Aged Care Rules 2025

made under the

Aged Care Act 2024

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This compilation is in 2 volumes

Volume 1:	**Chapters 1 to 5** **sections 1-5 to 177-20**
Volume 2:	Chapters 6 to 15 sections 187-1 to 610-1B Endnotes

Each volume has its own contents

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Prepared by the Office of Parliamentary Counsel, Canberra

About this compilation

This compilation

This is a compilation of the *Aged Care Rules 2025* that shows the text of the law as amended and in force on 1 August 2026 (the ***compilation date***).

The notes at the end of this compilation (the ***endnotes***) include information about amending laws and the amendment history of provisions of the compiled law.

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The effect of uncommenced amendments is not shown in the text of the compiled law. The details of amendments made up to, but not commenced at, the compilation date are underlined in the endnotes. Any uncommenced amendments affecting the law are accessible on the Register (www.legislation.gov.au).

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If the operation of a provision or amendment of the compiled law is affected by an application, saving or transitional provision that is not included in this compilation, details are included in the endnotes.

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For more information about any editorial changes made in this compilation, see the endnotes.

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The *Legislation Act 2003* provides for First Parliamentary Counsel to make presentational changes to a compilation. Presentational changes are applied to give a more consistent look and feel to legislation published on the Register, and enable the user to more easily navigate those documents.

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If the compiled law is modified by another law, the compiled law operates as modified but the modification does not amend the text of the law. Accordingly, this compilation does not show the text of the compiled law as modified. Any modifications affecting the law are accessible on the Register.

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Chapter 1—Introduction

Part 1—Preliminary

1-5 Name

This instrument is the *Aged Care Rules 2025*.

3-5 Authority

This instrument is made under the *Aged Care Act 2024*.

4-5 Simplified outline of this instrument

This instrument provides for matters for the purposes of the Act that relate to the delivery of funded aged care services to individuals under the Commonwealth aged care system.

Chapter 2 provides for matters relating to entry to the Commonwealth aged care system.

Chapter 3 provides for matters relating to provider registration.

Chapter 4 provides for matters relating to conditions on provider registration.

Chapter 5 provides for matters relating to registered provider, responsible person and aged care worker obligations.

Chapter 6 provides for matters relating to obligations of operators of aged care digital platforms.

Chapter 7 provides for matters relating to Commonwealth contributions for funding of aged care services.

Chapter 8 provides for matters relating to individual fees and contributions for funding of aged care services.

Chapter 9 provides for matters relating to accommodation payments and accommodation contributions for funding of aged care services.

Chapter 10 provides for matters relating to means testing for funding of aged care services.

Chapter 11 provides for matters relating to governance of the aged care system.

Chapter 12 provides for matters relating to regulatory mechanisms.

Chapter 13 provides for matters relating to information management.

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Section 4-5

Chapter 14 provides for the review and reconsideration of certain decisions made under this instrument.

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Part 2—Definitions

Division 1—Definitions—general

5-5 Definitions

Note: The following expressions used in this instrument are defined in the Act:

(a) associated provider;
(b) care and services plan;
(c) enrolled nurse;
(d) health service;
(e) means testing category;
(f) Multi-Purpose Service Program;
(g) National Law;
(h) nursing;
(i) nursing assistant;
(j) old Act;
(k) registered nurse;
(l) service agreement;
(m) specialist aged care program;
(n) subsidy basis;
(o) Transition Care Program;
(p) transition time.

In this instrument:

2023 MM category means a category for an area provided for by the Modified Monash Model, as the model existed on 13 April 2025, and known as MM 1, MM 2, MM 3, MM 4, MM 5, MM 6 or MM 7.

Aboriginal or Torres Strait Islander Health Practitioner means a person who is registered under the National Law in the Aboriginal and Torres Strait Islander health practice profession.

Aboriginal or Torres Strait Islander Health Worker means a person who:

(a) is:
  (i) a full member of the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners; and
  (ii) not an Aboriginal or Torres Strait Islander Health Practitioner; or
(b) holds a Certificate II or higher in Aboriginal or Torres Strait Islander Primary Health Care Practice from a registered training organisation.

accepted mental health condition means a mental health condition for which:

(a) the Repatriation Commission has accepted liability to pay a pension under the Veterans' Entitlements Act; or
(b) the Military Rehabilitation and Compensation Commission has accepted liability to pay compensation under the MRC Act or the *Safety, Rehabilitation and Compensation Act 1988*.

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accommodation bond agreement means an agreement between an individual in the pre-2014 accommodation class and a registered provider in relation to the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home of the provider that meets the requirements set out in section 287-25.

accommodation bond retention amount means an amount that a registered provider may deduct from an accommodation bond balance in accordance with section 287-95.

accommodation charge agreement means an agreement between an individual in the pre-2014 accommodation class and a registered provider in relation to the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home of the provider that meets the requirements set out in section 287-115.

accommodation wing, of an approved residential care home, includes any of the following:

(a) a building;
(b) a floor or level of a building;
(c) an annex to a building;

that is used to provide accommodation for an individual to whom funded aged care services are being delivered in the home.

ACN has the same meaning as in the *Corporations Act 2001*.

Act means the *Aged Care Act 2024*.

additional service fee means an additional service fee under section 146 of the *Aged Care (Consequential and Transitional Provisions) Rules 2025*.

ad hoc higher everyday living agreement: see section 284-2.

AFM assessment item means the Australian Modified Functional Independence Measure assessment item of the AN-ACC Assessment Tool.

AFM cognition score, for an individual, means the individual's total score for communication and social cognition on the AFM assessment item.

AFM communication score, for an individual, means the individual's total score for communication on the AFM assessment item.

AFM eating score, for an individual, means the individual's score for eating on the AFM assessment item.

AFM motor score, for an individual, means the individual's total score for self-care, sphincter control, transfers and locomotion on the AFM assessment item.

AFM social cognition score, for an individual, means the individual's total score for social cognition on the AFM assessment item.

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AFM transfers score, for an individual, means the individual's total score for transfers on the AFM assessment item.

Aged Care Assessment Manual means the Aged Care Assessment Manual, published by the Department, as existing on 29 June 2026.

Note: The Aged Care Assessment Manual could in 2026 be viewed on the Department's website (https://www.health.gov.au).

aged care financial report, for a registered provider, means the report required by section 166-310.

age pension has the same meaning as in Part 2.2 of the Social Security Act.

agitation score, for an individual, means the individual's score for physically aggressive or inappropriate behaviour on the Behaviour Resource Utilisation Assessment assessment item of the AN-ACC Assessment Tool.

AKPS assessment item means the Australia-modified Karnofsky Performance Status assessment item of the AN-ACC Assessment Tool.

AKPS score, for an individual, means the individual's score on the AKPS assessment item.

allied health assistant means a person who holds a Certificate IV in Allied Health Assistance from a registered training organisation.

allied health profession means a health profession other than the following:

(a) dental (including the profession of a dentist, dental therapist, dental hygienist, dental prosthetist and oral health therapist);
(b) medical;
(c) midwifery;
(d) nursing.

allied health professional means a person who is any of the following:

(a) a registered health practitioner who:
  (i) is registered under the National Law to practise an allied health profession, other than as a student (within the meaning of the National Law); or
  (ii) holds non-practising registration under the National Law in an allied health profession;
(b) an Aboriginal or Torres Strait Islander Health Worker;
(c) an art therapist;
(d) an audiologist;
(e) a certified practicing nutritionist;
(f) a counsellor;
(g) a dietitian;
(h) an exercise physiologist;
(i) a genetic counsellor;
(j) a music therapist;

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(k) an orthoptist;
(l) an orthotist;
(m) a pedorthist;
(n) a prosthetist;
(o) a recreational therapist;
(p) a rehabilitation counsellor;
(q) a social worker;
(r) a sonographer;
(s) a speech pathologist.

AN-ACC Assessment Tool means the Australian National Aged Care Classification Assessment Tool, published by the Department, as existing on 1 April 2021.

Note: The AN-ACC Assessment Tool could in 2025 be viewed on the Department's website (https://www.health.gov.au).

AN-ACC Reference Manual means the Australian National Aged Care Classification Reference Manual, published by the Department, as existing on 1 April 2021.

Note: The AN-ACC Reference Manual could in 2025 be viewed on the Department's website (https://www.health.gov.au).

annual accountability report, for a registered provider, means the report required under section 166-745.

annual activity report, for a registered provider, means the report required under section 166-725.

annual financial declaration statement, for a registered provider, means the statement required by section 166-605.

annual prudential compliance statement, for a registered provider, means the statement required by section 166-360.

annual statement of financial compliance and income and expenditure, for a registered provider, means the statement required by section 166-730.

annual wellness and reablement report, for a registered provider, means the report required under section 166-615.

antipsychotic medication, in relation to medication management, means the prescription of medications to an individual for the purposes of the treatment of a diagnosed condition of psychosis.

approval year, for an approved higher maximum accommodation payment amount, means the period of 1 year beginning on:
(a) the day the approval takes effect under section 290-25 or 290-30 (as applicable); or
(b) any later anniversary of that day.

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approved health practitioner means a medical practitioner, nurse practitioner or registered nurse.

approved higher maximum accommodation payment amount means a higher maximum accommodation payment amount (expressed as a refundable accommodation deposit amount) approved by the Pricing Authority under subsection 290(6) of the Act.

ARIA value, for a location, means the value given to that location in accordance with the methodology set out in the document titled *Measuring Remoteness: Accessibility/Remoteness Index of Australia (ARIA)*, Occasional Papers: New Series Number 14, published by the Department in October 2001, as the document existed on 1 July 2013.

Note: The document titled *Measuring Remoteness: Accessibility/Remoteness Index of Australia (ARIA)* could in 2025 be viewed on the Department's website (https://www.health.gov.au).

art therapist means a person who is registered with the Australian, New Zealand and Asian Creative Arts Therapies Association as a Creative Art Therapist.

assistance dog means a dog that is an assistance animal within the meaning of the *Disability Discrimination Act 1992*.

AT-HM List means the Assistive Technology and Home Modifications list published by the Department, as existing on 1 November 2025.

Note: The AT-HM List could in 2025 be viewed on the Department's website (https://www.health.gov.au).

audiologist means a person who:

(a) is both:
  (i) a full member of Audiology Australia; and
  (ii) certified by Audiology Australia as an accredited audiologist; or

(b) is a full or ordinary member, or fellow audiologist, of the Australian College of Audiology incorporating the Hearing Aid Audiology Society of Australia with a certificate of recognition of competency, issued by that College, as both a hearing rehabilitation specialist and a diagnostic rehabilitation specialist.

audited income and expenditure report, for a registered provider, means the report required under section 166-640.

Australian accounting standards means the accounting standards in force under section 334 of the *Corporations Act 2001*.

Australian Commission on Safety and Quality in Health Care means the Commission established by subsection 8(1) of the *National Health Reform Act 2011*.

Australia New Zealand Food Standards Code has the same meaning as in the *Food Standards Australia New Zealand Act 1991*.

Australian Privacy Principle has the same meaning as in the *Privacy Act 1988*.

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banning orders register means the register of banning orders established and maintained under section 507 of the Act.

Barthel Index means the questions used in the Barthel Index of Activities of Daily Living set out in Collin C, Wade DT, Davies S, Horne V. The Barthel ADL Index: a reliability study. Int Disabil Stud. 1988;10(2):61-3. doi: 10.3109/09638288809164103. PMID: 3403500.

Note: The Barthel Index could in 2026 be viewed in the Quality Indicator Program Manual on the Department's website (https://www.health.gov.au).

base interest rate, on a day in a month, means the rate (expressed as a percentage) that is the sum of the following:

(a) the below threshold rate on the first day of the month;
(b) 2%.

below threshold rate, on a day, means the below threshold rate under subsection 1082(1) of the Social Security Act on the day.

Braden activity score, for an individual, means the individual's score for activity on the Braden Scale assessment item of the AN-ACC Assessment Tool.

Braden total score, for an individual, means the individual's total score on the Braden Scale assessment item of the AN-ACC Assessment Tool.

building status amount, for an individual for a day: see subsection 230-15(1).

calculation day, for a quarter, means the 15th day of the calendar month before the calendar month in which the quarter begins.

care minute: a minute is a ***care minute*** if it is spent delivering direct care, other than the following:

(a) the planning or delivery of activities to a group of individuals;
(b) the provision or maintenance of aids, appliances or equipment.

care minutes performance statement, for a registered provider, means the statement required by section 166-335.

Category A residential care home means an approved residential care home that, immediately before the transition time, was a multi-purpose service (within the meaning of section 104 of the *Subsidy Principles 2014*) that was a Category A service within the meaning of section 88 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

Category B residential care home means an approved residential care home that, immediately before the transition time, was a multi-purpose service (within the meaning of section 104 of the *Subsidy Principles 2014*) that was a Category B service within the meaning of section 89 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

Category C residential care home means an approved residential care home that, immediately before the transition time, was a multi-purpose service (within the meaning of section 104 of the *Subsidy Principles 2014*) that was a Category C

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service within the meaning of section 90 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

Category D residential care home means an approved residential care home that is not a Category A residential care home, Category B residential care home or Category C residential care home.

certified practicing nutritionist means a person who is registered with the Australasian Association and Register of Practicing Nutritionists as a Certified Practicing Nutritionist.

chemical restraint: see subsection 17-5(2).

child safety compliance statement, for a registered provider, means the statement required by section 166-628.

CHSP is short for the program known as the Commonwealth Home Support Program.

CHSP contribution: see subsection 286-15(1).

compensation has the same meaning as in the *Health and Other Services (Compensation) Act 1995*.

compensation payer has the same meaning as in the *Health and Other Services (Compensation) Act 1995*.

complainant: see subsection 361-10(1).

complaint determination has the same meaning as in paragraph 361(1A)(d) of the Act.

compliance report, for a registered provider, means the report required under section 166-620.

conditionally included AT-HM item means a product, item of equipment or home modification:

(a) that is listed in the part of the AT-HM List headed "Conditional inclusions"; and

(b) that is not an excluded AT-HM item.

conditionally included communication and information management item means a product or item of equipment:

(a) that is listed in the part of the AT-HM List headed "Conditional inclusions" under "Communication and information management"; and

(b) that is not an excluded AT-HM item.

conditionally included domestic life item means a product or item of equipment:

(a) that is listed in the part of the AT-HM List headed "Conditional inclusions" under "Domestic life"; and

(b) that is not an excluded AT-HM item.

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consecutive unplanned weight loss, in relation to unplanned weight loss, means a decrease in the weight of an individual of any amount, as determined by comparing the weight of an individual from the finishing weight of the previous quarter against the starting weight, middle weight and finishing weight for the current quarter.

Consumer Experience Assessment means an assessment using the Quality-of-Care Experience questions.

contact includes physical contact, face-to-face contact, oral communication, written communication and electronic communication.

continuing service delivery branch: see subsection 263A-5(1).

continuity of care plan: see section 149-75.

Co-operatives National Law means the Law set out in the appendix to the *Co-operatives (Adoption of National Law) Act 2012* (NSW), and applying in a State or Territory under the following:

(a) *Co-operatives (Adoption of National Law) Act 2012* (NSW);
(b) *Co-operatives National Law Application Act 2013* (Vic.);
(c) *Co-operatives National Law Act 2020* (Qld);
(d) *Co-operatives National Law (South Australia) Act 2013* (SA);
(e) *Co-operatives National Law (Tasmania) Act 2015* (Tas.);
(f) *Co-operatives National Law (ACT) Act 2017* (ACT);
(g) *Co-operatives (National Uniform Legislation) Act 2015* (NT).

counsellor means a person who:

(a) is registered as a registered counsellor with:
  (i) the Australian Counselling Association; or
  (ii) the Psychotherapy and Counselling Federation of Australia; and
(b) has a qualification covered by level 7, 8, 9 or 10 of the Australian Qualifications Framework (within the meaning of the *Higher Education Support Act 2003*).

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counted mainstream individual: see subsection 176-15(5).

counted NATSIFACP individual: see subsection 176-35(5).

current wait time, for the allocation of a place for a classification type for a service group to an individual, on a day (the ***current day***) before the place is allocated to the individual, means the time starting at the time the individual's access approval for the classification type for the service group was given and ending at the end of the day before the current day.

daily remaining income amount, for an individual for a day: see subsection 231-17(5).

daily total essential expenses, for an individual for a day: see subsection 231-17(4).

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DAP index number, for an indexation day: see section 302-15.

day of eligible residential funded aged care services: see subsection 239-15(4).

day of recognised residential care: see subsections 176-20(4) and (5).

DEMMI score, for an individual, means the individual's total score on the De Morton Mobility Index assessment item.

De Morton Mobility Index assessment item means the De Morton Mobility Index assessment item of the AN-ACC Assessment Tool.

dietitian means a person who is accredited by Dietitians Australia as an Accredited Practising Dietitian.

disruptiveness score, for an individual, means the individual's score for verbally disruptive or noisy behaviour on the Behaviour Resource Utilisation Assessment assessment item of the AN-ACC Assessment Tool.

diverse cultural activities includes cultural activities for the following:

(a) Aboriginal or Torres Strait Islander persons;
(b) individuals from culturally, ethnically and linguistically diverse backgrounds;
(c) individuals who are lesbian, gay, bisexual, trans/transgender or intersex or other sexual orientations, gender diverse or bodily diverse.

diverse individual, means an individual who is:

(a) an Aboriginal or Torres Strait Islander person, including an Aboriginal or Torres Strait Islander person from the stolen generations; or
(b) a veteran or war widow; or
(c) from a culturally, ethnically and linguistically diverse background; or
(d) experiencing homelessness or at risk of experiencing homelessness; or
(e) a parent or child who is or was separated by forced adoption or removal; or
(f) an adult survivor of institutional child sexual abuse; or
(g) a care-leaver, including a Forgotten Australian or former child migrant placed in out of home care; or
(h) lesbian, gay, bisexual, trans/transgender or intersex or other sexual orientations or is gender diverse or bodily diverse; or
(i) an individual with disability or mental ill-health; or
(j) neurodivergent; or
(k) deaf, deafblind, vision impaired or hard of hearing.

diversional therapist means a person who holds any of the following qualifications from a registered training organisation:

(a) Certificate IV in Leisure and Health;
(b) Diploma in Leisure and Health;
(c) Bachelor of Health Science;
(d) Bachelor of Applied Science with a major in:
    (i) Leisure and Health; or

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(ii) Therapeutic Recreation.

emergency department presentation means when an individual presents to an emergency department or an urgent care centre including where that presentation is in person or via a technology enabled platform.

end-of-life care means the care provided in what is sometimes referred to as the terminal phase of life, where death is imminent and likely to occur within 3 months.

environmental restraint: see subsection 17-5(3).

excluded AT-HM item means a product, item of equipment or home modification that is listed in the part of the AT-HM List headed "Exclusions".

exercise physiologist means a person who is accredited by Exercise & Sports Science Australia as an Accredited Exercise Physiologist.

extra service fee means an extra service fee under section 145 of the *Aged Care (Consequential and Transitional Provisions) Rules 2025*.

fall means an event that results in an individual coming to rest inadvertently on the ground, floor or other lower level.

fall resulting in major injury means a fall that results in one or more of the following:

(a) bone fracture;
(b) joint dislocation;
(c) closed head injury with altered consciousness;
(d) closed head injury with subdural haematoma.

fee reduction supplement daily threshold amount for a day means the amount obtained by rounding down to the nearest cent the amount equal to 15% of the basic age pension amount (worked out on a per day basis) for the day.

fee reduction supplement fortnightly threshold amount for a fortnight means the amount obtained by rounding down to the nearest cent the amount equal to 15% of the basic age pension amount (worked out on a per fortnight basis) for the fortnight.

financial support statement, for a registered provider, means the statement required by section 166-315.

finishing weight, in relation to unplanned weight loss, means the weight of an individual recorded in the third month of a quarter.

first asset threshold: see subsection 319-5(6).

first income threshold: see subsection 319-5(2).

first subsidy year, for an approved residential care home and a registered provider, means the period of 12 months after the day the registered provider is first eligible for subsidy for the delivery (other than under a specialist aged care

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program) of a funded aged care service through the service group residential care to any individual in the approved residential care home.

formal agreement has the same meaning as in the old Act.

fortnightly base AT-HM individual amount, for an individual for a fortnight: see subsection 197-10(10).

fortnightly base home support individual amount, for an individual for a fortnight: see subsection 197-10(9).

fortnightly base individual amount, for an individual for a fortnight: see subsection 197-10(8).

fortnightly individual contribution cap, for an individual for a fortnight: see subsection 197-10(7).

fortnightly remaining income amount, for an individual for a fortnight: see subsection 197-10(6).

fortnightly total essential expenses, for an individual for a fortnight: see subsection 197-10(4).

fortnightly total income amount, for an individual for a fortnight: see subsection 197-10(5).

fourth asset threshold: see subsection 319-5(9).

fourth income threshold: see subsection 319-5(5).

general purpose financial report, for a registered provider, means the report required by section 166-345.

genetic counsellor means a person who is registered with the Human Genetics Society of Australasia as a Certified Genetic Councillor.

Ghent Global Incontinence Associated Dermatitis Categorisation Tool means the *Ghent Global IAD Categorisation Tool (GLOBIAD)*, version 1.0 (June 2017), developed by Skin Integrity Research Group, at Ghent University.

Note: The Ghent Global Incontinence Associated Dermatitis Categorisation Tool could in 2025 be viewed in the Quality Indicator Program Manual on the Department's website (https://www.health.gov.au).

giving day, for a financial support statement: see subsection 166-320(3).

grant agreement means one or more grants of financial assistance to a registered provider for the delivery of funded aged care services entered into by the System Governor on behalf of the Commonwealth under section 264 of the Act.

group A residential care home, for a payment period: see subsection 239-15(2).

group B residential care home, for a payment period: see subsection 239-15(3).

has specialised Aboriginal or Torres Strait Islander status: an approved residential care home ***has specialised Aboriginal or Torres Strait Islander status***

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on a day if a determination that the home has specialised Aboriginal or Torres Strait Islander status under subsection 243(3) of the Act is in effect on the day.

has specialised homeless status: an approved residential care home ***has specialised homeless status*** on a day if a determination that the home has specialised homeless status under subsection 243(3) of the Act is in effect on the day.

health profession has the same meaning as in the National Law.

health professional means a person who is registered under the National Law in a health profession.

health service standards assessment: see subsection 109-10(4).

higher cognitive ability: an individual who is mobile only with assistance has ***higher cognitive ability*** if the individual's AFM cognition score is 22 or more.

higher everyday living agreement: see section 284 of the Act.

higher function: an individual who is not mobile has ***higher function*** if the individual's RUG total score is 16 or less.

higher pressure sore risk: an individual who is not mobile has ***higher pressure sore risk*** if the individual's Braden total score is 13 or less.

home or community fee reduction supplement determination, for an individual, means a determination made under section 197-10 in relation to the individual (including as varied).

home or community place, for an approved residential care home of a registered provider in or from which the provider delivers funded aged care services through the service group home support, assistive technology or home modifications under the MPSP, means a place allocated to the registered provider for delivering those services in or from that home.

home support compounding factors: see section 81-7.

home support functional independence score, for an individual, means the individual's total score for the questions in the Integrated Assessment Tool with the following headings:

(a) "Health literacy difficulties";
(b) "Get to places out of walking distance";
(c) "Does the client drive?";
(d) "Undertake housework (heavy/moderate)";
(e) "Go shopping (assuming transportation)";
(f) "Prepare meals";
(g) "Take medicine";
(h) "Handle money";
(i) "Use the telephone";
(j) "Use other communication device";

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(k) "Use online services";
(l) "Walk";
(m) "Wheelchair mobility";
(n) "Climb stairs";
(o) "Take a bath or shower";
(p) "Dressing";
(q) "Grooming";
(r) "Eating";
(s) "Transfers";
(t) "Upper body strength";
(u) "Toilet use";
(v) "Toileting – bladder";
(w) "Toileting – bowels".

home support needs met score, for an individual, means the individual's total score for the questions in the Integrated Assessment Tool in the form "Is the need being met?".

hospital admission means when an individual is accepted by a hospital inpatient speciality service for ongoing management, whether planned or unplanned and including an admission of any length and occurring in any location.

ICD-10 Australian Modified Pressure Injury Classification System means the classification system contained in the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)*, as published by the Independent Health and Aged Care Pricing Authority, and as existing on 1 November 2025.

Note: The ICD-10-AM could in 2025 be viewed on the website of the Independent Health and Aged Care Pricing Authority (https://www.ihacpa.gov.au).

illness separated couple has the same meaning as in the Social Security Act.

in a service group: a funded aged care service is ***in a service group*** if the service is in a service type that is in the service group.

