capacity in the past that does not mean that they will not have capacity to make future or less complex choices.

The individual's right to make their own choices, decisions, mistakes and take risks must be respected. Providers are obliged to support and encourage care recipient autonomy and self-direction, whilst also being mindful of indicators of incapacity and potential abuse of their care recipients.

Capacity means being able to:

It is also important that the care recipient can apply their personal values to the decision, and that there is some stability and consistency to the decision-making over time. Another way of checking capacity is to ask them to explain the decision in their own words, including why the decision is made. Capacity is not an all or nothing concept. It is decision-specific and can also fluctuate over time. A person may lack capacity in one area (such as making complex financial decisions) but may be able to make decisions about other areas of life (such as the type of supports they need and who they would like to provide them).

The case study below provides guidance on what a provider could do to manage care planning with a care recipient who has dementia but still retains capacity to make choices about their care. It is important to remember that anyone who retains capacity has a right to their own dignity of risk.

Case study: Olga

Olga has been receiving home care services for several years. She has dementia and her needs have gradually increased, but she is capable of living semi-independently for now. Her two children live nearby and at least one of them visits daily. Olga gets on well with the care staff and makes it clear to them that she wants to keep doing as much of her own housework and personal care as she can.

Her children, however, express concern to the provider that she is no longer capable of making decisions that best meet her needs. They ask the provider to add laundry, ironing and bed-making to their duties, tasks that Olga has been doing herself until now without mishap. The care staff who look after her directly tell the service co-ordinator they think this change is unnecessary and risks making Olga unhappy and affecting her confidence. The provider has to balance the wishes of Olga's family with Olga's own preferences.

The main priorities are Olga's safety, her well-being, and respecting her wish to keep doing her daily tasks. There are certainly safety and hygiene issues to consider. So far, these have not arisen but may as Olga's dementia progresses. A care co-ordinator with experience in dementia meets with Olga to talk about these issues. Olga understands the concerns being raised by her children and decides that the risks discussed with her are outweighed by the importance of the benefits she get from doing her own laundry and ironing. She agrees to a small increase in staff supervision for these activities, and that the bed-making service can start. In explaining the plan to Olga's children, the co-ordinator emphasises how important it is for their mother to maintain a sense of independence, self-worth and purpose. The co-ordinator also makes it clear that the provider has carefully discussed the health and safety risks with their mother and will continue to monitor them from day to day.

12.2.3 Dementia Training Program

The Dementia Training Program is a program for providers that offers a national approach to accredited education, up-skilling, and professional development in dementia care. Services include:

- accredited dementia care vocational level training courses - free to eligible care workers in residential, respite, community care or the wider health services;
- an online training portal allowing staff to undertake web-based training; and
- tailored onsite training to aged care providers who request assistance, including a dementia skills and environment audit, followed by a tailored training package.

The Dementia Training Program website is at www.dementiatrainingaustralia.com.au.

12.2.4 Dementia Behaviour Management Advisory Services

The Dementia Behaviour Management Advisory Services (DBMAS) provides advice to providers and individuals caring for people living with dementia where behavioural and psychological symptoms of dementia (BPSD) are impacting on their care and quality of life. Access is through the 24 hour helpline, on **1800 699 799**, or the DBMAS website at www.dementia.com.au.

12.3 How do I manage issues related to changing cognition?

CDC encourages people receiving a package to continue to make choices and direct the support that they need. Some individuals, however, may have more difficulty engaging with CDC and making choices about their care goals and services. If they would like or need it, there are different ways in which they can be supported in their decision-making and in expressing their views about their service arrangements:

Strategy	Description
Representative	A person may appoint a representative to assist with their decision making or be authorised to make decisions on their behalf. This may take various forms, such as an informal arrangement with a friend, family member or ally, someone with a formal power of attorney or a legal guardian.
Supported decision-making	Supported decision-making is a model that has mainly been used for supporting people with disabilities, often cognitive disabilities, to make significant decisions and exercise their legal capacity. Specific decisions are addressed, weighed and concluded by the person with the disability, while drawing on the support of a network of people or an individual. Potential supporters may be friends, family, volunteers, community members or any other trusted person. These unpaid supporters may help the person with disability to gather, understand and consider relevant information about the decision in question, assist them to weigh pros and cons, predict likely outcomes and consequences or evaluate the available options. With this support, the person then makes the decision themselves. This process can be formally facilitated, for instance by creating written supported decision-making agreements. It often occurs informally, however, within the community, both to support people with impaired decision-making capacity and to support anyone in making a challenging decision. This model of support aims to build and extend the decision-making skills of those using it, developing the ability of people to make and communicate decisions with more independence and confidence. Source: Disability Advocacy Network Australia

Strategy	Description
Power of Attorney	Powers of attorney are legal documents that let a person choose someone they trust to make decisions for them. An enduring financial or medical power of attorney, or enduring guardianship, are a way a competent person can appoint others to make decisions and manage their affairs in the event they are unable to make decisions for themselves. Arrangements may differ in each State or Territory. Contact your Office of the Public Advocate in your State or Territory for further information.
Guardianship	Guardianship is the appointment of a person (a 'guardian') to make decisions for an adult with a disability (the 'represented care recipient) when they are unable to do so. All adults over the age of 18 years, regardless of disability, are entitled to make their own decisions when they are able to do so. Australian guardianship law is the key regulatory mechanism for protecting the health of young persons, adults with disabilities and the elderly. Australia has eight different guardianship regimes, which vary widely in their forms of regulation. See www.austguardianshiplaw.org for more information.
Care planning	All care recipient care plans should include a contingency plan, which is reviewed each year and provides clear guidance around what to do in the event that their capacity to make decisions regarding their care declines.
Advance care planning	Advance care planning provides an opportunity for people to think, discuss and plan for the medical treatment they would prefer if they became too ill in the future to express their wishes. An Advance Care Directive is a written document that records the medical treatment wishes of a person, which can then be used if they are unable to speak for themselves due to illness or injury. The document may also appoint a substitute decision maker and include non-medical wishes for end of life, such as spiritual care. You can find information about advance care planning at this link or on www.health.gov.au by searching "advance care planning". Information, guidance, and resources are available from the End of Life Directions for Aged Care website at this link or at www.eldac.com.au. Advance Care Planning Australia has information about contacts in each State and Territory. For more information see www.advancecareplanning.org.au.

The case study on the next page outlines how advance care planning can help provide the care recipient, their families and the approved provider with comfort through end of life planning.

Case study: Ricardo and Alicia

Ricardo and Alicia had been living in their own unit for three years when Ricardo, aged 70, was diagnosed with a rapid form of dementia. They contacted their provider to discuss extra services they expected to need as the illness progressed. Recognising how important it was for Ricardo's final months to be comfortable and dignified and to reflect his wishes, even when he could no longer express them, the provider encouraged them to make a formal advance care plan.

A staff member trained in developing advance care plans helped Ricardo identify his values and treatment preferences. What mattered to Ricardo most was staying in his home with his wife and dog, taking daily walks and looking after the unit's small garden. He did not want treatment that might extend his life while its quality deteriorated. Following the provider's protocol for end of

Case study: Ricardo and Alicia

life planning, the staff member worked with Ricardo and Alicia to document a detailed advance care plan. Ricardo was pleased everyone knew his clinical, cultural and spiritual preferences.

For more information on supported decision making in aged care please go to this link or search "Supported decision-making" at cdpc.sydney.edu.au/.

12.4 What do I do if care recipients need additional support in exercising their choice?

Advocacy has an important role in supporting care recipients in exercising choice and directing their services. An advocate can help them understand their rights and choices within their package, and supports them through decision-making processes. Advocacy can be particularly useful for people who are experiencing changing cognition.

The care recipient (either the care recipient or their representative) can request that another person assist them in dealings with their approved provider. An advocate is not the same as a representative, in that they may be present to support decision-making or negotiations with the provider, but are not necessarily authorised to make decisions for the individual.

Providers must allow the advocate of the care recipient's (or their representative's) choice access to the home care service.

An advocate may be made available through the National Aged Care Advocacy Program (NACAP). The NACAP is delivered on the behalf of the Australian Government by the Older Persons Advocacy Network (OPAN). It provides free, confidential and independent advocacy support to senior Australians receiving or looking to access Government-funded aged care services.

An advocate's support can help with the following:

For more information on advocacy services go to opan.com.au.

✓ Key points to remember

- Providers need to be ready and able to provide care and services to people with special needs and/or changing cognition. Care and services must be considerate of and appropriate to special needs and/or changing cognition.

- The Aged Care Diversity Framework and action plans can help providers consider how services may be appropriately tailored to people with diverse characteristics and life experiences. These can be found at this link, or by searching "Aged Care Diversity Framework action plans" at www.health.gov.au.
- Capacity can be difficult to navigate with a senior Australian and their family. This section outlines legal and advocacy strategies that providers can use to help with this.
- OPAN provides free, independent advocacy services. If care recipients need support making decisions, but can still make decisions for themselves, providers can connect them to this service.

13 Changing home care providers

This section outlines the obligations of a provider if one of their care recipients chooses to change home care providers. This includes details on how to calculate and transfer their unspent funds.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Section 56-2 of the *Aged Care Act 1997*
- *User Rights Principles 2014*
- *Accountability Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

13.1 When can a care recipient change home care providers?

Once receiving a package, a care recipient can change providers if they are looking for a better fit, or for any other reason. If they decide to make a change, their unspent Home Care funds (less any exit amount as agreed in the Home Care Agreement) will move with them to their new provider.

When someone transfers to a new provider, they must notify their existing provider that they no longer wish to receive care and agree on the date that services from the existing provider will cease. They should also advise their existing provider of who their new provider will be.

13.1.1 Agreeing on a cessation day

A care recipient may tell their existing provider they wish to change providers directly, or they may reactivate their referral code in My Aged Care, triggering a notification to the existing provider through the Provider Portal. The existing provider should discuss the care recipient's needs and the timing of their move once they become aware of their intent to change providers.

This includes agreeing on a cessation day for the existing home care services that takes into consideration the care recipient's situation, the terms of the Home Care Agreement, and legislative requirements of home care. As per the *Records Principles 2014*, the existing provider will need to document the agreed cessation day.

The existing provider must continue providing care up until the agreed cessation day.

13.2 How does this affect the claims for that care recipient's home care subsidy?

Reaching an agreed cessation day with the care recipient is important to know the period for which the existing provider can claim home care subsidy. It also allows the existing provider to accurately reconcile the balance of package funds and calculate any unspent funds.

The start date for the new provider must be on or after the cessation day of the existing provider. When someone changes providers and there is no gap in care, the start day for the new provider should be the same date as the cessation day for the existing provider. This ensures there is no gap in payment of home care subsidy.

When a care recipient changes home care provider, the existing provider is not paid a home care subsidy for the cessation day, while the new provider is paid home care subsidy for the start day. An example of how subsidies are paid to the existing provider and new provider when there is no gap in services to the care recipient is outlined in the table below:

Recipient	26 June	27 June	28 June	29 June	30 June
Existing provider	Subsidy paid	Last day of services, Subsidy paid	Cessation day		
New provider			Start date, Subsidy paid	Subsidy paid	Subsidy paid

Before providing home care services, the new approved provider should confirm the cessation day with both the care recipient and the existing provider to ensure there are no overlapping claims for home care subsidy. Where two or more approved providers claim subsidy for the same person on the same day, payment will be made to the provider that first entered into a Home Care Agreement with them. When the start day and the cessation day are the same date, this does not represent an overlapping claim as home care subsidy is not paid for the cessation day.

13.2.1 Notifying the cessation day and start date

The new provider must accept the care recipient's referral in My Aged Care and submit the ACER within 28 calendar days of the cessation day. They have 56 calendar days from their agreed cessation day to enter into a new Home Care Agreement with their new provider before their package is withdrawn.

The existing provider must notify the Australian Government that they have ceased providing services to a care recipient within 31 calendar days of their cessation day. This must be done by submitting the care recipient's name and their cessation day through the Aged Care Provider Portal. The Aged Care Provider Portal is at this link, or can be found by searching "Aged Care Provider Portal" at www.servicesaustralia.gov.au.

Note: For continuing care recipients if they wish to retain their pre-1 July 2014 fee arrangements they must enter care with the new provider within 28 days. For more information see **Appendix A**.

13.3 What are the obligations on providers?

13.3.1 Obligations for the existing approved provider

The diagram below outlines the obligations for the existing approved provider:

1. Provide cessation information to Services Australia	2. Notify care recipient of unspent amount/arrange payment	3. Retain records
Once a cessation day is agreed with the care recipient, the existing provider must notify Services Australia within 31 calendar days of care ceasing. It is important to remember that a home care subsidy is not paid for the cessation day.	Three steps must be taken: a. Calculate the unspent home care amount b. Provide written notice of the unspent home care amount c. Make payment of the unspent home care amount.	The existing provider must retain: • Written notice of the care recipient's unspent home care amount • Records relating to the payment of the unspent home care amount to the new provider.

Further information on the steps necessary to notify the care recipient of the unspent amount and arrange payment is outlined below:

a. Calculate the unspent home care amount

The steps and requirements for calculating a care recipient's unspent home care amount are detailed in the *User Rights Principles 2014*. Before completing the final reconciliation, the provider must make sure claims for the care recipient are up-to-date; that home care fees have been received; and all expenses have been identified, including any outstanding invoices from sub-contracted or brokered services.

Note: The calculation of unspent home care amount should not include:

- any home care fees paid in advance, as these should be must be separately refunded to the care recipient by the provider; or
- home care subsidy for the cessation day, as home care subsidy is not paid for the care recipient on that day.

b. Provide written notice of the unspent home care amount

Within 56 calendar days after the cessation day, the existing service provider must give the care recipient (or their representative) a written notice about their unspent home care amount. The written notice must include the:

- Cessation day for care and services.
- Exit amount that has been deducted (if applicable).
- Unspent home care amount, which is the balance of any unspent funds (less any exit amount) in the package budget, broken down into the following portions:
  - the care recipient portion, which is the unspent amount of home care fees paid to the provider by the care recipient, less any unpaid home care fees owed by the care recipient;
  - the Australian Government portion held by the provider (if any), which is the unspent amount of home care subsidy and supplements for a care recipient;
- Any unpaid home care fees which have been deducted (if applicable).

Under Improved Payment Arrangements, from 1 September 2021, the existing service provider will need to:

- transfer the care recipient portion of unspent funds to the new service provider if the care recipient is moving services, or
- refund the care recipient portion of unspent funds to the care recipient or their estate if the care recipient exits home care.

If a provider still holds the Australian Government portion of unspent funds for the care recipient, the existing service provider will need to:

- transfer the Australian Government portion to Services Australia where it will be held in the care recipient's home care account, available for use with their new provider, or
- return the Australian Government portion to Services Australia, where the funding will be reinvested by the Government into the Home Care Packages Program if the care recipient exits home care.

For providers who have opted-in to draw down on the Australian Government portion of unspent funds and have used these funds entirely, they will only need to transfer or refund the care recipient portion. The Australian Government portion of unspent funds will be in care recipient's home care account, managed by Services Australia.

Where a care recipient has unpaid home care fees, this is a matter for the approved provider to manage with them directly under the terms of the Home Care Agreement. The written notice must explain how the unspent home care amount will be paid, so they (or their estate) understands the process and the timeframes involved.

Providers cannot charge care recipients fees that they have waived in the past or fees that are not detailed in the Home Care agreement.

Refer to Section 13.4 for more information on exit amounts.

c. Make payment of unspent home care amount

The care recipient must notify their existing provider within 56 calendar days after the cessation day of the new provider who they have entered into a Home Care Agreement with. This is to allow their existing provider to arrange payment of the care recipient portion of the unspent home care amount to the new provider. If the existing provider is not notified within this period, the existing provider must treat any unspent home care amount as if the care recipient has left home care. This is discussed at Section 14**.**

The existing provider is required to make payment to the new provider as soon as possible, but within 70 calendar days, after the cessation day. The existing provider must also provide a copy of the written notice of the unspent home care amount to the new provider at the time the payment is made. This allows the new provider to identify the transferred amount for the care recipient.

13.3.2 Obligations for the new approved provider

The diagram below outlines the obligations for the new approved provider:

1. Accept the care recipient referral in My Aged Care	2. Develop a Home Care Agreement with the care recipient.	3. Provide care recipient entry information to Services Australia.
Providers must accept the care recipient's referral in the Provider Portal before submitting entry information to Services Australia.	The new provider should work in partnership with their new care recipient to develop a Home Care Agreement, care plan and package budget based on their assessed care needs.	The new provider must notify Services Australia within 28 calendar days of the care recipient starting care by submitting an ACER.

Once the new provider receives the unspent funds amount they must separately identify the transfer portion of the unspent home care amount in the care recipient's monthly statement. Under Improved Payment Arrangements (from 1 September 2021 onwards) the transfer portion will only consist of the care recipient portion of unspent funds. The Australian Government portion will be held in the care recipient's home care account.

Care recipients who join the HCP Program after 1 September 2021, will never have an Australian Government portion held by the provider. Any unspent funds held by the provider will be entirely made up of the care recipient portion.

13.4 When can I charge the exit amount?

The existing provider can charge the exit amount after the care recipient's cessation date, but before the transfer of the unspent funds (as outlined above).

Exit amounts may only be deducted if the care recipient leaves a provider's care (to change providers or to exit the HCP program altogether) and:

- the provider has published the exit amount on the My Aged Care website
- the care recipient has agreed to an exit amount in their Home Care Agreement
- the care recipient still has unspent funds held by the provider when they exit care.

If the criteria above are not met the provider will not be able to charge an exit fee for that care recipient.

The Department notes that the level of unspent funds held by providers is likely to reduce as a result of Improved Payment Arrangements (See Appendix E) and that this may impact on the ability to charge exit fees into the future.

An exit amount is not considered a type of care or service and cannot be charged as part of the price reported to Services Australia.

13.5 My organisation has undergone a merger or acquisition. How do I transfer my care recipients?

When a provider has undergone a merger or acquisition, their care recipients will need to be exited from their service and transferred to the new provider.

Services are required to contact the Department to advise of transfers, mergers or closures, including effective dates. The Department will advise Services Australia of this information.

It is also the services' responsibility to transfer all care recipient from the closing service to the continuing service.

Further guidance on obligations if a provider is subject to a merger or acquisition can be found at this link, or by searching "Transferring home care services to another approved provider" at www.health.gov.au.

Note that if a provider is looking to move care recipients from one of their home care services to another within their control, they can do this via a self-service process in the My Aged Care Provider Portal. Providers can find support with technology and guidance on how to use the My Aged Care Provider Portal at this link. They can also search "My Aged Care for service providers" at www.health.gov.au.

More information on administrative responsibilities is at Section 15 of this manual.

✓ Key points to remember

- Care recipients can change home care providers at any time.
- If someone receiving home care services chooses to change providers, it is important that they and their existing provider agree a cessation date. This affects the way the providers claim the care recipient's package subsidy and when the existing provider will need to transfer the care recipient's unspent funds.
- The existing provider must transfer the care recipient's unspent funds to their new provider as soon as possible, but within 70 calendar days, of the cessation date.
- If a provider has a transferring care recipient who entered care before 1 July 2014 and they want to opt into the post-1 July 2014 fee arrangements, they must complete the **"Continuing Care Recipient opting into the New Aged Care Arrangements from 1 July 2014 (AC022)"** form. The care recipient must submit this form to their new provider. The new provider must give them a copy of the *New Arrangements for Aged Care from 1 July 2014 – Home Care* publication before they transfer to the new service.

14 Leaving the HCP Program

This section tells providers the steps they need to take if a care recipient leaves the HCP Program.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 52D-1 and 56-2 of the *Aged Care Act 1997*
- *Fees and Payments Principles 2014 (No.2)*
- *User Rights Principles 2014*
- *Accountability Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

14.1 What administrative tasks do I need to complete?

14.1.1 Notify Services Australia of a care recipient ceasing care

Within 31 calendar days of a care recipient ceasing services, the provider must notify Services Australia through the Aged Care Provider Portal of their name, cessation date, and the reason for their departure (for example, moving to residential aged care or passing away). The Aged Care Provider Portal is at this link, or can be found by searching "Aged Care Provider Portal" at www.servicesaustralia.gov.au.

If a care recipient moves into permanent residential aged care, their start date with their residential aged care provider will be the date their home care provider ceases receiving payment of subsidies. It is important that the home care provider agrees with the individual and their residential aged care provider the cessation date for their package and the start date for residential care, to ensure the home care provider is eligible to receive all subsidies they are expecting to receive.

If a person passes away, in addition to making the necessary changes on the Provider Portal, providers should call My Aged Care on **1800 200 422** so they can update their record. This is important, as it will ensure future communications with family members are mindful of this fact, and do not cause further distress. Alternatively, providers can advise the care recipient's representative to call My Aged Care.

14.1.2 Complete hand over (if relevant)

It is important that aged care recipients have continuity of care. As a part of care management, providers should do a hand over with relevant parties when needed, to ensure each person's care needs are understood. Providers should seek the care recipient's permission to share their information and documentation about their care. This will ensure any new providers of aged care will have as much information as possible to inform the care they provide.

This should occur before the care recipient's cessation date. If it occurs after the cessation date, the provider will not be able to charge the care management to them.

This will not be required if the care recipient has passed away.

14.1.3 Make payment of unspent home care amount

If a care recipient leaves home care or passes away, their provider must undertake the following with respect to unspent funds:

- Transfer the care recipient portion to the person or their estate. If they are leaving the HCP Program, this must be completed within 70 days after the cessation date. If they have passed away, this must be completed within 14 days of being shown the probate of the Will or letters of administration.
- If the provider has not opted-in under Improved Payment Arrangements to draw down on the Australian Government portion of unspent funds (or if they have opted-in but not yet drawn down these funds to $0) the provider will need to notify the Australian Government of the Australian Government portion (including nil amounts) within 70 calendar days through the claims process managed by Services Australia.

Care recipients who join the HCP Program after 1 September 2021, will never have an Australian Government portion held by the provider. Any unspent funds held by the provider will be entirely made up of the care recipient portion.

14.2 When can I charge the exit amount?

Providers can charge the exit amount after the care recipient's cessation date, but before the transfer of the unspent funds (as outlined above).

If the value of the provider-held unspent funds are less than the value of the exit amount (as agreed in the Home Care Agreement), the provider can only charge the exit amount up to the value of the available unspent funds. If the care recipient has no unspent funds held by the provider then the provider cannot charge any exit amount.

See Section 13.4 for further detail on exit fees.

✓ Key points to remember

- Providers should support care recipients through their transition to other aged care programs.
- Providers must notify Services Australia when a care recipient leaves the HCP Program.
- Providers can charge the exit amount after the care recipient has ceased receiving services from them, but before they transfer the unspent funds. Providers should then make payment of their unspent home care amount in the appropriate portions to the Australian Government (if any) and to the care recipient (or their estate).

15 Providers' reporting and administrative responsibilities

Once providers are set up to provide services under the HCP Program they need to continue to comply with their disclosure and reporting obligations.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 9-1A, 9-2, 9-3, 9-3B, and 63-1 of the *Aged Care Act 1997*
- *Accountability Principles 2014*
- *Records Principles 2014*
- *Sanctions Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix D** for further detail on specific provider responsibilities.

15.1 My organisation's circumstances have changed. What do I need to do?

There are two types of changes that providers need to notify either the Department or the Commission about:

15.1.1 Changes to the home care service

Changes to the home care service includes things like changes of name, address or contact details. In short, if the change affects who or how the Department can contact the approved provider they must notify the Department.

This can be done by completing the form at this link. You can also find the form by searching "Notification of changes for Home Care Packages" at www.health.gov.au.

15.1.2 Material changes to suitability

Approved providers have an ongoing responsibility to ensure they are ready and able to provide legislatively compliant, high quality and safe home care services at all times. For more information on this, see Sections 2, 3 and 4 of this manual.

Provider suitability is assessed against the following five considerations:

1. Experience in providing aged care or other relevant forms of care
2. Understanding of approved provider responsibilities
3. Systems it has, or will have, in place to meet these responsibilities
4. Record of financial management and the methods used, or proposed to ensure sound financial management
5. Conduct as a provider (including compliance with responsibilities as a provider) and obligations arising from the receipt of any payments from the Australian Government for providing that aged care or any other relevant form of care.

If anything changes that materially affects these criteria, providers are required to disclose this information to the Commission. This information must be disclosed using the **"Notification of Material Change"** form. The form is at this link or can also be found by searching "Notification of a Material Change" at www.agedcarequality.gov.au.

All notifications must be made within 28 days of the change occurring. Penalties may be applied if a provider does not notify the Commission within this timeframe.

The **"Notification of Material Change Form"** (discussed above) can also be used by an approved provider to update information about its organisation which may include key personnel responsible for the overall governance of the organisation or the authorised contacts or address information.

15.2 My key personnel have changed. What do I need to do?

Providers are responsible for knowing who in their organisation meets the definition of key personnel as outlined in Section 8B of the *Aged Care Quality and Safety Commission Act 2018* and ensuring their key personnel are not a disqualified individual. Providers will be liable for any sanctions if it is determined that key personnel are disqualified individuals.

As discussed at Section 4, a disqualified individual is someone who has been convicted of an indictable offence, is insolvent or under administration, or is certified by a medical practitioner that they have a mental incapacity to perform their duties as key personnel. Each State and Territory law identifies different types of offences as being indictable. These typically include serious offences such as murder, manslaughter, the intentional or unlawful administration of drugs or poisons, or committing fraudulent or dishonest activities.

Providers must take reasonable steps to ensure none of their key personnel are a disqualified individual. The following steps are taken by the legislation to constitute 'reasonable steps'.

For each of a provider's existing key personnel:

- Ensure that the person understands the obligations of key personnel and of approved providers under the Act in relation to disqualified individuals
- If the provider reasonably believes that the person may be mentally incapable of performing his or her duties as one of their key personnel, make arrangements for the person to be examined by a registered medical practitioner
- If the provider reasonably believes that the person may be a disqualified individual, take the steps outlined below
- If the provider has ascertained that the person is a disqualified individual, ensure that the person ceases to be one of their key personnel.

For any person who proposes to become, or becomes, one of a provider's key personnel:

- Obtain a police certification for the person (this requires their written consent);
- Conduct a search of bankruptcy records; and
- Conduct previous employment and referee checks.

If a provider fails to take reasonable steps to ensure their key personnel are not disqualified individuals, they may be liable to pay a fine, face revocation of their approved provider status or, in certain circumstances, face a prison sentence.

Providers need to keep documentation, such as police checks, confirming the suitability of their key personnel. These obligations arise under the *Records Principles 2014* and have been outlined at **Appendix D** of this manual.

15.3 What are my financial disclosure obligations?

Approved providers must complete an Aged Care Financial Report (ACFR) annually, four months after the end of the financial year. All financial reporting requirements for residential aged care, HCP Program and short-term restorative care are reflected in the ACFR template so providers can report on all the aged care services they provide in one report to the Department.

15.3.1 Home Care financial reporting

To support all aged care providers to meet their legal obligation to complete the ACFR annually, the Department sends each provider an ACFR User Guide. This guide is sent out during August, and a customised cover letter explains which sections of the ACFR are relevant to the recipient's organisation.

Home care providers will be prompted to complete the Home Care Financial Report (HCFR) section of the ACFR. The HCFR is to be completed at a Planning Region level, with a home care service defined as an approved provider's home care operation within an aged care planning region. While some providers will have their Home Care Service IDs at the planning region level, others will have their Service IDs at the package level (i.e. Level two packages). Where Service IDs are at the package level, providers may be required to aggregate their financial information in order to complete the Financial Report.

15.3.2 Lodgement

Providers must lodge all required sections of the ACFR with the Department, via the online ACFR portal. The portal can be found at health.formsadministration.com.au. The ACFR portal can only be accessed through VANguard or myGovID login. You can continue to use your existing AUSKey to access Health services until the end of March 2020. For more information about the removal of AUSkey from My Aged Care, please see this link. Providers must complete and lodge their ACFR by 31 October for the previous financial year ending 30 June.

There are no provisions within the legislation to grant extensions. Providers must lodge their ACFRs early to provide adequate time to address any issues and finalise all components of the ACFR as it relates to their organisation. The Department may take compliance action if providers fail to comply with these requirements. A range of sanctions can be imposed on an approved provider including revoking or suspending approval as a provider of aged care services and restricting approval to provide aged care services. The type of sanctions imposed on an approved provider will depend on the nature of the non-compliance.

ACFRs cannot be lodged until all the required sections are completed and correct, and all necessary documents have been uploaded at the ACFR portal. The customised cover letter sent directly to all providers with each financial year's ACFR user guide will outline all sections relevant to providers delivering the HCP Program.

15.3.3 Pricing review

Providers must also review their full price list and do one of the following:

- Report to the Department that they have done so. This can be done by entering 'Confirm review of pricing information' in the My Aged Care Provider Portal.
- Update their price list. This will cause the 'last updated date' to update in the Department's systems, and will be sufficient evidence that the provider has reviewed their price list.

More information on obligations related to pricing is at **Appendix B**.

15.4 What happens if I am not compliant with my obligations or responsibilities?

The consequences of identified non-compliance by aged care providers depends on the risks posed by the non-compliance and the provider's response to the Commission's concerns. The Commission's primary concern is the risks to the health, welfare or interests of current and/or future recipients of aged care services.

Reflecting this, compliance can include things like education, repayments, issuing a non-compliance notice or sanctions. If there is a recurring non-compliance, continued unwillingness or inability by the provider to address the non-compliance, the Commission may revoke their approval to provide aged care. In some instances non-compliance could also result in a criminal charges for the most serious breaches.

Please note, other penalties or sanctions may also arise under other legislation, such as the consumer law.

✓ Key points to remember

- Providers must notify the Department of changes to their circumstances.
- Providers have annual obligations to report financial information to the Department. They can complete reporting for all aged care services they provide in one form.
- Providers must notify the Commission of material changes to suitability.
- Providers are responsible for ensuring that key personnel are not disqualified individuals.
- Providers also have an annual obligation to review their price list annually.
- If providers have a financial year that ends on 30 June, they must report their financial information by 31 October.
- On 1 January 2020 the Commission took on compliance functions, previously the responsibility of the Department of Health. The regulatory management of this matter now rests entirely with the Commission.

15.5 Reporting issues

Aged care providers must spend package funds appropriately.

15.5.1 Reporting suspected non compliance with provider requirements

The Commission has processes for people to raise a concern or make a complaint about the quality of care or services provided to people receiving Australian Government funded aged care. More information is available at this link or by searching for 'complaint' at www.aged carequality.gov.au.

The consequences of identified non-compliance by aged care providers depends on the risks posed.

When resolving complaints in relation to the care and services, if the Commission finds a provider used package funds inappropriately then it can initiate compliance action, including at a minimum, repayment of any amounts that have been incorrectly charged.

15.5.2 Reporting suspected fraud

The Department does not tolerate fraudulent use of HCP funding. If funding is used for purposes stipulated in the 'Specified Exclusions' table at 9.2.3 or for other items deemed not part of services

or care to be funded by a HCP, the Department may initiate a fraud investigation and take action accordingly.

The Department has the power to investigate allegations of fraud against health funding and programs and is actively engaged in intelligence gathering with external agencies.

IF YOU SEE SOMETHING, SAY SOMETHING BECAUSE FRAUD IS A CRIMINAL OFFENCE.

If you suspect that an approved provider, including a competitor, is engaging in fraud, or you have concerns about the financial management of HCP funding, please contact the Department via email at fraudsection@health.gov.au. Alternatively, you can call the Health Fraud Hotline on **1800 829 403**, between 9am to 5pm Australian Eastern Standard Time, Monday to Friday. You can report suspected fraud anonymously.

If an approved provider wants to self-report a concern, they should contact the Department.

16 Interface with other Programs and Schemes

This section provides information on what programs can be accessed at the same time as the HCP Program. It focusses on the Commonwealth Home Support Programme, because it is related to the HCP Program within the Australian Government continuum of care for senior Australians, but also discusses a broad range of other programs.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

No specific obligations arise. The *Aged Care Act 1997*, however, governs how the HCP Program interacts with other programs. As providers of services under the program, providers are expected to comply with those laws.

16.1 How does the HCP Program interface with other programs?

As outlined at Section 2, the HCP Program is a part of the Australian Government's continuum of care for senior Australians. The table below outlines what other services can or cannot be received at the same time as the HCP Program:

Services that may be received while receiving HCP Program services	Services that cannot be received while receiving HCP Program services
Commonwealth Home Support Programme^	Permanent Residential Aged Care
Community Visitors Scheme	Short Term Restorative Care
Continence Aids Payment Scheme	Transition Care Programme
DVA Programs	Multi-Purpose Services Program
Residential Respite Care*	National Aboriginal and Torres Strait Islander Flexible Aged Care Program
Dementia Behaviour Management Advisory Services (DBMAS)	
Palliative Care	
National Dementia Support Program	
National Disability Insurance Scheme (NDIS)^	

^Under limited circumstances

* Unless the care recipient has taken leave from their package.

16.2 What is the Commonwealth Home Support Programme?

The Commonwealth Home Support Programme (CHSP) represents the entry tier of the Australian Government aged care system. Investment in entry-level support that focuses on keeping people

independent and safe in their own homes can delay the need to move to more intensive forms of care. This benefits frail senior Australians through increasing their independence and quality of life as well as reducing Australian Government outlays for other forms of care, such as residential aged care.

Assessment for eligibility to access the CHSP is completed by the Regional Assessment Service (RAS). An ACAT may also approve eligibility.

The CHSP provides funding for a broad range of entry-level support services to assist frail senior Australians aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) and who have functional limitations (including cognitive), to remain living independently at home and in their community[2].

CHSP subsidised services are delivered on a short-term, episodic or ongoing basis, with a strong focus on activities that support independence and social connectedness and taking into account each person's individual goals, preferences and choices. As with the HCP Program, people receiving services through the CHSP may need to contribute funds towards their services[3].

As an 'entry-level' program, the CHSP is designed to provide relatively low intensity (small amounts) of a single service or a few services to a large number of frail senior Australians. These services are designed for senior Australians who need only a small amount of assistance or support to enable them to maintain their independence, continue living safely in their homes and participate in their communities.

The CHSP is not designed for senior Australians with more intensive, multiple or complex aged care needs, and does not replace or fund support services already provided for other programs or schemes, including the health care system. People with higher needs are supported through other aged care programs.

16.3 How does the HCP Program interact with Commonwealth Home Support Programme?

The HCP Program is designed to support senior Australians living in the community whose care needs exceed the level of support that can be provided through the CHSP.

CHSP service providers should only supply additional CHSP services to a person receiving a home care package where they have the capacity to do so without disadvantaging the CHSP target population. People who need CHSP subsidised services, but do not have access to other relevant support services, should be prioritised over people who are already receiving a home care package.

There are defined circumstances in which care recipients are able to receive specific CHSP subsidised services on a time-limited basis when they are in a package (that is, the additional CHSP services will not be charged to their package budget). These circumstances are limited, to ensure the CHSP continues to, in the main, deliver entry-level services.

They include:

- For care recipients on a Level one or two package: where the care recipient's package budget is already fully allocated, they can access additional, short-term or episodic Allied Health and

[2] **Note**: the eligible ages for the Assistance with Care and Housing (ACH) Sub-Program differ from those for the core Commonwealth Home Support Programme. Further detail on the sub-program can be found in the Commonwealth Home Support Programme Manual. The manual is at this link, or can be found by searching "Commonwealth Home Support Programme (CHSP) Manual" at www.health.gov.au/.

[3] This occurs through the 'Client Contribution Framework'. Further detail can be found at Chapter 5 of the Commonwealth Home Support Programme Manual (at the link above).

Therapy services or Nursing services from the CHSP, where these specific services may assist the care recipient to regain functionality after a setback (such as a fall).

- For care recipients on a Level one to four package: where the care recipient's package budget is already fully allocated and a carer requires it, they can access additional planned respite services under the CHSP (on a short-term basis).
- For care recipients on a Level one to four package: in an emergency (such as when a carer is not able to maintain their caring role), where the care recipient's package budget is already fully allocated, additional services under the broader CHSP can be obtained on an emergency or short-term basis. These instances must be time limited, monitored and reviewed.
- For care recipients on an interim Level one or two package who are waiting for a Level three or four package; where the care recipient's package budget is already fully allocated, they can access additional minor home modifications from the CHSP.
- For care recipients on a Level one to four package: care recipients who have transitioned from the CHSP may continue to access their existing CHSP social support group on an ongoing basis to allow the continuity of social relationships. This only applies to care recipients attending a pre-existing CHSP social support group service.

These instances should be time limited, monitored and reviewed. During these times, the package is not suspended; both the HCP Program and the CHSP will be received concurrently.

More information is available in the Commonwealth Home Support Programme Manual. The manual is at this link, or can be found by searching "Commonwealth Home Support Programme (CHSP) Manual 2020-2022" at www.health.gov.au.

You can also refer to the factsheet at this link for more information on how the HCP Program interacts with the Commonwealth Home Support Programme. You can also find the factsheet by searching "Commonwealth Home Support Programme interaction with Home Care Packages" at www.health.gov.au.

16.4 How does the HCP Program interact with other programs and schemes?

It may be possible for a person to receive care and services through a range of other programs and schemes that they cannot receive as part of a home care package. Key programs and schemes are outlined below. Providers should work with their care recipients to identify additional services that they may need, and to explore the best available combination of health and aged care services.

More detailed information about the individual programs is available on the My Aged Care website, at www.myagedcare.gov.au. You can also call the My Aged Care contact centre on **1800 200 422**. For information on how other programs or schemes interact with the HCP Program, please refer to information on the program or scheme of interest.

16.4.1 Residential Aged Care

Under the *Aged Care Act 1997*, an entry into permanent residential care will result in the withdrawal of an active home care package. If a care recipient is receiving HCP Program services and needs to permanently move to a residential aged care facility, their home care provider is responsible for discussing this move with them and mutually agreeing a cessation date.

16.4.2 Transition Care

Transition Care provides time-limited, goal-oriented and therapy-focused packages of services to senior Australians after a hospital stay.

People receiving HCP Program services are able to access transition care after a hospital stay if they are assessed and approved as eligible by an ACAT and take appropriate leave from their package. Information on leave can be found at Section 11.

This program is jointly funded by the Commonwealth and State or Territory governments.

16.4.3 Short Term Restorative Care

Short Term Restorative Care (STRC) provides a time-limited, goal-oriented, multi-disciplinary and co-ordinated package of services. STRC aims to reverse and/or slow 'functional decline' in senior Australians and improve their wellbeing.

A care recipient cannot receive STRC if they are also receiving a package. They may choose to end their STRC even if they have not yet met their physical and cognitive goals in order to enter the HCP Program. In this circumstance, the home care provider should ensure the care plan incorporates strategies to assist the care recipient to achieve these physical and cognitive goals.

16.4.4 Community Visitors Scheme

The Community Visitors Scheme (CVS) supports volunteers to make regular visits to senior Australians who are socially isolated or are at risk of social isolation or loneliness. CVS provides friendship and companionship by matching individuals with volunteer visitors.

The CVS is available to recipients of Australian Government subsidised residential aged care services or home care.

Further information about the CVS, including frequently asked questions, can be found at this link, or by searching "Community Visitors Scheme" at www.health.gov.au.

Any eligible care recipient whose quality of life could be improved by the companionship of a regular community visitor can be referred to the CVS. A CVS State Network Member can assist to find a CVS service provider in your area. The CVS State Network Member contact list is available from the CVS webpage at this link, or by searching "CVS State and Territory network members" at www.health.gov.au.

As part of the Lesbian Gay Bisexual Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy, the CVS was expanded to include services that specifically cater for the needs of LGBTI people.

Home care consumers who are socially isolated and whose quality of life would be improved by friendship and companionship may access the CVS program without any impact on services received through their package.

16.4.5 Continence Aids Payment Scheme

HCP Program care recipients are eligible to access the Continence Aids Payment Scheme, through Services Australia, as long as their care plan does not already include continence support.

16.4.6 DVA Programs

Senior veterans or a war widow/widower may be able to get aged care services from the DVA and the Department at the same time, as long as the same services are not accessed for both.

For example, a care recipient may access low-level domestic assistance and personal care through the Veterans' Home Care Program, and receive social assistance and respite through the home care package.

16.4.7 Residential Respite Care

People receiving HCP Program services are able to access residential respite if they are assessed and approved as eligible by an ACAT. Respite is standard practice to give carers a break, and needs to be accounted for in care planning with care recipients. This is discussed further at Section 10 of this manual.

Care recipients can receive respite at the same time as a package, provided that they are not receiving the same services from both. For example, they may have a period of residential respite care but choose not to take leave from their package if they need gardening or other services about the home to keep it safe and secure. Leave is discussed at Section 11.

16.4.8 Palliative Care

Palliative care may be beneficial to any person with a life-limiting illness, regardless of their age.

The aim of palliative care is to improve the quality of life for a person with a life-limiting illness, and to help them live well for as long as possible. People who have chronic or terminal health conditions may be supported by state and territory health palliative care specific services and housing systems, as well as the aged care system, to provide basic daily living support and care, such as assistance with daily chores, personal care, providing meals, transport assistance, respite care, home modifications and social support.

16.4.9 National Dementia Support Program

The National Dementia Support Program (NDSP) provides education, resources, and counselling and support to people living with dementia and their families and carers to improve awareness and understanding about the disease.

The NDSP offers a website and national helpline, where professional counselling or group and individual support sessions can be scheduled. These resources can help care recipients, including people living with dementia and their families and carers, with support strategies to cope with dementia, and provide advice on what to expect once a diagnosis of dementia is received. The NDSP also offers education and training to family members and carers of people living with dementia to help them remain in their own homes for longer, where appropriate, and help ensure they are aware of the requirements of people living with dementia.

People living with dementia, their families and carers and health professionals can contact the National Dementia Helpline on **1800 100 500** (free call). People can also go to www.dementia.org.au to discuss any concerns or access information about memory loss or dementia.

16.4.10 National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) funds reasonable and necessary supports that are not provided from other formal and informal sources. Care recipients cannot receive NDIS support and the HCP Program at the same time if they were over 65 years of age when they entered the HCP Program. If a person has been admitted to the HCP Program before turning the age of 65 years and has been determined eligible for the NDIS they are expected to move from their home care package as soon as possible. Until then, they may access both programs, as long as are not receiving the same care and services under both.

Providers can find more information on the NDIS at this link, or by searching “Provider toolkit” at www.nds.org.au.

The webpage at this link provides information that may be useful for providers who deliver home care to younger people who may also be eligible for the NDIS. You can also find the webpage by searching “providing aged care services to younger people” at www.health.gov.au.

Key points to remember

- Generally, care recipients cannot receive CHSP and HCP Program services at the same time. In limited circumstances they may be able to receive small amounts of top up CHSP at the same time as they receive HCP Program services.
- Care recipients can receive support from some other programs where needed. Some of these programs are listed at **Section 16.4**.
- The HCP Program cannot be received at the same time as STRC, transition care, or permanent residential aged care.

Appendix A: Pre-1 July 2014 arrangements

On 1 July 2014, the way home care fees are calculated changed. For people that received a package before 1 July 2014, these changes do not apply and they may continue to be asked to pay their current home care fees.

This manual has outlined the way the HCP Program currently operates, under the post-1 July 2014 arrangements. Care recipients who were in the program before 1 July 2014 however, are entitled to continue to receive home care on the basis of the pre-1 July 2014 arrangements.

If a person was receiving a package on or before 30 June 2014 and they move to a new home care service (and do not spend more than 28 days outside of care, other than on approved leave), they can opt into the fee arrangements that started on 1 July 2014.

To make this choice, they will need to complete and sign the **"Continuing Care Recipient opting into the New Aged Care Arrangements from 1 July 2014 (AC022)"** form and submit this form to the new provider before they transfer to the new service. Form AC022 is at this link or by searching "AC022" at www.servicesaustralia.gov.au. The new provider must submit this form with the ACER to Services Australia through the Services Australia Provider Portal. The new provider also needs to give the care recipient the *New Arrangements for Aged Care from 1 July 2014 – Home Care* publication available at this link or by searching for the form at www.health.gov.au.

If the care recipient does not complete this form and have it submitted to Services Australia before they transfer providers, they will automatically be classed as a 'continuing care recipient' and will remain on their pre-1 July 2014 fee arrangements. This is not a reviewable decision and must be done correctly in order to opt in to the post-1 July 2014 fee arrangements.

This section outlines how the package budget and leave work for pre-1 July 2014 care recipients, and provides a checklist of components that must be included in a Home Care Agreement with a pre-1 July 2014 care recipient. Unless indicated in this appendix, the HCP Program operates in the same manner for people receiving a home care package, regardless of when they entered the HCP Program.

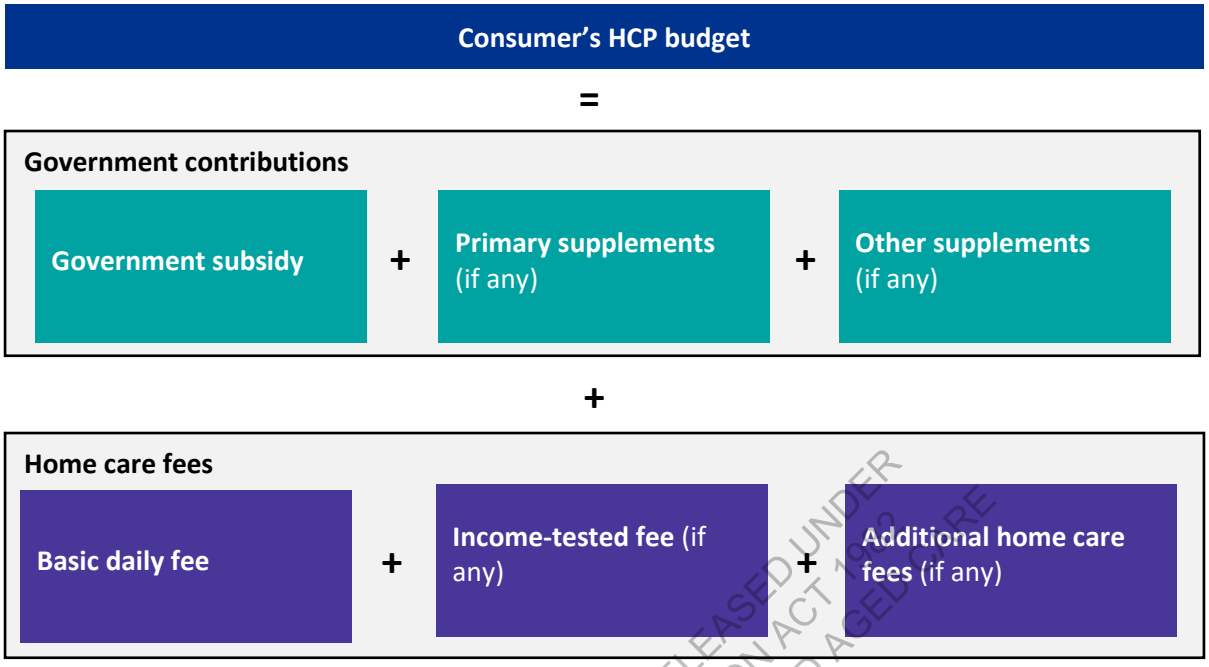
✓ **Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section**
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Section 56-2 of the *Aged Care Act 1997*
- Sections 60-1 and 60-2 of the *Aged Care (Transitional Provisions) Act 1997*
- *Aged Care (Transitional Provisions) Principles 2014*
- *User Rights Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations pursuant to them.

See **Appendix D** for further detail on specific provider responsibilities.

A.1 What makes up the package budget for care recipients in the pre-1 July 2014 arrangements?



A.2 How do I work out the Government contribution for pre-1 July 2014 care recipients?

The Government contribution can be determined by adding together the Government subsidy, plus any primary and other supplements for which the care recipient is eligible. This is outlined in the diagram at Section A.1 of this Appendix.

In home care, prior to 1 July 2014, there was no reduction in subsidy and primary supplements paid by Government if the provider did not charge the income tested fee. If collected, any fee would be additional to the value of the package. In setting these fees, providers need to consider if they would cause the care recipient financial hardship and reduce the level of fees as necessary.

The same subsidy and supplement rates will apply for people receiving a home care package, regardless of when they entered the HCP Program.

Pre-1 August 2013 care recipients who were receiving an Extended Aged Care at Home – Dementia (EACH-D) package are eligible for the dementia and cognition supplement plus the top up supplement. This supplement is automatically applied by Services Australia, and will automatically transfer to the new provider if the individual changes providers.

A.3 How do I work out the home care fees for pre-1 July 2014 care recipients?

Providers are responsible for working out the home care fees that they will charge to care recipients in the pre-1 July 2014 arrangements. The Services Australia income assessment that people who

entered the HCP Program after 1 July 2014 complete does not consider the pre-1 July 2014 fee structure.

A.3.1. Basic daily fee

- Level 1 - the maximum fee 15.68 per cent of the basic rate of the single age pension.
- Level 2 - the maximum fee 16.58 per cent of the basic rate of the single age pension.
- Level 3 - the maximum fee 17.05 per cent of the basic rate of the single age pension.
- Level 4 - the maximum fee 17.50 per cent of the basic rate of the single age pension.

A.3.2. Income tested fee

For care recipients with income above the basic rate of pension, providers can charge an additional amount of up to 50 per cent of income above the single Age Pension.

Calculating income

Income is defined as income after income tax and the Medicare levy. When calculating income for the purpose of determining ongoing fees, the following are excluded:

- any Pharmaceutical Allowance, Rent Assistance or Telephone Allowance;
- the Pension Supplement;
- the Clean Energy Supplement; and
- in the case of a Disability Pension payable under the *Veterans' Entitlements Act 1986* an amount equal to four per cent of the amount of the pension.

Please see Division 60 of the *Aged Care (Transitional Provisions) Act 1997* or section 130 of the *Aged Care (Transitional Provisions) Principles 2014* for more information.

A.3.3. Financial hardship

Home care recipients who began a home care package before 1 July 2014 are not eligible for the hardship supplement. Rather, these home care recipients are able to negotiate lower fees with their provider. The Aged Care (Transitional Provisions) Act 1997 allow providers to consider care recipients' other expenses such as high pharmaceutical bills, utilities and other living expenses when setting fees.

A.3.4. Review of fees

A review of fees should be conducted periodically (or whenever the care recipient requests a review). The care recipient should be encouraged to seek a review if their financial circumstances change.

The maximum fees may need to be varied when new rates for the Age Pension are announced each March and September. Providers may need to discuss the impact of these changes on fees with the care recipient and update their budget accordingly.

A.4 How does leave work for a care recipient in the pre-1 July 2014 arrangements?

Care recipients in the pre-1 July 2014 arrangements are entitled to take leave in the same circumstances as care recipients in the post-1 July 2014 arrangements, although the home care fees that will be payable differ. The table below outlines when home care fees will be payable:

Leave type	Home care fees
Hospital	Yes
Transition care	No
Residential respite care	No
Other leave	Yes

A.5 What do I need to include in a Home Care Agreement for a care recipient in the pre-1 July 2014 arrangements?

In addition to the components of a Home Care Agreement outlined at **Section 6.5** of this manual, a pre-1 July 2014 care recipient's Home Care Agreement will need to include the following:

- ☐ A statement that the provider may charge the care recipient home care fees in accordance with Division 6 of the *Aged Care (Transitional Provisions) Act 1997*
- ☐ A statement setting out which fee (if any), as determined in accordance with section 130 of the *Aged Care (Transitional Provisions) Principles 2014*, the provider will charge
- ☐ If the provider is charging the care recipient a daily amount of home care fees in accordance with Division 60 of the *Aged Care (Transitional Provisions) Act 1997* that is different from the daily amount of home care fees mentioned in their Schedule, the different amount and the reason for the different amount.

✓ Key points to remember

- Care recipients who entered the HCP Program before 1 July 2014, and who have not moved to the post-1 July 2014 arrangements, have different home care fee arrangements.
- Providers are responsible for calculating home care fees for pre-1 July 2014 care recipients.
- Providers will also need to ensure any Home Care Agreement entered into with a pre-1 July 2014 care recipient reflects the provisions that apply to them.

