Australian Government
Department of Health and Aged Care

The Australian National Aged Care Classification (AN-ACC) Funding Guide

28 February 2025

Contents

Purpose

The purpose of the Australian National Aged Care Classification (AN-ACC) Funding Guide (the Guide) is to provide information to approved providers on the AN-ACC funding model. It sets out how to receive AN-ACC subsidies, including relevant compliance requirements that may apply.

Disclaimer

This Guide addresses legislation in relation to the AN-ACC funding model that commenced on 1 October 2022.

The AN-ACC funding model is governed by the applicable aged care legislation and not this Guide. Residential care providers are responsible for understanding and complying with all legislation that is relevant to the delivery of residential care and respite care provided in a residential setting. This Guide is a general guide only and aspects of the legislation and policy have been simplified for ease of understanding. It is not a substitute for, and is not intended to replace, independent legal advice or legal obligations under the aged care legislation or provide any interpretation of the legislation.

Residential aged care providers and care recipients should consider the need to obtain their own independent legal advice relevant to their particular circumstances.

While we make every effort to make sure the information in this Guide is accurate and informative, the department does not make any representations nor provide any guarantees as to its accuracy, reliability, completeness or currency of the information. The department disclaims all and any liability to any person in respect of anything done by a person in reliance on this Guide, whether in whole or in part.

Guide updates

Date	Version	Content
23/9/2022	1.0	Initial publication
20/10/2022	1.1	Section 3 - split the former Table 1 into Tables 1a and 1b, with the amounts in Table 1b expressed as three decimal places. Table 5 in Section 5 updated to correct the title of AN-ACC respite classes and include Services Australia payment codes. Corrections and updates to example calculations in Appendix 3.
9/12/2022	1.2	Removed all references to the AN-ACC funding helpdesk, which closed permanently on 9 December 2022.
19/12/2022	1.3	Removed sections 3.3 - 3.8 (from version 1.2) – information on eligibility and application for Specialised Base Care Tariff status and replaced with URL link to new Specialised Status Guide for Residential Aged Care Approved Providers. Updated section 11.4 on 24/7 registered nursing and care minutes requirements.
04/05/2023	1.4	Updates throughout document to reflect new AN-ACC price from 1 July 2023 New Section 1.5 on funding higher wages through AN-ACC Section 4 – clarification of notification of palliative entry Removal of out-of-date information on decommissioned ACFI model

Date	Version	Content
06/06/2023	1.5	Updates to Section 4.2.3 on initial classification for palliative care to clarify the process
31/08/2023	1.6	New Section 10.1 on provider access and assistance to IHACPA for costing studies
10/10/2023	1.7	Updates to Section 1.2 and 1.5 due to Hotelling Supplement indexation Updates to various parts of Section 4 consistent with the updated palliative care form and process
01/12/2023	1.8	Updates for new AN-ACC price Removal of Section 1.5 on funding higher wages New Section 6.3 and update to Section 1.5 (formerly 1.6) on review of AN-ACC class reconsideration decisions
12/03/2024	1.9	Updates to Section 4 to clarify palliative entry process Updates to Section 11.4 on 24/7 RN reporting and care time reporting assessments Updates throughout document for clarification and currency of information
30/04/2024	1.10	Update to Section 11.2.1 to direct to current allied health information
26/06/2024	1.11	Minor edits throughout to improve consistency
11/09/2024	1.12	New Section 1.6 on AN-ACC price from 1 October 2024 New Section 3.4 on updates to Base Care Tariff categories and weightings from 1 October 2024 New Section 4.5 on voluntary assisted dying New Section 4.6 on updates to AN-ACC class weightings from 1 October 2024 New Section 5.5 on updates to respite class funding from 1 October 2024 Addition of Section 7.1.1 on assessment during acute injury or illness Update to Section 8 on one-off entry adjustment payment from 1 October 2024 Updates to some related definitions in glossary Removal of obsolete reporting training videos from Section 11.4.1
20/09/2024	1.13	Update to Section 7.1 on assessment timeframes
1/11/2024	1.14	Edits to incorporate changes and adjustments from **1 October 2024**, including: • increasing the Australian National Aged Care Classification (AN-ACC) price

Date	Version	Content
		• changing the AN-ACC Base Care Tariff (BCT) structure and funding for services in Modified Monash (MM) 1 to 5 locations, through changes to National Weighted Activity Unit (NWAU) weightings • changing AN-ACC class funding through changes to NWAU weightings • changing care minutes associated with each AN-ACC class. Moved references to funding changes and adjustments from 1 October 2024 (sections 1.6, 3.4, 4.6 and 5.5) to new Appendix 5. Updated the following terms to align with new Single Assessment System terms, including: • ACAT/ACAS assessor/assessment = aged care needs assessor/assessment or needs assessor/assessment • Assessment Management Organisation = assessment organisation • DEMMI tool = Integrated Assessment Tool (IAT) • AN-ACC assessor/assessment = residential aged care funding assessor/assessment Updated some definitions and added new terms in glossary.
7/11/2024	1.15	Update to Section 1.4 as care minutes targets are now findable in the Government Provider Management System, not the My Aged Care Service and Support Portal.
6/12/24	1.16	Update to Section 4.3.2 which describes reclassification assessment processes.
18/12/24	1.17	Update to Section 1.2.1 to remove historical content and add information regarding Upcoming changes to care minutes funding. Removal of Appendix 3 as historical content and renumbering previous Appendix 4 and 5.
28/2/25	1.18	Various updates to reflect new AN-ACC price as at 1 March 2025. These include: Sections 1.1, 4.1, 5.1, 8 and Appendix 3. Removal of Appendix 4 as historical content.


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Section 1: Introduction

1 Introduction

The Australian National Aged Care Classification (AN-ACC) funding model is a casemix funding model that represents the care component of residential aged care funding. AN-ACC is designed to provide equitable care funding to approved residential aged care services, by linking subsidy to characteristics of services and residents.

AN-ACC was developed for the Government at the University of Wollongong between 2017 and 2019. The model has been independently researched, trialed, and tested. For more information see the Resource Utilisation and Classification Study reports.

The Royal Commission into Aged Care Quality and Safety recommended that Government fund residential aged care through a casemix classification system, such as AN-ACC. See recommendation 120 of the final report.

The Department of Health and Aged Care (the department) is responsible for the administration of AN-ACC, with Services Australia responsible for payment of AN-ACC subsidies.

The fundamental elements of the AN-ACC funding model include:

- 3 funding components: a fixed component (Base Care Tariff (BCT)), a variable component (AN-ACC classification funding) and a one-off adjustment payment when a new permanent resident enters a service
- residential aged care (RAC) funding assessments: AN-ACC classification (funding) decisions are informed by RAC funding assessments completed by specially trained and clinically qualified RAC funding assessors from contracted assessment organisations
- independent pricing advice: AN-ACC funding reflects the actual cost of care, informed by independent analysis and pricing advice provided by the Independent Health and Aged Care Pricing Authority (IHACPA).

AN-ACC funding is paid in addition to any hotelling and accommodation funding providers receive.

For more AN-ACC resources, see Australian National Aged Care Classification funding model.

1.1 AN-ACC price and National Weighted Activity Unit

The Minister for Aged Care sets the National Efficient Price for AN-ACC (the AN-ACC price). The AN-ACC price from 1 March 2025 is $282.44 per day.

The AN-ACC funding model works by applying weightings, or National Weighted Activity Units (NWAUs), to the AN-ACC price. The NWAUs reflect variations in the costs of providing care, based on the characteristics of a service and its individual residents. The AN-ACC price is the price of a unit of care, or 1.00 NWAU.

In determining the AN-ACC price and weightings, the Minister considers pricing and costing advice provided by IHACPA. IHACPA's advice is based on the actual costs of delivering care based on analysis of provider financial reports and independent costing studies.

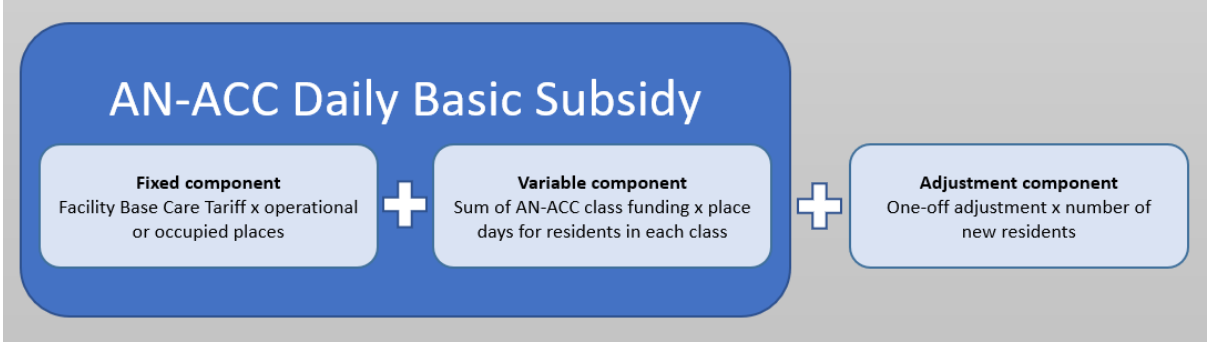
1.2 AN-ACC funding components

AN-ACC funding is delivered through 3 components:

- the BCT subsidy, a fixed funding component representing shared care costs that do not vary greatly between individual residents, which may include higher care costs due to service location (regional and remote services) or service specialisation (homeless or remote Aboriginal and Torres Strait Islander services)
- the AN-ACC classification subsidy, a variable funding component based on the characteristics and care needs of individual residents, which includes funding for services to meet their minimum care minute requirements
- one-off entry adjustment payments for transitioning a permanent resident into a service.

The BCT and AN-ACC classification components make up the AN-ACC Daily Basic Subsidy. An approved provider's total AN-ACC funding for a payment period is equal to their AN-ACC Daily Basic Subsidy plus any one-off adjustment funding for new permanent resident entries for the month (Figure 1).

Figure 1 AN-ACC Daily Basic Subsidy



1.2.1 Upcoming changes to AN-ACC funding

The government is making changes to AN-ACC funding by linking it to the delivery of care minutes in all non-specialised services in metropolitan areas (Modified Monash 1). This will not impact funding for specialised homeless services or services in regional, rural and remote areas.

Services that meet their care minutes targets will have no change to their overall funding level. Services that **do not** meet their care minutes targets will see their funding reduce from April 2026.

For more information see Changes coming to care minutes funding and Care minutes supplement estimator.

1.3 Monthly claims

The payment period for residential care is one calendar month. If an approved provider is operating more than one service, separate claims must be submitted for each service.

Approved providers can submit a claim for each payment period through the Services Australia Aged Care Provider Portal including details of each resident for whom they are claiming subsidies in that month.

1.3.1 Advance payments

Providers are paid in advance on a calendar monthly basis. Advances are calculated on an aged care service's entitlement for the period 2 months before the month in which the advance is paid. It is pro-rated for the number of calendar days in that month.