Note: See Part 3.

included AT-HM item means a product, item of equipment or home modification:

(a) that is listed in the part of the AT-HM List headed "Inclusions"; and
(b) that is not an excluded AT-HM item.

included communication and information management item means a product or item of equipment:

(a) that is listed in the part of the AT-HM List headed "Inclusions" under "Communication and information management"; and
(b) that is not an excluded AT-HM item.

included domestic life item means a product or item of equipment:

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(a) that is listed in the part of the AT-HM List headed “Inclusions” under “Domestic life”; and
(b) that is not an excluded AT-HM item.

included home modifications item means a product, item of equipment or home modification:
(a) that is listed in the part of the AT-HM List headed “Inclusions” under “Home modifications”; and
(b) that is not an excluded AT-HM item.

included managing body functions item means a product or item of equipment:
(a) that is listed in the part of the AT-HM List headed “Inclusions” under “Managing body functions”; and
(b) that is not an excluded AT-HM item.

included mobility item means a product or item of equipment:
(a) that is listed in the part of the AT-HM List headed “Inclusions” under “Mobility”; and
(b) that is not an excluded AT-HM item.

included self-care item means a product or item of equipment:
(a) that is listed in the part of the AT-HM List headed “Inclusions” under “Self-care”; and
(b) that is not an excluded AT-HM item.

income tested fee, for an individual in the pre-2014 residential contribution class for a day: see subsection 285A-13(1).

Note: For an individual in the pre-2014 residential contribution class, the calculation of the daily means tested amount involves the individual’s income but not their assets (see section 319-15).

Incontinence Associated Dermatitis means a type of irritant contact dermatitis characterised by erythema and oedema of the perianal or genital skin, and may be accompanied by bullae, erosion or secondary cutaneous infection.

Note: This definition is consistent with the Ghent Global Incontinence Associated Dermatitis Categorisation Tool.

independently mobile: an individual is ***independently mobile*** if the individual’s DEMMI score is 13 or more.

index number, for a quarter, means the All Groups Consumer Price Index number (being the weighted average of the 8 capital cities) published by the Australian Statistician for that quarter.

individual nominee: see subsection 6-15(2).

individual’s room, in an approved residential care home:
(a) means a room, or a part of a room, in the home that:
(i) is intended to be occupied as personal space by an individual to whom funded aged care services are delivered in the home; and

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(ii) contains a bed to be used by the individual; and

(b) includes:

(i) the areas that are in the immediate vicinity of the bed in the room or the part of the room; and

(ii) the contents of the room or the part of the room; and

(iii) an ensuite, or a shared bathroom and toilet, that is for the use of the individual.

Injune means the Injune Multi-Purpose Service, 7 Fifth Avenue, Injune Queensland 4454.

Integrated Assessment Tool means the Integrated Assessment Tool published by the Department, as existing on 29 June 2026.

Note: The Integrated Assessment Tool could in 2026 be viewed on the Department's website (https://www.health.gov.au).

Integrated Health and Aged Care Services Module means the Integrated Health and Aged Care Services Module published by the Australian Commission on Safety and Quality in Health Care, as existing on 30 June 2025.

Note: The Integrated Health and Aged Care Services Module could in 2025 be viewed on the website of the Australian Commission on Safety and Quality in Health Care (https://www.safetyandquality.gov.au).

judgment has the same meaning as in the *Health and Other Services (Compensation) Act 1995*.

key personnel of a person or body to which the Grantee Code of Conduct applies means:

(a) if the person or body is a registered provider—a responsible person of the registered provider;

(b) if the body is not a registered provider—any person who:

(i) is responsible for the executive decisions of the person or body; or

(ii) has authority or responsibility for (or significant influence over) planning, directing, operating or controlling the activities of the person or body.

Note: For ***responsible person*** of a registered provider, see section 12 of the Act.

local region means an aged care planning region specified in the document titled *2018 Aged Care Planning Regions by Statistical Areas Level 2 (SA2) 2016 - Australia* published by the Department, as existing on the day this instrument commences.

Note: The document titled *2018 Aged Care Planning Regions by Statistical Areas Level 2 (SA2) 2016 - Australia* could in 2025 be viewed on the Department's website (https://www.health.gov.au).

lower cognitive ability: an individual who is mobile only with assistance has ***lower cognitive ability*** if the individual's AFM cognition score is 10 or less.

lower function: an individual who is not mobile has ***lower function*** if the individual's RUG total score is 17 or more.

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lower pressure sore risk: an individual who is not mobile has ***lower pressure sore risk*** if the individual's Braden total score is 14 or more.

low means individual: an individual to whom a registered provider is delivering funded aged care services for a classification type for the service group residential care is a ***low means individual*** if, on the start day for the individual for the classification type, the individual's means tested amount was less than the maximum accommodation supplement amount for that day.

low means resident: see section 230-13.

low means resident percentage: see 230-13.

maximum daily amount of the transitional resident contribution: see subsection 285A-10(1).

maximum permissible interest rate for a day, means the maximum rate for the day worked out in accordance with section 301-5.

maximum possible daily accommodation payment amount for an individual for a day: see step 3 of the method statement in subsection 296-5(3).

means tested care fee, for an individual in the post-2014 residential contribution class: see subsection 285A-14(1).

means testing class: each of the following is a ***means testing class***:

(a) full-pensioner;
(b) part-pensioner;
(c) seniors health card holder;
(d) self-funded retiree.

mechanical restraint: see subsection 17-5(4).

medical or psychological treatment, in relation to a priority 1 reportable incident under section 165A-25, means treatment that may only be provided by a medical practitioner, nurse practitioner, registered nurse, psychologist or social worker.

medical practitioner has the same meaning as in the National Law.

medical treatment authority, for an individual (the ***individual concerned***), means an individual or body that, under an appointment in writing that is in effect under the law of the State or Territory in which the individual concerned accesses funded aged care services, can give informed consent to the provision of medical treatment (however described) to the individual concerned if the individual concerned lacks capacity to give that consent.

medication, in relation to medication management, means a chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease or otherwise enhancing the physical or mental health of an individual.

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medium cognitive ability: an individual who is mobile only with assistance has ***medium cognitive ability*** if the individual's AFM cognition score is between 11 and 21 (inclusive).

member of a couple has the same meaning as in the Social Security Act.

merging service delivery branch: see subsection 263A-5(1).

middle weight, in relation to unplanned weight loss, means the weight of an individual recorded in the second month of a quarter.

minimum monetary spend amount, for an approved residential care home that has been, or is proposed to be, significantly refurbished, means the amount worked out by multiplying $25,000 by 40% of the lower of:

(a) the total number of individual's rooms in the home before the commencement of the refurbishment; and

(b) the total number of individual's rooms in the home after the completion of the refurbishment.

mobile only with assistance: an individual is ***mobile only with assistance*** if the individual's DEMMI score is between 4 and 12 (inclusive).

Modified Monash Model means the model known as the Modified Monash Model developed by the Department for categorising metropolitan, regional, rural and remote locations according to both geographical remoteness and population size, based on population data published by the Australian Bureau of Statistics, as the model exists from time to time.

Note: In 2025, the Modified Monash Model categorisation for a location could be viewed on the Department's website (https://www.health.gov.au).

monthly performance report, for a registered provider, means the report required under section 166-610.

MPSP is short for Multi-Purpose Service Program.

MRC Act means the *Military Rehabilitation and Compensation Act 2004*.

music therapist means a person who is registered with the Australian Music Therapy Association as a Registered Music Therapist.

national efficient price: the ***national efficient price*** for residential care activity is $295.64.

National Law has the same meaning as in the *Health Insurance Act 1973*.

National Safety and Quality Health Service Standards means the standards of that name developed by the Australian Commission on Safety and Quality in Health Care under paragraph 9(1)(e) of the *National Health Reform Act 2011*, as existing on 31 May 2021.

Note: The National Safety and Quality Health Service Standards could in 2025 be viewed on the website of the Australian Commission on Safety and Quality in Health Care (https://www.safetyandquality.gov.au).

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NATSIFACP is short for the program known as the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

NDIS screening application means a screening application within the meaning of paragraph 181Y(5)(a) of the NDIS Act.

newly built home: see section 230-20.

nominated entity: see subsection 95-5(1).

non-subscription service means a funded aged care service that is not in a subscription service type.

non-subscription service type means a service type that is not a subscription service type.

no-show circumstances: see subsections 11A-5(3) and (4).

not mobile: an individual is ***not mobile*** if the individual's DEMMI score is 3 or less.

nurse practitioner has the same meaning as in the *Health Insurance Act 1973*.

NWAU (short for National Weighted Activity Unit) means a measure of residential care activity, expressed as a common unit, against which the national efficient price is set.

occupational therapist means a person who is registered under the National Law in the occupational therapy profession.

occupied bed, for an approved residential care home on a day, means an operational bed for the home that is occupied by an individual to whom funded aged care services are delivered on the day.

offline bed, for an approved residential care home, means a bed covered by the approval of the home that is covered by a notice under section 167 of the Act given in accordance with section 167-70 of this instrument.

old Act wait time, for an individual who, immediately before the transition time, was approved under section 22-1 of the old Act as a recipient of home care but was not a prioritised home care recipient (within the meaning of the old Act), means the time starting at the time the individual's approval as a recipient of home care was given and ending immediately before the transition time.

old Principles means Principles made under section 96-1 of the old Act.

operational bed, for an approved residential care home, means a bed covered by the approval of the home that is not an offline bed for the home.

orthoptist means a person who is registered with the Australian Orthoptic Board.

orthotist means a person who:

(a) is a certified member of the Australian Orthotic Prosthetic Association; and
(b) is certified by that Association as a qualified orthotist.

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pedorthist means a person who is registered with the Pedorthic Association of Australia as a Certified Pedorthist.

Pension Rate Calculator A means the Rate Calculator at the end of section 1064 of the Social Security Act.

permitted uses reconciliation has the meaning given by section 166-325.

physical restraint: see subsection 17-5(5).

physiotherapist means a person who is registered under the National Law in the physiotherapy profession.

police certificate, for a person, means:

(a) a report about the person's criminal conviction record prepared by:
  (i) the Australian Federal Police; or
  (ii) the Australian Criminal Intelligence Commission; or
  (iii) an agency accredited by the Australian Criminal Intelligence Commission; or
  (iv) the police force or police service of a State or Territory; or

(b) for a responsible person of a registered provider that delivers funded aged care services in South Australia, or an aged care worker delivering funded aged care services in South Australia—the screening check known as the Aged Care Sector Employment Check issued to the person by the Department administered by the Minister administering the *Child Safety (Prohibited Persons) Act 2016* (SA).

polypharmacy, in relation to medication management, means the prescription of 9 or more medications to an individual.

post-2014 flexible accommodation class: an individual is in the ***post-2014 flexible accommodation class*** if:

(a) the individual entered a flexible care service (within the meaning of the old Act) before the transition time; and

(b) the approved provider of the service charged the individual an accommodation payment (within the meaning of the old Act); and

(c) if, at the transition time, the individual is not accessing funded aged care services through the residential care service group under a specialist aged care program:
  (i) the individual has a transition break period; and
  (ii) the transition break period is not more than 28 days; and

(d) since the transition time, the individual has not ceased accessing funded aged care services through the residential care service group under a specialist aged care program for a continuous period of more than 28 days.

post-2014 home contribution class: an individual is in the ***post-2014 home contribution class*** if, on 12 September 2024, the individual was approved as a recipient of home care (within the meaning of the old Act).

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post-2014 residential accommodation class: an individual is in the ***post-2014 residential accommodation class*** if:

(a) at the transition time, the individual is in the post-2014 residential contribution class; and

(b) since the transition time, the individual has not:

(i) both:

(A) elected, in the approved form, to cease being a member of the post-2014 residential contribution class; and

(B) ceased accessing funded aged care services in an approved residential care home and started accessing funded aged care services in another approved residential care home; or

(ii) ceased accessing funded aged care services in an approved residential care home for a continuous period of more than 28 days.

post-2014 residential contribution class: an individual is in the ***post-2014 residential contribution class*** if the individual has not elected, in the approved form, to cease being a member of the class, and:

(a) all of the following apply to the individual:

(i) before the transition time, the individual entered residential care (within the meaning of the old Act) other than as a recipient of respite care (within the meaning of that Act) and other than residential care provided through a multi-purpose service (within the meaning of the *Subsidy Principles 2014*);

(ii) immediately before the transition time, the individual was not a continuing residential care recipient (within the meaning of the old Act);

(iii) if, at the transition time, the individual is not accessing funded aged care services in an approved residential care home:

(A) the individual has a transition break period; and

(B) the transition break period is not more than 28 days; or

(b) all of the following apply to the individual:

(i) the individual is a member of the post-2014 home contribution class at the transition time;

(ii) the individual has entered residential care after the transition time;

(iii) the individual has not elected, in the approved form, to cease being a member of the post-2014 home contribution class.

pre-2014 accommodation class: an individual is in the ***pre-2014 accommodation class*** at a particular time (the ***test time***) that is on or after the transition time if:

(a) immediately before the transition time, any of the following agreements were in effect for the individual:

(i) a formal agreement (within the meaning of the old Act);

(ii) an accommodation bond agreement (within the meaning of the *Aged Care (Transitional Provisions) Act 1997*);

(iii) an accommodation charge agreement (within the meaning of the *Aged Care (Transitional Provisions) Act 1997*); or

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(b) all of the following apply to the individual:
  (i) immediately before the transition time, an agreement of a kind mentioned in paragraph (a) was not in effect for the individual;
  (ii) at the transition time, the individual was not accessing funded aged care services in an approved residential care home, but had previously received residential care through a residential care service (within the meaning of the old Act), and the most recent agreement of any kind under the old Act that had been in effect for the individual was an agreement of a kind mentioned in paragraph (a);
  (iii) at the test time, the individual has a transition break period and the transition break period is not more than 28 days; or

(c) both of the following apply to the individual:
  (i) immediately before the transition time, an agreement of a kind mentioned in subparagraph (a)(ii) or (iii) was not in effect for the individual, but the individual was eligible under the old Act to enter into such an agreement;
  (ii) at the transition time, the individual was accessing funded aged care services in an approved residential care home;

unless, before the test time, the individual:

(d) had ceased accessing funded aged care services in an approved residential care home (the ***first home***); and

(e) had started accessing funded aged care services in another approved residential care home (the ***second home***); and

(f) had elected in the approved form, before starting to access funded aged care services in the second home, to cease being a member of the pre-2014 residential contribution class.

pre-2014 maximum permissible interest rate: see section 287-165.

pre-2014 minimum permissible asset value: see subsection 287-45(3).

pre-2014 residential contribution class: an individual is in the ***pre-2014 residential contribution class*** if:

(a) immediately before the transition time, the individual was a continuing residential care recipient (within the meaning of the old Act); and

(b) if, at the transition time, the individual is not accessing funded aged care services in an approved residential care home:
  (i) the individual has a transition break period; and
  (ii) the transition break period is not more than 28 days; and

(c) the individual has not elected, in the approved form, to cease being a member of the class.

pressure injury means a localised injury to the skin or underlying tissue, or both, usually over a bony prominence as a result of pressure, shear or a combination of these factors.

previous weight, in relation to unplanned weight loss by an individual in a quarter, means the individual's finishing weight for the previous quarter.

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price agreement day, for an individual and an approved residential care home, means:

(a) the day on which the registered provider for the approved residential care home and the individual enter into an accommodation agreement for the approved residential care home in accordance with section 293 of the Act; or

(b) if the accommodation agreement between the registered provider for the approved residential care home and the individual is varied because the individual proposes to change the individual's room and the proposed move is voluntary—the day on which the accommodation agreement is varied in relation to the individual's room; or

(c) if the individual is notified by the registered provider for the approved residential care home that the individual's room is to be changed for 28 days or longer, and the proposed move is not voluntary—the day on which the notice is given.

Pricing Authority advice activity means an activity mentioned in paragraph 131A(1)(c) of the *National Health Reform Act 2011* conducted for the purpose of performing a function mentioned in paragraph 131A(1)(a) of that Act.

principal home has the meaning given by section 11A of the Social Security Act other than subsections 11A(8) and (9) of that Act (which deal with the effect of absences from the principal home).

Note: An individual's principal home may be in a retirement village (see section 12 of the Social Security Act).

priority 1 notice: see section 165A-25.

priority 1 reportable incident: see section 165A-25.

priority 2 notice: see section 165A-30.

priority 2 reportable incident: see section 165A-30.

priority category waiting proportion, for a priority category for a classification type for the service group home support on a day, means the number of waiting individuals who have that priority category for the classification type for the service group divided by the total number of waiting individuals for all priority categories for the classification type for the service group on the day.

prosthetist means a person who:

(a) is a certified member of the Australian Orthotic Prosthetic Association; and

(b) is certified by that Association as a qualified prosthetist.

qualifying residential care home, for a payment period: see subsection 239-15(1).

quality indicators report, for a registered provider, means the report required by Subdivision B of Division 3 of Part 2 of Chapter 5.

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Quality-of-Care Experience questions means the questions in the Quality of Care Experience Aged Care Consumers (QCE-ACC) Tool (2020) developed by Flinders University, as existing on 20 March 2026.

Note: The Quality-of-Care Experience questions could in 2026 be viewed in the Quality Indicator Program Manual on the Department's website (https://www.health.gov.au).

Quality of Life Assessment means an assessment using the Quality of Life questions.

Quality of Life questions means the questions in the Quality of Life Aged Care Consumers (QOL-ACC) Tool (2021) developed by Flinders University, as existing on 20 March 2026.

Note: The Quality of Life questions could in 2026 be viewed in the Quality Indicator Program Manual on the Department's website (https://www.health.gov.au).

quarterly financial report, for a registered provider, means the report required by section 166-340.

queue rate means:

(a) for the priority category high for the classification type ongoing for the service group home support—0.25; or

(b) for the priority category medium for the classification type ongoing for the service group home support—1.5; or

(c) for the priority category standard for the classification type ongoing for the service group home support—2.

recreational therapist means a person who is a certified member of the Australian Recreational Therapy Association.

reduced daily amount of the resident contribution, for an individual for a day: see subsection 231-17(7).

reference period, for a quarter, has the meaning given by subsection 176-20(6).

refunding event means:

(a) in relation to the refund of a refundable deposit balance—an event referred to in paragraph 311(1)(a) or (b) of the Act; or

(b) in relation to the refund of an accommodation bond balance—an event referred to in paragraph 287-102(1)(a) or (b) of this instrument.

refund period means:

(a) in relation to the refund of a refundable deposit balance—the period within which the refundable deposit balance must be refunded in accordance with section 311 of the Act; or

(b) in relation to the refund of an accommodation bond balance—the period within which the accommodation bond balance must be refunded in accordance with section 287-102 of this instrument.

refurbishment cost, for an approved residential care home that has been, or is proposed to be, significantly refurbished, means:

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(a) unless paragraph (b) applies—the total cost of the refurbishment or proposed refurbishment of the home; or

(b) if the refurbishment or proposed refurbishment includes fire safety improvements, and the cost of the fire safety improvements is more than 25% of the minimum monetary spend amount for the home—the total cost of the refurbishment or proposed refurbishment, reduced by the amount by which the cost of the fire safety improvements exceeds 25% of the minimum monetary spend amount for the home.

registered health practitioner has the same meaning as in the National Law.

registered nurse staff member means a staff member of a registered provider who is a registered nurse.

registered training organisation has the same meaning as in the *National Vocational Education and Training Regulator Act 2011*.

rehabilitation counsellor means a person who is a member of the Australian Society of Rehabilitation Counsellors.

reimbursement arrangement has the same meaning as in the *Health and Other Services (Compensation) Act 1995*.

remedial massage therapist means a person who holds either of the following qualifications from a registered training organisation:

(a) a Diploma of Remedial Massage Therapy;

(b) a Certificate IV in Massage Therapy.

required combined staff average number of care minutes, per individual per day in respect of an approved residential care home for a quarter: see subsection 176-20(1).

required registered nurse average number of care minutes, per individual per day in respect of an approved residential care home for a quarter: see subsection 176-20(2).

residential care compounding factors: see section 81-8.

residential care fee reduction supplement determination, for an individual, means a determination made under subsection 231-16(2) in relation to the individual (including as varied).

residential care place, for an approved residential care home of a registered provider in which the provider delivers funded aged care services through the service group residential care under the MPSP, means a place allocated to the registered provider for delivering those services in that home.

restorative care means an intensive short-term period of care after an illness or injury to help an individual maintain or regain independence.

restorative care partner: see subsection 148-40(4).

restrictive practices nominee: see subsection 6-15(1).

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restrictive practices substitute decision-maker: see section 6-20.

Rockwood frailty score, for an individual, means the individual's score on the Rockwood Frailty Score assessment item of the AN-ACC Assessment Tool.

RRMA Classification means the document titled *Rural, Remote and Metropolitan Area Classification*, as existing at the transition time, setting out certain categories of areas in Australia that have been determined by the Department by reference to population size and remoteness of locality on the basis of 1991 census data published by the Australian Bureau of Statistics in 1994.

Note: The RRMA Classification for a location could in 2025 be viewed on the Department's website (https://www.health.gov.au).

RUG total score, for an individual, means the individual's total score on the Resource Utilisation Group - Activities of Daily Living assessment item of the AN-ACC Assessment Tool.

seclusion: see subsection 17-5(6).

second asset threshold:

(a) for an individual in the post-2014 residential contribution class: see paragraph 319-5(7)(a); or
(b) in any other case: see paragraph 319-5(7)(b).

second income threshold: see subsection 319-5(3).

seniors health card has the same meaning as in the Social Security Act.

serious offence conviction: a person has a ***serious offence conviction*** if the person has been:

(a) convicted of murder or sexual assault; or
(b) convicted of, and sentenced to imprisonment for, any other form of assault.

service activity report, for a registered provider, means the report required under section 166-645.

service delivery report, for a registered provider, means the report required under section 166-625.

service demographics report, for a registered provider, means the report required under section 166-735.

settlement has the same meaning as in the *Health and Other Services (Compensation) Act 1995*.

significant compounding factors:

(a) for a classification assessment for an individual for a classification type for the service group home support—the individual has ***significant compounding factors*** if the home support compounding factors for the individual, considered together, indicate that the individual has significantly higher care needs relative to the needs of other individuals

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with similar home support functional independence scores and home support needs met scores; and

(b) for a classification assessment for an individual for the classification type ongoing for the service group residential care—an individual mentioned in an item of the table in section 81-8 has ***significant compounding factors*** if the residential care compounding factors for the individual, considered together, indicate that the individual has significantly higher care needs relative to the needs of other individuals mentioned in that item.

significantly refurbished home means an approved residential care home in relation to which a determination under subsection 230-30(1) or 230-35(1) is in effect.

significant unplanned weight loss, in relation to unplanned weight loss, means a decrease in the weight of an individual that is equal to or greater than 5%, as determined by comparing the finishing weight of the previous quarter against the finishing weight for the current quarter.

Social Security Act means the *Social Security Act 1991*.

social worker means a person who is certified by the Australian Association of Social Workers as an Accredited Social Worker.

sonographer means a person who is registered with the Australian Sonographer Accreditation Registry as an Accredited Medical Sonographer.

specialist Aboriginal or Torres Strait Islander programs means specialist programs for Aboriginal or Torres Strait Islander persons and includes, but is not limited to, the following:

(a) programs to deliver care and services that are culturally safe for, and tailored to meet the particular needs of, the Aboriginal or Torres Strait Islander persons to whom funded aged care services are being delivered in the approved residential care home in question;

(b) programs to promote social and cultural engagement and participation of Aboriginal or Torres Strait Islander persons.

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specialist aged care program fee: see subsection 286-10(1).

specialist homeless programs means specialist programs for persons with a background as a homeless person and includes, but is not limited to, the following:

(a) programs and interventions to manage complex behavioural needs of persons with that background;

(b) programs to promote social engagement and participation of persons with that background.

speech pathologist means a person who is certified by Speech Pathology Australia as a Certified Practising Speech Pathologist.

standing higher everyday living agreement: see section 284-2.

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starting weight, in relation to unplanned weight loss, means the weight of an individual recorded in the first month of a quarter.

Statement of Accounting Concepts SAC 1 means Statement of Accounting Concepts SAC 1 "Definition of the Reporting Entity" published by the Australian Accounting Standards Board, as existing on 6 March 2020.

Note: The Statement of Accounting Concepts SAC 1 could in 2025 be viewed on the website of the Australian Accounting Standards Board (https://www.aasb.gov.au).

subscription service means a funded aged care service in a subscription service type.

subscription service type means any of the following service types:

(a) subscription allied health and therapy;
(b) subscription domestic assistance;
(c) subscription home maintenance and repairs;
(d) subscription home or community general respite;
(e) subscription meals;
(f) subscription nursing care;
(g) subscription personal care;
(h) subscription social support and community engagement;
(i) subscription therapeutic services for independent living;
(j) subscription transport.