Appendix B: 1 July 2019 changes to pricing

New pricing requirements were introduced on 1 July 2019 to improve transparency for senior Australians. These requirements enable direct comparisons between home care providers, and are intended to curb problematic charging practices by some providers.

Key legislation, instruments and determinations underpinning this section
Note, this section is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Section 56-2 of the *Aged Care Act 1997*
- *User Rights Principles 2014*.

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with their obligations pursuant to them.

See **Appendix D** for further detail on specific provider responsibilities.

B.1 What is the pricing Schedule and what do providers need to do with it?

All home care providers are required to publish their pricing information in a new standardised pricing comparability Schedule (the Schedule) on the My Aged Care Service Finder. The Schedule has been designed to:

- encourage senior Australians to consider other factors in addition to the price of the service when choosing an approved provider
- provide clear and unambiguous pricing information on the common home care package services
- achieve price comparability across common home care package services
- limit any impact on the ability of providers to innovate by catering for different business models
- ensure equity in the requirements across providers and allowing dedicated areas to promote their value statement and point of difference.

The Schedule includes five common home care services:

- personal care
- nursing
- cleaning and household tasks
- light gardening
- in-home respite.

The Schedule also displays information on maximum exit amounts. Providers will also be able to indicate if they charge a per kilometre cost for a care worker to travel to the care recipient's location; or if they charge an extra amount if a care recipient wishes to sub-contract, and receive services through a different provider. Providers will need to explain their approach to any separate cost, for example, if it is charged separately or included in the service price.

Within the Schedule, providers will need to nominate a single price (the most common) for each common home care service within the Schedule. Where providers offer genuine care recipient choice of different prices for a service, they will also be able to enter the minimum and maximum price points. This may be where an approved provider arranges services via sub-contracting arrangements and therefore can offer their care recipients different prices for a service.

Providers will be able to complete a different pricing Schedule where required, for example to account for regional variability in pricing.

Providers must review, and if required, update their pricing Schedule on My Aged Care annually. This will ensure accurate pricing information is published. Current pricing information must also be included within each individual Home Care Agreement. As discussed at Section 15 providers are required to complete one of the following, to show that they have reviewed their Schedule:

- Report to the Department that they have done so. Providers can do this by entering 'Confirm review of pricing information' in the My Aged Care Provider Portal.
- Update their price list. This will cause the 'last updated date' to update in the Department's systems, and will be sufficient evidence that the provider has reviewed their price list.

B.1.1. Relationship between published and contracted price

The price published in the Schedule will be the default price charged.

A copy of the Schedule must be included within a care recipient's Home Care Agreement. This ensures the published price is a meaningful and accurate indication of the costs charged under a home care package.

There are situations where the contracted price will need to differ from the published price. For example, where the care recipient has a particular request. In these instances, the home care provider will need to negotiate and agree a price with their care recipient. This difference in price and accompanying reason will need to be clearly outlined within the Home Care Agreement and package budget. It is expected this would be an exception. In most instances, the price published will be the price charged.

B.1.2. Obligations through transition

For care recipients already in the program at 1 July 2019, providers have until 1 July 2020 to:

- review their Home Care Agreement and include a copy of the pricing schedule
- charge them the prices in that schedule, unless otherwise agreed — any different prices and the reason must be included in their Home Care Agreement
- roll any separate business-related administration costs they are retaining into service prices
- make sure any administration costs are reasonable.

B.1.3. Compliance

These pricing changes apply to all home care providers. This is to ensure consistency across the sector and allow all senior Australians to benefit.

Providers' compliance with these requirements is actively monitored. Compliance action may be taken, consistent with the compliance policy and procedures, as discussed throughout this manual.

B.2 How do the pricing changes affect care management?

Care management, often called case management or care coordination, is a key component of every home care package. The introduction of the Schedule provides an opportunity to better define care management, and educate senior Australians.

Providers need to indicate the cost for care management services and outline their approach to care management in the Schedule. Care management may include:

- ensuring each consumer gets safe and effective personal care and/or clinical care
- reviewing the Home Care Agreement and care plan
- coordination and scheduling of services
- ensuring the care is aligned with other supports
- providing a point of contact for the home care consumer or their support network
- ensuring care is culturally appropriate
- identifying and addressing risks to the home care consumer's safety.

Care management should ensure there is no overlap, over-servicing or mismanagement of services. These services may be provided in different ways including face-to-face or via phone or email.

B.3 How do the pricing changes affect the way administration costs can be charged?

There are different components to administration costs; package management costs, and other administration costs. Providers are able to include their fortnightly package management costs across each home care package level in the Schedule.

Package management is the ongoing organisational activities associated with ensuring the smooth delivery and management of a home care package. It may include the costs for preparing monthly statements; managing package funds; and compliance and quality assurance activities required for home care.

It does not include costs that are unrelated to supporting a care recipient's care or costs associated with running any business, such as marketing, office rent, insurance, or activities completed before a person enters into a Home Care Agreement.

Any other administrative costs that need to be recouped from a home care package, apart from package management, will need to be included in the unit price for specific care services. This will ensure people can see the all inclusive cost of delivering the service. Providers cannot charge more than a reasonable amount for any administration-related costs.

For more information on the 1 July 2019 changes to pricing please see this link or search "Price transparency for Home Care Packages" at www.health.gov.au.

Appendix C: Compensation payments

If a person receives a compensation entitlement under a judgment, a settlement, or a reimbursement arrangement, their home care package budget is amended slightly to account for this. A compensation entitlement includes things like a permanent impairment or incapacity payment to a veteran, a workplace insurance claim settlement, a motor vehicle accident claim settlement, or some types of common law settlements (such as, potentially, an award for personal injury caused by negligence).

The provider is responsible for asking the care recipient if they have a compensation entitlement and, if so, notifying the Department of that entitlement. Providers can notify the Department when they complete the form to notify a new care recipient starting in their care, discussed at Section 6, or at any other time by completing an ACER. An ACER can be completed using paper **"Aged care entry record form AC021"** at this link or by searching "AC021" at www.servicesaustralia.gov.au.

If a claim has not been settled, subsidies will continue to be paid on the care recipient's behalf up until the date liability has been accepted. Once the compensation insurer has agreed to pay or to contribute to the care costs, payment of subsidies will cease with the date of effect from the date of liability or settlement. Providers should notify the Department as soon as they become aware of a care recipient's compensations claims.

If a provider does not advise the Department that a care recipient is entitled to compensation and the Department later becomes aware of this, the Department will need to recover funds in arrears.

C.1 Package budget with compensation entitlement

If a provider has entered into a Home Care Agreement with a care recipient who has a compensation entitlement, and they have notified the Department, the Department will advise both parties of the amount of the compensation reduction amount. The provider will then be able to invoice the care recipient for the total amount of the compensation payment reduction and home care fees (if applicable). The amount is deducted from the Government's contribution and added to the care recipient's contribution.

Below is an example of a budget, including a compensation entitlement:

How do we calculate Sonali's package budget?

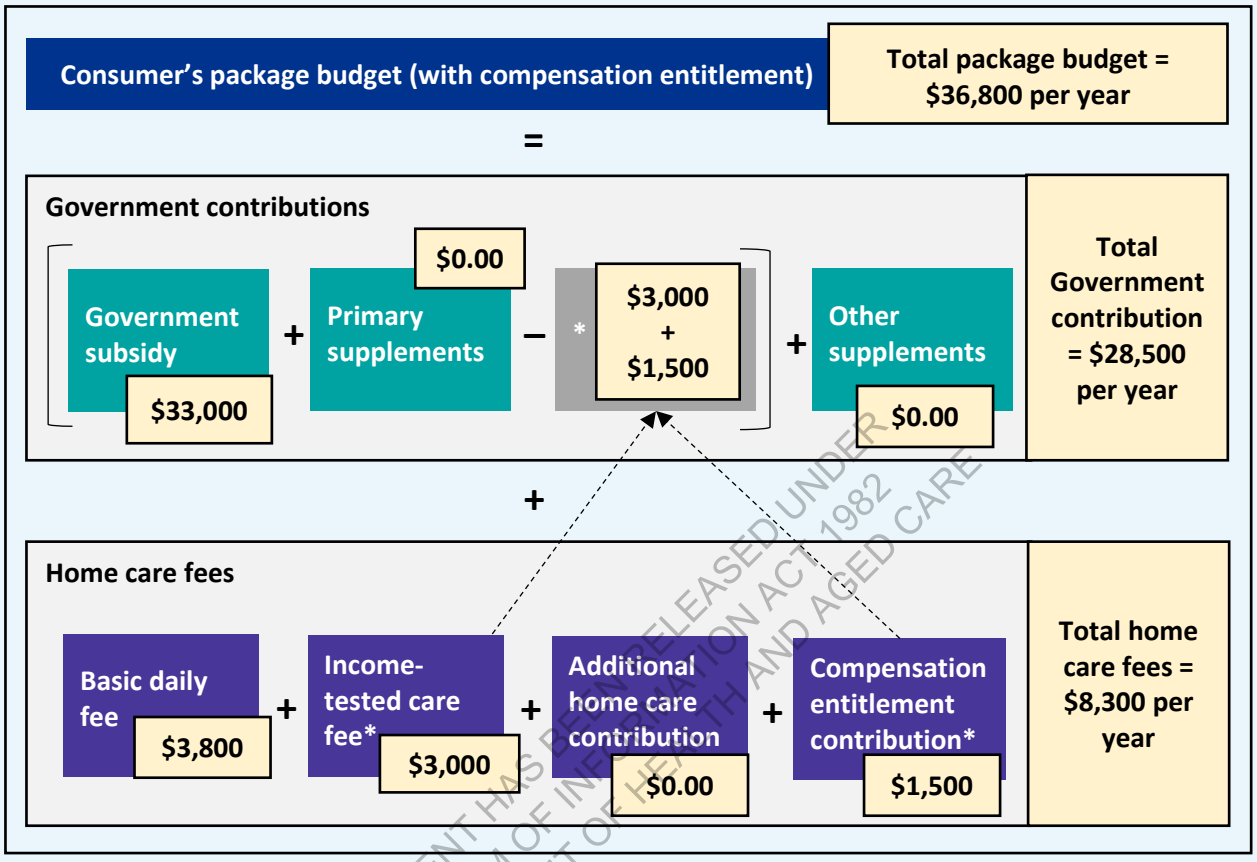
Fact scenario

- Sonali has been assigned a Level 3 package. The value of her package is approximately $33,000 per year.
- Sonali is not eligible for any primary or other supplements.
- The basic daily fee for Sonali's package level is $3,800 per year.
- Sonali has completed her income assessment, and has been assessed by Services Australia as being able to pay an additional $3,000 per year in income tested care fees.
- Sonali received a workplace injury settlement. Her provider notified Services Australia of the value of the settlement, and Sonali was told she would need to contribute an additional $1,500 per year in compensable entitlement contributions.
- Sonali did not agree to pay any additional fees in her Home Care Agreement.

How do we calculate Sonali's package budget?

Calculation of package budget

The diagram below outlines how Sonali's home care budget is calculated:



Appendix D: Responsibilities of approved providers

Approved providers must deliver aged care that aligns with the responsibilities and standards that are specified in the *Aged Care Act 1997* (the Act) and associated legislation. This information is designed to assist approved providers to meet their obligations as providers of aged care.

Quality of care – Part 4.1 in the *Aged Care Act 1997*

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Quality of care	Approved providers must comply with the Aged Care Quality Standards.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 3
Quality of care	Providers must maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 4
Care and services	An approved provider of a home care service must provide a package of care and services selected from those specified in Part 1 of Schedule 3 of the Quality of Care Principles. Extracted at section 9.2 of this manual.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 9
Care and services	Part 2 of Schedule 3 of the Quality of Care Principles specify excluded items that must not be included in the package of care and services provided under section 13 of the Quality of Care Principles. Extracted at section 9.3 of this manual.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 9
Care and services	Care and services provided to the care recipient must be consistent with the care recipient's care plan.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 7

Rights of care recipients – Part 4.2 in the *Aged Care Act 1997*

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Budgets, fees and pricing	An approved provider of home care must not charge for the care recipient's entry to the service through which the care is, or is to be, provided.	Section 56-2(a) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 6
Budgets, fees and pricing	If the care recipient is a post-1 July 2014 care recipient, providers must not charge more than the maximum daily amount. The maximum daily amount depends on the care recipient and will need to be worked out using the home care fee calculator. The home care fee calculator is at section 52D-2 of the *Aged Care Act 1997.*	Sections 52D-1, 52D-2 and 56-2(b) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Budgets, fees and pricing	If a care recipient who is a post-1 July 2014 care recipient leaves the HCP Program, any fees paid in advance in respect of a period occurring after the care recipient's death, or the cessation of home care, must be refunded to the care recipient.	Sections 52D-1 and 56-2(b) of the *Aged Care Act 1997*	*Fees and Payments Principles 2014 (No.2)* *User Rights Principles 2014*	Section 14
Budgets, fees and pricing	If the care recipient is a pre-1 July 2014 care recipient, providers must charge no more for provision of the care and services then the amount permitted by the *Aged Care (Transitional Provisions) Principles.* This is outlined in Appendix A Section 3 of this manual.	Section 56-2(c) of the *Aged Care Act 1997* Sections 60-1(a) and 60-2 of the *Aged Care (Transitional Provisions) Act 1997*	*Aged Care (Transitional Provisions) Principles 2014* *User Rights Principles 2014*	Appendix A
Budgets, fees and pricing	Care recipients must not be required to pay home care fees more than one month in advance.	Section 52D-1 of the *Aged Care Act 1997* Section 60-1(b) of the *Aged Care (Transitional Provisions) Act 1997*	*User Rights Principles 2014*	Appendix A

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Budgets, fees and pricing	Providers must not charge home care fees for any period prior to the time the care recipient was being provided with home care.	Sections 56-2(b), 56-2(c) and 52D-1 of the *Aged Care Act 1997* Section 60-1(c) of the *Aged Care (Transitional Provisions) Act 1997*	*User Rights Principles 2014*	Appendix A
Fees and payments	If a care recipient who is a pre-1 July 2014 care recipient leaves the HCP Program, any fees paid in advance in respect of a period occurring after the care recipient's death, or the cessation of home care, must be refunded as soon as practicable to the care recipient or a person authorised to receive the refund for the care recipient's estate.	Section 60-1(d) of the *Aged Care (Transitional Provisions) Act 1997*	*Aged Care (Transitional Provisions) Principles 2014*	Appendix A
Agreements with care recipients	Providers must provide such other care and services as agreed in the Home Care Agreement between the approved provider and the care recipient.	Section 56-2(e) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Fees and payments	Providers must charge no more for any other care or services than an amount agreed beforehand with the care recipient.	Section 56-2(d) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Budgets, fees and pricing	Providers must give the care recipient an itemised account of any other care or services.	Section 56-2(d) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Stability of approved provider	Providers must provide security of tenure to care recipients. The approved provider may cease to provide home care to the care recipient only if: • the care recipient cannot be cared for in the community with the resources available to the approved provider; or	Section 56-2(f) and 63-1AA of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	• the care recipient notifies the approved provider, in writing, that they wish to move to a location where home care is not provided by the provider; or • the care recipient notifies the approved provider, in writing, that they no longer wishes to receive the home care; or • the care recipient's condition changes to the extent that the care recipient no longer needs home care, or the care recipient's needs, as assessed by an aged care assessment team, can be more appropriately met by other types of services or care; or • the care recipient: has not paid to the approved provider, for a reason within the care recipient's control, any home care fee specified in the home care agreement between the care recipient and the approved provider; and has not negotiated an alternative arrangement with the approved provider for payment of the home care fee; or • the care recipient has: intentionally caused serious injury to or infringed the right of a staff member (to work in a safe environment) of the approved provider.			
Agreements with care recipients	Providers must offer to enter into a Home Care Agreement with the care recipient, and, if the care recipient wishes, to enter into such an agreement.	Section 56-2(g) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 6
Agreements with care recipients	The Home Care Agreement must include specified provisions. These are extracted at Section 6 of this manual.	Section 61-1 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 6
Monitoring, compliance and other access	Providers must allow people acting for bodies that have been paid advocacy grants under Part 5.5 to have access to each home care	Section 56-2(j) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 12

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	service through which they provide home care.			
Rights of care recipients	Providers must not act in a way which is inconsistent with the legal and consumer rights of a care recipient.	Sections 54-1(1)(d) and 56-2(k) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 3 and 6
Rights of care recipients	Providers must give a prospective care recipient a copy of the Charter of Aged Care Rights ('the Charter'). The copy of the Charter that is provided must: • be signed by a staff member of the provider; • include the signature of the care recipient or their authorised person, if they have signed it; • include the date on which the care recipient or their authorised person was given reasonable opportunity to sign the Charter, if they have not signed it, • set out the full name of the care recipient, • set out the full name of an authorised person who was present at the time the copy of the Charter was given to the care recipient, if relevant, and • set out the date on which the copy of the Charter was given to the care recipient. This must be done before the care recipient enters into a home care agreement with the provider the provider's home care service, or by 1 December 2019 for care recipients who were already receiving home care services from the provider on 1 July 2019.	Sections 56-2(k) and 56-2(l) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3
Rights of care recipients	Providers must give a prospective care recipient information about their rights and responsibilities (including in relation to the payment of home care fees), and the rights	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	and responsibilities of their provider. This must be done before the care recipient enters into a home care agreement with the provider.			
Rights of care recipients	Providers must assist prospective care recipients to understand information provided to them, including the Charter of Aged Care Rights.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3
Rights of care recipients	Providers must ensure that the care recipient, or an authorised person of the care recipient, has been given reasonable opportunity to sign a copy of the Charter of Aged Care Rights (after it has been provided to them).	Section 56-2of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3
Rights of care recipients	Providers must take reasonable steps to prevent the provider, or a person employed or otherwise engaged by the provider, from causing damage to a care recipient's home and other property in the course of providing the home care.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	-
Rights of care recipients	Providers must provide such information as is reasonably necessary to assist a care recipient to choose the care and services that best meet his or her goals and assessed needs and preferences, within the limits of the resources available.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 8
Care and services	Providers must give care recipients a written plan of the care and services that they will receive before the care recipient receives home care or within 14 days of the date on which they commence receiving home care.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 8
Budgets, fees and pricing	Providers must give care recipients invoices that are clear and in a format that is understandable.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10
Budgets, fees and pricing	Providers must periodically review the home care fees that each care recipient is liable to pay, including if requested to do so by a care recipient on the grounds that the care	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	recipient's financial circumstances have changed.			
Budgets, fees and pricing	Providers must provide notice of their pricing Schedule to the Secretary before offering to enter into a Home Care Agreement with a care recipient.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B
Budgets, fees and pricing	Providers must review their pricing Schedule and price list at least every 12 months, and: • if there is to be a change, provide the Secretary with an updated notice, or • if there is not to be a change, provide the Secretary with a written notice that they have reviewed the information.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B
Care recipients changing providers/ leaving	If a pre-1 July 2014 care recipient intends to move to another home care service, the provider that is to provide the new service must give the care recipient written notice of the following: • If the care recipient moves to the new service within 28 days of leaving the old service, they may make a written choice to be covered by the post-1 July 2014 arrangements in relation to the new service. That choice cannot be made after they have already moved to the new service. If they do not make a choice before entering the new service they will be covered by the pre-1 July 2014 arrangements. • If the care recipient moves to the new service 28 days or more after leaving the old service, they will automatically be covered by the post-1 July 2014 arrangements. • If the care recipient is covered by the post-1 July 2014 arrangements that may result in a change to their fees payable.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix A

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	• If the care recipient moves from the pre-1 July 2014 arrangements to the post-1 July 2014 arrangements, they cannot make a choice to return to the pre-1 July 2014 arrangements.			
Care recipients changing providers/ leaving	If a pre-1 July 2014 care recipient intends to move to another home care service, the provider that is to provide the new service must give the care recipient a copy of the document titled 'New Arrangements for Aged Care – for 1 July 2014', published by the Department, as it exists on 1 July 2014.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix A
Budgets, fees and pricing	Providers must give every care recipient to whom they provide, or are to provide, home care, a written individualised budget which sets out a budget for the care and services detailed in the care recipient's care plan. The budget must be provided as soon as practicable after the provider has all the necessary information to complete it. The budget must state the amount of home care subsidy payable to the provider for the care recipient in respect of the period agreed between the care recipient and provider, and the maximum amount of home care fees payable by the care recipient in respect of that period.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Budgets, fees and pricing	Providers must prepare a care recipient's individualised budget: • in partnership with the care recipient, and • considering the care recipient's goals, assessed needs, preferences, resources available, and the services selected by the care recipient.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Budgets, fees and pricing	Providers must review and, if necessary, revise the individualised budget of the care recipient if:	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	• a change to the care and services to be provided through the home care service is proposed, or • the costs or providing the care and services change, or • the care recipient requests the provider to do so. If the care recipient requests the review, the review must be completed within 14 days of the request.			
Budgets, fees and pricing	If the provider reviews the individualised budget they must give the care recipient of a copy of the revised individualised budget and help them to understand it.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10
Budgets, fees and pricing	Providers must give all care recipients a written monthly statement of the available funds and the expenditure in respect of the home care provided to the care recipient during the month. The statement must be provided as soon as practicable after the provider has all the necessary information to complete it. The monthly statement must specify: • the amount of home care subsidy paid or payable to the provider for the care recipient in respect of the month; • the total amount of home care fees paid or payable by the care recipient in respect of the month; • the total amount paid or payable by the provider in respect of the home care provided to the care recipient during the month; • an itemised list of the care and services provided to the care recipient during the month and the total amount paid or payable in relation to each kind of care or service; • the total amount (if any) of the funds received or to be received in respect of any previous month	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	for the provision of home care to the care recipient that have not been spent; • if, during the month, the transfer portion of the care recipient's unspent home care amount was received by the approved provider—the amount that was received.			
Budgets, fees and pricing	Providers must help care recipients to understand their monthly statements.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10
Care recipients changing providers/ leaving	Provider must give notice to care recipients or, if the care recipient has passed away, their legal personal representative, of care recipients ceasing to receive care from their service within 56 days of the cessation day. The notice must specify: • the cessation day, • the care recipient's total unspent home care amount and amounts broken into the Commonwealth portion, the care recipient portion and the transfer portion, • the exit amount deducted (if relevant), • the unpaid home care fee amount deducted (if relevant). The notice must also explain how unspent funds will be transferred.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 14
Care recipients changing providers/ leaving	Providers must pay the care recipient and transfer portion of unspent funds as specified in the *User Rights Principles*. The relevant tables have been extracted at Sections 13 and 14 of this manual.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 13 and 14
Care recipients changing providers/ leaving	Providers who are making payment of a transfer amount to a care recipient's new provider must give the new provider the notice issued to the care recipient on their cessation at the time they pay the transfer portion to the new provider.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 13

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Care recipients changing providers/ leaving	Providers must give written notice to the Secretary, in an approved form, within 70 days after a care recipient's cessation day that specifies if there is a Commonwealth portion of the care recipient's unspent home care amount, or if the Commonwealth portion of the care recipient's unspent home care amount is nil.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 13 and 14
Care recipients changing providers/ leaving	Providers must not deduct an exit amount for a care recipient leaving their care from a care recipient's unspent funds unless the exit amount was agreed in the Home Care Agreement, and the provider's standard exit amount was notified to the Secretary in the pricing Schedule before that Home Care Agreement was executed.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 13 and 14
Care recipients changing providers/ leaving	Providers must not charge an exit amount greater than the maximum exit amount specified in their pricing Schedule as published before the Home Care Agreement was executed.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 13 and 14
Care recipients changing providers/ leaving	Providers must not charge an exit amount greater than the value of the care recipient's unspent funds.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 13 and 14
Budgets, fees and pricing	Providers must not charge care recipients for costs (however described) that are business costs as a separate charge.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B
Budgets, fees and pricing	Providers must not charge care recipients more than a reasonable amount for travel, sub-contracting arrangements and package management.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B
Budgets, fees and pricing	Providers must not charge care recipients more than a reasonable amount for business costs that are part of the price charges for providing care and services.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Budgets, fees and pricing	Providers must charge care recipients the fees and/or prices listed in their pricing Schedule (as it applies on the relevant day the service was provided) unless the Home Care Agreement specifies a different fee and/or price and the reason for the different amount. **Note:** this does not apply to care recipients who were receiving home care services from the provider prior to 1 July 2019. This obligation will come into effect for those care recipients on 1 July 2020.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B
Rights of care recipients	Provider must establish a complaints resolution mechanism for their aged care service.	Section 56-4(1) of the *Aged Care Act 1997*	-	Section 10
Rights of care recipients	Providers must use their complaints resolution mechanism to address any complaints made by or on behalf of a care recipient to whom care is provided through the service. The complaints resolution mechanism must be the complaints resolution mechanism provided for in the Home Care Agreement entered into between the provider and the care recipient.	Section 56-4(1) of the *Aged Care Act 1997*	-	Section 10
Rights of care recipients	Providers must advise a complainant of any other mechanisms that are available to address complaints, and provide such assistance as the care recipient requires to use those mechanisms.	Section 56-4(1) of the *Aged Care Act 1997*	-	Section 10
Rights of care recipients	Providers must comply with any requirement made of the provider in relation to a direction made by the Aged Care Quality and Safety Commissioner.	Section 56-4(1) of the *Aged Care Act 1997* Section 21(2) of the *Aged Care Quality and Safety Commission Act*	*Aged Care Quality and Safety Commission Rules 2018*	Section 3

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Information and record keeping	Personal information must not be used other than: • for a purpose connected with the provision of aged care to the person by the approved provider; or • for a purpose for which the personal information was given by or on behalf of the person to the approved provider.	Sections 56-2(h) and 62-1 of the *Aged Care Act 1997*	-	-
Information and record keeping	Except with the written consent of the person, personal information must not be disclosed to any other person other than: • for a purpose connected with the provision of aged care to the care recipient by the approved provider; or • for a purpose connected with the provision of aged care to the care recipient by another approved provider; or • for a purpose for which the personal information was given by or on behalf of the care recipient; or • for the purpose of complying with an obligation under the *Aged Care Act 1997*, the *Aged Care (Transitional Provisions) Act 1997* or any of the principles.	Section 56-2(h) and 62-1(b) of the *Aged Care Act 1997*	-	-
Information and record keeping	Personal information must be protected with security safeguards that it is reasonable in the circumstances to take against the loss or misuse of the information.	Section 61-1(c) of the *Aged Care Act 1997*	-	-

Accountability – Part 4.3 in the *Aged Care Act 1997*

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Record keeping	Providers must keep the following kinds of records about care recipients: • assessments of care recipients;	Sections 63-1(1)(a) and 87-2 of the *Aged Care*	*Records Principles 2014*	-

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	• individual care plans; • medical records, progress notes and other clinical records; • schedules of fees and charges; • Home Care Agreements; • accounts of care recipients; • records relating to care recipients' entry, discharge and leave arrangements, including death certificates where appropriate; • records relating to a determination that a care recipient is a care recipient with financial hardship; • in relation to a continuing home care recipient of care to whom the approved provider starts to provide home care through a home care service on or after 1 July 2014—a record of whether the care recipient made a written choice regarding whether they would be covered by the pre or post-1 July 2014 arrangements; • up-to-date records of: the name and contact details of at least one representative of each care recipient; and the name and contact details of any other representative of a care recipient; • copies of unspent funds notices; • records relating to the payment of the care recipient portion or transfer portion of care recipients' unspent home care amounts; • copies of notices of published exit amounts; • records required by the National Aged Care Mandatory Quality Indicator Program Manual to be kept.	*Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*		
Record keeping	Providers must keep all required records for care recipients for three years after the 30 June of the year in	Section 63-1(2) of the *Aged Care*	*Records Principles 2014*	-

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	which they ceased to provide care to the care recipient.	*Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*		
Record keeping	Providers must keep records relating to each copy of the Charter of Aged Care Rights given a care recipient. **Note:** this requirement does not apply if the care recipient does not enter the provider's home care service.	Sections 63-1(1)(a) and 87-2 of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	*Records Principles 2014*	-
Record keeping	Providers must keep records that enable them to demonstrate that: • they have police certificates for all staff members or volunteers that are not more than three years old; • for any period where a staff member or volunteer was without a police certification, an application for a police certificate had been made, and • any statutory declaration required to be made by a staff member or volunteer has been made. Police certificates must be kept in compliance with the *Privacy Act 1988*.	Sections 63-1(1)(a) and 87-2 of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	*Records Principles 2014*	-
Record keeping	Providers must keep records (in written or electronic form) that enable claims for payments of subsidy to be properly verified. These records must be kept for three years after 30 June of the year in which the record was made.	Section 63-1 of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	-	-

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Record keeping	Providers must keep records (in written or electronic form) that enable proper assessments to be made of whether the approved provider had complied, or is complying, with its responsibilities. These records must be kept for three years after the 30 June of the year in which the record was made.	Section 63-1(1) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	-	-
Monitoring, compliance and other access	Providers must co-operate with any person who is exercising powers under Part 6.4 in relation to the service and comply with Part 6.4 in relation to the person's exercise of those powers. Part 6.4 of the *Aged Care Act 1997* makes provisions for authorised officers to exercise monitoring and questioning powers. The following obligations arise in relation to exercise of those powers: • a person at any premises entered into under a warrant must provide reasonable assistance to an authorised officer; • a person whom the Secretary has requested to give evidence pursuant to section 93-1 must attend at a time and place specified in the notice, take any oath or affirmation requirement, and answer any questions put by an officer or produce any documents (or copies or documents) as are referred to in the notice. (They may refuse any requests that lead to self-incrimination, or do not relate to: a) the affairs of a corporation that is/has been an approved provider or b) the payment of a subsidy).	Sections 63-1(1)(b) and 90-1 to 94-2 of the *Aged Care Act 1997*	-	-
Monitoring, compliance	Providers must co-operate with any person who is exercising powers under Part 8 of the *Aged Care Quality*	Section 63-1(1)(ba) of the *Aged*	-	-

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
and other access	*and Safety Commission Act 2018* in relation to the services. Part 8 of the *Aged Care Quality and Safety Commission Act 2018* currently enables authorised officers and regulatory officials to enter and search premises.	*Care Act 1997* Part 8 of the *Aged Care Quality and Safety Commission Act 2018*		
Reporting and disclosure	Providers must notify the Secretary of the name and address of the service in relation to each home care service, in the form approved by the Secretary, before providing home care through the service.	Sections 9-1A and 63-1(1)(c) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	-	Sections 5 and 15
Reporting and disclosure	Providers must notify the Secretary of any changes to the name and address of the service within 28 days of the change.	Sections 9-1A and 63-1(1)(c) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	-	Section 15
Reporting and disclosure	Providers must notify the Aged Care Quality and Safety Commissioner (the Commissioner) of any change of circumstances that materially affects the approved provider's suitability to be a provider of aged care within 28 days of the change. Commonwealth for providing that aged care. If that change in circumstances relates, wholly or partly, to key personnel becoming a disqualified individual, the approved provider must notify the Secretary of the reason why they are, or are about to become, a disqualified individual.	Sections 9-1 and 63-1(1)(c) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	-	Section 15

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Reporting and disclosure	Providers must respond to a written request from the Commissioner for information relating to: • the provider's suitability to be a provider of aged care, • payments made under the *Aged Care Act 1997* or *Aged Care (Transitional Provisions) Act 1997*, • the provider's financial situation, within 28 days after the request was made, or within any shorter period as is specified in the notice, or (if a periodic request is made with respect to financial information) before the time or times worked out in accordance with the request.	Sections 9-2, 9-3, 9-3B and 63-1(1)(c) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	-	Section 15
Monitoring, compliance and other access	Providers must allow RAS assessors, ACAT assessors, or other people authorised by the Secretary to assess the care needs of any care recipient, access to the service.	Section 63-1(1)(g) of the *Aged Care Act 1997*	-	-
Monitoring, compliance and other access	Providers to comply with any agreement they make in lieu of revocation of approved provider status, and with any undertaking they give to respond to notice to remedy non-compliance.	Sections 66-2(1)(b), 63-1(1)(k) and 67-4 of the *Aged Care Act 1997*	-	-
Reporting and disclosure	Providers must notify the Secretary, in writing and in an approved form, of each care recipient who starts to be provided with home care through the service. Notice must be provided within 28 days of the date the care recipient starts to be provided with home care through the service.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles*	Section 6
Reporting and disclosure	Providers must notify the Secretary, in writing and in an approved form, of each care recipient who ceases to be provided with home care through the service. Notice must be provided within 31 days of the date the care recipient ceases to be provided with home care through the service.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Sections 13 and 14

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Reporting and disclosure	Providers must give the Secretary an aged care financial report each financial year, within four month of the end of the financial year. The report must be signed by one of the providers' key personnel (who is authorised by the provider to sign the report).	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Section 15
Reporting and disclosure	If a provider of an aged care service receives an aged care workforce census form sent by or on behalf of the Department, the approved provider must complete the form and return it to the Department by the date specified in the form.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	-
Staff and volunteers	A provider must not allow a person to become a staff member or volunteer of the provider, unless satisfied that: • the person has a police certificate that is not more than three years old; or the person has applied for a police certificate, will be supervised when with care recipients, and has completed a statutory declaration stated that they have not been convicted murder or sexual assault, or convicted or imprisoned for any other form of assault; and • the police certificate does not record that the person has been convicted of murder or sexual assault, or convicted or imprisoned for any other form of assault; and • if the person has been, at any time after turning 16, a citizen or permanent resident of a country other than Australia—the person has made a statutory declaration stating that the person has never been convicted of murder or sexual assault, or convicted or imprisoned for any other form of assault.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Section 4

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Staff and volunteers	Providers must continue to satisfy the above requirements related to police certificates and suitability of staff members or volunteers. Providers must ensure that each person who is a staff member or volunteer is not allowed to continue to be a staff member or volunteer unless the above is satisfied.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Section 15
Staff and volunteers	Providers must take reasonable measures to require each person who is a staff member or volunteer to notify them if they are convicted of murder or sexual assault, or convicted or imprisoned for any other form of assault.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Sections 4 and 15
Monitoring, compliance and other access	Providers must do the following in relation to each of their key personnel: • ensure that the person understands the obligations of key personnel and of approved providers under the Act in relation to disqualified individuals; and • if the provider reasonably believes that the person may be mentally incapable of performing his or her duties as one of the approved provider's key personnel—make arrangements for the person to be examined by a registered medical practitioner; and • if the provider has ascertained that the person is a disqualified individual—ensure that the person ceases to be one of the approved provider's key personnel.	Section 63-1A of the *Aged Care Act 1997*	*Sanctions Principles 2014*	Sections 4 and 15
Monitoring, compliance and other access	Providers must do the following in relation to each person who proposes to become, or becomes, one of their key personnel:	Section 63-1A of the *Aged Care Act 1997*	*Sanctions Principles 2014*	Sections 4 and 15

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	• obtain (with the person's written consent) a police certificate for the person; and • conduct a search of bankruptcy records; and • conduct previous employment and referee checks.			
Monitoring, compliance and other access	If the Secretary requests it, providers must provide information related to the steps the provider has taken to ensure that a person who is a key personnel is not a disqualified individual.	Section 63-1A of the *Aged Care Act 1997*	*Sanctions Principles 2014*	-
Monitoring, compliance and other access	An approved provider of home care must do all things reasonably practicable to ensure that there is no change to circumstances materially affecting their suitability to provide aged care.	63-1C of the *Aged Care Act 1997*	-	-

Appendix E: Improved Payment Arrangements

The Australian Government is changing the way Home Care Program providers are paid.

Phase 1 (implemented on 1 February 2021)

- Providers are funded in arrears rather than in advance.
- Payments for each month are claimed in the next month, for the full subsidy, based on the number of care recipients in care.

Phase 2 (implemented on 1 September 2021)

- Providers are paid in arrears, based on actual care and services delivered.
- The Government holds the Commonwealth portion of unspent funds, in each care recipient's home care account, until needed by the care recipient.

Legislation to support Phase 1 was passed by Parliament in December 2020, and for Phase 2 in February 2021. This measure reduces the financial and prudential risks of providers holding substantial amounts of unspent funds, as these will be held by the Government instead.

As mentioned in 2.5 of this manual, the Government offers free accounting and business advisory services to all home care providers to help them review their operations and provide advice on business management and financial strategies. For more information go to this link or visit the website at www.pwc.com.au/health/aged-care-advisory.html.

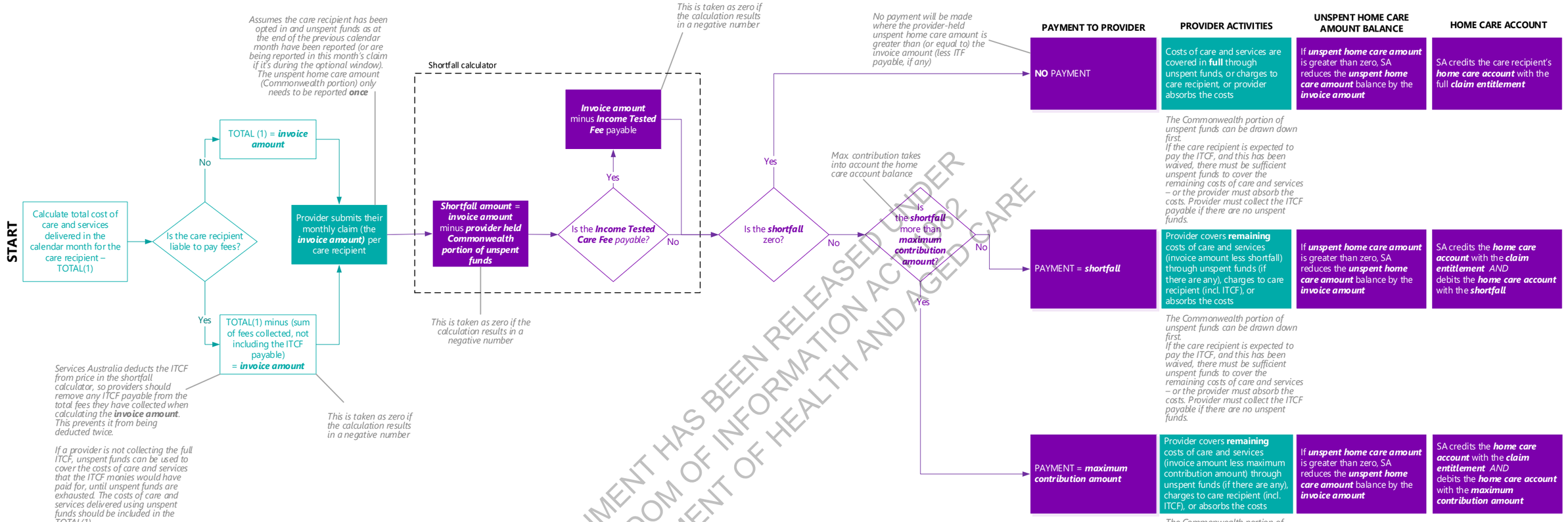
You can find further information about Improved Payment Arrangements, such as the Questions & Answers, provider and care recipient fact sheets and calculators are available on this link or by searching "Improved Payment Arrangements" at www.health.gov.au.

Attachment A shows the claim processes for providers under Improved Payment Arrangements [updated 19 August 2021].

Australian Government
Department of Health

Attachment A – Claims Process

Claim Process if a Provider Chooses to 'Opt-in'



Services Australia activity Provider activity

Invoice amount / price

Definition: the amount a provider can submit in their monthly claim for the care recipient.

Calculation:
1. Tally the total cost of care and services delivered for the care recipient in the calendar month being claimed and any administrative, care management costs
2. Tally the total fees collected/payable – including BDF, ITCF, and any other fees agreed with the care recipient
3. Deduct ITCF payable from the total at step 2. This is the available home care fees.
4. Deduct the total at step 3 from the total at step 1.

Legislative reference: Subsidy Principles 2014, 99B Price for home care

Claim entitlement / Commonwealth contribution amount

Definition: the amount of government subsidy a care recipient is entitled to for the month.

Calculation:
1. Tally the basic monthly Government subsidy amount + primary supplements (if any) – Income Tested Care Fee (if any) + other supplements (if any)

Legislative reference: Aged Care Act 1997, s 48-1A Commonwealth contribution amount

Maximum contribution amount

Definition: the total amount of Government subsidies available to cover the price for the care recipient, including this months' claim entitlement and the balance of the home care account.

Calculation:
1. Sum of the care recipient's claim entitlement and the balance of their home care account at the end of the previous month.

Legislative reference: Subsidy Principles 2014, Division 5 – Shortfall amount

Shortfall amount

Definition: in this case, where the provider has opted in the care recipient to return their provider-held unspent Commonwealth funds, the shortfall is the invoice amount, less any funds the provider is returning (unspent home care amount), less the Income Tested Care Fee the care recipient is liable to pay (if any)

Calculation:
1. Invoice amount minus unspent home care amount, up to the amount to cover the invoice amount or 100% of the unspent home care amount
3. The result of step 1 less the Income Tested Care Fee (if any)
3. If the result of step 2 is negative, this is taken as zero

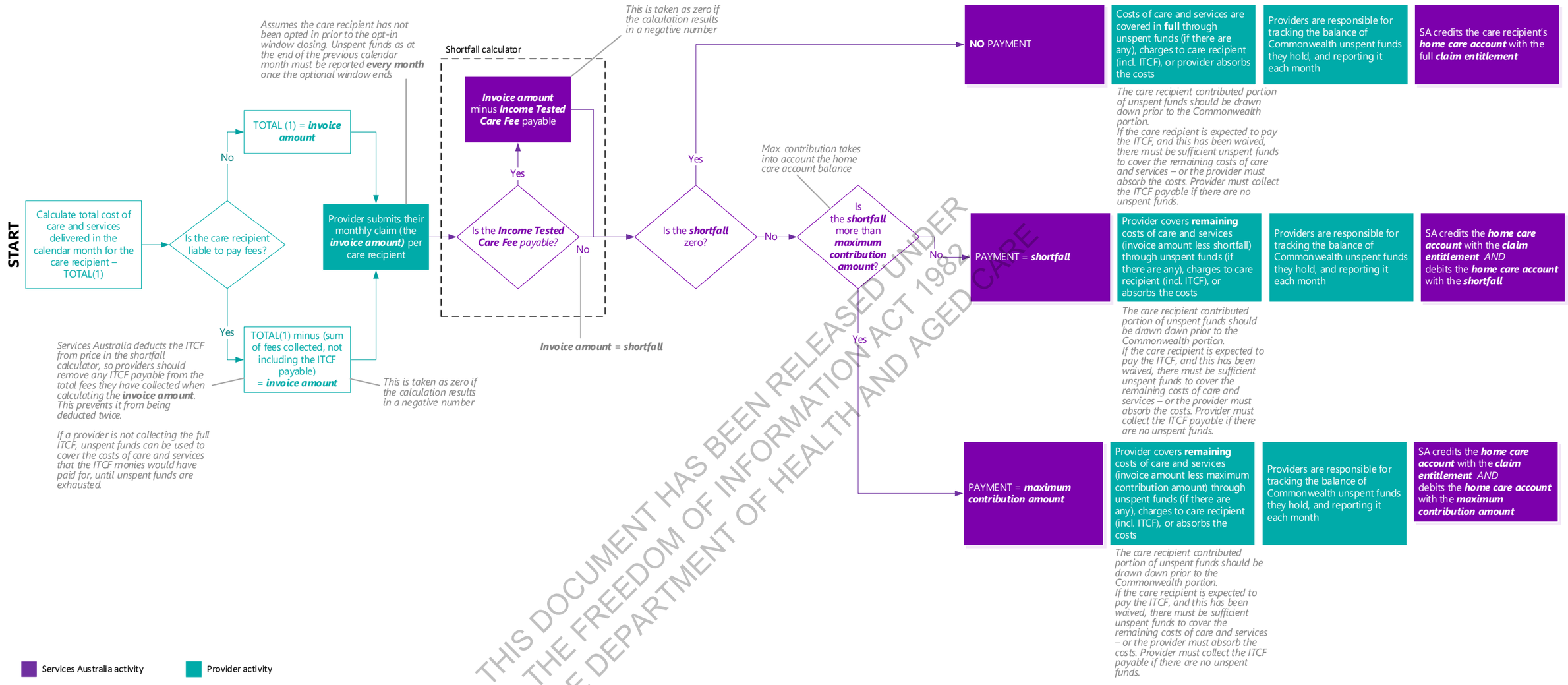
Legislative reference: Aged Care Act 1997, s 48-13 Shortfall amount; *Subsidy Principles 2014,* Division 5 – Shortfall amount

Unspent home care amount

Definition: the Commonwealth portion of the provider-held unspent funds, as at the end of the previous calendar month.

This only needs to be reported ONCE by the provider, after which the balance of the Commonwealth portion of the provider-held unspent funds is updated by Services Australia (if required) with each monthly claim submitted, until the balance reaches zero.

Claim process if a provider chooses NOT to 'opt-in'



Services Australia activity Provider activity

Invoice amount / price

Definition: the amount a provider can submit in their monthly claim for the care recipient.

Calculation:
1. Tally the total cost of care and services delivered for the care recipient in the calendar month being claimed and any administrative, care management costs
2. Tally the total fees collected/payable – including BDF, ITCF, and any other fees agreed with the care recipient
3. Deduct ITCF payable from the total at step 2. This is the available home care fees.
4. Deduct the total at step 3 from the total at step 1.

Legislative reference: Subsidy Principles 2014, 99B Price for home care

Claim entitlement / Commonwealth contribution amount

Definition: the amount of government subsidy a care recipient is entitled to for the month.

Calculation:
1. Tally the basic monthly Government subsidy amount + primary supplements (if any) – Income Tested Care Fee (if any) + other supplements (if any)

Legislative reference: Aged Care Act 1997, s 48-1A Commonwealth contribution amount

Maximum contribution amount

Definition: the total amount of Government subsidies available to cover the price for the care recipient, including this months' claim entitlement and the balance of the home care account.

Calculation:
1. Sum of the care recipient's claim entitlement and the balance of their home care account at the end of the previous month.

Legislative reference: Subsidy Principles 2014, Division 5 – Shortfall amount

Shortfall amount

Definition: in this case, where the provider has not opted in the care recipient to return their provider-held unspent Commonwealth funds (or the care recipient doesn't have unspent funds) the shortfall is the invoice amount less the Income Tested Care Fee the care recipient is liable to pay (if any)

Calculation:
1. Invoice amount minus the Income Care Tested Fee
2. If the result of step 1 is negative, this is taken as zero

Legislative reference: Aged Care Act 1997, s 48-13 Shortfall amount; *Subsidy Principles 2014,* Division 5 – Shortfall amount

Unspent home care amount

Definition: the Commonwealth portion of the provider-held unspent funds, as at the end of the previous calendar month.

This needs to be reported EVERY MONTH by the provider until the balance reaches zero.

Australian Government
Department of Health

Appendix F: Unspent funds under Improved Payment Arrangements – calculating and reporting

The unspent funds calculation on the next page is an example of how to work out unspent funds leading up to 31 August 2021 (the last day before Improved Payment Arrangements Phase 2 began on 1 September 2021). The example is based on the percentage of the unspent funds held by the provider that have come from Government subsidies and supplements as opposed to the care recipient fees. The purpose of calculating these unspent funds this is to set a baseline for the Government and care recipient portions of unspent funds and enable consistent reporting under Improved Payment Arrangements.

Providers will need to reconcile the Government portion of unspent funds they are currently holding for each care recipient to support meeting the 31 December 2021 deadline for reporting. The amount that should be reported is the Government portion of unspent funds held for each care recipient at the end of the previous claim month.

Under Improved Payments Arrangements, there is no need to recalculate the percentage breakdown of Government and care recipient portions when a care recipient exits care.

From 1 September 2021, the provider must be tracking the care recipient portion and (if they have not opted-in) tracking the Government portion separately. If the provider has opted-in, Services Australia will track the Government portion on their behalf.

From 1 September 2021 onwards, if there are changes to the subsidies and fees paid to the provider, this change should be applied to the Government portion of unspent funds. If there are changes to the fees paid by the care recipient, this should be applied to the care recipient portion of unspent funds. When a care recipient leaves care, these fees should be included in the care recipient portion of unspent funds once all claims have been finalised.

After 1 January 2022 providers who have chosen not to opt-in will need to continue to report on the Government portion of unspent funds held for a care recipient each month.

If a provider has agreed to waive the income tested care fee with the care recipient, and the care recipient has not paid any other fees, the Government portion would comprise 100 percent of the unspent funds.

Unspent funds – worked example for pre-1 September 2021 (Improved Payment Arrangements Phase 2)

- May has received care from a home care provider for 2 years.

Commonwealth contributions (Government subsidy and supplements):	$15,000
Care recipient contributions (Home care fees):	$5,000
Total accumulated funds:	$20,000

- During this time, she has received $18,000 worth of services.

Total accumulated: - Total debits:	$20,000 $18,000
Total unspent funds amount:	$2,000

- Calculate what proportion of May's total home care package budget came from the Commonwealth and from care recipient fees, as below:

Total accumulated funds: $20,000	
Commonwealth portion: $15,000/$20,000 = 75%	Care recipient portion: $5,000/$20,000 = 25%

- Then apply these proportions to the unspent funds amount:

Unspent funds amount: $20,000	
Commonwealth portion: 75% of $2,000 = $1,500	Care recipient portion: 25% of $2,000 = $500

Australian Government
Department of Health

Appendix G: Glossary

Term	Meaning
ACAT	Aged Care Assessment Team. ACATs are known as Aged Care Assessment Services (ACAS) in Victoria.
ACER	Aged Care Entry Record. ACERs are used to notify Services Australia of new care recipients entering care, or changes to existing care recipients' circumstances.
Australian Government	The Federal Government of Australia.
The Commission	The Aged Care Quality and Safety Commission. The Commission is a statutory body, responsible for overseeing the Aged Care Quality Standards across the aged care sector.
The Department	The Australian Government Department of Health
The Standards	The Aged Care Quality Standards. The Standards are established under the *Aged Care Act 1997*, and all approved providers of aged care are expected to be compliant.
Approved provider (or provider)	An approved provider of aged care is an organisation that has been approved to provide residential care, home and/or flexible care under the *Aged Care Act 1997*.
Basic daily fee	Refers to a home care fee that a care recipient may be asked to pay by a home care provider based on their package level (separate to the Government subsidy).
Care plan	A care plan is a document that defines the care, services and/or purchases that a care recipient is going to use their package budget to fund.
Care recipient	A person who is receiving care and services under a package funded by the Australian Government, under the *Aged Care Act 1997*
CDC	Consumer directed care.
Consumer	Includes other people who are authorised to act on behalf of the care recipient.
Commonwealth Home Support Programme	This program provides home and community care services for frail senior Australians aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.
Dignity of risk	An individual's right to make choices to take reasonable risks.
DVA	Department of Veterans' Affairs
Exclusions	Care, services or purchases that cannot be funded from a package budget.
FAS	VANguard Federated Authentication Service

Term	Meaning
Home care	A type of aged care for which a home care subsidy is payable under Part 3.2 of the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997*.
Home care consumer (or consumer)	A person who is receiving care and services under a package funded by the Australian Government. In the *Aged Care Act 1997*, this person is referred to as a "care recipient".
Home care provider (or approved provider)	An organisation approved by the Department of Health under Part 2.1 of the Act as suitable to provide home care. In the *Aged Care Act 1997*, this person or body is referred to as an "approved provider".
Home Care Agreement	An agreement entered into by a care recipient and a home care provider outlining rights and responsibilities and what services will be provided to the care recipient under the package.
Home Care Packages Program	The Australian Government program that provides funding for packages aimed at supporting people to remain living at home.
HCP	Home care package
Home care account	On 1 September 2021, Services Australia will create a home care account for each care recipient. See Appendix E for further information.
Home care subsidy	The subsidy payable to a home care provider by the Australian Government under Part 3.2 of the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997*.
Inclusions	Care, services or purchases that can be funded from a package budget.
Income-tested care fee	Refers to a home care fee a care recipient may be asked to pay based on an income assessment.
Instrument	Primary legislation, delegated legislation, or a determination under legislation.
Improved Payment Arrangements	Changes to how the Australian Government pays home providers. See Appendix E for further information.
Key personnel	Key personnel are: • People responsible for the executive decisions of the applicant (this includes directors and board members), whether or not the person is employed by the applicant • People having authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the applicant, whether or not the person is employed by the applicant • Any person responsible for nursing services provided, or to be provided, by the applicant, whether or not the person is employed by the applicant • Any person who is, or is likely to be, responsible for the day-to-day operation of an aged care service conducted, or proposed to be conducted, by the applicant, whether or not the person is employed by the applicant.