Services Australia will make any relevant adjustments once providers have lodged their claim for the month the advance was paid.

1.4 Means testing of payments

AN-ACC does not change residential aged care means assessments, which continue to determine:

- if a resident is eligible for government assistance with their accommodation costs, and any additional contribution they can be asked to pay
- the means-tested care fee payable.

Subsidy reductions are calculated using the resident's AN-ACC class, and Standard MM 1 BCT category, irrespective of the actual BCT category of the service. This means that the location of a service does not impact the means tested care fee payable by residents.

1.5 AN-ACC provider portals

Approved providers view the AN-ACC status of residents and make claims for AN-ACC subsidies through online portals.

Department of Health and Aged Care's My Aged Care Service and Support Portal:

- interact with the resident's RAC funding assessment and classification process, and view classification outcomes
- upload a Palliative care status form, and view the status and outcome of palliative care entry submissions
- request reclassification of residents
- request reconsideration of a RAC funding assessment where a provider believes that the assessment was not completed in a satisfactory manner or the AN-ACC class assigned does not reflect the usual condition of the resident.

Services Australia Aged Care Provider Portal:

- submit client entry records for all new residents, including residents entering for palliative care, permanent care, and respite care
- submit claims for each residential care service for each payment period, including details of each resident for whom subsidies are claimed
- notify when a resident leaves a service.

Section 2: Eligibility for AN-ACC funding

2 Eligibility for AN-ACC funding

Residential care subsidy is a payment by the government to certain approved providers for providing residential care to certain care recipients, through residential aged care services. AN-ACC is a type of residential care subsidy.

Residential care subsidy under AN-ACC can only be paid if:

- the resident's provider is an approved provider of residential care
- the resident has been assessed and is approved for residential respite or permanent residential care by an aged care needs assessor (needs assessor)
- the resident's care is provided through an accredited residential aged care service
- the resident's service has an allocation of places
- there is not a restriction on subsidy.

The Aged Care Quality and Safety Commission is responsible for approving providers and accrediting residential aged care services. For more information, see Aged Care Quality and Safety Commission – Aged care homes.

2.1 Emergency entry

If a person enters residential care under urgent circumstances, without an aged care needs assessment (needs assessment) and approval, the provider must complete the emergency case section of the Application for Care form and send the form to their local assessment organisation within 5 business days of care commencing.

The department may extend this period by request in exceptional circumstances. On receipt of the form, the assessment organisation will schedule a suitable time with the provider for the resident's comprehensive needs assessment.

2.2 Respite eligibility

To be eligible to access government-subsidised residential respite care, a person must receive a needs assessment from an assessment organisation.

Approval for respite care allows for a resident to receive 63 days of respite care in a financial year. On request, the assessment delegate can grant a 21-day extension.

If a resident is eligible for residential respite care, the approved provider must create a client entry record in the Services Australia Aged Care Provider Portal and enter the person into 'residential respite care' in order to receive respite payments for the resident.

The respite resident's provider can request residential respite extensions through the My Aged Care Service and Support Portal.

Section 3: Base Care Tariff (fixed funding)

3 Base Care Tariff (fixed funding)

The BCT subsidy is the fixed funding component of the AN-ACC Daily Basic Subsidy. The BCT subsidy covers care costs that do not change significantly with changes in individual resident characteristics or small changes in occupancy, but are determined by the overall needs of the service. For example:

- the cost of providing general oversight of residents eating in common areas
- higher costs associated with a service's location (e.g., regional and remote services)
- the additional costs of providing specialised programs and supports (specialised homeless or remote Aboriginal and Torres Strait Islander services).

The BCT subsidy is determined at the individual service level. There are 6 BCT subsidy categories, based on a service's 2019 Modified Monash Model (MMM) location and/or specialisation (homeless or remote and very remote Aboriginal and Torres Strait Islander).

Services automatically receive a BCT category based on their Modified Monash (MM) location. Services must seek approval from the department to access specialised BCT categories.

Tables 1a and 1b outline the BCT categories and their corresponding Services Australia payment statement code, NWAU value, funding basis and BCT subsidy, from 1 March 2025. For the funding prior to this date, see Schedule of Subsidies and Supplements for Aged Care.

Table 1a BCT funding for services where funding is calculated based on occupied places

BCT Category	Services Australia Payment Statement code	NWAU*	Funding Basis	Funding per occupied place^
Standard MM 1	Fixed subsidy – class 6	0.50	Occupied places	$141.22
Standard MM 2-3	Fixed subsidy – class 4	0.55	Occupied places	$155.34
Standard MM 4-5	Fixed subsidy – class 7	0.57	Occupied places	$160.99
Specialised homeless	Fixed subsidy – class 5	0.92	Occupied places	$259.84

Table 1b BCT funding for services where funding is calculated based on operational places

BCT Category	Services Australia Payment Statement code	NWAU*	Funding Basis	Notional funding per operational place**
Standard MM 6 – 7	Fixed subsidy – class 3H	0.68 for first 29 places	Operational places	$192.059
Standard MM 6 – 7	Fixed subsidy – class 3L	0.52 for places 30 and above	Operational places	$146.869
Specialised Aboriginal and Torres Strait Islander MM 6	Fixed subsidy – class 2	0.78	Operational places	$220.303
Specialised Aboriginal and Torres Strait Islander MM 7	Fixed subsidy – class 1	1.80	Operational places	$508.392

* The value of 1 NWAU is equivalent to the AN-ACC price. The AN-ACC price is $282.44 from 1 March 2025.
^ Rounded to the nearest cent per place per day.
** Notional funding per 'operational place' for calculating the service total uses three decimal places per place per day, to reduce rounding effects on the per resident per day subsidy amounts.

3.1 The Modified Monash Model

The MMM is a measure of remoteness and population size used by the department to define whether a location is a city, regional, rural, remote, or very remote. Locations are categorised from MM 1 – MM 7, with MM 1 denoting a major city and MM 7 a very remote location. AN-ACC uses 2019 MMM categories.

Providers can find the 2019 MMM category of their aged care service by typing the street address into the department's health workforce locator tool and selecting 2019 as the MMM classification filter.

Table 2 explains the location classifications used in the MMM.

Table 2 Modified Monash Model

Modified Monash Category (MM 2019)	Description – including the Australian Statistical Geography Standard – Remoteness Area (2016)
MM 1	Metropolitan areas: Major cities accounting for 70% of Australia's population. All areas categorised ASGS-RA1.
MM 2	Regional centres: Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas that are in, or within a 20km drive of a town with over 50,000 residents. For example: Ballarat, Mackay, Toowoomba, Kiama, Albury, Bunbury.

Modified Monash Category (MM 2019)	Description – including the Australian Statistical Geography Standard – Remoteness Area (2016)
MM 3	Large rural towns: Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas that are not MM 2 and are in, or within a 15km drive of a town between 15,000 to 50,000 residents. For example: Dubbo, Lismore, Yeppoon, Busselton.
MM 4	Medium rural towns: Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas that are not MM 2 or MM 3, and are in, or within a 10km drive of a town with between 5,000 to 15,000 residents. For example: Port Augusta, Charters Towers, Moree.
MM 5	Small rural towns: All remaining Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas. For example: Mount Buller, Moruya, Renmark, Condamine.
MM 6	Remote communities: Remote mainland areas (ASGS-RA 4) AND remote islands less than 5kms offshore. For example: Cape Tribulation, Lightning Ridge, Alice Springs, Mallacoota, Port Hedland. Additionally, islands that have an MM 5 classification with a population of less than 1,000 without bridges to the mainland will now be classified as MM 6 for example: Bruny Island.
MM 7	Very remote communities: Very remote areas (ASGS-RA 5). For example: Longreach, Coober Pedy, Thursday Island and all other remote island areas more than 5kms offshore.

Source: Modified Monash Model – fact sheet

MMM categories are based on the Australian Statistical Geography Standard – Remoteness Areas framework and are updated after each Census.

3.1.1 MMM boundary changes

If MMM boundaries change, such as a MM 5 locations being reclassified to MM 4 or vice versa, approved providers will be notified of the date of the change at least 6 months in advance to plan for changes in their BCT subsidy.

3.2 BCT National Weighted Activity Units

Each BCT category has a corresponding NWAU value. These values determine the amount of subsidy provided under each BCT category. This allows BCT subsidies to be weighted to reflect the different structural characteristics of residential aged care services, such as:

- higher fixed care costs and often low and/or variable occupancy levels experienced by remote and very remote facilities (MM 6 and 7)
- increased costs of providing care in small rural towns (MM 5)
- additional costs of providing specialised care to vulnerable groups such as residents with a history of homelessness and Aboriginal and Torres Strait Islander residents in remote and very remote communities.

3.2.1 BCT funding basis

BCT funding is paid per occupied place or per operational place. Services located in:

- MM 1 – 5 locations (and specialised homeless services) receive the BCT subsidy for the number of occupied places.

- MM 6 and MM 7 locations receive the BCT subsidy for the number of operational places, unless they are a specialised homeless service.

Occupied places exclude provisionally allocated places. Operational places exclude provisionally allocated places, offline places and any places for which subsidy is not payable (for example because of sanctions). See definitions in section 64M of the Aged Care (Subsidy, Fees and Payments) Determination 2014 and section 84 of the Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014.

3.3 Specialised BCT status – homeless status and Aboriginal and Torres Strait Islander status

For information on eligibility criteria, the application process and operational requirements for the Specialised Homeless status or the Specialised Aboriginal and Torres Strait Islander status, see the Specialised Status Guide for Residential Aged Care Approved Providers.

Section 4: AN-ACC classification subsidy – permanent residents (variable funding)

4 AN-ACC classification subsidy – permanent residents (variable funding)

The AN-ACC classification subsidy is a variable funding component based on the individual characteristics of aged care residents. Different arrangements apply to permanent residents and respite residents. This section deals with the AN-ACC classification subsidy for permanent residents, including palliative residents, and details the types of permanent classifications, reclassification, and the subsidy dates of effect.

See Section 5 for details on the variable subsidy for respite residents.

Approved providers can view any of their residents' AN-ACC classifications in the My Aged Care Service and Support Portal. Approved providers can also view the classification history of their residents, including active and inactive classes. A new classification (initial classification or reclassification) will normally be available within 24 hours after a RAC funding assessment was completed.

4.1 AN-ACC classifications

There are 13 AN-ACC classes for permanent residents, including a class for planned admissions for palliative care. The AN-ACC class determines the amount of variable subsidy the approved provider will be paid for the resident.

Table 3 outlines the AN-ACC classes for permanent residential care and corresponding NWAU values and subsidy amounts, from 1 March 2025. For the funding prior to this date, see Schedule of Subsidies and Supplements for Aged Care | Australian Government Department of Health and Aged Care.