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supported individual: an individual is a ***supported individual*** if, immediately before the transition time, the individual was a supported resident within the meaning of the *Aged Care (Transitional Provisions) Act 1997*.

surplus and uncommitted funds, for a registered provider and a financial year, means financial assistance the System Governor, on behalf of the Commonwealth, has granted the registered provider in the financial year relating to the same or similar activities and that are:

(a) surplus and uncommitted; and
(b) confirmed by provided financial statements.

target classification type wait time: see section 93-14.

target priority category wait time, for a priority category for a classification type for the service group home support on a day, means:

(a) for the priority category urgent—1 month; or
(b) for the priority category high, medium or standard—the result of multiplying the wait time factor on the day by the queue rate for the priority category.

TCP is short for Transition Care Program.

third asset threshold: see subsection 319-5(8).

third income threshold: see subsection 319-5(4).

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transitional agreed amount: see subsection 285A-25(2).

transitional basic daily fee: see subsection 285A-11(1).

transitional bed reservation fee: see subsection 285A-20(1).

transitional compensation payment fee: see subsection 285A-10(2).

transitional higher everyday living agreement: see subsection 285A-25(2).

transitional higher everyday living fee: see subsection 285A-25(1).

transitional pre-entry fee: see subsection 285A-15(1).

transitional pre-entry period: see subsection 285A-15(1).

transitional resident contribution: see subsection 285A-5(1).

transition break period, for an individual, means the sum of:

(a) the number of days in a continuous period that ended immediately before the transition time during which the individual was not being provided with residential care through a residential care service (within the meaning of the old Act) other than because the person was on leave (within the meaning of that Act); and

(b) the number of days in a continuous period beginning at the transition time during which the individual was not accessing funded aged care services in an approved residential care home.

The period mentioned in paragraph (a) and the period mentioned in paragraph (b) must each be a period of at least one day.

unavoidable service cost: see subsections 284-11(16) and (17).

unplanned weight loss means:

(a) significant unplanned weight loss; or

(b) consecutive unplanned weight loss.

unrealisable asset has the meaning given by subsections 11(12) and (13) of the Social Security Act.

unreduced daily amount of the resident contribution, for an individual for a day: see subsection 231-17(6).

unreduced individual contribution, for the delivery of a funded aged care service to an individual on a day, means the amount that would be the individual contribution for the delivery of the service to the individual on the day if step 4 in the method statement in subsection 273(2) of the Act were disregarded.

veteran means a person:

(a) who is taken to have rendered eligible war service under section 7 of the Veterans' Entitlements Act; or

(b) in respect of whom a pension is payable under subsection 13(6) of that Act; or

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(c) who is:
  (i) a member of the Forces within the meaning of subsection 68(1) of that Act; or
  (ii) a member of a Peacekeeping Force within the meaning of that subsection; or

(d) who is:
  (i) a member within the meaning of the MRC Act; or
  (ii) a former member within the meaning of that Act; or

(e) who is an employee within the meaning of the *Safety, Rehabilitation and Compensation Act 1988*.

Note: The Acts mentioned in paragraphs (d) and (e) provide that, in some cases:
(a) a member of the Forces, or a member of a Peacekeeping Force, includes a person who is no longer serving; and
(b) an employee includes a person who has ceased to be an employee.

Veterans' Entitlements Act means the *Veterans' Entitlements Act 1986*.

waiting individual, for a priority category for a classification type for a service group on a day, means an individual who:

(a) has an access approval in effect for the classification type for the service group; and
(b) has been assigned the priority category for the classification type for the service group; and
(c) has not been allocated a place for the classification type for the service group.

wait time factor: see section 93-13.

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6-5 References to actions taken or statements given

In this instrument, a reference to an action taken or a statement given by one of the following persons is a reference to such actions or statements that are within the person's professional scope of practice:

(a) an allied health assistant;
(b) an allied health professional;
(c) a diversional therapist;
(d) a registered health practitioner;
(e) a remedial massage therapist.

6-15 Nominating restrictive practices nominees

(1) ***Restrictive practices nominee***, for a restrictive practice in relation to an individual, means:

(a) if there is only a single individual nominee for the restrictive practice in relation to the individual—that individual nominee; or
(b) if there is only a nominee group for the restrictive practice in relation to the individual—that nominee group; or

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(c) if there is more than one individual nominee, or a nominee group and one or more individual nominees, for the restrictive practice in relation to the individual—the individual nominee or nominee group (as applicable) that takes precedence (see paragraph (9)(a)).

(2) ***Individual nominee***, for a restrictive practice in relation to an individual (the ***individual concerned***), means an individual:

(a) who has been nominated by the individual concerned, in accordance with this section, as an individual who can give informed consent to the use of the restrictive practice in relation to the individual concerned if the individual concerned lacks capacity to give that consent; and

(b) who has agreed, in writing, to the nomination (and has not withdrawn that agreement); and

(c) who has capacity to give the informed consent mentioned in paragraph (a).

(3) ***Nominee group***, for a restrictive practice in relation to an individual (the ***individual concerned***), means a group of individuals:

(a) who have been nominated by the individual concerned, in accordance with this section, as a group of individuals who can jointly give informed consent to the use of the restrictive practice in relation to the individual concerned if the individual concerned lacks capacity to give that consent; and

(b) each of whom has agreed, in writing, to the nomination (and has not withdrawn that agreement); and

(c) each of whom has capacity to give the informed consent mentioned in paragraph (a).

(4) An individual may make, vary or revoke a nomination only if the individual concerned has capacity to do so.

(5) A nomination, or a variation or revocation of a nomination, must be made in writing.

(6) A nomination (or varied nomination) of a group may nominate not more than 3 individuals as members of the group.

(7) A nomination (or varied nomination) may include only one nomination of a group.

(8) An individual may be nominated as an individual, or as a member of a group, but not both.

(9) If a nomination (or a varied nomination) nominates more than one individual nominee, or both one or more individual nominees and a nominee group, the nomination (or varied nomination) must:

(a) state the order of precedence in which the individual nominees and nominee group (as applicable) are nominated; and

(b) if a nominee group is nominated—state the rules that will apply if the members of the group cannot agree on whether to give informed consent as mentioned in paragraph (3)(a) in a particular case.

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(10) An individual (the ***individual concerned***) may nominate, as an individual or a member of a group, an aged care worker of a registered provider that is delivering funded aged care services to the individual concerned only if the aged care worker is the partner or a relative of the individual concerned.

6-20 Meaning of *restrictive practices substitute decision-maker*

(1) An individual or body is the ***restrictive practices substitute decision-maker*** for a restrictive practice in relation to an individual (the ***individual concerned***) if:

(a) the individual or body is appointed by the law of the State or Territory in which the individual concerned accesses funded aged care services as an individual or body that can give informed consent to the use of the restrictive practice in relation to the individual concerned if the individual concerned lacks capacity to give that consent; or

(b) under an appointment in writing that is in effect under the law of the State or Territory in which the individual concerned accesses funded aged care services, the individual or body can give informed consent to the use of the restrictive practice in relation to the individual concerned if the individual concerned lacks capacity to give that consent.

(2) The following table has effect if:

(a) there is no such individual or body appointed for the restrictive practice in relation to the individual concerned under the law of the State or Territory in which the individual concerned accesses funded aged care services; and

(b) either:

(i) there is no clear mechanism for appointing such an individual or body under the law of the State or Territory; or

(ii) an application has been made for an appointment under the law of the State or Territory in relation to the use of the restrictive practice in relation to the individual concerned, but there is a significant delay in deciding the application.

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Meaning of *restrictive practices substitute decision-maker*

Item	Column 1 For a restrictive practice in relation to the individual concerned, if …	Column 2 the *restrictive practices substitute decision-maker* for that restrictive practice in relation to the individual concerned is …
1	there is a restrictive practices nominee for the restrictive practice in relation to the individual concerned	that restrictive practices nominee.
2	item 1 does not apply to the restrictive practice in relation to the individual concerned, but the individual concerned has a partner: (a) with whom the individual concerned has a close continuing relationship; and (b) who has agreed, in writing, to act as a	that partner.

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Meaning of *restrictive practices substitute decision-maker*

Item	Column 1 For a restrictive practice in relation to the individual concerned, if …	Column 2 the *restrictive practices substitute decision-maker* for that restrictive practice in relation to the individual concerned is …
	restrictive practices substitute decision-maker for the restrictive practice in relation to the individual concerned (and has not withdrawn that agreement); and (c) who has capacity to act as a restrictive practices substitute decision-maker for the restrictive practice in relation to the individual concerned	
3	items 1 and 2 do not apply to the restrictive practice in relation to the individual concerned, but the individual concerned has a relative or friend: (a) who, immediately before the individual concerned entered an approved residential care home, was an unpaid carer for the individual; and (b) who has a personal interest in the welfare of the individual concerned on an unpaid basis; and (c) with whom the individual concerned has a close continuing relationship; and (d) who has agreed, in writing, to act as a restrictive practices substitute decision-maker for the restrictive practice in relation to the individual concerned (and has not withdrawn that agreement); and (e) who has capacity to act as a restrictive practices substitute decision-maker for the restrictive practice in relation to the individual concerned	(a) if there is one such relative or friend—that relative or friend; or (b) if there are 2 or more such relatives or friends—the eldest of those relatives or friends.
4	items 1, 2 and 3 do not apply to the restrictive practice in relation to the individual concerned, but the individual concerned has a relative or friend: (a) who has a personal interest in the welfare of the individual concerned on an unpaid basis; and (b) with whom the individual concerned has a close continuing relationship; and (c) who has agreed, in writing, to act as a restrictive practices substitute	(a) if there is one such relative or friend—that relative or friend; or (b) if there are 2 or more such relatives or friends—the eldest of those relatives or friends.

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Meaning of *restrictive practices substitute decision-maker*

Item	Column 1 For a restrictive practice in relation to the individual concerned, if …	Column 2 the *restrictive practices substitute decision-maker* for that restrictive practice in relation to the individual concerned is …
	decision-maker for the restrictive practice in relation to the individual concerned (and has not withdrawn that agreement); and (d) who has capacity to act as a restrictive practices substitute decision-maker for the restrictive practice in relation to the individual concerned	
5	items 1, 2, 3 and 4 do not apply to the restrictive practice in relation to the individual concerned, but there is a medical treatment authority for the individual concerned	(a) if there is one such medical treatment authority—that medical treatment authority; or (b) if there are 2 or more such medical treatment authorities and the law of the State or Territory in which the individual concerned accesses funded aged care services provides for the order of precedence of the medical treatment authorities—the medical treatment authority that takes precedence under that law; or (c) if: (i) there are 2 or more medical treatment authorities; and (ii) the law of the State or Territory in which the individual concerned accesses funded aged care services does not provide for the order of precedence of the medical treatment authorities; and (iii) one of the medical treatment authorities is an individual; that individual; or (d) if: (i) there are 2 or more medical treatment authorities; and (ii) the law of the State or Territory in which the individual concerned accesses funded aged care services does not provide for the order of precedence of the medical treatment authorities; and (iii) one or more of the medical treatment authorities are individuals; the eldest of those individuals.

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(3) For the purposes of paragraph (a) of column 1 of item 3 of the table in subsection (2), a person was an unpaid carer for the individual concerned if:

(a) the person was not employed, hired, retained or contracted (whether directly or through an employment or recruiting agency) as a carer for the individual concerned; and

(b) no payment or benefit other than one or more of the following was or will be made or given to the person for being a carer for the individual concerned:

(i) a carer payment or equivalent benefit;

(ii) payment in kind;

(iii) a payment or benefit as a beneficiary under the will of the individual concerned.

(4) For the purposes of paragraph (b) of column 1 of item 3 of the table and paragraph (a) of column 1 of item 4 of the table in subsection (2), a person has a personal interest in the welfare of the individual concerned on an unpaid basis if:

(a) the person is not employed, hired, retained or contracted (whether directly or through an employment or recruiting agency) to have that interest; and

(b) no payment or benefit other than one or more of the following is or will be made or given to the person for having that interest:

(i) a carer payment or equivalent benefit;

(ii) payment in kind;

(iii) a payment or benefit as a beneficiary under the individual's will.

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Division 2—Matters prescribed for definitions in section 7 of the Act

7-1 Accommodation bond

For the purposes of the definition of ***accommodation bond*** in section 7 of the Act, an ***accommodation bond*** means an amount that does not accrue daily and that is paid or payable by an individual in the pre-2014 accommodation class in accordance with an accommodation bond agreement.

7-2 Accommodation bond balance

For the purposes of the definition of ***accommodation bond balance*** in section 7 of the Act, an ***accommodation bond balance*** is, at a particular time, an amount equal to the difference between:

(a) an accommodation bond, other than:
  (i) an accommodation bond that is to be paid by periodic payment; or
  (ii) the part of an accommodation bond that is to be paid by periodic payment; and

(b) the sum of any amounts that have been, or are permitted to be, deducted from the accommodation bond in accordance with Subdivision D of Division 3 of Part 2 of Chapter 9 of this instrument as at that time.

7-3 Accommodation charge

For the purposes of the definition of ***accommodation charge*** in section 7 of the Act, an ***accommodation charge*** means an amount that accrues daily and that is paid or payable by an individual in the pre-2014 accommodation class in accordance with an accommodation charge agreement.

7-8 Approved needs assessors

Approving entities

(1) For the purposes of paragraph (a) of the definition of ***approved needs assessor*** in section 7 of the Act, the kind of entity is an entity specified in the document titled *Single Assessment System assessment organisations by service area, region, state and territory*, published by the Department, as existing on the day this instrument commences.

Note: The document titled *Single Assessment System assessment organisations by service area, region, state and territory* could in 2025 be viewed on the Department's website (https://www.health.gov.au).

Criteria

(2) For the purposes of paragraph (b) of the definition of ***approved needs assessor*** in section 7 of the Act, the criteria for a person are that the person is an individual who is employed or otherwise engaged by:

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(a) an entity (a ***prescribed entity***) prescribed by subsection (1) of this section; or

(b) an entity engaged by a prescribed entity.

Note: An individual engaged by an entity includes an independent contractor.

7-11 Cost

For the purposes of the definition of ***cost*** in section 7 of the Act, the cost for the delivery by a registered provider of a funded aged care service for which the subsidy basis is cost means the amount charged by the provider for the delivery of the service.

7-12 Direct care

For the purposes of the definition of ***direct care*** in section 7 of the Act, the following funded aged care services are prescribed:

(a) the funded aged care services listed and described in items 2, 3, 4, 5, 6 and 7 of the table in section 8-150 of this instrument;

(b) the funded aged care services listed and described in items 3, 4, 5 and 6 of the table in section 8-155 of this instrument.

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7-13 Entry contribution

For the purposes of the definition of ***entry contribution*** in section 7 of the Act, an ***entry contribution*** means a payment that was made before 1 October 1997 by an individual in the pre-2014 accommodation class in accordance with a formal agreement.

7-14 Entry contribution balance

For the purposes of the definition of ***entry contribution balance*** in section 7 of the Act, an ***entry contribution balance*** is, at a particular time, an amount equal to the difference between:

(a) the amount of an entry contribution; and

(b) the sum of any amounts that have been, or are permitted to be, deducted from the entry contribution in accordance with a formal agreement as at that time.

7-17 Entry day

(1) This section is made for the purposes of the definition of ***entry day*** in section 7 of the Act.

Classification type ongoing

(2) The first day an individual accesses a funded aged care service for the classification type ongoing through a service group is the entry day for the individual for that classification type for that service group.

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Classification type short-term for the service groups home support, assistive technology and home modifications

(3) The first day an individual accesses a funded aged care service for a classification level for the classification type short-term for the service group home support, assistive technology or home modifications is the entry day for the individual for the period of effect for that classification level.

Classification type short-term for the service group residential care

(4) The first day an individual accesses a funded aged care service for the classification type short-term for the service group residential care is the entry day for the individual for that classification type for that service group.

Classification type hospital transition

(5) The first day an individual accesses a funded aged care service for a classification level for the classification type hospital transition for a service group is the entry day for the individual for the period of effect for that classification level.

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7-19 Homeowner

For the purposes of the definition of ***homeowner*** in section 7 of the Act:

(a) an individual who is not a member of a couple is a ***homeowner*** if:
  (i) the individual has a right or interest in the individual's principal home; and
  (ii) the individual's right or interest in the individual's principal home gives the individual reasonable security of tenure in the home; and

(b) an individual who is a member of a couple is a ***homeowner*** if:
  (i) the individual, or the individual's partner, has a right or interest in one residence that is the individual's principal home, or the partner's principal home, or the principal home of both of them; and
  (ii) the individual's right or interest, or the partner's right or interest, in the home gives the individual, or the individual's partner, reasonable security of tenure in the home.

7-20 Lifetime cap

For the purposes of the definition of ***lifetime cap*** in section 7 of the Act, the amount is:

(a) unless paragraph (b) applies—$137,917.01; or

(b) for an individual in the post-2014 home contribution class or the post-2014 residential contribution class—$86,185.23.

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Section 7-21

7-21 Price charged

For the purposes of the definition of ***price charged*** in section 7 of the Act, the price charged for the delivery by a registered provider of a funded aged care service means the amount charged by the provider for the delivery of the service.

7-22 Serious injury or illness

For the purposes of the definition of ***serious injury or illness*** in section 7 of the Act, each of the following is a serious injury or illness:

(a) malnutrition;

(b) dehydration.

7-23 Service delivery branch

For the purposes of the definition of ***service delivery branch*** in section 7 of the Act, a ***service delivery branch*** of a registered provider means a place of business of the registered provider through which the provider delivers funded aged care services to an individual through the service group home support, assistive technology or home modifications.

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Part 3—Aged care service list

Division 1—Preliminary

8-5 Aged care service list

For the purposes of subsection 8(1) of the Act:

(a) each service listed and described in an item of a table in a section of Division 2, 4, 6 or 8 of this Part is a service for which funding may be payable under the Act; and

(b) this Part lists and describes each service, and specifies the service type that the service is in; and

(c) this Part specifies, for each service type:

(i) the service group the service type is in; and

(ii) any specialist aged care program under which the service type can be delivered; and

(iii) whether the service type can only be delivered under a specialist aged care program; and

(iv) each provider registration category under which the service type can be delivered; and

(d) this Part specifies, for each service mentioned in paragraph 8(1)(g) of the Act:

(i) the means testing category for the service; and

(ii) the subsidy basis for the service; and

(e) this Part specifies, for the service groups home support, assistive technology and home modifications, that all service types in those service groups must be delivered in a home or community setting; and

(f) this Part specifies, for the service group residential care, that all service types in the service group must be delivered in a residential care home.

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8-10 Subsidy basis

The subsidy basis for each funded aged care service referred to in paragraph 8(1)(g) of the Act is cost.

8-12 Service types

For the purposes of subsection 8(2) of the Act, the following service types are prescribed:

(a) allied health and therapy;

(ab) subscription allied health and therapy;

(b) assistance with transition care;

(c) care management;

(d) community cottage respite;

(e) domestic assistance;

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(ea) subscription domestic assistance;
(f) equipment and products;
(g) hoarding and squalor assistance;
(h) home adjustments;
(i) home maintenance and repairs;
(ia) subscription home maintenance and repairs;
(j) home or community general respite;
(ja) subscription home or community general respite;
(k) meals;
(ka) subscription meals;
(l) nursing care;
(la) subscription nursing care;
(m) nutrition;
(n) personal care;
(na) subscription personal care;
(o) residential accommodation;
(p) residential clinical care;
(q) residential everyday living;
(r) residential non-clinical care;
(s) restorative care management;
(t) social support and community engagement;
(ta) subscription social support and community engagement;
(u) therapeutic services for independent living;
(ua) subscription therapeutic services for independent living;
(v) transport;
(w) subscription transport.

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Division 2—Home support service types

8-15 Allied health and therapy

(1) A service listed and described in an item of the following table is in the service type allied health and therapy.

(2) The service requirements for a service listed and described in an item of the following table are that:

(a) the service is for the individual to regain or maintain physical, functional or cognitive abilities that support the individual to remain safe and independent at home; and

(b) the service is within the parameters specified in subsection (3); and

(c) the service is for the management of conditions related to age-related disability or decline.

(3) For the purposes of paragraph (2)(b), the parameters for a service are the following:

(a) the service may include clinical intervention, expertise, care and treatment, review, education (including techniques for self-management), and advice and supervision to improve capacity;

(b) the service aims to give the individual the skills and knowledge to manage their own condition and promote independent recovery where appropriate;

(c) the service may be delivered in person or via telehealth, as appropriate;

(d) the service may be delivered individually or in a group-based format (such as clinically supervised group exercise classes), as appropriate;

(e) for a service other than the services listed and described in items 6 and 7 of the following table—the service may be delivered:

(i) directly by a registered health practitioner or allied health professional (as applicable); or

(ii) by an allied health assistant or aged care worker, under the supervision of a registered health practitioner or allied health professional where safe and appropriate to do so;

(f) for the service listed and described in item 6 of the following table—the service may be delivered:

(i) directly by an Aboriginal or Torres Strait Islander Health Practitioner; or

(ii) by an allied health assistant or aged care worker, under the supervision of an Aboriginal or Torres Strait Islander Health Practitioner, where safe and appropriate to do so;

(g) for a service listed and described in item 7 of the following table—the service may be delivered:

(i) directly by an Aboriginal or Torres Strait Islander Health Worker; or

(ii) by an allied health assistant or aged care worker, under the supervision of an Aboriginal or Torres Strait Islander Health Worker, where safe and appropriate to do so.

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Services in the service type allied health and therapy		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Allied health assistance	Allied health therapy assistance that meets the service requirements specified in subsection (2)
2	Podiatry	Podiatry that meets the service requirements specified in subsection (2)
3	Social work	Social work activities that meet the service requirements specified in subsection (2)
4	Speech pathology	Speech pathology that meets the service requirements specified in subsection (2)
5	Diet or nutrition	Assistance with diet or nutrition that meets the service requirements specified in subsection (2)
6	Aboriginal or Torres Strait Islander Health Practitioner assistance	Assistance provided by an Aboriginal or Torres Strait Islander Health Practitioner that meets the service requirements specified in subsection (2)
7	Aboriginal or Torres Strait Islander Health Worker assistance	Assistance provided by an Aboriginal or Torres Strait Islander Health Worker that meets the service requirements specified in subsection (2)
8	Physiotherapy	Physiotherapy that meets the service requirements specified in subsection (2)
9	Psychology	Psychology that meets the service requirements specified in subsection (2)
10	Exercise physiology	Exercise physiology that meets the service requirements specified in subsection (2)
11	Occupational therapy	Occupational therapy that meets the service requirements specified in subsection (2)
12	Counselling or psychotherapy	Counselling or psychotherapy that meets the service requirements specified in subsection (2)
13	Music therapy	Music therapy that meets the service requirements specified in subsection (2)

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8-16 Subscription allied health and therapy

A service listed and described in an item of the following table is in the service type subscription allied health and therapy.

Services in the service type subscription allied health and therapy		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Subscription access to allied health assistance	Access to the service listed and described in item 1 of the table in section 8-15 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day

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Services in the service type subscription allied health and therapy

Item	Column 1 Service	Column 2 Description
2	Subscription access to podiatry	Access to the service listed and described in item 2 of the table in section 8-15 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
3	Subscription access to social work	Access to the service listed and described in item 3 of the table in section 8-15 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
4	Subscription access to speech pathology	Access to the service listed and described in item 4 of the table in section 8-15 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
5	Subscription access to diet or nutrition	Access to the service listed and described in item 5 of the table in section 8-15 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
6	Subscription access to Aboriginal or Torres Strait Islander Health Practitioner assistance	Access to the service listed and described in item 6 of the table in section 8-15 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
7	Subscription access to Aboriginal or Torres Strait Islander Health Worker assistance	Access to the service listed and described in item 7 of the table in section 8-15 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
8	Subscription access to physiotherapy	Access to the service listed and described in item 8 of the table in section 8-15 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
9	Subscription access to psychology	Access to the service listed and described in item 9 of the table in section 8-15 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
10	Subscription access to exercise physiology	Access to the service listed and described in item 10 of the table in section 8-15 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
11	Subscription access to occupational therapy	Access to the service listed and described in item 11 of the table in section 8-15 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
12	Subscription access to counselling or psychotherapy	Access to the service listed and described in item 12 of the table in section 8-15 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
13	Subscription	Access to the service listed and described in item 13 of the table in

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Services in the service type subscription allied health and therapy		
Item	**Column 1** **Service**	**Column 2** **Description**
	access to music therapy	section 8-15 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day

8-20 Assistance with transition care

A service listed and described in the following table is in the service type assistance with transition care.