Term	Meaning
Leave	A care recipient suspending care, services and purchases under their package for a specified period of time.
Maximum contribution amount	The full Government subsidy and anything available in the care recipient's home care account
Monthly statement	A document provided to care recipients every month that shows the package budget funds available to that care recipient and what has been spent from the budget.
My Aged Care	My Aged Care is the starting point to access Australian Government-funded aged care services. The phone line and website can help senior Australians, their families and carers to get the help and support they need.
NAPS	National Approved Provider System
National priority system	The national priority system is a standardised process for prioritising assignment of packages.
Package budget	The funds available to be spent under a care recipient's package. A care recipient's package budget is made up of contributions from the Australian Government and, where applicable, home care fees paid by the care recipient themselves.
Pre-1 July 2014 care recipients	Care recipients who entered the HCP Program before 1 July 2014. Packages for pre-1 July 2014 care recipients have different home care fee arrangements.
Price	The amount that providers report to Services Australia in their claim. Providers report the price per care recipient, each month. Services Australia refers to the price as the invoice amount.
Principles	Delegated legislation made under the *Aged Care Act 1997*.
Reablement	Reablement is an approach to aged care, involving time-limited interventions that are targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities.
Residential aged care	This program provides high-levels of care to people in a residential aged care home.
Security of tenure	Security of tenure means providers are required to continue to deliver the agreed care and services for as long as the care recipient needs those services.
Services Australia	Formerly known as Department of Human Services
Shortfall amount	The price (minus the Commonwealth portion of any unspent funds which are being returned, for providers that opt-in), minus any income-tested care fee the care recipient is assessed to pay.
Subsidy	An Australian Government contribution to all care recipient's package budgets, determined on the basis of the level of the package the care recipient has been allocated.

Term	Meaning
Supplement	An Australian Government contribution to a care recipient's package budget, where the care recipient satisfies the specific eligibility criteria for that contribution.
The Act	*Aged Care Act 1997.*
The Principles	• *Accountability Principles 2014* • *Approval of Care Recipients Principles 2014* • *Approved Provider Principles 2014* • *Committee Principles 2014* • *Fees and Payments Principles 2014 (No.2)* • *Information Principles 2014* • *Quality of Care Principles 2014* • *Records Principles 2014* • *Sanctions Principles 2014* • *Subsidy Principles 2014* • *User Rights Principles 2014*
Unspent funds	Any component of a care recipient's package budget that has not been spent, including the balance of the provider-held care recipient contributed unspent funds, the provider-held Commonwealth portion of unspent funds, and the Services Australia home care account balance (Government held unspent funds)
Wellness	Wellness is an approach to aged care involving assessment, planning and delivery of supports that build on the strengths, capacity and goals of individuals, and encourage actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home.

OFFICIAL

Home Care Packages Program

Operational Manual

A guide for home care providers

Version 1.3 – January 2023

Contents

Reviews

Date	Summary of changes
March 2020	Manual (v1.0) first issued
February 2021	Manual revised (v1.1). Includes content about Improved Payment Arrangements, the Aged Care Provider Portal, addressing people receiving care and services under a package funded by the Australian Government as care recipients, updated web links and minor updates to wording.
September 2021	Manual revised (v1.2). Includes content about Improved Payment Arrangements.
January 2023	Manual revised (v1.3). Updates to Chapter 9: Inclusions and Exclusions including a decision tree and template providers can use to document agreed care and services with the care recipient; replaces all references to Department of Health with the Department of Health and Aged Care. Updates to Chapter 7 - Care Planning. Updates to Chapter 15: How does the HCP Program interact with other programs and schemes? Content updated to include information on price caps, pricing guidance, Serious Incident Response Scheme and unspent funds. All content has been revised and updated for currency.

Disclaimer

The Home Care Packages Program is governed by the applicable legislation. Home care providers are responsible for understanding and complying with all legislation that is relevant to delivering home care.

If in doubt home care providers should consider the need to obtain their own appropriate legal advice relevant to their circumstances, especially in relation to the formulation of Home Care Agreements.

In addition to the legislation referred to in this Manual, other Australian Government portfolios and each state and territory may have its own separate legislation that is relevant to providers' operations as a home care provider. It is the provider's responsibility to understand and meet their obligations as they relate to all applicable legislation.

Any guidance released by the Department of Health and Aged Care is based on the policy intent of the program and a practical interpretation of the legislation.

In addition to this Manual, there are information resources that may further help providers understand their responsibilities and obligations as an approved provider. These Australian Government resources are available from:

- The Department of Health and Aged Care www.health.gov.au
- My Aged Care www.myagedcare.gov.au
- The Aged Care Quality and Safety Commission www.agedcarequality.gov.au
- Services Australia www.servicesaustralia.gov.au
- The Australian Competition and Consumer Commission www.accc.gov.au
- Australian Tax Office https://www.ato.gov.au/

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1 Introduction

This section discusses management of the Home Care Packages (HCP) Program Provider Manual (this manual) including how it will be updated, and how to provide feedback on the manual.

1.1 What does this manual contain?

This manual provides guidance on the Australian Government's policy context and operational requirements for the HCP Program for approved home care providers.

A HCP Program consumer manual has also been developed and is available at www.health.gov.au and www.myagedcare.gov.au. However, if you are looking for a high-level summary of the program, you can find information at:

- This link or by searching "Home Care Packages Program" at www.health.gov.au; or
- This link or by searching "Home Care Packages" at www.myagedcare.gov.au.

1.2 How will the manual be updated?

The Home Care Packages Program and the broader aged care system continue to operate in an environment of change.

The Department of Health and Aged Care ('the Department') will update the manual, as required, to ensure its currency and accuracy. The table at page five of this manual outlines the revisions that have been made since its release.

Please refer to the online version of the manual at www.health.gov.au to ensure that you have the most recent version. The footer of each page includes the issue date of the manual.

1.3 If I want to talk to someone about my questions, who can I contact?

To answer any questions you have, the My Aged Care contact centre is open Monday to Friday 8am-8pm and Saturday 10am-2pm. You can call the My Aged Care provider and assessor helpline on **1800 836 799**.

The My Aged Care contact centre is closed on Sundays and public holidays.

1.4 Who may I get additional assistance from?

Your state office will be able to assist you with program management enquiries that cannot be answered by My Aged Care.

WA	WAPlaces@health.gov.au
NSW/ACT	NSWPlaces@health.gov.au
VIC	homecarevic@health.gov.au
QLD	QLDPlaces@health.gov.au

SA	SAPlaces@health.gov.au
TAS	TASPlaces@health.gov.au
NT	NTPlaces@health.gov.au

The following peak bodies may be a further source of information and support for delivering aged care services generally:

Peak body	Website	Phone number
Aged & Community Care Providers Association (ACCPA)	https://www.accpa.asn.au/	**1300 222 721**
COTA Australia	www.cota.org.au	**(02) 6154 9740**
Federation of Ethnic Communities Councils of Australia (FECCA)	fecca.org.au/	**(02) 6282 5755**
National Aboriginal Communities Controlled Health Organisation (NACCHO) Affiliates	www.naccho.org.au	**(02) 6246 9300**
National Seniors	nationalseniors.com.au/	**(07) 3233 9198**
Older Persons' Advocacy Network (OPAN)	opan.com.au/	**1800 700 600**
Australian Association of Gerontology	https://www.aag.asn.au/	

✓ Key points to remember

- If you are reading a printed copy of this manual, please make sure it is the most up to date version. You can find the most current version of the manual by going to https://www.health.gov.au/resources/publications/home-care-packages-program-operational-manual-a-guide-for-home-care-providers.
- Throughout this Manual older Australians who receive funding through the HCP Program are called 'care recipients' in line with the legislation. Information about the Aged Care Quality and Safety Commission will refer to older Australians as 'consumers' in line with governing legislation.

2 The Home Care Packages Program

This section provides an overview of the HCP Program, including the underlying philosophy and intent of the Program.

2.1 What is the philosophy underpinning Home Care?

The Australian Government seek to meet to the needs and preferences of older Australians by placing them at the centre of aged care services. Australians are living longer and healthier lives. It is important that, as people age, they have choice about their care. Reviews into aged care have found that older Australians do not want to be passive recipients of services.

Rather they want the opportunity to play an active role in where they live, which provider they choose to deliver their care and the ways in which services are provided. Feedback has also consistently shown that older Australians wish to remain living independently in their own homes for as long as possible. In response, the Australian Government has progressively implemented a number of reforms to the aged care sector in order to deliver a consumer directed care (CDC) approach to aged care services.

The Australian Government funds a range of aged care services from entry level home support to residential care for high needs.

Care recipients may also contribute to the cost of their Home Care Package depending on their financial situation and the provider they choose.

Three principles underpin these programs:

This is a diagram that lists the principles. The first is that older Australians should have access to care and services that support them to live in their own homes for as long as they can and choose to. The second is that older Australians can and should make decisions on the care and services they receive under Commonwealth Government subsidised aged care programs. The third is that the best care outcomes come from older Australians and home care providers working together.

2.2 What is the intent of the Home Care Packages Program?

The HCP Program supports older Australians with complex ageing related care needs to live independently in their own homes, using a consumer-directed care approach to maintain the care recipient's capabilities as they age. Home care packages ('packages') deliver co-ordinated packages of care and services to meet people's assessed ageing related care needs within the limits of their

individual home care budget and the scope of the Program. How care and services are identified and delivered should reflect and respect the individual, their ageing related care needs, personal situation and preferences.

All packages are delivered using a CDC model. The aim of this approach to planning and managing care and services is to give care recipients choice and flexibility in the supports they access, based on their ageing related needs, and how they are delivered.

The Aged Care Quality Standards require providers to deliver safe and effective services and supports for daily living that optimise the person's independence, health, well-being and quality of life. Services and supports for daily living include, but are not limited to domestic assistance, home maintenance, transport and recreational and social activities.

These may include services and supports to maintain care recipient's capabilities:

- well and independent – including personal care, nursing services, allied health
- safe in their home – including cleaning, home maintenance and modifications specific to ageing related capabilities, assistive technology
- connected to their community – including transport, social support services.

It is important to note that a Home Care Package is not a source of income that care recipients can use completely at their own discretion.

Providers need to work with care recipients to ensure that funding is used appropriately and transparently. Care recipients should be actively involved in deciding how their package funds are spent. This includes due consideration of the legislated exclusions from a package. Care recipients will accrue unspent funds if their package funds are not fully expended each month.

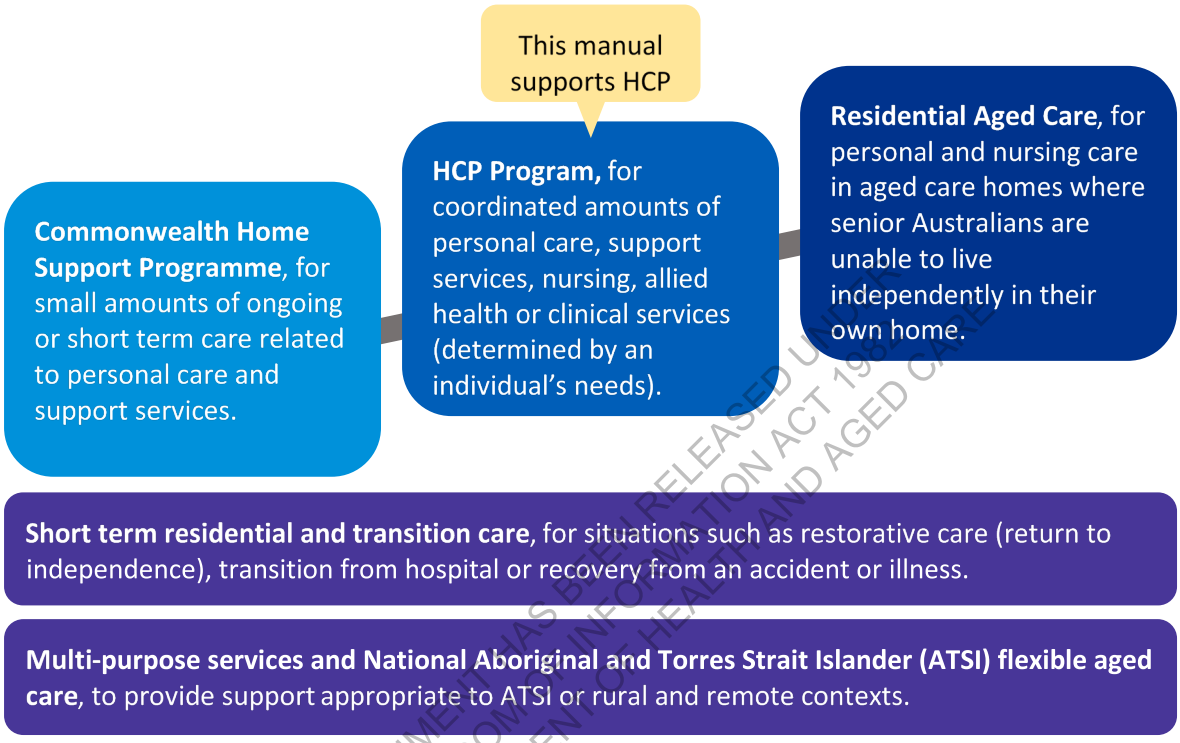
Different people, and their support networks, will want different levels of involvement in planning and managing their package, including self-management. At every level, providers will need to work with care recipients to balance their duty of care with an individual's right to make choices that take reasonable risks. This right is known as 'dignity of risk' and is discussed further at Section 9. An approved provider is responsible for the compliance and quality of all care and services provided under a package.

Changes introduced in September 2021 known as the Improved Payment Arrangements allow for greater transparency of unspent funds in the Program. These changes move the responsibility for holding the Commonwealth portion of unspent funds for care recipients from the provider to the Australian Government. This reduces the prudential risk in home care over time and improve protections for care recipients' home care funds as the program grows. The changes also reinforce the focus on delivering services to meet consumers needs and choices. See **Appendix F** for more information on Improved Payment Arrangements.

Changes to management and administration charges were introduced in January 2023 to reduce excessive prices and improve price transparency for care recipients and their families. These changes include capping how much providers can charge for care and package management, eliminating exit amounts and charging separately for costs associated with third party services. This ensures more funds are available to meet the assessed needs of care recipients. See **Appendix C** for more information on price capping.

2.3 What is the scope of the Home Care Packages Program?

The HCP Program is part of the Australian Government's continuum of care for older Australians. It addresses the level of need between the CHSP (which offers a relatively small amount of care and support services) and residential aged care (a high level of care in a residential aged care home). The following diagram outlines where the HCP Program sits within the continuum:



Access to home services programs is determined by an independent assessment by an Aged Care Assessment Team (ACAT) or a Regional Assessment Service (RAS). My Aged Care will connect older Australians to the correct assessment service for their needs (see Section 6).

Some people will receive services through flexible care or CHSP and will then be assessed for the HCP Program; others will start their Government-supported aged care with the HCP Program. There is no requirement that anyone participates in programs earlier in the continuum of care to be eligible for the HCP Program. Further information on the interaction of these and other aged care programs is included at Section 16.

The HCP Program provides a subsidy and supplements (where an individual is eligible) towards a co-ordinated package of care, services and care management to meet each person's assessed ageing related care needs, care goals and preferences. There are four levels of packages to reflect the different levels of assessed ageing related care needs to support people to safely remain living at home as long as it is appropriate.

The types of care and services that can be subsidised by the Australian Government under the HCP Program should keep people well and independent, and maintain the capabilities of the older Australians as they age and keep them connected to their community. Primary categories of in-scope supports are set out in the table below:

Ageing related services to keep people well and independent	**Ageing related** services to keep people safe in their home	**Ageing related** services to keep people connected to their community
• Personal care • Nursing • Allied health and therapy services • Meal preparation and dietetics	• Domestic assistance • Home maintenance • Minor home modifications • Goods equipment and assistive technology • Respite	• Transport • Social support

The HCP Program **cannot** be used for types of care that are funded, or jointly funded, by the Australian Government through other initiatives such as the dental, pharmaceutical, or medical systems e.g., Medicare Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS), or be used to fund private dental, pharmaceutical, medical costs, or spectacles as these care types are out of scope for the policy intent of the program.

The HCP Program **is not** an income support program and cannot be used for general income expenses.

Further guidance on how to decide what can be included under a package is included at Section **9.**

2.4 How are a care recipient's ageing related care needs and goals established?

When a care recipient enters the HCP Program, their provider should ensure they understand that care recipient's assessed ageing related care needs and help them to establish goals for their care. The documentation from their ACAT assessment will record assessed care needs at the time of assessment, and providers will need to discuss these with them. In the time between the assessment and assignment of a package, assessed care needs may have changed. Providers are required to identify and assess, as per their obligations under the Aged Care Quality Standards, how these needs have changed and can be met within the framework of the HCP Program. This can be done when discussing which care and services to provide under a package.

As part of this conversation, providers and care recipients should consider any supports already in place or accessible through a carer, family members, friends, local community and other services should be considered. The package can be used to access complementary care and services, maximising the supports available.

Each care recipient's package should equally be directed by their personal goals. A wellness approach should be taken to delivering all care and services. Where possible and clinically appropriate, care and service should also align with reablement.

Wellness is an approach that involves the assessment, planning and delivery of supports that build on an individual's strengths, capacity and goals. This includes encouraging actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home.

Wellness as a philosophy is based on the premise that, even with frailty, chronic illness or disability, people generally have the desire and capacity to make gains in their physical, social and emotional wellbeing to live autonomously and as independently as possible.

Reablement involves short-term or time-limited interventions that are targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities. Like wellness, reablement aims to assist people to reach their goals and

maximise their independence and autonomy. Supports could include training in a new skill or re-learning a lost skill, minor modification to a person's home environment or having access to equipment or assistive technology.

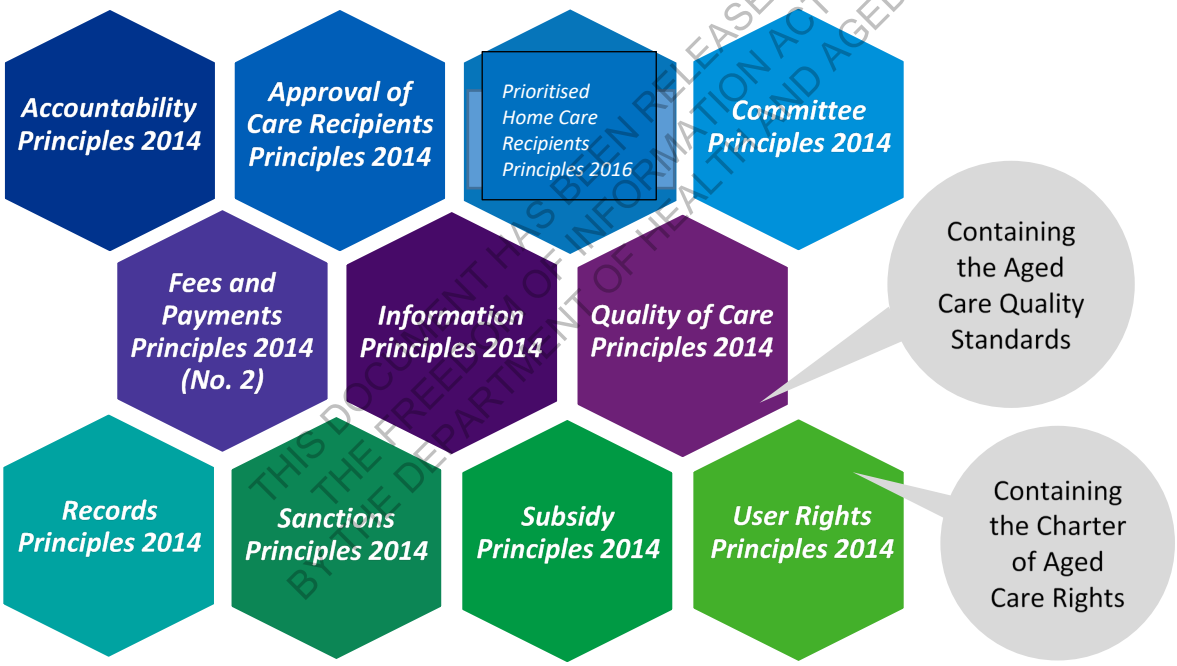
More information about wellness and reablement is at Section 7.3 of this manual.

2.5 What governs the Home Care Packages Program?

There are three tiers of laws that govern the HCP Program. These are:

- **Principal legislation.** This is the overarching law enacted by Parliament.
- **Legislative instruments.** These are subordinate legislation made with powers provided by the principal legislation. These instruments provide more details on how the HCP Program operates.
- **Determinations.** These are instruments that the legislation enables, if needed, to set out or clarify specific facts and details about the HCP Program.

For care recipients who entered the HCP Program after 1 July 2014, the *Aged Care Act 1997* governs the HCP Program. A number of legislative instruments, titled 'Principles', have been made to support that legislation. Eleven of these Principles are relevant to the HCP Program and have been cited throughout this manual. 'The Principles' (relevant to post-1 July 2014 care recipients in the HCP Program) are listed below for reference:



One determination is relevant for post-1 July 2014 care recipients: the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

In addition to the above law, transitional provisions have been established for people who entered the HCP Program before 1 July 2014 (pre-1 July 2014 care recipients). These are established by the following legislation, instrument and determination:

- *Aged Care (Transitional Provisions) Act 1997*
- *Aged Care (Transitional Provisions) Principles 2014*
- *Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014*.

Information regarding these pre-1 July 2014 provisions is at **Appendix A** of this manual.

Finally, provider compliance and the quality of aged care is governed by the following legislation and instrument:

- *Aged Care Quality and Safety Commission Act 2018*
- *Aged Care Quality and Safety Commission Rules 2018.*

The Federal Register of Legislation is frequently updated. As a result, this manual does not include links to the legislation. You will be able to find the most recent version by searching the title of the instrument you are looking for at www.legislation.gov.au[1].

The Department funds the Business Advisory Service to provide accounting and business advisory services to approved providers to maximise business performance and service viability. This involves reviewing and assessing the organisation then providing advice and business management and financial strategies. For more information go to this link or visit the website at www.pwc.com.au/health/aged-care-advisory.html.

✓ Key points to remember

- The HCP Program supports older Australians with complex ageing related care needs to live independently in their own homes, using a consumer-directed care approach to ensure the support suits a person's needs and goals.
- The HCP Program is designed to provide more co-ordinated care and services than the CHSP, but less intensive care than residential aged care.
- The HCP Program operates using a CDC model to provide more choice and flexibility to care recipients. Providers remain responsible for ensuring the delivery of quality and appropriate care.
- The HCP Program is governed by the *Aged Care Act 1997* and a number of other laws (including the Principles) all of which must guide providers in delivering packages.

[1] If you are not sure if you have the most recent version, you can check by looking at the top left corner of the web page. If you have the right version the words 'In force- latest version' will be marked in green above the heading 'View Series'. If it is not the current version, it will say 'In force – Superseded version' in red text.

3 Rights and responsibilities

This section outlines rights and responsibilities that should underpin delivery of the Home Care Packages Program.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 54-1, 56-2, and 56-4 of the *Aged Care Act 1997*
- *User Rights Principles 2014*
- *Quality of Care Principles 2014*
- *Accountability Principles 2014*
- *Record Principles 2014*
- *Aged Care Quality and Safety Commission Rules 2018*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

3.1 Charter of Aged Care Rights

The *User Rights Principles 2014*, made under the *Aged Care Act 1997*, contains the Charter of Aged Care Rights. The Charter came into effect from 1 July 2019 and applies to all Australian Government funded aged care recipients of the HCP Program. The Charter consists of 14 individual consumer rights and is extracted below:

Charter of Aged Care Rights
I have the right to: 1. safe and high quality care and services 2. be treated with dignity and respect 3. have my identity, culture and diversity valued and supported 4. live without abuse and neglect 5. be informed about my care and services in a way I understand 6. access all information about myself, including information about my rights, care and services 7. have control over and make choices about my care, and personal and social life, including where the choices involve personal risk 8. have control over, and make decisions about, the personal aspects of my daily life, financial affairs and possessions 9. my independence 10. be listened to and understood 11. have a person of my choice, including an aged care advocate, support me or speak on my behalf 12. complain free from reprisal, and to have my complaints dealt with fairly and promptly 13. personal privacy and to have my personal information protected 14. exercise my rights without it adversely affecting the way I am treated.

3.2 What responsibilities do I (as an approved provider) have in relation to the Charter of Aged Care Rights?

Approved providers must not act in a way that is inconsistent with the Charter of Aged Care Rights. Providers also have responsibilities, in relation to the Charter to:

- Give consumers a copy of the Charter signed by a staff member of the provider.
- Give the consumer information about their rights under the Charter.
- Assist the consumer to understand their rights under the Charter.
- Ensure the consumer, or their authorised person, is given a reasonable opportunity to sign a copy of the Charter.
- Keep a record of the Charter given to the consumer, which includes the:
  - signature of a staff member of the provider;
  - date on which the provider gave the consumer a copy of the Charter;
  - date on which the provider gave the consumer (or their authorised person) a reasonable opportunity to sign the Charter;
  - consumer (or authorised persons)'s signature (if they choose to sign); and
  - full name of the consumer (and authorised person, if applicable).

Providers must offer all consumers the choice to sign the Charter of Aged Care Rights. They are not required to sign and can receive care and services if they choose not to sign.

Asking the consumer to sign provides them with an opportunity to acknowledge that their provider has given them a copy of the Charter, has assisted them to understand it and that they understand their rights. Providers must meet all the consumer rights in the Charter of Aged Care Rights whether they sign their copy or not.

Resources to support the sector's understanding of the Charter, including a booklet, are available on the Commission's website at this link, or by searching "Charter of Aged Care Rights" at www.agedcarequality.gov.au.

3.3 What responsibilities do aged care consumers have in relation to the Charter of Aged Care Rights?

All people involved in aged care – care recipients, their families, carers, visitors and the aged care workforce – must respect and be considerate of each other. Quality aged care outcomes are more likely to be achieved in an environment of mutual respect. Aged care consumers are expected to:

- give providers the information they need to properly deliver care and services;
- comply with the conditions of their Home Care Agreement and pay fees outlined in the agreement on time; and
- respect the rights of aged care workers to work in a safe environment. Any kind of violence, harassment or abuse towards staff or others is not acceptable.
- Home Care Agreements have terms and conditions that set out the rights and responsibilities of the parties who have entered into the agreement. Home Care Agreements are discussed in detail at Section 6.

3.4 What responsibilities do I have as an approved provider?

Approved providers must understand and comply with a range of provider responsibilities specified in the *Aged Care Act 1997* (the Act) and associated legislation. These responsibilities relate to:

- the quality of care they provide
- user rights for the people to whom the care is provided
- accountability for the care that is provided, and the basic suitability of their key personnel
- pricing accountability for what they charge care recipients.

For information on responsibilities under the aged care legislation, see **Appendix E**.

3.4.1 Security of tenure

As part of responsibilities outlined in **Appendix E** providers are bound by security of tenure. Security of tenure means providers must deliver the agreed care and services for as long as the care recipient needs those services. Providers may only stop delivering home care where the requirements under the *User Rights Principles 2014* are met. Section 17 of the *User Rights Principles 2014* provides:

Exceptions to security of tenure

(1) For Section 56-2(f) of the Act, this section specifies the security of tenure that an approved provider of home care must provide to a care recipient to who the approved provider provides, or is to provide, home care.

(2) The approved provider may cease to provide home care to the care recipient only if:

(a) the care recipient cannot be cared for in the community with the resources available to the approved provider; or

(b) the care recipient notifies the approved provider, in writing, that they wish to move to a location where home care is not provided by the provider; or

(c) the care recipient notifies the approved provider, in writing, that they no longer wishes to receive the home care; or

(d) the care recipient's condition changes to the extent that:

(i) the care recipient no longer needs home care; or

(ii) the care recipient's needs, as assessed by an aged care assessment team, can be more appropriately met by other types of services or care; or

(e) the care recipient:

(i) has not paid to the approved provider, for a reason within the care recipient's control, any home care fee specified in the Home Care Agreement between the care recipient and the approved provider; and

(ii) has not negotiated an alternative arrangement with the approved provider for payment of the home care fee; or

(f) the care recipient has:

(i) intentionally caused serious injury to a staff member (as defined in section 63-1AA of the Act) of the approved provider; or

Exceptions to security of tenure
(ii) intentionally infringed the right of a staff member (as defined in section 63-1AA of the Act) of the approved provider to work in a safe environment.

Note: an approved provider of aged care is an organisation that has been approved to provide residential care, home and/or flexible care under the *Aged Care Act 1997.* For more information on becoming an approved provider see Section 4.

A provider should not use security of tenure provisions to cancel a home care agreement where a care recipient does not consent to a change. Cancelling an agreement on the basis of security of tenure should only ever be used as a last resort. If you use this provision, you will have to demonstrate sufficient grounds for terminating provision of care. Where service provision is no longer viable, you are expected to assist your care recipients to find a new provider, local to the region or support them to be referred to another system such as psychogeriatric care. For more information on negotiating changes to a home care agreement see section 6.7.1.

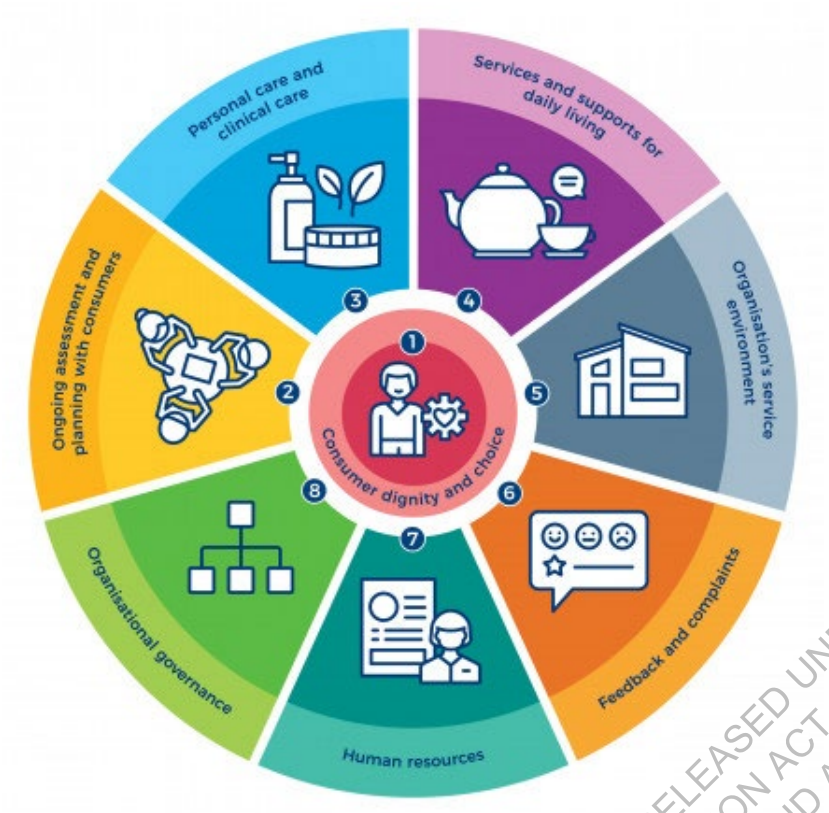
Where care recipients exhibit challenging behaviours that pose a risk to the worker, such as aggressive or disinhibited behaviours, a provider should consider any underlying health conditions that may be the cause of this behaviour and work with the care recipient and their nominee to put protocols in place to ensure the safety of the worker/s, including:

- scheduling two workers at a time (the provider may need to call My Aged Care to request a Support Plan Review by an ACAT if the package budget does not support such an arrangement);
- case conferencing with the care recipient's General Practitioner (GP) and other health professionals on a behaviour management plan (MBS items may be payable for GPs and other health professionals to participate if behaviours relate to a chronic disease; a provider would fund their involvement through care management charges); and
- contacting services such as Dementia Behaviour Management Advisory Service (DBMAS).

Providers continue to have legal obligations to worker safety that must be weighed up against the Charter of Aged Care Rights. If the above strategies do not foster a positive outcome, the provider may consider terminating the home care agreement.

3.4.2 Aged Care Quality Standards

Providers are also responsible for delivering quality care and services in a way that complies with the Aged Care Quality Standards ('the Standards'). All approved providers will be assessed against these standards and they must be able to provide evidence of their compliance with, and performance against, all the Standards.



The Standards focus on outcomes for consumers and reflect the level of care and services the community can expect from organisations that provide Australian Government funded aged care services. The Standards are made up of eight individual standards, outlined in the following diagram:

Source: Aged Care Quality and Safety Commission

The Standards are at this link, or can be found by searching "Download the Aged Care Quality Standards images" at www.agedcarequality.gov.au.

The Aged Care Quality and Safety Commission (the Commission) has developed the *Guidance and Resources for providers to support the Aged Care Quality Standards* (Guidance and Resources). It describes the Commission's expectations and provides supporting information, suggested practices, examples and evidence required to ensure compliance. It also indicates any matters that quality assessors will consider in evaluating compliance. It is available at this link or by searching "Quality Standards" at www.agedcarequality.gov.au and clicking on 'Quality Standards'.

3.5 How is compliance with the Aged Care Quality Standards assessed?

The Commission conducts quality reviews to assess whether approved providers deliver care and services in accordance with the Quality Standards. It also monitors quality through assessment contacts.

The Commission's quality assessors assess provider performance against the Quality Standards by collecting evidence and arriving at findings based on this evidence. Quality assessors collect evidence through:

- interviewing consumers or representatives;
- interviewing staff and management;
- sampling consumer records;

- reviewing documents such as policies, procedures, agreements and registers; and/or
- observing the environment, activities in progress and any interaction with consumers or representatives.

These assessment and monitoring processes are undertaken in accordance with the *Aged Care Quality and Safety Commission Rules 2018,* established under the *Aged Care Quality and Safety Commission Act 2018*. The rules can be located by searching "Aged Care Quality and Safety Commission Rules" at www.legislation.gov.au.

Through engagement and education work the Commission aims to build confidence and trust in aged care, empower consumers, support providers to comply with quality standards, and promote best practice service provision. Further information about the Commission's functions are available at this link, or by searching "Providers" at www.agedcarequality.gov.au/.

Further information regarding the Commission's assessment and monitoring process is available on the Commission's website at www.agedcarequality.gov.au/.

Provider governing bodies should familiarise themselves with Quality and Safety in Home Services – 5 Key Areas of Risk: Guidance for governing bodies of home service providers on the Commission's website.

✓ Key points to remember

- The Charter of Aged Care Rights provides the same rights to all consumers, regardless of the type of Australian Government funded aged care and services they receive, including the HCP Program. Quality aged care outcomes are best achieved in an environment of mutual respect.
- All supports provided as a part of a home care package need to be compliant with the Aged Care Quality Standards.
- All approved providers are responsible for understanding and complying with all relevant responsibilities under the law.

3.6 Serious and immediate health and safety risk management and reporting?

From 1 December 2022, the Serious Incident Response Scheme (SIRS) will also apply to home care and flexible care delivered in home and community settings.

The SIRS aims to reduce abuse and neglect in aged care.

Approved providers must comply with the incident management and reporting requirements under the *Aged Care Act 1997* (Part 4.1, Division 54) and the *Quality of Care Principles 2014* (Part 4B). The information below provides a high level summary of the SIRS requirements.

Approved providers should refer to the legislation for information on detailed requirements and check the Aged Care Quality and Safety Commission's (Commission) website at www.agedcarequality.gov.au/sirs for further SIRS information, including provider resources. Alternatively, the Commission can be contacted by emailing sirs@agedcarequality.gov.au or calling on 1800 081 549.

For more information refer to the SIRS guidance for providers on the Aged Care Quality and Safety Commission website.

4 Becoming an approved provider

To deliver care under the HCP Program, an organisation must become an approved provider. An approved provider of aged care is an organisation that has been approved to provide residential care, home and/or flexible care under the *Aged Care Quality and Safety Commission Act 2018* (the Act). Approved providers must comply with their responsibilities under the *Aged Care Act 1997.*

This section explains who can become an approved provider, how to complete the application process to become an approved provider, and what steps an organisation needs to take (if it gets approval as an approved provider) in order to provide services.

✓ **Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section**
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 54-1 and 63-1 of the *Aged Care Act 1997*
- *Aged Care Quality and Safety Commission Act 2018.*
- *Quality of Care Principles 2014*
- *Accountability Principles 2014*
- *User Rights Principles 2014*
- *Records Principles 2014*
- *Sanctions Principles 2014*.

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

4.1 What considerations do I need to satisfy to become an approved provider of Home Care Packages?

To be approved as a provider of aged care under the Act, providers must satisfy the matters established in Part 7A of the *Aged Care Quality and Safety Commission Act 2018*. A fee is payable to apply. Further information about becoming an approved provider is available at this link or by searching "Becoming an approved aged care provider" at www.agedcarequality.gov.au. To be approved, applicants must satisfy the following considerations:

Consideration 1.	Consideration 2.	Consideration 3.	Consideration 4.
The applicant must make the application in writing using the approved form and pay the application fee.	The applicant's organisation must be incorporated.	The applicant must be suitable to provide aged care.	The applicant must not have any disqualified individuals as key personnel.

4.1.1 Application process

To become an approved provider, an applicant needs to apply in writing. Corporations must apply using whichever of the forms is most applicable to their circumstances. You can access all

application forms at this link, or by searching "Becoming an approved aged care provider" at www.agedcarequality.gov.au.
The table below outlines the forms that can be used to apply, and the circumstances in which an applicant should use each form.

1. New applicant	2. Existing service provider	3. Government organisation
This form is for organisations that are not currently approved to provide any type of care under the Act. **Note**: if the applicant is an approved provider of CHSP only, and wants to provide home care, they must apply as a new applicant.	This form is for an existing approved provider that wants to provide another care type. Because existing approved providers have already had their suitability to provide aged care approved through a previous assessment process, the application form seeks specific detail to assess suitability to provide home care.	States, Territories, authorities of a State or Territory and local government authorities are taken to be approved in respect of all types of aged care. A simplified form has been developed for these Government organisations to enable the creation of a Departmental record and payment of subsidies to the organisation.

If you need further guidance, please see this link, or search "Guidance for applicants seeking to provide aged care" at www.agedcarequality.gov.au.

4.1.2 Incorporated organisations

Only organisations that are incorporated are eligible to become an approved provider of home care, residential care or flexible care. This means that if the applicant is a sole trader, partnership or other unincorporated entity, they cannot be approved as a provider of aged care under the Act and the application cannot be accepted. Definitions of each of these organisation structures can be found at www.business.gov.au.

States, Territories and local governments are automatically approved to provide aged care.

4.1.3 Suitability to provide aged care

Part 7A of the *Aged Care Quality and Safety Commission Act 2018* lists the areas each applicant must be assessed against. These are:

1. Experience in providing aged care or other relevant forms of care
2. Understanding of approved provider responsibilities
3. Systems it has, or will have, in place to meet these responsibilities
4. Record of financial management and the methods used, or proposed to ensure sound financial management
5. Conduct as a provider (including compliance with responsibilities as a provider) and obligations arising from the receipt of any payments from the Australian Government for providing aged care (if the applicant has been a provider of aged care).

It is up to the applicant to effectively demonstrate how and why their organisation meets these suitability considerations.

4.1.4 Key personnel

Identifying key personnel is a critical component of becoming an approved provider. Applicants must ensure they understand the meaning of key personnel and establish who within the organisation meet this definition. Key personnel are:

- People responsible for the executive decisions of the applicant (this includes directors and board members), whether or not the person is employed by the applicant;
- People having authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the applicant, whether or not the person is employed by the applicant;
- Any person responsible for nursing services provided, or to be provided, by the applicant, whether or not the person is employed by the applicant; and
- Any person who is, or is likely to be, responsible for the day-to-day operation of an aged care service conducted, or proposed to be conducted, by the applicant, whether or not the person is employed by the applicant.

There are specific requirements about who can/cannot be key personnel. Key personnel cannot be a disqualified individual. A disqualified individual is someone who has been convicted of an indictable offence, is insolvent or under administration, or is of unsound mind. Each State and Territory law identifies different types of offences as being indictable. These typically include serious offences such as murder, manslaughter, the intentional or unlawful administration of drugs or poisons, or committing fraudulent or dishonest activities. The applicant must also be certain that none of their key personnel are disqualified.

Under the *Sanctions Principles 2014*, all approved providers, including those providing home care, have ongoing responsibilities to continue to ensure key personnel meet the requirements about who can/cannot be key personnel as outlined in the Act. They also have reporting obligations if changes to key personnel materially affect their suitability to provider care, including if they become disqualified, or if changes to key personnel affects the organisation's contact details. This is discussed at Section 15 of this manual.

4.2 How do I know if I have been approved to provide packages?

Applicants must be notified if they have or have not been approved as a provider of aged care within 90 days of receiving a complete application. Applications cannot be assessed unless all the required documents have been provided. Applicants may be asked to provide additional information resulting in delays assessing their application.

Alternatively, applications may not be accepted and will be returned. In these cases, applicants will be informed of the reason the application was not accepted. If an applicant is required to provide further information, they will have 28 days to submit this. Once the information is received, a further 90 day timeframe for decision applies. Once an application is deemed complete, the applicant will receive written confirmation and advice that the application has progressed to assessment.

If the applicant is approved to provide aged care, they will receive a letter which includes the National Approved Provider System (NAPS) ID. You can find more information on NAPS at Section 5 of this manual.

4.2.1 Appeals pathways (if you are dissatisfied with the outcome of the assessment)

If the applicant would like reconsideration of the assessment of their application, they should submit a notice in writing within 14 days of receiving the decision letter. The request must detail the reasons for making the request and should take into account the reasons that the application was not approved. Reconsideration requests can be submitted by emailing approvedproviderapplications@agedcarequality.gov.au.

A different decision maker then reconsiders the decision, and decides whether to confirm, vary, or set the decision aside and substitute a new decision.

If the applicant wishes to appeal the outcome of the reconsideration they can make an application to the Administrative Appeals Tribunal (AAT).

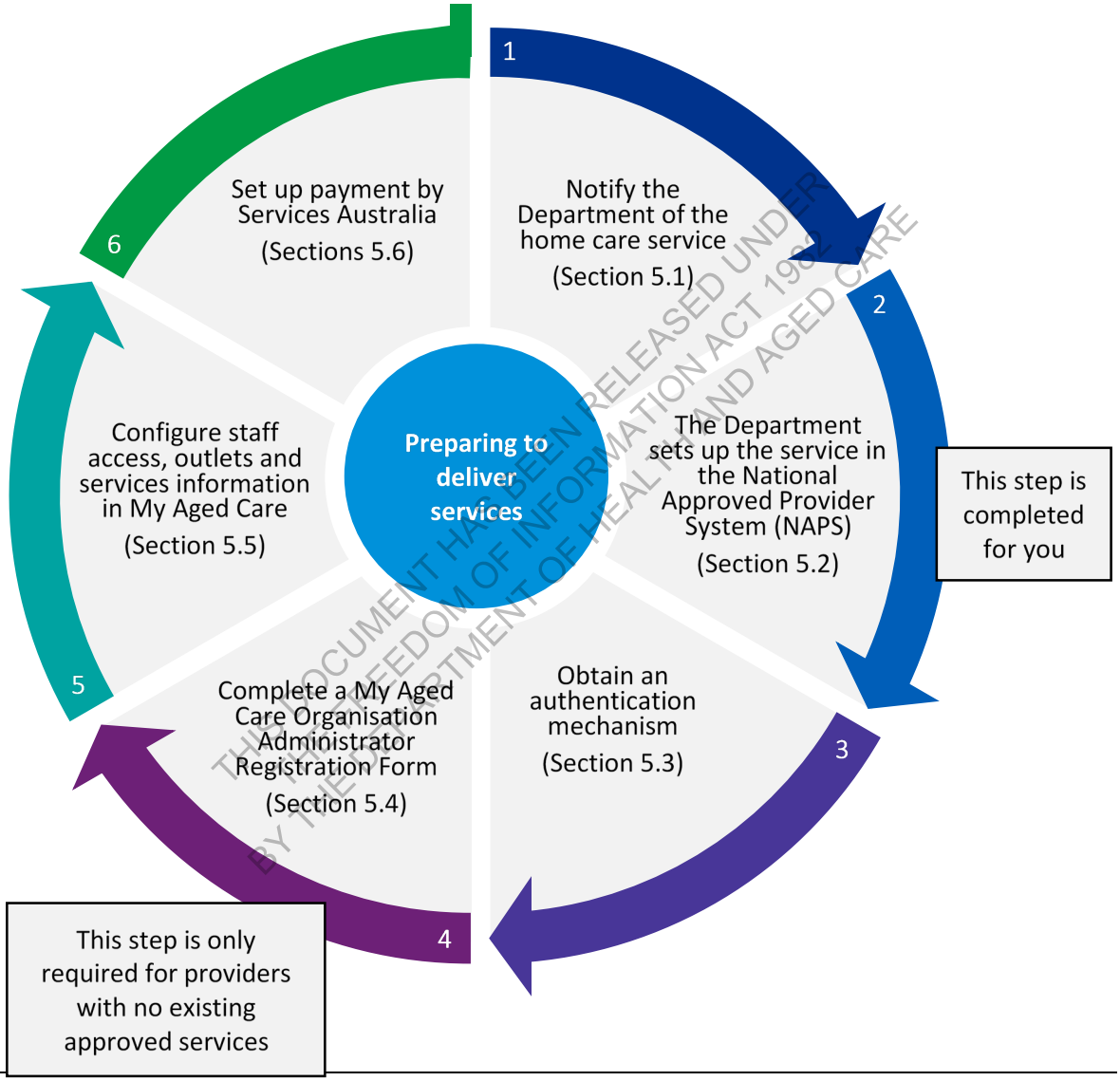
You can find information on making an application to the AAT at www.aat.gov.au/.

✓ Key points to remember

- In order to provide Government-subsidised home care under the HCP Program, an organisation must be an approved provider.
- To become an approved provider, an organisation must be a corporation, and must show that they can meet the suitability matters and have the ability to provide quality aged care services.
- Organisations will need to apply to the Aged Care Quality and Safety Commission to become an approved provider.

5 Preparing to deliver services as an approved provider

This section provides information on each of the activities providers need to complete before they can deliver services as an approved provider. It includes processes, requirements and systems. These steps may be completed in a different order to suit provider needs. The diagram below outlines an order that may be helpful for providers.



Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 9-1A and 63-1 of the *Aged Care Act 1997.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

5.1 How do I notify the Department of my home care service?

Providers who have been approved will receive a confirmation approval letter from the Aged Care Quality and Safety Commission advising of their approved provider status and National Approved Provider System (NAPS) ID. This is also known as the Provider NAPS ID. Providers then need to notify the Department of the home care services that they will provide. This can be done by completing the **"Home Care Service Notification form"**. The form can be found at this link or by searching "Notification of changes for Home Care Packages" at www.health.gov.au.

A separate form must be submitted for each home care service from which providers intend to provide home care. This form must be lodged before starting to provide care through that service. Providers must do this to be able to claim and receive subsidies for home care services.

Once the **"Home Care Service Notification form"** has been submitted, the provider will receive an email with a tracking ID and a PDF of the completed form.

There are specific processes for moving home care services to another approved provider, merging home care services and combining home care services. Information on these is in Section 13.5.

5.2 How does NAPS registration work?

The Department will directly submit **"Home Care Service Notification forms"** to the most relevant State or Territory office for processing.

The state-based team will enter the details into the NAPS system. The provider will be notified by email once the information has been processed (new services or changes to existing services) and will receive a Service ID for any new services. It is important to note that it can take up to 48 hours for a new service to appear in My Aged Care.

The provider can use this Service ID to submit claims to Services Australia.

5.3 How do I obtain authentication mechanism?

New providers will need an authentication mechanism to securely access and use the My Aged Care system.

From late March 2020, My Aged Care will support the following login methods:

- VANguard Federated Authentication Service (FAS); and
- myGovID and Relationship Authorisation Manager (RAM).

VANguard FAS

VANguard FAS integrates with an organisation's local network, allowing individuals to reuse their username and password to access external agencies without sharing the user's credentials. Staff authenticate once with their My Aged Care portal with subsequent authentications being transparent to the user.

VANguard FAS provides:

- Users with an improved login experience – allowing users to Single Sign On to My Aged Care using their own organisation credentials;
- Organisations with a single place to manage their authorisations – user access is controlled through an organisation's existing on-boarding and off-boarding procedures.

VANguard FAS is delivered by the Department of Industry, Innovation and Science (DIIS) and is suitable for any organisation with corporate network infrastructure that includes a Single Sign-On System (e.g. Active Directory Federation Server). There are no fees payable to DIIS for using FAS.

To find out more or get started with FAS, organisations can email the VANguard service desk at VANguard.Customer@industry.gov.au with their contact details and organisation name, phone number and email address.

myGovID and RAM

The Australian Taxation Office has introduced a flexible and secure way to access Government online services. These are:

- myGovID – an authentication service that allows you to prove who you are online. It is different to your myGov account.
- Relationship Authorisation Manager – an authorisation service that allows you to act on behalf of an organisation online when linked with your myGovID.

Together, myGovID and RAM offer a secure login experience:

- Users log in by authenticating with their myGovID app each time they access My Aged Care, protecting their digital identity.
- Organisations use RAM to control user access to Government online services from a single place.

myGovID and RAM form a whole-of-government solution that can be used to access many other Government online services.

5.4 How do I complete the My Aged Care Administrator Form?

Providers with no existing Provider Portal administrators will need to nominate an Organisation Administrator by completing and submitting the **"My Aged Care Organisation Administrator Registration Form"** located at this link or by searching "My Aged Care – Organisation Administrator Registration Form" at www.health.gov.au. The Department will email this form to providers at the appropriate time.

This allows the Department to set up the initial administrator for a provider organisation, to allow access to the Provider Portal. Once the Organisation Administrator registration form has been processed, the Department will contact the Organisation Administrator via email regarding next steps.

The nominated Organisation Administrator will be the first person from a provider organisation to log into the portal. They will be responsible for setting up staff access and managing the organisation's information and portal structure. The My Aged Care Assessor Portal – Organisation Administrator User Guide is available at this link or by searching "Organisation Administrator User Guide" at www.health.gov.au. Additionally, the My Aged Care – Provider Portal User Guide: Part 1 Administrator Functions is available at this link or by searching "My Aged Care – Provider Portal User Guide Part 1" at www.health.gov.au.

Established users can then set up 'Outlets' and 'Services' in the portal and add the organisation's service information. Once the service item is 'Operational' and the outlet is 'Active', referrals can be received from My Aged Care. The My Aged Care – Provider Portal User Guide: Part 2 is available at this link or by searching "My Aged Care - Provider Portal User Guide Part 2" at www.health.gov.au.

Note: the Department recommends the initial administrator sets up other staff in a provider organisation as Organisation Administrators to allow for back up access.

Providers can find the My Aged Care Provider Portal at this link or by searching "For service providers" at www.myagedcare.gov.au.

5.5 How do I configure my information in the My Aged Care Provider Portal?

The My Aged Care Provider Portal is a web-based platform that allows providers to self-manage information about the services they provide. This information is displayed on the public 'find a provider' tool on the My Aged Care website, and is used by care recipients and their carers to search and compare potential home care providers that can best meet their assessed ageing related care needs in their preferred location. It is also used by My Aged Care contact centre staff and assessors to refer people to service(s). It allows providers to accept and reject referrals.

It is essential that providers ensure all of their information on this platform is current, correct and complete. It should be written for care recipients in plain English with enough detail to support their decision-making. A Quick Reference Guide on the procedures for creating and maintaining information about service delivery outlets is available at this link, or by searching "My Aged Care Process Overviews – Home Care Packages" on www.health.gov.au.

As an approved provider, details of services are automatically listed within the 'find a provider' tool. Providers, however, will need to ensure that these details are complete.

Providers can set up 'Outlets' and 'Services' in the portal and add the organisation's service information. Once the service item is 'Operational' and the outlet is 'Active', referrals can be received from My Aged Care.