Table 3 Variable funding rates by AN-ACC class

AN-ACC class	Resident description	NWAU	AN-ACC ^
Class 1	Admit for palliative care	0.80	$225.95
Class 2	Independent without compounding factors	0.19	$53.66
Class 3	Independent with compounding factors	0.37	$104.50
Class 4	Assisted mobility, high cognition, without compounding factors	0.25	$70.61
Class 5	Assisted mobility, high cognition, with compounding factors	0.44	$124.27
Class 6	Assisted mobility, medium cognition, without compounding factors	0.40	$112.98

AN-ACC class	Resident description	NWAU	AN-ACC ^
Class 7	Assisted mobility, medium cognition, with compounding factors	0.55	$155.34
Class 8	Assisted mobility, low cognition	0.64	$180.76
Class 9	Not mobile, higher function, without compounding factors	0.52	$146.87
Class 10	Not mobile, higher function, with compounding factors	0.70	$197.71
Class 11	Not mobile, lower function, lower pressure sore risk	0.66	$186.41
Class 12	Not mobile, lower function, higher pressure sore risk, without compounding factors	0.66	$186.41
Class 13	Not mobile, lower function, higher pressure sore risk, with compounding factors	0.80	$225.95

^ Rounded to the nearest cent per person per day

4.1.1 Default subsidy rates

One of 2 default subsidy rates applies until a permanent resident is assigned an AN-ACC class. For permanent non-palliative residents, the default rate is equal to the Class 8 subsidy. For permanent residents being admitted for the purpose of planned palliative care, the default rate is equal to the Class 1 subsidy.

The default Class 8 classification will be replaced by the resident's actual classification once the outcome of their RAC funding assessment is known. Payments are adjusted in the next pay period to account for any difference between the default and actual rate of subsidy.

4.2 Initial classification

To classify a resident and pay the related subsidy, information about the characteristics of the resident must first be collected through a RAC funding assessment of the resident's care needs. Residents entering for non-palliative care will undergo a standard RAC funding assessment to determine their classification (see Section 4.2.1), while residents approved by the department for palliative care entry are assessed based on a medical assessment completed by their medical practitioner (see Section 4.2.3).

4.2.1 Initial classification assessment (non-palliative)

When a provider notifies Services Australia of a new resident who does not yet have a permanent classification, a RAC funding assessment referral will be automatically generated.

If the RAC funding assessment is completed before the resident permanently leaves the residential aged care service the resident will receive an initial classification, which will determine the subsidy paid to the provider.

In limited circumstances (see Section 4.4.2), a resident who permanently leaves a residential aged care service before their initial RAC funding assessment has been completed, and

then immediately enters another service may:

- subsequently be assessed; and
- receive an initial classification backdated to their time in the first service, with effect on the subsidy paid to both services.

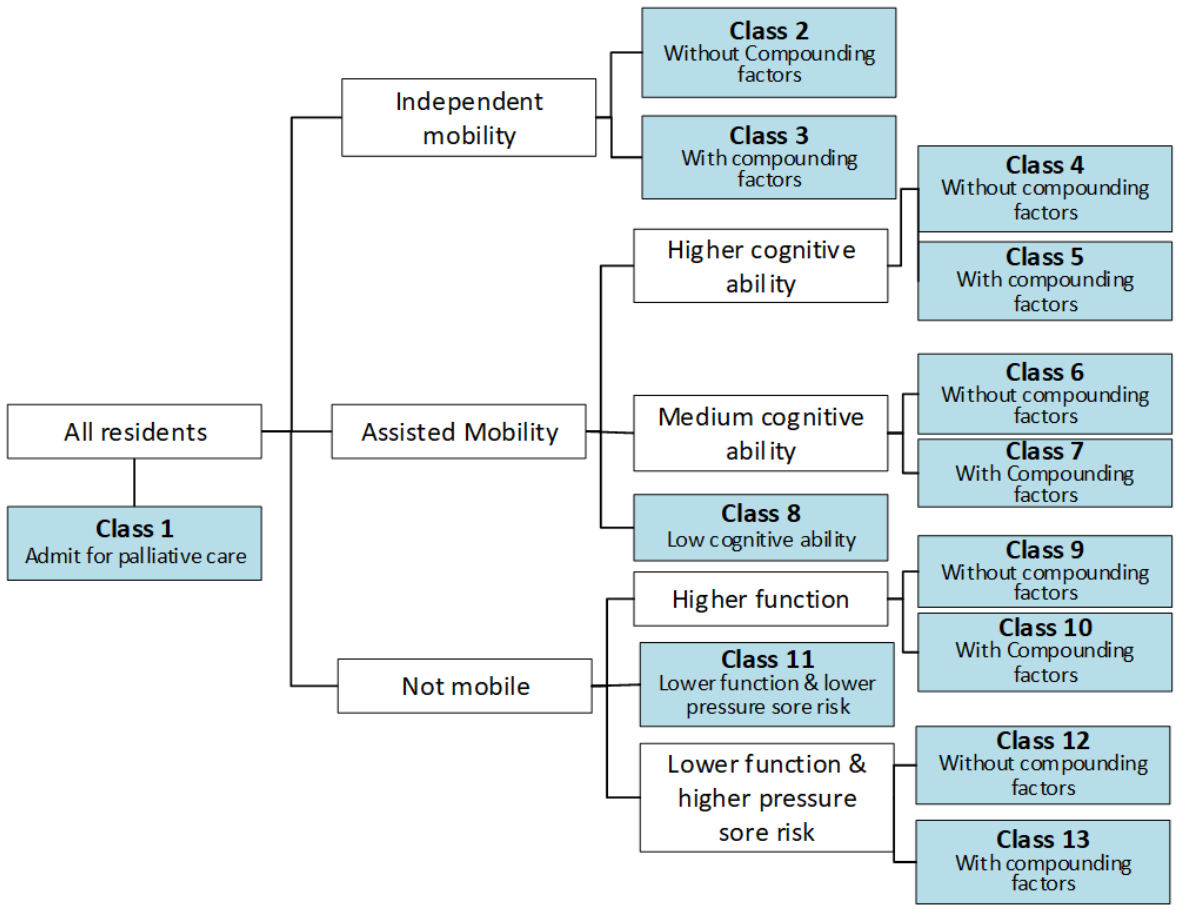
In all other circumstances, a resident who permanently leaves a residential aged care service before their initial RAC funding assessment has been completed will remain unclassified. The relevant default rate will be the final rate paid for their stay.

4.2.2 Classification levels

After a RAC funding assessment is completed and submitted to the department by a RAC funding assessor, the department processes the assessment data received and assigns the resident a classification status.

AN-ACC classifications employ a branching casemix approach to group residents with like characteristics (as recorded through RAC funding assessments) and like average care costs (Figure 2).

Figure 2 AN-ACC Variable Funding Classes



4.2.2.1 Compounding factors

In some cases, placing a resident into a classification level depends on whether the resident has significant compounding factors. Which compounding factors are relevant for the classification decision varies based on the resident's circumstances as outlined in section 4A of the Classification Principles 2014.

4.2.3 Entry for AN-ACC Class 1 (Admit for Palliative Care)

When a new resident enters permanent residential aged care to receive planned palliative care the provider may request Class 1 subsidy for the resident.

To be eligible to receive Class 1 subsidy, the provider must ensure each of the following eligibility requirements have been met:

- a medical assessment has taken place no more than 3 months prior to, and no later than 14 days following, the care recipient's date of entry into the residential care service to receive permanent (non-respite) residential aged care. The medical assessment must be completed by a medical practitioner or nurse practitioner who is independent of the provider
- the medical assessment must provide an estimated life expectancy of 3 months or less
- the medical assessment must provide an Australia-Modified Karnofsky Performance Scale (AKPS) score of 40 or less (the resident is in bed for at least 50% of the time and requires special care and assistance).

Approved providers accepting a new resident for planned palliative care can submit a request for Class 1 subsidy by submitting a completed Palliative Care Status Form.

4.2.3.1 Class 1 palliative care entry process

The Class 1 palliative care entry process is:

- notify the resident's entry for planned palliative care by completing the Aged Care Entry Record (ACER) in the Services Australia Aged Care Provider Portal within 28 days of the resident's entry to the service, after determining that the resident meets all eligibility requirements
- submit the completed Palliative Care Status Form by attaching it to the IT palliative care application in the My Aged Care Service and Support Portal **within 14 days of submitting the ACER**.

Providers are responsible for ensuring all parts of the Palliative Care Status Form have been completed correctly. This involves discussing the planned palliative care with the resident and recording their consent, as well as ensuring the medical assessment page of the form has been completed by the resident's medical practitioner or nurse practitioner, based on a medical assessment which must take place no more than 3 months prior to, and no later than 14 days following, the care recipient's date of entry into the residential care service to receive permanent (non-respite) residential aged care.

The department may give an extension to submit the Palliative Care Status Form in exceptional circumstances.

4.2.3.2 Approval of Class 1 palliative care entry

The department reviews all Palliative Care Status Forms. If all the eligibility requirements are met, the resident will receive an allocation of AN-ACC Class 1 status, and the provider will receive Class 1 subsidy for the resident for the entire duration of their stay.

Residents who are allocated Class 1 status do not require a RAC funding assessment.

4.2.3.3 Rejection of Class 1 palliative care entry

The department may reject Class 1 status for a resident where any of the Class 1 eligibility requirements have not been met, for example if:

- the resident is palliative but is assessed by their medical practitioner or nurse practitioner as having an AKPS score of 50 or more and/or a life expectancy of more than 3 months
- the Palliative Care Status Form is incomplete, unclear or illegible
- the medical assessment in Part B of the Palliative Care Status Form pre-dates the resident's entry by more than 3 months
- the medical assessment is dated more than 14 days following the resident's permanent date of entry
- late submission (over 28 days) of the ACER (see Section 4.2.3.4 below).

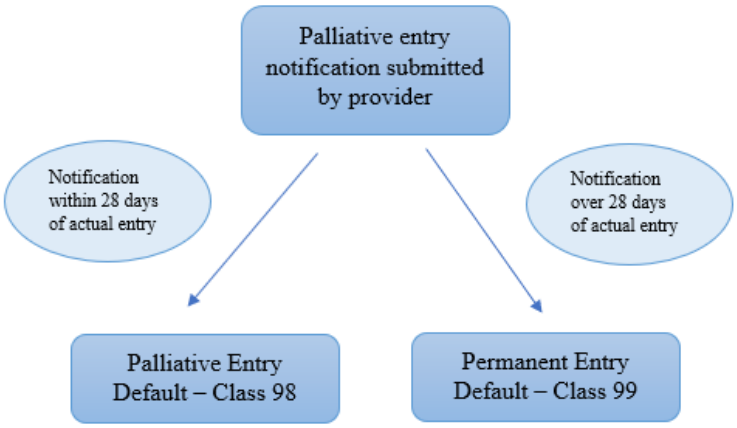
If the department rejects the request for AN-ACC Class 1 status, the resident will be considered a standard permanent resident and the process for standard permanent entry applies. This includes referring the resident for a RAC funding assessment to determine their AN-ACC classification.