Services in the service type assistance with transition care		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Transition care management	Initial and ongoing assessment, planning and management, and coordination and monitoring, of the individual's movement from hospital, through the TCP and back into the community or into a residential care home, including the following: (a) ensuring that: (i) the individual's care and services plan is carried out; and (ii) progress against the care and services plan goals is monitored; (b) acting as a central point of contact; (c) liaising with and organising all care requirements provided by external service providers (including registered health practitioners and allied health professionals); (d) administration and operation of the TCP, including documentation relating to the individual; (e) arranging for another aged care assessment if needed prior to the completion of the individual's transition care episode; (f) managing the individual's transition into their post transition care arrangements, including a comprehensive written and verbal handover Note: For requirements for care and services plans, see paragraph 148(e) of the Act and Subdivisions A and D of Division 3 of Part 4 of Chapter 4 of this instrument. For Aged Care Quality Standards for care and services plans, see subsections 15-20(1) to (3) of this instrument.
2	Assistance to access medical practitioner	Transport for the individual to visit a medical practitioner, or assistance in arranging a home visit by a medical practitioner
3	Transition care medication management	The following: (a) implementation of a safe and efficient system to manage prescribing, procuring, dispensing, supplying, packaging, storing and administering of both prescription and over-the-counter medicines; (b) administration of, and monitoring the effects of, medication (including injections), including supervision and physical assistance with taking both prescription and over-the-counter medication under the delegation and clinical supervision of a registered nurse or other appropriate registered health practitioner

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Services in the service type assistance with transition care

Item	Column 1 Service	Column 2 Description
4	Transition care emergency or after hours assistance	Having at least one suitably skilled employee of the registered provider or an appropriate agency continuously on call to give emergency assistance when needed
5	Transition care continence management	The following: (a) assisting the individual to: (i) maintain continence or manage incontinence; and (ii) use aids and appliances designed to assist continence management; (b) the supply of aids and appliances designed to assist continence management to meet the individual's needs, including the following: (i) commode chairs, over-toilet chairs, bed-pans, uridomes, and catheter and urinary drainage appliances; (ii) as many continence aids (such as disposable urinal covers, pants, pads, chair pads and enemas) as are needed to meet the individual's needs
6	Waste disposal	Safe disposal of transition care related organic and inorganic waste material

8-25 Care management

A service listed and described in an item of the following table is in the service type care management.

Services in the service type care management

Item	Column 1 Service	Column 2 Description
1	Home support care management	Activities that ensure funded aged care services contribute to the overall wellbeing of the individual, including implementing the care and services plan for the individual, service coordination, monitoring, review and evaluation, advocacy, support and education, but not including administrative costs funded through prices on services Note: For requirements for care and services plans, see paragraph 148(e) of the Act and Subdivisions A and D of Division 3 of Part 4 of Chapter 4 of this instrument. For Aged Care Quality Standards for care and services plans, see subsections 15-20(1) to (3) of this instrument.

8-30 Community cottage respite

A service listed and described in the following table is in the service type community cottage respite.

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Services in the service type community cottage respite		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Cottage respite	Overnight care for the individual that is provided: (a) in a cottage-style respite facility; and (b) in a community setting (other than in the individual's home, the home of a carer of the individual or the home of a host family); and (c) to provide respite for a carer of the individual

8-35 Domestic assistance

A service listed and described in an item of the following table is in the service type domestic assistance.

Services in the service type domestic assistance		
Item	**Column 1** **Service**	**Column 2** **Description**
1	General house cleaning	The following: (a) the provision of, or assistance with, light household cleaning, including mopping, vacuuming, washing dishes, and general tidying of surface areas, that ensure the individual remains safe at home; (b) the supply of equipment or consumables required for cleaning mentioned in paragraph (a); but not including professional cleaning that would usually be paid for by an individual (such as carpet cleaning, pest control, dry cleaning or pet care)
2	Laundry services	The following: (a) the provision of, or assistance with, laundry activities including but not limited to the laundering of clothing and bedding and the ironing of clothing; (b) the supply of consumables required for laundry activities mentioned in paragraph (a); but not including dry cleaning
3	Shopping assistance	The provision of shopping, or assistance with shopping activities, including developing a shopping list, online shopping, driving to a shop and assisting with the collection of shopping, but not including the cost of the shopping

8-36 Subscription domestic assistance

A service listed and described in an item of the following table is in the service type subscription domestic assistance.

Services in the service type subscription domestic assistance		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Subscription	Access to the service listed and described in item 1 of the table in

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Services in the service type subscription domestic assistance		
Item	**Column 1** **Service**	**Column 2** **Description**
	access to general house cleaning	section 8-35 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
2	Subscription access to laundry services	Access to the service listed and described in item 2 of the table in section 8-35 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
3	Subscription access to shopping assistance	Access to the service listed and described in item 3 of the table in section 8-35 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day

8-40 Hoarding and squalor assistance

A service listed and described in the following table is in the service type hoarding and squalor assistance.

Services in the service type hoarding and squalor assistance		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Hoarding and squalor supports	Services for an individual who is experiencing symptoms of hoarding disorder or who is living in severe domestic squalor, including, for example, the following: (a) implementing the care and services plan for the individual; (b) a one-off clean-up; (c) review and evaluation; (d) linking the individual to specialist support services Note: For requirements for care and services plans, see paragraph 148(e) of the Act and Subdivisions A and D of Division 3 of Part 4 of Chapter 4 of this instrument. For Aged Care Quality Standards for care and services plans, see subsections 15-20(1) to (3) of this instrument.

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8-45 Home maintenance and repairs

A service listed and described in an item of the following table is in the service type home maintenance and repairs.

Services in the service type home maintenance and repairs		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Gardening	The provision of, or assistance with, maintenance of a residential garden, including essential light gardening such as mowing lawns, pruning shrubs and clearing yards that contribute to maintaining the individual's home in a safe and habitable condition, but not including the following:

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Services in the service type home maintenance and repairs

Item	Column 1 Service	Column 2 Description
		(a) professional gardening services that would usually be paid for by an individual (such as tree removal, landscaping or farm or water-feature maintenance); (b) gardening services that relate to visual appeal rather than safety or accessibility (such as installing and maintaining plants, garden beds and compost); (c) services that are the responsibility of other parties (such as landlords or government housing authorities)
2	Assistance with home maintenance and repairs	Essential minor repairs and maintenance: (a) that the individual used to be able to do themselves, or that are required to maintain safety (such as cleaning gutters, replacing lightbulbs and repairing broken door handles); or (b) that are required to address an imminent age-related safety risk (such as repairing uneven flooring that poses a falls risk or a section of carpet damaged by a wheelchair); but not including the following: (c) professional maintenance and repair services that would usually be paid for by an individual (such as professional pest extermination, installing cabinetry or replacing carpets due to usual wear and tear); (d) services that are the responsibility of other parties (such as landlords or government housing authorities)
3	Expenses for home maintenance and repairs	The supply of equipment or consumables required for that service

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8-46 Subscription home maintenance and repairs

A service listed and described in an item of the following table is in the service type subscription home maintenance and repairs.

Services in the service type subscription home maintenance and repairs

Item	Column 1 Service	Column 2 Description
1	Subscription access to gardening	Access to the service listed and described in item 1 of the table in section 8-45 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
2	Subscription access to assistance with home maintenance and repairs	Access to the service listed and described in item 2 of the table in section 8-45 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day

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8-50 Home or community general respite

A service listed and described in an item of the following table is in the service type home or community general respite.

Services in the service type home or community general respite

Item	Column 1 Service	Column 2 Description
1	Flexible respite	Support and assistance for the individual that is provided: (a) during the day or overnight; and (b) in the individual's home; and (c) to provide respite for a carer of the individual
2	Community and centre-based respite	Small day outings or structured group activities for the individual that are provided: (a) to enable the individual to develop, maintain or support independent living and social interaction; and (b) in a community setting; and (c) to provide respite for a carer of the individual

8-51 Subscription home or community general respite

A service listed and described in an item of the following table is in the service type subscription home or community general respite.

Services in the service type subscription home or community general respite

Item	Column 1 Service	Column 2 Description
1	Subscription access to flexible respite	Access to the service listed and described in item 1 of the table in section 8-50 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
2	Subscription access to community and centre-based respite	Access to the service listed and described in item 2 of the table in section 8-50 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day

8-55 Meals

A service listed and described in an item of the following table is in the service type meals.

Services in the service type meals

Item	Column 1 Service	Column 2 Description
1	Meal	Preparation, packaging and delivery of pre-prepared meals, but not including

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Services in the service type meals		
Item	**Column 1** **Service**	**Column 2** **Description**
	delivery	the following: (a) the cost of ingredients; (b) takeaway food delivery; (c) meal delivery for other members of the household
2	Meal preparation	Support to prepare meals in the home or community, but not including the cost of ingredients

8-56 Subscription meals

A service listed and described in an item of the following table is in the service type subscription meals.

Services in the service type subscription meals		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Subscription access to meal delivery	Access to the service listed and described in item 1 of the table in section 8-55 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
2	Subscription access to meal preparation	Access to the service listed and described in item 2 of the table in section 8-55 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day

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8-60 Nursing care

(1) A service listed and described in an item of the following table is in the service type nursing care.

Clinical care matters

(2) For items 1 to 3 of the following table, the clinical care matters are the following:
- (a) the assessment, treatment and monitoring of clinical conditions;
- (b) administration of medications;
- (c) wound care;
- (d) clinical continence management;
- (e) management of skin integrity;
- (f) education;
- (g) specialist service linkage.

Services in the service type nursing care		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Registered	Clinical care provided by a registered nurse, including but not limited to the

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Services in the service type nursing care		
Item	**Column 1** **Service**	**Column 2** **Description**
	nurse clinical care	clinical care matters specified in subsection (2)
2	Enrolled nurse clinical care	Clinical care provided by an enrolled nurse, including but not limited to the clinical care matters specified in subsection (2)
3	Nursing assistant clinical care	Clinical care provided by a nursing assistant, including but not limited to the clinical care matters specified in subsection (2)
4	Nursing care consumables	The supply of consumables used in delivering the clinical care mentioned in items 1 to 3, including oxygen and specialised products for wound care, continence management and skin integrity

8-61 Subscription nursing care

A service listed and described in an item of the following table is in the service type subscription nursing care.

Services in the service type subscription nursing care		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Subscription access to registered nurse clinical care	Access to the service listed and described in item 1 of the table in section 8-60 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
2	Subscription access to enrolled nurse clinical care	Access to the service listed and described in item 2 of the table in section 8-60 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
3	Subscription access to nursing assistant clinical care	Access to the service listed and described in item 3 of the table in section 8-60 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day

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8-65 Nutrition

A service listed and described in an item of the following table is in the service type nutrition.

Services in the service type nutrition		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Nutrition supports	The supply of: (a) supplementary dietary products (enteral and oral); and

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Services in the service type nutrition		
Item	**Column 1** **Service**	**Column 2** **Description**
		(b) aids; that are: (c) required for conditions related to age-related functional decline or impairment; and (d) prescribed by a dietitian or registered health practitioner

8-70 Personal care

A service listed and described in an item of the following table is in the service type personal care.

Services in the service type personal care		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Assistance with self-care and activities of daily living	Attendant care to meet essential and ongoing needs (such as mobility, eating and hygiene), but not including professional services that would usually be paid for by an individual (such as waxing or hairdressing)
2	Assistance with self-administration of medications	Assistance with self-administration of medications, including arranging for medications to be dispensed by a pharmacist, but not including prescribing or administering medications
3	Continence management (non-clinical)	Attendant non-clinical care to manage continence needs (such as support to access advice or funding, or assistance changing aids)

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8-71 Subscription personal care

A service listed and described in an item of the following table is in the service type subscription personal care.

Services in the service type subscription personal care		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Subscription access to assistance with self-care and activities of daily living	Access to the service listed and described in item 1 of the table in section 8-70 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
2	Subscription access to assistance with self-administration	Access to the service listed and described in item 2 of the table in section 8-70 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day

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Services in the service type subscription personal care		
Item	**Column 1** **Service**	**Column 2** **Description**
	of medications	
3	Subscription access to continence management (non-clinical)	Access to the service listed and described in item 3 of the table in section 8-70 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day

8-75 Restorative care management

A service listed and described in an item of the following table is in the service type restorative care management.

Services in the service type restorative care management		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Home support restorative care management	The provision of specialist coordination services for individuals with the classification level SAH restorative care pathway for the classification type short-term for the service group home support, but not including administrative costs funded through prices on services

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8-80 Social support and community engagement

(1) A service listed and described in an item of the following table is in the service type social support and community engagement.

Excluded costs

(2) For items 2, 3 and 4 of the following table, the excluded costs are fees associated with participation in an activity (such as tickets, accommodation and membership fees).

Services in the service type social support and community engagement		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Group social support	Support in a group setting to facilitate meeting the individual's need for social contact or company or participation in community life (including diverse cultural activities), including service and activity identification and linkage
2	Individual social support	Support on an individual basis to facilitate meeting the individual's need for social contact or company or participation in community life (including diverse cultural activities), including the following: (a) service and activity identification and linkage; (b) assistance to participate in social interactions (in-person or online);

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Services in the service type social support and community engagement

Item	Column 1 Service	Column 2 Description
		(c) assistance to visit services or participate in telephone and web-based check-in services; but not including the excluded costs specified in subsection (2)
3	Accompanied activities	Accompanying the individual to facilitate: (a) meeting the individual's need for social contact or company or participation in community life (including diverse cultural activities), but not including the excluded costs specified in subsection (2); or (b) the individual's attendance at medical or other appointments, but not including the cost of the appointments
4	Cultural support	Culturally focused support to facilitate meeting the individual's need for social contact or company or participation in community life (including diverse cultural activities), including the following: (a) service and activity identification and linkage; (b) assistance to access translating and interpreting services and translation of information into the individual's chosen language; (c) referral pathways to advocacy or community organisations; (d) assistance in attending cultural and community events; but not including the excluded costs specified in subsection (2)
5	Digital education and support	Technology-focused support to facilitate meeting the individual's need for social contact or company or participation in community life (including diverse cultural activities), including provision of or assistance with access to training, or direct assistance in the use of technologies to improve digital literacy to aid independence and participation (such as paying bills online, accessing telehealth services and connecting with digital social programs), but not including the purchase of smart devices for the purpose of online engagement
6	Assistance to maintain personal affairs	Support for maintaining the individual's financial and legal affairs to facilitate meeting the individual's need for social contact or company or participation in community life (including diverse cultural activities), but not including service fees (such as funeral plans or accountant's fees)
7	Expenses to maintain personal affairs	An internet or phone service (or both) for an individual who is homeless or is at risk of homelessness, and who needs support to maintain connection to funded aged care services

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8-81 Subscription social support and community engagement

A service listed and described in an item of the following table is in the service type subscription social support and community engagement.

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Services in the service type subscription social support and community engagement

Item	Column 1 Service	Column 2 Description
1	Subscription access to group social support	Access to the service listed and described in item 1 of the table in section 8-80 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
2	Subscription access to individual social support	Access to the service listed and described in item 2 of the table in section 8-80 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
3	Subscription access to accompanied activities	Access to the service listed and described in item 3 of the table in section 8-80 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
4	Subscription access to cultural support	Access to the service listed and described in item 4 of the table in section 8-80 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
5	Subscription access to digital education and support	Access to the service listed and described in item 5 of the table in section 8-80 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
6	Subscription access to assistance to maintain personal affairs	Access to the service listed and described in item 6 of the table in section 8-80 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
7	Subscription access to expenses to maintain personal affairs	Access to the service listed and described in item 7 of the table in section 8-80 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day

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8-85 Therapeutic services for independent living

(1) A service listed and described in an item of the following table is in the service type therapeutic services for independent living.

(2) For a service listed and described in the following table, the service requirements are that:

(a) the service uses evidence-based techniques to manage social, mental and physical wellbeing in support of the individual remaining safe and independent at home; and

(b) the service is within the parameters specified in subsection (3); and

(c) the service is for the management of conditions related to age-related disability or decline; and

(d) the service does not include relaxation massage or fees associated with participation in an activity (such as tickets, accommodation, membership fees, or supplies for an activity such as craft materials).

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(3) For the purposes of paragraph (2)(b), the parameters for a service are the following:

(a) the service may include treatment, education and advice;

(b) the service aims to give the individual the skills and knowledge to manage their own condition and promote independent recovery where appropriate;

(c) the service may be delivered in person or via telehealth, as appropriate;

(d) the service may be delivered individually or in a group-based format, as appropriate;

(e) the service may be delivered:

(i) directly by a registered health practitioner or allied health professional (as applicable); or

(ii) by an allied health assistant or aged care worker, under the supervision of a registered health practitioner or allied health professional, where safe and appropriate to do so.

Services in the service type therapeutic services for independent living

Item	Column 1 Service	Column 2 Description
1	Acupuncture	Acupuncture: (a) provided by a registered health practitioner; and (b) that meets the service requirements specified in subsection (2); but not including herbal medicine
2	Chiropractics	Chiropractic therapy: (a) provided by a registered health practitioner; and (b) that meets the service requirements specified in subsection (2)
3	Diversional therapy	Diversional therapy: (a) provided by an allied health professional or a diversional therapist; and (b) that meets the service requirements specified in subsection (2)
4	Remedial massage	Remedial massage: (a) prescribed by an allied health professional; and (b) provided by an allied health professional or a remedial massage therapist; and (c) that meets the service requirements specified in subsection (2)
5	Art therapy	Art therapy: (a) provided by an allied health professional; and (b) that meets the service requirements specified in subsection (2)
6	Osteopathy	Osteopathy: (a) provided by a registered health practitioner; and (b) that meets the service requirements specified in subsection (2)

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8-86 Subscription therapeutic services for independent living

A service listed and described in an item of the following table is in the service type subscription therapeutic services for independent living.

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Services in the service type subscription therapeutic services for independent living		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Subscription access to acupuncture	Access to the service listed and described in item 1 of the table in section 8-85 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
2	Subscription access to chiropractics	Access to the service listed and described in item 2 of the table in section 8-85 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
3	Subscription access to diversional therapy	Access to the service listed and described in item 3 of the table in section 8-85 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
4	Subscription access to remedial massage	Access to the service listed and described in item 4 of the table in section 8-85 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
5	Subscription access to art therapy	Access to the service listed and described in item 5 of the table in section 8-85 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day
6	Subscription access to osteopathy	Access to the service listed and described in item 6 of the table in section 8-85 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day

8-90 Transport

(1) A service listed and described in an item of the following table is in the service type transport.

Excluded things

(2) For the items of the following table, the excluded things are the following:
- (a) an individual's purchase of a vehicle;
- (b) an individual's vehicle running costs;
- (c) licence costs;
- (d) professional transit services (such as public transport, flights or ferries);
- (e) travel for holidays.

Services in the service type transport		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Direct transport	Provision of a car and driver for group and individual transport services to connect the individual with their usual activities, and including fuel, but not including the excluded things specified in subsection (2)
2	Indirect	Supply of a service voucher for taxi or rideshare services for group and

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Services in the service type transport		
Item	**Column 1** **Service**	**Column 2** **Description**
	transport	individual transport services to connect the individual with their usual activities, but not including the excluded things specified in subsection (2)

8-91 Subscription transport

A service listed and described in an item of the following table is in the service type subscription transport.

Services in the service type subscription transport		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Subscription access to direct transport	Access to the service listed and described in item 1 of the table in section 8-90 by way of a subscription arrangement under which the service is made available to the individual during a particular period on a day

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Division 3—Other specified matters for home support service types

8-95 All service types must be delivered in a home or community setting

All service types in the service group home support must be delivered in a home or community setting.

8-100 Other specified matters—non-subscription service types that can only be delivered under specialist aged care programs

A service type mentioned in column 1 of an item of the following table:

(a) is in the service group home support; and

(b) can only be delivered under a specialist aged care program mentioned in column 2 of the item; and

(c) can be delivered under a provider registration category mentioned in column 3 of the item.

Other specified matters

Item	Column 1 Service type	Column 2 Specialist aged care programs	Column 3 Provider registration categories
1	Assistance with transition care	TCP	Nursing and transition care
2	Community cottage respite	(a) CHSP; (b) MPSP; (c) NATSIFACP	Personal and care support in the home or community
3	Hoarding and squalor assistance	(a) CHSP; (b) MPSP; (c) NATSIFACP	Advisory and support services

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8-105 Other specified matters—other non-subscription service types

Service group, specialist aged care programs and provider registration categories

(1) A service type mentioned in column 1 of an item of the following table:

(a) is in the service group home support; and

(b) can be delivered under a specialist aged care program mentioned in column 2 of the item; and

(c) can be delivered under a provider registration category mentioned in column 3 of the item.

Means testing categories

(2) The means testing category for a service in a service type mentioned in column 1 of an item of the following table is the means testing category mentioned in column 4 of the item.

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Other specified matters

Item	Column 1 Service type	Column 2 Specialist aged care programs	Column 3 Provider registration categories	Column 4 Means testing category
1	Allied health and therapy	(a) CHSP; (b) MPSP; (c) NATSIFACP; (d) TCP	Personal and care support in the home or community	Clinical supports
2	Care management	(a) MPSP; (b) NATSIFACP	Personal and care support in the home or community	Clinical supports
3	Domestic assistance	(a) CHSP; (b) MPSP; (c) NATSIFACP; (d) TCP	Home and community services	Everyday living
4	Home maintenance and repairs	(a) CHSP; (b) MPSP; (c) NATSIFACP; (d) TCP	Home and community services	Everyday living
5	Home or community general respite	(a) CHSP; (b) MPSP; (c) NATSIFACP	Personal and care support in the home or community	Independence
6	Meals	(a) CHSP; (b) MPSP; (c) NATSIFACP; (d) TCP	Home and community services	Everyday living
7	Nursing care	(a) CHSP; (b) MPSP; (c) NATSIFACP; (d) TCP	Nursing and transition care	Clinical supports
8	Nutrition	(a) MPSP; (b) NATSIFACP; (c) TCP	Personal and care support in the home or community	Clinical supports
9	Personal care	(a) CHSP; (b) MPSP; (c) NATSIFACP; (d) TCP	Personal and care support in the home or community	Independence
10	Restorative care management	(a) MPSP; (b) NATSIFACP	Personal and care support in the home or community	Clinical supports
11	Social support and community engagement	(a) CHSP; (b) MPSP; (c) NATSIFACP	Advisory and support services	Independence
12	Therapeutic	(a) CHSP;	Personal and care support	Independence

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Other specified matters

Item	Column 1 Service type	Column 2 Specialist aged care programs	Column 3 Provider registration categories	Column 4 Means testing category
	services for independent living	(b) MPSP; (c) NATSIFACP	in the home or community	
13	Transport	(a) CHSP; (b) MPSP; (c) NATSIFACP	Home and community services	Independence

8-106 Other specified matters—subscription service types

Service group and provider registration category

(1) A service type mentioned in column 1 of an item of the following table:
  (a) is in the service group home support; and
  (b) can be delivered under the provider registration category subscription trial.

Means testing categories

(2) The means testing category for a service in a service type mentioned in column 1 of an item of the following table is the means testing category mentioned in column 2 of the item.

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Other specified matters

Item	Column 1 Service type	Column 2 Means testing category
1	Subscription allied health and therapy	Clinical supports
2	Subscription domestic assistance	Everyday living
3	Subscription home maintenance and repairs	Everyday living
4	Subscription home or community general respite	Independence
5	Subscription meals	Everyday living
6	Subscription nursing care	Clinical supports
7	Subscription personal care	Independence
8	Subscription social support and community engagement	Independence
9	Subscription therapeutic services for independent living	Independence
10	Subscription transport	Independence

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Division 4—Assistive technology service types

8-110 Equipment and products

(1) A service listed and described in an item of the following table is in the service type equipment and products.

Means testing category

(2) For a service listed and described in any of items 1 to 10 of the following table, the means testing category is independence.

(3) For the service listed and described in item 11 of the following table, the means testing category is clinical supports.