This must include pricing information. New pricing requirements were introduced on 1 July 2019 to improve transparency for older Australians, to enable direct comparisons between providers, and to curb problematic charging practices by some providers. Information on providers' pricing obligations are at **Appendix B** and **Appendix C**.

From 1 January 2023, the amount a provider can charge for care and package management will be capped at 20 per cent and 15 per cent of the package level respectively. Additionally, providers will no longer be able to charge exit amounts or charge separately for costs associated with third party services. Updates to the My Aged Care Provider Portal will occur in February 2023 to support these changes. Providers affected by the changes will need to discuss pricing changes with their care recipients. Learn more about what the changes are and how you can prepare for them by searching "Home Care Packages Program update – November 2022" on www.health.gov.au.

Providers can also list other information on the 'find a provider' tool, which can help promote their services. This could include:

- cultural specialisations;
- religious specialisations;
- languages other than English that carers speak;
- specialised services; and/or
- ability to provide services to individuals with diverse needs.

Guidance on completing the 'specialisations' section of the provider portal is available from this link or by searching "My Aged Care Provider Portal User Guide" on www.health.gov.au.

Providers can configure this information, and their financial information, at an organisation and/or outlet level. This means that a larger provider can set up information for all the outlets they have, and then let the outlets provide further information, or amend the provided information, as required. A smaller provider can set all their information up at one time.

The Department expect providers' service information to meet their requirements for managing service information in the 'find a provider' tool on My Aged Care. The Department can choose to remove organisations who do not comply. The requirements include:

- the same service, with the same NAPS Service ID, must only be listed once per location i.e. the service must only appear once in the search results for that location;
- outlet and service item names must not include phone numbers or marketing slogans; and
- service delivery areas must reflect only those locations where the provider can deliver service.

Further information on these requirements is available at this link, or by searching "Managing your home care service information" at www.health.gov.au.

5.6 How do I set up payment of subsidies with Services Australia?

Services Australia administers payments for aged care subsidies and supplements (where relevant) on behalf of the Department. Providers will need to set up their organisation with Services Australia to make claims for services and receive payments. They will need to complete and return the following forms to Services Australia:

- **"Aged Care approved provider statement form"** (AC003). AC003 is at this link, or can be found by searching "AC003" at www.servicesaustralia.gov.au.
- **"Register, amend or remove users for Aged Care Provider Portal form"** (AC004). AC004 is at this link, or can be found by searching "AC004" at www.servicesaustralia.gov.au.
- **"Application to add or change approved care service's bank details form"** (AC015). AC015 is at this link, or can be found by searching "AC015" at www.servicesaustralia.gov.au.

For more general Services Australia information, see this link or search "Aged care providers" at www.servicesaustralia.gov.au.

✓ Key points to remember

- If an organisation is approved as an approved provider, there are six administrative tasks that need to be completed before they can provide services to care recipients. These are outlined in the diagram at the start of this section, but can be summarised as:

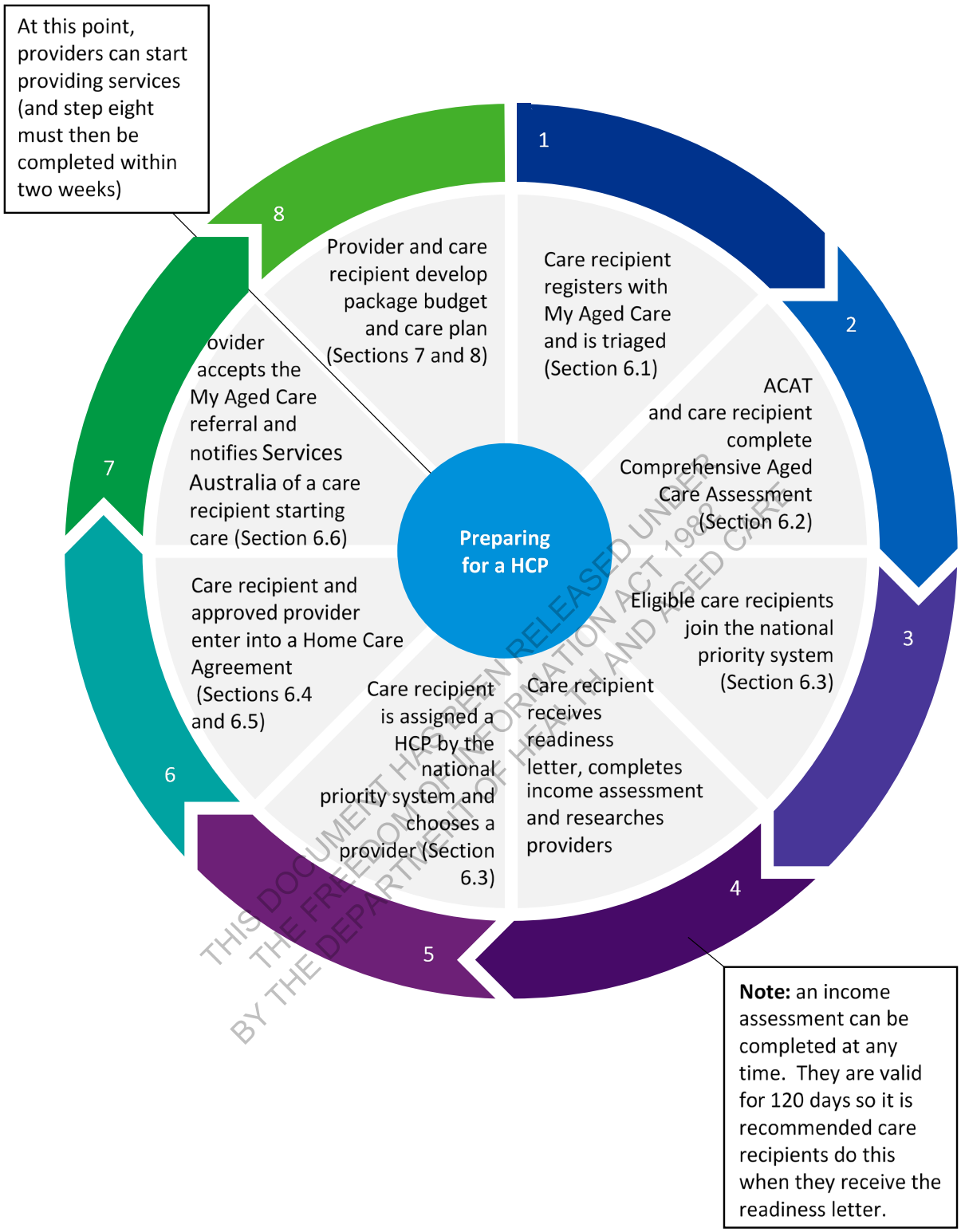
1. Notify the Department of the Home Care service
2. The Department sets up the service in the National Approved Provider System (NAPS)
3. Obtain an authentication mechanism
4. Complete a My Aged Care Organisation Administrator Form
5. Configure staff access, outlets and services information in My Aged Care
6. Set up payment by Services Australia.

Providers can complete these steps in a different order if they would like. If providers follow the above order, this process may run more smoothly.

6 Eligibility for care recipients to receive Australian Government funded packages

This section sets out the steps that care recipients need to take to receive services under a package. This information has been provided to support providers to help care recipients navigate this process, if needed. This section also sets out the steps that providers need to take after an individual has been assigned a package, but before they can start providing Government-subsidised home care services to that individual.

Note: care plans need to be reviewed regularly during the course of delivering a home care package. This review process is discussed at Section 10.3.



Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section

Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 56-2 and 63-1 of the *Aged Care Act 1997*
- *Accountability Principles 2014*

- *User Rights Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

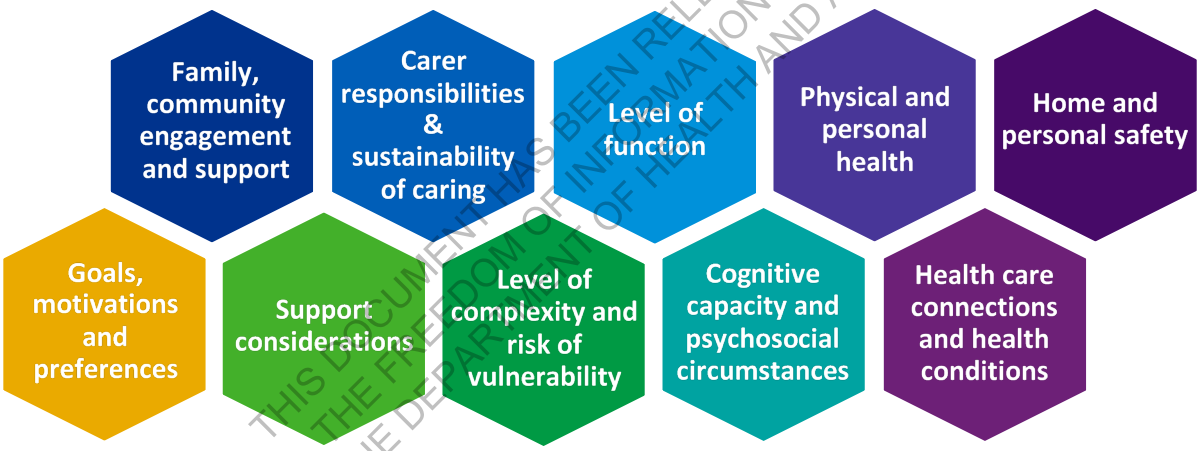
See **Appendix E** for further detail on specific provider responsibilities.

6.1 How do care recipients start the process to get a package?

Care recipients and/or their representative complete a screening with My Aged Care to determine their pathway to aged care services. They can do this by calling the My Aged Care contact centre on **1800 200 422** which will generate a reference for a face-to-face assessment based on the information given at the screening. If this information indicates a comprehensive assessment is required, the My Aged Care contact centre will refer them to an ACAT to conduct the assessment.

6.2 What is a comprehensive aged care assessment and how does it work?

Eligibility for the HCP Program is assessed by an ACAT. The comprehensive assessment will consider:



The assessment identifies an individual's strengths and areas of difficulties across these factors, which will be considered as the assessor works with them to develop a support plan. In some instances, it may be appropriate to use a supplementary assessment tool clarify their individual needs further.

The assessor will make recommendations based on the person's care needs at that time. After conducting a comprehensive assessment, an ACAT will send their assessment findings and recommendations to the ACAT delegate to determine eligibility for aged care services under the Act. Information on how to prepare for an assessment and what to expect has been provided in the HCP Program Consumer Manual.

Everyone assessed will receive the outcome of their assessment by mail. The letter will contain the assessment decision confirming eligibility for a package, the level of package approved (if eligible), the reasons and evidence supporting the decision and a copy of their support plan developed during their assessment.

6.3 What is the national priority system?

The national priority system is the system that assigns packages. Once an older Australian is assessed as eligible, they will be placed in the national priority system, where they will wait for the assignment of a package. They will not be able to access Australian Government subsidised home care services under the HCP Program until they have been assigned a package.

The national priority system ensures the equitable assignment of packages based on a person's assessed care needs and circumstances; not where they live. The system only takes into account:

- priority for home care services as determined by the ACAT during the comprehensive assessment; and
- the date of approval for home care at that level.

Older Australians who were actively seeking care at the time of their approval will be automatically placed in the national priority system and set as 'seeking services'. They will receive a package as soon as one is available based only on the above two factors.

Those who are not actively seeking care at the time of their approval should inform their assessor. They will then be set as 'not seeking services' and will not be assigned a package until they are advised otherwise. If Older Australians who was 'not seeking services' wishes to be assigned a package, they will need to indicate that they are actively seeking care. Following this, they will be assigned a package as soon as one is available.

An Older Australian can request to be set as 'seeking services' or 'not seeking services' at any point. This can be done by calling the My Aged Care contact centre on **1800 200 422**, or by using the My Aged Care Client Portal at this link, or by searching "View your My Aged Care client record" at www.myagedcare.gov.au.

The Department releases packages regularly, generally weekly, as indicated by the national priority system. The number of packages released at each level takes into account the number of new packages that are available, as well as the number of packages that other people have left or not accepted in previous weeks. Projected wait times for a package are available in time-bands in the client portal.

6.4 What does an eligible care recipient need to do to be assigned a package (after they have been assessed as eligible)?

Eligible home care recipients will receive a letter notifying them that they have been assigned a package.

After being assigned a package, care recipients have 56 calendar days from the date their package is assigned to find an approved provider and enter into a Home Care Agreement that best meets their needs. If a care recipient wants more time to find a suitable provider, they can contact the My Aged Care Contact Centre and request a 28 day extension, giving them a total of 84 calendar days to enter into a Home Care Agreement.

If the care recipient has not entered into a Home Care Agreement within 56 calendar days (or 84 calendar days with the extension), the package is withdrawn. This means the package is no longer assigned to them, and approved providers are not able to claim a subsidy.

If a person is assigned their approved level of package and it is withdrawn, they will be removed from the national priority system. If they later decide they want to receive services through a package, they need to re-join the national priority system by calling My Aged Care. People who

re-join the national priority system will have their date of entry recorded as the date they were originally approved for home care at that specific package level.

Providers may receive a referral in the provider portal through one of two ways:

- a system generated referral – created either by the My Aged Care contact centre or by a member of an ACAT; or
- a direct referral – direct receipt of a person's referral code e.g. an eligible person has presented their package assignment letter and requested that the provider deliver their services.

From the referral record providers can view the referral summary and a person's record. This will help them make an informed decision about whether they can deliver the services required by the person and when they need services to start.

Check the My Aged Care client record carefully for any active services and do not commit a package if a care recipient is currently in home care, residential aged care or Short-Term Restorative Care until cessation date with current provider has been confirmed.

Committing a package while another entry is in place, may result in a dispute, so keep records of all conversations with My Aged Care, care recipient and current provider. Failure to engage with current provider to confirm cessation date may result in an overpayment of subsidy and debt collection activities by Services Australia if two services claim for the one care recipient for the same period. Ensure you are aware of all program interfaces. Read more at How does the HCP Program interact with other programs and schemes?.

Detailed information on managing referral care recipients' records on My Aged Care is available at this link or by searching "My Aged Care for service providers" on www.health.gov.au.

6.5 What should I include in a Home Care Agreement?

When a care recipient chooses an organisation as their approved provider, the provider must enter into a Home Care Agreement with them before starting to deliver services and receive payment under the HCP Program. A provider is not eligible for subsidy on behalf of the care recipient if a Home Care Agreement is not in effect. Where a Home Care Agreement is not in effect, and a provider claims subsidy from the Commonwealth, the provider is liable for a debt owed to the Commonwealth for the period in which a Home Care Agreement was not in effect.

To ensure compliance, providers should follow guidance available on www.health.gov.au and search "Home care agreements for Home Care Packages".

Providers should ensure their Home Care Agreements do not contain unfair contract terms. Although businesses may use standard form contracts for efficiency, it is important that businesses consider a consumer's (care recipient) rights when preparing their contracts. An Australia-wide law protects recipients from unfair terms in standard form consumer contracts. The law offers recipients increased protection in circumstances where they have little or no opportunity to negotiate with the provider.

Providers cannot charge people for entry or exit to the service. For more information on exit charges, see 13.4 When can I charge an exit amount?

The Home Care Agreement sets out the terms and conditions by which a provider will deliver care and services to a care recipient. It is the legal contract between a provider and a care recipient and captures each parties' responsibilities. It is critical that providers seek legal advice and assistance in drafting agreements.

The Act and Principles set out strict conditions by which the Home Care Agreement must comply. It is essential that providers understand the requirements under the Act.

A Home Care Agreement for people who started receiving services after 1 July 2014 must be written in plain English that is readily accessible. It must not contain any provision that would have the effect of the care recipient being treated less favourably in relation to any matter than they would otherwise be treated under any law of the Commonwealth in relation to the matter. Finally, it must include the following:

6.5.1 Relationship with the care recipient

#	Requirement	Legislation citation
1	A statement specifying that home care will be delivered on a CDC basis. CDC has been discussed at Section 2.1 of this manual.	Section 23(2)(b)(i) of the *User Rights Principles 2014*
2	A statement specifying the care recipient's rights in relation to decisions about the care and services that are to be provided. CDC has been discussed at Section 2.1 of this manual. **Note**: any changes to the Home Care Agreement must be agreed through informed, mutual consent of the provider and the care recipient. Variation of the Home Care Agreement is discussed at Section 6.5.5.	Section 23(2)(b)(iv) of the *User Rights Principles 2014*
3	A statement outlining: • that a care recipient is entitled to make a complaint about the provision of their care and services without fear of reprisal; and • the complaints mechanism the provider has in place. For more information on designing a complaints mechanism see Section 10.	Section 61-1(1)(f) of the *Aged Care Act 1997* Section 23(4) of the *User Rights Principles 2014*
4	A statement outlining any responsibilities of the care recipient as a recipient of home care from the service.	Section 61-1(1)(g) of the *Aged Care Act 1997*

6.5.2 Care and services

#	Requirement	Legislation citation
5	The date the provider will start to provide home care to the care recipient. If they are transferring from another provider, please see Section 13 of this manual.	Section 23(2)(a) of the *User Rights Principles 2014*
6	A statement specifying the level of home care to be provided. This will be the package level that the care recipient has been assigned. This process has been discussed at Section 6 of this manual.	Section 23(2)(b)(iii) of the *User Rights Principles 2014*
7	A statement specifying the care and services that the care recipient will receive. This will also need to be outlined in the care plan, as discussed in Section 7 of this manual.	Section 23(2)(b)(ii) of the *User Rights Principles 2014*
8	A statement specifying that the provider will give the care recipient copies of their care plan and package budget, including any updated copies if the provider and the care recipient make any changes to the care plan and package budget. Home Care Agreements entered into before 1 July 2015 do not need to be updated to include this provision. In practice, however, providers must provide their care recipients with these documents.	Section 23(2)(b)(v) of the *User Rights Principles 2014*
9	A statement that the care recipient may suspend, on a temporary basis, the provision of home care (known as taking leave) if the provider is notified. Leave has been discussed more generally at Section 11 of this manual.	Section 23(2)(f) of the *User Rights Principles 2014*
10	The amounts that the care recipient will be liable to pay to the approved provider for any period of suspension. Fees payable during suspension (leave) are discussion at Section 11 of this manual.	Section 61-1(1)(e) of the *Aged Care Act 1997*

6.5.3 Pricing and budget

#	Requirement	Legislation citation
11	A statement of home care fees (Income tested fees, Basic daily fee & additional fees) that the provider will charge to the care recipient. **Note**: the discussion at Item 13 of this table, below.	Section 23(2)(c)(i) of the *User Rights Principles 2014*

#	Requirement	Legislation citation
12	A statement of the policies and practices that the provider will follow in setting the price that the care recipient will be liable to pay to the approved provider for the provision of the care and services. Fees are discussed at Section 8 of this manual. Appendix C includes information on 1 January 2023 prices changes. Further information on how providers set, publish and charge for care and services can found on www.health.gov.au by searching "Pricing for Home Care Packages".	Section 61-1(1)(c) of the *Aged Care Act 1997*
13	A copy of the provider's Schedule as published on My Aged Care at the time the agreement is signed. This is discussed further in **Appendix B** of this manual. All agreements entered into after 1 July 2019 must comply with the new pricing requirements. All prior agreements must be updated to become compliant by 1 January 2023. The prices under the Agreement must be the same as those in the pricing schedule published on My Aged Care at the time the agreement is signed unless the provider and care recipient discuss and agree to a variation in pricing. If the provider and care recipient reach agreement on a variation, this must be documented within the Home Care Agreement. If the care recipient is to be charged an amount of the basic daily fee (discussed in Section 8 of this manual) that is different from the amount of the fee in the schedule, the provider and care recipient must also reach agreement on a variation, and this must be documented within the Home Care Agreement.	Sections 23(2)(ba)-(bc) of the *User Rights Principles 2014* Section 23(2)(c)(ii) of the *User Rights Principles 2014*
14	A statement specifying that the provider will give the care recipient a statement of the available funds and expenditure in respect of each month for the care and services provided to the care recipient during the month (a monthly statement). Monthly statements have been discussed further at Section 10.	Section 23(2)(cb) of the *User Rights Principles 2014*
15	A statement specifying that any care recipient portion or transfer portion of the care recipient's unspent home care amount will be paid in accordance with Part 3 Division 3A of the *User Rights Principles 2014*. For more information on how to action this please see Sections 13 and 14.	Section 23(2)(cc) of the *User Rights Principles 2014*

#	Requirement	Legislation citation
16	Provision for financial information to be given to the care recipient about the home care that the care recipient will receive, including a statement that the approved provider must, within seven days after a request by the care recipient, give the care recipient: • A clear and simple presentation of the financial position of the home care service, including the costs of home care that explains any ongoing fees payable by the care recipient. • A copy of the most recent statement of the audited accounts of the home care service or, if the home care service is operated as part of a broader organisation, the most recent statement of the audited accounts of the organisation's aged care component (that includes the home care service).	Section 23(2)(d) of the *User Rights Principles 2014*

6.5.4 Administration

#	Requirement	Legislation citation
17	A guarantee that the provider will take all reasonable steps to protect the confidentiality, as far as legally permissible, of information provided by the care recipient. Details of the use of information that is to be made by the provider and each person or entity to who the provider discloses the information.	Section 23(2)(e) of the *User Rights Principles 2014*
18	A statement specifying the home care service through which the approved provider will provide care to the care recipient.	Section 61-1(1)(a) of the *Aged Care Act 1997*
19	A statement specifying the levels of care and services that the provider has the capacity to provide to the care recipient while they are being provided with care through the home care outlet. **Note**: while an approved provider must be able to deliver all levels of packages, they are not required to be able to do so at all services.	Section 61-1(1)(b) of the *Aged Care Act 1997*
20	If the care recipient is not to be provided with the home care service on a permanent basis – the period for which the care and services will be provided.	Section 61-1(1)(d) of the *Aged Care Act 1997*

6.5.5 Variation or termination

#	Requirement	Legislation citation
21	A statement that the agreement may be varied by the approved provider if the variation is necessary to implement the *A New Tax System (Goods and Services Tax) Act 1999,* but that the agreement must not be varied pursuant to the above unless the provider has given reasonable notice of the variation, in writing, to the care recipient.	Sections 23(3)(a)(i) and 23(3)(b() of the *User Rights Principles 2014*

#	Requirement	Legislation citation
22	A statement that, in any case other than that discussed at Item 21 above, can only be varied by mutual consent, following adequate consultation of the care recipient with the provider. Mutual consent requires active acknowledgement by the care recipient. Mutual consent **is not** characterised by sending a letter to a care recipient to inform them of a change, offering an opt out and taking their silence as approval.	Section 23(3)(b) of the *User Rights Principles 2014*
23	A statement that the agreement must not be varied in a way that is inconsistent with *A New Tax System (Goods and Services Tax) Act 1999*, the *Aged Care Act 1997* or the *Extra Service Principles 2014*. **Note**: in their current form, the *Extra Services Principles 2014* contemplate residential care services only. They have not been considered further.	Section 23(3)(c) of the *User Rights Principles 2014*
24	The conditions under which either party may terminate the provision of home care, noting that providers may only terminate the provision of home care were security of tenure allows it. Security of tenure has been discussed at Section 3.4 of this manual.	Section 23(2)(g) of the *User Rights Principles 2014*

Home Care Agreements with care recipients who are in the pre-1 July 2014 arrangements must include different items. These are outlined in **Appendix A**.

6.6 What should I consider when entering into a Home Care Agreement with a care recipient?

In addition to obligations under the *Aged Care Act 1997*, outlined in **Appendix E**, providers have obligations under consumer and competition law. When negotiating with care recipients for the delivery of care and services and drafting the Home Care Agreement providers should also have regard to all these obligations.

The Australian Competition & Consumer Commission (ACCC) has developed guidelines for consumers and providers that outline consumer and business rights and obligations under the competition and consumer law (as they relate to the HCP Program).

The provider guide is at this link, or can be found by searching "Home care services – your business rights & obligations" at www.accc.gov.au. The consumer guide is at this link, or can be found by searching "Home care – a guide to your consumer rights" at www.accc.gov.au.

Approved providers should confirm with the care recipient or their family who has been authorised to enter into the Agreement. In some circumstances, other arrangements may be in place for an authorised representative to act on their behalf.

The Department cannot provide individual advice on business practices, nor is the Department in a position to offer legal advice. Providers may wish to seek independent legal advice about business arrangements and how they align with the legislation.

6.7 What do I do if a care recipient won't sign a Home Care Agreement?

Both the care recipient and the provider should sign the Home Care Agreement. The care recipient should be given a copy of the signed Home Care Agreement.

A care recipient, however, does not necessarily need to sign the Home Care Agreement for it to be in place. As long as there is mutual agreement between them (or their authorised representative) and the provider regarding the care and services to be delivered as part of the package, the agreement is considered 'in place'.

In the event that a care recipient does not sign the agreement, providers should keep detailed records of reasons why the agreement is not signed. This is because they must always be able to provide proof that an agreement is in place. Proof may include:

- a copy of the Home Care Agreement document the provider offered to the care recipient
- a file note of the discussion with the care recipient about the basis of the agreement (including the date the discussion took place); and/or
- proof that the provider is providing a package as described in the agreement.

6.7.1 When a care recipient does not agree to changes to an existing home care agreement

If a care recipient does not agree to the proposed changes, a provider needs to:

- negotiate to reach agreement with the care recipient – and provide a detailed rationale in a format that the care recipient will understand
- encourage a care recipient to seek independent advice from consumer advocates, family members, or legal advisers
- advise a care recipient they are able to change providers (My Aged Care provides a range of tools to support choice).

6.8 I don't speak the same language as my care recipient. How can I arrange interpreting services?

For home care recipients who speak a language other than English as their first language, the Department of Home Affairs provides free interpreting services through the Translating and Interpreting Service (TIS National). Providers must register online for a TIS National Code. You can find information on this at this link or by searching "Interpreting support for Home Care Package service providers" at www.health.gov.au.

The intention of TIS National is primarily to assist care recipients to understand their package, including the Home Care Agreement, the package budget and monthly statements. When TIS National is used for this purpose including if required to discuss the monthly budget, there is no cost to the provider and there should not be any charges made to the care recipient's package budget.

TIS National is available 24 hours a day, seven days a week and provides both telephone and onsite services. Bookings can be made online via www.tisnational.gov.au. Alternatively, providers can call 131 450 for immediate telephone interpreting or 1300 655 082 for on-site bookings.

When accessing TIS National, providers will need to quote their service's unique code. If a provider is unsure of their care recipient's client code, they can contact TIS National on 1300 655 820.

Note: if providers are unable to provide aged care workers from TIS National, that can communicate in the required language, they may negotiate with the care recipient to engage a different organisation.

From 1 January 2023, a provider must not charge a separate amount for coordinating third-party services, even if:

- the provider made a business decision to engage a third-party or

- the care recipient chose a third-party to provide those services.

For more information on engaging a third party see section 7.5.

The agreed position and the responsibilities of the provider, care recipient and interpreter should be documented and included in the Home Care Agreement. Further information about the Translating and Interpreting Services charges for non-English speakers is available at www.tisnational.gov.au.

6.9 How and why do I notify Services Australia of a care recipient starting care with my service?

Providers need to declare care recipient entry information to Services Australia within 28 calendar days of when they commenced their home care services. Providers will first need to accept the referral in the My Aged Care Provider Portal, and then complete the paperwork to notify Services Australia. This paperwork can be completed through the Aged Care Provider Portal or through the submission of an Aged Care Entry Record (ACER).

The Aged Care Provider Portal can be found at this link, or by searching "Aged Care Provider Portal" at www.servicesaustralia.gov.au. An ACER can be completed using paper form AC021 at this link or by searching "AC021" at www.servicesaustralia.gov.au.

Entry information must be provided to Services Australia as early as possible and before the care recipient's package take up deadline to ensure their package is not withdrawn. If providers do not advise Services Australia of entry information, or if they do not have a Home Care Agreement in place, they will not be paid any applicable subsidy or supplements.

At this time, providers should also inform the Department if a care recipient has commenced a package and also receives a compensation entitlement. This is discussed at **Appendix C**.

✓ Key points to remember

- Before older Australians can receive services under the HCP Program, they need to register with My Aged Care, be assessed by an ACAT as eligible for the program, and be assigned a package through the national priority system.
- Once they have been assigned a package, they need to enter into a Home Care Agreement with a provider within 56 days (or 84 days with an extension).
- If providers are entering into a Home Care Agreement with a care recipient, they are bound by the obligations of consumer law. Providers can find out more in the ACCC provider guide at this link, or by searching "Home care services – your business rights & obligations" at www.accc.gov.au.
- If providers do not advise Services Australia of entry information they will not be paid any applicable subsidy or supplements.
- A free interpreting service is available to help providers negotiate the Home Care Agreement, develop the care plan with the care recipient and advise on the monthly budget. If the provider cannot provide aged care workers who speak the required language, they can negotiate with the care recipient to charge translation fees to their package budget.

7 Care planning

This section defines what a care plan is and outlines some strategies providers may use to complete care planning with care recipients.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 54-1 and 56-2 of the *Aged Care Act 1997*
- *User Rights Principles 2014*
- *Quality of Care Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers must familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

7.1 What is a care plan?

A care plan is a document that identifies a care recipient's assessed care and service needs, goals and preferences and details how the care and services are to be delivered as agreed with the care recipient to meet their care needs, goals and preferences. The package budget is discussed at Section 8.

Providers will need to undertake assessment and planning for care and services together with the care recipient within 14 calendar days of starting to provide care services. The assessment and planning has a focus on optimising health and well-being in accordance with the assessed ageing related care needs, goals and preferences. Providers must undertake initial and ongoing assessment and planning to meet Standard 2 of the Aged Care Quality Standards (see Section 3).

Assessment and planning is covered by the price deducted from care recipients' package for care management, consistent with a provider's advertised prices on My Aged Care. There should not be a separate charge for initial assessment over and above the agreed charge for care management costs. The legislation prohibits providers from charging a care recipient for entry to their service.

During the care planning process, providers will need to take into account any supports the care recipient already has in place, such as carers, family members, local community and other services. For each care recipient, providers need to be able to demonstrate assessment and planning that:

- includes consideration of risks to the care recipient's health and well-being to inform the delivery of safe and effective care and services;
- identifies and addresses the care recipient's current assessed ageing related care needs, goals and preferences, including advance care planning and end of life planning if the care recipient wishes;
- is based on working with the care recipient and others that the care recipient wishes to involve in assessment, planning and review of the care recipient's care and services; and
- includes other organisations, and individuals and providers of other care and services that are involved in the care of the care recipient.

The care planning document should provide a detailed outline of services to be delivered, including how, when and where. This information should be specific, for example 2-3pm Tuesdays, rather

than 'Tuesday'. Once the care plan and package budget (as discussed at Section 8) have been agreed, providers must give a copy to the care recipient for their records.

Information on approaches to care planning is set out at Section 7.3. Information on what services can (or cannot) be included in a care plan is set out at Section **9**.

7.2 How do I work with a care recipient to develop their care plan?

Because the HCP Program uses a CDC model and is governed by the Quality Standards (as discussed at Section 2.2), providers will need to work with a care recipient to develop their care plan with reference to the ACAT assessment. This is an opportunity to support the care recipient to understand the policy intent of the HCP Program and work out a care plan that assists them to manage their ageing related care needs and goals. To do this, providers will need to consider their obligations under the Quality Standards relating to care planning and understand what the potential inclusions and exclusions are for each individual home care package. Guidance on how to do this is set out at Appendix A.

The Department does not prescribe which validated tools, if any, should be used to inform care planning. However, if providers are looking for examples of what tools may be useful when conducting a care plan, it should be noted that currently ACATs may make use of the following tools when conducting the NSAF (listed below). Some of these tools may have licensing restrictions. If in doubt, providers are encouraged to contact the copyright holder of the tool, if they wish to use these tools for care planning/management purposes:

- Older Americans Resources and Services (OARD) Instrumental Activities of Daily Living
- Barthel Index of Activities of Daily Living
- Kimberley Indigenous Cognitive Assessment – Activities of Daily Living
- Revised Urinary Incontinence Scale (RUIS)
- Revised Faecal Incontinence Scale (RFIS)
- South Australian Oral Health Referral Pad
- Oral Health Assessment Tool (OHAT) for Non-Dental Professionals
- Mini-Nutritional Assessment (MNA)
- Brief Pain Inventory (Short Form)
- Resident's Verbal Brief Pain Inventory
- Abbey Pain Scale
- Alcohol Use Disorders Identification Test
- Standardised Mini-Mental State Examination
- Rowland Universal Dementia Scale
- Informant Questionnaire on Cognitive Decline in the Elderly
- Kessler 10
- Geriatric Depression Scale

One other validated tool used to determine eligibility for the dementia and cognition supplement is the *Psychogeriatric Assessment Scales*. The Commonwealth has enduring copyright over this tool, and this tool may be used freely by providers for all care planning/management purposes.

If the care recipient consents, there may be merit in case conferencing with their GP and other health professionals to support the development of their care plan. GPs and other health professionals may be able to access MBS items to fund their involvement in any case conferencing if

the care recipient has a chronic disease. A provider's involvement would be funded by HCP care management charges to the package.

Providers will also need to help care recipients understand what care, services, and/or purchases they can afford within their package budget. They should prepare for care plan conversations by developing an understanding of the likely components of each individualised package. The information found at Section 8 of this manual will help providers to do this.

Please note, if charges have been levied against a package for excluded items the provider will, at a minimum, be required to repay any amounts that have been unlawfully charged against the budget back into the package.

7.3 What approaches can I employ to work with a care recipient to develop their care plan?

When working with a care recipient to develop goals, providers may consider whether reablement or wellness approaches to providing care might help them meet their goals. Giving consideration to these two contemporary approaches supports providers to ensure that the care and services they deliver align with the core principles of the HCP Program. These concepts underpin a number of aged care services, and are outlined, at a high level, below.

No matter which approach to care planning providers choose to take, it is important to remember that care planning is a collaborative process, between the provider and the care recipient.

7.3.1 Wellness approach

Wellness is an approach that involves assessment, planning and delivery of supports that build on care recipients' strengths, capacity and goals, and encourages actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home. Wellness as a philosophy is based on the premise that, even with frailty, chronic illness or disability, care recipients generally have the desire and capacity to make gains in their physical, social and emotional wellbeing and to live autonomously and as independently as possible.

This approach supports care recipients to undertake a task or activity themselves, or with limited assistance, and to increase satisfaction with any achievements. It underpins all assessment and service provision, whether the need for assistance is episodic, fluctuates in intensity or type over time, or is of an ongoing nature.

The case study on the next page outlines how a wellness approach can make a difference.

Case study: Jing

Jing likes to keep busy and tries to do as many jobs around the house as possible. Lately, she has been unable to hang up some of her heavier clothing items on the line. The traditional approach would involve support workers coming into Jing's home once a week to hang out the clothes for her. The wellness approach would encourage the support worker to work with Jing to hang out her bigger, heavier items and encourage her to hang her smaller items by using a laundry trolley and an easy-to-reach drying rack. In this way, Jing can continue to do things for herself and can act independently to do all her washing except for those items she needs some support to lift. This preference is reflected in Jing's care plan.

Source: Silverchain

7.3.2 Reablement approach

Reablement involves time-limited interventions that are targeted toward a care recipient's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities. Like wellness, reablement aims to assist care recipients to reach their goals and maximise their independence and autonomy. Supports could include training in a new skill or re-learning a lost skill, minor modification to a person's home environment or having access to equipment or assistive technology.

In practice, reablement can mean different things for different people – it all depends on their individual situation. For example, it might mean working with the care recipient to:

- practice daily activities, such as cooking and bathing, to help them regain skills and get their confidence back;
- find new ways to do some things so that they feel safer and more confident;
- look at what else might help (for example, support to go out, personal alarms, home modifications or other equipment, such as bath rails); and/or
- involve their relatives and/or carers in helping them to live more independently – and discuss any support they might need.

The kind of supports reablement might draw on vary, but could include the following:

- equipment and technology to help a care recipient live more independently at home;
- skills for independent living provided through intensive, short-term support; and/or
- outreach - help with transport and getting out and about.

7.4 If two people live together, can they have one care plan that contains information for both of them?

Older Australians who live together must undergo individual assessments by an ACAT. These assessments will generate individual support plans. Each care recipient must be assigned a package and have their own care plan.

They may, however, elect to pool their resources to fund joint care or services across both of their package budgets. For example, if both have been assessed as requiring cleaning services once a week, they may pool resources to share the cost of the cleaner between the two packages. Providers are required to include information about their respective home care fees payable in the Home Care Agreement, and the calculated home care fee amount being recorded in their respective package budgets.

7.5 What do I do if a care recipient wants services my company doesn't deliver?

Providers can deliver home care directly, or can engage third party organisations or individuals to deliver care and services. This includes where a provider:

- sources and coordinates care and services through a third-party (including subcontractors, labour hire or brokered services)
- purchases goods, equipment, and assistive technology from a third party.

You may engage third parties on an ad hoc or ongoing basis to meet your care recipients' needs or their requests for specific workers or service providers.

Approved providers should, where possible, facilitate services being delivered by the person chosen by the care recipient. With CDC, if someone prefers a particular care worker to deliver their services, they can ask the provider to engage that care worker. Providers must discuss this cost with the care recipient before the care plan is agreed. It is good practice to document this conversation for records.

From 1 January 2023, providers must publish all-inclusive prices for third-party services and cannot set or charge a separate amount to cover administrative costs arising from using third-party services. This is regardless of whether:

- they made a business decision to engage a third-party
- the care recipient chose a third-party to provide those services.

This is to make costs more transparent and easier for care recipients to understand and compare.

The Department's website sets out how providers can incorporate costs into care and package management and direct charges when using a third-party. This information can be found on www.health.gov.au by searching "Third-party services for Home Care Packages".

It is expected most, if not all, additional costs to an approved provider associated with delivering third party services will be recouped through care and package management charges.

The Department cannot advise whether providers should add a percentage to their direct service charges from 1 January 2023. Prices must be value for money and consider the effort and resources it takes to coordinate the care and service delivered.

Regardless of how the services are delivered, providers remain responsible for ensuring services are delivered in a way that meets the requirements of the Act and the Aged Care Quality Standards, including care planning. Providers must also ensure services are delivered in line with the agreed care plan. The care plan will need to be revised periodically to ensure that the sub-contracted services continue to meet the care recipient's assessed ageing related care needs.

Approved providers also need to remember that they, not the sub-contracted service provider, remain responsible for meeting all regulatory responsibilities. These regulatory responsibilities include ensuring that all police checks, and key personnel suitability requirements are met, as well as all obligations under the legislation. **Note**: a list of provider responsibilities is extracted at **Appendix E**.

If the third-party arrangements materially affect approved provider suitability they will need to be disclosed to the Commission. When and how to do this is discussed at Section 15.

7.6 Are there any other models of care delivery which I should be aware of?

The Australian Government is supportive of innovative delivery of services under the HCP Program, to the extent that they are compliant with the intent and scope of the Program.

Home care support must still be offered on a CDC basis. This means the Home Care Agreement must be developed together with the care recipient and the supports delivered must meet the care recipient's assessed ageing related care needs, personal care goals and the care plan.

Charging for services that are not provided is likely to lead to sanctions. Providers must also continue to meet all their obligations under the Act and Principles.

7.7 Can I decline a care recipient's request to sub-contract services?

In some circumstances, providers may not be able to accommodate the care recipient's preferences. This will need to be considered on a case-by-case basis, based on what is reasonable in the circumstances.

The following list provides a guide to home care providers as to when a request to use a particular service provider might be declined.

- The proposed service may cause harm or pose a threat to the health and/or safety of the care recipient or staff.
- The proposed service is outside the scope of the HCP Program.
- The home care provider would not be able to comply with its responsibilities under aged care legislation or other Australian Government or State/Territory laws.
- The requested third-party service provider will not enter into a contract with the home care provider.
- There have been previous difficulties or negative experiences with the requested service provider.
- The cost of the service/item is beyond the scope of the available funds for the package.

Where the provider is not able to give effect to the care recipient's preferences or request for services, the reasons must be clearly explained to them and documented.

7.8 What do I need to provide to the care recipient at the end of their first care planning process?

Providers will need to give the care recipient a copy of their care plan within 14 calendar days of commencing service delivery and the package budget as soon as practicable. The package budget must identify what the budget is made up of (that is, the Government contributions and the home care fees) and how those budget funds have been allocated to care and services under the care plan.

Providers will need to consider pricing obligations when developing the budget. The budget is discussed at Section 8. Pricing obligations are discussed at **Appendix B**.

✓ Key points to remember

- Providers need to complete a care plan for all new care recipients within 14 calendar days of them starting services.
- Providers will need to collaborate with the care recipient to develop their care plan. When thinking about how to approach the care planning process, providers should consider taking a wellness or reablement approach.
- Providers' role in the care planning process is to help care recipients understand what care, services, or purchases they can choose to get from their package based on assessed need, and to enable them to make choices between those care and services.

8 A care recipient's package budget

As discussed at Section 7, providers need to work with each new care recipient to develop a care plan within 14 calendar days of the day the Home Care Agreement is completed. The individualised package budget needs to be done as soon as providers have all the information needed and the care plan is place. This section explains what makes up a package budget and how to calculate each component. All the financial aspects of the HCP Program are defined by the legislation. Providers should refer to the legislation for more information.

This section provides information relevant to people who entered the HCP Program after 1 July 2014, or who have opted into the post-1 July 2014 arrangements. For information on the pre-1 July 2014 arrangements, see **Appendix A**.

✓ **Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section**
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

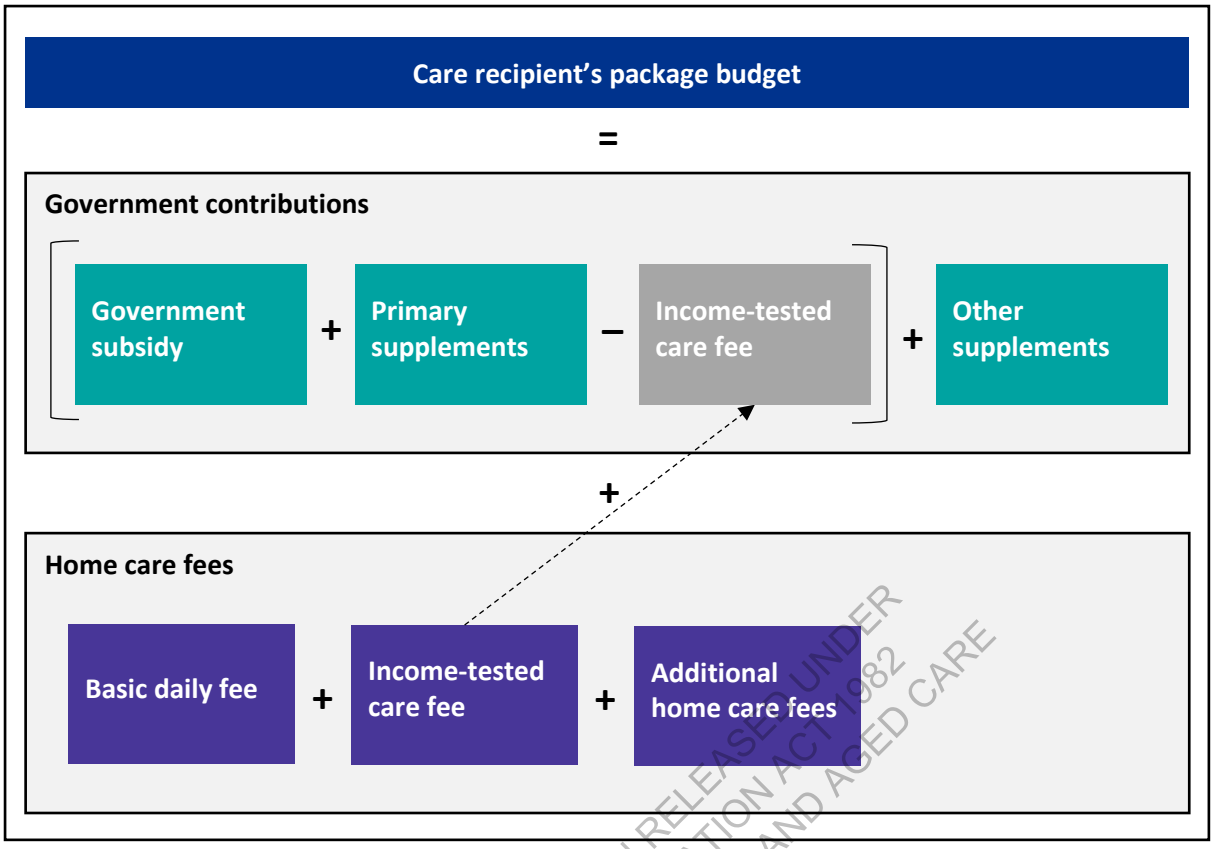
- Sections 47, 48, 52D-1, 56-2 and 96 of the *Aged Care Act 1997*
- *User Rights Principles 2014*
- *Fees and Payments Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

8.1 What makes up a care recipient's package budget?

Each care recipient's package budget is made up of contributions from the Australian Government and, where applicable, the home care fees payable by the care recipient. The components of a post-1 July 2014 package budget may include:



Note: It should be noted that a care recipient's package budget will be affected if they have received a compensable payment amount. These are discussed in **Appendix C**.

8.2 How do I determine the amount of Government contribution to a care recipient's budget?

The Government contribution is calculated as follows:

1. The basic subsidy amount
2. Plus any primary supplements (oxygen supplement, enteral feeding supplement, dementia and cognition supplement, veterans' supplement)
3. Less any reductions in subsidy and primary supplements (income-tested care fee)
4. Plus any other supplement (hardship supplement, viability supplement).

The Government subsidy and supplements are payable, and calculated daily, even on days a care recipient does not receive a service.

8.2.1 Basic subsidy

The subsidy is paid in accordance with the level of package the care recipient has been assigned. There are four package levels, outlined in the table below:

Package	Needs
Level one	Basic care
Level two	Low level care
Level three	Intermediate care
Level four	High level care

The current amount that can be paid by the Government can be accessed at this link or by searching "Home care packages subsidy" at www.health.gov.au.

8.2.2 Supplements

If care recipients are eligible, providers can also claim for supplements that will be added to the subsidy amount. An authorised signatory of the approved provider must sign the dementia, oxygen and enteral feeding claim forms. Once a form is completed, the form and supporting evidence can be emailed to Services Australia via aged.care.liaison@servicesaustralia.gov.au. Providers should keep copies of all supplement forms and supporting evidence in the associated care recipient's records.

Any supplements providers claim for a care recipient must be added to their total package budget. Although they will be eligible for supplements if they require particular types of supports, the supplement funds do not have to be used to provide that specific support. Supplements are an acknowledgement of additional needs, and the supplement funds can be used in the same ways as any other component of a package budget.

Providers can claim supplements for eligible care recipients on any package level; whether they are on a level one, two, three of four package.

The table below identifies and describes each of the supplements, and outlines the administration requirements.

Primary supplements

Supplement	Description	Application process and payment	What happens if the care recipient changes providers?
The Dementia and Cognition Supplement in Home Care	The dementia and cognition supplement provides additional funding in recognition of the extra costs of caring for people with cognitive impairment associated with dementia and other conditions. For further information go to this link, or search "Dementia and cognition supplement for home care" at www.health.gov.au.	Assessment using one of the prescribed tools by an approved assessor. The approved provider is responsible for lodging an application with Services Australia.	Supplement automatically transfers to new provider. The new provider must obtain a copy of the record of assessment undertaken by the care recipient.

Supplement	Description	Application process and payment	What happens if the care recipient changes providers?
The Veterans' Supplement in Home Care	The veterans' supplement in home care provides additional funding for veterans with a mental health condition accepted by the Department of Veterans' Affairs (DVA) as related to their service. For further information go to this link, or search "Veterans' supplement for aged care" www.health.gov.au.	DVA determines eligibility and advises Services Australia. No action required by provider.	Supplement automatically transfers to new provider.
Oxygen Supplement	The oxygen supplement is for care recipients with a specified medical need for the continual administration of oxygen. For further information go to this link, or search "Oxygen supplement" www.health.gov.au.	Paid to provider to help pay for specialised products and equipment. The approved provider is responsible for completing the application form available on the Services Australia website. Once the form is completed, the form and supporting evidence can be returned to Services Australia.	Supplement does not automatically transfer. The new provider needs to submit a new application to Services Australia, including medical evidence.
Enteral Feeding Supplement	The enteral feeding supplement is for care recipients with a specified medical need for enteral feeding. For further information go to this link, or search "Enteral feeding supplement" at www.health.gov.au.	Paid to provider to help pay for specialised products and equipment. The approved provider is responsible for completing the application form available on the Services Australia website. Once the form is completed, the form and supporting evidence can be returned to Services Australia.	Supplement does not automatically transfer. The new provider needs to submit a new form to Services Australia, including medical evidence.

Other supplements

Supplement	Description	Application process and payment	What happens if the care recipients changes providers?
Viability Supplement in Home Care	The viability supplement is paid to providers on behalf of recipients of home care in rural and remote areas in recognition of the higher costs of delivering care and services in these areas. For further information go to this link, or search "Viability supplement for aged care" at www.health.gov.au.	Provide location details (suburb and postcode) to Services Australia through entry event and location event screen in the Aged Care Provider Portal.	Supplement automatically transfers to the new provider if a care recipient remains at the same location. The new provider must enter the same postcode and suburb on the Aged Care Provider Portal. A care recipient who relocates will automatically be reassessed for viability supplement based on their new location.
Hardship Supplement	The hardship supplement is available to recipients of home care in genuine financial hardship who do not have income to pay their costs of aged care due to circumstances beyond their control. Care recipients who have commenced receiving a package on or after 1 July 2014 need to apply to Services Australia for financial hardship assistance. For further information go to this link, or search "Financial hardship assistance" at www.health.gov.au.	Paid to provider as a hardship supplement in lieu of the basic daily fee and/or income-tested care fee. Care recipients (or their representative) applies and submits form to Services Australia.	Supplement automatically transfers to new provider if a valid approval exists. As this supplement is time-limited, the new provider should confirm if the care recipient is receiving a hardship supplement and the validity period.

The schedule of aged care subsidies and supplements contains the current daily rate for HCP Program subsidies and supplements. The schedule can be found at this link or by searching "Schedule of subsidies and supplements" at www.health.gov.au.

8.3 How do I determine the amount of a care recipient's home care fees?

There are three types of legislated fees a provider may ask a care recipient to pay:

- the basic daily fee;
- an income-tested care fee (mandatory); and
- any other amounts they have agreed to pay for additional care and services.

If a care recipient wishes to purchase additional services over and above those they could otherwise afford under the package, their provider can agree with them a further amount for additional care and services to increase the value of the package.

These fees are part of the individualised package budget and must be included in the Home Care Agreement as a statement of fees that may be payable. Providers must discuss any fees to be paid by the care recipient before they commence services.

If the care recipient is on leave there may be changes to the subsidy, supplements and home care fees payable. Please see Section 11 of this manual.

8.3.1 Basic daily fee

Providers can ask everyone to pay the basic daily fee. It is set by the Australian Government at:

- Level one - the maximum fee is 15.68 per cent of the single person rate of the basic age pension.
- Level two - the maximum fee is 16.58 per cent of the single person rate of the basic age pension.
- Level three - the maximum fee is 17.05 per cent of the single person rate of the basic age pension.
- Level four - the maximum fee is 17.50 per cent of the single person rate of the basic age pension.

Rates for the basic daily fee are reviewed in March and September each year in line with changes to the Age Pension. The current rates are available in the schedule of fees and charges for residential and home care. The schedule can be found at this link or by searching "Charging fees for aged care services" at www.health.gov.au.

As the maximum basic daily fee is linked to the package level, an increase in package level may result in an increase to the basic daily fee.

Home care fees are payable, and calculated daily, even on days a care recipient does not receive a service. The Government subsidy and supplements are payable, and calculated, in the same way.

8.3.2 Income tested care fee

The income-tested care fee is a contribution that care recipients may be asked to pay if they can afford to do so, and is in addition to the basic daily fee. The income tested care fee is determined through an income assessment, which is conducted by Services Australia or DVA as applicable.