4.2.3.4 Notification of palliative entry

Palliative residents have limited life expectancy, so timely creation of an entry record in the My Aged Care Service and Support Portal is essential. Providers must notify the department of palliative entry through this portal within 28 days of the resident's actual entry to the service.

Where a **palliative entry notification is submitted after 28 days**, the resident will not receive AN-ACC Class 1 status and the payment of Class 1 subsidy will be rejected. The resident will instead receive the non-palliative Class 99 default rate of subsidy (equivalent to Class 8) and will be referred for a RAC funding assessment.

Figure 3 Notification of palliative entry



In Figure 3 above, Class 98 is equal to AN-ACC Class 1 and Class 99 is equal to AN-ACC Class 8.

4.2.3.5 Death of the resident prior to classification

If the **palliative entry notification is submitted within 28 days**, and the resident passes away before the Class 1 is assigned, the service will receive AN-ACC Class 98 (equivalent to Class 1) for each day of care provided.

If the **palliative entry notification** is **not submitted within 28 days** and the resident passes away before the RAC funding assessment, AN-ACC Class 99 (equivalent to Class 8) will remain the final rate for each day of care provided.

4.3 Reclassification

Reclassification is an AN-ACC classification level with a new date of effect replacing an existing classification. The AN-ACC class after a reclassification may be different from or be the same as the previous class.

4.3.1 Reclassification request

An approved provider can request that the department reclassify a permanent resident if, since their existing classification took effect, any of the following criteria are met:

- there has been a change in the care recipient's cognitive ability, compounding factors, function, mobility, or pressure sore risk
- the care recipient has been an inpatient of a hospital for a total of at least 5 days
- the care recipient has been an inpatient of a hospital for a total of at least 2 days and was administered general anaesthetic while an inpatient
- for a care recipient with an existing classification level of Class 9, Class 10, Class 11, Class 12, or Class 13 – at least 6 months have passed
- for a care recipient with an existing classification level of Class 2, Class 3, Class 4, Class 5, Class 6, Class 7, or Class 8 – at least 12 months have passed.

Reclassification requests can be made through the My Aged Care Service and Support Portal after a client entry record has been entered in the Services Australia Aged Care Provider Portal.

If a resident with an AN-ACC permanent classification moves to another residential aged care service to be admitted for palliative care (that is, to get AN-ACC Class 1) the entry process at the new service includes a step that will generate the necessary reclassification request.

If the reclassification request was made in error, or is no longer required, the request can be recalled in the My Aged Care Service and Support Portal.

4.3.2 Reclassification assessment

As for an initial classification, to reclassify a resident requires data about the characteristics of the resident. This is collected through a RAC funding assessment.

The same 2 types of RAC funding assessments apply, a standard RAC funding assessment and an admit for planned palliative care assessment.

A standard reclassification assessment will typically occur within 28 days of the request being received and an urgent assessment will typically occur within 14 days. Please refer to the My Aged Care – Provider Portal User Guide for further information.

A reclassification to planned palliative care can only occur where a resident moves to a new service.

4.3.3 Reclassification not required with resident transfers

Approved providers do not need to submit a reclassification request for a resident who transfers into their care from another provider's aged care service.

If the resident already has an AN-ACC class, the new approved provider will receive payment based on that AN-ACC class. If the resident has not been assessed, an initial

referral for a RAC funding assessment will be issued.

Where a resident transfers to a new service and the receiving provider believes that, since their existing classification took effect, any of the reclassification criteria above are met, the provider can request a reclassification of the resident.

4.4 Subsidy date of effect

The date of effect of a permanent classification for subsidy purposes depends on whether the classification is an initial classification or a reclassification.

4.4.1 Initial classification (subsidy date of effect)

Generally, a resident's initial classification will affect subsidy from the resident's day of entry (or from 1 October 2022 if the resident entered before 1 October 2022 but was classified afterward).

Once the initial classification takes effect, the subsidy for the actual classification will replace any default subsidy paid up to that time. Any difference between actual and default subsidy will be adjusted through the payment system.

4.4.2 Resident permanently leaves before classification

If an unclassified resident permanently leaves a residential aged care service before a RAC funding assessment and the related classification decision, then the resident usually remains unclassified, and the default subsidy applies to their stay without adjustment.

The exception is if the resident permanently leaves but then enters a different residential aged care service within 28 days. In this case only, a classification assigned at the second service will have effect from the day of entry to the first service. The subsidy for the classification will replace any default subsidy paid up to that time at both services. Any difference between actual and default subsidy at both services will be adjusted through the payment system.

4.4.3 Reclassification (subsidy date of effect)

For a reclassification, the new AN-ACC permanent resident classification will take effect from the day the reclassification request was made. Once assigned, the subsidy for the actual classification will replace any default subsidy paid up to that time. Any difference between actual and default subsidy will be adjusted through the payment system.

4.4.3.1 Resident permanently leaves before reclassification

If a permanent resident for whom a reclassification has been requested leaves a residential aged care service before the reclassification assessment and decision is made, then the resident's classification does not change in respect of their time at that service.

As part of this, any outstanding RAC funding assessment referral for the resident is withdrawn. If the resident later enters another service and is reclassified, then the new classification has effect only from the date of the subsequent reclassification request made at the second service.

4.5 Voluntary assisted dying

Voluntary assisted dying (VAD) is when someone chooses medical assistance to end their life because they have an advanced medical condition that causes intolerable suffering.

Eligibility for VAD is legislated by state/territory law and is separate to a resident's other care needs. Providers should contact their relevant state/territory health department for more information about VAD.

Where a change in a resident's care needs coincides with end of life, a reclassification request can be made through the My Aged Care Service and Support Portal.

Section 5: AN-ACC classification subsidy – respite residents (variable funding)

5 AN-ACC classification subsidy – respite residents (variable funding)

The AN-ACC classification subsidy is a variable funding component based on the individual characteristics of aged care residents. Different classification subsidy arrangements apply to permanent residents and respite residents. This section applies to AN-ACC subsidy for 6respite residents, and will explain the types of respite classifications, reclassification and the subsidy dates of effect.

In addition, a supplement is paid to support accommodation costs for all residential respite care recipients. This funding is aligned with the maximum amount of accommodation supplement for permanent residents. For more information, see Appendix 3.

Approved providers can view any of their residents' AN-ACC classifications in the My Aged Care Service and Support Portal. Approved providers can also view the classification history of their residents, including active and inactive classes. A new classification (initial classification or reclassification) will be available within 7 days after the RAC funding assessment is completed.

5.1 AN-ACC respite resident classification and related subsidy

There are 3 AN-ACC classifications for respite residents. The AN-ACC class will determine an amount of subsidy the approved provider will be paid for meeting the respite resident's care needs.

Table 4 outlines the AN-ACC classes for respite residential care and corresponding NWAU values and subsidy amounts, from 1 March 2025. For the funding prior to this date, see Schedule of Subsidies and Supplements for Aged Care.

Table 4 Respite classes

Respite Class	Services Australia Payment Statement code	Resident description	NWAU	Respite Class Funding^
Respite Class 1	Variable subsidy – class 101	Independent mobility	0.365	$103.09
Respite Class 2	Variable subsidy – class 102	Assisted mobility	0.479	$135.29
Respite Class 3	Variable subsidy – class 103	Not mobile	0.691	$195.17

^Subsidy rounded to the nearest cent.

Approved providers can use any of their allocated places that have taken effect to provide residential respite care.

5.1.1 Default subsidy rates

Where a person with a respite care approval enters for residential respite care without an AN-ACC respite classification, a default subsidy equal to the Respite Class 102 subsidy will apply.

The actual subsidy for a respite class, once assigned, will replace the relevant default rate from the date of effect of the classification.

If a respite resident leaves a residential aged care service before a RAC funding assessor can undertake a RAC funding assessment, the referral will transfer to an assessment organisation to undertake the DEMMI-modified in the community before another respite episode, to enable a classification decision that will have as its date of effect the first day of the previous respite episode.

5.2 Initial classification

Generally, to classify a respite resident, and pay the related subsidy, required data about the characteristics of the resident must first be collected through a needs assessment. Exceptions may apply to persons who were approved for and/or in respite care before 1 October 2022.

5.2.1 Transitional respite classification arrangements

If a person had a residential respite approval and was assessed and classified for an AN-ACC respite class before 1 October 2022, that AN-ACC respite class continues to apply.

If a person had a residential respite approval but was not assessed and classified for an AN-ACC respite class before 1 October 2022 they were assigned an AN-ACC respite class on 1 October 2022 according to the following rule:

- if the person had an ACFI low care respite classification – this automatically became a Respite Class 101 residential respite classification on 1 October 2022
- if the person had an ACFI high care respite classification, or an ACFI high care respite classification and an ACFI low care respite classification – this automatically became a Respite Class 102 residential respite classification on 1 October 2022.

5.2.2 Initial classification assessment

When a provider notifies Services Australia of the entry of a resident who does not yet have a respite classification, a RAC funding assessment referral to the department will be generated automatically to undertake the DEMMI-modified whilst the resident is in the aged care facility.

5.2.2.1 Classification levels

After a RAC funding assessment is completed and submitted to the department by a RAC funding assessor, the department processes the RAC funding assessment data received and assigns the resident a classification level as follows:

- if the care recipient is independently mobile – Respite Class 101
- if the care recipient is mobile only with assistance – Respite Class 102
- if the care recipient is not mobile – Respite Class 103.

5.3 Reclassification

Reclassification is a classification level with a new date of effect replacing an existing classification. The class after a reclassification may be different from or the same as the

previous class.

5.3.1 Reclassification request

An approved provider can request the department reclassify a respite resident if, since the existing classification of the care recipient took effect, any of these criteria are met:

- the care recipient changed from being independently mobile to being mobile only with assistance
- the care recipient changed from being independently mobile to being not mobile
- the care recipient changed from being mobile only with assistance to being not mobile.

Reclassification requests can be made through the My Aged Care Service and Support Portal after a client entry record has been entered in the Services Australia Aged Care Provider Portal.

Approved providers must select one of the respite reclassification criteria when submitting a reclassification request in the portal – see My Aged Care – Provider Portal User Guide: Part 2 Team Leader and Staff Member Functions

If the reclassification request was made in error, or is no longer required, the request can be recalled in the My Aged Care Service and Support Portal.

5.3.2 Reclassification assessment

As for an initial classification, to reclassify a resident required data about the characteristics of the resident must be collected through a RAC funding assessment.

5.3.3 Reclassification not required with resident transfers

Approved providers do not need to submit a reclassification request for a resident who transfers into their care from another provider's aged care service.

If the resident already has an AN-ACC class, the new approved provider will receive payment based on that AN-ACC class. If the resident has not been assessed, an initial referral for a RAC funding assessment will be issued.

5.4 Subsidy date of effect of classifications

The date of effect of a residential respite classification for subsidy purposes depends on whether the classification is a transitional classification, an initial classification, or a new classification for an already classified resident.