Services in the service type equipment and products

Item	Column 1 Service	Column 2 Description
1	Managing body functions items (non-loan)	A service: (a) that consists of the sourcing, supply and provision to the individual, other than on loan, of included managing body functions items; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
2	Managing body functions items (loan)	A service: (a) that consists of the sourcing, supply and provision to the individual, on loan, of included managing body functions items; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
3	Self-care items (non-loan)	A service: (a) that consists of the sourcing, supply and provision to the individual, other than on loan, of included self-care items; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
4	Self-care items (loan)	A service: (a) that consists of the sourcing, supply and provision to the individual, on loan, of included self-care items; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
5	Mobility items (non-loan)	A service: (a) that consists of the sourcing, supply and provision to the individual, other than on loan, of included mobility items; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
6	Mobility items (loan)	A service: (a) that consists of the sourcing, supply and provision to the individual, on loan, of included mobility items; and

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Services in the service type equipment and products

Item	Column 1 Service	Column 2 Description
		(b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
7	Domestic life items (non-loan)	A service: (a) that consists of the sourcing, supply and provision to the individual, other than on loan, of either or both of the following: (i) included domestic life items; (ii) conditionally included domestic life items, if the conditions specified for the items in the AT-HM List are satisfied; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
8	Domestic life items (loan)	A service: (a) that consists of the sourcing, supply and provision to the individual, on loan, of either or both of the following: (i) included domestic life items; (ii) conditionally included domestic life items, if the conditions specified for the items in the AT-HM List are satisfied; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
9	Communication and information management items (non-loan)	A service that: (a) consists of the sourcing, supply and provision to the individual, other than on loan, of either or both of the following: (i) included communication and information management items, other than items that the individual is able to access under the Hearing Services Program administered by the Department; (ii) conditionally included communication and information management items, if the conditions specified for the items in the AT-HM List are satisfied and the individual is not able to access the items under the Hearing Services Program administered by the Department; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
10	Communication and information management items (loan)	A service that: (a) consists of the sourcing, supply and provision to the individual, on loan, of either or both of the following: (i) included communication and information management items, other than items that the individual is able to access under the Hearing Services Program administered by the Department; (ii) conditionally included communication and information management items, if the conditions specified for the items in the AT-HM List are satisfied and the individual is not able to access the items under the Hearing Services Program administered by the Department; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
11	Assistive	Either:

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Services in the service type equipment and products

Item	Column 1 Service	Column 2 Description
	technology prescription and clinical support	(a) the following, delivered by a registered health practitioner or an allied health professional: (i) identifying an issue or problem that restricts the individual's physical, functional or cognitive ability; (ii) assessing the level of assistive technology needed for the individual to regain or maintain physical, functional or cognitive ability; (iii) identifying included AT-HM items and conditionally included AT-HM items (other than included home modifications items) that will assist the individual to regain or maintain physical, functional or cognitive ability; or (b) any of the following wraparound activities for the supply to an individual of an included AT-HM item or a conditionally included AT-HM item under a service listed and described in any of items 1 to 10 of this table: (i) setting up, fitting or providing training on the use of the item; (ii) providing support and troubleshooting to minimise abandonment of the item; (iii) maintenance and follow up for the item (including evaluating the effects on the individual's functioning); (iv) if the supply of the item to the individual is covered by a service listed and described in any of item 2, 4, 6, 8 or 10 of this table—maintenance, repair and refurbishment of the item or, at the end of the item's safe working life, disposal of the item; (v) administrative activities relating to the supply of the item

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Division 5—Other specified matters for assistive technology service types

8-115 All service types must be delivered in a home or community setting

All service types in the service group assistive technology must be delivered in a home or community setting.

8-120 Other specified matters for assistive technology service types

The service type equipment and products:

(a) is in the service group assistive technology; and

(b) can be delivered under any of the following specialist aged care programs:

(i) CHSP;

(ii) MPSP;

(iii) NATSIFACP;

(iv) TCP; and

(c) can be delivered under the provider registration category assistive technology and home modifications.

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Division 6—Home modifications service types

8-125 Home adjustments

(1) Each service listed and described in the following table is in the service type home adjustments.

Means testing category

(2) For the service listed and described in item 1 of the following table, the means testing category is independence.

(3) For the service listed and described in item 2 of the following table, the means testing category is clinical supports.

Services in the service type home adjustments

Item	Column 1 Service	Column 2 Description
1	Home modifications items	A service: (a) that consists of the sourcing, supply and provision to the individual of included home modifications items; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
2	Home modifications prescription and clinical support	Either: (a) the following, delivered by a registered health practitioner or an allied health professional: (i) identifying an issue or problem that restricts the individual's physical, functional or cognitive ability; (ii) assessing the level of home modification needed for the individual to regain or maintain physical, functional or cognitive ability; (iii) identifying included home modifications items that will assist the individual to regain or maintain physical, functional or cognitive ability; or (b) any of the following wraparound activities for the supply to an individual of an included home modifications item under the service listed and described in item 1 of this table: (i) setting up, fitting or providing training on the use of the item; (ii) coordination activities relating to the supply of the item

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Division 7—Other specified matters for home modifications service types

8-130 All service types must be delivered in a home or community setting

All service types in the service group home modifications must be delivered in a home or community setting.

8-135 Other specified matters for home modifications service types

The service type home adjustments:

(a) is in the service group home modifications; and

(b) can be delivered under any of the following specialist aged care programs:

(i) CHSP;

(ii) MPSP;

(iii) NATSIFACP; and

(c) can be delivered under the provider registration category assistive technology and home modifications.

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Division 8—Residential care service types

8-140 Residential accommodation

Each service listed and described in the following table is in the service type residential accommodation.

Services in the service type residential accommodation

Item	Column 1 Service	Column 2 Description
1	Accommodation	The following: (a) capital infrastructure costs and depreciation of buildings and grounds used by individuals; (b) communal areas for living, dining and recreation, as well as personal accommodation in either individual or shared rooms; (c) refurbishments and replacements of fixtures, fittings and infrastructure; (d) maintenance, of buildings and grounds used by individuals, to address normal wear and tear
2	Accommodation administration	Administration relating to the general operation of the residential care home, including accommodation agreements, accommodation bond agreements and accommodation charge agreements

8-145 Residential everyday living

Each service listed and described in the following table is in the service type residential everyday living.

Services in the service type residential everyday living

Item	Column 1 Service	Column 2 Description
1	Operational administration and emergency assistance	The following: (a) administration relating to: (i) the delivery of the other services listed and described in this table; and (ii) service agreements; (b) emergency assistance, including the following: (i) at all times, having at least one suitable employee of the registered provider onsite and able to take action in an emergency; (ii) if an individual is in need of urgent medical attention—providing emergency assistance in accordance with the registered provider's protocol for providing such assistance; (iii) activation of emergency plans in the case of fire, floods or other emergency; (iv) contingency planning for emergencies;

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Services in the service type residential everyday living

Item	Column 1 Service	Column 2 Description
		(v) staff training for emergencies
2	Communication services	Access for individuals to an external telecommunications mechanism in the residential care home (and in individuals' rooms if requested), such as telephone, internet or wi-fi services, but not including any usage charges or device costs
3	Utilities	The following: (a) utility running costs for the residential care home (such as electricity, water and gas); (b) heating and cooling for bedrooms and common areas to a comfortable temperature; (c) testing and tagging of all electrical equipment provided by the registered provider; but not including electrical equipment brought into the residential care home by individuals
4	Cleaning services and waste disposal	The following: (a) cleanliness and tidiness of the entire residential care home, including the individual's personal area unless the individual chooses to and is able to maintain their personal area themselves; (b) safe disposal of organic and inorganic waste material
5	Communal furnishings	Fit-for-purpose communal lounge and dining furniture, including the following: (a) televisions; (b) if the residential care home has a communal outdoor space—outdoor furniture
6	Bedroom and bathroom furnishings	The following (other than bedroom and bathroom furnishings that are customised or that the individual chooses to provide): (a) a bed and a mattress that meet the individual's care, safety and comfort needs, including, if required, a bed that is adjustable to cater for the individual's needs and accommodates the individual's height and weight; (b) equipment or technologies used to ensure the safety of the individual in bed and to avoid injury to the individual and to aged care workers; (c) pillows (including, if required, pressure cushions, tri pillows and wedge pillows); (d) a bedside table, bedside locker or bedside chest of drawers, wardrobe space, draw screens (for shared rooms), a visitor chair (if required) and an over bed table (if required); (e) a fixture or item of furniture where the individual can safely lock and store valuables, if this is not provided by the furniture items mentioned in paragraph (d); (f) a chair, with arms, that meets the individual's care, safety and comfort needs, including, if required, a chair with particular features, such as an air, water or gel chair; (g) a shower chair (if required), containers for personal laundry, and

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Services in the service type residential everyday living

Item	Column 1 Service	Column 2 Description
		waste collection containers or bins for bedrooms and bathrooms; (h) bed linen, blankets or doonas, air or ripple mattresses (if required), absorbent or waterproof covers, sheeting and bed pads (if required), bath towels, hand towels and face washers; (i) laundering of all products mentioned in paragraph (h)
7	Toiletry goods	The supply of the following goods (or substitutes if needed to meet the individual's medical needs, including specialist products for conditions such as dermatitis) but not including alternative items requested on the basis of the individual's personal preferences: (a) facial cleanser (or alternatives such as facial wipes), shower gel or soap, shower caps, shampoo and conditioner; (b) toothpaste, toothbrushes and mouthwash; (c) hairbrush or comb, shaving cream and disposable razors; (d) tissues and toilet paper; (e) moisturiser and deodorant; (f) cleaning products for dentures, hearing aids, glasses and artificial limbs (and their storage containers)
8	Personal laundry	The following: (a) laundering (other than by a special cleaning process such as dry cleaning or hand washing) items that can be machine washed, using laundry detergents that meet the individual's medical needs, such as skin sensitivities; (b) if requested, ironing of machine washed clothes (other than underwear and socks); (c) a labelling system for the individual's clothing, but not including alternate labelling systems requested on the basis of the individual's personal preferences; (d) return of personal laundry to the individual's clothing storage space
9	Meals and refreshments	The following: (a) at least 3 meals served each day (including the option of dessert with either lunch or dinner) plus morning tea, afternoon tea and supper, of adequate variety, quality and quantity to meet the individual's nutritional and hydration needs; (b) special diets where required to meet the individual's medical, cultural or religious needs, including but not limited to enteral feeding, nutritional supplements, texture modified meals and thickened fluids, diets to address food allergies and intolerances, and vegetarian, vegan, kosher and halal diets (but not for meeting the individual's social preferences on food source such as non-genetically modified and organic); (c) reasonable flexibility in mealtimes, if requested, so the individual can exercise choice; (d) a variety of non-alcoholic beverages available at all times (such as water, milk, fruit juice, tea and coffee);

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Services in the service type residential everyday living		
Item	**Column 1** **Service**	**Column 2** **Description**
		(e) eating and drinking utensils and eating aids if needed; (f) snack foods of adequate variety, including fruit and options suitable for texture modified diets, available at all times in the residential care home

8-150 Residential non-clinical care

Each service listed and described in the following table is in the service type residential non-clinical care.

Services in the service type residential non-clinical care		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Care and services administration	Administration related to: (a) the delivery of the other services listed and described in the other items of this table; and (b) the delivery of the services in the service type residential clinical care
2	Personal care assistance	Personal assistance, including individual attention, individual supervision and physical assistance, with the following: (a) bathing, showering, personal hygiene and grooming (other than hairdressing); (b) dressing, undressing and using dressing aids; (c) eating and drinking, and using utensils and eating aids (including actual feeding if necessary); (d) cleaning of personal items (and their storage containers) needed for daily living, including dentures, hearing aids, glasses, mobility aids and artificial limbs
3	Communication	Assistance with daily communication, including the following: (a) assistance to address difficulties arising from impaired hearing, sight or speech, cognitive impairment, or lack of common language (for example, visual aids such as cue cards, paper-based photo or alphabet spelling communication boards or books, photo based easy language written information, and menu and activity choice boards or learning of key phrases); (b) fitting sensory communication aids and checking hearing aid batteries
4	Emotional support	The following: (a) if the individual is experiencing social isolation, loneliness or emotional distress—ongoing emotional support to, and supervision of, the individual (including pastoral support); (b) if the individual is new to the residential care home—assisting the individual to adjust to their new living environment;

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Services in the service type residential non-clinical care

Item	Column 1 Service	Column 2 Description
		(c) provision of culturally safe supports that have been determined in consultation with the individual and their supporters (if required)
5	Mobility and movement needs	The following (other than the provision of motorised wheelchairs, electric mobility scooters, customised aids, or mobility aids requested on the basis of the individual's personal preferences): (a) assisting the individual with moving, walking and wheelchair use; (b) assisting the individual with using devices and appliances designed to aid mobility; (c) the fitting of artificial limbs and other personal mobility aids; (d) supply and maintenance of crutches, quadruped walkers, walking frames, wheeled walkers, standing walkers, walking sticks, wheelchairs and tilt-in-space chairs; (e) aids and equipment used by aged care workers to move the individual, including for individuals with bariatric needs; taking into account: (f) the individual's care, safety and comfort needs; and (g) the individual's ability to use aids, appliances, devices and equipment; and (h) the safety of other individuals and of aged care workers and visitors to the residential care home
6	Continence management	The following: (a) assisting the individual to: (i) maintain continence or manage incontinence; and (ii) use aids and appliances designed to assist continence management; (b) the supply of aids and appliances designed to assist continence management to meet the individual's needs, including the following: (i) commode chairs, over-toilet chairs, bed-pans, uridomes, and catheter and urinary drainage appliances; (ii) as many continence aids (such as disposable urinal covers, pants, pads, chair pads and enemas) as are needed to meet the individual's needs
7	Recreational and social activities	Tailored recreational programs and leisure activities (including communal recreational equipment and products) aimed at preventing loneliness and boredom, creating an enjoyable and interesting environment, and maintaining and improving the social interaction of the individual. These programs and activities must include the option of: (a) at least one recreational or social activity each day that is not screen-based, television-based or meal-based; and (b) regular outings into the community (but not including the cost of entry tickets, transport or purchased food and beverages associated with the outings)

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8-155 Residential clinical care

Each service listed and described in the following table is in the service type residential clinical care.

Services in the service type residential clinical care

Item	Column 1 Service	Column 2 Description
1	Care and services plan oversight	Ensuring that: (a) the individual's care and services plan is carried out; and (b) progress against the care and services plan goals is monitored Note: For requirements for care and services plans, see paragraph 148(e) of the Act and Subdivisions A and D of Division 3 of Part 4 of Chapter 4 of this instrument. For Aged Care Quality Standards for care and services plans, see subsections 15-20(1) to (3) of this instrument.
2	Allied health, rehabilitation and therapeutic exercise therapy programs	Allied health, rehabilitation and therapeutic exercise therapy programs that are: (a) designed by: (i) appropriate registered health practitioners; or (ii) appropriate allied health professionals; or (iii) appropriate registered health practitioners and appropriate allied health professionals; and (b) designed in consultation with the individual and their supporters (if required); and (c) delivered in individual or group settings; and (d) delivered by, or under the supervision, direction or appropriate delegation of: (i) registered health practitioners; or (ii) allied health professionals; or (iii) registered health practitioners and allied health professionals; and (e) aimed at maintaining and restoring the individual's physical, functional and communication abilities to perform daily tasks for themselves, including through: (i) maintenance therapy that is designed to provide ongoing therapy services to prevent reasonably avoidable physical and functional decline and maintain and improve levels of independence in everyday living; and (ii) if required, more focused restorative care therapy on a time-limited basis that is designed to allow the individual to reach a level of independence at which maintenance therapy will meet their needs; but not including the following: (f) intensive, long-term rehabilitation services required following (for example) serious illness or injury, surgery or trauma; (g) allied health services and appointments made for or by the individual or their supporters that are in addition to those required to meet the individual's care needs under programs covered by paragraphs (a) to (e)

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Services in the service type residential clinical care

Item	Column 1 Service	Column 2 Description
3	Medication management	The following: (a) implementation of a safe and efficient system to manage prescribing, procuring, dispensing, supplying, packaging, storing and administering of both prescription and over-the-counter medicines; (b) administration and monitoring of the effects of medication (via all routes (including injections)), including supervision and physical assistance with taking both prescription and over-the-counter medication, under the delegation and clinical supervision of a registered nurse or other appropriate registered health practitioner; (c) reviewing the appropriateness of medications as needed under the delegation and clinical supervision of a registered nurse, or other appropriate registered health practitioner; but not including the cost of prescription and over-the-counter medications
4	Nursing	Services provided by or under the supervision of a registered nurse, including but not limited to the following: (a) initial comprehensive clinical assessment for input to the care and services plan for the individual, carried out: (i) in line with the individual's needs, goals and preferences; and (ii) by a registered nurse; and (iii) if required, in consultation with other appropriate registered health practitioners, appropriate allied health professionals, or appropriate registered health practitioners and appropriate allied health professionals; (b) ongoing regular comprehensive clinical assessment of the individual, including identifying and responding appropriately to change or deterioration in function, behaviour, condition or risk, carried out: (i) in line with the individual's needs, goals and preferences; and (ii) by a registered nurse, or an enrolled nurse under appropriate delegation by a registered nurse; and (iii) if required, in consultation with other appropriate registered health practitioners, appropriate allied health professionals, or appropriate registered health practitioners and appropriate allied health professionals; (c) all other nursing services, carried out: (i) by a registered nurse, or an enrolled nurse under appropriate delegation by a registered nurse; and (ii) if required, in consultation with other appropriate registered health practitioners, appropriate allied health professionals, or appropriate registered health practitioners and appropriate allied health professionals Note 1: Examples of services include (but are not limited to) the following: (a) ongoing monitoring and evaluation of the individual, and identification where care may need to be escalated or altered due to the changing health or needs of the individual; (b) maintaining accurate, comprehensive, and up-to-date clinical documentation of the individual's care; (c) assistance with, or provision of support for, personal hygiene,

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Services in the service type residential clinical care

Item	Column 1 Service	Column 2 Description
		including oral health management and considerations for bariatric care needs; (d) chronic disease management, including blood glucose monitoring; (e) if the individual is living with cognitive decline—support and supervision of the individual; (f) if the individual is living with mental health decline—support and supervision of the individual; (g) establishment and supervision of a pain management plan, including the management and monitoring of chronic pain; (h) medication management (as listed and described in item 3 of this table); (i) insertion, maintenance, monitoring and removal of devices, including intravenous lines, naso-gastric tubes, catheters and negative pressure devices; (j) if the individual has identified feeding and swallowing needs—support for the individual; (k) skin assessment and the prevention and management of pressure injury wounds; (l) establishment and supervision of a continence management plan; (m) stoma care; (n) wound management, including of complex and chronic wounds; (o) provision of bandages, dressings, swabs, saline, drips, catheters, tubes and other medical items required as a part of nursing services; (p) assistance with, and ongoing supervision of, breathing, including oxygen therapy, suctioning of airways and tracheostomy care; (q) required support and observations for peritoneal dialysis treatment; (r) assisting or supporting an individual to use appropriate healthcare technology in support of their care, including telehealth; (s) risk management relating to infection prevention and control; (t) advance care planning, palliative care and end-of-life care. Note 2: For requirements for care and services plans, see paragraph 148(e) of the Act and Subdivisions A and D of Division 3 of Part 4 of Chapter 4 of this instrument. For Aged Care Quality Standards for care and services plans, see subsections 15-20(1) to (3) of this instrument.
5	Dementia and cognition management	If the individual has dementia or other cognitive impairments: (a) development of an individual therapy and support program designed and carried out to: (i) prevent or manage a particular condition or behaviour; and (ii) enhance the individual's quality of life; and (iii) enhance care for the individual; and (b) ongoing support (including specific encouragement) to motivate or enable the individual to take part in general activities of the residential care home (if appropriate)
6	General access to medical and allied health services	The following: (a) making arrangements for registered health practitioners to visit the individual for any necessary registered health practitioner appointments (but not the cost of the appointments or any gap payments charged for the appointments); (b) making arrangements for the individual to attend any necessary

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Services in the service type residential clinical care

Item	Column 1 Service	Column 2 Description
		registered health practitioner appointments (but not the cost of the appointments or any gap payments charged for the appointments, or transport or escort costs); (c) if required, making arrangements for allied health professionals to visit the individual, or for the individual to visit an allied health professional, for any services or appointments mentioned in paragraph (f) of item 2 of this table (but not the cost of the appointments or any gap payments charged for the appointments, or transport or escort costs); (d) if required, provision of audio-visual equipment for use with telehealth appointments; (e) arranging for an ambulance in emergency situations

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Division 9—Other specified matters for residential care service types

8-160 Service types must be delivered in a residential care home

Each service type in the service group residential care must be delivered in a residential care home.

8-165 Other specified matters for residential care service types

Each service type set out in Division 8:

(a) is in the service group residential care; and

(b) can be delivered under the following specialist aged care programs:

(i) NATSIFACP;

(ii) MPSP;

(iii) TCP; and

(c) can be delivered under the provider registration category residential care.

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Part 4—Other key concepts

11-5 Provider registration categories

For the purposes of paragraph 11(3)(b) of the Act, the following categories are prescribed:

(a) home and community services;
(b) assistive technology and home modifications;
(c) advisory and support services;
(d) personal and care support in the home or community;
(e) nursing and transition care;
(f) subscription trial.

Note: The category residential care is a provider registration category (see paragraph 11(3)(a) of the Act).

11A-5 Delivery of funded aged care services

Late cancellations

(1) For the purposes of subparagraph 11A(3)(a)(ii) of the Act, the period of 2 business days is prescribed.

Prescribed circumstances—no-show circumstances

(2) For the purposes of paragraph 11A(3)(b) of the Act, the prescribed circumstances are that no-show circumstances apply in relation to the service.

(3) ***No-show circumstances*** apply in relation to the service if:
(a) the service was to be delivered by the registered provider to the individual through the service group home support, assistive technology or home modifications; and
(b) the service was scheduled to be delivered by the registered provider to the individual on the day referred to in paragraph 11A(2)(b) of the Act at an agreed time and place; and
(c) the only reason that the service was not delivered was:
(i) the individual was required to be present (whether physically, by video link or other means) for the delivery of the service; and
(ii) the individual was not present as agreed for the delivery of the service on that day and at that time and place; and
(iii) the individual did not cancel the delivery of the service before the agreed time.

(4) ***No-show circumstances*** also apply in relation to the service if:
(a) the service was to be delivered by the registered provider to the individual through the service group home support, assistive technology or home modifications; and

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(b) the service was scheduled to be delivered by the registered provider to the individual on the day referred to in paragraph 11A(2)(b) of the Act at an agreed time and place; and

(c) the only reason that the service was not delivered was because the individual refused, or refused or failed to facilitate, access to the agreed place necessary for the delivery of the service.

Circumstances in which subsection 11A(2) of the Act does not apply to a service

(5) For the purposes of paragraph 11A(5)(a) of the Act, the circumstances in which subsection 11A(2) of the Act does not apply to a service is that the service was to have been delivered under a specialist aged care program.

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Part 5—Aged Care Code of Conduct

14-1 Purpose of this Part

For the purposes of section 14 of the Act, this Part prescribes requirements relating to the conduct of the following:

(a) registered providers;
(b) aged care workers of registered providers;
(c) responsible persons of registered providers.

Note: These requirements are the ***Aged Care Code of Conduct***: see section 7 of the Act.

14-5 Requirements

When delivering funded aged care services to individuals, I must:

(a) act with respect for individuals' rights to freedom of expression, self-determination and decision-making in accordance with applicable laws and conventions; and
(b) act in a way that treats individuals with dignity and respect, and values their diversity; and
(c) act with respect for the privacy of individuals; and
(d) deliver funded aged care services in a safe and competent manner, with care and skill; and
(e) act with integrity, honesty and transparency; and
(f) promptly take steps to raise and act on concerns about matters that may impact the quality and safety of funded aged care services; and
(g) deliver funded aged care services free from:
  (i) all forms of violence, discrimination, exploitation, neglect and abuse; and
  (ii) sexual misconduct; and
(h) take all reasonable steps to prevent and respond to:
  (i) all forms of violence, discrimination, exploitation, neglect and abuse; and
  (ii) sexual misconduct.

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14-10 Application of requirements

(1) The requirements apply to the following in accordance with this section:
  (a) registered providers;
  (b) aged care workers of registered providers;
  (c) responsible persons of registered providers.

(2) The requirements apply as if the reference to "I" in section 14-5 was a reference to all of the following:
  (a) a registered provider;

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(b) an aged care worker of a registered provider;
(c) a responsible person of a registered provider.

(3) For the purposes of the application of requirements to the delivery of funded aged care services to individuals by a responsible person of a registered provider, the requirements apply to the performance by the responsible person of the responsibilities and functions of the responsible person.

Note: Provisions relevant to compliance with the Aged Care Code of Conduct include the following:
(a) section 142 of the Act (civil penalties for non-compliance with conditions of registration of registered providers);
(b) section 145 of the Act (condition of registration of registered providers);
(c) section 173 of the Act (civil penalties for aged care workers);
(d) section 174 of the Act (civil penalties for responsible persons);
(e) subparagraph 498(2)(d)(i) of the Act (grounds for banning orders against individuals who are or were aged care workers or responsible persons of a registered provider).

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Part 6—Aged Care Quality Standards

Division 1—Purpose and application

15-1 Purpose of this Division

For the purposes of subsection 15(1) of the Act, this Division:

(a) prescribes standards relating to the quality of funded aged care services delivered by a registered provider; and

(b) provides for the application of the standards to registered providers in specified provider registration categories.