If a care recipient has been assessed as needing to pay the income tested care fee, this will be deducted from the Government subsidy paid to the provider by Services Australia.

From 1 September 2021, if a care recipient's assessed income tested care fee is equal to or less than the price reported to Services Australia, no Government subsidy entitlement will be paid to the provider. Any unspent government subsidy will accrue in the care recipient's home care account for future care and services. See Appendix E for more information on Improved Payment Arrangements.

It is the responsibility of the provider to put in place the business processes to collect and manage income tested care fees from care recipients who have been assessed as needing to pay the fee.

Fees must be outlined in the Home Care Agreement and providers must discuss and agree these fees with the care recipient before they start services.

If prior to 1 September 2021, a provider was not collecting all or part of the income tested care fee because a care recipient was not using all of their package, this can continue as long as they:

- made a business decision prior to 1 September 2021 that they would not collect the income-tested care fee from care recipients where they are not using the full amount of their package; AND
- can demonstrate that they had not collected fees from that care recipient on an ongoing basis (not just ad-hoc) for some months prior to 1 September 2021; AND
- hold unspent funds and have not opted-in for this care recipient so have access to unspent funds.

Once the unspent funds that the provider holds for the care recipient have been used, or if the care recipient has no unspent funds, providers will only be able to waive the income tested care fee by using retained earnings (i.e. the provider pays the income tested care fee for the care recipient and reports it on the monthly statement, including any accumulation of the care recipient portion of funds if the package is underspent). If providers are not able to do this, the care recipient will need to start contributing their assessed income tested care fee.

The Services Australia home care account cannot be invoiced for amounts that would otherwise be payable by the income tested care fee. Doing so may result in regulatory action being brought against the provider.

This should not impact full pensioners as their means test is automatically matched by Services Australia through Government data and full pensioners do not pay the income tested care fee.

Providers cannot charge care recipients retrospectively for the income tested care fees that they have waived in the past.

If an income tested care fee is refunded to a provider due to a quarterly review, the fees must be returned to the care recipient. If the care recipient has already left care and their balance has been settled, then the income tested care fee must be refunded to the care recipient or their estate. If an income tested care fee is increased due to a quarterly review, the provider must ask the care recipient to pay the increased fee. If the care recipient has already left care and their balance has been settled, the income tested care fee should be claimed from the care recipient or their estate. If the provider does not collect the income tested care fee from care recipients, the provider could be out of pocket for package expenses and will be liable to pay these expenses out of retained earnings.

Once the Home Care Agreement has been entered into, providers may ask the care recipient to pay home care fees up to one month in advance. Providers cannot ask for payment of any home care fees before their package begins.

8.3.3 Income assessment

The easiest way for a care recipient to complete an income assessment is to use form SS313, at this link, or by searching **"Authorising a person or organisation to enquire or act on your behalf form (SS313)"** at www.servicesaustralia.gov.au. This is a dynamic form and will present different questions based on the answers provided.

If the care recipient prefers to complete a hardcopy form, they can download a copy of the **"Authorising a person or organisation to enquire or act on your behalf form (SS313)"** from the Services Australia website at this link or by searching "SS313" at www.servicesaustralia.gov.au. Or call Services Australia on **1800 227 475** to ask a copy to be sent to them. If the care recipient receives a means tested income support payment, they can call Services Australia on **1800 227 475**

or DVA on **1800 555 254** and request a pre commencement letter for home care. Services Australia (or DVA) will have sufficient information to calculate their maximum home care fees payable.

For an estimate of home care fees for the person, My Aged Care has a home care fee estimator at this link, or can be found by searching "Fee estimator" at www.myagedcare.gov.au.

Providers must continue to support care recipients to understand fees and their means assessment. This may also require providing information about how to request to Services Australia review of the assessment decision, or how to apply for financial hardship supports through Services Australia.

Delayed income assessment

A care recipient may begin to receive services prior to their means test being finalised. Services Australia assume no income tested care fee is payable and will pay the full monthly claim entitlement until the care recipient is assigned a 'means not disclosed status'.

If a care recipient is assigned a 'means not disclosed status' Services Australia assume the full income tested care fee is payable. This may result in a provider being paid less than the care recipient is entitled to.

Once a means test outcome is finalised, Services Australia will apply the correct income tested subsidy reduction backdated to the date the care recipient first entered the Home Care Packages Program. This means that:

- If a care recipient's means test outcome has resulted in an overpayment to the provider, Services Australia will deduct the overpayment from the next payment to the provider.
- If a care recipient paid income tested care fees in excess of what they were required to pay, the provider must repay these to the care recipient.

To manage risk for new care recipients, providers can apply the maximum income tested fee, the second daily cap in the Schedule of Fees and Charges, for any care recipients where they have not received their initial means testing advice. This should not impact pensioners as their means tests are automatically matched by Services Australia through Government data and full pensioners do not pay the income tested fee.

Providers should manage their cash-flow accordingly to cover any future liabilities arising from a late submitted means test.

Means testing adjustments

If a care recipient is paying an income tested care fee and receives a delayed income assessment which determines they should have been paying a lower contribution than the maximum income tested fee, or no fee, the provider must refund the difference to the care recipient once the care recipient fees are set.

If a care recipient receives a delayed income assessment which determines they should have been paying a higher income tested care fee, this is backdated to their date of entry. This means the income tested subsidy reduction is also backdated. An adjustment will be applied in the next claim, and the subsidy paid for that care recipient in the next claim would be reduced by the backdated adjustment amount.

If the adjustment amount was greater than the care recipient's payment determination for the current claim month, this would result in a negative payment amount for the care recipient for the month. This negative amount would be factored into the overall service payment. The provider may then claim the underpaid income tested care fee from the care recipient.

If an income tested care fee is refunded to a provider due to a quarterly review but the care recipient has already left care and their balances have been settled the following applies:

- If the care recipient has exited care to move to another provider, the refunded income tested care fee can be transferred from the previous provider to the new provider
- If the care recipient has exited care, due to entry into residential care or has passed away, then the income tested care fee can be refunded to the care recipient/or their estate.

If a care recipient does not agree with the outcome of their means test, they can request Services Australia to review this decision. If a care recipient is unable to pay their fees due to financial hardship, they can apply for financial hardship help from the Government.

8.3.4 Annual and lifetime caps

There are annual and lifetime caps that apply to the income-tested care fee. The current caps are at this link or can be found by searching "Schedule of Fees and Charges for Residential and Home Care" at www.health.gov.au. Once the annual cap is reached, the care recipient cannot be asked to pay any more income-tested or means-tested care fees until the next anniversary of when they first started receiving aged care. Providers can still ask for payment of the basic daily fee.

Services Australia will notify the provider and care recipient once the cap has been reached. The Government will pay the remaining income-tested care fees by way of increased subsidy to the provider after these caps have been reached.

8.3.5 Worked example

How do we calculate Adam's package budget?

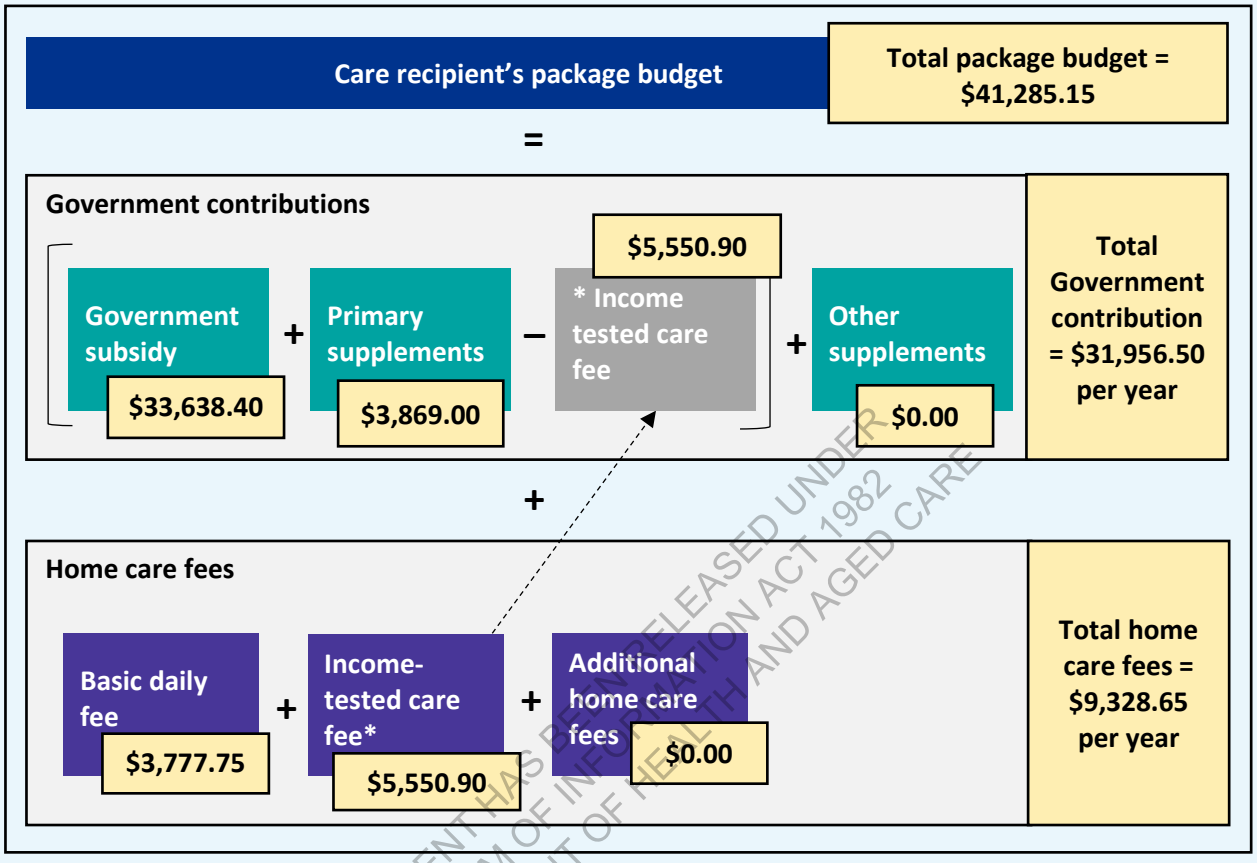
Fact scenario

- Adam lives at home with his partner David.
- Adam has been assigned a level three package. The value of his daily package subsidy is $92.16 per day (as at 20 September 2019). This equates to $33,638.40 per year.
- Adam is also eligible for the dementia and cognition supplement. The value of the supplement at his package level is $10.60 per day. This equates to $3,869.00 per year.
- Adam is not eligible for any other supplements.
- The basic daily fee for Adam's package level is $10.35 per day. This equates to $3,777.75 per year.
- Adam has completed his income assessment, and has been assessed by Services Australia as being able to pay an additional $15.24 per day or $5,550.90 per year in income-tested care fees.
- Adam did not agree to pay any additional fees in his Home Care Agreement.

How do we calculate Adam's package budget?

Calculation of package budget

The diagram below outlines how Adam's home care budget is calculated:



The Government subsidy and supplements of Adam's Home Care Package is valued at $37,507.40 ($33,638.40 + $3,869.00) per year.

The amount of basic daily fee charged adds to Adam's package budget. It has no impact on the amount of Government subsidy and supplements that are paid.

Adam, however, has been assessed by Services Australia as being able to contribute $5,550.90 per year towards his income tested care fee. The Government subsidy and primary supplement payable for Adam's care to his provider is reduced by Adam's income tested care fee. That is, $33,638.40 + 3,869.00 - $5,550.90 = $31,956.50.

If Adam fails to meet his responsibilities, including the payment of fees, as described in section 17 of the *User Rights Principles 2014*, his home care provider may cease to provide home care to him under the security of tenure provisions. Adam's Home Care Agreement must contain a statement setting out which home care fees are payable by him and the conditions under which either party may terminate the provision of home care.

8.4 What do I do if a care recipient is facing financial hardship?

If someone thinks they will face financial hardship when paying their aged care fees, they can apply to Services Australia for financial hardship assistance. Each case is considered on an individual basis. Depending on their situation, they may apply for financial assistance with the:

- basic daily fee; and/or
- income-tested care fee.

Care recipients experiencing financial hardship may be granted assistance with one, both or neither of these fees. If financial hardship assistance is granted, a hardship supplement will be paid to the provider in lieu of the basic daily fee and/or income tested care fee.

For more information on eligibility criteria and assessments for financial hardship go to this link, or by searching "Hardship supplement for aged care" at www.health.gov.au.

8.5 When should I review a care recipient's home care fees?

Rates for the basic daily fee are reviewed and changes announced in March and September each year in line with new rates for the Age Pension. Providers may need to discuss the impact of these fees changes with the care recipient and update their package budget accordingly.

Services Australia conducts a quarterly review of income-tested care fees in January, March, July and September. If a care recipient's financial circumstances change the care recipient can request a review with Services Australia or DVA.

For care recipients in the pre-1 July 2014 arrangements, see **Appendix A**.

✓ Key points to remember

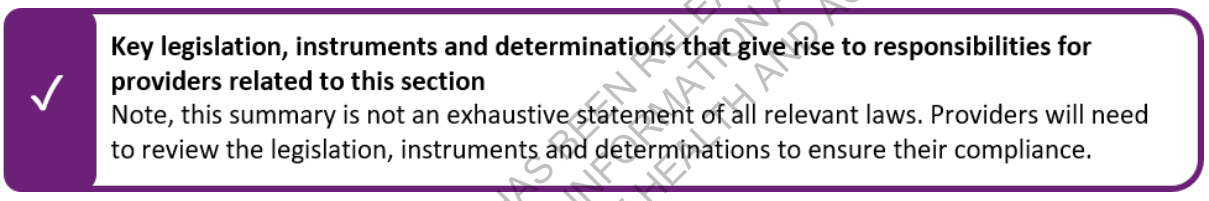
- A package budget is made up of Government subsidies and supplements, and home care fees.
- A care recipient's home care fees will depend on their circumstances. All care recipients may be asked to pay a basic daily fee. Some may also be asked to pay an income tested care fee.
- Government subsidy and supplements are payable, and calculated daily, even on days a care recipient does not receive a service. Home care fees are also payable, and calculated daily.
- It is a business decision for the provider if they choose to collect the basic daily fee. Collecting this fee adds to the package budget and provides access to more care and services.
- It is the responsibility of the provider to put in place the business processes to collect and manage income tested care fees from care recipients who have been assessed as needing to pay the fee. Providers should work with their care recipients to ensure they are receiving the level of care and services they require.

9 Inclusions and exclusions

This section outlines the ageing related care and services that can and cannot be included in a Home Care Agreement, care plan and individualised budget. It gives providers information and tools to use when working with care recipients to develop a care plan that optimises health and wellbeing in accordance with their assessed ageing related care needs, care goals and preferences, and helps them to maintain their capabilities as they age.

Under a CDC service delivery model, care recipients have choice over the types of ageing related care and services they access and how these are delivered. Decisions on what is included or excluded in the care plan need to reflect that they have a 'dignity of risk' (under the Charter of Aged Care Rights) to accept the personal risks associated with making these choices. Providers need to balance this with their ongoing accountability for what each package budget is being spent on, and for delivering quality of care. This is necessary to ensure providers are compliant with the Aged Care Quality Standards and any relevant Australian Government or State and Territory laws.

To meet these obligations, providers may need to have challenging conversations with care recipients and their carers about whether a type of care, service or item can be included. A framework of considerations is included in Section 9.5 to support these discussions. It is also important that providers document and retain records of the reasons why a service or item is included or excluded.



Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Section 54-1 of the *Aged Care Act 1997*
- *Quality of Care Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual. Providers should familiarise themselves with the obligations required of them. See **Appendix E** for further detail on specific provider responsibilities.

Providers will need to act in compliance with all relevant State, Territory and Australian Government laws. A list of relevant Australian Government laws can be found at this link, or by searching "Legislation" at www.agedcarequality.gov.au/. The Aged Care Quality Standards can be found at this link or by searching "Quality Standards" at www.agedcarequality.gov.au/. Please consult your State or Territory register of legislation for information on relevant State or Territory laws.

9.1 How do I work out what services can be included in a care recipient's care plan?

The HCP Program is designed to provide a mix of services and supports that are customised to meet the individual care needs and goals of each eligible person. As discussed at Section 7, that mix is determined through care planning. Care planning involves:

- collaborating with the care recipient to discuss their assessed care needs and care goals;
- deciding which care and service types will best assist them to meet these needs and goals; and
- detailing these care and services types in the care plan.

When working with each person to clarify their assessed care needs and care goals, providers should encourage them to think about what supports will optimise their health and wellbeing. Their

priorities and preferences are a key part of the discussion to co-produce their care plan. Care and services included in the care plan that will be purchased using the package budget should be drawn, for the most part, from the legislated inclusions, and must not include any legislated exclusions (see Section 9.2).

Sometimes a care recipient will seek a care or service type that is not specified as an inclusion or exclusion in the legislation. This means that you will need to work with care recipients to determine if the service, support or purchase:

- is directly linked to their identified care needs and goals;
- supports for daily living that is important for the care recipient's health and wellbeing;
- is necessary for them to support functional safety in their home;
- can be delivered within their available package budget; and
- would be considered an acceptable use of Government funds.

You will also need to consider whether you have the capacity and capability to deliver, or source, the proposed support.

The framework supports providers to take a flexible and responsive approach to working with care recipients on whether to provide proposed care and services that are not identified in the legislated inclusions. It allows providers to take a person-centred approach to care planning that supports a balance between assessed care needs, care goals and individual preferences, and considers individual circumstances such as financial and social position, cultural diversity and location.

The following framework has been designed to support decision making when it comes to determining what can and cannot be included as part of a package:

Consider and understand the care recipient's care needs and care goals to support them in living independently in their own home (in the short and medium term).

The care recipient's care needs and care goals must be clearly understood by both the provider and the care recipient, noting that these care needs and care goals can change over time. Information provided in the ACAT assessment and discussions with the care recipient will provide the basis for understanding this.

For each care and service type the questions on the next page will need to be considered.

These questions have been developed to help providers determine with care recipients if a care or service type should be included as part of their package. The questions have been grouped by category. To draw a conclusion, it is important that all the questions are considered on balance of each other.

Document all discussions about the inclusion or exclusion

All discussions surrounding inclusions and exclusions for each care recipient should be clearly documented. Care and services to be included in the package should be clearly documented in the care plan and package budget. Where a provider is unable to give effect to the care recipient's preferences or request for services, the reasons must be clearly explained to the care recipient and documented. Documenting these discussions provides justification for the decisions regarding inclusions and exclusions of a package. Providers may be required to produce this documentation as evidence for the Aged Care Quality and Safety Commission or the Department.

9.2 Specified Inclusions

As outlined in the above framework, the legislation provides guidance about specific items that can be included or must be excluded. It is worth remembering, however, that the care or service is only included when it meets assessed care needs and care goals.

This guidance is outlined in the *Quality of Care Principles 2014*.

The inclusions have been extracted below:

9.2.1 Care services

Service inclusions	Content
Personal services	Personal assistance, including individual attention, supervision and physical assistance, with: • Bathing, showering including providing shower chairs if necessary, personal hygiene and grooming, dressing and undressing, and using dressing aids • Toileting • Mobility • Transfer (including in and out of bed).

Service inclusions	Content
Activities of daily living	Personal assistance, including individual attention, individual supervision and physical assistance, with communication including assistance to address difficulties arising from impaired hearing, sight or speech, or lack of common language, assistance with the fitting of sensory communication aids, checking hearing aid batteries, cleaning spectacles and assistance using the telephone.
Nutrition, hydration, meal preparation and diet	Includes: • Assistance with preparing meals • Assistance with special diet for health, religious, cultural or other reasons • Assistance with using eating utensils and eating aids and assistance with actual feeding, if necessary • Providing enteral feeding formula and equipment.
Management of skin integrity	Includes providing bandages, dressings, and skin emollients.
Continence management	Includes: • Assessment for and, if required, providing disposable pads and absorbent aids, commode chairs, bedpans and urinals, catheter and urinary drainage appliances and enemas • Assistance in using continence aids and appliances and managing continence.
Mobility and dexterity	Includes: • Providing crutches, quadruped walkers, walking frames, walking sticks and wheelchairs • Providing mechanical devices for lifting, bed rails, slide sheets, sheepskins, tri-pillows, and pressure relieving mattresses • Assistance in using the above aids.

9.2.2 Support services

Service inclusions	Content
Support services	Includes: • Cleaning • Personal laundry services, including laundering of care recipient's clothing and bedding that can be machine-washed, and ironing • Arranging for dry-cleaning of care recipient's clothing and bedding that cannot be machine-washed • Light gardening • Medication management • Rehabilitative support, or helping to access rehabilitative support, to meet a professionally determined therapeutic need • Emotional support including ongoing support in adjusting to a lifestyle involving increased dependency and assistance for the care recipient and carer, if appropriate • Support for care recipients with cognitive impairment, including individual therapy, activities and access to specific programs designed to prevent or manage a particular condition or behaviour, enhance quality of life and provide ongoing support • Providing 24-hour on-call access to emergency assistance including access to an emergency call system if the care recipient is assessed as requiring it • Transport and personal assistance to help the care recipient shop, visit health practitioners or attend social activities • Respite care • Home maintenance, reasonably required to maintain the home and garden in a condition of functional safety and provide an adequate level of security, such as cleaning gutters • Modifications to the home, such as easy access taps, shower hose or bath rails • Assisting the care recipient, and the homeowner if the homeowner is not the care recipient, to access technical advice on major home modifications • Advising the care recipient on areas of concern in their home that pose safety risks and ways to mitigate the risks • Arranging social activities and providing or co-ordinating transport to social functions, entertainment activities and other out of home services • Assistance to access support services to maintain personal affairs.
Leisure, interests and activities	Includes encouragement to take part in social and community activities that promote and protect the care recipient's lifestyle, interests and wellbeing.

Service inclusions	Content
Care management	Includes ongoing assessment and planning undertaken on at least a monthly basis to ensure that the care recipient receives the care and services they need. This includes: • regularly assessing the care recipient's needs, goals and preferences • reviewing the care recipient's home care agreement and care plan • ensuring the care recipient's care and services are aligned with other supports • partnering with the care recipient and the care recipient's representatives about the care recipient's care and services • ensuring that the care recipient's care and services are culturally safe • identifying and addressing risks to the care recipient's safety, health and wellbeing.

9.2.3 Clinical services

Service inclusions	Content
Clinical care	Includes: • Nursing, allied health and therapy services such as speech therapy, podiatry, occupational or physiotherapy services • Other clinical services such as hearing and vision services.
Access to other health and related services	Includes referral to health practitioners or other related service providers.

The *Quality of Care Principles 2014* have also established a number of services that must not be included in the package. These are always excluded; even if they may advance the care recipient's assessed care needs and care goals, they are not aligned to the intent and scope of the HCP Program. Specified exclusions are listed in detail below:

9.3 Specified Exclusions

The *Quality of Care Principles 2014* lists those care and services that must not be included in the package. These are always excluded; even if they may advance the care recipient's assessed ageing related care needs and goals, as they are not aligned to the intent and scope of the HCP Program.

The following items **must not** be included in a package of care and services under the HCP Program.

Exclusions	Examples
Services, goods or supports that people are expected to cover out of their general income throughout their life regardless of age	• General home services that were never, or are generally not completed independently prior to age-related functional decline, including home repairs/maintenance/specialist cleaning performed by a tradesperson or other licensed professional • Food (**except** as part of enteral feeding requirements or items listed under food for special medical purposes as per the Australia New Zealand Food Standards Code – Standard 2.9.5). Further information on food is below under Meal services

Exclusions	Examples

	• Home insurance
	• Rates
	• Water, sewage, gas and electricity costs
	• Private transport related costs including vehicle registration, vehicle repairs, vehicle insurance and petrol
	• Local transit costs of public bus, ferry or train fares
	• Funeral plans / insurance costs
	• Pet care and associated costs such as pet food; registration; taxidermy, cremation
	• Internet and telephone costs, **exceptions include**:
	  ○ Care recipients who are homeless or at risk of homelessness (as identified in a care recipient's ACAT assessment) can use HCP funds for the ongoing monthly charges to ensure connection with service providers
	  ○ Care recipients who require the internet or landline to support delivery of medication management, remote monitoring service or delivery of an included service on the phone can use HCP funds to set-up telecommunications connections (e.g., to get internet connected)
	• Beauty therapy (e.g., manicures) and hairdressing
	• Cost of entertainment activities, such as club memberships and tickets to sporting events
	• Travel and accommodation for holidays
	• Supplies to participate in any activity, e.g. gardening or craft
	• Using HCP funds to pay for solicitors or accountants for maintaining care recipients' personal affairs
	• Funeral costs and funeral plans
	• Gym or pool memberships/access costs when not prescribed for aged-related functional decline and monitored by health professional operating within their scope of practice

Accommodation costs	• Assistance with home purchase • Mortgage payments • Rent • Permanent residential care (subsidised or private) and residential respite (subsidised) • Heating and cooling costs (installation and repairs) • Whitegoods and electrical appliances (except items designed specifically for frailty such as a tipping kettle) • Household furniture and furnishings: ○ lounge suites and recliners which do not support a care recipient's mobility, dexterity and functional care needs and goals

Exclusions	Examples
	○ Other general household furniture such as coffee tables, wardrobes, and bookshelves. ○ Massage chairs when not prescribed by treating medical practitioner and/or allied health professional ○ General mattress and frame for bed (exceptions for pressure relieving mattress or mattress/frame for an electrical adjustable bed or hospital bed) • Replacement/maintenance/servicing/cleaning of: ○ Water tanks ○ Solar panels ○ Fencing ○ Roofs ○ Heating and cooling or hot water systems ○ Swimming pools • Home modifications or capital items that are not related to the care recipient's ageing-related care needs, for example: ○ Windows, roofs, pergolas, sunrooms, decking ○ Home modifications that don't support ageing safely e.g., non-accessible bathroom and kitchen modifications; non-standard fittings in accessible bathroom modifications (e.g., mosaic tiles) ○ Home modifications requiring development applications ○ Aesthetic modifications of any kind ○ Repainting the home ○ Major plumbing ○ Emptying of septic tank; remedying sewage surcharge (matter for water company/insurer) ○ Major electrical work, e.g., rewiring house ○ Replacement of entire floor and floor coverings throughout the home unless safe passage for mobility equipment required or slip hazard reduction required, as recommended by a health professional for care recipients at risk of falls ○ Replacement of foundation e.g., concrete/cement slab ○ Significant changes to the floorplan of the home, such as adding a new bathroom or extension Extensive gardening services such as: • Planting and maintaining crops, natives and ornamental plants • The installation and/or maintenance of raised garden beds • Compost heaps • Watering systems

Exclusions	Examples
	• Water features and rock gardens • Landscaping • Tree removal • Removal of garden beds • Removal of shrubbery (unless preventing safe access and egress)
Payment of home care fees	• Defined at section 52D of the *Aged Care Act 1997* • Includes income tested care fees, basic daily fees and additional fees

Payment of fees or charges for care or services funded or jointly funded by the Australian Government	• Co-payments for state/territory government funded programs, such as subsidised taxi vouchers and/or aids and equipment schemes
	• Dentures, dentistry and dental surgery
	• Prescription glasses or contact lenses
	• Prostheses (e.g., artificial limb)
	• Spectacles
	• Hearing aids available under the Hearing Services Program. Contact the Hearing Service Program (HSP) for guidance on hearing aid replacement and delegate approval for non-standard hearing aids. **Exceptio**n if care recipient is not a pension concession card holder as HCP may cover like for like of typical hearing aid covered by HSP in this case only.
	• Continence aids if a participant in the CAPS program
	• Diagnostic imaging
	• Natural therapies, including:
	  ○ Alexander technique
	  ○ Aromatherapy
	  ○ Bowen therapy
	  ○ Buteyko
	  ○ Feldenkrais
	  ○ Homeopathy
	  ○ Iridology
	  ○ Kinesiology
	  ○ Naturopathy
	  ○ Pilates (except sessions supervised by an exercise physiologist or physiotherapist)
	  ○ Reflexology
	  ○ Rolfing
	  ○ Shiatsu
	  ○ Tai chi (except sessions supervised by a Chinese Medicine Practitioner, exercise physiologist or physiotherapist)
	  ○ Western herbalism
	  ○ Yoga (except sessions supervised by an exercise physiologist or physiotherapist)
	• Payment for informal care – a Carer's Payments is available to fund the support of family and friends

Exclusions	Examples
	• Section 16.1 of the HCP Program Manual specifies more information about what ageing related programs can and cannot be accessed while receiving a HCP.
Payment for services and items covered by the Medicare Benefits Schedule (MBS) or the Pharmaceutical Benefits Scheme (PBS) (or items that should be considered for funding through these schemes)	• Co-payments or gap fees, including for services covered by private health insurance ○ Medications, vitamins and supplements (as well as items not covered by the PBS such as off-indication prescriptions, medicines not endorsed for listing by the Pharmaceutical Benefits Advisory Committee (PBAC) or medicines where the manufacturer has chosen not to list the product on the PBS ○ Consultation/tests/surgery with medical practitioner (GPs and specialists) ○ The only **exception** to this is a private appointment (i.e. not covered by MBS) with a GP to meet evidence requirements for the dementia and cognition supplement and oxygen and enteral feeding supplements • Hospital costs • Ambulance cover • Private health insurance premiums
Provision of cash debit cards or like payments to care recipients for any purpose	• Debit cards (unless the provider has rigorous systems in place to vet every payment and keep on file all receipts in accordance with the *Records Principles 2014*. Debit cards may pose issues for GST credits. Consult with the ATO for more information). • Cash payments or gift vouchers/cards, including online vouchers and coupons • Transfer of subsidy into care recipient or their family's personal/business bank account without rigorous acquittal by provider of funds against receipts matched to the Home Care Agreement, care plan and individualised budget in accordance with the *Records Principles 2014*.

9.4 Meal services

In relation to meal services and whether food can be included in a HCP:

- preparation and delivery of meals can be included
- the raw food component of those meals cannot be included, except in the case of enteral feeding.

The Department has not mandated a standard split/ratio for the raw food component. This is a business decision for the company providing the meal services to calculate how much the raw food component is. Home care providers should discuss with the care recipient the amount of the raw food contribution, as well as how and who it is paid to, as part of the negotiation with the meals provider and the care recipient.

Food referred to as 'takeaway' is also an excluded item. 'Takeaway' food is generally defined as food you would buy from a restaurant or food outlet.

9.5 How does a provider respectfully decline a request?

The following list provides a guide to providers on when it might be reasonable to decline a request from a care recipient:

- The proposed service may cause harm or pose a risk to the health and/or safety of the care recipient or staff.
- The proposed service is outside the scope of the *Quality of Care Principles 2014.*
- The provider would not be able to comply with its responsibilities under aged care legislation or other Australian Government or State/Territory laws.
- The care recipient's choice of service provider is outside the provider's preferred list of service providers and all reasonable effort has been made to establish an acceptable sub-contracting arrangement.
- The requested service provider will not enter into a contract with the provider.
- There have been previous difficulties or negative experiences with the suggested service provider.
- The cost of the service/item is beyond the scope of the available funds for the package.

The following is a case study of when an item might be clinically necessary, but is excluded:

Case study: Yashwant

Yashwant is in his 80s and on a level three package. He has accrued approximately $5,000 in unspent funds. Yashwant needs a new set of hearing aids. He can get these devices fully subsidised under the Australian Government Hearing Services Program. He has decided, however, that he would like to use his unspent funds to get different hearing aids that are partially subsidised or not available through the Hearing Services program.

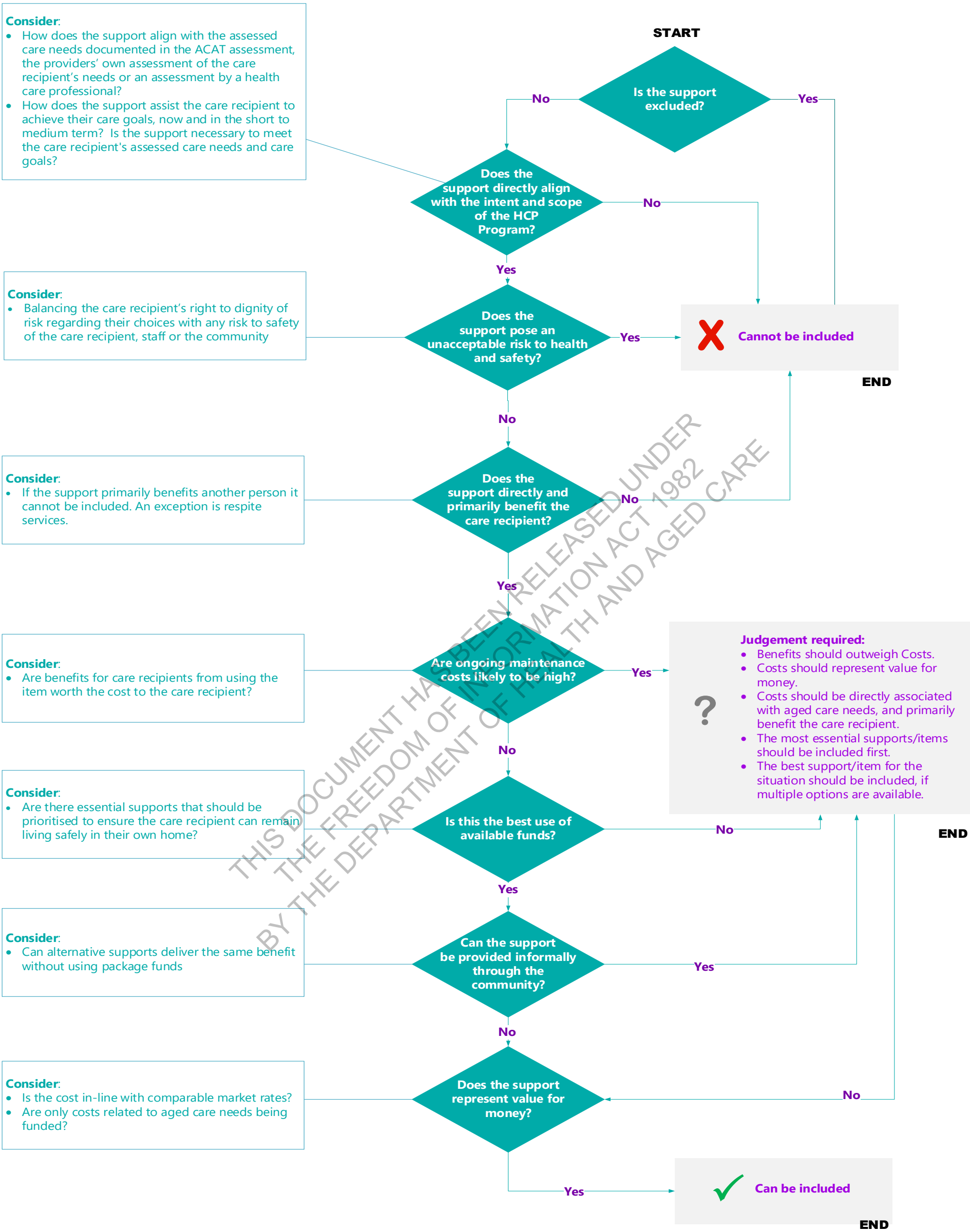
Yashwant's care manager meets with him to discuss his unspent funds. Yashwant notifies her that he would like to use $3,000 of his package towards a new pair of hearing aids.

Yashwant's case manager explains to him that unfortunately, his package cannot be used for care, services or purchases that are already available through other publicly funded programs such as the Hearing Services Program. His care manager asks permission to contact his audiologist to learn more. On contacting his audiologist, they reveal that they thought the Home Care Package Program could be used to purchase the more expensive hearing aids.

The care manager confirms it cannot. The audiologist thanks the care manager for the clarification.

Below is a decision tree and a template that providers can use to discuss the inclusions/exclusions framework when working with care recipients to develop their care plan and individualised budget.

9.6 Inclusions/Exclusions Framework – Decision Tool



9.7 Inclusion/Exclusion Framework – Template

Care recipient's Name:.....

Provider's Name:.....

Care or Service:.....

Inclusion/exclusion framework (fill in with reference to Inclusions/Exclusions Framework Tool)

Questions	Document discussions and considerations
Is the support specifically excluded under the Aged Care Legislation?	
Does the support directly align with the intent and scope of the HCP Program?	
Does the support pose a risk to the health and safety of the care recipient?	
Does the support pose a risk to the health and safety of staff and the community?	
Is the support directly targeted at the care recipient, or does it significantly benefit others, instead of the care recipient?	
How does the support align with the assessed ageing related care needs as documented in the ACAT assessment, the providers' own assessment of the care recipient's needs or an assessment by a health care professional?	
How does the support assist the care recipient to achieve their ageing related care goals, now and in the short to medium term? Is the support necessary to meet the care recipient's ageing related assessed care needs and care goals?	
Has the evidence-base for the support which addresses a particular assessed ageing related care need been considered?	
Does the support require maintenance to ensure the safe use of the item that represents a significant portion of the budget? Is it difficult to provide the maintenance required?	
Is there an opportunity cost associated with the support? Will the care recipient miss out on a support identified in	

their assessment if package funding is used for a large purchase?	
Can the support be provided informally through the community?	
Does the support represent value for money to meet the care recipient's assessed ageing related care needs?	

Determination: The care or service type…… is an Inclusion / Exclusion (circle one) to the care plan

9.8 Guidance on allied health

Introduction

This guidance is intended to assist home care providers and home care recipients to understand the allied health services which can and cannot be funded through a Home Care Package (HCP).

Information on allied health can be found on the Department of Health and Aged Care's website at: https://www.health.gov.au/health-topics/allied-health/

Allied Health
HCP funds can be used for allied health services but must only be used when the service is:

- required due to care recipient's age-related functional decline or to assess the need for aids and equipment
- delivered by an accredited provider, and
- not concurrently being funded by another government program.

Age-related functional decline
Age-related functional decline can be defined as a reduction in ability to perform activities of daily living (e.g., self-care activities) due to a decrease in physical and/or cognitive functioning associated with ageing.

Aids and equipment
Recommendations for aids and equipment, care and services may be funded under the HCP, provided they meet the other requirements of the inclusions and exclusions framework.
Goods, Equipment and Assistive Technology (GEAT) are available as part of a Home Care Package where there is an assessed need.

- Health professionals operating within their scope of practice may assess for GEAT. For further guidance on suitability of a health professional to assess for an item, consult Department of Veterans' Affairs Rehabilitation Appliances Program at https://www.dva.gov.au/sites/default/files/2022-03/rap-schedule-march-2022.pdf (for reference purposes only - noting not all equipment covered by DVA is available under HCP).

Accreditation and criminal history checks
Allied health providers must meet their respective accreditation and registration requirements and operate within the scope of practice of their regulated or self-regulated body. Depending on the respective accreditation and registration requirements, this may permit activities being undertaken by allied health assistants.

Example 1: Speech pathologists funded under the HCP Program must hold the Speech Pathology Australia Certified Practising Speech Pathologist credential.

Example 2: HCP funds can be used to pay for treatment from a registered podiatrist but not for a reflexologist which is not an accredited or registered profession.

Not all allied health professions are registered with Ahpra. Some are self-regulated by a national professional association. The Ahpra regulated professions must adhere to the Criminal History Registration Standard, which requires the applicant to declare their criminal history on initial registration, and upon annual renewal disclose any changes to their criminal history. The self-regulated professions vary in whether they require professionals to declare criminal history on registration and/or renewal.

As there is not yet a consistent standard across the diverse allied health professions in regard to criminal history checks, a provider must seek this from prospective allied health employees to meet the requirements under the *Accountability Principles 2014*.

It is standard practice for allied health professionals to provide this on engagement with state and territory employers (such as in the form of a police check) and is then often maintained on a regular basis through credentialling requirements. Most allied health professionals are expected to maintain a working with vulnerable people check for any employment in a public setting, so this rule is not likely to be an impost to accessing allied health. Providers should consider seeking the following documentation from the allied health professional:

- Police check; **or**
- In some jurisdictions, a working with vulnerable people card may satisfy the requirements of the *Accountability Principles 2014*. However, providers should check with their relevant jurisdiction if this card is based on a police check no older than three years, and screens out persons who were convicted of murder, sexual assault; and conviction and imprisonment for any other form of assault; **or**
- NDIS worker screening clearance.

Other government programs

HCP funds cannot be used for allied health services when the service is:

- rebated by Medicare Benefits Schedule (MBS) or their private health insurance (even if only partially)
- treating a lifelong disability (except where trajectory is impacted by ageing e.g., post-polio syndrome)
- treating a short-term illness or chronic health condition where ageing is not a confounding factor to the severity of the condition

HCP funds cannot be used for allied health if the services are not related to age related functional decline, and/or the service is also being funded by another Government funding program such as the Medicare Chronic Disease Management program. Care recipients with a chronic (or terminal) medical condition, which is being managed by their GP, can access Chronic Disease Management through the MBS. Information on *Chronic Disease Management - Individual Allied Health Services* under Medicare can be found at: https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-medicare-allied-health-brochure.htm

Care recipients should work with their provider to identify the best way to use their HCP funds alongside other funding streams.

> Example: A care recipient with Type II diabetes who is eligible for a Chronic Disease Management Plan through the MBS should make use of this plan first to access allied health and diabetes nursing services. When all access to allied health and nursing is exhausted under this plan and further support is required to address ageing related functional decline (if a confounding factor to the diabetes diagnosis), a care recipient may access these services through the HCP.

Psychology
Psychology services may be covered under Medicare's GP Mental Health Treatment Plans if the GP considers the care recipient has a diagnosable mental disorder and should be used in the first instance. Where these supports are exhausted and access to a psychologist is required for ageing related functional decline, this may be funded under the HCP. Psychiatry is a strict exclusion.

Acupuncture
Some GPs practice acupuncture and if available care recipients must go through their GP or other primary care provider to access this under the MBS.

Providers should only fund acupuncture where it can be demonstrated that the practitioner is an Ahpra registered Chinese Medicine Practitioner, and that the care recipient is not using private health insurance. Care recipients are still expected to seek advice from their GP before engaging in acupuncture as a suitable treatment.

Acupuncture may then be provided through a HCP where it meets the person's assessed care needs, it can be identified in their care plan and must fit within the available budget for their package level.

Gap Payments

Gap payments cannot be charged to the HCP budget, as many gap payments relate to services that are also funded or partly funded by the Australian Government, such as the MBS and the PBS.

While health insurers are not precluded from paying a benefit when the treatment is eligible for other benefits (e.g., HCP funds), many do not pay benefits for services funded by other programs. Private health insurers can pay benefits for various goods and services under general treatment. General treatment cover provides benefits for allied health service providers. There are various limits that may apply, for example a maximum amount or percentage limit per service, per year, or lifetime limits. Health insurers usually find it necessary to limit these benefits to keep the cost of policies affordable.

9.9 How can package funds be used to make large purchases (i.e., the cost exceeds monthly subsidy/fees payable), such as assistive aids, equipment and accessible home modifications, for care recipients?

Large purchases, defined as those items where the cost exceeds the monthly subsidy/fees payable such as assistive aids, equipment and accessible home modifications, must be:

- agreed within the care recipient's care plan;
- be within the available budget for the package level, with any charges or additional service fees mutually agreed with the care recipient through the Home Care Agreement before purchase:
- be related to the care recipient's ageing related care needs, which may require an assessment from a health professional operating within their scope of practice e.g., an occupational therapist, physiotherapist or registered nurse to ensure the aid/equipment/home modification is fit for purpose.
    - The cost of the assessment by the health professional may be covered by the existing charges for care management or direct service charge.
    - In considering suitability of what type of health professionals should make the assessment, providers are to make use of their clinical judgement or alternatively can

consult the following resources from other Australian Government programs for guidance on comparable health professional assessors for aids and equipment:

- Department of Veterans' Affairs Rehabilitation Appliances Program at https://www.dva.gov.au/sites/default/files/2022-03/rap-schedule-march-2022.pdf (for reference purposes only - noting not all equipment covered by DVA is available under HCP).
- Providers may also wish to review the product list for the geat2GO program for the Commonwealth Home Support Programme at https://www.indigosolutions.org.au/docs/default-source/geat/geat2go-product-list-june-2022.xlsx?sfvrsn=9a17b1d5_2 which characterises products under General, Under Advice, Physiotherapist and Prescribed.

Providers can access unspent funds (including the home care account balance) to pay for large purchases.

Where a care recipient has transferred providers, their home care account (including any returned provider held Commonwealth unspent funds) will be under quarantine for a 70-day period – the new provider must wait until day 71 (release of unspent funds) to make the purchase.

Providers must not split the cost over multiple claim months unless the item is being leased.

Where a care recipient has paid upfront for an allowable item, the provider may only reimburse them within the relevant claim month. If a care recipient moves to a new provider and they obtained an item from their previous provider, a care recipient cannot seek reimbursement from their new provider.

Example 1. Mauve is with a provider that offers self-management, and she has an unspent funds balance of $10,000 and receives a monthly subsidy of $4,086.32. She buys a power wheelchair worth $3,000 in July. The purchase has been agreed in her care plan and she provides the provider her tax invoice and receipt. Her provider lodges the July claim for the service in the first week of August, including the price Mauve paid for the power wheelchair (which is GST free) + the price of her other care and services for the month of July – the total of the aggregated invoice is $7,000. The claim is approved and paid by Services Australia. The provider reimburses Mauve for the purchase.

Example 2. Petro has an unspent funds balance of $10 and receives a monthly subsidy of $704.20 and pays fees of $282.24 monthly. He has been assessed as requiring an accessible bathroom modification which will cost around $20,000. His provider advises him that this purchase cannot be made until he has accrued sufficient unspent funds and must be weighed up against the risk to his wellbeing of him not receiving other care and services such as wound management and transport to social activities. His provider discusses with him more affordable options, such as an over the toilet frame, to meet his aged care needs in the interim.

Where the cost exceeds available funds for the care recipient, like in Example 2, providers and their care recipients can:

- charge the care recipient additional service fees (agreement and consent required) to make up the difference – however, it is important to note that once additional services fees are charged, there is no capacity to use HCP funds to recompense the care recipient;
- postpone the purchase until there are sufficient funds to cover the costs;
- enter leasing arrangements (including to lease to buy) where appropriate; and
- if not on Level 4, arrange a Support Plan Review through an ACAT if the package is over-allocated through the provision of monthly care and services; and the need for the large purchase is crucial.

There are certain circumstances where a HCP care recipient can access CHSP services over and above the services provided through the HCP budget. See the Commonwealth Home Support Programme Manual for more information. This may be subject to the available capacity of CHSP providers and their available funding, given CHSP clients will be the priority. Care recipient contributions, additional to income tested care fee and basic daily fee, may apply.

9.10 Considerations for home modifications

Home modifications must only be provided to improve safety and accessibility and promote independence (e.g., widening doorways for wheelchair access, removing shower hobs).

Works must be recommended by a health professional operating within their scope of practice and tailored to the ageing-related needs of the care recipient. Any works completed must align with the recommendations of the health professional. All work must be conducted by a qualified tradesperson with appropriate licensing and insurances as per state/territory government laws. Building work must be in line with the Building Code of Australia.

Providers are responsible for the resolution of any disputes, including escalating the matter to the relevant consumer protection agency if necessary.

If a care recipient departs HCP unexpectedly, any remaining balance for the works, provided works were agreed to before date of departure, can be reconciled from the home care account within the 70-day period from date of cessation only.

9.11 What happens if the care recipient is not the homeowner or changes are required to common property covered by strata?

HCP funds can be used for modifications relating to the care recipient's ageing related needs when they are not the owner of the property, or modifications are needed to be made to common property in a strata where safe egress and access is required for the care recipient.

To avoid disputes, it is prudent for the provider to ascertain the ownership/management of any premises prior to agreeing to use HCP to fund any works to modify the property. The provider should also seek assurances that the care recipient's residence at the premises is secure and stable. However, this needs to be balanced against their current care needs and goals. For example, if a grab rail will prevent a fall, even if the care recipient has only been able to secure residence for a short period of time or is nearing the end of a lease agreement, and if the package budget allows it, this may still be a good investment of HCP funds. Conversely, it may not be prudent to modify a bathroom or a kitchen to make it more accessible if the care recipient does not have security of residence.

Providers should assist the care recipient, if the not the owner, or if the care recipient's residence is under strata, to obtain permissions from owners or body corporates before the commencement of any works.

However, any changes to common property in a strata complex to assist a care recipient's egress and access needs must be considered carefully. It is a poor outcome if the care recipient pays for the whole modification when others will benefit; and is risked being devoid of funds for personal care and/or other services. Negotiation should take place to understand what portion the strata will pay, and whether there is option for the strata to pay for the whole project if it benefits multiple residents also requiring safe egress and access from the building. It is also advisable to seek advice from the state/territory government body responsible for strata to understand the body corporate's

responsibilities under the *Disability Discrimination Act 1992*, noting the operation of this Act may vary across jurisdictions.

Providers and care recipients should also consider that the nature of how HCP funds are paid means that if a care recipient departs the Program there is no capacity to access HCP funds to return the property to its state before the modification. Thus, it must be made clear to any landlord/strata that all modifications will be considered permanent unless private arrangements with private means are made between the care recipient and owner/management.

10 Delivering care under a package

Once a provider has started providing services to a care recipient (in line with their care plan and package budget), they will need to manage their care. This section outlines the ordinary administrative things providers need to do to make sure care recipients are getting the best outcomes possible from their package.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 47, 48, 56-2, 56-4 and 96 of the *Aged Care Act 1997*
- *User Rights Principles 2014*.

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

10.1 Commencing services

Once a person is assigned a package and has entered into their Home Care Agreement, their care and services can begin. The date care is first delivered should be specified in their Agreement. Their package starts on the day the Home Care Agreement is entered into, not from the day that care is first delivered. Therefore, the commencement date on the ACER form may be the same or earlier than the date that care is first delivered. The commencement date on the ACER has to be within the package take up timeframe.

Check the care recipient's My Aged Care client record for active services before submitting the ACER. Do not lodge the ACER if they are currently receiving home care, residential aged care or Short-Term Restorative Care, until you have liaised with the current provider to confirm the care recipient's agreed cessation date from that provider. Document all conversations.

Do not lodge the ACER until a Home Care Agreement is in place.

Care and services should then be delivered according to the care plan that the provider and the care recipient have developed in partnership.

On 1 September 2021, as part of the Improved Payment Arrangements changes, Services Australia created a home care account for each care recipient who was in care, with a balance of $0. All new care recipients commencing after 1 September 2021 will also have a home care account created for them.

From 1 September 2021, when a provider lodges their monthly claim the Government subsidy less any income tested care fees payable will be used to cover the price. If the Government subsidy is:

- More than the price, the difference will accrue in the home care account for future use.
- Less than the price, Services Australia will draw down on the home care account balance to cover the difference.

Care recipients will retain their full Government subsidy under these changes. Appendix E provides further detail on Improved Payment Arrangements.

10.1.1 Client summary tab

A 'client summary tab' is available in the My Aged Care client record. This is also known as the 'Client journey dashboard'. This tab provides key information about the care recipient in one place, which may include:

- assessment information;
- approvals;
- service recommendations;
- service delivery information;
- goals and reablement; and
- any periods of linking support.

Information will only be displayed where it is applicable to that individual person.

More information is available at this link or by searching "My Aged Care - Client summary tab" at www.health.gov.au.

10.2 How do I claim the Government subsidy for services I provide?

Providers can only claim the home care subsidy for people who have been assigned a package from the national priority system and have a Home Care Agreement in place. This means that providers can only claim the Government subsidy from the date they entered into the Home Care Agreement, not the date they start negotiating with the care recipient or completing pre-service delivery care planning.

Services Australia will know the date a provider commences delivering services to a care recipient through the submission of the ACER. This must be completed within 28 days of when they entered home care.

The Services Australia payment system checks provider claims against the My Aged Care listing of care for people with an assigned package. Services Australia cannot process a claim for a care recipient if they do not have a package that is assigned and active.

The home care subsidy can only be paid once the Home Care Agreement has been entered into. The subsidy cannot be claimed for discussions and meetings with the care recipient (or carers and family members), or any services provided to them before the Home Care Agreement is entered into. Claiming for subsidy prior to entering into a Home Care Agreement with a care recipient will result in the provider owing a debt to the Commonwealth for such time that care was provided without a Home Care Agreement being in place.