5.4.1 October 2022 transitional classification (subsidy date of effect)

The date of effect of a respite classification for subsidy purposes is 1 October 2022 if:

- the person was assigned an AN-ACC respite classification prior to 1 October 2022
- the person had an ACFI low care respite classification – this automatically became a Respite Class 101 residential respite classification on 1 October 2022
- the person had an ACFI high care respite classification – this automatically became a Respite Class 102 residential respite classification on 1 October 2022.

5.4.2 Initial classification (subsidy date of effect)

Respite residents at 1 October 2022 received a respite classification with a date of effect of 1 October 2022 for subsidy purposes.

For a person who enters a residential care service for respite care after 1 October 2022 without an AN-ACC classification, the initial AN-ACC residential respite classification takes effect for subsidy purposes from the day of entry (or from 1 October 2022 if they entered before 1 October 2022 but were classified afterward).

In this case, once the classification takes effect, the subsidy for the actual classification will replace any default subsidy paid up to that time. Any difference between actual and default subsidy will be adjusted through the payment system.

5.4.2.1 Resident leaves before initial classification

If an unclassified respite resident ends a respite episode at a residential aged care service before an assessment and classification decision can be made then the department will attempt to arrange a RAC funding assessment to be performed in the community before another respite episode, to enable a classification decision that will have as its date of effect the first day of the first respite episode entered on or after 1 October 2022.

If the person dies before a RAC funding assessment can be performed in the community and an initial classification decision made, the person remains unclassified for the respite period, and the default subsidy applies to their stay without adjustment.

5.4.3 Reclassification: subsidy date of effect

For a reclassification, the new AN-ACC respite resident classification will take effect from the day the reclassification request was made. Once assigned, the subsidy for the actual classification will replace any default subsidy paid up to that time. Any difference between actual and default subsidy will be adjusted through the payment system.

5.4.3.1 Resident leaves before initial classification decision made

If an unclassified respite resident ends a respite episode at a residential aged care service before an assessment and classification decision can be made then the department will attempt to arrange a RAC funding assessment to be performed in the community before another respite episode, to enable a reclassification decision that will have as its date of effect the day of the reclassification request.

If the person dies or starts a new respite episode before an assessment can be performed in the community and a classification decision made, the person remains at their existing classification for the respite period, and that subsidy rate applies to their stay.

Section 6: Reconsideration of classification decisions

6 Reconsideration of classification decisions

An approved provider or resident can request a reconsideration through the My Aged Care Service and Support Portal within 28 days after they receive notification of an AN-ACC initial classification decision or reclassification decision if they believe either of the following has occurred:

- the RAC funding assessor did not compete the RAC funding assessment in a satisfactory manner, resulting in an inaccurate classification
- the resident's condition during the RAC funding assessment did not accurately reflect their usual condition or relevant information was not considered, resulting in an inaccurate classification.

An approved provider must select one of those criteria to submit the reconsideration request. Additional information can be included as free text. A request can relate to either a permanent or a respite classification or reclassification decision.

Approved providers can request reconsideration of an AN-ACC classification through the My Aged Care Service and Support Portal – see My Aged Care – Provider Portal User Guide: Part 2 Team Leader and Staff Member Functions

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6.1 Reconsideration assessment

A reconsideration request will generate a referral for a new RAC funding assessment to be completed. The new RAC funding assessment will be completed by a different RAC funding assessor and, where possible, one employed by a different assessment organisation than the first RAC funding assessor's employer.

In performing the RAC funding assessment, the new RAC funding assessor will consider any specific issues raised by the provider. These issues can be raised by entering free text in the request screen in the My Aged Care Service and Support Portal.

The department will consider the RAC funding assessment results in making the decision to confirm, vary or set aside the original decision.

6.2 Reconsideration decision date of effect

The decision to confirm, vary or set aside the classification will take effect from the day of the original decision, unless another day is specified in the notice of decision.

6.3 Review of reconsideration decision

Providers may seek review of a reconsideration decision by application to the Administrative Review Tribunal.

Section 7: Residential aged care funding assessment

7 Residential aged care funding assessment

Following the submission of a new client entry record for a resident entering care, a referral for a residential aged care (RAC) funding assessment is automatically generated and assigned to one of the assessment organisations that is responsible for conducting RAC funding assessments in the service's area. RAC funding assessments may also be triggered by requests for reclassification or reconsideration.

Visit the department's website for information on the funding assessment pathways for an aged care resident.

7.1 Assessment timeframe

Once a referral is received and accepted by an assessment organisation, it will be assigned to a RAC funding assessor who will arrange for the RAC funding assessment to be completed. From the date of referral:

- 90% of all accepted assessments will be completed within 28 calendar days; and
- 97% of all accepted assessments will be completed within 56 calendar days.

Providers are able to see the status of the referral in the My Aged Care Service and Support Portal.

If a provider has submitted an entry record and cannot see the referral for the resident, they should email ANACCassessments@health.gov.au.

Following completion of the RAC funding assessment, an AN-ACC class will normally be assigned to the resident the next day and viewable in the My Aged Care Service and Support Portal

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Residents, and their nominated representatives, can see the AN-ACC class that has been assigned to them in the My Aged Care Online Account, which can be accessed through their MyGov account.

7.1.1 Assessment during acute illness or injury

Where a resident scheduled for a RAC funding assessment has an acute illness or injury (such as COVID-19 or a broken bone), the RAC funding assessor may work with the provider, facility manager, or care manager to reschedule the assessment. This is because of the temporary nature of acute illness or injury. RAC funding assessments at this time may not reflect the resident's typical care needs and/or a RAC funding assessment may be inappropriate for the resident (for example, they are in pain or unwell).

Rescheduling a RAC funding assessment until a resident has recovered supports timely, more accurate assessments and ensures the stability of the resident. It also ensures that funding and care minutes reflect the ongoing needs of the resident.

7.2 Assessor qualifications

All RAC funding assessors employed by an assessment organization, are experienced aged care clinicians who have satisfied a screening and accreditation processes. This includes confirmation that:

- they are an unrestricted registered nurse, occupational therapist, or physiotherapist with AHPRA

- they have at least 5 years of clinical experience in the delivery of aged care services or related health services as a registered nurse, occupational therapist, or physiotherapist (as the case requires)
- a police certificate issued for the person within the last 2 years does not record that the person has a serious offence conviction in Australia
- for persons who have been a permanent resident of a country other than Australia while over 16 years of age, a statutory declaration that the person does not have a serious offence conviction in that country.

In addition, RAC funding assessors complete a comprehensive training course on the use of the AN-ACC Assessment Tool and are required to achieve a pass mark of at least 75% in their final exam.

For respite assessments, aged care needs assessors (needs assessors) are guided by the Integrated Assessment Tool (IAT) User Guide and trained in use of the DEMMI-modified tool (respite assessments).

7.3 AN-ACC Assessment Tool (permanent residents)

RAC funding assessors use the AN-ACC Assessment Tool to assess permanent residents.

The AN-ACC assessment tool was designed by clinical experts in health and aged care and comprises a suite of tools that focus on the characteristics of residents that drive the costs of care, including:

- Technical Nursing Requirements
- Resource Utilisation Groups – Activities of Daily Living (RUG-ADL)
- Australia-modified Karnofsky Performance Status
- Rockwood Clinical Frailty Scale
- Braden Scale for Predicting Pressure Sore Risk
- De Morton Mobility Index (DEMMI) – modified
- Australian Functional Measure (AFM)
- Behaviour Resource Utilisation Assessment (BRUA)

A RAC funding assessment using the AN-ACC assessment tool considers the resident's:

- physical ability, including pain
- cognitive ability, including memory, communication, sequencing, social skills, and problem solving
- behaviour, including cooperation, agitation, wandering, passive resistance and verbal aggression
- mental health, including depression and anxiety.

7.4 Respite Assessments

Needs assessors use the De Morton Mobility Index - modified (DEMMI-modified) tool within the Integrated Assessment Tool (IAT) to assess respite residents.

Unlike a funding assessment, which must be performed while a person is at a residential aged care service, the DEMMI-modified component of a needs assessment can also be performed in the community, under the direction of either a RAC funding assessor or a needs assessor.

Most people approved for respite care will be assessed using the DEMMI-modified tool at the time of their standard aged care needs assessment and will not need to be assessed again on entry to a service unless the approved provider makes a reclassification request.

The DEMMI-modified tool must be used in a face-to-face setting.

7.5 Assessment quality assurance

7.5.1 Data analysis

Analysis of RAC funding assessment data provides information on trends, anomalies and patterns. This is used to refine RAC funding assessor training or check specific assessment results.

7.5.2 Dual assessments

A RAC funding assessor assigned to conduct a RAC funding assessment will sometimes be required to do the assessment alongside another funding assessor as part of a dual assessment process for quality assurance purposes. Only the first RAC funding assessor's data will be used to make the classification decision. The results of the second assessment are reviewed within the department.

RAC funding assessors are restricted from engaging with each other during the quality assurance assessment to ensure the integrity of the dual assessment process.

RAC funding assessors must meet certain requirements for a dual assessment to be conducted, including that both RAC funding assessors must:

- have spent the same or similar amount of time at the service of the resident being assessed.
- observe the resident at the same time and attend the full assessment of the resident
- have access to the same information at the same time.

7.6 Provider assessment responsibilities

An approved provider must give specific types of assistance to a RAC funding assessor if the assessor (including through their assessment organisation) has given at least 2 days prior notice in writing that they need access to a residential aged care service on a particular day or days.

RAC funding assessor visits are only triggered by provider actions (such as admitting new residents, requesting reclassifications, or requesting reconsiderations).

Assessment organisations will endeavour to schedule requested visits at times convenient to providers, subject to the need to complete RAC funding assessments in target timeframes and subject to impacts of events such as public health emergencies or natural disasters.

The approved provider must allow the RAC funding assessor timely access to the following on the specified day as required to make the RAC funding assessments:

- all areas of the premises used to provide care through the service
- staff members of the approved provider who are on those premises on the specified day
- the care recipients whose care needs are to be assessed
- records relating to the care needs of those care recipients.

If an approved provider does not provide access and assistance to RAC funding assessors, the provider is in breach of responsibilities under Chapter 4 of the Aged Care Act 1997 (the Act). The Aged Care Quality and Safety Commission may investigate and as necessary apply any appropriate measures permitted under the Aged Care Quality and Safety Commission Act 2018, with the aim of ensuring the provider supplies that assistance immediately and into the future.

For legislation, see paragraph 63-1(1)(ha) of the *Aged Care Act 1997*, sections 4A and 4B of the *Accountability Principles 2014* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*.

Section 8: One-off adjustment payment

8 One-off entry adjustment payment

Providers are paid a one-off entry adjustment payment each time a permanent resident enters a residential aged care service, including residents transferring from one service to another or a transferring from respite to permanent care at the same service. This supports costs related to initial planning and monitoring required when a resident permanently enters a new care environment.