15-5 Application of standards

Standards 1 to 4

(1) Standards 1 to 4 apply to a registered provider in any of the following provider registration categories:

(a) personal and care support in the home or community;

(b) nursing and transition care;

(c) residential care.

(1A) Standards 1 to 4 apply to a registered provider in the provider registration category subscription trial if the provider is also in a provider registration category referred to in paragraph (1)(a) or (b).

Standard 5

(2) Standard 5 applies to a registered provider in either of the following provider registration categories:

(a) nursing and transition care;

(b) residential care.

(2A) Standard 5 applies to a registered provider in the provider registration category subscription trial if the provider is also in the provider registration category referred to in paragraph (2)(a).

(3) Subsections 15-30(1) and (2) (Standard 5—*Outcome 5.1—Clinical governance*) apply to a registered provider in the provider registration category personal and care support in the home or community that delivers, or intends to deliver, either of the following service types:

(a) care management;

(b) restorative care management.

Standards 6 and 7

(4) Standards 6 and 7 apply to a registered provider in the provider registration category residential care.

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Division 2—The standards

15-10 Standard 1—The individual

Outcome 1.1—Person-centred care

(1) The registered provider demonstrates that the provider understands that the safety, health, wellbeing and quality of life of individuals is the primary consideration in the delivery of funded aged care services.

Note: See also subsection 144(2) of the Act (rights and principles).

(2) The provider demonstrates that the provider understands and values individuals, including their identity, culture, ability, diversity, beliefs and life experiences.

Note: See also section 23 of the Act (Statement of Rights) and section 144 of the Act (rights and principles).

(3) The provider demonstrates that the provider develops funded aged care services with, and tailored to, individuals, taking into account their needs, goals and preferences.

Outcome 1.2—Dignity, respect and privacy

(4) The provider must deliver funded aged care services to individuals in a way that:
(a) is free from all forms of discrimination, abuse and neglect; and
(b) treats individuals with dignity and respect; and
(c) respects the personal privacy of individuals.

Note: See section 23 of the Act (Statement of Rights) and section 144 of the Act (rights and principles).

(5) The provider:
(a) demonstrates that the provider understands the rights of individuals under the Statement of Rights; and
(b) must have practices in place to ensure that the provider acts compatibly with the Statement of Rights, in accordance with subsection 24(2) of the Act (acting compatibly with the Statement of Rights).

Note: See also section 144 of the Act (rights and principles).

Outcome 1.3—Choice, independence and quality of life

(6) The provider must support individuals to exercise choice and make decisions about their funded aged care services, and provide them with support to exercise choice and make decisions when they want or need it.

(7) The provider must provide individuals with timely, accurate, tailored and sufficient information about their funded aged care services, in a way they understand.

Note: See also section 29 of the Act (giving information and documents to supporters).

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(8) The provider must support individuals to exercise dignity of risk to achieve their goals and maintain independence and quality of life.

Outcome 1.4—Transparency and agreements

(9) Before entering into any agreements with individuals about the delivery of funded aged care services, the provider must provide individuals with:
  (a) the opportunity to exercise autonomy; and
  (b) the time they need to consider the agreement; and
  (c) an opportunity to seek advice.

Note: Refer to sections 148-65 and 148-70 of this instrument in relation to the requirements for entering into a service agreement, details and contents of such an agreement.

(10) The provider must support individuals to understand and make informed decisions about their agreements, fees and invoices.

15-15 Standard 2—The organisation

Outcome 2.1—Partnering with individuals

(1) The registered provider must engage in meaningful and active partnerships with individuals to inform organisational priorities and continuous improvement.

Note: See also section 147 of the Act and Division 2 of Part 4 of Chapter 4 of this instrument (conditions of registration relating to continuous improvement).

Outcome 2.2a—Quality, safety and inclusion culture to support aged care workers to deliver quality care

(2) The governing body must lead a culture of quality, safety and inclusion that supports aged care workers to provide quality funded aged care services by:
  (a) focussing on continuous improvement; and
  (b) embracing diversity; and
  (c) prioritising the safety, health and wellbeing of aged care workers.

Note: See also section 147 of the Act and Division 2 of Part 4 of Chapter 4 of this instrument (conditions of registration relating to continuous improvement).

Outcome 2.2b—Quality, safety and inclusion culture to support individuals

(3) The governing body must lead a culture of quality, safety and inclusion that supports individuals accessing quality funded aged care services by:
  (a) focussing on continuous improvement; and
  (b) embracing diversity; and
  (c) prioritising the safety, health and wellbeing of individuals.

Note: See also section 147 of the Act and Division 2 of Part 4 of Chapter 4 of this instrument (conditions of registration relating to continuous improvement).

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Outcome 2.3—Accountability, quality system and policies and procedures

(4) The governing body is accountable for the delivery of quality funded aged care services and must maintain oversight of all aspects of the provider's operations.

(5) The provider must use a quality system to enable and drive continuous improvement of the provider's delivery of funded aged care services.

Note: See also section 147 of the Act and Division 2 of Part 4 of Chapter 4 of this instrument (conditions of registration relating to continuous improvement).

(6) The provider must:

(a) maintain current policies and procedures that guide the way aged care workers undertake their roles; and

(b) require aged care workers to follow the policies and procedures.

Outcome 2.4—Risk management

(7) The provider must use a risk management system to identify, manage and continuously review risks to individuals, aged care workers and the provider's operations.

Note: See also section 147 of the Act and Division 2 of Part 4 of Chapter 4 of this instrument (conditions of registration relating to continuous improvement).

Outcome 2.5—Incident management

(8) The provider must use an incident management system to:

(a) safeguard individuals; and

(b) acknowledge, respond to, effectively manage and learn from incidents.

Note: See also section 164 of the Act and Division 1 of Part 10 of Chapter 4 of this instrument (conditions of registration relating to incident management).

Outcome 2.6a—Complaints and feedback management—for aged care workers

(9) The provider must encourage and support aged care workers to make complaints and give feedback about the provider's delivery of funded aged care services without reprisal.

Note: See also section 165 of the Act and Division 2 of Part 10 of Chapter 4 of this instrument (conditions of registration relating to complaints, feedback and whistleblowers).

Outcome 2.6b—Complaints and feedback management—for individuals

(10) The provider must encourage and support individuals and others to make complaints and give feedback about the provider's delivery of funded aged care services without reprisal.

Note: See also section 165 of the Act and Division 2 of Part 10 of Chapter 4 of this instrument (conditions of registration relating to complaints, feedback and whistleblowers).

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Section 15-15

Outcomes 2.6a and 2.6b—Complaints and feedback management

(11) The provider must:

(a) acknowledge and transparently manage all complaints and feedback; and

(b) use complaints and feedback to contribute to the continuous improvement of funded aged care services.

Note: See also section 165 of the Act and Division 2 of Part 10 of Chapter 4 of this instrument (conditions of registration relating to complaints, feedback and whistleblowers), and section 147 of the Act and Division 2 of Part 4 of Chapter 4 of this instrument (conditions of registration relating to continuous improvement).

Outcome 2.7—Information management

(12) The provider must ensure that information recorded about an individual:

(a) is accurate and current; and

(b) is able to be accessed and understood by the individual, supporters of the individual, aged care workers, registered health practitioners, allied health professionals, allied health assistants and others involved in the individual's care.

Note: See also section 155 of the Act (provision of information to individuals) which sets out conditions applicable to registered providers to allow access to records and information to individuals and explain those records and information to those individuals. Subsection 156(3) of the Act in specified circumstances allows independent aged care advocates access to records and information held by a registered provider about an individual.

(13) The provider must ensure that the information of individuals is kept confidential and is managed appropriately, in line with their informed consent.

Note: See also section 154 of the Act (personal information and record keeping) which requires registered providers as a condition of their registration to keep and retain kinds of records in accordance with requirements set out in this instrument, and section 168 of the Act (protection of personal information) which requires registered providers to ensure the protection of personal information.

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Outcome 2.8—Workforce planning

(14) The provider must demonstrate that the provider understands and manages their workforce needs and plans for the future.

Outcome 2.9—Human resource management

(15) The provider must deliver funded aged care services to individuals by aged care workers who:

(a) are skilled and competent in their roles; and

(b) hold relevant qualifications for their roles; and

(c) have expertise and experience relevant to delivering quality funded aged care services.

Note: See also section 152 of the Act (workforce and aged care worker requirements) which requires registered providers as a condition of their registration to comply with workforce screening and other requirements in relation to the employment of aged care workers.

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(16) The provider must provide aged care workers with training and supervision to enable them to effectively perform their roles.

Outcome 2.10—Emergency and disaster management

(17) The provider must demonstrate that emergency and disaster management planning considers and manages risks to the health, safety and wellbeing of individuals and aged care workers.

15-20 Standard 3—The care and services

Outcome 3.1—Assessment and planning

(1) The registered provider must actively engage with:
  (a) individuals to whom the provider delivers funded aged care services; and
  (b) supporters of individuals (if any); and
  (c) any other persons involved in the care of individuals;
in developing and reviewing the individual's care and services plans through ongoing communication.

(2) Care and services plans must:
  (a) describe the current care needs, goals and preferences of individuals; and
  (b) include strategies for risk management and preventative care.

(3) The provider must ensure that care and services plans are regularly reviewed and are used by aged care workers to guide the delivery of funded aged care services.

Note: See also section 148-80 of this instrument (requirements for care and services plans-general) which provides details in relation to the development of care and services plans for an individual.

Outcome 3.2—Delivery of funded aged care services

(4) The provider must ensure that individuals receive quality funded aged care services that:
  (a) meet their care needs, goals and preferences; and
  (b) optimise their quality of life, reablement and maintenance of function.

(5) The provider must ensure that funded aged care services are delivered in a way that is culturally safe and culturally appropriate for individuals with specific needs and diverse backgrounds.

Outcome 3.3—Communicating for safety and quality

(6) The provider must ensure that critical information relevant to the delivery of funded aged care services to individuals is communicated effectively:
  (a) to the individuals; and
  (b) between aged care workers delivering the services; and
  (c) to supporters of the individuals and other persons supporting the individuals; and

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(d) to registered health practitioners, allied health professionals, allied health assistants and others involved with the individual's care.

(7) The provider must ensure that risks to individuals, and changes and deterioration in the condition of individuals, are escalated and communicated as appropriate.

Outcome 3.4—Planning and coordination of funded aged care services

(8) The provider must ensure that individuals receive funded aged care services that are planned and coordinated, including where multiple health providers and registered providers, supporters of individuals and other persons supporting individuals are involved.

15-25 Standard 4—The environment

Outcome 4.1a—Environment—services delivered in the individual's home

(1) When delivering funded aged care services to individuals in their homes, the registered provider must support the individuals to mitigate environmental risks relevant to the services.

Outcome 4.1b—Environment—services delivered other than in the individual's home

(2) Where the provider delivers funded aged care services to individuals other than in their homes, the provider must ensure that individuals are able to access funded aged care services in a clean, safe and comfortable environment that optimises their sense of belonging, interaction and function.

Outcomes 4.1a and 4.1b—Equipment

(3) Where the provider uses equipment in the delivery of any funded aged care services to individuals, or provides equipment to individuals, the equipment must be safe and must meet the needs of the individuals.

Outcome 4.2—Infection prevention and control

(4) The provider must have an appropriate infection prevention and control system.

(5) The provider must ensure that aged care workers use hygienic practices and take appropriate infection prevention and control precautions when delivering funded aged care services.

15-30 Standard 5—Clinical care

Outcome 5.1—Clinical governance

(1) The governing body must ensure:

(a) that the governing body continuously improves the safety and quality of clinical care services delivered to individuals; and

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(b) that the provider delivers safe and quality clinical care services to individuals.

Note: See also section 147 of the Act and Division 2 of Part 4 of Chapter 4 of this instrument (conditions of registration relating to continuous improvement).

(2) The registered provider must integrate clinical governance into corporate governance to actively manage and improve the safety and quality of clinical care services delivered to individuals.

Outcome 5.2—Preventing and controlling infections in delivering clinical care services

(3) The provider must ensure that individuals, aged care workers, registered health practitioners and others are encouraged and supported to use antimicrobials appropriately to reduce risks of increasing resistance.

(4) The provider must ensure that infection risks are minimised and, if they occur, are controlled effectively.

Outcome 5.3—Safe and quality use of medicines

(5) The provider must encourage and support individuals, aged care workers, registered health practitioners and allied health professionals to use medicines in a way that maximises benefits and minimises the risks of harm.

(6) The provider must ensure that:
(a) before administering medicine to an individual, the medicine has been prescribed for the individual; and
(b) medicines are appropriately and safely administered, monitored and reviewed by registered health practitioners, considering the clinical needs and informed decisions of the individual.

(7) The provider must ensure that medicine-related adverse events are monitored and reported, and are used to inform safety and quality improvement.

Outcome 5.4—Comprehensive care

(8) The provider must ensure that individuals receive comprehensive, safe and quality clinical care services that are evidence-based, person-centred and delivered by registered health practitioners, allied health professionals, allied health assistants or nursing assistants.

(9) Clinical care delivered by the provider must encompass clinical assessment, prevention, planning, treatment, management and review to minimise harm and optimise quality of life, reablement and maintenance of function.

(10) The provider must have systems and processes that support coordinated and multidisciplinary clinical care services:
(a) that are delivered to individuals, in partnership with individuals, supporters of individuals and other persons supporting individuals; and
(b) that are aligned with the individuals' needs, goals and preferences.

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(11) The provider must support early identification of, and response to, changing clinical needs.

Outcome 5.5—Safety of clinical care services

(12) The provider must identify, monitor and manage high impact and high prevalence risks in the delivery of clinical care services:
  (a) to ensure the delivery of safe and quality clinical care services; and
  (b) to reduce the risk of harm to individuals.

Outcome 5.6—Cognitive impairment

(13) The provider must ensure that individuals who experience cognitive impairment (whether acute, chronic or transitory) receive comprehensive funded aged care services that:
  (a) optimise clinical outcomes; and
  (b) are aligned with the individuals' needs, goals and preferences.

(14) The provider must identify situations and events that may lead to changes in behaviours.

Outcome 5.7—Palliative care and end-of-life care

(15) The provider must recognise and address the needs, goals and preferences of individuals for palliative care and end-of-life care, and must preserve the dignity of individuals in those circumstances.

(16) The provider must ensure that the pain and symptoms of individuals are actively managed, with access to specialist palliative and end-of-life care when required.

(17) The provider must ensure that supporters of individuals and other persons supporting individuals are informed and supported, including during the last days of life.

Note: See also section 29 of the Act (giving information and documents to supporters).

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15-35 Standard 6—Food and nutrition

Outcome 6.1—Partnering with individuals on food and drinks

(1) The registered provider must partner with individuals to deliver a quality food and drinks service that includes appetising and varied food and drinks and an enjoyable dining experience.

Note: See also item 9 of the table in section 8-145 of this instrument (residential everyday living—meals and refreshments).

Outcome 6.2—Assessment of nutritional needs and preferences

(2) The provider must demonstrate that the provider understands the specific nutritional needs of individuals and assesses the current needs, abilities and preferences of individuals in relation to what and how they eat and drink.

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Outcome 6.3—Provision of food and drinks

(3) The provider must provide individuals with:
  (a) food and drinks that meet their nutritional needs and are appetising and flavoursome; and
  (b) variation and choice about what they eat and drink; and
  (c) choice about how much they eat and drink.

Outcome 6.4—Dining experience

(4) The provider must support individuals to eat and drink.

(5) The provider must ensure that the dining experience meets the needs and preferences of individuals to support social engagement, function and quality of life.

15-40 Standard 7—The residential community

Outcome 7.1—Daily living

(1) The registered provider must ensure that individuals receive funded aged care services that optimise their quality of life, promote use of their skills and strengths and enable them to do the things they want to do.

(2) The provider must ensure that individuals feel safe in their residential care home.

Outcome 7.2—Transitions

(3) The provider must ensure that individuals experience a well-coordinated transition, whether planned or unplanned, to or from a provider.

Note: See also section 149 of the Act (starting and ceasing the provision of funded aged care services and continuity of those services).

(4) The provider must set out clear responsibility and accountability for the delivery of funded aged care services to individuals between aged care workers, registered health practitioners, allied health professionals and allied health assistants, and across organisations.

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Part 7—Reportable incidents and restrictive practices

Division 1—Reportable incidents

16-5 Defining and clarifying expressions relating to reportable incidents

(1) For the purposes of subsection 16(2) of the Act, this section prescribes definitions or clarifications of expressions used in paragraphs 16(1)(a), (b), (c), (d), (e), (f) and (h) of the Act (which deal with incidents that have occurred, are alleged to have occurred, or are suspected of having occurred, in connection with the delivery of funded aged care services to an individual by a registered provider).

Unreasonable use of force

(2) In paragraph 16(1)(a) of the Act, the expression "unreasonable use of force against the individual" includes conduct ranging from a deliberate and violent physical attack to use of unwarranted physical force.

(3) To avoid doubt, that expression does not cover gently touching the individual:
- (a) for the purposes of providing funded aged care services; or
- (b) to attract the individual's attention; or
- (c) to guide the individual; or
- (d) to comfort the individual when the individual is distressed.

Unlawful sexual contact, or inappropriate sexual conduct

(4) In paragraph 16(1)(b) of the Act, the expression "unlawful sexual contact, or inappropriate sexual conduct, inflicted on the individual" includes the following:
- (a) if the contact or conduct is inflicted by a person who is an aged care worker of the registered provider—the following:
  - (i) any conduct or contact of a sexual nature inflicted on the individual, including (without limitation) sexual assault, an act of indecency and the sharing of an intimate image of the individual;
  - (ii) any touching of the individual's genital area, anal area or breast in circumstances where this is not necessary to deliver funded aged care services to the individual;
- (b) any non-consensual contact or conduct of a sexual nature, including (without limitation) sexual assault, an act of indecency and the sharing of an intimate image of the individual;
- (c) engaging in conduct relating to the individual with the intention of making it easier to procure the individual to engage in sexual contact or conduct.

(5) However, that expression does not include consensual contact or conduct of a sexual nature between the individual and a person who is not an aged care worker of the registered provider, including another individual to whom the registered provider delivers funded aged care services.

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Psychological or emotional abuse

(6) In paragraph 16(1)(c) of the Act the expression "psychological or emotional abuse of the individual" includes conduct that:

(a) has caused the individual psychological or emotional distress; or

(b) could reasonably have been expected to have caused an individual psychological or emotional distress.

(7) Conduct covered by subsection (6) includes (without limitation) the following:

(a) taunting, bullying, harassment or intimidation;

(b) threats of maltreatment;

(c) humiliation;

(d) unreasonable refusal to interact with the individual or acknowledge the individual's presence;

(e) unreasonable restriction of the individual's ability to engage socially or otherwise interact with people;

(f) repetitive conduct or contact which does not constitute unreasonable use of force but the repetition of which:

(i) has caused the individual psychological or emotional distress; or

(ii) could reasonably have been expected to have caused an individual psychological or emotional distress.

Unexpected death

(8) In paragraph 16(1)(d) of the Act the expression "unexpected death of the individual" includes death in circumstances where:

(a) the individual was accessing funded aged care services in an approved residential care home of a registered provider and reasonable steps were not taken by the registered provider to prevent the death; or

(b) the death was a result of:

(i) funded aged care services delivered by the registered provider; or

(ii) a failure of the registered provider to deliver funded aged care services.

Stealing or financial coercion

(9) In paragraph 16(1)(e) of the Act the expression "stealing from, or financial coercion of, the individual by an aged care worker of the provider" includes the following:

(a) stealing from the individual by an aged care worker of the registered provider;

(b) conduct by an aged care worker of the registered provider that:

(i) is coercive or deceptive in relation to the individual's financial affairs; or

(ii) unreasonably controls the individual's financial affairs.

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Neglect

(10) In paragraph 16(1)(f) of the Act the expression "neglect of the individual" means circumstances in which a registered provider, aged care worker, or responsible person of the registered provider:

(a) has delivered funded aged care services to the individual that exposes the individual to the risk of serious injury or illness; or

(b) has caused or contributed (including through reckless or intentional behaviour) to:

(i) a significant failure to deliver funded aged care services to the individual; or

(ii) a systematic pattern of conduct; or

(c) has delivered a grossly inadequate funded aged care services to the individual; or

(d) has been reckless or intentionally negligent in delivering funded aged care services to the individual.

Unexplained absence

(11) In paragraph 16(1)(h) of the Act the expression "unexplained absence of the individual in the course of the delivery of funded aged care services to the individual" means:

(a) for an individual accessing funded aged care services in an approved residential care home—an absence of the individual from the home in circumstances where there are reasonable grounds to report the absence to police; or

(b) for an individual accessing funded aged care services in a home or community setting—an absence of the individual from the setting during the delivery of funded aged care services to the individual in circumstances where there are reasonable grounds to report the absence to police.

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16-10 Acts, omissions and events that are not reportable incidents—general

(1) For the purposes of paragraph 16(3)(b) of the Act, an act, omission or event covered by one of the following subsections is not a ***reportable incident***.

Approved residential care homes—incidents resulting from refusal by individuals of delivery of services

(2) This subsection covers an incident if the incident results from an individual accessing funded aged care services in an approved residential care home deciding to refuse the delivery of funded aged care services.

Home or community settings—incidents resulting from choices made by individuals about services to be delivered

(3) This subsection covers an incident if:

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(a) the incident occurred, is alleged to have occurred, or is suspected of having occurred, in connection with the delivery of funded aged care services in a home or community setting to an individual by a registered provider; and

(b) apart from this subsection, the incident would be a reportable incident under paragraph 16(1)(f) of the Act (neglect of the individual), but would not otherwise be a reportable incident; and

(c) the incident results from a choice made by the individual about the funded aged care services the registered provider is to deliver to the individual, or how the services are to be delivered by the provider; and

(d) before the incident occurred, is alleged to have occurred, or is suspected of having occurred, the individual had communicated the individual's choice to the provider, and the provider had recorded the individual's choice in writing.

16-15 Acts, omissions and events that are not reportable incidents—use of restrictive practices in a home or community setting

For the purposes of paragraph 16(3)(b) of the Act, the use of a restrictive practice in relation to an individual is not a ***reportable incident*** if:

(a) the restrictive practice is used in connection with the delivery of funded aged care services to the individual in a home or community setting; and

(b) before the restrictive practice is used, the following matters were set out in the care and services plan for the individual:

(i) the circumstances in which the restrictive practice may be used in relation to the individual, including the individual's behaviours of concern that are relevant to the need for the use;

(ii) the manner in which the restrictive practice is to be used, including its duration, frequency and intended outcome; and

(c) the restrictive practice is used:

(i) in the circumstances set out in the plan; and

(ii) in the manner set out in the plan; and

(iii) in accordance with any other provisions of the plan that relate to the use; and

(d) details about the use of the restrictive practice are documented as soon as practicable after the restrictive practice is used.

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Division 2—Restrictive practices

17-5 Practices and interventions that are restrictive practices in relation to individuals

(1) For the purposes of subsection 17(2) of the Act, each of the following is a restrictive practice in relation to an individual:

(a) chemical restraint;
(b) environmental restraint;
(c) mechanical restraint;
(d) physical restraint;
(e) seclusion.

(2) ***Chemical restraint*** is a practice or intervention that is, or that involves, the use of medication or a chemical substance for the primary purpose of influencing an individual's behaviour, but does not include the use of medication prescribed for:

(a) the treatment of, or to enable treatment of, the individual for:
(i) a diagnosed mental disorder; or
(ii) a physical illness; or
(iii) a physical condition; or
(b) end-of-life care for the individual.

(3) ***Environmental restraint*** is a practice or intervention that restricts, or that involves restricting, an individual's free access to all parts of the individual's environment (including items and activities) for the primary purpose of influencing the individual's behaviour.

(4) ***Mechanical restraint*** is a practice or intervention that is, or that involves, the use of a device to prevent, restrict or subdue an individual's movement for the primary purpose of influencing the individual's behaviour, but does not include the use of a device for therapeutic or non-behavioural purposes in relation to the individual.

(5) ***Physical restraint*** is a practice or intervention that:

(a) is or involves the use of physical force to prevent, restrict or subdue movement of an individual's body, or part of an individual's body, for the primary purpose of influencing the individual's behaviour; but
(b) does not include the use of a hands-on technique in a reflexive way to guide or redirect the individual away from potential harm or injury if it is consistent with what could reasonably be considered to be the exercise of care towards the individual.

(6) ***Seclusion*** is a practice or intervention that is, or that involves, the sole confinement of an individual in a room or a physical space at any hour of the day or night where:

(a) voluntary exit is prevented or not facilitated; or
(b) it is implied that voluntary exit is not permitted;

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for the primary purpose of influencing the individual's behaviour.