10.2.1 Improved Payment Arrangements

The Australian Government changed the way providers were paid and unspent funds were managed over two phases:

Phase 1 (implemented on 1 February 2021)

- Providers funded in arrears rather than in advance.
- Payments for each month claimed in the next month, for the full subsidy, based on the number of care recipients in care.

Phase 2 (implemented on 1 September 2021)

- Providers paid in arrears, based on actual care and services delivered.

- The Government holds the Commonwealth portion of unspent funds, in each care recipient's home care account, until needed by the care recipient.

Legislation to support Phase 1 was passed by Parliament in December 2020, and for Phase 2 in February 2021. This measure reduces the financial and prudential risks of providers holding substantial amounts of unspent funds, as these will be held by the Government instead.

Where a care recipient has transferred providers, their home care account (including any returned provider held Commonwealth unspent funds) will be under quarantine for a 70-day period – the new provider must wait until day 71 (release of unpent funds) to access these funds. Monthly subsidy remains payable throughout this period.

More information about the Improved Payment Arrangements can be found in Appendix E.

10.2.2 Claiming payments through Services Australia

For claims for months post September 2021 onwards

Providers started submitting claims through Services Australia under the new model from the September 2021 claim period (from 1 October 2021). Providers claim through the Services Australia Aged Care Portal, Aged Care Web Services or through paper claims.

Providers only need to claim a total dollar amount for each care recipient in their monthly claim (this is referred to as the price or invoice amount). The price reported to Services Australia should incorporate the services delivered to care recipients minus any Basic Daily Fee or other care fees charged (not including the income tested care fee).

Package management and care management are considered services and can be included as part of the price. GST is not included in the claim.

Providers do not need to include an itemised list of fees, care and services delivered to the care recipient during the relevant month to Services Australia. However, this information must be provided to the care recipient as part of their detailed monthly statement. Services Australia may request this information if there is a dispute.

Providers should be accurate in their claiming and claim the costs associated with the services delivered in the month even if they have exceeded the subsidy. Providers cannot split the cost over multiple claim months. Instead, providers will be paid the lesser of: *The shortfall amount or the maximum contribution amount*. Any outstanding amounts for the claim period must be covered by the provider or by unspent funds held by the provider for the care recipient – or additional service fees payable by the care recipient.

Services Australia will automatically deduct the income tested care fee payable from the payment made to providers, for care recipients who are assessed as needing to pay it.

Supplements will automatically be applied by Services Australia if the home care recipient is eligible. It will be included as part of the calculation completed by Services Australia of the subsidy available to the care recipient.

If the Government subsidy is more than the price, the difference will accrue in the home care account for future use. A care recipient's home care account balance will be available to their current service provider through the Aged Care Provider Portal and the payment statement Services Australia issues to providers.

Further information on the new model is available at Appendix E, with Attachment A to explain the claims process.

10.3 How should I manage my care recipients' package services?

Care management is a service providers must provide to all care recipients.

A care recipient should be allocated a care manager by a provider. The care manager is responsible for enabling the steps discussed at Sections 6, 7 and 8 (initial assessment, care planning and establishing the Home Care Agreement), as well as:

- regularly assessing the person's needs, goals and preferences
- reviewing the Home Care Agreement and care plan;
- ensuring care and services are aligned with other supports;
- partnering with the care recipient and the care recipient's representatives about their care
- ensuring that care and services are culturally safe
- identifying and addressing risks to the care recipient's safety, health and wellbeing;
- referral to an ACAT (e.g. if their needs change);
- case conferencing with care recipient's treating health professionals and/or GP, if appropriate, and where care recipient has consented to the interaction; and
- supporting timely and appropriate referral to individuals, other organisations and/or providers of other care and services.

A provider's care management service must comply with the Aged Care Quality Standards, including:

- Standard 1 – Support care recipients to make informed choices.
- Standard 2 – Initial and ongoing assessment and planning with care recipients.
- Standard 3 – Deliver safe and effective personal and clinical care.
- Standard 4 – Provide safe and effective services and supports to support daily living and allow independence.
- Standard 8 – Engage and support care recipients in the development, delivery and evaluation of care and services.

For more information on care management visit www.health.gov.au and search for "Care management and care plans for Home Care Packages".

10.4 What happens if a care recipient wants to self-manage their package?

Self-management means that a care recipient is involved in designing and directing their care, taking a lead role in making decisions to manage their package. This includes choosing preferred workers, and scheduling and co-ordinating their care and services. Care recipients can ask to do this because the HCP Program operates under a CDC model. Providers who offer this option should ensure that what is involved is fully understood.

It is important that both the provider and the care recipient understand that the approved provider is ultimately responsible for compliance with the legislation (see Section 2), Aged Care Quality Standards (see Section 3), and scope and intent of the HCP Program (see Section 2). Providers will still need to have oversight over what services self-managing care recipients receive services from and how they spend their package budget. Providers will also continue to undertake some required activities such as reviewing the care plan.

A provider must still provide care management to ensure delivery of safe and quality care and services based on their needs, goals and preferences. This may incur some costs and staff effort, so

providers can charge a care management price proportionate to the work incurred to oversee the care recipient's self-management.

10.5 Can a care recipient employ family and friends to deliver their care?

Payment to families and friends for care services are typically a program exclusion. Family and friends may instead access the Carer's Payment - https://www.servicesaustralia.gov.au/carer-payment

Using subsidy to pay for family carers raises serious probity issues under the *Public Governance, Performance and Accountability Act 2013* under which the aged care special appropriation sits – generally this is an exclusion unless it is a thin market (i.e. rural and remote Australia; Aboriginal and Torres Strait Islander and CALD populations) and the family member is especially qualified, doesn't live with the care recipient and the provider and family member (in their capacity as a personal care worker or health professional) have agreed a robust probity plan with the provider. It is a strict exclusion if the family member is already receiving a Carer's payment.

10.6 How often does the care plan need to be reviewed?

The care manager must review a care recipient's care plan:

- regularly and at least once every 12 months, to make sure the care and services received through the package still meet the care recipient's needs;
- at any time when requested by the care recipient's or their carer;
- if the care recipient has been receiving services through a lower level package than their approved level, and they get upgraded to a higher package level; and/or
- if there has been a change in the care recipient's package budget.

Reviews may also occur more frequently than every 12 months. Reasons for an additional or earlier review may include:

- a health crisis or episode;
- a change in care need that cannot be met within the package budget available for the package;
- a change in living or carer arrangements;
- ongoing or increasing use of clinical services; or
- the use of a large amount (or all) of the remaining funds.

When thinking about how often to review the care plan, providers should be aware of compliance with Standards 2 and 3 of the Aged Care Quality Standards. For more information on the standards see Section 3 of this manual.

The review should have a reablement and wellness focus that does not assume a decline in the care recipient's health and functioning. It should involve:

- a review of current ageing related care needs, care goals and preferences;
- an evaluation of the quality and success of the services and supports that have been provided;
- a renegotiation and update of the care plan and individualised package budget; and
- support for the care recipient to continue to make informed choices about their care and services, and the life they choose to live, including whether they wish to change their level of involvement and decision-making in the management of the package.

Wellness and reablement are discussed further at Section 7.3.

The review should be done in person, wherever possible. Phone and video technology or other remote monitoring digital technology may also be used, where clinically appropriate.

Review of the care recipient's care needs may lead to significant changes in the nature of the support provided to them. The provider should support the care recipient (and anyone else they choose to involve, such as family or advocates), as much as possible, in any changes resulting from the review of the care plan.

As part of the review process, providers in consultation with care recipients, may need to undertake a further reassessment of care and service needs to determine if care and service needs have increased and require further supports or if needs have changed and require adjustments to the way care and services are delivered.

Another ACAT assessment may be required if the care recipient's care needs have increased significantly so that they potentially require more support in order to remain in their home, or entry to residential care or residential respite. Some care recipients may already have suitable approvals. To determine if an approval is already in place, providers can review their My Aged Care client record. If they do need a new ACAT assessment, the provider can assist to arrange this, with their permission. However, if unspent funds remain available in the package or if funds have been diminished without value for money consideration for purchases of aids and equipment and/or home modifications, ACAT reassessment is inadvisable.

As discussed at Section 7, providers need to undertake initial and ongoing assessment and planning for care and services in partnership with each person they enter into a Home Care Agreement with. Providers cannot change a care plan without mutual consent from the care recipient.

Review of the care plan is an included service, paid for out of the care management cost (if any), as agreed in the Home Care Agreement. Providers cannot charge additional costs to the care recipient's package budget for each time they request a review of their care plan or Home Care Agreement.

While the care plan should be reviewed regularly for effectiveness, if someone is asking for recurrent reviews of their care plan where their circumstances have not changed, providers should discuss why they are requesting reviews of the care plan, and what can be done to help. Providers should document records of these conversations taking place.

Note: where there is a change to the care recipient's care plan, the package budget will also need to be updated.

10.7 What is a monthly statement and what does it need to have in it?

Providers are required by the *User Rights Principles 2014* to issue care recipients with monthly statements that show the package budget funds available to them and what has been spent from their budget. Providers may also include any agreed additional charges. A monthly statement should clearly show services delivered so that the care recipient and/or their carers can easily understand how the service provider is charging for the package.

The following amounts must be itemised and included in the monthly statement:

- The amount of home care subsidy for the care recipient for the month
- The amount of home care fees (if any) paid or payable by the care recipient for the month, and any unpaid home care fees relating to previous months.
- An itemised list of:

  - The care and services provided to the care recipient during the month (including travel, subcontracting arrangements and package management) for which the care recipient was charged;
  - The price that the provider charged the care recipient for the month;
  - The total of those prices;
- The care recipient's unspent home care amount (provider-held unspent funds) in respect of: the previous month; and the current month;
- If, during the month, the provider received the care recipient portion of unspent funds from another provider – the amount that was received.

From the September 2022 payment period, you must split out the care recipient's unspent funds into the:

- Commonwealth portion of provider-held funds
- care recipient portion of provider-held funds
- home care account balance

The monthly statement should align with the provider claim for care and services delivered during the month (the payment period). That is, both the claim and the statement should include care and services even if the payment for these services has not been finalised, for example as it was delivered by a sub-contractor and the invoice has not been received. Any adjustments can be reflected in subsequent months (in both the claim and statement).

Any unspent funds amount must carry over from month to month, and from year to year, for as long as that person continues to receive a package.

Providers must continue providing detailed monthly statements for all care recipients. Providers must provide the total amount of all unspent funds they hold, including the funds being held in the home care account (if any).

Statements do not need to break down the unspent funds balance into the provider-held care recipient portion, Commonwealth portions, or the home care account balance until providers are ready to include this information. The Department will review this early in 2022, to determine the date at which this reporting requirement becomes mandatory. Advance notice will be provided to the sector.

A non-mandatory better practice monthly statement template and guide has been developed and providers should strive to align with this.

Services Australia will expand the payment statement issued to providers to report the balance of Government subsidy held within each care recipient's home care account and any provider-held amounts returned.

10.8 What are unspent funds and how can they be used for care and services?

Unspent funds are the total amount of home care subsidy, supplements (if applicable) and home care fees that have not been spent or committed on a person's care. Since 31 December 2021 – under the Improved Payment Arrangements Phase 2 changes (see Appendix F and Appendix G) – providers must report the Commonwealth portion of unspent funds they hold for each care recipient to Services Australia. Unspent funds may be made up of the following:

- provider-held Commonwealth portion of unspent funds
- provider-held care recipient portion of unspent funds
- Services Australia held home care account balance

10.9 How can I work with my care recipients to manage unspent amounts?

Providers should work with care recipients to ensure they are able to benefit from the full use of their package and budget. However, there are several reasons why unspent funds may accumulate in a package budget – key examples are listed below:

Reason	Information
Care recipient choice	The package budget for a care recipient's assessed level of care should be used to meet their current care needs. However, they may actively choose to set aside a small proportion of their package budget for future events, such as leave of a carer.
Temporary leave	Care recipients can temporarily suspend their package if they take leave. Depending on the reason, the full rate of home care subsidy is payable for up to 28 cumulative or consecutive days (depending on the leave type) in a financial year and they may continue to be asked to pay their home care fees. After this, the subsidy is payable at a rate of 25 per cent. Further information on leave arrangements for subsidy, supplements and home care fees is at Section 11.

If a care recipient transfers to a new service provider, the previous provider will need to transfer the care recipient portion of unspent funds to the new service.

If a care recipient exits the HCP Program, the provider must transfer the care recipient portion of unspent funds back to the care recipient or the care recipient's estate.

If a care recipient exits the HCP Program the Commonwealth Government portion of unspent funds must be returned to the Government.

Providers have a legal obligation to transfer any unspent funds if someone changes provider, or return unspent funds if they leave home care.

This is discussed further at Sections 13 and 14. The Department uses information about the returned Commonwealth Government portion of unspent funds as an input to determine the number of packages to be released to people on the national priority system.

Further information on the treatment of unspent funds under Improved Payment Arrangements is available at Appendix F and Appendix G.

The table below outlines two strategies providers may use to help manage any unspent funds they may hold for care recipients:

Strategy	Information
Revise the care plan and package budget	Providers should work together with their care recipients to develop a plan that meets their assessed care needs. This includes talking about the funds available and how to spend those funds, through the package budget. This may include an agreement, based on the care recipient's choice, to set aside a small part of their package budget for future care needs. It is important to be able to save for future events, such as a carer going on holiday or needing respite. Providers should also ensure record keeping regarding care recipients' days in care are accurate and up to date (see section 11 for further information on leave).

Strategy	Information
Actively manage packages	Providers also play an important role in managing their care recipient's package. Providers will receive a notification if their care recipient's package is upgraded. The provider should talk to their care recipient about their assessed care needs and make updates to the care plan, Home Care Agreement and package budget as soon as possible, so that more essential services can be arranged. Doing this quickly will prevent unspent funds accumulating from the date of the automatic package upgrade.

10.10 What happens when a care recipient's care needs have increased?

A care recipient's care needs may increase significantly so that they potentially require home care at a higher level or entry to residential care. In these circumstances, they may need another assessment by an ACAT. With the care recipient's prior consent providers can assist in arranging the ACAT assessment. Providers can do this by submitting a Support Plan Review (SPR) request via the My Aged Care provider portal. More information is available at this link or by searching "request a Support Plan Review" at www.health.gov.au.

Care recipients can request a SPR themselves by calling My Aged Care.

If it is determined that another assessment is necessary, the provider should attach supporting documentation about the care recipient's care arrangements. For example, a package budget or care plan. These attachments are required to be attached to the SPR requests for people who are receiving a package. The My Aged Care contact centre will also request this information when submitting SPR requests on behalf of service providers.

If someone is already in receipt of a Level Four package, they may need to consider other options including:

- reviewing their care plan to identify alternatives and priorities (for example, reducing higher cost services, such as support on weekends, and replacing with informal supports);
- purchasing additional care and services from their own funds if an option; or
- the benefits of residential care, either as short-term respite to complement their package or as a long-term option.

10.10.1 Respite

The primary purpose of respite is to support and maintain the care relationship between carers and care recipients by providing good quality respite care for the care recipient so their carer may take a break from their usual care arrangements. Respite can be provided in the home, in a day centre, in a Cottage-style accommodation (overnight community respite), or residential setting.

Respite in the home may take the form of additional services where the carer would otherwise provide those services. This could include providing a break during the day for the carer or overnight respite to allow the carer to rest.

Residential respite provides temporary care in an aged care home. Residential respite may be used on a planned or emergency basis. An ACAT approval is required to access this care.

A package can be suspended when a home care package recipient is receiving residential respite. For information on taking 'leave', see **Section 11**. In this case, the services delivered under the

package would be put on hold. Providers are unable to collect the basic daily fee from the care recipient, however, the income-tested care fee may remain payable. If this occurs, it is important for the home care provider to engage with the residential respite provider to ensure continuity of care and allow the care recipient to be supported in their continuing care goals. This may be facilitated by sharing their home care plan with the residential respite provider. This will allow the respite provider to consider any wellness or reablement approaches that remain relevant within the residential setting.

It is also important that the residential respite provider enters their payment claim correctly in the Services Australia payments system. If they enter a claim for permanent residential care this will result in the withdrawal of an active package.

Alternatively, a care recipient may choose to receive residential respite and their home care package services at the same time. This may be an appropriate option where some of their assessed care needs can continue to be met by the home care provider outside the aged care home. For example, maintaining a safe environment for their return.

In this situation, it is vital that the home care provider engages with the residential respite provider to share the care plan and ensure there is no duplication of services. Again, it is important to consider wellness, reablement and continuing care goals. A care recipient must also be made aware of the impact this will have on their fee arrangements (see **Section 11**).

Private Respite

If a HCP care recipient does not have a current ACAT approval for residential respite care, or decides not to use government funded residential respite care, HCP funds can be used to pay for a non-government funded bed in a private respite care facility. Providers would also need to consider 'cost effectiveness' and 'value for money' in purchasing private respite, turning to the most cost-effective and economical respite that meets the care recipient's needs.

Care recipients may wish to consider private respite care as an alternative way to gain access to respite care. If the HCP is used to contribute towards the cost of private respite care, it would be appropriate for a care recipient to discuss this with their approved provider as using the HCP funds for respite in a private facility will impact on the package budget and the capacity to deliver other care and services.

The duration must be monitored. Payment for long-term residential care is an exclusion.

Cottage Respite

Cottage respite provides overnight care delivered in a cottage-style facility or community setting other than in the home of the carer or care recipient. Service providers are required to structure services in such a way that allows them to be as responsive as possible to requests from carers for short-term or non-ongoing respite.

If a carer would like to arrange for respite services, whether in the home or residential facilities, they may wish to contact the Carer Gateway on 1800 422 737. The Carer Gateway can book short-term and emergency respite in residential facilities and help carers access a range of other respite options, including in-home and centre-based respite.

The Carer Gateway provides practical information and support, accessed via www.carergateway.gov.au.

10.11 What if I can't meet the care recipient's needs?

Once providers enter into a Home Care Agreement, they are required to continue to deliver the agreed care and services for as long as the care recipient needs those services. As discussed at Section 3.4, this is called security of tenure.

There are exceptions to security of tenure, such as when the care recipient can no longer be cared for safely in their home. These exceptions are extracted in full at Section 3.4.

If providers do not think they can meet the care recipient's needs, but none of the exceptions to security of tenure apply, they should consider sub-contracted arrangements to help fulfil obligations under security of tenure. Sub-contracting is discussed at Section 7.

If the reason the provider cannot meet the care recipient's needs is due to the provider being unable to make contact with the care recipient and/or their authorised representative for a period of multiple months, the provider must place the care recipient on social leave until such time that contact is made. Should communication continue to be unanswered the provider may send notice to terminate the Home Care Agreement to the care recipient advising they have a reasonable period of time to respond to the request (e.g., four weeks) before date of cessation; and that upon termination of the Home Care Agreement the care recipient has 56 days to enter into a new Home Care Package or will otherwise lose their unspent funds. However, the provider should also consider the vulnerability of the care recipient. For example, if the care recipient is homeless, it may be a better outcome to leave them on perpetual social leave until such time that the care recipient is able to re-engage with the aged care system.

10.12 What do I do if I think someone is being subjected to elder abuse?

The World Health Organization defines elder abuse as 'a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person'. It can take various forms, such as physical, psychological or emotional, sexual and financial abuse. It can also be the result of intentional or unintentional neglect.

If providers would like to talk to someone about potential or actual elder abuse they can call the national **1800 ELDERHelp** (**1800 353 374**) line. This service provides information on how to get help, support and referrals to assist with potential or actual elder abuse.

Providers may have obligations in relation to elder abuse under State or Territory laws in the jurisdictions in which they operate. Each State and Territory provides information about abuse and abuse prevention, as well as useful contacts and options for getting help:

State/Territory	Organisation or resource	Contact
Australian Capital Territory	Older Persons Abuse Prevention Referral and Information Line (APRIL)	**02 6205 3535**
New South Wales	NSW Elder Abuse Helpline	**1800 628 221**
Northern Territory	Elder Abuse Information Line	**1800 037 072**
Queensland	Elder Abuse Prevention Unit	**1300 651 192**

State/Territory	Organisation or resource	Contact
South Australia	Aged Rights Advocacy Service Elder Abuse Phoneline	**08 8232 5377** **1800 700 600**
Tasmania	Tasmanian Elder Abuse Helpline	**1800 441 169**
Victoria	Seniors Rights Victoria	**1300 368 821**
Western Australia	Elder Abuse Helpline	**1300 724 679**

Providers can find a case study that provides an example of financial elder abuse at this link or by searching "case studies" at www.agedcarequality.gov.au.

10.13 What do I need to do to manage complaints?

The Aged Care Quality Standards require providers to have a complaints management function in place. The purpose of this function should be:

- **For the care recipient to:** feel safe, encouraged and supported to give feedback and make complaints; feel engaged in processes to address feedback and complaints; and feel comfortable that appropriate action has been taken.
- **For the provider to:** regularly seek input and feedback from care recipients, carers, the workforce and others; and use the input and feedback to inform continuous improvements for individual and the whole organisation.

The complaints function must be outlined in every Home Care Agreement. If it is appropriate, providers may want to refer a care recipient to the Commission material on making a complaint at this link or by searching "making a complaint" at www.agedcarequality.gov.au/.

If a complaint arises, the provider must:

a. use their complaints resolution mechanism to address the complaint; and

b. advise the complainant of any other mechanisms that are available to address complaints, such as the Commission.

It is important that providers view complaints as an opportunity to further develop their customer service by gaining insights into the needs and wants of care recipients. If staff are open to complaints and educated on how to manage them, complaints can be an opportunity to address minor issues before they become significant, and to build positive relationships with care recipients, their families, friends and representatives.

The Commission 'Better Practice Guide to Complaint Handling in Aged Care Services' provides information on how to design a complaints function. It is at this link, or by searching "Better Practice Guide to Complaint Handling in Aged Care Services" at www.agedcarequality.gov.au/.

The Commission also has case studies that outline some strategies providers might use to resolve complaints. These can be found at this link or by searching "Case studies" at www.agedcarequality.gov.au/.

10.14 Contingency funds

Providers are required to discuss future planning, including any large purchases, with their care recipients and take these into account when planning package budgets. This must then be

documented in a care recipient's Home Care Agreement and their care plan. Providers must ensure care recipients understand and agree to their care plan before services are put in place.

Unspent funds can be used to pay for a care recipient's future care and services, such as in the event of a change in care needs. In some cases, care recipients and providers may agree to not fully utilise the package budget on care and services in order to 'save' unspent funds for future use.

Charging and claiming for "contingency" is not consistent with the policy intent of the HCP Program.

Contingency fees cannot be charged and accrued for future needs. Under Improved Payment Arrangements, from 1 September 2021, any additional fees should only be used for current identified and delivered care and service needs, noting:

- Payment by Services Australia is only paid in arrears for services already delivered and providers should no longer be accruing unspent funds.
- The Department does not support unnecessary fees which may have adverse impacts on the financial wellbeing of care recipients and do not serve to benefit the care recipient. In line with *Aged Care (Transition Provisions) Act 1997*, Part 4.2 which sets out the responsibilities relating to home care fees.
- Any additional fees a care recipient contributes are drawn down first by deduction from the price reported to Services Australia as part of a monthly claim.
- Where the claim is less than the subsidy, any unspent funds accruing would be the Commonwealth portion in the home care account and these funds would therefore not be available for reimbursement to the care recipient upon departure.
- In line with the *Aged Care Act 1997*, Part 3A.1, 52D-1(d): if the care recipient dies or provision of home care ceases—any fees paid in advance in respect of a period occurring after the care recipient's death, or the cessation of home care, must be refunded in accordance with the Fees and Payments Principles.

✓ Key points to remember

- Providers are required to review each care recipient's care plan regularly, at least once per year, and if their care needs change or they request it.
- Changes to a care recipient's care plan will result in changes to their package budget.
- Providers are required to give care recipient's monthly statements. This is a financial document and shows them what makes up their package budget and how it is being spent.
- Approved providers and all of their employees need to be aware of elder abuse, including obligations in regards to reporting and response to elder abuse, which vary by State or Territory.
- Providers need to have a complaints management function in place, and they must use it to manage complaints they receive.
- From 1 September 2021, providers receive funding based on the actual services delivered to care recipients in the previous month. This aligns home care with other Government-funded programs like the National Disability Insurance Scheme, as well as modern business practices. These changes will not affect care recipients' subsidy entitlements.

11 Leave

This section outlines what providers need to do if someone wants to take leave from receiving services under their package (also known as suspension) and how that affects their budget.

This section provides information relevant to care recipients who entered the HCP Program after 1 July 2014, or who have opted into the post-1 July 2014 arrangements. For information on the pre-1 July 2014 arrangements, see **Appendix A**.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

The *Fees and Payments Principles 2014 (No.2)* and the *Subsidies Principles 2014* outline how leave operates within the HCP Program. As providers of services under the program, providers are expected to comply with those laws.

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

11.1 When can a care recipient take leave?

Care recipients are allowed to temporarily suspend their package for any reason. Leave may be taken:

- for a hospital stay;
- for transition care following a hospital stay;
- to receive residential respite care; and/or
- other reasons (such as social leave).

A care recipient's security of tenure is not affected by the choice to take leave. They must, however, notify their provider that they are choosing to take leave from their package and specify the date that leave commences, or they will be liable for services delivered. This notification is not required to be in writing, but providers need to record the leave dates, and how and who informed them of the leave.

Providers must include information in each Home Care Agreement, explaining how the care recipient can notify them if they are planning to take leave. If they choose to take leave, the provider should work with them to update their care plan accordingly. See What if I can't meet the care recipient's needs? for circumstance (non-contactable for multiple months) where a provider may place a care recipient on social leave without their consent.

11.2 What is the impact of leave on the home care subsidy and supplements?

The amount of home care subsidy paid to the provider is dependent on the type of leave the care recipient takes from their package, as set out in the table on the next page:

Type of leave	Impact on payment of subsidy or eligible supplements to provider
• **Hospital** • **Transition Care**	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 consecutive days in a financial year, for each episode of hospitalisation or transition care at each particular package level. • After 28 consecutive days, the subsidy is payable at 25% of the basic subsidy rate. • After 28 consecutive days, primary supplements* are not payable.
• **Residential respite care** • **Social leave****	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 cumulative days in a financial year at each particular package level. • After 28 cumulative days, the subsidy is payable at 25% of the basic subsidy rate. • After 28 cumulative days, primary supplements* are not payable.

* Primary supplements are oxygen, enteral feeding, dementia and cognition, and veterans. Other eligible supplements (such as the viability and hardship supplements) continue to be paid during periods of leave. Supplements are discussed at **Section 8.2.2**.

** Package suspension for any other reason.

11.3 What is the impact of leave on home care fees?

A care recipient may be required to pay ongoing home care fees to the provider while they are on leave from their package. The amount and type of fee that can be charged while a care recipient is on leave from their package is set out below:

Leave type	Basic daily fee	Income-tested care fee
Hospital	Yes	Yes - payable at the full rate for 28 **consecutive** days, after which the care recipient can be asked to pay the lesser of their income-tested care fee or 25% of the basic subsidy rate for their package level.
Transition care	No	Yes - payable (at the full rate for 28 **consecutive** days, after which the care recipient can be asked to pay the lesser of their income-tested care fee or 25% of the basic subsidy rate for their package level.
Residential respite	No	Yes - payable at the full rate for 28 **cumulative** days, after which the care recipient can be asked to pay the lesser of their income-tested care fee or 25% of the basic subsidy rate for their package level.
Social leave	Yes	Yes - payable at the full rate for 28 **cumulative** days, after which the care recipient can be asked to pay the lesser of their income-tested care fee or 25% of the basic subsidy rate for their package level.

11.4 What is the impact of leave on monthly statements?

Any subsidy, relevant supplements or home care fees paid or payable to the provider while the care recipient is on leave must be included in their monthly statement.

11.5 How do leave balances work?

A care recipient's leave balance resets on 1 July each year or if their package level changes at any time. Leave balances are specific to each person receiving a home care package and will transfer with them, for example, if they change providers.

Worked examples:

A care recipient has been in hospital for more than 28 consecutive days, and because they advised their provider to suspend their package, the basic subsidy has stepped down to 25% after the 28th day. The care recipient then moves into transition care for a period. How is the rate of subsidy calculated and how should the home care fees be calculated?

Hospital leave and transition care leave are two different types of leave. Each time a care recipient accesses either hospital leave or transition care leave, their provider receives the full subsidy amount for up to 28 consecutive days, after which the subsidy reduces to 25% of the basic subsidy rate. The leave will also impact on their basic daily fee and income-tested care fee (if applicable).

Hospital leave: the care recipient's provider would receive the full home care subsidy for up to 28 consecutive days for each episode of hospital leave. During this period, the provider can continue to charge them the basic daily fee and the income-tested care fee.

After 28 consecutive days, the subsidy will be reduced to 25% of the basic subsidy rate. The basic daily fee remains payable, however, the income-tested care fee may change (if the new subsidy rate is less than the income-tested care fee). Services Australia will notify the provider and care recipient of any adjustments through the quarterly review process.

If the care recipient is admitted to transition care immediately after being discharged from hospital, the provider will recommence receiving the full subsidy for up to 28 consecutive days of transition care leave. During this period, the provider cannot charge the basic daily fee but may continue to charge the income-tested care fee. After 28 consecutive days, the subsidy reduces to 25% of the basic subsidy rate. The income-tested care fee remains payable but may change if the new subsidy rate is lower than the income-tested care fee. Services Australia will notify the provider and care recipient of any adjustments through the quarterly review process.

Note 1, the income-tested care fee will be reduced to the lesser of the income-tested care fee or the reduced subsidy. This means that for some care recipients the Government will stop paying the subsidy and primary supplements.

Note 2, this worked example assumes that the care recipient chooses to take leave while they are in hospital. If they do not take leave from their package and want to continue receiving some services (for part or all of the leave period), they may be asked to pay the basic daily fee and the income-tested fee.

A care recipient is on leave in hospital but needs minor modifications to the home before they can be released from the hospital to go home. Do I need to do these minor modifications for the care recipient while they are on leave?

In situations such as a hospital stay, it is usually expected that the care recipient is provided with a full range of care and services in the hospital setting. They can, however, choose not to suspend their package and discuss with the provider what services should continue during the period of the hospital stay and have that reflected in their care plan. This might include minor home modifications if there are sufficient funds available in the package to fund the required work.

Therefore, if the care recipient wants minor home modifications to be done within their package, they will need to return from leave in order for these to be done. If they will not agree to return from leave to have the modifications done then the provider does not have to provide for any care, services, or purchases under their package until they return from leave.

A care recipient is going on a three month holiday. Their home needs household maintenance services (such as mowing) in order to make the home safe while they are away ready for their return home. Can I charge to the package budget while they are on leave?

If the care recipient requires care, services, or purchases to be actioned during a period of planned leave then they cannot take leave from their package.

Providers can amend their care plan so that the care and services they will not use are not scheduled during the period they are away. The funds typically used to pay for these will accrue as unspent funds in their package budget. These funds should be used for care and services that will advance their care goals when the care recipient returns from leave.

✓ Key points to remember

- People can take a break from receiving services under their package. This is known as taking leave, and does not affect their entitlement to receive home care services when they want to come back from leave.
- The Government may still pay the Home Care subsidy to that care recipient's home care account while they are on leave. This will depend on the reason the care recipient is taking leave, and how much leave they have already taken in the financial year.
- Depending on the type of leave and how much leave, the care recipient may be asked to pay their basic daily fee and income tested care fee.

12 Responding to special needs and changing cognition in home care package delivery

As discussed at Section 2.1, the HCP Program is underpinned by a CDC model. This means that aged care services should be designed in partnership with the care recipient and adapted to their individual needs and care goals. An individual's needs may include special needs or changes to their cognitive function.

Approved providers need to be ready and able to respectfully and safely provide aged care services to people with special needs and changing cognition. They have a right to have their special needs and/or changing cognition respected. Any services must treat each care recipient with dignity and respect, enable them to maintain their identity, and account for and cater to any special needs and/or changing cognition if they would like them to, or if it is necessary for them to remain living safely in their home.

This section defines the terms 'special needs' and 'changing cognition', and outlines strategies providers may employ to support care recipients with special needs and/or changing cognition.

✓ **Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section**
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

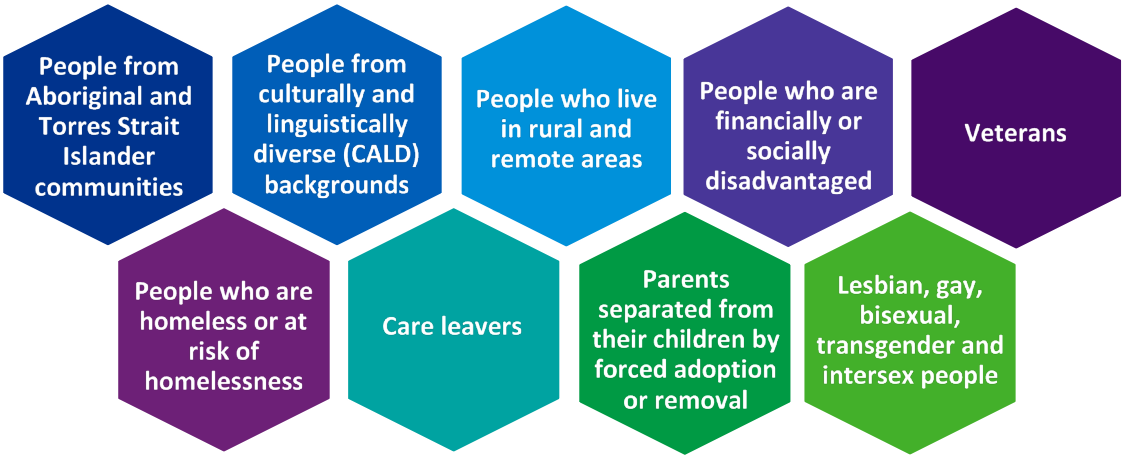
- Section 56-2 of the *Aged Care Act 1997*
- *User Rights Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

12.1 What are special needs?

The *Aged Care Act 1997* defines nine types of special needs, as outlined in the figure below:



When thinking about whether a person has any of the above special needs, providers should not focus on what they look like or whether they show certain physical characteristics. Instead, they should think about how the care recipient sees themselves, and their circumstances.

This manual does not provide specific guidance on what providers should do when providing services to people with each type of special need. This is because the HCP Program is based on a CDC model, which focusses on the needs of the individual. Each person will view their special needs differently and their needs will have different impacts on their lives. Approved providers should be open and respectful, and work together with them to design a program of care and services that is adapted to their particular circumstances.

When working with people with special needs, it is worth remembering that they may have had negative experiences of discrimination, or other adverse actions, in the past. The best way to approach this is to work in partnership with them and have open and respectful conversations about their care needs and goals.

The Commission provides several examples on meeting the care needs of aged care recipients with special needs at this link. Or you can search "case studies" at www.agedcarequality.gov.au/.

The Aged Care Diversity Framework and action plans also helps providers consider how their services may be appropriately tailored to care recipients with diverse characteristics and life experiences. These can be found at this link, or by searching "Aged Care Diversity Framework action plans" at www.health.gov.au.

12.2 What is changing cognition?

Changing cognition is not defined by legislation; it is a broad term used to describe dementia or other changes in care recipient capacity and memory.

12.2.1 Early warning signs of dementia

Early symptoms of dementia often vary a great deal, which can make it hard to identify. Providers' clinicians or other service providers may have regular contact with care recipients. This means they are well placed to help identify when someone may be in the early stages of dementia.

Dementia Australia provides guidance on early warning signs of dementia, which may be helpful to the provider and their team members in identifying whether one of their care recipients may be living with dementia. It can be found at Warning signs of dementia | Dementia Australia or by searching "Warning signs of dementia" at www.dementia.org.au.

12.2.2 Determining capacity

If a provider's staff member, or a care recipient's family and/or friends are concerned about signs of dementia or other changes in cognition, providers will need to determine whether the person still has 'capacity' to make a choice for themselves. 'Capacity' is a legal term, and as a starting point, must always be assumed (even if the care recipient has been diagnosed with dementia or another type of cognitive impairment). It is also decision-specific. Just because someone has not had capacity in the past that does not mean that they will not have capacity to make future or less complex choices.

The individual's right to make their own choices, decisions, mistakes and take risks must be respected. Providers are obliged to support and encourage care recipient autonomy and self-direction, whilst also being mindful of indicators of incapacity and potential abuse of their care recipients.

Capacity means being able to:

It is also important that the care recipient can apply their personal values to the decision, and that there is some stability and consistency to the decision-making over time. Another way of checking capacity is to ask them to explain the decision in their own words, including why the decision is made. Capacity is not an all or nothing concept. It is decision-specific and can also fluctuate over time. A person may lack capacity in one area (such as making complex financial decisions) but may be able to make decisions about other areas of life (such as the type of supports they need and who they would like to provide them).

The case study below provides guidance on what a provider could do to manage care planning with a care recipient who has dementia but still retains capacity to make choices about their care. It is important to remember that anyone who retains capacity has a right to their own dignity of risk.

Case study: Olga

Olga has been receiving home care services for several years. She has dementia and her needs have gradually increased, but she is capable of living semi-independently for now. Her two children live nearby and at least one of them visits daily. Olga gets on well with the care staff and makes it clear to them that she wants to keep doing as much of her own housework and personal care as she can.

Her children, however, express concern to the provider that she is no longer capable of making decisions that best meet her needs. They ask the provider to add laundry, ironing and bed-making to their duties, tasks that Olga has been doing herself until now without mishap. The care staff who look after her directly tell the service co-ordinator they think this change is unnecessary and risks making Olga unhappy and affecting her confidence. The provider has to balance the wishes of Olga's family with Olga's own preferences.

The main priorities are Olga's safety, her well-being, and respecting her wish to keep doing her daily tasks. There are certainly safety and hygiene issues to consider. So far, these have not arisen but may as Olga's dementia progresses. A care co-ordinator with experience in dementia meets with Olga to talk about these issues. Olga understands the concerns being raised by her children and decides that the risks discussed with her are outweighed by the importance of the benefits she get from doing her own laundry and ironing. She agrees to a small increase in staff supervision for these activities, and that the bed-making service can start. In explaining the plan to Olga's children, the co-ordinator emphasises how important it is for their mother to maintain a sense of independence, self-worth and purpose. The co-ordinator also makes it clear that the provider has carefully discussed the health and safety risks with their mother and will continue to monitor them from day to day.

12.2.3 Dementia Training Program

The Dementia Training Program is a program for providers that offers a national approach to accredited education, up-skilling, and professional development in dementia care. Services include:

- accredited dementia care vocational level training courses - free to eligible care workers in residential, respite, community care or the wider health services;
- an online training portal allowing staff to undertake web-based training; and
- tailored onsite training to aged care providers who request assistance, including a dementia skills and environment audit, followed by a tailored training package.

The Dementia Training Program website is at www.dementiatrainingaustralia.com.au.

12.2.4 Dementia Behaviour Management Advisory Services

The Dementia Behaviour Management Advisory Services (DBMAS) provides advice to providers and individuals caring for people living with dementia where behavioural and psychological symptoms of dementia (BPSD) are impacting on their care and quality of life. Access is through the 24 hour helpline, on **1800 699 799**, or the DBMAS website at www.dementia.com.au.

12.3 How do I manage issues related to changing cognition?

CDC encourages people receiving a package to continue to make choices and direct the support that they need. Some individuals, however, may have more difficulty engaging with CDC and making choices about their care goals and services. If they would like or need it, there are different ways in which they can be supported in their decision-making and in expressing their views about their service arrangements:

Strategy	Description
Representative	A person may appoint a representative to assist with their decision making or be authorised to make decisions on their behalf. This may take various forms, such as an informal arrangement with a friend, family member or ally, someone with a formal power of attorney or a legal guardian.
Supported decision-making	Supported decision-making is a model that has mainly been used for supporting people with disabilities, often cognitive disabilities, to make significant decisions and exercise their legal capacity. Specific decisions are addressed, weighed and concluded by the person with the disability, while drawing on the support of a network of people or an individual. Potential supporters may be friends, family, volunteers, community members or any other trusted person. These unpaid supporters may help the person with disability to gather, understand and consider relevant information about the decision in question, assist them to weigh pros and cons, predict likely outcomes and consequences or evaluate the available options. With this support, the person then makes the decision themselves. This process can be formally facilitated, for instance by creating written supported decision-making agreements. It often occurs informally, however, within the community, both to support people with impaired decision-making capacity and to support anyone in making a challenging decision. This model of support aims to build and extend the decision-making skills of those using it, developing the ability of people to make and communicate decisions with more independence and confidence. Source: Disability Advocacy Network Australia

Strategy	Description
Power of Attorney	Powers of attorney are legal documents that let a person choose someone they trust to make decisions for them. An enduring financial or medical power of attorney, or enduring guardianship, are a way a competent person can appoint others to make decisions and manage their affairs in the event they are unable to make decisions for themselves. Arrangements may differ in each State or Territory. Contact your Office of the Public Advocate in your State or Territory for further information.
Guardianship	Guardianship is the appointment of a person (a 'guardian') to make decisions for an adult with a disability (the 'represented care recipient) when they are unable to do so. All adults over the age of 18 years, regardless of disability, are entitled to make their own decisions when they are able to do so. Australian guardianship law is the key regulatory mechanism for protecting the health of young persons, adults with disabilities and the elderly. Australia has eight different guardianship regimes, which vary widely in their forms of regulation. See www.austguardianshiplaw.org for more information.
Care planning	All care recipient care plans should include a contingency plan, which is reviewed each year and provides clear guidance around what to do in the event that their capacity to make decisions regarding their care declines.
Advance care planning	Advance care planning provides an opportunity for people to think, discuss and plan for the medical treatment they would prefer if they became too ill in the future to express their wishes. An Advance Care Directive is a written document that records the medical treatment wishes of a person, which can then be used if they are unable to speak for themselves due to illness or injury. The document may also appoint a substitute decision maker and include non-medical wishes for end of life, such as spiritual care. You can find information about advance care planning at this link or on www.health.gov.au by searching "advance care planning". Information, guidance, and resources are available from the End of Life Directions for Aged Care website at this link or at www.eldac.com.au. Advance Care Planning Australia has information about contacts in each State and Territory. For more information see www.advancecareplanning.org.au.

The case study on the next page outlines how advance care planning can help provide the care recipient, their families and the approved provider with comfort through end of life planning.

Case study: Ricardo and Alicia

Ricardo and Alicia had been living in their own unit for three years when Ricardo, aged 70, was diagnosed with a form of dementia that is progressing rapidly. They contacted their provider to discuss extra services they expected to need as the illness progressed. Recognising how important it was for Ricardo's final months to be comfortable and dignified and to reflect his wishes, even when he could no longer express them, the provider encouraged them to make a formal advance care plan.

A staff member trained in developing advance care plans helped Ricardo identify his values and treatment preferences. What mattered to Ricardo most was staying in his home with his wife and dog, taking daily walks and looking after the unit's small garden. He did not want treatment that

Case study: Ricardo and Alicia

might extend his life while its quality deteriorated. Following the provider's protocol for end of life planning, the staff member worked with Ricardo and Alicia to document a detailed advance care plan. Ricardo was pleased everyone knew his clinical, cultural and spiritual preferences.

For more information on supported decision making in aged care please go to this link or search "Supported decision-making" at cdpc.sydney.edu.au/.

12.4 What do I do if care recipients need additional support in exercising their choice?

Advocacy has an important role in supporting care recipients in exercising choice and directing their services. An advocate can help them understand their rights and choices within their package, and supports them through decision-making processes. Advocacy can be particularly useful for people who are experiencing changing cognition.

The care recipient (either the care recipient or their representative) can request that another person assist them in dealings with their approved provider. An advocate is not the same as a representative, in that they may be present to support decision-making or negotiations with the provider, but are not necessarily authorised to make decisions for the individual.

Providers must allow the advocate of the care recipient's (or their representative's) choice access to the home care service.

An advocate may be made available through the National Aged Care Advocacy Program (NACAP). The NACAP is delivered on the behalf of the Australian Government by the Older Persons Advocacy Network (OPAN). It provides free, confidential and independent advocacy support to older Australians receiving or looking to access Government-funded aged care services.

An advocate's support can help with the following:

For more information on advocacy services go to opan.com.au.

✓ Key points to remember

- Providers need to be ready and able to provide care and services to people with special needs and/or changing cognition. Care and services must be considerate of and appropriate to special needs and/or changing cognition.

- The Aged Care Diversity Framework and action plans can help providers consider how services may be appropriately tailored to people with diverse characteristics and life experiences. These can be found at this link, or by searching "Aged Care Diversity Framework action plans" at www.health.gov.au.
- Capacity can be difficult to navigate with an older Australian and their family. This section outlines legal and advocacy strategies that providers can use to help with this.
- OPAN provides free, independent advocacy services. If care recipients need support making decisions, but can still make decisions for themselves, providers can connect them to this service.

13 Changing home care providers

This section outlines the obligations of a provider if one of their care recipients chooses to change home care providers. This includes details on how to calculate and transfer their unspent funds.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Section 56-2 of the *Aged Care Act 1997*
- *User Rights Principles 2014*
- *Accountability Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

13.1 When can a care recipient change home care providers?

Once receiving a package, a care recipient can change providers if they are looking for a better fit, or for any other reason. If they decide to make a change, their unspent Home Care funds (less any exit amount as agreed in the Home Care Agreement if departing before 1 January 2023) will move with them to their new provider.

When someone transfers to a new provider, they must notify their existing provider that they no longer wish to receive care and agree on the date that services from the existing provider will cease. They should also advise their existing provider of who their new provider will be.

13.1.1 Agreeing on a cessation day

A care recipient may tell their existing provider they wish to change providers directly, or they may reactivate their referral code in My Aged Care, triggering a notification to the existing provider through the Provider Portal. The existing provider should discuss the care recipient's needs and the timing of their move once they become aware of their intent to change providers.

This includes agreeing on a cessation day for the existing home care services that takes into consideration the care recipient's situation, the terms of the Home Care Agreement, and legislative requirements of home care. As per the *Records Principles 2014*, the existing provider will need to document the agreed cessation day.

The existing provider must continue providing care up until the agreed cessation day.

13.2 How does this affect the claims for that care recipient's home care subsidy?

Reaching an agreed cessation day with the care recipient is important to know the period for which the existing provider can claim home care subsidy. It also allows the existing provider to accurately reconcile the balance of package funds and calculate any unspent funds.

The start date for the new provider must be on or after the cessation day of the existing provider. When someone changes providers and there is no gap in care, the start day for the new provider should be the same date as the cessation day for the existing provider. This ensures there is no gap in payment of home care subsidy.

When a care recipient changes home care provider, the existing provider is not paid a home care subsidy for the cessation day, while the new provider is paid home care subsidy for the start day. An example of how subsidies are paid to the existing provider and new provider when there is no gap in services to the care recipient is outlined in the table below:

Recipient	26 June	27 June	28 June	29 June	30 June
Existing provider	Subsidy paid	Last day of services, Subsidy paid	Cessation day		
New provider			Start date, Subsidy paid	Subsidy paid	Subsidy paid

Before providing home care services, the new approved provider should confirm the cessation day with both the care recipient and the existing provider to ensure there are no overlapping claims for home care subsidy. Where two or more approved providers claim subsidy for the same person on the same day, payment will be made to the provider that first entered into a Home Care Agreement with them. When the start day and the cessation day are the same date, this does not represent an overlapping claim as home care subsidy is not paid for the cessation day.

13.2.1 Notifying the cessation day and start date

The new provider must accept the care recipient's referral in My Aged Care and submit the ACER within 28 calendar days of the cessation day. They have 56 calendar days from their agreed cessation day to enter into a new Home Care Agreement with their new provider before their package is withdrawn.

The existing provider must notify the Australian Government that they have ceased providing services to a care recipient within 31 calendar days of their cessation day. This must be done by submitting the care recipient's name and their cessation day through the Aged Care Provider Portal. The Aged Care Provider Portal is at this link, or can be found by searching "Aged Care Provider Portal" at www.servicesaustralia.gov.au.

Note: For continuing care recipients if they wish to retain their pre-1 July 2014 fee arrangements they must enter care with the new provider within 28 days. For more information see **Appendix A**.

13.3 What are the obligations on providers?

13.3.1 Obligations for the existing approved provider

The diagram below outlines the obligations for the existing approved provider:

1. Provide cessation information to Services Australia	2. Notify care recipient of unspent amount/arrange payment	3. Retain records
Once a cessation day is agreed with the care recipient, the existing provider must notify Services Australia within 31 calendar days of care ceasing. It is important to remember that a home care subsidy is not paid for the cessation day.	Three steps must be taken: a. Calculate the unspent home care amount b. Provide written notice of the unspent home care amount c. Make payment of the unspent home care amount.	The existing provider must retain: • Written notice of the care recipient's unspent home care amount • Records relating to the payment of the unspent home care amount to the new provider.

Further information on the steps necessary to notify the care recipient of the unspent amount and arrange payment is outlined below:

a. Calculate the unspent home care amount

The steps and requirements for calculating a care recipient's unspent home care amount are detailed in the *User Rights Principles 2014*. Before completing the final reconciliation, the provider must make sure claims for the care recipient are up-to-date; that home care fees have been received; and all expenses have been identified, including any outstanding invoices from sub-contracted or brokered services.

Note: The calculation of unspent home care amount should not include:

- any home care fees paid in advance, as these must be separately refunded to the care recipient by the provider; or
- home care subsidy for the cessation day, as home care subsidy is not paid for the care recipient on that day.

b. Provide written notice of the unspent home care amount

Within 56 calendar days after the cessation day, the existing service provider must give the care recipient (or their representative) a written notice about their unspent home care amount. The written notice must include the:

- Cessation day for care and services.
- Exit amount that has been deducted (if applicable/prior to 1 January 2023).
- Unspent home care amount, which is the balance of any unspent funds (less any exit amount if departure occurred prior to 1 January 2023) in the package budget, broken down into the following portions:
  - the care recipient portion, which is the unspent amount of home care fees paid to the provider by the care recipient, less any unpaid home care fees owed by the care recipient;
  - the Australian Government portion held by the provider (if any), which is the unspent amount of home care subsidy and supplements for a care recipient;
- Any unpaid home care fees which have been deducted (if applicable).

Under Improved Payment Arrangements, from 1 September 2021, the existing service provider will need to:

- transfer the care recipient portion of unspent funds to the new service provider if the care recipient is moving services, or
- refund the care recipient portion of unspent funds to the care recipient or their estate if the care recipient exits home care.

If a provider still holds the Commonwealth portion of unspent funds for the care recipient, the existing service provider will need to:

- transfer the Commonwealth portion to Services Australia where it will be held in the care recipient's home care account, available for use with their new provider, or
- return the Commonwealth portion to Services Australia, where the funding will be reinvested by the Government into the Home Care Packages Program if the care recipient exits home care.

For providers who have opted-in to draw down on the Commonwealth portion of unspent funds and have used these funds entirely, they will only need to transfer or refund the care recipient portion. The Commonwealth portion of unspent funds will be in care recipient's home care account, managed by Services Australia.

Where a care recipient has unpaid home care fees, this is a matter for the approved provider to manage with them directly under the terms of the Home Care Agreement. The written notice must explain how the unspent home care amount will be paid, so they (or their estate) understands the process and the timeframes involved.

Providers cannot charge care recipients fees that they have waived in the past or fees that are not detailed in the Home Care agreement.

Refer to Section 13.4 for more information on exit amounts.

c. Make payment of unspent home care amount

The care recipient must notify their existing provider within 56 calendar days after the cessation day of the new provider who they have entered into a Home Care Agreement with. This is to allow their existing provider to arrange payment of the care recipient portion of the unspent home care amount to the new provider. If the existing provider is not notified within this period, the existing provider must treat any unspent home care amount as if the care recipient has left home care. This is discussed at Section 14.

The existing provider is required to make payment to the new provider as soon as possible, but within 70 calendar days, after the cessation day. The existing provider must also provide a copy of the written notice of the unspent home care amount to the new provider at the time the payment is made. This allows the new provider to identify the transferred amount for the care recipient.