The one-off entry adjustment payment will be paid after claims information has been submitted through the Services Australia Aged Care Provider Portal.

This funding component is 5.28 NWAU multiplied by the ANACC price, or $1,491.28 per new resident from 1 March 2025.

Section 9: Leave

9 Leave

The Aged Care Act 1997 (the Act) provides the number of days a resident may be on leave from the residential aged care service. For each day the resident is on leave, the care recipient is taken, for the purposes of the Act, to be provided with care and the approved provider of the residential aged care service will continue to receive resident fees and government subsidy as though the resident was receiving care.

9.1 Hospital leave

A resident can take unlimited days of leave to receive hospital treatment. A subsidy continues to be paid for residents during periods of hospital leave. Hospital leave is not available until after a resident has entered the aged care service.

9.2 Extended hospital leave

Extended hospital leave is where a resident has hospital leave for a continuous period of 29 days or more, to receive treatment in hospital.

For residents who are on extended hospital leave, the subsidy amounts paid to the aged care service is reduced from the 29th day onward to an amount equal to the amount of BCT for the service (that is, not including the amount linked to the resident's AN-ACC class).

Resident fees cannot be increased during extended hospital leave to cover the reduction in subsidy payments.

9.3 Social leave

Residents are entitled to up to 52 overnight absences (that is, 52 days of social leave) per financial year. This allows residents to spend time with their families, without losing their place at the service.

Subsidies to the service will continue during social leave, however, government subsidies for that resident will cease once the resident has used up their 52 days of social leave. The resident can take extra social leave but may be charged an additional amount by the provider to secure their place. While on social leave, the resident continues to pay their agreed basic daily fees, means tested care fee and daily accommodation payments.

9.4 Emergency leave

In certain circumstances, the Government may activate emergency leave by declaring an emergency situation. This includes such things as pandemics, epidemics, or natural disasters. Emergency leave gives permanent aged care residents the option to take special leave during the declared emergency, to temporarily leave their service.

While a resident is on emergency leave, aged care services will continue to be paid their ANACC subsidy, ensuring providers are not disadvantaged and residents do not have to pay additional fees to hold their place.

Since August 2022 emergency leave has had a separate claiming code in the Services Australia Aged Care Provider Portal.

An emergency situation is currently in place until 31 December 2024.

For more information on aged care leave, see managing temporary leave for residential aged care.

Section 10: Pricing updates

10 Pricing updates

The Government is responsible for setting the AN-ACC price under the AN-ACC funding model. The Independent Health and Aged Care Pricing Authority (IHACPA) provides annual pricing advice to the Government to inform AN-ACC price adjustments. IHACPA may also make recommendations regarding adjustments to the NWAU values (weightings) for AN-ACC BCTs and AN-ACC casemix classifications.

10.1 Providing access and assistance to IHACPA

Under Part 1B of the *Accountability Principles 2014*, approved providers of residential care services must allow persons performing IHACPA advice activities access to the service and provide such persons with all reasonable facilities and assistance necessary for the performance of those activities.

IHACPA advice activities means the collection and review of data, costing and other studies, and consultations, for the purpose of providing advice to Ministers on aged care pricing or costing matters.

IHACPA must give notice in writing that access to a service on a day is required and/or that data must be provided on a day and/or that access to a relevant person on a day is required. A notice must be given at least 14 days before the specified day.

If access to the service is required, the approved provider must allow the persons performing the activity timely access on the specified day as required:

- all areas of the premises of the service, other than the personal rooms of care recipients who are not participating in the IHACPA advice activity (e.g., costing study)
- service staff who are on the premises of the service on the specified day
- the care recipients who are provided with residential care through the service and are participating care recipients for the activity
- records kept by the approved provider.

Reasonable facilities and assistance necessary includes, but is not limited to:

- site orientation, including guidance on how to safely navigate the premises of the service
- dissemination of information to service staff in relation to the service and care recipients and their families or representatives
- access to facilities at the premises of the service for working onsite at the premises
- instructions necessary for accessing records of the service.

If data must be provided, the notice may specify the form or quality of the data and how it is to be provided.

A relevant person is a member of the key personnel or service staff who is either specified personally or who is responsible for a matter specified in the notice.

Section 11: Provider obligations

11 Provider obligations

Approved providers are required to provide services to residents in accordance with their obligations under the Aged Care Act 1997 (the Act) and the associated Aged Care Quality Standards (Quality Standards).

11.1 Aged Care Act 1997

The Act is the main law that covers government-funded aged care, including:

- eligibility
- funding
- regulation
- approval of providers
- subsidies and fees
- standards
- quality of care
- rights of people receiving care
- non-compliance.

There is a suite of principles that sit under the Act providing more detail on these rules, including the Quality of Care Principles 2014 (the Principles). The Principles set out the responsibilities of approved providers in providing residential and home care services.

The Government is consulting on development of a new Aged Care Act.

11.2 Specified care and services

It is the responsibility of an approved provider to determine how best to meet the care needs of their residents, including ensuring that the specified care and services detailed under Schedule 1 of the Principles are provided to all residents who need them.

11.2.1 Allied health services

Providers are required to make a range of services available to residents as needed, as detailed under Schedule 1 of the Principles. This includes access to allied health services as part of an individual therapy program aimed at maintaining or restoring a resident's ability to perform daily tasks.

From 1 October 2022, ACFI funding for allied health care was rolled into AN-ACC. Under AN-ACC, providers are still funded for and required to provide allied health care services to residents.

See Allied health under AN-ACC for more information on the allied health services obligations of providers.

11.2.2 Care planning

Under the Principles, care planning must be carried out by a nurse practitioner or registered nurse, with ongoing management and evaluation carried out by a nurse practitioner, registered nurse or enrolled nurse acting within their scope of practice.

RAC funding assessments are not a care plan and services must continue to provide care planning in accordance with their legislated obligations.

11.2.3 Additional Services

Approved providers cannot charge care recipients additional fees for care and services outlined in Part 3 of Schedule 1 of the Principles.

Approved providers cannot charge additional service fees:

- for specified care and services outlined in of the Principles
- for services already covered by the payment of an extra service fee or accommodation payment
- for services required to be delivered under their responsibilities as a provider.

Providers may charge a fee for genuine additional care and services if they can demonstrate that they are not otherwise required to be provided or are substantially better than the standard that must be provided under Schedule 1 of the Principles. Providers must not charge more for additional services than an amount agreed beforehand with the resident and must give them an itemised account of the additional services.

11.3 Quality Standards

The Quality Standards focus on outcomes for residents and reflect the level of care and services the community can expect from organisations that provide Government-subsidised aged care services.

The Aged Care Quality and Safety Commission is responsible for monitoring the quality of care and services of residential aged care facilities against the Quality Standards.

11.4 24/7 registered nurse and care minutes responsibilities

From 1 July 2023, approved providers must have a registered nurse on site and on duty 24 hours a day, 7 days a week.

From 1 October 2022, the government provided additional funding to help residential aged care providers deliver a sector-wide average of 200 minutes of care per resident per day (including 40 minutes of registered nurse time), based on care provided by:

- registered nurses (registered with the Nursing and Midwifery Board of Australia)
- enrolled nurses (registered with the Nursing and Midwifery Board of Australia)
- personal care workers / assistants in nursing.

Care minutes requirements became mandatory from 1 October 2023.

From 1 October 2024, care minutes increased to an average casemix adjusted 215 minutes (including 44 minutes of registered nurse time).

Any changes to individual resident AN-ACC classifications resulting from a reclassification or reconsideration process may affect the provider's care minutes targets at the service level.

For more information see the Care minutes and 24/7 registered nurse responsibility guides.

11.4.1 Care staff minutes reporting

Approved providers are required to report their care staffing minutes through the Quarterly Financial Report (QFR). Data from QFRs will be used to determine each aged care service's performance against their care minutes targets, including when these become mandatory.

Reporting on care minutes will be one of the measurable indicators used to inform the Star Rating system on the My Aged Care website. Star Ratings will help older Australians, their

carers, and families to compare the care minutes delivered by different services and choose one that is right for them.

11.4.2 24/7 RN reporting

Approved providers must report monthly on their registered nurse coverage at each facility they manage on the Government Provider Management System.

For more information, see 24/7 registered nurse reporting.

11.4.3 Care time reporting assessments

Care time reporting assessments check the accuracy of care minutes and 24/7 registered nurse information reported by residential aged care services in the QFR and registered nurse coverage reports.

Approved providers are required to keep, and on request produce, documentation that supports their reporting. Examples of the types of records and documentation likely to be requested for care time assessments include, but are not limited to:

- enterprise agreements
- Australian Health Practitioner Regulation Agency (AHPRA) IDs
- position descriptions
- staff rosters
- pay records (with tax file numbers redacted)
- resident occupancy records
- documents supporting day-to-day procedures and activities associated with care and lifestyle activities
- processes and controls to ensure accurate reporting.

For more information see Care time reporting assessments.

11.5 Residents exiting from care

Residents may choose to leave a residential aged care service at any time, or they could be asked to leave due to certain circumstances.

If a resident is asked to leave a service, the approved provider must comply with certain requirements, including notifying Services Australia through the Aged Care Provider Portal.

These requirements also apply in circumstances where the resident passes away.

Providers must notify Services Australia within 28 days if a resident exits care, to ensure the integrity of AN-ACC funding.

Appendices

Appendix 1: Glossary

Term	Explanation
ACFI basic subsidy	Defunct subsidy now incorporated into AN-ACC.
Aged Care Act 1997	Main law that covers government-funded aged care. It sets out rules for things like funding, regulation, approval of providers, quality of care and the rights of people receiving care.
Aged Care Assessment Service (ACAS)	Defunct term. Please see “aged care needs assessor”.
Aged Care Assessment Teams (ACATs)	Defunct term. Please see “aged care needs assessor”.
Aged care needs assessment	An assessment that either a clinical or non-clinical aged care needs assessor completes using the Integrated Assessment Tool (IAT). For residential **respite** care funding, the AN-ACC respite class is determined via a needs assessment using the IAT. For residential **permanent** care, see “residential aged care funding assessment”.
Aged care needs assessor or needs assessor	Aged care assessors who conduct needs assessments using the Integrated Assessment Tool (IAT). For residential **respite** care funding, the AN-ACC respite class is determined via a needs assessment using the IAT. Defunct terms: • Aged Care Assessment Service (ACAS) • Aged Care Assessment Teams (ACATs) • Regional Assessment Service (RAS) assessor. For residential **permanent** care, see “residential aged care funding assessor”.
Aged Care Quality and Safety Commission	End-to-end regulator of aged care services responsible for provider approval, administering the Serious Incidents Response Scheme and reducing the use of restrictive practices.
Aged Care Quality Standards	Standards that outline service obligations on providers, including delivery of care plans and allied health services.
Allied health services	Services provided by a broad range of health professionals who are not doctors, dentists, nurses, or midwives. Funding for allied health services is included in AN-ACC. Providers are required to make services available to residents. Requirements are detailed in Schedule 1 of the Quality of Care Principles 2014.
AN-ACC assessment	Defunct term. Please see “Residential aged care funding assessment”.
AN-ACC Assessment Tool	Tool used by residential aged care funding assessors to conduct residential aged care funding assessments.