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Part 8—Supporters

Division 1—Actions and duties of supporters

28-5 Role of guardians etc—prescribed classes of persons

For the purposes of paragraph 28(2)(d) of the Act, a prescribed class of persons is restrictive practices substitute decision-makers.

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Division 2—Registration of supporters

37-5 Registration of supporters—matters the System Governor must take into consideration

(1) For the purposes of paragraph 37(6)(c) of the Act, this section prescribes other matters the System Governor must take into consideration in deciding whether to register a person under subsection 37(1) of the Act as a supporter of an individual.

(2) Another matter is, for a person who is a person covered by subsection 28(2) of the Act, the nature of the person's decision-making authority as such a person (including the extent to which it extends to making decisions relevant to the delivery of funded aged care services to the individual).

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Chapter 2—Entry to the Commonwealth aged care system

Part 1—Introduction

55-5 Simplified outline of this Chapter

This Chapter provides for matters relating to entry to the Commonwealth aged care system under Chapter 2 of the Act.

Part 2 of this Chapter relates to eligibility of individuals for entry to the Commonwealth aged care system, and deals with:

(a) applying for access to funded aged care services; and
(b) the assessment tool for aged care needs assessments and circumstances in which reassessments are required;
(c) approval of access to funded aged care services.

Part 3 of this Chapter relates to classification, and deals with:

(a) requirements for classification assessments; and
(b) the period for making classification decisions and the period of effect of classification levels for classification types for service groups for individuals; and
(c) prescribing classification levels for classification types for service groups, including criteria used to establish certain classification levels and methods or procedures for deciding certain classification levels.

Part 4 of this Chapter relates to prioritisation, and deals with:

(a) priority category decisions; and
(b) priority categories for classification types for service groups and eligibility criteria for those priority categories; and
(c) circumstances in which urgency ratings will apply to individuals in relation to the classification type ongoing or short-term for the service group residential care.

Part 5 of this Chapter relates to place allocation, and deals with:

(a) allocation of places to individuals, including methods that the System Governor must follow in deciding the order of allocation of places to individuals for certain classification types and service groups; and
(b) allocation of places to registered providers for certain specialist aged care programs.

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Part 2—Eligibility for entry

Division 1—Applying for access to funded aged care services

56-5 Classes of persons who may apply on behalf of individuals

For the purposes of subsection 56(1) of the Act, the following classes of persons are prescribed in relation to an individual:

(a) supporters of the individual;
(b) registered health practitioners;
(c) allied health professionals;
(d) aged care workers of registered providers;
(e) registered providers;
(f) social workers (however described);
(g) individuals employed or engaged as care finders under the care finder program funded by the Department;
(h) individuals employed or engaged as elder care supporters under the elder care support program funded by the Department;
(i) family members, friends, advocates and carers of the individual;
(j) independent aged care advocates.

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57-5 Period for deciding whether to make eligibility determinations

For the purposes of subsection 57(2) of the Act, the period for making a decision under subsection 57(1) of the Act on an application for access to funded aged care services is 28 days after receiving the application.

58-5 Information to be provided for eligibility determinations

For the purposes of paragraph 58(b) of the Act, each of the following is prescribed as a kind of information relating to an individual's care needs:

(a) a declaration by the individual, made orally or in writing, that the individual has care needs;
(b) a written statement by a person in a class of persons referred to in section 56-5 of this instrument that sets out the individual's care needs;
(c) written medical records of the individual's care needs.

Note: For the definition of ***care needs***, see section 7 of the Act.

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Division 2—Aged care needs assessments and reassessments

Subdivision A—Aged care needs assessments

62-5 Assessment tool

For the purposes of subsection 62(1) of the Act, the Integrated Assessment Tool is prescribed.

Subdivision B—Aged care needs reassessments

64-5 Significant changes in circumstances

For the purposes of subparagraph 64(1)(c)(i) of the Act, each of the following is prescribed as a significant change in circumstances in relation to an individual who is accessing funded aged care services other than through the service group residential care:

(a) a carer for the individual has permanently ceased to provide some or all care to the individual;

(b) the individual has experienced an event, or a decline in their condition, that is likely to mean that the individual will require:

(i) more frequent access to a funded aged care service that is covered by the individual's access approval and that the individual has been accessing; or

(ii) access to a funded aged care service that is covered by the individual's access approval but that the individual has not been accessing; or

(iii) access to a funded aged care service that is not covered by the individual's access approval.

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64-10 Other circumstances—individuals accessing funded aged care services other than through the service group residential care—general

For the purposes of subparagraph 64(1)(c)(ii) of the Act, each of the following is prescribed as other circumstances in relation to an individual who is accessing funded aged care services other than through the service group residential care:

(a) a carer for the individual has temporarily ceased to provide some or all care to the individual;

(b) the individual has experienced an event, or a decline in their condition, that is likely to mean that the individual will require access to a funded aged care service that is not covered by the individual's access approval;

(c) all of the following apply:

(i) the individual has an access approval in effect for the classification type ongoing or short-term for the service group home support;

(ii) on the date of the application for the reassessment, the individual has a prognosis of a life expectancy of 3 months or less;

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(iii) on the date of the application for the reassessment, the individual has an AKPS score of 40 or less;

(iv) the individual has not previously had the classification level SAH end-of-life pathway in effect;

(v) a notice in the approved form containing evidence of the matters referred to in subparagraphs (ii) and (iii) has been given to the System Governor;

(d) both of the following apply:

(i) the individual has an access approval in effect for the classification type short-term for the service group home support;

(ii) the individual has, or has previously had, the classification level SAH end-of-life pathway in effect;

(e) both of the following apply:

(i) the classification level SAH end-of-life pathway for the classification type short-term for the service group home support has been established for the individual by a classification decision;

(ii) the individual will require access to funded aged care services in the service group assistive technology;

(f) both of the following apply:

(i) the classification level SAH restorative care pathway for the classification type short-term for the service group home support has been established for the individual by a classification decision;

(ii) the individual will require access to funded aged care services in the service group assistive technology or home modifications;

(g) both of the following apply:

(i) the individual has an access approval in effect for the classification type ongoing for the service group home support;

(ii) repairs or maintenance are required for an included AT-HM item or a conditionally included AT-HM item that the individual owns or has been loaned or rented under a Commonwealth aged care program (including under the old Act);

(h) both of the following apply:

(i) the individual has an access approval in effect for the classification type ongoing for the service group home support;

(ii) the individual has a condition referred to in subsection 211-10(2) of this instrument;

(i) both of the following apply:

(i) the individual has an access approval in effect for the classification type ongoing for the service group home support;

(ii) the individual has an assistance dog.

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64-11 Other circumstances—individuals accessing funded aged care services other than through the service group residential care—individuals wishing to access subscription services

For the purposes of subparagraph 64(1)(c)(ii) of the Act, the following are prescribed as other circumstances in relation to an individual who is accessing funded aged care services other than through the service group residential care:

(a) the individual has an access approval and a classification level in effect for the classification type ongoing for the service group home support;

(b) the individual's access approval covers (as applicable) a non-subscription service type or a non-subscription service for which there is a corresponding subscription service type or subscription service;

(c) funded aged care services are being delivered to the individual through the service group home support by a registered provider that is, or has been invited by the System Governor to apply to be, registered in the provider registration category subscription trial;

(d) the provider has explained to the individual the parameters of the access provided by (as applicable) funded aged care services in the corresponding subscription service type or the corresponding subscription service, as delivered or proposed to be delivered by the provider;

(e) the individual's application for reassessment referred to in paragraph 64(1)(b) of the Act states that the individual:

(i) wishes to access (as applicable) funded aged care services in the corresponding subscription service type or the corresponding subscription service; and

(ii) consents to the collection of the individual's personal information for the purpose of evaluating the delivery of (as applicable) funded aged care services in the corresponding subscription service type or the subscription service.

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64-15 Information for reassessments in other circumstances

For the purposes of paragraph 64(2)(b) of the Act, each of the following is prescribed as a kind of information in relation to an individual:

(a) information in the application for the aged care needs reassessment;

(b) information provided, orally or in writing, by any of the following about the individual's need for funded aged care services:

(i) a registered health practitioner;

(ii) an allied health professional;

(iii) a registered provider delivering the funded aged care service home support care management or home support restorative care management to the individual;

(c) information provided, orally or in writing, by an approved needs assessor following a review by the assessor of the report of the most recent aged care needs assessment for the individual;

(d) information in the most recent application for a classification reassessment for the individual.

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Division 3—Approval of access to funded aged care services

Subdivision A—General

65-5 Approval of services in service types for individuals

For the purposes of subparagraph 65(2)(b)(ii) of the Act, the following service types are prescribed:

(a) allied health and therapy;
(ab) subscription allied health and therapy;
(b) therapeutic services for independent living;
(c) subscription therapeutic services for independent living.

65-10 Eligibility requirements—service group home support

For the purposes of paragraph 65(3)(b) of the Act, the eligibility requirement for the service group home support for an individual are that:

(a) the individual has a total score of less than 20 for the questions in the Integrated Assessment Tool with the following headings:
  (i) "Climb stairs";
  (ii) "Eating";
  (iii) "Dressing";
  (iv) "Take a bath or shower";
  (v) "Grooming";
  (vi) "Transfers";
  (vii) "Toilet use";
  (viii) "Toileting – bladder";
  (ix) "Toileting – bowels";
  (x) "Walk"; or
(b) the individual has a total score of less than 14 for the questions in the Integrated Assessment Tool with the following headings:
  (i) "Get to places out of walking distance";
  (ii) "Undertake housework (heavy/moderate)";
  (iii) "Go shopping (assuming transportation)";
  (iv) "Prepare meals";
  (v) "Take medicine";
  (vi) "Handle money";
  (vii) "Use the telephone"; or
(c) the individual has a score of greater than zero for the questions in the sections of the Integrated Assessment Tool headed "Cognition" and "Medical and Medications"; or
(d) the individual has a score of greater than zero for the questions in the sections of the Integrated Assessment Tool headed "Psychological"; or

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(e) the individual has a score of greater than zero for the questions in the section of the Integrated Assessment Tool headed "Physical, Personal Health and Frailty".

65-15 Eligibility requirements—service groups assistive technology and home modifications

For the purposes of paragraph 65(3)(b) of the Act, the eligibility requirement for the service groups assistive technology and home modifications for an individual is that the service group home support is approved for the individual.

65-20 Eligibility requirements—service group residential care

For the purposes of paragraph 65(3)(b) of the Act, the eligibility requirement for the service group residential care for an individual is that the individual is not able to live in a home or community setting without support.

65-30 Period for making decisions

For the purposes of subsection 65(5) of the Act, the period for making decisions under subsections 65(1) and (2) of the Act for an individual is 14 days after receiving an assessment report for the individual provided under section 63 of the Act, or information relating to the individual that is provided to the System Governor in accordance with paragraph 64(2)(b) of the Act, as applicable.

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Subdivision AB—Conditions on approvals of service types or services in certain service groups

69-5 Conditions on approvals of subscription service types or subscription services—prescribed matters

Application

(1) This section applies to the inclusion, under subsection 69(1) of the Act, of conditions on the approval of a subscription service type, or a subscription service, under paragraph 65(2)(b) of the Act for an individual.

Kind of registered provider

(2) For the purposes of paragraph 69(2)(b) of the Act, the kind of registered provider is a registered provider that is registered in the provider registration category subscription trial.

Subdivision B—Period of effect of approval

71-5 Alternative entry—when access approval takes effect—circumstances and period for making application

For the purposes of paragraph 71(3)(b) of the Act, the following circumstances and period are prescribed for an individual:

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(a) the circumstances are that a registered provider that delivers funded aged care services under the MPSP or the NATSIFACP is delivering aged care services to the individual;

(b) the period is 30 days after the first day an aged care service covered by the individual's access approval was delivered to the individual by the provider.

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Part 3—Classification

Division 1—Classification assessments

75-5 Circumstances in which classification assessment not required

For the purposes of paragraph 75(5)(a) of the Act, the circumstances in which a classification assessment otherwise required under paragraph 75(1)(b) or subsection 75(2) of the Act in relation to an individual for a classification type for a service group is not required to be undertaken are that:

(a) the classification type is ongoing or short-term for the service group residential care; and

(b) the individual is accessing funded aged care services under a specialist aged care program in an approved residential care home.

76-10 Assessment tools and other requirements for classification assessments required under subsection 75(1) or (2) of the Act and carried out by approved needs assessors

(1) This section is made for the purposes of subparagraphs 76(1)(a)(i) and (b)(i) of the Act.

Service groups home support, assistive technology and home modifications

(2) For an assessment for an individual for a classification type for the service group home support, assistive technology or home modifications:

(a) the assessment tool is the Integrated Assessment Tool; and

(b) the other requirements are that the assessment must be carried out in accordance with the Aged Care Assessment Manual.

Classification type ongoing for service group residential care

(3) For an assessment for an individual for the classification type ongoing for the service group residential care:

(a) the assessment tool is the AN-ACC Assessment Tool; and

(b) the other requirements are that the assessment must be carried out in accordance with the AN-ACC Reference Manual.

Classification type short-term for service group residential care

(4) For an assessment for an individual for the classification type short-term for the service group residential care:

(a) the assessment tool is the De Morton Mobility Index assessment item; and

(b) the other requirements are that the assessment must be carried out in accordance with the part of the AN-ACC Reference Manual that relates to that item.

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76-15 Circumstances and information for classification assessments required under paragraph 75(1)(a) or subsection 75(2) of the Act and carried out by the System Governor

(1) This section is made for the purposes of subparagraph 76(1)(a)(ii) of the Act for an assessment for an individual for a classification type for a service group.

Classification type short-term for service groups home support and assistive technology—end-of-life

(2) The following circumstances and kind of information are prescribed for the classification type short-term for the service groups home support and assistive technology:

(a) the circumstances are that:

(i) the individual has an access approval in effect for the classification type short-term for the service group home support;

(ii) on the date of the individual's application for access to funded aged care services, there were reasonable grounds to believe that the individual had a prognosis of a life expectancy of 3 months or less and an AKPS score of 40 or less;

(iii) the individual has not previously had the classification level SAH end-of-life pathway in effect;

(b) the kind of information is information that provides evidence of the matters mentioned in paragraph (a).

(3) The following circumstances and kind of information are prescribed for the classification type short-term for the service groups assistive technology and home modifications and the classification type ongoing for the service group home support:

(a) the circumstances are that:

(i) the individual has an access approval in effect for the classification type short-term for the service group home support;

(ii) the individual has previously had the classification level SAH end-of-life pathway in effect;

(b) the kind of information is information that provides evidence of the matters mentioned in paragraph (a).

(4) The following circumstances and kind of information are prescribed for the classification type short-term for the service group assistive technology:

(a) the circumstances are that:

(i) the classification level SAH end-of-life pathway for the classification type short-term for the service group home support has been established for the individual by a classification decision;

(ii) the individual will require access to funded aged care services in the service group assistive technology;

(b) the kind of information is information that provides evidence of the matters mentioned in paragraph (a).

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Classification type short-term for service group assistive technology or home modifications—restorative care pathway

(5) The following circumstances and kind of information are prescribed for the classification type short-term for the service group assistive technology and home modifications:

(a) the circumstances are that:

(i) the classification level SAH restorative care pathway for the classification type short-term for the service group home support has been established for the individual by a classification decision;

(ii) the individual will require access to funded aged care services in the service group assistive technology or home modifications;

(b) the kind of information is information that provides evidence of the matters mentioned in paragraph (a).

Classification type short-term for service group assistive technology—repairs or maintenance for included and conditionally included AT-HM items

(6) The following circumstances and kind of information are prescribed for the classification type short-term for the service group assistive technology:

(a) the circumstances are that:

(i) a classification level for the classification type ongoing for the service group home support has been established for the individual by a classification decision; and

(ii) repairs or maintenance are required for an included AT-HM item or a conditionally included AT-HM item that the individual owns or has been loaned or rented under a Commonwealth aged care program (including under the old Act);

(b) the kind of information is information that provides evidence of the matter mentioned in subparagraph (a)(ii).

Classification type short-term for service groups assistive technology and home modifications—progressive conditions

(7) The following circumstances and kind of information are prescribed for the classification type short-term for the service groups assistive technology and home modifications:

(a) the circumstances are that:

(i) a classification level for the classification type ongoing for the service group home support has been established for the individual by a classification decision; and

(ii) the individual has a condition referred to in subsection 211-10(2) of this instrument;

(b) the kind of information is information that provides evidence of the matter mentioned in subparagraph (a)(ii).

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Classification type ongoing for service group assistive technology —assistance dog

(8) The following circumstances and kind of information are prescribed for the classification type ongoing for the service group assistive technology:

(a) the circumstances are that:

(i) the individual has an access approval in effect for the classification type ongoing for the service group home support;

(ii) the individual has an assistance dog;

(b) the kind of information is information that provides evidence of the matter mentioned in subparagraph (a)(ii).

Classification type short-term for service groups assistive technology and home modifications—aged care needs reassessments in certain circumstances

(9) The following circumstances and kinds of information are prescribed for the classification type short-term for the service groups assistive technology and home modifications:

(a) the circumstances are that:

(i) a classification level for the classification type short-term for the service group home support has been established for the individual by a classification decision; and

(ii) the circumstances referred to in paragraph 64-10(b) of this instrument (aged care needs reassessments in certain circumstances) apply to the individual;

(b) the kinds of information are the kinds of information referred to in paragraphs 64-15(a), (b) and (c) of this instrument.

Classification type ongoing for service group residential care—palliative care pathway

(10) The following circumstances and kind of information are prescribed for the classification type ongoing for the service group residential care, for an individual accessing funded aged care services in the form of palliative care in an approved residential care home of a registered provider:

(a) the circumstances are that:

(i) on and after the individual's start day for the home, the provider has delivered funded aged care services in the form of palliative care to the individual in the home; and

(ii) on the individual's start day for the home, there were reasonable grounds to believe that the individual had a prognosis of a life expectancy of 3 months or less and an AKPS score of 40 or less; and

(iii) the provider gives the System Governor a notice in the approved form containing the kind of information referred to in paragraph (b) within 14 days, or such longer period as is agreed in writing between the System Governor and the provider, after the provider gives the System Governor a start notification for the individual;

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(b) the kind of information is information that provides evidence of the matters mentioned in subparagraph (a)(ii).

76-20 Circumstances and information for classification assessments required under paragraph 75(1)(b) of the Act (on application for classification reassessment) and carried out by the System Governor

(1) This section is made for the purposes of subparagraph 76(1)(b)(ii) of the Act for an assessment for an individual for a classification type for a service group.

Classification type short-term for service group assistive technology—increased needs

(2) The following circumstances and kind of information are prescribed for the classification type short-term for the service group assistive technology:

(a) the circumstances are that:

(i) a classification level for the classification type short-term for the service group assistive technology, other than the classification level AT high, has been established for the individual by a classification decision; and

(ii) the individual needs an increased amount of assistive technology to mitigate functional decline or impairment and enable them to safely live in their home and community;

(b) the kind of information is information that provides evidence of the circumstances mentioned in subparagraph (a)(ii).

Classification type short-term for service group assistive technology—individuals with classification level AT transitional

(3) The following circumstances and kind of information are prescribed for the classification type short-term for the service group assistive technology:

(a) the circumstances are that:

(i) the classification level AT transitional for the classification type short-term for the service group assistive technology has been established for the individual by a classification decision; and

(ii) subsection (4) applies to the individual;

(b) the kind of information is information that provides evidence of the circumstances mentioned in subparagraph (a)(ii).

(4) This subsection applies to the individual if:

(a) the individual has a condition referred to in subsection 211-10(2) of this instrument; or

(b) the System Governor has reviewed the report of the most recent aged care needs assessment for the individual and considers that the individual needs assistive technology to mitigate functional decline or impairment and enable them to safely live in their home and community (see paragraph (a) in column 2 of items 1 to 3 of the table in subsection 81-25(1) of this instrument (criteria for the classification levels AT low, AT medium and AT high)).

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Classification type short-term for service group home modifications—increased needs

(5) The following circumstances and kind of information are prescribed for the classification type short-term for the service group home modifications:

(a) the circumstances are that:

(i) a classification level for the classification type short-term for the service group home modifications, other than the classification level HM high, has been established for the individual by a classification decision; and

(ii) the individual needs an increased amount of home modifications to mitigate functional decline or impairment and enable them to safely live in their home and community;

(b) the kind of information is information that provides evidence of the circumstances mentioned in subparagraph (a)(ii).

Classification type short-term for service group home modifications—individuals with classification level HM transitional

(6) The following circumstances and kind of information are prescribed for the classification type short-term for the service group home modifications:

(a) the circumstances are that:

(i) the classification level HM transitional for the classification type short-term for the service group home modifications has been established for the individual by a classification decision; and

(ii) the System Governor has reviewed the report of the most recent aged care needs assessment for the individual and considers that the individual needs home modifications to mitigate functional decline or impairment and enable them to safely live in their home and community (see paragraph (a) in column 2 of items 1 to 3 of the table in subsection 81-30(1) of this instrument (criteria for the classification levels HM low, HM medium and HM high));

(b) the kind of information is information that provides evidence of the circumstances mentioned in subparagraph (a)(ii).

Classification type ongoing for service group residential care—palliative care pathway

(7) The following circumstances and kind of information are prescribed for the classification type ongoing for the service group residential care, for an individual accessing funded aged care services in the form of palliative care in an approved residential care home of a registered provider:

(a) the circumstances are that:

(i) on and after the individual's start day for the home, the provider has delivered funded aged care services in the form of palliative care to the individual in the home; and

(ii) on the individual's start day for the home, there were reasonable grounds to believe that the individual had a prognosis of a life expectancy of 3 months or less and an AKPS score of 40 or less; and

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(iii) the provider gives the System Governor a notice in the approved form containing the kind of information referred to in paragraph (b) within 14 days, or such longer period as is agreed in writing between the System Governor and the provider, after the date of the application for classification reassessment for the individual;

(b) the kind of information is information that provides evidence of the matters mentioned in subparagraph (a)(ii).

76-25 Classification assessments for classification type ongoing for service group residential care—skills, qualifications and other requirements for approved needs assessors

Skills and qualifications

(1) For the purposes of paragraph 76(2)(a) of the Act, the skills and qualifications for an approved needs assessor are that the assessor is a registered nurse, occupational therapist or physiotherapist.

Other requirements

(2) For the purposes of paragraph 76(2)(b) of the Act, the other requirements for an approved needs assessor are the following:

(a) the assessor has 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);

(b) a police certificate issued for the assessor within the last 3 years does not record that the assessor has a serious offence conviction in Australia;

(c) if, at any time after turning 16, the assessor has been a citizen or permanent resident of a country other than Australia—the assessor has made a statutory declaration that the assessor does not have a serious offence conviction in that country.

Note: Approved needs assessors must carry and produce identity cards issued under subsection 343A(1) of the Act when performing functions or exercising powers under the Act as approved needs assessors (see section 343A-10 of this instrument).

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Division 2—Classification decisions

Subdivision A—Period for making classification decisions

78-5 Period for making classification decisions

For the purposes of subsection 78(4) of the Act, the period for making a decision under subsection 78(1) of the Act to establish a classification level for an individual for a classification type for a service group is 14 days after the occurrence of whichever of the events referred to in subsection 78(1) of the Act are applicable for the individual.

Subdivision B—Period of effect of classification levels

80-5 Purpose of this Subdivision

For the purposes of subsection 80(1) of the Act, this Subdivision prescribes, subject to subsection 80(3) of the Act, the period of effect for a classification level for a classification type for a service group that has been established under section 78 of the Act for an individual.

Note: For the period of effect for classification levels taken to be established for individuals by the *Aged Care (Consequential and Transitional Provisions) Determination 2025*, see the *Aged Care (Consequential and Transitional Provisions) Rules 2025*.

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80-10 Service group home support—classification type ongoing

CHSP class

(1) For the classification level CHSP class for the classification type ongoing for the service group home support, established for an individual by a classification decision, the period of effect:

(a) starts at the start of the day the individual's access approval for the classification type for the service group was given; and

(b) ends at the end of the earlier of the following (as applicable):

(i) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) the day the individual dies.

SAH class 1, 2, 3, 4, 5, 6, 7 or 8

(2) For the classification level SAH class 1, 2, 3, 4, 5, 6, 7 or 8 for the classification type ongoing for the service group home support, established for an individual by a classification decision, the period of effect:

(a) starts at the start of the day a place allocated under subsection 92(1) of the Act to the individual for the classification type for the service group takes effect under section 92A of the Act; and

(b) ends at the end of the earlier of the following (as applicable):

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(i) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
(ii) the day the individual dies.