13.3.2 Obligations for the new approved provider

The diagram below outlines the obligations for the new approved provider:

1. Accept the care recipient referral in My Aged Care	2. Develop a Home Care Agreement with the care recipient.	3. Provide care recipient entry information to Services Australia.
Providers must accept the care recipient's referral in the Provider Portal before submitting entry information to Services Australia.	The new provider should work in partnership with their new care recipient to develop a Home Care Agreement, care plan and package budget based on their assessed care needs.	The new provider must notify Services Australia within 28 calendar days of the care recipient starting care by submitting an ACER.

Once the new provider receives the unspent funds amount they must separately identify the transfer portion of the unspent home care amount in the care recipient's monthly statement. Under Improved Payment Arrangements (from 1 September 2021 onwards) the transfer portion will only consist of the care recipient portion of unspent funds. The Commonwealth portion will be held in the care recipient's home care account.

Care recipients who join the HCP Program after 1 September 2021, will never have an Commonwealth portion held by the provider. Any unspent funds held by the provider will be entirely made up of the care recipient portion.

13.4 When can I charge an exit amount?

From 1 January 2023, providers cannot charge a care recipient an exit amount in any circumstance.

If a person leaves a provider's care before 1 January 2023, the provider can charge an exit amount if:

- the provider has published the exit amount on the My Aged Care website
- the care recipient has agreed to an exit amount in their Home Care Agreement
- the care recipient still has unspent funds held by the provider when they exit care.

This can occur even if accounts are finalised after 1 January 2023.

Activities related to care recipient's exiting or moving to a new provider, such as transferring documents, may be covered under package management or care management, where reasonable and appropriate.

13.5 My organisation has undergone a merger or acquisition. How do I transfer my care recipients?

When a provider has undergone a merger or acquisition, their care recipients will need to be exited from their service and transferred to the new provider.

Services are required to contact the Department to advise of transfers, mergers or closures, including effective dates. The Department will advise Services Australia of this information.

It is also the services' responsibility to transfer all care recipient from the closing service to the continuing service.

Further guidance on obligations if a provider is subject to a merger or acquisition can be found at this link, or by searching "Transferring home care services to another approved provider" at www.health.gov.au.

Note that if a provider is looking to move care recipients from one of their home care services to another within their control, they can do this via a self-service process in the My Aged Care Provider Portal. Providers can find support with technology and guidance on how to use the My Aged Care Provider Portal at this link. They can also search "My Aged Care for service providers" at www.health.gov.au.

More information on administrative responsibilities is at Section 15 of this manual.

✓ Key points to remember

- Care recipients can change home care providers at any time.
- If someone receiving home care services chooses to change providers, it is important that they and their existing provider agree a cessation date. This affects the way the providers claim the care recipient's package subsidy and when the existing provider will need to transfer the care recipient's unspent funds.
- The existing provider must transfer the care recipient's unspent funds to their new provider as soon as possible, but within 70 calendar days, of the cessation date.
- If a provider has a transferring care recipient who entered care before 1 July 2014 and they want to opt into the post-1 July 2014 fee arrangements, they must complete the **"Continuing Care Recipient opting into the New Aged Care Arrangements from 1 July 2014 (AC022)"** form. The care recipient must submit this form to their new provider. The new provider must give them a copy of the *New Arrangements for Aged Care from 1 July 2014 – Home Care* publication before they transfer to the new service.

14 Leaving the HCP Program

This section tells providers the steps they need to take if a care recipient leaves the HCP Program.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 52D-1 and 56-2 of the *Aged Care Act 1997*
- *Fees and Payments Principles 2014 (No.2)*
- *User Rights Principles 2014*
- *Accountability Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

14.1 What administrative tasks do I need to complete?

14.1.1 Notify Services Australia of a care recipient ceasing care

Within 31 calendar days of a care recipient ceasing services, the provider must notify Services Australia through the Aged Care Provider Portal of their name, cessation date, and the reason for their departure (for example, moving to residential aged care or passing away). The Aged Care Provider Portal is at this link, or can be found by searching "Aged Care Provider Portal" at www.servicesaustralia.gov.au.

If a care recipient moves into permanent residential aged care, their start date with their residential aged care provider will be the date their home care provider ceases receiving payment of subsidies. It is important that the home care provider agrees with the individual and their residential aged care provider the cessation date for their package and the start date for residential care, to ensure the home care provider is eligible to receive all subsidies they are expecting to receive.

If a person passes away, in addition to making the necessary changes on the Provider Portal, providers should call My Aged Care on **1800 200 422** so they can update their record. This is important, as it will ensure future communications with family members are mindful of this fact, and do not cause further distress. Alternatively, providers can advise the care recipient's representative to call My Aged Care.

14.1.2 Complete hand over (if relevant)

It is important that aged care recipients have continuity of care. As a part of care management, providers should do a hand over with relevant parties when needed, to ensure each person's care needs are understood. Providers should seek the care recipient's permission to share their information and documentation about their care. This will ensure any new providers of aged care will have as much information as possible to inform the care they provide.

This should occur before the care recipient's cessation date. If it occurs after the cessation date, the provider will not be able to charge the care management to them.

This will not be required if the care recipient has passed away.

14.1.3 Make payment of unspent home care amount

If a care recipient leaves home care or passes away, their provider must undertake the following with respect to unspent funds:

- Transfer the care recipient portion to the person or their estate. If they are leaving the HCP Program, this must be completed within 70 days after the cessation date. If they have passed away, this must be completed within 14 days of being shown the probate of the Will or letters of administration.
- If the provider has not opted-in under Improved Payment Arrangements to draw down on the Commonwealth portion of unspent funds (or if they have opted-in but not yet drawn down these funds to $0) the provider will need to notify the Australian Government of the Commonwealth portion (including nil amounts) within 70 calendar days through the claims process managed by Services Australia.

Care recipients who join the HCP Program after 1 September 2021, will never have an Commonwealth portion held by the provider. Any unspent funds held by the provider will be entirely made up of the care recipient portion.

- Providers should support care recipients through their transition to other aged care programs.
- Providers must notify Services Australia when a care recipient leaves the HCP Program.

15 Providers' reporting and administrative responsibilities

Once providers are set up to provide services under the HCP Program they need to continue to comply with their disclosure and reporting obligations.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 9-1A, 9-2, 9-3, 9-3B, and 63-1 of the *Aged Care Act 1997*
- *Accountability Principles 2014*
- *Records Principles 2014*
- *Sanctions Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

15.1 My organisation's circumstances have changed. What do I need to do?

There are two types of changes that providers need to notify either the Department or the Commission about:

15.1.1 Changes to the home care service

Changes to the home care service includes things like changes of name, address or contact details. In short, if the change affects who or how the Department can contact the approved provider they must notify the Department.

This can be done by completing the form at this link. You can also find the form by searching "Notification of changes for Home Care Packages" at www.health.gov.au.

15.1.2 Material changes to suitability

Approved providers have an ongoing responsibility to ensure they are ready and able to provide legislatively compliant, high quality and safe home care services at all times. For more information on this, see Sections 2, 3 and 4 of this manual.

Provider suitability is assessed against the following five considerations:

1. Experience in providing aged care or other relevant forms of care
2. Understanding of approved provider responsibilities
3. Systems it has, or will have, in place to meet these responsibilities
4. Record of financial management and the methods used, or proposed to ensure sound financial management
5. Conduct as a provider (including compliance with responsibilities as a provider) and obligations arising from the receipt of any payments from the Australian Government for providing that aged care or any other relevant form of care.

If anything changes that materially affects these criteria, providers are required to disclose this information to the Commission. This information must be disclosed using the **"Notification of Material Change"** form. The form is at this link or can also be found by searching "Notification of a Material Change" at www.agedcarequality.gov.au.

All notifications must be made within 28 days of the change occurring. Penalties may be applied if a provider does not notify the Commission within this timeframe.

The **"Notification of Material Change Form"** (discussed above) can also be used by an approved provider to update information about its organisation which may include key personnel responsible for the overall governance of the organisation or the authorised contacts or address information.

15.2 My key personnel have changed. What do I need to do?

Providers are responsible for knowing who in their organisation meets the definition of key personnel as outlined in Section 8B of the *Aged Care Quality and Safety Commission Act 2018* and ensuring their key personnel are not a disqualified individual. Providers will be liable for any sanctions if it is determined that key personnel are disqualified individuals.

As discussed at Section 4, a disqualified individual is someone who has been convicted of an indictable offence, is insolvent or under administration, or is certified by a medical practitioner that they have a mental incapacity to perform their duties as key personnel. Each State and Territory law identifies different types of offences as being indictable. These typically include serious offences such as murder, manslaughter, the intentional or unlawful administration of drugs or poisons, or committing fraudulent or dishonest activities.

Providers must take reasonable steps to ensure none of their key personnel are a disqualified individual. The following steps are taken by the legislation to constitute 'reasonable steps'.

For each of a provider's existing key personnel:

- Ensure that the person understands the obligations of key personnel and of approved providers under the Act in relation to disqualified individuals
- If the provider reasonably believes that the person may be mentally incapable of performing his or her duties as one of their key personnel, make arrangements for the person to be examined by a registered medical practitioner
- If the provider reasonably believes that the person may be a disqualified individual, take the steps outlined below
- If the provider has ascertained that the person is a disqualified individual, ensure that the person ceases to be one of their key personnel.

For any person who proposes to become, or becomes, one of a provider's key personnel:

- Obtain a police certification for the person (this requires their written consent);
- Conduct a search of bankruptcy records; and
- Conduct previous employment and referee checks.

If a provider fails to take reasonable steps to ensure their key personnel are not disqualified individuals, they may be liable to pay a fine, face revocation of their approved provider status or, in certain circumstances, face a prison sentence.

Providers need to keep documentation, such as police checks, confirming the suitability of their key personnel. These obligations arise under the *Records Principles 2014* and have been outlined at **Appendix E** of this manual.

15.3 What are my financial disclosure obligations?

Approved providers must complete an Aged Care Financial Report (ACFR) annually, four months after the end of their financial year. All financial reporting requirements for residential aged care, HCP Program and short-term restorative care are reflected in the ACFR template so providers can report on all the aged care services they provide in one report to the Department.

15.3.1 Home Care financial reporting

To support all aged care providers to meet their legal obligation to complete the ACFR annually, the Department sends each provider an ACFR User Guide. This guide is sent out during August, and a customised cover letter explains which sections of the ACFR are relevant to the recipient's organisation.

Home care providers will be prompted to complete the Home Care Financial Report (HCFR) section of the ACFR. The HCFR is to be completed at a Planning Region level, with a home care service defined as an approved provider's home care operation within an aged care planning region. While some providers will have their Home Care Service IDs at the planning region level, others will have their Service IDs at the package level (i.e. Level two packages). Where Service IDs are at the package level, providers may be required to aggregate their financial information in order to complete the Financial Report.

Commencing with the 2021-22 ACFR, non-government home care providers are also required to complete the Approved Provider Income & Expenditure Statement, Approved Provider Balance Sheet and Approved Provider Cash Flow Statement which all collect financial data on the total operations of the approved provider, not just home care. There have also been recent changes to who can sign the Declaration which is required to be submitted with the ACFR.

> If the approved provider is not a State, a Territory, an authority of a State or Territory or a local government authority, the aged care financial report must be signed by:
>
> (a) if the provider is a body corporate that is incorporated, or taken to be incorporated, under the Corporations Act 2001—a director of the body corporate for the purposes of that Act; and
>
> (b) otherwise—a member of the provider's governing body.
>
> If the approved provider is a State, a Territory, an authority of a State or Territory or a local government authority, the aged care financial report must be signed by one of the approved provider's key personnel who is authorised by the provider to sign the report.

15.3.2 Lodgement

Providers must lodge all required sections of the ACFR with the Department, via the online ACFR portal. The portal can be found at health.formsadministration.com.au. The ACFR portal can only be accessed through VANguard or myGovID login. Providers must complete and lodge their ACFR by 31 October for the previous financial year ending 30 June.

There are no provisions within the legislation to grant extensions. Providers must lodge their ACFRs early to provide adequate time to address any issues and finalise all components of the ACFR as it relates to their organisation. The Department may take compliance action if providers fail to comply with these requirements. A range of sanctions can be imposed on an approved provider including revoking or suspending approval as a provider of aged care services and restricting approval to provide aged care services. The type of sanctions imposed on an approved provider will depend on the nature of the non-compliance.

ACFRs cannot be lodged until all the required sections are completed and correct, and all necessary documents have been uploaded at the ACFR portal. The customised cover letter sent directly to all providers with each financial year's ACFR user guide will outline all sections relevant to providers delivering the HCP Program.

15.3.3 Pricing review

Providers must also review their full price list and do one of the following:

- Report to the Department that they have done so. This can be done by entering 'Confirm review of pricing information' in the My Aged Care Provider Portal.
- Update their price list. This will cause the 'last updated date' to update in the Department's systems, and will be sufficient evidence that the provider has reviewed their price list.

More information on obligations related to pricing is at **Appendix B**.

15.4 What happens if I am not compliant with my obligations or responsibilities?

The consequences of identified non-compliance by aged care providers depends on the risks posed by the non-compliance and the provider's response to the Commission's concerns. The Commission's primary concern is the risks to the health, welfare or interests of current and/or future recipients of aged care services.

Reflecting this, compliance can include things like education, repayments, issuing a non-compliance notice or sanctions. If there is a recurring non-compliance, continued unwillingness or inability by the provider to address the non-compliance, the Commission may revoke their approval to provide aged care. In some instances non-compliance could also result in a criminal charges for the most serious breaches.

Please note, other penalties or sanctions may also arise under other legislation, such as the consumer law.

✓ Key points to remember

- Providers must notify the Department of changes to their circumstances.
- Providers have annual obligations to report financial information to the Department. They can complete reporting for all aged care services they provide in one form.
- Providers must notify the Commission of material changes to suitability.
- Providers are responsible for ensuring that key personnel are not disqualified individuals.
- Providers also have an annual obligation to review their price list annually.
- If providers have a financial year that ends on 30 June, they must report their financial information by 31 October.
- On 1 January 2020 the Commission took on compliance functions, previously the responsibility of the Department of Health and Aged Care. The regulatory management of this matter now rests entirely with the Commission.

15.5 Reporting issues

Aged care providers must spend package funds appropriately.

15.5.1 Reporting suspected non-compliance with provider requirements

The Commission has processes for people to raise a concern or make a complaint about the quality of care or services provided to people receiving Australian Government funded aged care. More information is available at this link or by searching for 'complaint' at www.aged carequality.gov.au.

The consequences of identified non-compliance by aged care providers depends on the risks posed.

When resolving complaints in relation to the care and services, if the Commission finds a provider used package funds inappropriately then it can initiate compliance action, including at a minimum, repayment of any amounts that have been incorrectly charged.

15.5.2 Reporting suspected fraud

The Department does not tolerate fraudulent use of HCP funding. If funding is used for purposes stipulated in the 'Specified Exclusions' table at 9.2.3 or for other items deemed not part of services or care to be funded by a HCP, the Department may initiate a fraud investigation and take action accordingly.

The Department has the power to investigate allegations of fraud against health funding and programs and is actively engaged in intelligence gathering with external agencies.

IF YOU SEE SOMETHING, SAY SOMETHING BECAUSE FRAUD IS A CRIMINAL OFFENCE.

The Department can investigate allegations of fraud against health funding and programs. If you suspect someone is engaging in fraud, please contact the Department with the details of your concerns via email at agedcarefraud@health.gov.au. Alternatively, you can call the Health Fraud Hotline on **1800 829 403**, open 9am to 5pm Australian Eastern Standard Time, Monday to Friday. You can report suspected fraud anonymously.

If an approved provider wants to self-report a concern, they should contact the Department.

16 Interface with other Programs and Schemes

This section provides information on what programs can be accessed at the same time as the HCP Program. It focusses on the CHSP, because it is related to the HCP Program within the Australian Government continuum of care for older Australians, but also discusses a broad range of other programs.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

No specific obligations arise. The *Aged Care Act 1997*, however, governs how the HCP Program interacts with other programs. As providers of services under the program, providers are expected to comply with those laws.

16.1 How does the HCP Program interface with other programs?

As outlined at Section 2, the HCP Program is a part of the Australian Government's continuum of care for older Australians. The table below outlines what other services can or cannot be received at the same time as the HCP Program:

Services that may be received while receiving HCP Program services	Services that cannot be received while receiving HCP Program services
Commonwealth Home Support Programme^	Permanent residential aged care
Community Visitors Scheme	Short Term Restorative Care
Continence Aids Payment Scheme	Transition Care Programme
DVA Programs	Multi-Purpose Services Program
Residential Respite Care*	National Aboriginal and Torres Strait Islander Flexible Aged Care Program
Dementia Behaviour Management Advisory Services (DBMAS)	Disability Support for Older Australians
Palliative Care	
National Dementia Support Program	
National Disability Insurance Scheme (NDIS)^	

^Under limited circumstances

* Unless the care recipient has taken leave from their package.

16.2 What is the Commonwealth Home Support Programme?

The CHSP represents the entry tier of the Australian Government aged care system. Investment in entry-level support that focuses on keeping people independent and safe in their own homes can

delay the need to move to more intensive forms of care. This benefits frail older Australians through increasing their independence and quality of life as well as reducing Australian Government outlays for other forms of care, such as residential aged care.

Assessment for eligibility to access the CHSP is completed by the Regional Assessment Service (RAS). An ACAT may also approve eligibility.

The CHSP provides funding for a broad range of entry-level support services to assist frail older Australians aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) and who have functional limitations (including cognitive), to remain living independently at home and in their community[2].

CHSP subsidised services are delivered on a short-term, episodic or ongoing basis, with a strong focus on activities that support independence and social connectedness and taking into account each person's individual goals, preferences and choices. As with the HCP Program, people receiving services through the CHSP may need to contribute funds towards their services[3].

As an 'entry-level' program, the CHSP is designed to provide relatively low intensity (small amounts) of a single service or a few services to a large number of frail older Australians. These services are designed for older Australians who need only a small amount of assistance or support to enable them to maintain their independence, continue living safely in their homes and participate in their communities.

The CHSP is not designed for older Australians with more intensive, multiple or complex aged care needs, and does not replace or fund support services already provided for other programs or schemes, including the health care system. People with higher needs are supported through other aged care programs.

16.3 How does the HCP Program interact with Commonwealth Home Support Programme?

The HCP Program is designed to support older Australians living in the community whose care needs exceed the level of support that can be provided through the CHSP.

CHSP service providers should only supply additional CHSP services to a person receiving a home care package where they have the capacity to do so without disadvantaging the CHSP target population. People who need CHSP subsidised services, but do not have access to other relevant support services, should be prioritised over people who are already receiving a home care package.

There are defined circumstances in which care recipients are able to receive specific CHSP subsidised services on a time-limited basis when they are in a package (that is, the additional CHSP services will not be charged to their package budget). These circumstances are limited, to ensure the CHSP continues to, in the main, deliver entry-level services.

[2] **Note**: the eligible ages for the Assistance with Care and Housing (ACH) Sub-Program differ from those for the core Commonwealth Home Support Programme. Further detail on the sub-program can be found in the Commonwealth Home Support Programme Manual. The manual is at this link, or can be found by searching "Commonwealth Home Support Programme (CHSP) Manual" at www.health.gov.au/.

[3] This occurs through the 'Client Contribution Framework'. Further detail can be found at Chapter 5 of the Commonwealth Home Support Programme Manual (at the link above).

They include:

- For care recipients on a Level one or two package: where the care recipient's package budget is already fully allocated, they can access additional, short-term or episodic Allied Health and Therapy services or Nursing services from the CHSP, where these specific services may assist the care recipient to regain functionality after a setback (such as a fall).
- For care recipients on a Level one to four package: where the care recipient's package budget is already fully allocated and a carer requires it, they can access additional planned respite services under the CHSP (on a short-term basis).
- For care recipients on a Level one to four package: in an emergency (such as when a carer is not able to maintain their caring role), where the care recipient's package budget is already fully allocated, additional services under the broader CHSP can be obtained on an emergency or short-term basis. These instances must be time limited, monitored and reviewed.
- For care recipients on an interim Level one or two package who are waiting for a Level three or four package; where the care recipient's package budget is already fully allocated, they can access additional minor home modifications from the CHSP.
- For care recipients on a Level one to four package: care recipients who have transitioned from the CHSP may continue to access their existing CHSP social support group on an ongoing basis to allow the continuity of social relationships. This only applies to care recipients attending a pre-existing CHSP social support group service.

For care recipients on Level one to four package or awaiting their package: where there is urgent need, and the care recipient has insufficient funds in their package budget for goods, equipment and assistive technology (GEAT), they may access GEAT in the short term. These instances should be time limited, monitored and reviewed. During these times, the package is not suspended; both the HCP Program and the CHSP will be received concurrently.

More information is available in the Commonwealth Home Support Programme Manual. The manual is at this link, or can be found by searching "Commonwealth Home Support Programme (CHSP) Manual 2020-2022" at www.health.gov.au.

16.4 How does the HCP Program interact with other programs and schemes?

It may be possible for a person to receive care and services through a range of other programs and schemes that they cannot receive as part of a home care package. Key programs and schemes are outlined below. Providers should work with their care recipients to identify additional services that they may need, and to explore the best available combination of health and aged care services.

More detailed information about the individual programs is available on the My Aged Care website, at www.myagedcare.gov.au. You can also call the My Aged Care contact centre on **1800 200 422**. For information on how other programs or schemes interact with the HCP Program, please refer to information on the program or scheme of interest.

16.4.1 National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFAC)

The National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFAC) is a separate aged care program specifically for Aboriginal and Torres Strait Islander peoples. Aboriginal and Torres Strait Islander peoples can access either HCP or the (NATSIFAC) but they cannot access both services. Where Aboriginal and Torres Strait Islander people access HCP, culturally appropriate aged care services similar to the NATSIFAC home-care like program is appropriate.

16.4.2 Residential Aged Care

Under the *Aged Care Act 1997*, an entry into permanent residential care will result in the immediate withdrawal of an active home care package. If a care recipient is receiving HCP Program services and needs to permanently move to a residential aged care facility, their home care provider is responsible for discussing this move with them and mutually agreeing a cessation date where entry is foreseen.

Sometimes entry to permanent residential care is unforeseen. HCP providers should thus plan with care recipients when negotiating the Home Care Agreement on how they will be alerted to an entry into permanent residential care so that they can cease service provision with immediacy. Home care providers are also encouraged to create linkages with hospitals and residential care services in their region to support continuity of care for the care recipient.

16.4.3 Check all prospective home care recipients' My Aged Care client records for any active permanent residential care services before committing a package

COVID-19 emergency leave in residential care has created situations where care recipients are on long-term leave from residential care, sometimes for six months or longer – these care recipients may enter the National Priority System and be assigned a HCP. This is allowed by the system to ensure the care recipient is given choice and control to exit residential care.

However, HCP providers should thus check prospective care recipient's My Aged Care client record carefully before committing a package on their behalf and reject any care recipients who are still entered into permanent residential care until such time that they have:

- formally exited permanent residential care, or
- the home care provider has contacted the residential aged care service and confirmed cessation date; and a start date for home care is agreed to by both the care recipient and residential aged care service.

Do not lodge the ACER until cessation date from permanent residential aged care is known. Once known, and if a Home Care Agreement is in place, make the entry date for home care for the day after departure from residential aged care.

If there is a lag in agreeing a cessation date from residential aged care, and the package assignment letter from My Aged Care is withdrawn in the interim, either

1) the care recipient can call My Aged Care and ask to be placed back on the National Priority System – a new package will be assigned within a short period of time – entry can then be lodged from date of package assignment; or

2) where the care recipient requires the package assignment referral code to be urgently reassigned for continuity of care, call My Aged Care and ask them to make an escalation to the Department for delegate approval of package reassignment.

16.4.4 Care recipient believed they were in residential respite but were entered for permanent residential care

Where a care recipient believes they are in residential respite, and a residential aged care service submits an entry into the aged care portal or to Services Australia for permanent residential care or backdates a permanent care entry to override the period the care recipient was in residential respite, home care providers should contact the residential aged care service (if known) and ask them to change the entry.

Where the matter is still unresolved, providers should encourage the care recipient to make a complaint to the Aged Care Quality and Safety Commission for exposing the care recipient to loss of

unspent funds and or making the care recipient liable to pay the home care provider private fees if care and services continued (i.e. the package was not suspended due to the need to support the care recipient to return to the community e.g. home modifications, light gardening; podiatry; speech pathology) for the period while the care recipient was thought to be in residential respite.

16.4.5 Care recipient knowingly enters permanent residential care while receiving a HCP

Where a care recipient knowingly entered permanent residential aged care, but did not alert their home care provider, depending on the terms of the Home Care Agreement, they may be liable to pay privately for any HCP care and services provided while they were in permanent residential aged care.

Providers must warn care recipients that entry to permanent residential care will result in the immediate termination of their package. In addition, entry to permanent residential care will potentially result in the loss of their Commonwealth unspent funds and, where relevant, a refund of their care recipient portion of unspent funds, **if** they do not return to the package within 56 days. Where a care recipient has been in residential care for more than 56 days, and the care recipient intends to return to the community. Care recipients must notify My Aged Care several weeks in advance of their return to facilitate re-assignment of their package.

Any HCP care and services provided to a care recipient who has withdrawn from the Program cannot be funded through the HCP.

16.4.6 Resolution options for overlapping home care and residential care service claims

For retrospective overlapping claims, Services Australia will contact both the residential aged care service and HCP providers and may ask for copies of Home Care Agreements and resident agreements to consider which claim to pay. Services Australia may offer you alternative options to seek recompense. It is suggested you follow this advice.

If a HCP provider is unhappy with the outcome, contact your state/territory office to discuss other options for resolution. When contacting the state office, providers will need to provide copies of Home Care Agreements, care plans, individualised budgets, monthly statements, record of communication with care recipient and/or nominee, and record of communication with residential aged care service (if any) when making their case.

In extenuating circumstances where a care recipient has been in permanent residential care for less than 70 days and they exit residential care and return to the community, and where the residential care service is unable to retrospectively change the entry and an open complaint exists with the Aged Care Quality and Safety Commission, the delegate to the Secretary of the Department of Health and Aged Care may agree to prospectively reinstate the HCP and the home care account balance of the affected care recipient should there be evidence, substantiated by the Aged Care Quality and Safety Commission, that

a) choice and control was not provided to them by the residential aged care service because the residential aged care service did not have the respite allocation to admit them for residential respite; or

b) where an acute health event led to an emergency admission and the care recipient and their family were not in a position to exercise choice and control.

16.4.7 Transition Care

Transition care provides time-limited, goal-oriented and therapy-focused packages of services to older Australians after a hospital stay. Transition care aims to optimise the functioning and independence of older Australians after their hospital episode, and where possible, delay a person's entry into residential aged care.

People receiving HCP Program services are able to access transition care after a hospital stay if they are assessed and approved as eligible by an ACAT and take appropriate leave from their package. Information on leave can be found at Section 11. It is the responsibility of the care recipient to notify their HCP provider of their intention to take leave and enter transition care. It is expected, however, that the care recipient's home care provider discuss the provision of care with the relevant transition care provider to coordinate care provision and ensure that the care recipient's care needs are met.

People receiving Transition Care cannot commence receiving HCP Program services until after they have completed their Transition Care episode. Therefore, it is strongly recommended that HCP providers check for active transition care episodes and discuss this criterion with potential home care recipients to ensure that they are aware that their transition care episode will cease if they enter into a HCP agreement. It is expected that any transition from transition care to HCP will be discussed with the TCP provider before commencement of the home care package, and coordinated between the providers to ensure the care recipients' continuing care needs are met.

This program is jointly funded by the Commonwealth and State or Territory governments. Further information, including in relation to the interface between transition care and the HCP Program, is available in the Transition Care Programme Guidelines.

16.4 Short-Term Restorative Care

Short Term Restorative Care (STRC) provides a time-limited, goal-oriented, multi-disciplinary and co-ordinated package of services. STRC aims to reverse and/or slow 'functional decline' in older Australians and improve their wellbeing.

A care recipient cannot receive STRC if they are also receiving a package. Therefore, it is strongly recommended that providers check for active STRC episodes and discuss this criterion with potential HCP care recipients to ensure they are aware their STRC episode will immediately cease if they enter into a HCP agreement. It is expected that any transition from STRC to HCP will be discussed with the STRC provider before commencement of the home care package, and coordinated between the providers to ensure the care recipients' continuing care needs are met.

Care recipients may choose to end their STRC even if they have not yet met their physical and cognitive goals in order to enter the HCP Program. In this circumstance, the home care provider should ensure the care plan incorporates strategies to assist the care recipient to achieve these physical and cognitive goals.

16.4.8 Community Visitors Scheme

The Community Visitors Scheme (CVS) supports volunteers to make regular visits to older Australians who are socially isolated or are at risk of social isolation or loneliness. CVS provides friendship and companionship by matching individuals with volunteer visitors.

The CVS is available to recipients of Australian Government subsidised residential aged care services or home care.

Further information about the CVS, including frequently asked questions, can be found at this link, or by searching "Community Visitors Scheme" at www.health.gov.au.

Any eligible care recipient whose quality of life could be improved by the companionship of a regular community visitor can be referred to the CVS. A CVS State Network Member can assist to find a CVS service provider in your area. The CVS State Network Member contact list is available from the CVS webpage at this link, or by searching "CVS State and Territory network members" at www.health.gov.au.

As part of the Lesbian Gay Bisexual Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy, the CVS was expanded to include services that specifically cater for the needs of LGBTI people.

Home care recipients who are socially isolated and whose quality of life would be improved by friendship and companionship may access the CVS program without any impact on services received through their package.

16.4.9 Continence Aids Payment Scheme

HCP Program care recipients can receive funding support under the CAPS so long as the HCP does not include continence aids as part of their care plan. This is consistent with the eligibility requirements noted in the CAPS application form and guidelines.

The Continence Aids Payment Scheme (CAPS) is an Australian Government scheme that provides a payment to eligible people to assist with some of the costs of their continence products. Continence Aids Payment Scheme (CAPS) | Continence Foundation of Australia

Under a Home Care Package, the amount of care will vary from person to person, depending on factors such as the type of care and services being offered to the person, how and when those services are delivered, and whether some of the available budget is being used for specific items such as aids and equipment.

The care and services provided must be identified in the care plan, and must fit within the available budget for the package level. Continence is listed as an included item as per the Home Care Packages Provider Manual (refer to link below).

https://www.health.gov.au/resources/publications/home-care-packages-program-operational-manual-a-guide-for-home-care-providers

Alternatively, HCP Program care recipients are eligible to access the Continence Aids Payment Scheme, through Services Australia, as long as their care plan does not already include continence support.

A major resource of help for carers is the National Continence Helpline. The National Continence Helpline is staffed by professional continence nurse advisors who provide prompt and confidential advice and referral for people with incontinence, their families and carers, as well as health professionals and organisations with an interest in continence management. The Helpline can arrange for resources and publications and provide advice regarding continence products and suppliers.

The National Continence Helpline operates from 8am to 8pm, Monday to Friday on 1800 33 00 66.

If people feel that their circumstances have changed or they need more support, call My Aged Care to discuss if a review of their needs is appropriate to determine if more care and services are required. Please note that it is up to the independent ACAT to firstly accept the referral for a review, and if accepted, determine whether a change of priority or level or both (as applicable) is required.

16.4.10 DVA Programs

Older veterans or a war widow/widower may be able to get aged care services from the DVA and the Department at the same time, as long as the same services are not accessed for both.

For example, a care recipient may access low-level domestic assistance and personal care through the Veterans' Home Care Program, and receive social assistance and respite through the home care package.

16.4.11 Residential Respite Care

People receiving HCP Program services are able to access residential respite if they are assessed and approved as eligible by an ACAT. Respite is standard practice to give carers a break, and needs to be accounted for in care planning with care recipients. This is discussed further at Section 10 of this manual.

Care recipients can receive respite at the same time as a package, provided that they are not receiving the same services from both. For example, they may have a period of residential respite care but choose not to take leave from their package if they need gardening or other services about the home to keep it safe and secure. Leave is discussed at Section 11.

16.4.12 Palliative Care

Palliative care and HCP Program

Across the aged care and palliative care sectors, there is an expectation for home care workers to use a palliative approach to care.

The Palliative Approach

The palliative approach to care reflects a positive and open attitude towards dying and death, although it is important to note that 'palliative care' is not confined to the end stages of illness.

The use of a palliative approach to care by home care providers is reinforced in Standards 2 and 4 of the Aged Care Standards. Standard 2 details the need for service providers to undertake assessment and planning to address current needs. The use of the palliative approach by aged care workers enables assessment and planning of the palliative care needs of care recipients with life limiting illness (e.g. dementia, heart disease, cancer) as well as end-of-life planning. The assessment and planning done by the home care provider will identify and address the care recipient's current needs, goals and preferences, including advance care planning and end of life planning.

Standard 4 Services and supports for daily living connects very well to the services and supports included in the Home Care Package Program listed in Section 9.2 Home Care Manual.

It should be noted that many care recipients will be well managed by aged care workers and primary care providers such as General Practitioner and allied health providers and will not require specialist palliative care services (SPC). When a care recipient has complex or complicated symptoms which cannot be managed by aged care workers using a palliative approach, a referral to a specialist palliative care service is appropriate.

The skill mix and scope of practice of specialist palliative care team members is highly specialised and outside of the skill mix of the palliative approach provided by Home Care Providers. Overall, specialist palliative care services offer a consultancy service where the SPC Team member will review/assess the care recipient, liaise with primary care providers and HC provider and develop a palliative care plan for the care recipient. The responsibility for everyday care such as personal care, ongoing generalist nursing, support services, care management and clinical care remains with the HCP Provider. There is no duplication of services across Nursing with the involvement of SPC services as the services they provide are outside of the expectations of the palliative approach to care of home care providers.

<u>Specialist palliative care services</u>

While the Australian Government provides a national leadership, education and policy role in palliative care, it provides funding to state and territory governments for the delivery of specialist care services in their jurisdictions. This arrangement enables each state and territory government to make decisions about the provision and delivery of specialist palliative care services in their health systems, to meet the needs of their community. This forms part of their responsibilities through

hospital and community service provision. Information on specialist palliative care service providers can be found here: Find a palliative care service provider | Australian Government Department of Health and Aged Care

Resources for aged care workers

The Australian Government provides funding for education, experiential learning and resources in the Palliative Approach to Care. The ***Program of Experience in the Palliative Approach – PEPA***, pepaeducation.com is available to all aged care workers. The experiential and learning resources cover all levels of aged care workers (personal care workers, enrolled nurses, endorsed enrolled nurses and registered nurses). Aged care workers are expected to utilise a palliative approach to care when caring for older Australians across the three tiers of support for aged care. In 2020, PEPA released Learning guides for Care Workers as a learning resource on adopting a palliative approach to care. Learning & Placement Guides - PEPA (pepaeducation.com). An aged care worker who has a working knowledge of the palliative approach to care will be able to assess and plan for the palliative care and end-of-life needs of care recipients.

The ***End of Life Directions for Aged Care (ELDAC) Project***, End of Life Directions for Aged Care - ELDAC aims to improve the palliative care skills and advance care planning expertise of aged care providers and GPs providing health care for recipients of aged care services. ELDAC provides a range of resources to support aged care workers to deliver quality palliative care including toolkits, services to improve connections between aged, primary and specialist palliative care services and palliative care navigation services.

Also available to the aged care sector is **palliAGED**, a resource that provides palliative care evidence and practice information for those providing care and also for older Australians, their families and friends. PalliAGED is managed through the Flinders University CareSearch project. More information about palliAGED can be found here: palliAGED Home.

A comprehensive list of the palliative care funded programs and initiatives can be found here:

Palliative care initiatives and programs | Australian Government Department of Health and Aged Care

Guidelines for spiritual care in aged care can be found here:

National-Guidelines-for-Spiritual-Care-in-Aged-Care-DIGITAL.pdf (meaningfulageing.org.au)

16.4.13 National Dementia Support Program

The National Dementia Support Program (NDSP) provides education, resources, and counselling and support to people living with dementia and their families and carers to improve awareness and understanding about the disease.

The NDSP offers a website and national helpline, where professional counselling or group and individual support sessions can be scheduled. These resources can help care recipients, including people living with dementia and their families and carers, with support strategies to cope with dementia, and provide advice on what to expect once a diagnosis of dementia is received. The NDSP also offers education and training to family members and carers of people living with dementia to help them remain in their own homes for longer, where appropriate, and help ensure they are aware of the requirements of people living with dementia.

People living with dementia, their families and carers and health professionals can contact the National Dementia Helpline on **1800 100 500** (free call). People can also go to www.dementia.org.au to discuss any concerns or access information about memory loss or dementia.

16.4.14 National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) funds reasonable and necessary supports that are not provided from other formal and informal sources. Care recipients cannot receive the same care and services through NDIS support and the HCP Program at the same time. Providers can find more information on the NDIS at this link, or by searching "Provider toolkit" at www.nds.org.au.

The webpage at this link provides information that may be useful for providers who deliver home care to younger people who may also be eligible for the NDIS. You can also find the webpage by searching "providing aged care services to younger people" at www.health.gov.au.

16.4.15 Disability Support for Older Australians

DSOA provides support to older people with disability who are receiving state-administered specialist disability services at the time of implementation of the CoS Programme but are ineligible for the NDIS.

People receiving DSOA funding are eligible for aged care services, however, if they chose to accept a HCP or enter residential aged care they are required to exit the DSOA Program.

Section 6.3 of the DSOA program manual covers Aged care assessments:

- A DSOA client can initiate an ACAT to access supports not available under the DSOA Program (CHSP services such as social support, transport, home maintenance etc); or
- A DSOA client feels their needs can be met through either a HCP or residential aged care and accept that accessing these services will mean exiting the DSOA Program.

The DSOA service provider needs to make clear to aged care assessors if:
a) the client is being referred to access supports not available under the DSOA Program; or

b) the referral is because the client is expressing an interest in accessing aged care supports instead of the DSOA Program.

✓ Key points to remember

- Generally, care recipients cannot receive CHSP and HCP Program services at the same time. In limited circumstances they may be able to receive small amounts of top up CHSP at the same time as they receive HCP Program services.
- Care recipients can receive support from some other programs where needed. Some of these programs are listed at **Section 16.4**.
- The HCP Program cannot be received at the same time as STRC, transition care, or permanent residential aged care.

Appendix A: Pre-1 July 2014 arrangements

On 1 July 2014, the way home care fees are calculated changed. For people that received a package before 1 July 2014, these changes do not apply and they may continue to be asked to pay their current home care fees.

This manual has outlined the way the HCP Program currently operates, under the post-1 July 2014 arrangements. Care recipients who were in the program before 1 July 2014, however, are entitled to continue to receive home care on the basis of the pre-1 July 2014 arrangements.

If a person was receiving a package on or before 30 June 2014 and they move to a new home care service (and do not spend more than 28 days outside of care, other than on approved leave), they can opt into the fee arrangements that started on 1 July 2014.

To make this choice, they will need to complete and sign the **"Continuing Care Recipient opting into the New Aged Care Arrangements from 1 July 2014 (AC022)"** form and submit this form to the new provider before they transfer to the new service. Form AC022 is at this link or by searching "AC022" at www.servicesaustralia.gov.au. The new provider must submit this form with the ACER to Services Australia through the Services Australia Provider Portal. The new provider also needs to give the care recipient the *New Arrangements for Aged Care from 1 July 2014 – Home Care* publication available at this link or by searching for the form at www.health.gov.au.

If the care recipient does not complete this form and have it submitted to Services Australia before they transfer providers, they will automatically be classed as a 'continuing care recipient' and will remain on their pre-1 July 2014 fee arrangements. This is not a reviewable decision and must be done correctly in order to opt into the post-1 July 2014 fee arrangements.

This section outlines how the package budget and leave work for pre-1 July 2014 care recipients, and provides a checklist of components that must be included in a Home Care Agreement with a pre-1 July 2014 care recipient. Unless indicated in this appendix, the HCP Program operates in the same manner for people receiving a home care package, regardless of when they entered the HCP Program.

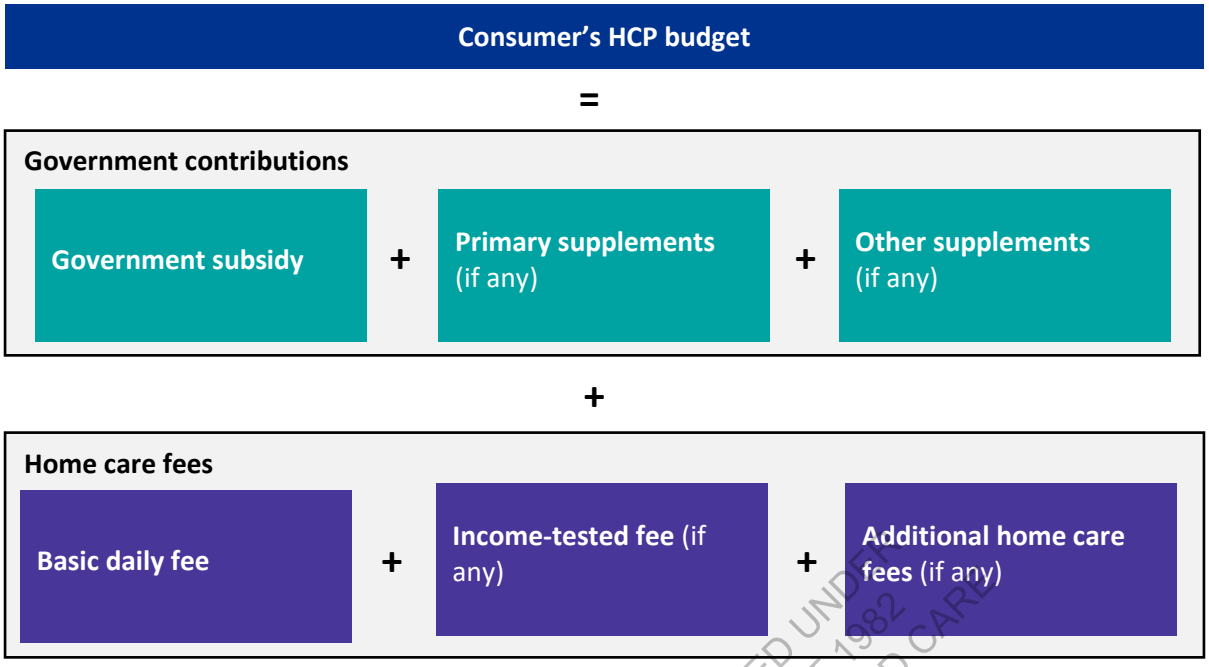
✓ **Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section**
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Section 56-2 of the *Aged Care Act 1997*
- Sections 60-1 and 60-2 of the *Aged Care (Transitional Provisions) Act 1997*
- *Aged Care (Transitional Provisions) Principles 2014*
- *User Rights Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations pursuant to them.

See **Appendix E** for further detail on specific provider responsibilities.

What makes up the package budget for care recipients in the pre-1 July 2014 arrangements?



How do I work out the Government contribution for pre-1 July 2014 care recipients?

The Government contribution can be determined by adding together the Government subsidy, plus any primary and other supplements for which the care recipient is eligible. This is outlined in the diagram at Section 0 of this Appendix.

In home care, prior to 1 July 2014, there was no reduction in subsidy and primary supplements paid by Government if the provider did not charge the income tested fee. If collected, any fee would be additional to the value of the package. In setting these fees, providers need to consider if they would cause the care recipient financial hardship and reduce the level of fees as necessary.

The same subsidy and supplement rates will apply for people receiving a home care package, regardless of when they entered the HCP Program.

Pre-1 August 2013 care recipients who were receiving an Extended Aged Care at Home – Dementia (EACH-D) package are eligible for the dementia and cognition supplement plus the top up supplement. This supplement is automatically applied by Services Australia, and will automatically transfer to the new provider if the individual changes providers.

How do I work out the home care fees for pre-1 July 2014 care recipients?

Providers are responsible for working out the home care fees that they will charge to care recipients in the pre-1 July 2014 arrangements. The Services Australia income assessment that people who entered the HCP Program after 1 July 2014 complete does not consider the pre-1 July 2014 fee structure.

Basic daily fee

- Level 1 - the maximum fee 15.68 per cent of the basic rate of the single age pension.
- Level 2 - the maximum fee 16.58 per cent of the basic rate of the single age pension.
- Level 3 - the maximum fee 17.05 per cent of the basic rate of the single age pension.
- Level 4 - the maximum fee 17.50 per cent of the basic rate of the single age pension.

Income tested fee

For care recipients with income above the basic rate of pension, providers can charge an additional amount of up to 50 per cent of income above the single Age Pension.

Calculating income

Income is defined as income after income tax and the Medicare levy. When calculating income for the purpose of determining ongoing fees, the following are excluded:

- any Pharmaceutical Allowance, Rent Assistance or Telephone Allowance;
- the Pension Supplement;
- the Clean Energy Supplement; and
- in the case of a Disability Pension payable under the *Veterans' Entitlements Act 1986* an amount equal to four per cent of the amount of the pension.

Please see Division 60 of the *Aged Care (Transitional Provisions) Act 1997* or section 130 of the *Aged Care (Transitional Provisions) Principles 2014* for more information.

Financial hardship

Home care recipients who began a home care package before 1 July 2014 are not eligible for the hardship supplement. Rather, these home care recipients are able to negotiate lower fees with their provider. The Aged Care (Transitional Provisions) Act 1997 allow providers to consider care recipients' other expenses such as high pharmaceutical bills, utilities and other living expenses when setting fees.

Review of fees

A review of fees should be conducted periodically (or whenever the care recipient requests a review). The care recipient should be encouraged to seek a review if their financial circumstances change.

The maximum fees may need to be varied when new rates for the Age Pension are announced each March and September. Providers may need to discuss the impact of these changes on fees with the care recipient and update their budget accordingly.

How does leave work for a care recipient in the pre-1 July 2014 arrangements?

Care recipients in the pre-1 July 2014 arrangements are entitled to take leave in the same circumstances as care recipients in the post-1 July 2014 arrangements, although the home care fees that will be payable differ. The table below outlines when home care fees will be payable:

Leave type	Home care fees
Hospital	Yes
Transition care	No
Residential respite care	No
Other leave	Yes

What do I need to include in a Home Care Agreement for a care recipient in the pre-1 July 2014 arrangements?

In addition to the components of a Home Care Agreement outlined at **Section 6.5** of this manual, a pre-1 July 2014 care recipient's Home Care Agreement will need to include the following:

- ☐ A statement that the provider may charge the care recipient home care fees in accordance with Division 6 of the *Aged Care (Transitional Provisions) Act 1997*

- ☐ A statement setting out which fee (if any), as determined in accordance with section 130 of the *Aged Care (Transitional Provisions) Principles 2014*, the provider will charge
- ☐ If the provider is charging the care recipient a daily amount of home care fees in accordance with Division 60 of the *Aged Care (Transitional Provisions) Act 1997* that is different from the daily amount of home care fees mentioned in their Schedule, the different amount and the reason for the different amount.

✓ Key points to remember

- Care recipients who entered the HCP Program before 1 July 2014, and who have not moved to the post-1 July 2014 arrangements, have different home care fee arrangements.
- Providers are responsible for calculating home care fees for pre-1 July 2014 care recipients.
- Providers will also need to ensure any Home Care Agreement entered into with a pre-1 July 2014 care recipient reflects the provisions that apply to them.

Appendix B: 1 July 2019 changes to pricing

Pricing requirements were introduced on 1 July 2019 to improve transparency for older Australians. These requirements enable direct comparisons between home care providers, and are intended to curb problematic charging practices by some providers.

Key legislation, instruments and determinations underpinning this section
Note, this section is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Section 56-2 of the *Aged Care Act 1997*
- *User Rights Principles 2014*.

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with their obligations pursuant to them.

See **Appendix E** for further detail on specific provider responsibilities.

What is the pricing Schedule and what do providers need to do with it?

All home care providers are required to publish their pricing information in a new standardised pricing comparability Schedule (the Schedule) on the My Aged Care Service Finder. The Schedule has been designed to:

- encourage older Australians to consider other factors in addition to the price of the service when choosing an approved provider
- provide clear and unambiguous pricing information on the common home care package services
- achieve price comparability across common home care package services
- limit any impact on the ability of providers to innovate by catering for different business models
- ensure equity in the requirements across providers and allowing dedicated areas to promote their value statement and point of difference.

The Schedule includes five common home care services:

- personal care
- nursing
- cleaning and household tasks
- light gardening
- in-home respite.

Providers will also be able to indicate if they charge a per kilometre cost for a care worker to travel to the care recipient's location.

Providers will need to explain their approach to any separate cost, for example, if it is charged separately or included in the service price.

Providers should explain their approach to charging for third-party services.

Within the Schedule, providers will need to nominate a single price (the most common) for each common home care service within the Schedule. Where providers offer genuine care recipient choice of different prices for a service, they will also be able to enter the minimum and maximum price points.

Providers will be able to complete a different pricing Schedule where required, for example to account for regional variability in pricing.

Providers must review, and if required, update their pricing Schedule on My Aged Care annually. This will ensure accurate pricing information is published. Current pricing information must also be included within each individual Home Care Agreement. As discussed at Section 15 providers are required to complete one of the following, to show that they have reviewed their Schedule:

- Report to the Department that they have done so. Providers can do this by entering 'Confirm review of pricing information' in the My Aged Care Provider Portal.
- Update their price list. This will cause the 'last updated date' to update in the Department's systems, and will be sufficient evidence that the provider has reviewed their price list.

Relationship between published and contracted price

The price published in the Schedule will be the default price charged.

A copy of the Schedule must be included within a care recipient's Home Care Agreement. This ensures the published price is a meaningful and accurate indication of the costs charged under a home care package.

There are situations where the contracted price will need to differ from the published price. For example, where the care recipient has a particular request. In these instances, the home care provider will need to negotiate and agree a price with their care recipient. This difference in price and accompanying reason will need to be clearly outlined within the Home Care Agreement and package budget. It is expected this would be an exception. In most instances, the price published will be the price charged.

Obligations through transition

For care recipients already in the program at 1 July 2019, providers have until 1 July 2020 to:

- review their Home Care Agreement and include a copy of the pricing schedule
- charge them the prices in that schedule, unless otherwise agreed — any different prices and the reason must be included in their Home Care Agreement
- roll any separate business-related administration costs they are retaining into service prices
- make sure any administration costs are reasonable.

Compliance

These pricing changes apply to all home care providers. This is to ensure consistency across the sector and allow all older Australians to benefit.

Providers' compliance with these requirements is actively monitored. Compliance action may be taken, consistent with the compliance policy and procedures, as discussed throughout this manual.

How do the pricing changes affect care management?

Care management, often called case management or care coordination, is a mandatory component of every home care package. The introduction of the Schedule provides an opportunity to better define care management, and educate older Australians.

Providers need to indicate the cost for care management services and outline their approach to care management in the Schedule.

Care management should ensure there is no overlap, over-servicing or mismanagement of services. These services may be provided in different ways including face-to-face or via phone or email.

How do the pricing changes affect the way administration costs can be charged?

There are different components to administration costs; package management costs, and other administration costs. Providers are able to include their fortnightly package management costs across each home care package level in the Schedule.

Package management is the ongoing organisational activities associated with ensuring the smooth delivery and management of a home care package. It may include the costs for preparing monthly statements; managing package funds; and compliance and quality assurance activities required for home care.

It does not include costs that are unrelated to supporting a care recipient's care or costs associated with running any business, such as marketing, office rent, insurance, or activities completed before a person enters into a Home Care Agreement.

Any other administrative costs that need to be recouped from a home care package, apart from package management, will need to be included in the unit price for specific care services. This will ensure people can see the all-inclusive cost of delivering the service. Providers cannot charge more than a reasonable amount for any administration-related costs.

For more information on the 1 July 2019 changes to pricing please see this link or search "Price transparency for Home Care Packages" at www.health.gov.au.

Appendix C: 1 January 2023 changes to pricing

The Australian Government is reducing excessive administration and management charges in the HCP Program. This ensures that more funds are available to meet the needs of care recipients. A number of changes came into effect on 1 January 2023.

Charging for care and package management

Providers must not charge more than the amount specified in the User Rights Principles 2014 for care and package management per day. The table below shows maximum daily prices for care management and package management. These will increase in line with basic subsidy increases.