Term	Explanation
AN-ACC class	Classification of residents that reflects their characteristics and determines the associated variable subsidy. Determined through residential aged care funding assessment.
AN-ACC subsidy	Variable AN-ACC funding component based on the characteristics of aged care residents.
AN-ACC Daily Basic Subsidy	See Section 1 for an explanation of the AN-ACC Daily Basic Subsidy.
AN-ACC price (National Efficient Price)	Price set by the Government that represents the subsidy for standard day of care, also known as the National Efficient Price.
AN-ACC Transition Fund	Grant fund to support eligible providers with transition from ACFI to AN-ACC.
Assessment organisations	Organisations that are employed as part of the Single Assessment System workforce to do aged care assessments, including residential aged care funding assessments using the AN-ACC Assessment Tool and aged care needs assessments using the IAT. Defunct term: Assessment Management Organisations (AMOs).
Australian National Aged Care Classification (AN-ACC)	Funding model for residential aged care, effective from 1 October 2022.
Base Care Tariff (BCT)	Fixed AN-ACC funding component for services reflecting characteristics such as location and specialisations for remote Aboriginal and Torres Strait Islander or homelessness.
Base Care Tariff (BCT) category	Fixed funding category based on MMM location and approved specialisation. Category determines funding basis of occupied or operational places.
Care minutes	Minutes of care provided by registered nurses, enrolled nurses, personal care workers and assistants in nursing to residents each day. The care minutes requirement became mandatory from 1 October 2023. From 1 October 2024, care minutes increased to an average casemix adjusted 215 minutes (including 44 minutes of registered nurse time).
Care plan	A document that outlines a person's care needs, the services they will receive to meet those needs and who will provide the services. Providers must continue to deliver care plans under AN-ACC.
De Morton Mobility Index - modified (DEMMI-modified)	The tool used to assess the mobility of older people within AN-ACC for respite funding purposes.
Default class	Default statuses given to residents pending AN-ACC assessment and assignment of ongoing AN-ACC class.
Department of Health and Aged Care (the department)	The Australian Government department responsible for the administration of the AN-ACC funding model.
Homeless supplement	Defunct subsidy now incorporated into AN-ACC.

Term	Explanation
Hotelling supplement	Supplement provided in addition to AN-ACC from 1 July 2023, for hotelling services such as cleaning, catering and gardening
Independent Health and Aged Care Pricing Authority (IHACPA)	Independent body that provides AN-ACC price recommendations to the Government. Formerly named the Independent Hospital Pricing Authority (IHPA).
Integrated Assessment Tool (IAT)	The IAT replaced the NSAF on 1 July 2024, for assessing the eligibility of older people for government-subsidised aged care. The IAT includes the De Morton Mobility Index – modified (DEMMI-modified) assessment tool, used for needs assessments for residential **respite** care. The AN-ACC Assessment Tool will continue to be used for RAC funding assessments for residential **permanent** care.
Leave	Days a resident may be absent from a residential care service without losing their place, as defined by the Act.
Modified Monash Model (MMM)	Measure of remoteness and population size used by the department to define whether a location is city, rural, remote, or very remote. Locations are categorised from MM 1 to MM 7, with MM 1 denoting a major city and MM 7 a very remote location.
My Aged Care Client Portal	Portal for aged care residents where they can view their AN-ACC class.
My Aged Care Service and Support Portal	Portal for providers to manage information about their services, manage referrals, update client records, generate reports and ask an assessor to review a client's AN-ACC or Respite classification.
National Weighted Activity Units (NWAUs)	Weightings applied to the ANN-ACC price to reflect variations in the costs of providing care, based on the characteristics of a service and the individual care needs of a resident.
Occupied places	Allocated places in a service occupied by residents with an approval for residential respite or residential permanent care.
One-off entry adjustment payment	One-off payment each time a resident enters a residential aged care service, including transfers between services. This supports costs related to entry of a resident to a new care environment.
Operational places	Allocated places in a service, less places that are offline and those for which subsidy is not payable, independent of occupation by residents.
Palliative care	Palliative care helps people live as fully and comfortably as possible with a life-limiting or terminal illness. Palliative care aims to ease the suffering of patients and their families.
Palliative care status form	Form that must be completed and signed by a medical or nurse practitioner, the care recipient and the provider prior to the care recipient entering residential care.
Palliative entry	Entry to a service for palliative care under AN-ACC Class 1, with life expectancy of less than 3 months and an Australia-Modified Karnofsky Performance (AKPS) score of 40 or less.

Term	Explanation
Permanent entry	Entry of a resident into a service on a permanent basis.
Provider	Approved organisation that satisfies requirements for delivering residential care. Providers may deliver multiple residential care services.
Provisional places	Allocated places in a service, where the provider is not ready to provide care immediately. Excluded from BCT funding.
Quality Standards	Standards that reflect level of care services must provide to residents, monitored by the Aged Care Quality and Safety Commission.
Quarterly Financial Report (QFR)	Mandatory report by approved providers. Includes care minutes reporting.
Reclassification	Change to AN-ACC class of a resident to reflect a change in care needs. Providers can request reclassification through the My Aged Care Service and Support Portal at any time, if any of the criteria specified under Section 4.3.1 are met. The AN-ACC class after a reclassification may be different from or the same as the previous class.
Reconsideration	Request by provider for re-assessment of AN-ACC classification. Providers can make a reconsideration request within 28 days after they receive notification of an AN-ACC initial classification decision or reclassification decision, if they believe the initial or new classification is inaccurate (see Section 6 for more information).
Remote service	Service in MM 6 or MM 7 categories.
Resident	Person receiving accommodation and personal care 24 hours a day in an aged care service. Residents also receive access to nursing and general health care services.
Residential aged care funding assessment	An assessment a residential aged care funding assessor completes using the AN-ACC assessment tool. Defunct term: AN-ACC assessment.
Residential aged care funding assessor	An aged care assessor who is completing a residential aged care funding assessment using the AN-ACC assessment tool. Defunct term: AN-ACC assessor.
Residential care subsidy	Payment by the Government to certain approved providers for providing residential care to certain care recipients. AN-ACC is a residential care subsidy.
Respite assessment	Assessment conducted by aged care needs assessors using the IAT when undertaking the DEMMI-modified tool in a home setting. Additionally Respite Assessments can be undertaken by a RAC funding assessor in a residential aged care setting. See also “aged care needs assessments”, noting any “assessment” references in this document only refer to residential aged care assessments.

Term	Explanation
Respite care	Residential care provided as an alternative care arrangement with the primary purpose of giving a carer or a care recipient a short-term break from their usual care arrangements.
Respite supplement	From 1 October 2022, respite supplement is paid for respite accommodation costs for all residential respite care recipients, aligned with the maximum amount of accommodation supplement for permanent residents.
Royal Commission into Aged Care Quality and Safety report	Report on aged care tabled on 1 March 2021. AN-ACC was implemented in response to recommendations in this report.
Service	The undertaking through which subsidy is paid to an approved provider of residential care.
Services Australia	Agency responsible for AN-ACC payment and claims IT system – the Service Australia Aged Care Provider Portal.
Services Australia Aged Care Provider Portal	Portal for aged care provider to make claims for aged care subsidies and supplements.
Single Assessment System workforce	The new aged care assessment workforce, which brings together Regional Assessment Service (RAS), Aged Care Assessment Teams (ACATs) and Australian National Aged Care Classification (AN-ACC) assessors from late 2024.
Single Assessment System or Single Assessment System for aged care	The new aged care assessment system, which brings together Regional Assessment Service (RAS), Aged Care Assessment Teams (ACATs) and Australian National Aged Care Classification (AN-ACC) assessors from late 2024. More information is available on the department's website.
Specialised Aboriginal and Torres Strait Islander service	Service that meets specialised Aboriginal and Torres Strait Islander provider and resident requirements. Only remote (MM 6) or very remote (MM 7) locations are eligible.
Specialised homeless service	Service that meets specialised homeless provider and resident requirements. May be in any MMM location.
Subsidies and supplements team	Department team that assesses eligibility requirements for specialised BCT categories.
Voluntary assisted dying	Voluntary assisted dying (VAD) is when someone chooses medical assistance to end their life because they have an advanced medical condition that causes intolerable suffering.
Viability supplement	Defunct subsidy now replaced by AN-ACC.

Appendix 2: Resources

Information source	Description
Resources and factsheets	Resources and factsheets are located here.
Social media	Follow us on Facebook, X, LinkedIn and Instagram.
Subscriptions	Subscribe to the department's newsletters here for aged care updates.
Ageing and Aged Care Engagement Hub	Find engagement activities and register your interest to be involved in workshops, focus groups, webinars, and surveys. Website: https://www.agedcareengagement.health.gov.au/
My Aged Care service provider and assessor helpline	For help with the My Aged Care system or technical support for providers and assessors. Phone: 1800 836 799 The helpline is available from 8:00am to 8:00pm Monday to Friday and 10:00am to 2:00pm Saturday, local time across Australia.

The below resources are referenced in this Guide or are relevant to AN-ACC.

Royal Commission into Aged Care

- Royal Commission into Aged Care Quality and Safety

Department of Health and Aged Care

- Department of Health and Aged Care website
- Residential aged care funding reform
- Australian National Aged Care Classification funding model
- Australian National Aged Care Classification (AN-ACC) assessment pathways for an aged care resident
- My Aged Care Service and Support Portal
- My Aged Care – Provider Portal User Guide: Part 2 Team Leader and Staff Member Functions
- Aged care assessment programs
- Single Assessment System
- Modified Monash Model
- Aged care workforce
- Health Workforce Locator
- Responsibilities of approved aged care providers
- Specialised Status Guide for Residential Aged Care Approved Providers
- What is the AN-ACC Transition Fund?
- Quality in aged care
- Palliative care status form
- AN-ACC Reference Manual and AN-ACC Assessment Tool
- AN-ACC assessment process and classification (assessment organisations)
- Managing temporary leave for residential aged care
- Aged care laws in Australia

- Quarterly financial report
- Exiting residents from residential aged care
- My Aged Care – Application for Care Form
- My Aged Care Client Portal
- Care minutes and 24/7 registered nurse responsibilities – guides for residential aged care providers
- Residential aged care funding reform update – Webinar 18 September 2024
- Care costs and care minutes reporting (video)
- Registered Nurse Care Minutes Reporting (video)

Services Australia

- Services Australia website
- Services Australia Aged Care Provider Portal
- Digital claiming for aged care providers
- Residential Aged Care means assessment

Aged Care Quality and Safety Commission

- Aged Care Quality and Safety Commission website
- Aged care homes
- Becoming an approved aged care provider
- Approval and accreditation
- Changes to residential aged care place allocation
- Quality standards

Independent Health and Aged Care Pricing Authority (IHACPA)

- Independent Health and Aged Care Pricing Authority

Legislation

- Aged Care Act 1997
- Aged Care (Transitional Provisions) Act 1997
- Quality of Care Principles 2014
- Classification Principles 2014

Appendix 3: Payment calculations

The calculations and examples below are based on funding for a single day only and apply from 1 March 2025. To estimate funding for a monthly payment period, providers will need to apply the calculation methodology for each funding component (where applicable) for each day based on the number of residents that were in care.

Any estimates providers make using the methodology are a point in time estimate only, based on the service's existing AN-ACC resident classifications.

All figures are based on the AN-ACC price of $282.44 from 1 March 2025.

Step 1: fixed funding (BCT)

The way BCT funding is calculated differs across the BCT categories. For Standard MM 6 – 7, Specialised Aboriginal and Torres Strait Islander MM 6 and Aboriginal and Torres Strait Islander MM 7, it is calculated per operational place. For Standard MM 1 – 4, Standard MM 5 and Specialised Homeless service groups, it is calculated per occupied place.

Table 5 shows the daily BCT funding per place for Standard MM 6 – 7, Specialised Indigenous and Torres Strait Islander MM 6 and Specialised Indigenous and Torres Strait Islander MM 7 service groups. The BCT funding per place is based on the NWAU for the BCT category multiplied by the ANACC price.

Table 5 BCT funding per operational place

BCT Category	Services Australia Payment Statement code	NWAU	Funding Basis	Notional funding per operational place
Standard MM 6 – 7	Fixed subsidy – class 3H	0.68 for first 29 places	Operational places	$192.059
	Fixed subsidy – class 3L	0.52 for places 30 and above	Operational places	$146.869
Specialised Aboriginal and Torres Strait Islander MM 6	Fixed subsidy – class 2	0.78	Operational places	$220.303
Specialised Aboriginal and Torres Strait Islander MM 7	Fixed subsidy – class 1	1.80	Operational places	$508.392

The BCT funding for a single day for each of these BCT categories can be calculated using the formula: [BCT funding per place x number of places].

For example, ABC Aged Care Services is a Standard, remote (MM 6) 28 place service, with 25 residents in care. The BCT funding that ABC Aged Care Services would receive is $5,377.652 for the day ($192.059 x 28 places), provided there is at least one resident in care.

Table 6 shows the daily BCT funding per occupied place for Standard MM 1, MM 2-3 and MM 4-5 and Specialised Homeless service groups. The BCT funding per occupied place is based on the NWAU for the service group multiplied by the AN-ACC price.

Table 6 BCT funding per occupied place

BCT Category	Services Australia Payment Statement code	NWAU	Funding Basis	Funding per occupied place
Standard MM 1	Fixed subsidy – class 6	0.50	Occupied places	$141.22
Standard MM 2-3	Fixed subsidy – class 4	0.55	Occupied places	$155.34
Standard MM 4-5	Fixed subsidy – class 7	0.57	Occupied places	$160.99
Specialised homeless	Fixed subsidy – class 5	0.92	Occupied places	$259.84

The BCT funding for a single day for each of these BCT categories can be calculated using the formula: [BCT funding per place x number of occupied places].

For example, XYZ Aged Care Services is a metropolitan Standard (MM 1) 100 place service, with 90 places occupied. The BCT funding XYZ Aged Care Services would receive is $12,709.80 for the day based on the 90 occupied places ($141.22 x 90 places).

Step 2: variable funding (AN-ACC class)

Variable funding is based on each resident's AN-ACC classification. Table 7 shows the NWAUs and variable funding per resident per day associated with each of the AN-ACC classes. The AN-ACC class funding is based on the NWAU for the AN-ACC class multiplied by the AN-ACC price.

Table 7 AN-ACC class funding

AN-ACC class	Resident description	NWAU	AN-ACC Class funding (NWAU x Price)
Class 1	Admit for palliative care	0.80	$225.95
Class 2	Independent without compounding factors	0.19	$53.66
Class 3	Independent with compounding factors	0.37	$104.50
Class 4	Assisted mobility, high cognition, without compounding factors	0.25	$70.61
Class 5	Assisted mobility, high cognition, with compounding factors	0.44	$124.27
Class 6	Assisted mobility, medium cognition, without compounding factors	0.40	$112.98
Class 7	Assisted mobility, medium cognition, with compounding factors	0.55	$155.34
Class 8	Assisted mobility, low cognition	0.64	$180.76
Class 9	Not mobile, higher function, without compounding	0.52	$146.87

AN-ACC class	Resident description	NWAU	AN-ACC Class funding (NWAU x Price)
	factors		
Class 10	Not mobile, higher function, with compounding factors	0.70	$197.71
Class 11	Not mobile, lower function, lower pressure sore risk	0.66	$186.41
Class 12	Not mobile, lower function, higher pressure sore risk, without compounding factors	0.66	$186.41
Class 13	Not mobile, lower function, higher pressure sore risk, with compounding factors	0.80	$225.95
Class 98	Default class for residents entering permanent care to receive palliative care	0.80	$225.95
Class 99	Default class for residents entering for permanent care (other than entry for palliative care)	0.64	$180.76

The variable funding for a service per day is calculated using the formula: [sum of (AN-ACC Class funding x number of residents)].

For example, ABC Aged Care Services had 25 residents:

- 10 residents are in AN-ACC Class 3
- 10 residents are in AN-ACC Class 5
- 5 residents are in AN-ACC Class 8

The variable funding that ABC Aged Care Services would receive is $3,191.50 for that day based on the differing resident funding levels:

Table 8 Total variable funding for one day

AN-ACC Component	Calculation	Funding Amount for day
Variable Funding	$104.50 x 10 residents +	$1,045.00
	$124.27 x 10 residents +	$1,242.70
	$180.76 x 5 residents	$903.80
Total variable funding		**$3,191.50**

Step 3: one-off entry adjustment funding

The new entrant adjustment funding is provided as a one-off funding when a new permanent resident enters a service to cover the one-off costs associated with transitioning into a new care environment. This funding component is 5.28 NWAU multiplied by the AN-ACC price, or $1,491.28 per new resident, and is separate to the AN-ACC Daily Basic Subsidy.

For example, if ABC Aged Care Services had 5 new residents enter the service for the month, the service would receive $7,456.40 in new entrant funding that month ($1,491.28 x 5 residents).

Step 4: total AN-ACC funding

Here is what the total AN-ACC funding would look like for ABC Aged Care Services, which is a non-specialist, remote (MM 6) 28 place service, with the following 25 residents (of which 5 were new entrants):

- 10 residents are in AN-ACC Class 3
- 10 residents are in AN-ACC Class 5
- 5 residents are in AN-ACC Class 8

The total AN-ACC funding that ABC Aged Care Services would receive is $16,025.55 ($8,569.15 for the AN-ACC Daily Basic Subsidy plus $7,456.40 for the one-off adjustment). The funding incorporates:

Table 9 Total AN-ACC funding for one day

Funding	AN-ACC Component	Calculation	Funding Amount for day
AN-ACC Daily Basic Subsidy	BCT funding	$192.059 x 28 places	$5,377.65 ^
	Variable funding	$104.50 x 10 residents + $124.27 x 10 residents + $180.76 x 5 residents	$3,191.50
One-off adjustment	New entrant adjustment funding	$1,491.28 x 5 residents	$7,456.40
Total AN-ACC funding			**$16,025.55**

^ Amount rounded to 2 decimal places.

If the residents at ABC Aged Care Services did not change over the month, the total AN-ACC funding that ABC Aged Care Services would receive for the month would be the Daily Basic Subsidy ($8,569.15) multiplied by 30 days for the month ($257,074.50) plus the one-off adjustment of $7,456.40 for a total of $264,530.90. The funding incorporates:

Table 3 Total AN-ACC funding for one month

Funding	AN-ACC Component	Calculation	Funding Amount for day
AN-ACC Daily Basic Subsidy	BCT + variable funding	$8,569.15 x 30 days	$257,074.50
One-off adjustment	New entrant adjustment funding	$1,491.28 x 5 residents	$7,456.40
Total AN-ACC funding for month			**$264,530.90**

Step 5: calculate respite funding

BCT funding is calculated identically for both permanent residential care and residential respite care.

Variable funding for respite is based on each resident's residential respite classification. Table 11 shows the NWAUs and per resident per day funding associated with each of the 3 respite classes. The Respite class funding is based on the NWAU for the applicable AN-ACC respite class multiplied by the AN-ACC price.

Table 4 Respite class funding

Respite Class	Services Australia Payment Statement code	Resident description	NWAU	Respite Class Funding
Respite Class 1	Variable subsidy – class 101	Independent mobility	0.365	103.09
Respite Class 2	Variable subsidy – class 102	Assisted mobility	0.479	135.29
Respite Class 3	Variable subsidy – class 103	Not mobile	0.691	195.17
Respite Class 100	Variable subsidy – class 103	Default class for residents entering for respite care	0.479	135.29

The variable respite funding for a facility for a single day is calculated using the formula: [sum of (Respite class funding x number of residents)]

For example, Johnny's Aged Care Services had 7 respite residents:

- 2 residents are in respite Class 101
- 2 residents are in respite Class 102
- 3 residents are in respite Class 103

The variable funding that Johnny's Aged Care Services would receive is $1,062.27 for that day based on the differing resident respite class funding levels:

Table 5 Total variable respite funding for one day

Respite class	Number of residents	Respite Class Funding	Variable funding amount per day
Class 101	2	$103.09	$206.18
Class 102	2	$135.29	$270.58
Class 103	3	$195.17	$585.51
Variable respite funding			**$1,062.27**

Respite supplement funding is also provided for all respite care residents:

Table 6 Daily respite supplement funding per resident

Respite supplement category	Daily funding amount per respite resident
If a service is significantly refurbished or newly built on or after 20 April 2012	$69.49
If on the day the service meets building requirements in Schedule 1 of Aged Care (Transitional Provisions) Principles 2014	$45.31
If on the day the service does not meet those requirements	$38.07

Total respite care funding is equal to the applicable BCT funding, plus the variable respite funding (based on each resident's residential respite classification), plus applicable respite supplement funding. Amount is rounded to 2 decimal places.

For example, Johnny's Aged Care Services is a significantly refurbished metropolitan (MM 1) non-specialist service. Table 14 shows the total respite care funding for the delivery of care at this service for a single day.

Table 7 Total respite funding for one day

Funding	Calculation	Funding amount per day
BCT funding*	$141.22 x 7 residents	$988.54
Variable funding	$103.09 x 2 residents + $135.29 x 2 residents + $195.17 x 3 residents	$1,062.27
Respite supplement funding (significantly refurbished)	$69.49 x 7 residents	$486.43
Total respite care funding		**$2,537.24**

* BCT for standard MM 1 facilities used.