Item	HCP Level 1:	Care management	Package management
1	Level 1	$5.03	$3.77
2	Level 2	$8.85	$6.64
3	Level 3	$19.25	$14.44
4	Level 4	$29.19	$21.89

The caps set the maximum amount a provider can charge. They are not the target price for these services or an indicator of what is considered a 'reasonable' price.

Providers can continue to charge for care and package management at a fortnightly or monthly rate and do not have to pro rata the price if the care recipient ceases their home care part way through a period.

Providers cannot charge for package management in a calendar month where no services (other than care management) are delivered, except for the first month of care.

Additionally, to support providers in setting their prices, the Government is clarifying that care management is a mandatory support service.

Charging for third-party services and exit amounts

Providers cannot charge separately for third-party services (prices must be all-inclusive).

Providers cannot charge exit amounts.

Pricing for all services

Prices for all care and services must be reasonable and justifiable. This means they must be value for money and consider the effort and resources it takes to coordinate them.

The Government will closely monitor provider behaviour following implementation of this measure, including identifying any providers:

- appearing to be systematically raising prices to meet the caps
- unreasonably shifting costs to other billing areas.

For further information on how providers set, publish and charge for care and services see: Pricing for Home Care Packages or go to www.health.gov.au and search "Pricing for Home Care Packages".

Appendix D: Compensation payments

If a person receives a compensation entitlement under a judgment, a settlement, or a reimbursement arrangement, their home care package budget is amended slightly to account for this. A compensation entitlement includes things like a permanent impairment or incapacity payment to a veteran, a workplace insurance claim settlement, a motor vehicle accident claim settlement, or some types of common law settlements (such as, potentially, an award for personal injury caused by negligence).

The provider is responsible for asking the care recipient if they have a compensation entitlement and, if so, notifying the Department of that entitlement. Providers can notify the Department when they complete the form to notify a new care recipient starting in their care, discussed at Section 6, or at any other time by completing an ACER. An ACER can be completed using paper **"Aged care entry record form AC021"** at this link or by searching "AC021" at www.servicesaustralia.gov.au.

If a claim has not been settled, subsidies will continue to be paid on the care recipient's behalf up until the date liability has been accepted. Once the compensation insurer has agreed to pay or to contribute to the care costs, payment of subsidies will cease with the date of effect from the date of liability or settlement. Providers should notify the Department as soon as they become aware of a care recipient's compensations claims.

If a provider does not advise the Department that a care recipient is entitled to compensation and the Department later becomes aware of this, the Department will need to recover funds in arrears.

Package budget with compensation entitlement

If a provider has entered into a Home Care Agreement with a care recipient who has a compensation entitlement, and they have notified the Department, the Department will advise both parties of the amount of the compensation reduction amount. The provider will then be able to invoice the care recipient for the total amount of the compensation payment reduction and home care fees (if applicable). The amount is deducted from the Government's contribution and added to the care recipient's contribution.

Below is an example of a budget, including a compensation entitlement:

How do we calculate Sonali's package budget?

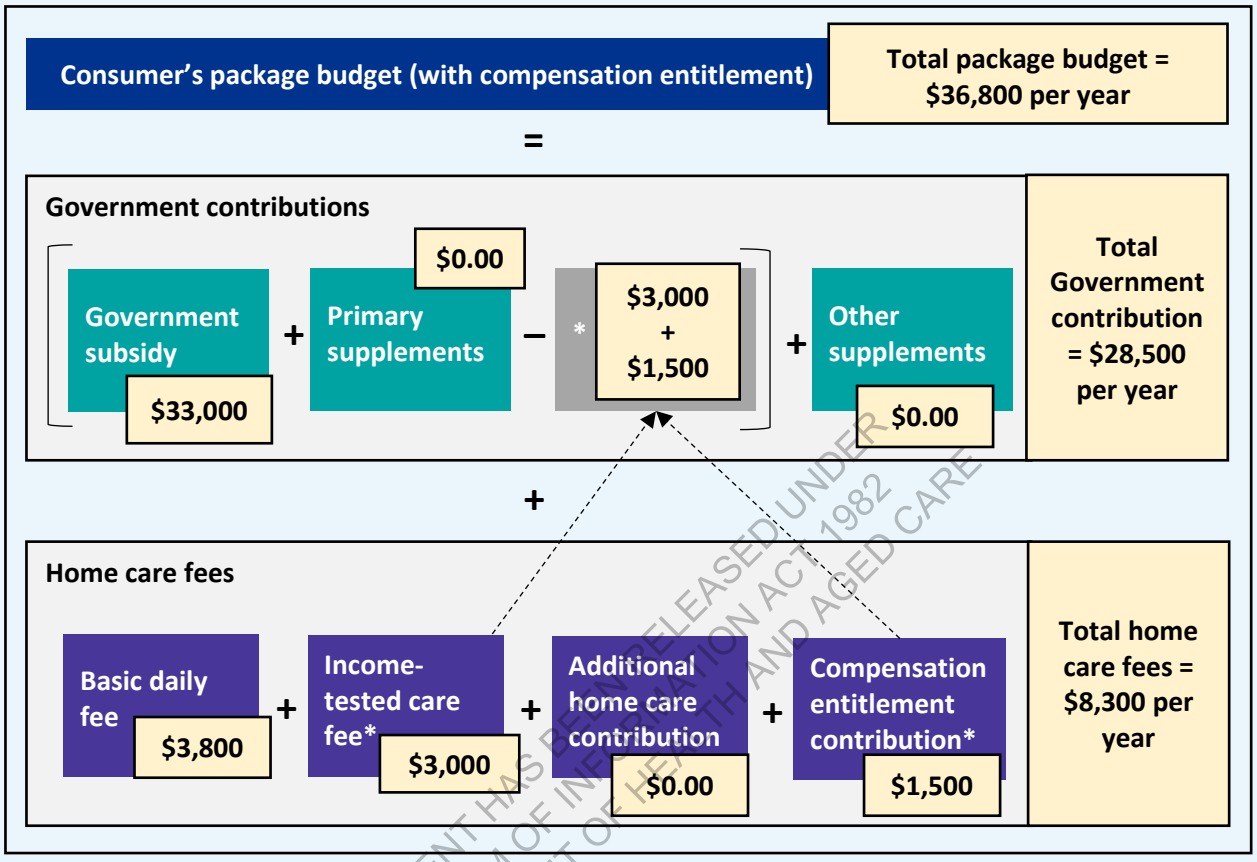
Fact scenario

- Sonali has been assigned a Level 3 package. The value of her package is approximately $33,000 per year.
- Sonali is not eligible for any primary or other supplements.
- The basic daily fee for Sonali's package level is $3,800 per year.
- Sonali has completed her income assessment, and has been assessed by Services Australia as being able to pay an additional $3,000 per year in income tested care fees.
- Sonali received a workplace injury settlement. Her provider notified Services Australia of the value of the settlement, and Sonali was told she would need to contribute an additional $1,500 per year in compensable entitlement contributions.
- Sonali did not agree to pay any additional fees in her Home Care Agreement.

How do we calculate Sonali's package budget?

Calculation of package budget

The diagram below outlines how Sonali's home care budget is calculated:



Appendix E: Responsibilities of approved providers

Approved providers must deliver aged care that aligns with the responsibilities and standards that are specified in the *Aged Care Act 1997* (the Act) and associated legislation. This information is designed to assist approved providers to meet their obligations as providers of aged care.

Quality of care – Part 4.1 in the *Aged Care Act 1997*

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Quality of care	Approved providers must comply with the Aged Care Quality Standards.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 3
Quality of care	Providers must maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 4
Care and services	An approved provider of a home care service must provide a package of care and services that includes: (a) care management; and (b) at least one other service that is specified in Part 1 of Schedule 3 of the Quality of Care Principles (or is agreed per subsection 13(2) of the Quality of Principles 2014). Extracted at section 9.2 of this manual.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 9
Care and services	Part 2 of Schedule 3 of the Quality of Care Principles specify excluded items that must not be included in the package of care and services provided under section 13 of the Quality of Care Principles. Extracted at section 9.3 of this manual.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 9
Care and services	Care and services provided to the care recipient must be consistent with the care recipient's care plan.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 7

Rights of care recipients – Part 4.2 in the *Aged Care Act 1997*

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Budgets, fees and pricing	An approved provider of home care must not charge for the care recipient's entry to the service through which the care is, or is to be, provided.	Section 56-2(a) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 6
Budgets, fees and pricing	If the care recipient is a post-1 July 2014 care recipient, providers must not charge more than the maximum daily amount. The maximum daily amount depends on the care recipient and will need to be worked out using the home care fee calculator. The home care fee calculator is at section 52D-2 of the *Aged Care Act 1997.*	Sections 52D-1, 52D-2 and 56-2(b) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Budgets, fees and pricing	If a care recipient who is a post-1 July 2014 care recipient leaves the HCP Program, any fees paid in advance in respect of a period occurring after the care recipient's death, or the cessation of home care, must be refunded to the care recipient.	Sections 52D-1 and 56-2(b) of the *Aged Care Act 1997*	*Fees and Payments Principles 2014 (No.2)* *User Rights Principles 2014*	Section 14
Budgets, fees and pricing	If the care recipient is a pre-1 July 2014 care recipient, providers must charge no more for provision of the care and services then the amount permitted by the *Aged Care (Transitional Provisions) Principles.* This is outlined in Appendix A Section 3 of this manual.	Section 56-2(c) of the *Aged Care Act 1997* Sections 60-1(a) and 60-2 of the *Aged Care (Transitional Provisions) Act 1997*	*Aged Care (Transitional Provisions) Principles 2014* *User Rights Principles 2014*	Appendix A
Budgets, fees and pricing	Care recipients must not be required to pay home care fees more than one month in advance.	Section 52D-1 of the *Aged Care Act 1997* Section 60-1(b) of the *Aged Care (Transitional*	*User Rights Principles 2014*	Appendix A

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
		Provisions) Act 1997		
Budgets, fees and pricing	Providers must not charge home care fees for any period prior to the time the care recipient was being provided with home care.	Sections 56-2(b), 56-2(c) and 52D-1 of the *Aged Care Act 1997* Section 60-1(c) of the *Aged Care (Transitional Provisions) Act 1997*	*User Rights Principles 2014*	Appendix A
Fees and payments	If a care recipient who is a pre-1 July 2014 care recipient leaves the HCP Program, any fees paid in advance in respect of a period occurring after the care recipient's death, or the cessation of home care, must be refunded as soon as practicable to the care recipient or a person authorised to receive the refund for the care recipient's estate.	Section 60-1(d) of the *Aged Care (Transitional Provisions) Act 1997*	*Aged Care (Transitional Provisions) Principles 2014*	Appendix A
Agreements with care recipients	Providers must provide such other care and services as agreed in the Home Care Agreement between the approved provider and the care recipient.	Section 56-2(e) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Fees and payments	Providers must charge no more for any other care or services than an amount agreed beforehand with the care recipient.	Section 56-2(d) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Budgets, fees and pricing	Providers must give the care recipient an itemised account of any other care or services.	Section 56-2(d) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Stability of approved provider	Providers must provide security of tenure to care recipients. The approved provider may cease to provide home care to the care recipient only if:	Section 56-2(f) and 63-1AA of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	• the care recipient cannot be cared for in the community with the resources available to the approved provider; or • the care recipient notifies the approved provider, in writing, that they wish to move to a location where home care is not provided by the provider; or • the care recipient notifies the approved provider, in writing, that they no longer wishes to receive the home care; or • the care recipient's condition changes to the extent that the care recipient no longer needs home care, or the care recipient's needs, as assessed by an aged care assessment team, can be more appropriately met by other types of services or care; or • the care recipient: has not paid to the approved provider, for a reason within the care recipient's control, any home care fee specified in the home care agreement between the care recipient and the approved provider; and has not negotiated an alternative arrangement with the approved provider for payment of the home care fee; or • the care recipient has: intentionally caused serious injury to or infringed the right of a staff member (to work in a safe environment) of the approved provider.			
Agreements with care recipients	Providers must offer to enter into a Home Care Agreement with the care recipient, and, if the care recipient wishes, to enter into such an agreement.	Section 56-2(g) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 6
Agreements with care recipients	The Home Care Agreement must include specified provisions. These are extracted at Section 6 of this manual.	Section 61-1 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 6

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Monitoring, compliance and other access	Providers must allow people acting for bodies that have been paid advocacy grants under Part 5.5 to have access to each home care service through which they provide home care.	Section 56-2(j) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 12
Rights of care recipients	Providers must not act in a way which is inconsistent with the legal and consumer rights of a care recipient.	Sections 54-1(1)(d) and 56-2(k) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 3 and 6
Rights of care recipients	Providers must give a prospective care recipient a copy of the Charter of Aged Care Rights ('the Charter'). The copy of the Charter that is provided must: • be signed by a staff member of the provider; • include the signature of the care recipient or their authorised person if they have signed it; • include the date on which the care recipient or their authorised person was given reasonable opportunity to sign the Charter, if they have not signed it, • set out the full name of the care recipient, • set out the full name of an authorised person who was present at the time the copy of the Charter was given to the care recipient, if relevant, and • set out the date on which the copy of the Charter was given to the care recipient. This must be done before the care recipient enters into a home care agreement with the provider the provider's home care service, or by 1 December 2019 for care recipients who were already receiving home care services from the provider on 1 July 2019.	Sections 56-2(k) and 56-2(l) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Rights of care recipients	Providers must give a prospective care recipient information about their rights and responsibilities (including in relation to the payment of home care fees), and the rights and responsibilities of their provider. This must be done before the care recipient enters into a home care agreement with the provider.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3
Rights of care recipients	Providers must assist prospective care recipients to understand information provided to them, including the Charter of Aged Care Rights.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3
Rights of care recipients	Providers must ensure that the care recipient, or an authorised person of the care recipient, has been given reasonable opportunity to sign a copy of the Charter of Aged Care Rights (after it has been provided to them).	Section 56-2of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3
Rights of care recipients	Providers must take reasonable steps to prevent the provider, or a person employed or otherwise engaged by the provider, from causing damage to a care recipient's home and other property in the course of providing the home care.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	-
Rights of care recipients	Providers must provide such information as is reasonably necessary to assist a care recipient to choose the care and services that best meet his or her goals and assessed needs and preferences, within the limits of the resources available.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 8
Care and services	Providers must give care recipients a written plan of the care and services that they will receive before the care recipient receives home care or within 14 days of the date on which they commence receiving home care.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 8
Budgets, fees and pricing	Providers must give care recipients invoices that are clear and in a format that is understandable.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Budgets, fees and pricing	Providers must periodically review the home care fees that each care recipient is liable to pay, including if requested to do so by a care recipient on the grounds that the care recipient's financial circumstances have changed.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Budgets, fees and pricing	Providers must provide notice of their pricing Schedule to the Secretary before offering to enter into a Home Care Agreement with a care recipient.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B
Budgets, fees and pricing	Providers must review their pricing Schedule and price list at least every 12 months, and: • if there is to be a change, provide the Secretary with an updated notice, or • if there is not to be a change, provide the Secretary with a written notice that they have reviewed the information.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B
Care recipients changing providers/ leaving	If a pre-1 July 2014 care recipient intends to move to another home care service, the provider that is to provide the new service must give the care recipient written notice of the following: • If the care recipient moves to the new service within 28 days of leaving the old service, they may make a written choice to be covered by the post-1 July 2014 arrangements in relation to the new service. That choice cannot be made after they have already moved to the new service. If they do not make a choice before entering the new service they will be covered by the pre-1 July 2014 arrangements. • If the care recipient moves to the new service 28 days or more after leaving the old service, they will automatically be covered by	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix A

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	the post-1 July 2014 arrangements. • If the care recipient is covered by the post-1 July 2014 arrangements that may result in a change to their fees payable. • If the care recipient moves from the pre-1 July 2014 arrangements to the post-1 July 2014 arrangements, they cannot make a choice to return to the pre-1 July 2014 arrangements.			
Care recipients changing providers/ leaving	If a pre-1 July 2014 care recipient intends to move to another home care service, the provider that is to provide the new service must give the care recipient a copy of the document titled 'New Arrangements for Aged Care – for 1 July 2014', published by the Department, as it exists on 1 July 2014.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix A
Budgets, fees and pricing	Providers must give every care recipient to whom they provide, or are to provide, home care, a written individualised budget which sets out a budget for the care and services detailed in the care recipient's care plan. The budget must be provided as soon as practicable after the provider has all the necessary information to complete it. The budget must state the amount of home care subsidy payable to the provider for the care recipient in respect of the period agreed between the care recipient and provider, and the maximum amount of home care fees payable by the care recipient in respect of that period.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Budgets, fees and pricing	Providers must prepare a care recipient's individualised budget: • in partnership with the care recipient, and • considering the care recipient's goals, assessed needs, preferences, resources available,	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	and the services selected by the care recipient.			
Budgets, fees and pricing	Providers must review and, if necessary, revise the individualised budget of the care recipient if: • a change to the care and services to be provided through the home care service is proposed, or • the costs or providing the care and services change, or • the care recipient requests the provider to do so. If the care recipient requests the review, the review must be completed within 14 days of the request.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10
Budgets, fees and pricing	If the provider reviews the individualised budget they must give the care recipient a copy of the revised individualised budget and help them to understand it.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10
Budgets, fees and pricing	Providers must give all care recipients a written monthly statement of the available funds and the expenditure in respect of the home care provided to the care recipient during the month. The statement must be provided as soon as practicable after the provider has all the necessary information to complete it. The monthly statement must specify: • the amount of home care subsidy paid or payable to the provider for the care recipient in respect of the month; • the total amount of home care fees paid or payable by the care recipient in respect of the month; • the total amount paid or payable by the provider in respect of the home care provided to the care recipient during the month; • an itemised list of the care and services provided to the care recipient during the month and the total amount paid or payable	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	in relation to each kind of care or service; • the total amount (if any) of the funds received or to be received in respect of any previous month for the provision of home care to the care recipient that have not been spent; • if, during the month, the transfer portion of the care recipient's unspent home care amount was received by the approved provider—the amount that was received.			
Budgets, fees and pricing	Providers must help care recipients to understand their monthly statements.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10
Care recipients changing providers/ leaving	Provider must give notice to care recipients or, if the care recipient has passed away, their legal personal representative, of care recipients ceasing to receive care from their service within 56 days of the cessation day. The notice must specify: • the cessation day, • the care recipient's total unspent home care amount and amounts broken into the Commonwealth portion, the care recipient portion and the transfer portion, • the exit amount deducted (if relevant/prior to January 2023), • the unpaid home care fee amount deducted (if relevant). The notice must also explain how unspent funds will be transferred.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 14
Care recipients changing providers/ leaving	Providers must pay the care recipient and transfer portion of unspent funds as specified in the User Rights Principles. The relevant tables have been extracted at Sections 13 and 14 of this manual.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 13 and 14

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Care recipients changing providers/ leaving	Providers who are making payment of a transfer amount to a care recipient's new provider must give the new provider the notice issued to the care recipient on their cessation at the time they pay the transfer portion to the new provider.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 13
Care recipients changing providers/ leaving	Providers must give written notice to the Secretary, in an approved form, within 70 days after a care recipient's cessation day that specifies if there is a Commonwealth portion of the care recipient's unspent home care amount, or if the Commonwealth portion of the care recipient's unspent home care amount is nil.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 13 and 14
Care recipients changing providers/ leaving	Providers must not deduct an exit amount for a care recipient leaving their care from a care recipient's unspent funds after 1 January 2023, unless the care recipient leaves before 1 January 2023 and the exit amount was agreed in the Home Care Agreement, and the provider's standard exit amount was notified to the Secretary in the pricing Schedule before that Home Care Agreement was executed.	Section 56-2(aa) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 13 and 14
Budgets, fees and pricing	Providers must not charge care recipients separately for costs (however described) that are business costs or costs of providing care or services through a subcontracting arrangement.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B and Appendix C
Budgets, fees and pricing	Providers must not charge care recipients more than a reasonable amount for care or services; and travel, sub-contracting arrangements and package management.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B
Budgets, fees and pricing	Providers must not charge care recipients more than a reasonable amount for business costs and costs of providing care or services through a subcontracting arrangement.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B and Appendix C

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Budgets, fees and pricing	Providers must charge care recipients the fees and/or prices listed in their pricing Schedule (as it applies on the relevant day the service was provided) unless the Home Care Agreement specifies a different fee and/or price and the reason for the different amount.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B
Budgets, fees and pricing	An approved provider of home care must not charge more for a home care service than is specified in the User Rights Principles 2014.	Section 56-2(ab) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix C
Rights of care recipients	Provider must establish a complaints resolution mechanism for their aged care service.	Section 56-4(1) of the *Aged Care Act 1997*	-	Section 10
Rights of care recipients	Providers must use their complaints resolution mechanism to address any complaints made by or on behalf of a care recipient to whom care is provided through the service. The complaints resolution mechanism must be the complaints resolution mechanism provided for in the Home Care Agreement entered into between the provider and the care recipient.	Section 56-4(1) of the *Aged Care Act 1997*	-	Section 10
Rights of care recipients	Providers must advise a complainant of any other mechanisms that are available to address complaints, and provide such assistance as the care recipient requires to use those mechanisms.	Section 56-4(1) of the *Aged Care Act 1997*	-	Section 10
Rights of care recipients	Providers must comply with any requirement made of the provider in relation to a direction made by the Aged Care Quality and Safety Commissioner.	Section 56-4(1) of the *Aged Care Act 1997* Section 21(2) of the *Aged Care Quality and Safety Commission Act*	*Aged Care Quality and Safety Commission Rules 2018*	Section 3

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Information and record keeping	Personal information must not be used other than: • for a purpose connected with the provision of aged care to the person by the approved provider; or • for a purpose for which the personal information was given by or on behalf of the person to the approved provider.	Sections 56-2(h) and 62-1 of the *Aged Care Act 1997*	-	-
Information and record keeping	Except with the written consent of the person, personal information must not be disclosed to any other person other than: • for a purpose connected with the provision of aged care to the care recipient by the approved provider; or • for a purpose connected with the provision of aged care to the care recipient by another approved provider; or • for a purpose for which the personal information was given by or on behalf of the care recipient; or • for the purpose of complying with an obligation under the *Aged Care Act 1997*, the *Aged Care (Transitional Provisions) Act 1997* or any of the principles.	Section 56-2(h) and 62-1(b) of the *Aged Care Act 1997*	-	-
Information and record keeping	Personal information must be protected with security safeguards that it is reasonable in the circumstances to take against the loss or misuse of the information.	Section 61-1(c) of the *Aged Care Act 1997*	-	-

Accountability – Part 4.3 in the *Aged Care Act 1997*

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Record keeping	Providers must keep the following kinds of records about care recipients:	Sections 63-1(1)(a) and 87-2 of	*Records Principles 2014*	-

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	• assessments of care recipients; • individual care plans; • medical records, progress notes and other clinical records; • schedules of fees and charges; • Home Care Agreements; • accounts of care recipients; • records relating to care recipients' entry, discharge and leave arrangements, including death certificates where appropriate; • records relating to a determination that a care recipient is a care recipient with financial hardship; • in relation to a continuing home care recipient of care to whom the approved provider starts to provide home care through a home care service on or after 1 July 2014—a record of whether the care recipient made a written choice regarding whether they would be covered by the pre or post-1 July 2014 arrangements; • up-to-date records of: the name and contact details of at least one representative of each care recipient; and the name and contact details of any other representative of a care recipient; • copies of unspent funds notices; • records relating to the payment of the care recipient portion or transfer portion of care recipients' unspent home care amounts; • copies of notices of published exit amounts; • records required by the National Aged Care Mandatory Quality Indicator Program Manual to be kept.	the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	*User Rights Principles 2014*	

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Record keeping	Providers must keep all required records for care recipients for three years after the 30 June of the year in which they ceased to provide care to the care recipient.	Section 63-1(2) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	*Records Principles 2014*	-
Record keeping	Providers must keep records relating to each copy of the Charter of Aged Care Rights given a care recipient. **Note:** this requirement does not apply if the care recipient does not enter the provider's home care service.	Sections 63-1(1)(a) and 87-2 of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	*Records Principles 2014*	-
Record keeping	Providers must keep records that enable them to demonstrate that: • they have police certificates for all staff members or volunteers that are not more than three years old; • for any period where a staff member or volunteer was without a police certification, an application for a police certificate had been made, and • any statutory declaration required to be made by a staff member or volunteer has been made. Police certificates must be kept in compliance with the *Privacy Act 1988*.	Sections 63-1(1)(a) and 87-2 of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	*Records Principles 2014*	-
Record keeping	Providers must keep records (in written or electronic form) that enable claims for payments of subsidy to be properly verified. These records must be kept for	Section 63-1 of the *Aged Care Act 1997* and Part 7B of	-	-

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	three years after 30 June of the year in which the record was made.	the *Aged Care Quality and Safety Commission Act 2018*		
Record keeping	Providers must keep records (in written or electronic form) that enable proper assessments to be made of whether the approved provider had complied, or is complying, with its responsibilities. These records must be kept for three years after the 30 June of the year in which the record was made.	Section 63-1(1) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	-	-
Monitoring, compliance and other access	Providers must co-operate with any person who is exercising powers under Part 6.4 in relation to the service and comply with Part 6.4 in relation to the person's exercise of those powers. Part 6.4 of the *Aged Care Act 1997* makes provisions for authorised officers to exercise monitoring and questioning powers. The following obligations arise in relation to exercise of those powers: • a person at any premises entered into under a warrant must provide reasonable assistance to an authorised officer; • a person whom the Secretary has requested to give evidence pursuant to section 93-1 must attend at a time and place specified in the notice, take any oath or affirmation requirement, and answer any questions put by an officer or produce any documents (or copies or documents) as are referred to in the notice. (They may refuse any requests that lead to self-incrimination, or do	Sections 63-1(1)(b) and 90-1 to 94-2 of the *Aged Care Act 1997*	-	-

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	not relate to: a) the affairs of a corporation that is/has been an approved provider or b) the payment of a subsidy).			
Monitoring, compliance and other access	Providers must co-operate with any person who is exercising powers under Part 8 of the *Aged Care Quality and Safety Commission Act 2018* in relation to the services. Part 8 of the *Aged Care Quality and Safety Commission Act 2018* currently enables authorised officers and regulatory officials to enter and search premises.	Section 63-1(1)(ba) of the *Aged Care Act 1997* Part 8 of the *Aged Care Quality and Safety Commission Act 2018*	-	-
Reporting and disclosure	Providers must notify the Secretary of the name and address of the service in relation to each home care service, in the form approved by the Secretary, before providing home care through the service.	Sections 9-1A and 63-1(1)(c) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	-	Sections 5 and 15
Reporting and disclosure	Providers must notify the Secretary of any changes to the name and address of the service within 28 days of the change.	Sections 9-1A and 63-1(1)(c) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	-	Section 15
Reporting and disclosure	Providers must notify the Aged Care Quality and Safety Commissioner (the Commissioner) of any change of circumstances that materially affects the approved provider's suitability to be a provider of aged care within	Sections 9-1 and 63-1(1)(c) of the *Aged Care Act 1997* and Part 7B of	-	Section 15

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	28 days of the change. Commonwealth for providing that aged care. If that change in circumstances relates, wholly or partly, to key personnel becoming a disqualified individual, the approved provider must notify the Secretary of the reason why they are, or are about to become, a disqualified individual.	the *Aged Care Quality and Safety Commission Act 2018*		
Reporting and disclosure	Providers must respond to a written request from the Commissioner for information relating to: • the provider's suitability to be a provider of aged care, • payments made under the *Aged Care Act 1997* or *Aged Care (Transitional Provisions) Act 1997*, • the provider's financial situation, within 28 days after the request was made, or within any shorter period as is specified in the notice, or (if a periodic request is made with respect to financial information) before the time or times worked out in accordance with the request.	Sections 9-2, 9-3, 9-3B and 63-1(1)(c) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	-	Section 15
Monitoring, compliance and other access	Providers must allow RAS assessors, ACAT assessors, or other people authorised by the Secretary to assess the care needs of any care recipient, access to the service.	Section 63-1(1)(g) of the *Aged Care Act 1997*	-	-
Monitoring, compliance and other access	Providers to comply with any agreement they make in lieu of revocation of approved provider status, and with any undertaking they give to respond to notice to remedy non-compliance.	Sections 66-2(1)(b), 63-1(1)(k) and 67-4 of the *Aged Care Act 1997*	-	-

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Reporting and disclosure	Providers must notify the Secretary, in writing and in an approved form, of each care recipient who starts to be provided with home care through the service. Notice must be provided within 28 days of the date the care recipient starts to be provided with home care through the service.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles*	Section 6
Reporting and disclosure	Providers must notify the Secretary, in writing and in an approved form, of each care recipient who ceases to be provided with home care through the service. Notice must be provided within 31 days of the date the care recipient ceases to be provided with home care through the service.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Sections 13 and 14
Reporting and disclosure	Providers must give the Secretary an aged care financial report each financial year, within four month of the end of the financial year. The report must be signed by one of the providers' key personnel (who is authorised by the provider to sign the report).	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Section 15
Reporting and disclosure	If a provider of an aged care service receives an aged care workforce census form sent by or on behalf of the Department, the approved provider must complete the form and return it to the Department by the date specified in the form.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	-
Staff and volunteers	A provider must not allow a person to become a staff member or volunteer of the provider, unless satisfied that: • the person has a police certificate that is not more than three years old; or the person has applied for a police certificate, will be supervised when with care recipients, and has completed a statutory	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Section 4

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	declaration stated that they have not been convicted murder or sexual assault, or convicted or imprisoned for any other form of assault; and • the police certificate does not record that the person has been convicted of murder or sexual assault, or convicted or imprisoned for any other form of assault; and • if the person has been, at any time after turning 16, a citizen or permanent resident of a country other than Australia—the person has made a statutory declaration stating that the person has never been convicted of murder or sexual assault, or convicted or imprisoned for any other form of assault.			
Staff and volunteers	Providers must continue to satisfy the above requirements related to police certificates and suitability of staff members or volunteers. Providers must ensure that each person who is a staff member or volunteer is not allowed to continue to be a staff member or volunteer unless the above is satisfied.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Section 15
Staff and volunteers	Providers must take reasonable measures to require each person who is a staff member or volunteer to notify them if they are convicted of murder or sexual assault, or convicted or imprisoned for any other form of assault.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Sections 4 and 15
Monitoring, compliance and other access	Providers must do the following in relation to each of their key personnel: • ensure that the person understands the obligations of key personnel and of approved providers under the Act in	Section 63-1A of the *Aged Care Act 1997*	*Sanctions Principles 2014*	Sections 4 and 15

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	relation to disqualified individuals; and • if the provider reasonably believes that the person may be mentally incapable of performing his or her duties as one of the approved provider's key personnel—make arrangements for the person to be examined by a registered medical practitioner; and • if the provider has ascertained that the person is a disqualified individual—ensure that the person ceases to be one of the approved provider's key personnel.			
Monitoring, compliance and other access	Providers must do the following in relation to each person who proposes to become, or becomes, one of their key personnel: • obtain (with the person's written consent) a police certificate for the person; and • conduct a search of bankruptcy records; and • conduct previous employment and referee checks.	Section 63-1A of the *Aged Care Act 1997*	*Sanctions Principles 2014*	Sections 4 and 15
Monitoring, compliance and other access	If the Secretary requests it, providers must provide information related to the steps the provider has taken to ensure that a person who is a key personnel is not a disqualified individual.	Section 63-1A of the *Aged Care Act 1997*	*Sanctions Principles 2014*	-
Monitoring, compliance and other access	An approved provider of home care must do all things reasonably practicable to ensure that there is no change to circumstances materially affecting their suitability to provide aged care.	Section 63-1C of the *Aged Care Act 1997*	-	-

Appendix F: Improved Payment Arrangements

The Australian Government changed the way Home Care Program providers are paid.

Phase 1 (implemented on 1 February 2021)

- Providers are funded in arrears rather than in advance.
- Payments for each month are claimed in the next month, for the full subsidy, based on the number of care recipients in care.

Phase 2 (implemented on 1 September 2021)

- Providers are paid in arrears, based on actual care and services delivered.
- The Government holds the Commonwealth portion of unspent funds, in each care recipient's home care account, until needed by the care recipient.

Legislation to support Phase 1 was passed by Parliament in December 2020, and for Phase 2 in February 2021. This measure reduces the financial and prudential risks of providers holding substantial amounts of unspent funds, as these will be held by the Government instead.

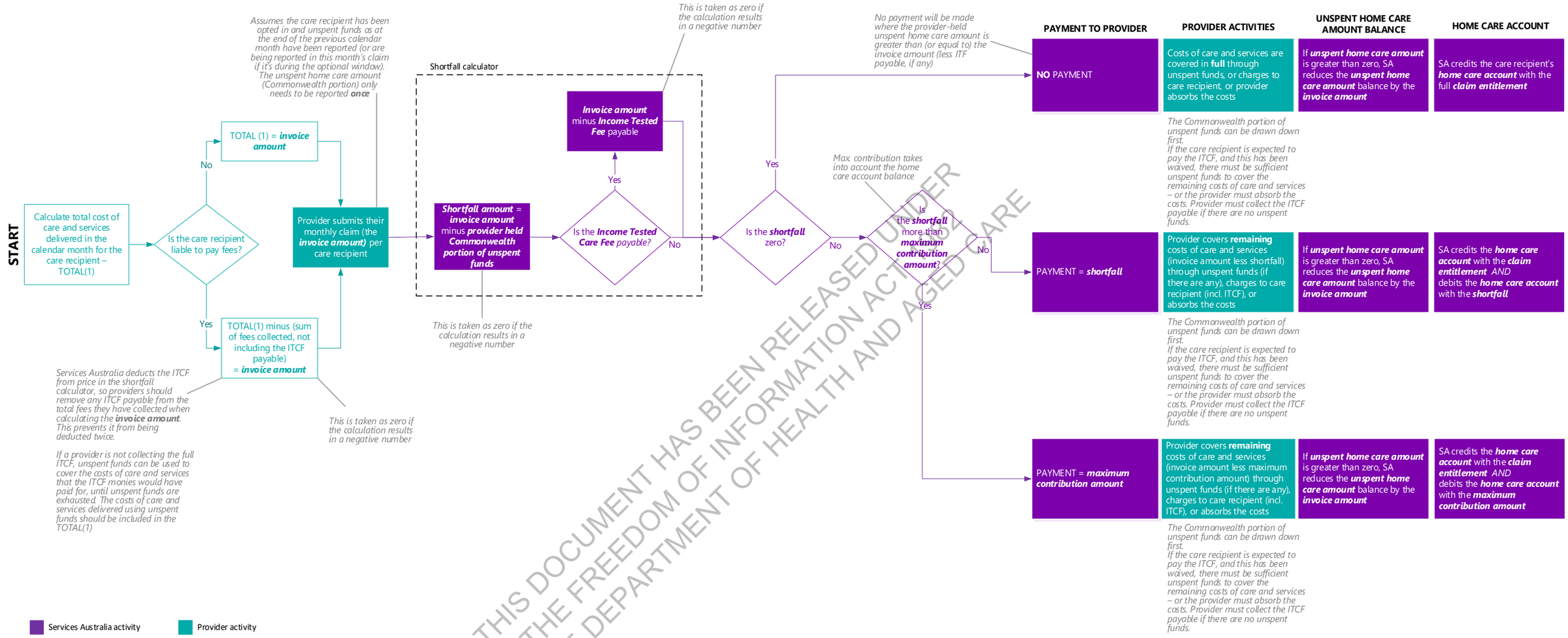
As mentioned in 2.5 of this manual, the Government offers free accounting and business advisory services to all home care providers to help them review their operations and provide advice on business management and financial strategies. For more information go to this link or visit the website at www.pwc.com.au/health/aged-care-advisory.html.

You can find further information about Improved Payment Arrangements, such as the Questions & Answers, provider and care recipient fact sheets and calculators are available on this link or by searching "Improved Payment Arrangements" at www.health.gov.au.

Attachment A shows the claim processes for providers under Improved Payment Arrangements [updated 19 August 2021].

Attachment A – Claims Process

Claim Process if a Provider Chooses to 'Opt-in'



Services Australia activity Provider activity

Invoice amount / price

Definition: the amount a provider can submit in their monthly claim for the care recipient.

Calculation:
1. Tally the total cost of care and services delivered for the care recipient in the calendar month being claimed and any administrative, care management costs
2. Tally the total fees collected/payable – including BDF, ITCF, and any other fees agreed with the care recipient
3. Deduct ITCF payable from the total at step 2. This is the available home care fees.
4. Deduct the total at step 3 from the total at step 1.

Legislative reference: Subsidy Principles 2014, 99B Price for home care

Claim entitlement / Commonwealth contribution amount

Definition: the amount of government subsidy a care recipient is entitled to for the month.

Calculation:
1. Tally the basic monthly Government subsidy amount + primary supplements (if any) – Income Tested Care Fee (if any) + other supplements (if any)

Legislative reference: Aged Care Act 1997, s 48-1A Commonwealth contribution amount

Maximum contribution amount

Definition: the total amount of Government subsidies available to cover the price for the care recipient, including this months' claim entitlement and the balance of the home care account.

Calculation:
1. Sum of the care recipient's claim entitlement and the balance of their home care account at the end of the previous month.

Legislative reference: Subsidy Principles 2014, Division 5 – Shortfall amount

Shortfall amount

Definition: in this case, where the provider has opted in the care recipient to return their provider-held unspent Commonwealth funds, the shortfall is the invoice amount, less any funds the provider is returning (unspent home care amount), less the Income Tested Care Fee the care recipient is liable to pay (if any)

Calculation:
1. Invoice amount minus unspent home care amount, up to the amount to cover the invoice amount or 100% of the unspent home care amount
3. The result of step 1 less the Income Tested Care Fee (if any)
3. If the result of step 2 is negative, this is taken as zero

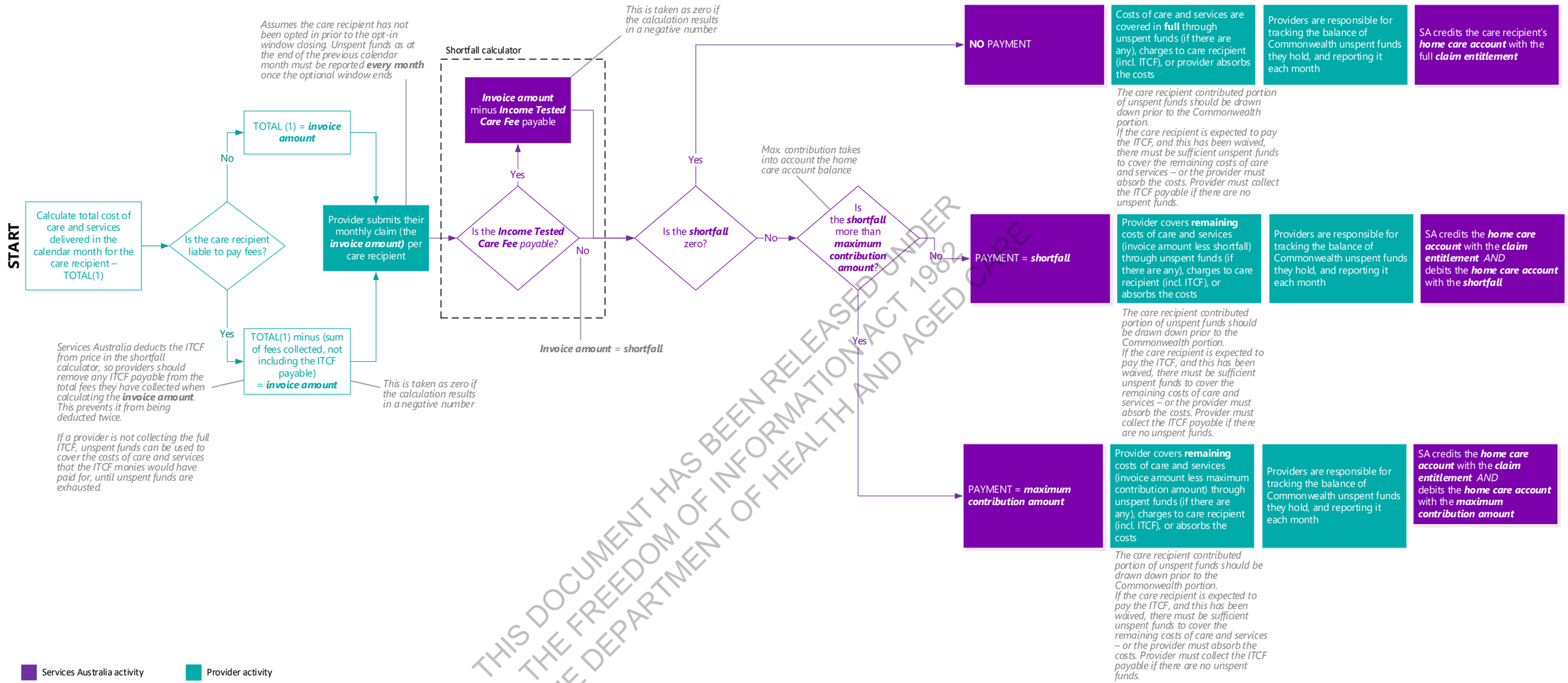
Legislative reference: Aged Care Act 1997, s 48-13 Shortfall amount; *Subsidy Principles 2014,* Division 5 – Shortfall amount

Unspent home care amount

Definition: the Commonwealth portion of the provider-held unspent funds, as at the end of the previous calendar month.

This only needs to be reported ONCE by the provider, after which the balance of the Commonwealth portion of the provider-held unspent funds is updated by Services Australia (if required) with each monthly claim submitted, until the balance reaches zero.

Claim process if a provider chooses NOT to 'opt-in'



Services Australia activity Provider activity

Invoice amount / price

Definition: the amount a provider can submit in their monthly claim for the care recipient.

Calculation:
1. Tally the total cost of care and services delivered for the care recipient in the calendar month being claimed and any administrative, care management costs
2. Tally the total fees collected/payable – including BDF, ITCF, and any other fees agreed with the care recipient
3. Deduct ITCF payable from the total at step 2. This is the available home care fees.
4. Deduct the total at step 3 from the total at step 1.

Legislative reference: Subsidy Principles 2014, 99B Price for home care

Claim entitlement / Commonwealth contribution amount

Definition: the amount of government subsidy a care recipient is entitled to for the month.

Calculation:
1. Tally the basic monthly Government subsidy amount + primary supplements (if any) – Income Tested Care Fee (if any) + other supplements (if any)

Legislative reference: Aged Care Act 1997, s 48-1A Commonwealth contribution amount

Maximum contribution amount

Definition: the total amount of Government subsidies available to cover the price for the care recipient, including this months' claim entitlement and the balance of the home care account.

Calculation:
1. Sum of the care recipient's claim entitlement and the balance of their home care account at the end of the previous month.

Legislative reference: Subsidy Principles 2014, Division 5 – Shortfall amount

Shortfall amount

Definition: in this case, where the provider has not opted in the care recipient to return their provider-held unspent Commonwealth funds (or the care recipient doesn't have unspent funds) the shortfall is the invoice amount less the Income Tested Care Fee the care recipient is liable to pay (if any)

Calculation:
1. Invoice amount minus the Income Care Tested Fee
2. If the result of step 1 is negative, this is taken as zero

Legislative reference: Aged Care Act 1997, s 48-13 Shortfall amount; *Subsidy Principles 2014,* Division 5 – Shortfall amount

Unspent home care amount

Definition: the Commonwealth portion of the provider-held unspent funds, as at the end of the previous calendar month.

This needs to be reported EVERY MONTH by the provider until the balance reaches zero.

Appendix G: Unspent funds under Improved Payment Arrangements – calculating and reporting

The unspent funds calculation on the next page is an example of how to work out unspent funds leading up to 31 August 2021 (the last day before Improved Payment Arrangements Phase 2 began on 1 September 2021). The example is based on the percentage of the unspent funds held by the provider that have come from Government subsidies and supplements as opposed to the care recipient fees. The purpose of calculating these unspent funds this is to set a baseline for the Government and care recipient portions of unspent funds and enable consistent reporting under Improved Payment Arrangements.

Providers will need to reconcile the Government portion of unspent funds they are currently holding for each care recipient to support meeting the 31 December 2021 deadline for reporting. The amount that should be reported is the Government portion of unspent funds held for each care recipient at the end of the previous claim month.

Under Improved Payments Arrangements, there is no need to recalculate the percentage breakdown of Government and care recipient portions when a care recipient exits care.

From 1 September 2021, the provider must be tracking the care recipient portion and (if they have not opted-in) tracking the Government portion separately. If the provider has opted-in, Services Australia will track the Government portion on their behalf.

From 1 September 2021 onwards, if there are changes to the subsidies and fees paid to the provider, this change should be applied to the Government portion of unspent funds. If there are changes to the fees paid by the care recipient, this should be applied to the care recipient portion of unspent funds. When a care recipient leaves care, these fees should be included in the care recipient portion of unspent funds once all claims have been finalised.

After 1 January 2022 providers who have chosen not to opt-in will need to continue to report on the Government portion of unspent funds held for a care recipient each month.

If a provider has agreed to waive the income tested care fee with the care recipient, and the care recipient has not paid any other fees, the Government portion would comprise 100 percent of the unspent funds.

Unspent funds – worked example for pre-1 September 2021 (Improved Payment Arrangements Phase 2)

- May has received care from a home care provider for 2 years.

Commonwealth contributions (Government subsidy and supplements):	$15,000
Care recipient contributions (Home care fees):	$5,000
Total accumulated funds:	$20,000

- During this time, she has received $18,000 worth of services.

Total accumulated: - Total debits:	$20,000 $18,000
Total unspent funds amount:	$2,000

- Calculate what proportion of May's total home care package budget came from the Commonwealth and from care recipient fees, as below:

Total accumulated funds: $20,000	
Commonwealth portion: $15,000/$20,000 = 75%	Care recipient portion: $5,000/$20,000 = 25%

- Then apply these proportions to the unspent funds amount:

Unspent funds amount: $20,000	
Commonwealth portion: 75% of $2,000 = $1,500	Care recipient portion: 25% of $2,000 = $500

Appendix H: Glossary

Term	Meaning
ACAT	Aged Care Assessment Team. ACATs are known as Aged Care Assessment Services (ACAS) in Victoria.
ACER	Aged Care Entry Record. ACERs are used to notify Services Australia of new care recipients entering care, or changes to existing care recipients' circumstances.
Australian Government	The Federal Government of Australia.
The Commission	The Aged Care Quality and Safety Commission. The Commission is a statutory body, responsible for overseeing the Aged Care Quality Standards across the aged care sector.
The Department	The Australian Government Department of Health and Aged Care
Quality Standards	The Aged Care Quality Standards. The Quality Standards are established under the *Aged Care Act 1997*, and all approved providers of aged care are expected to be compliant.
Approved provider (or provider)	An approved provider of aged care is an organisation that has been approved to provide residential care, home and/or flexible care under the *Aged Care Act 1997*.
Basic daily fee	Refers to a home care fee that a care recipient may be asked to pay by a home care provider based on their package level (separate to the Government subsidy).
Care plan	A care plan is a document that defines the care, services and/or purchases that a care recipient is going to use their package budget to fund.
Care recipient	A person who is receiving care and services under a package funded by the Australian Government, under the *Aged Care Act 1997*
CDC	Consumer directed care.
Consumer	Consumer means a person to whom an approved provider provides, or is to provide, care through an aged care service. Includes other people who are authorised to act on behalf of the care recipient.
Commonwealth Home Support Programme	This program provides home and community care services for frail older Australians aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.
Dignity of risk	An individual's right to make choices to take reasonable risks.
DVA	Department of Veterans' Affairs
Exclusions	Care, services or purchases that cannot be funded from a package budget.
FAS	VANguard Federated Authentication Service

Term	Meaning
Home care	A type of aged care for which a home care subsidy is payable under Part 3.2 of the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997*.
Home care recipient (or care recipient)	A person who is receiving care and services under a package funded by the Australian Government. In the *Aged Care Act 1997*, this person is referred to as a "care recipient".
Home care provider (or approved provider)	An organisation approved by the Department of Health and Aged Care under Part 2.1 of the Act as suitable to provide home care. In the *Aged Care Act 1997*, this person or body is referred to as an "approved provider".
Home Care Agreement	An agreement entered into by a care recipient and a home care provider outlining rights and responsibilities and what services will be provided to the care recipient under the package.
Home Care Packages Program	The Australian Government program that provides funding for packages aimed at supporting people to remain living at home.
HCP	Home care package
Home care account	On 1 September 2021, Services Australia will create a home care account for each care recipient. See Appendix E for further information.
Home care subsidy	The subsidy payable to a home care provider by the Australian Government under Part 3.2 of the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997*.
Inclusions	Care, services or purchases that can be funded from a package budget.
Income-tested care fee	Refers to a home care fee a care recipient may be asked to pay based on an income assessment.
Instrument	Primary legislation, delegated legislation, or a determination under legislation.
Improved Payment Arrangements	Changes to how the Australian Government pays home providers. See Appendix E for further information.
Key personnel	Key personnel are: • People responsible for the executive decisions of the applicant (this includes directors and board members), whether or not the person is employed by the applicant • People having authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the applicant, whether or not the person is employed by the applicant • Any person responsible for nursing services provided, or to be provided, by the applicant, whether or not the person is employed by the applicant • Any person who is, or is likely to be, responsible for the day-to-day operation of an aged care service conducted, or proposed to be conducted, by the applicant, whether or not the person is employed by the applicant.

Term	Meaning
Leave	A care recipient suspending care, services and purchases under their package for a specified period of time.
Maximum contribution amount	The full Government subsidy and anything available in the care recipient's home care account
Monthly statement	A document provided to care recipients every month that shows the package budget funds available to that care recipient and what has been spent from the budget.
My Aged Care	My Aged Care is the starting point to access Australian Government-funded aged care services. The phone line and website can help older Australians, their families and carers to get the help and support they need.
NAPS	National Approved Provider System
National priority system	The national priority system is a standardised process for prioritising assignment of packages.
Package budget	The funds available to be spent under a care recipient's package. A care recipient's package budget is made up of contributions from the Australian Government and, where applicable, home care fees paid by the care recipient themselves.
Pre-1 July 2014 care recipients	Care recipients who entered the HCP Program before 1 July 2014. Packages for pre-1 July 2014 care recipients have different home care fee arrangements.
Price	The amount that providers report to Services Australia in their claim. Providers report the price per care recipient, each month. Services Australia refers to the price as the invoice amount.
Principles	Delegated legislation made under the *Aged Care Act 1997*.
Reablement	Reablement is an approach to aged care, involving time-limited interventions that are targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities.
Residential aged care	This program provides high-levels of care to people in a residential aged care home.
Security of tenure	Security of tenure means providers are required to continue to deliver the agreed care and services for as long as the care recipient needs those services.
Services Australia	Formerly known as Department of Human Services
Shortfall amount	The price (minus the Commonwealth portion of any unspent funds which are being returned, for providers that opt-in), minus any income-tested care fee the care recipient is assessed to pay.
Subsidy	An Australian Government contribution to all care recipient's package budgets, determined on the basis of the level of the package the care recipient has been allocated.

Term	Meaning
Supplement	An Australian Government contribution to a care recipient's package budget, where the care recipient satisfies the specific eligibility criteria for that contribution.
The Act	*Aged Care Act 1997.*
The Principles	• *Accountability Principles 2014* • *Approval of Care Recipients Principles 2014* • *Committee Principles 2014* • *Fees and Payments Principles 2014 (No.2)* • *Information Principles 2014* • *Quality of Care Principles 2014* • *Records Principles 2014* • *Prioritised Home Care Recipients Principles 2016* • *Sanctions Principles 2014* • *Subsidy Principles 2014* • *User Rights Principles 2014*
Unspent funds	Any component of a care recipient's package budget that has not been spent, including the balance of the provider-held care recipient contributed unspent funds, the provider-held Commonwealth portion of unspent funds, and the Services Australia home care account balance (Government held unspent funds)
Wellness	Wellness is an approach to aged care involving assessment, planning and delivery of supports that build on the strengths, capacity and goals of individuals, and encourage actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home.