80-15 Service group home support—classification type short-term

SAH restorative care pathway

(1) For the classification level SAH restorative care pathway for the classification type short-term for the service group home support, established for an individual by a classification decision, the period of effect:
(a) starts at the start of the day a place allocated under subsection 92(1) of the Act to the individual for the classification type for the service group takes effect under section 92A of the Act; and
(b) ends at the earliest of the following (as applicable):
(ii) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
(iii) the end of the maximum period of effect for the classification level (see section 80-55);
(iv) the end of the day the individual dies.

SAH end-of-life pathway

(2) For the classification level SAH end-of-life pathway for the classification type short-term for the service group home support, established for an individual by a classification decision, the period of effect:
(a) starts at the start of the day a place allocated under subsection 92(1) of the Act to the individual for the classification type for the service group takes effect under section 92A of the Act; and
(b) ends at the earliest of the following (as applicable):
(i) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
(ii) the end of the maximum period of effect for the classification level (see section 80-57);
(iii) the end of the day the individual dies.

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80-20 Service group assistive technology—classification type ongoing

For the classification level assistance dogs for the classification type ongoing for the service group assistive technology, established for an individual by a classification decision, the period of effect:
(a) starts at the start of the day a place allocated under subsection 92(1) of the Act to the individual for the classification type for the service group takes effect under section 92A of the Act; and
(b) ends at the end of the earlier of the following (as applicable):
(i) the day that the individual ceases to have an assistance dog;

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(ii) the day the individual dies.

80-25 Service group assistive technology—classification type short-term

AT CHSP

(1) For the classification level AT CHSP for the classification type short-term for the service group assistive technology, established for an individual by a classification decision, the period of effect:

(a) starts at the start of the day the individual's access approval for the classification type for the service group was given; and

(b) ends at the end of the earlier of the following (as applicable):

(i) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) the day the individual dies.

AT low, AT medium and AT high

(2) For the classification level AT low, AT medium or AT high for the classification type short-term for the service group assistive technology, established for an individual by a classification decision, the period of effect:

(a) starts at the start of the day a place allocated under subsection 92(1) of the Act to the individual for the classification type for the service group takes effect under section 92A of the Act; and

(b) ends at the earliest of the following (as applicable):

(i) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) the end of the account period for the individual's notional assistive technology account established in respect of that classification level;

(iii) the end of the day the individual dies.

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80-30 Service group home modifications—classification type short-term

HM CHSP

(1) For the classification level HM CHSP for the classification type short-term for the service group home modifications, established for an individual by a classification decision, the period of effect:

(a) starts at the start of the day the individual's access approval for the classification type for the service group was given; and

(b) ends at the end of the earlier of the following (as applicable):

(i) the later of the following:

(A) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

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(B) if the System Governor approves a later time than the time mentioned in sub-subparagraph (A) for the individual under subsection (3)—that later time;

(ii) the day the individual dies.

HM low, HM medium and HM high

(2) For the classification level HM low, HM medium or HM high for the classification type short-term for the service group home modifications, established for an individual by a classification decision, the period of effect:

(a) starts at the start of the day a place allocated under subsection 92(1) of the Act to the individual for the classification type for the service group takes effect under section 92A of the Act; and

(b) ends at the earlier of the following (as applicable):

(i) the latest of the following:

(A) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(B) the end of the account period for the individual's notional home modifications account established in respect of that classification level;

(C) if the System Governor approves a later time than the time mentioned in sub-subparagraph (A) or (B) for the individual under subsection (3)—that later time;

(ii) the end of the day the individual dies.

Approval of later time for services scheduled for delivery

(3) The System Governor must approve a time that is 12 months after the time that would otherwise apply under subparagraph (1)(b)(i) or (2)(b)(i) (as applicable) for an individual if a registered provider gives the System Governor evidence mentioned in subsection (4):

(a) in the approved form; and

(b) within the account period for the individual's notional home modifications account established in respect of that classification level.

(4) For the purposes of subsection (3), the evidence is evidence that a service in the service group home modifications to be delivered by the registered provider to the individual has been scheduled for delivery, and is in progress, but will not be delivered before the time that would otherwise apply under subparagraph (1)(b)(i) or (2)(b)(i) (as applicable).

80-35 Service group residential care—classification type ongoing

Class 0

(1) For the classification level class 0 for the classification type ongoing for the service group residential care, established in accordance with section 81-42 of this instrument for an individual to whom paragraph 78(1)(c) of the Act applies:

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(a) subject to paragraph (b), the period of effect:
  (i) starts at the start of the entry day for the classification type for the service group for the individual; and
  (ii) ends at the end of the day the individual dies; and
(b) if the classification level class 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 or 13 (the ***higher classification level***) is in effect for the individual on a day under subsection (2), the classification level class 0 is not in effect for the individual on the day.

Classes 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13

(2) For the classification level class 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 or 13 for the classification type ongoing for the service group residential care, established for an individual by a classification decision, the period of effect:
(a) starts:
  (i) unless subparagraph (ii), (iii) or (iv) applies—at the start of the entry day for the classification type for the service group for the individual; or
  (ii) unless subparagraph (iii) or (iv) applies—if, before the day the classification decision is made:
    (A) the classification level class 0 is in effect for the individual under subsection (1); and
    (B) the individual started accessing funded aged care services in an approved residential care home; and
    (C) the individual did not cease to access funded aged care services in that home for a period of more than 28 days;
  —at the start of the individual's start day for that home; or
  (iii) unless subparagraph (iv) applies—if, before the day the classification decision is made:
    (A) the classification level class 0 is in effect for the individual under subsection (1); and
    (B) the individual started accessing funded aged care services in an approved residential care home; and
    (C) the individual ceased to access funded aged care services in that home for a period of more than 28 days;
  —at the start of the day after the end of that period when the individual resumed accessing ongoing funded aged care services in an approved residential care home; or
  (iv) if the classification decision relates to a classification assessment undertaken in accordance with paragraph 75(1)(b) of the Act (that is, following an application for classification reassessment)—the day the application for classification reassessment was made; and
(b) ends at the end of the day the individual dies.

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80-40 Service group residential care—classification type short-term

Respite class 0

(1) For the classification level respite class 0 for the classification type short-term for the service group residential care, established in accordance with section 81-42 of this instrument for an individual to whom paragraph 78(1)(c) of the Act applies:

(a) subject to paragraphs (b) and (c)—the period of effect consists of each day on or after the entry day for the classification type for the service group for the individual on which:

(i) a registered provider delivers funded aged care services to the individual for the classification type for the service group at an approved residential care home of the provider (other than under a specialist aged care program); and

(ii) the number of days on which the individual had previously accessed funded aged care services for the classification type for the service group at an approved residential care home (other than under a specialist aged care program) during the financial year in which the day occurred is less than the maximum period of effect for the classification level (see section 80-60); and

(b) if the classification level respite class 1, 2 or 3 (the ***higher classification level***) is in effect for the individual on a day under subsection (2), the classification level respite class 0 is not in effect for the individual on the day; and

(c) the period of effect ends at the end of the earliest of the following (as applicable):

(i) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) the day the individual dies.

Respite classes 1, 2 and 3

(2) For the classification level respite class 1, 2 or 3 for the classification type short-term for the service group residential care, established for an individual by a classification decision:

(a) subject to paragraphs (b) and (c)—the period of effect consists of each day on or after the entry day for the classification type for the service group for the individual on which:

(i) a registered provider delivers funded aged care services to the individual for the classification type for the service group at an approved residential care home of the provider (other than under a specialist aged care program); and

(ii) the number of days on which the individual had previously accessed funded aged care services for the classification type for the service group at an approved residential care home (other than under a specialist aged care program) during the financial year in which the

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day occurred is less than the maximum period of effect for the classification level (see section 80-60); and

(b) if the classification decision relates to a classification assessment undertaken in accordance with paragraph 75(1)(b) of the Act (that is, following an application for classification reassessment)—the period of effect consists of each day on or after the day the application for classification reassessment was made on which:

(i) a registered provider delivers funded aged care services to the individual for the classification type for the service group at an approved residential care home of the provider (other than under a specialist aged care program); and

(ii) the number of days on which the individual had previously accessed funded aged care services for the classification type for the service group at an approved residential care home (other than under a specialist aged care program) during the financial year in which the day occurred is less than the maximum period of effect for the classification level (see section 80-60); and

(c) the period of effect ends at the end of the earliest of the following (as applicable):

(i) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) the day the individual dies.

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80-45 Service group home support, assistive technology or residential care—classification type hospital transition

Service group home support

(1) For the classification level HS HT class for the classification type hospital transition for the service group home support, established for an individual by a classification decision:

(a) the classification level does not take effect if a start day for the individual for the classification type for the service group does not occur within 28 days from the day the access approval that is in effect for the individual took effect; and

(b) subject to paragraph (c)—the period of effect for the classification level consists of each day on or after the start day for the individual for the classification level on which:

(i) a registered provider delivers funded aged care services to the individual for the classification type for the service group; and

(ii) the number of days on which the individual had previously accessed funded aged care services for the classification type for the service group is less than the maximum period of effect for the classification level (see section 80-65); and

(c) the period of effect for the classification level ends at the earliest of the following (as applicable):

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(i) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) if, after the start of the period of effect and before the end of the maximum period of effect for the classification level (see section 80-65), the individual does not access funded aged care services for the classification type for the service group for a total of 7 days—the end of the most recent day on which the individual accessed funded aged care services for the classification type for the service group;

(iii) the end of the maximum period of effect for the classification level (see section 80-65);

(iv) the end of the day the individual dies.

Service group assistive technology

(2) For the classification level AT HT class for the classification type hospital transition for the service group assistive technology, established for an individual by a classification decision:

(a) the classification level does not take effect if a start day for the individual for the classification type for the service group does not occur within 28 days from the day the access approval that is in effect for the individual took effect; and

(b) subject to paragraph (c)—the period of effect for the classification level consists of each day on or after the start day for the individual for the classification level on which:

(i) a registered provider delivers funded aged care services to the individual for the classification type for the service group; and

(ii) the number of days on which the individual had previously accessed funded aged care services for the classification type for the service group is less than the maximum period of effect for the classification level (see section 80-65); and

(c) the period of effect for the classification level ends at the earliest of the following (as applicable):

(i) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) if, after the start of the period of effect and before the end of the maximum period of effect for the classification level (see section 80-65), the individual does not access funded aged care services for the classification type for the service group for a total of 7 days—the end of the most recent day on which the individual accessed funded aged care services for the classification type for the service group;

(iii) the end of the maximum period of effect for the classification level (see section 80-65);

(iv) the end of the day the individual dies.

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Service group residential care

(3) For the classification level RC HT class for the classification type hospital transition for the service group residential care, established for an individual by a classification decision:

(a) the classification level does not take effect if a start day for the individual for the classification type for the service group does not occur within 28 days from the day the access approval that is in effect for the individual took effect; and

(b) subject to paragraph (c)—the period of effect for the classification level consists of each day on or after the start day for the individual for the classification level on which:

(i) a registered provider delivers funded aged care services to the individual for the classification type for the service group; and

(ii) the number of days on which the individual had previously accessed funded aged care services for the classification type for the service group is less than the maximum period of effect for the classification level (see section 80-65); and

(c) the period of effect for the classification level ends at the earliest of the following (as applicable):

(i) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) if, after the start of the period of effect and before the end of the maximum period of effect for the classification level (see section 80-65), the individual does not access funded aged care services for the classification type for the service group for a total of 7 days—the end of the most recent day on which the individual accessed funded aged care services for the classification type for the service group;

(iii) the end of the maximum period of effect for the classification level (see section 80-65);

(iv) the end of the day the individual dies.

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Subdivision BA—Circumstances in which classification levels resume being in effect for a period

80-47 Purpose of this Subdivision

For the purposes of subsection 80(1) of the Act, this Subdivision prescribes, subject to subsection 80(3) of the Act, circumstances in which a classification level for an individual that has ceased being in effect resumes being in effect for a period.

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80-49 Circumstances in which classification levels resume being in effect for a period—service groups home support, assistive technology and home modifications

Service group home support

(1) A classification level for a classification type for the service group home support for an individual that has ceased being in effect because a classification level for the classification type ongoing for the service group residential care has taken effect for the individual:

(a) resumes being in effect if the individual notifies the System Governor that the individual needs the classification level to resume being in effect; and

(b) resumes being in effect when the individual so notifies the System Governor; and

(c) remains in effect in accordance with section 80 of the Act and Subdivision B of Division 2 of Part 3 of Chapter 2 of this instrument.

(2) Subsection (1) does not apply to the classification level CHSP class for the classification type ongoing for the service group home support.

Classification type short-term for service group assistive technology

(3) A classification level (the ***individual's old AT classification level***) for the classification type short-term for the service group assistive technology for an individual that has ceased being in effect because a classification level for the classification type ongoing for the service group residential care has taken effect for the individual:

(a) resumes being in effect if:

(i) the individual notifies the System Governor that the individual needs the classification level to resume being in effect; and

(ii) when the individual so notifies the System Governor, the account period for the individual's notional assistive technology account established in respect of the individual's old AT classification level has not ended; and

(b) resumes being in effect when the individual so notifies the System Governor; and

(c) remains in effect in accordance with section 80 of the Act and Subdivision B of Division 2 of Part 3 of Chapter 2 of this instrument.

Classification type short-term for service group home modifications

(4) A classification level (the ***individual's old HM classification level***) for the classification type short-term for the service group home modifications for an individual that has ceased being in effect because a classification level for the classification type ongoing for the service group residential care has taken effect for the individual:

(a) resumes being in effect if:

(i) the individual notifies the System Governor that the individual needs the classification level to resume being in effect; and

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(ii) when the individual so notifies the System Governor, the account period for the individual's notional home modifications account established in respect of the individual's old HM classification level has not ended; and

(b) resumes being in effect when the individual so notifies the System Governor; and

(c) remains in effect in accordance with section 80 of the Act and Subdivision B of Division 2 of Part 3 of Chapter 2 of this instrument.

Subdivision C—Maximum period of effect of classification levels

80-50 Purpose of this Subdivision

For the purposes of subsection 80(1) of the Act, this Subdivision prescribes, for certain classification levels, the maximum period of effect for the classification level.

80-55 Service group home support—classification type short-term—classification level SAH restorative care pathway

For the classification level SAH restorative care pathway for the classification type short-term for the service group home support, the maximum period of effect is 112 days.

80-57 Service group home support—classification type short-term—classification level SAH end-of-life pathway

For the classification level SAH end-of-life pathway for the classification type short-term for the service group home support, the maximum period of effect is 112 days.

80-60 Service group residential care—classification type short-term

(1) For a classification level for the classification type short-term for the service group residential care, the maximum period of effect is:

(a) 63 days; or

(b) for an individual for whom the System Governor has increased the number of days for the classification level under subsection (5)—the number of days as so increased (or as most recently increased).

Note: The maximum period of effect for the classification type short-term for the service group residential care relates to a financial year (see section 80-40).

Increase in number of days for classification levels for individuals

(2) A registered provider may apply to the System Governor for a determination of an increased number of days for the classification level for an individual under subsection (5).

(3) An application under subsection (2) must be made in the approved form.

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(4) The System Governor must consider an application under subsection (2) and decide whether to determine an increased number of days under subsection (5).

(5) The System Governor may increase the number of days for the classification level for the individual by up to 21 if the System Governor is satisfied that an increase in the number of days is necessary because of any of the following:
  (a) carer stress;
  (b) severity of the individual's condition;
  (c) absence of the individual's carer;
  (d) any other relevant matter.

(6) The System Governor must give written notice to the registered provider of the System Governor's decision within 28 days after the application was made.

(7) The notice of decision must include the day the decision takes effect, which may be before the day the decision is made.

(8) An increase under subsection (5) may be made more than once.

80-65 Service group home support, assistive technology or residential care—classification type hospital transition

(1) For a classification level for the classification type hospital transition for the service group home support, assistive technology or residential care, the maximum period of effect is:
  (a) 84 days; or
  (b) for an individual for whom the System Governor determines one or more additional periods for the classification level under subsection (5)—84 days plus those additional periods.

Extension of maximum period of effect for classification levels for individuals

(2) A registered provider may apply to the System Governor for a determination of an additional period for the classification level for an individual under subsection (5).

(3) An application under subsection (2) must be made:
  (a) in the approved form; and
  (b) within:
    (i) the period referred to in paragraph (1)(a); or
    (ii) if an additional period has been determined for the individual for the classification level under subsection (5)—that additional period.

(4) The System Governor must consider an application under subsection (2) and decide whether to determine an additional period under subsection (5).

(5) The System Governor may determine one or more additional periods, together totalling not more than 42 days, for the classification level for the individual if the System Governor is satisfied that the individual requires access to funded aged care services for that level for the additional periods.

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(6) The System Governor must give written notice to the registered provider of a decision under subsection (5) within 28 days after the application was made.

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Division 3—Classification levels and procedures

Subdivision A—Introduction

81-5 Purpose of this Division

For the purposes of section 81 of the Act, this Division prescribes:

(a) classification levels for classification types for service groups; and

(b) for certain classification levels—criteria that are to be used in establishing the classification level of an individual for a classification type for a service group; and

(c) for certain classification levels—methods or procedures that the System Governor must follow in deciding classification levels for an individual for a classification type for a service group; and

(d) for the service groups home support, assistive technology and home modifications—compounding factors (based on results against relevant assessment items mentioned in subsection 77(2) of the Act) that will be used to establish an individual's classification level; and

(e) for the service group residential care:

(i) compounding factors (based on results against relevant assessment items mentioned in subsection 77(2) of the Act) that will be used to establish an individual's classification level; and

(ii) the scientific population study that will be used by the System Governor to derive a method for establishing when these compounding factors, taken together, are significant because they indicate the individual has significantly higher care needs relative to the needs of other individuals.

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81-7 Meaning of *home support compounding factors*

The home support compounding factors, for an individual, means the individual's scores for the following groups of questions in the Integrated Assessment Tool:

(a) the questions in the sections headed "Cognition" and "Medical and Medications";

(b) the questions in the section headed "Social";

(c) the questions under the headings "Toileting - Bladder" and "Toileting - Bowels";

(d) the questions in the section headed "Carer Profile";

(e) the questions in the section headed "Psychological";

(f) the questions in the section headed "Physical, Personal Health and Frailty".

81-8 Meaning of *residential care compounding factors*

The following table sets out the ***residential care compounding factors*** for individuals.

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Residential care compounding factors for individuals

Item	Column 1 For an individual who …	Column 2 the residential care compounding factors are the following …
1	is independently mobile	(a) the individual's AFM cognition score; (b) the individual's agitation score; (c) the individual's AKPS score; (d) the individual's RUG total score; (e) whether the individual requires daily injections.
2	is mobile only with assistance and has higher cognitive ability	(a) the individual's AFM motor score; (b) the individual's AFM social cognition score; (c) the individual's AKPS score; (d) the individual's Braden activity score; (e) whether the individual has fallen in the last 12 months; (f) whether the individual requires daily injections.
3	is mobile only with assistance and has medium cognitive ability	(a) the individual's AFM communication score; (b) the individual's disruptiveness score; (c) the individual's Rockwood Frailty Score; (d) the individual's RUG total score; (e) whether the individual requires complex wound management; (f) whether the individual requires daily injections.
4	is not mobile and has higher function	(a) the individual's AFM transfers score; (b) the individual's Braden total score; (c) the individual's disruptiveness score; (d) whether the individual requires complex wound management; (e) whether the individual requires daily injections.
5	is not mobile and has lower function and higher pressure sore risk	(a) the individual's AFM eating score; (b) the individual's disruptiveness score; (c) whether the individual has fallen in the last 12 months; (d) whether the individual has lost more than 10% of their body weight in the last 12 months; (e) whether the individual requires daily injections.

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81-9 Scientific population study for residential care compounding factors

The scientific population study to be used as mentioned in paragraph 81(4)(b) of the Act is the Resource Utilisation and Classification Study undertaken by the Australian Health Services Research Institute at the University of Wollongong.

Note: The reports of the Resource Utilisation and Classification Study could in 2025 be viewed on the Department's website (https://www.health.gov.au).

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Subdivision B—Classification levels and criteria

81-10 Service group home support—classification type ongoing

Non-transitional classification levels and criteria

(1) The following table sets out the non-transitional classification levels for the classification type ongoing for the service group home support and the criteria for those classification levels.

Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
1	CHSP class	Any of the following: (a) the individual: (i) has a home support functional independence score of 42-48; and (ii) has a home support needs met score of 35 or 36; (b) the individual: (i) has a home support functional independence score of 42-48; and (ii) has a home support needs met score of 0-34; (c) the individual: (i) has a home support functional independence score of 35-41; and (ii) has a home support needs met score of 31-36; (d) the individual: (i) has a home support functional independence score of 35-41; and (ii) has a home support needs met score of 0-30; and (iii) does not have significant compounding factors
2	SAH class 1	Either: (a) the individual: (i) has a home support functional independence score of 35-41; and (ii) has a home support needs met score of 0-30; and (iii) has significant compounding factors; or (b) the individual: (i) has a home support functional independence score of 30-34; and (ii) has a home support needs met score of 30-36; and (iii) does not have significant compounding factors
3	SAH class 2	Either: (a) the individual: (i) has a home support functional independence score of 30-34; and (ii) has a home support needs met score of 30-36; and (iii) has significant compounding factors; or

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Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
		(b) the individual: (i) has a home support functional independence score of 30-34; and (ii) has a home support needs met score of 0-29; and (iii) does not have significant compounding factors
4	SAH class 3	Either: (a) the individual: (i) has a home support functional independence score of 30-34; and (ii) has a home support needs met score of 0-29; and (iii) has significant compounding factors; or (b) the individual: (i) has a home support functional independence score of 25-29; and (ii) has a home support needs met score of 28-36; and (iii) does not have significant compounding factors
5	SAH class 4	Either: (a) the individual: (i) has a home support functional independence score of 25-29; and (ii) has a home support needs met score of 28-36; and (iii) has significant compounding factors; or (b) the individual: (i) has a home support functional independence score of 25-29; and (ii) has a home support needs met score of 0-27; and (iii) does not have significant compounding factors
6	SAH class 5	Either: (a) the individual: (i) has a home support functional independence score of 25-29; and (ii) has a home support needs met score of 0-27; and (iii) has significant compounding factors; or (b) the individual: (i) has a home support functional independence score of 0-24; and (ii) has a home support needs met score of 29-36; and (iii) does not have significant compounding factors
7	SAH class 6	Either: (a) the individual: (i) has a home support functional independence score of 0-24; and (ii) has a home support needs met score of 29-36; and (iii) has significant compounding factors; or (b) the individual:

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Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
		(i) has a home support functional independence score of 0-24; and (ii) has a home support needs met score of 23-28; and (iii) does not have significant compounding factors
8	SAH class 7	Either: (a) the individual: (i) has a home support functional independence score of 0-24; and (ii) has a home support needs met score of 23-28; and (iii) has significant compounding factors; or (b) the individual: (i) has a home support functional independence score of 0-24; and (ii) has a home support needs met score of 0-22; and (iii) does not have significant compounding factors
9	SAH class 8	The individual: (a) has a home support functional independence score of 0-24; and (b) has a home support needs met score of 0-22; and (c) has significant compounding factors

(1A) Despite subsection (1), if an individual is accessing services funded under the program known as the Disability Support for Older Australians Program, the criteria for the classification level CHSP class is that the individual is accessing those services under that program.

Transitional classification levels

(2) The transitional classification levels for the classification type ongoing for the service group home support are the following:

(a) HCP class 1;
(b) HCP class 2;
(c) HCP class 3;
(d) HCP class 4;
(e) CHSP transitional;
(f) HSO NATSIFACP;
(g) HSO MPSP.

Note: Transitional classification levels for the classification type ongoing for the service group home support are established for certain classes of individuals to whom subsection 2(2) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024* applies—see the *Aged Care (Consequential and Transitional Provisions) Determination 2025*.

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81-15 Service group home support—classification type short-term

Non-transitional classification levels and criteria

(1) The following table sets out the non-transitional classification levels for the classification type short-term for the service group home support and the criteria for those classification levels.

Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
1	SAH restorative care pathway	The individual: (a) does not meet the criteria for the classification level CHSP class for the classification type ongoing for the service group home support; and (b) does not meet the criteria for the classification level SAH end-of-life pathway for the classification type short-term for the service group home support; and (c) is not accessing, and does not have the potential to benefit from accessing, funded aged care services delivered through the service group home support under the TCP; and (d) is residing in a home or community setting; and (e) needs restorative care to prevent or delay the individual from needing to access ongoing funded aged care services in the service group home support in circumstances mentioned in paragraph 64-5(b); and (f) has goals in line with restorative care outcomes (for example improving function and being independent); and (g) either: (i) has not had the classification level SAH restorative care pathway in effect in the previous 90 days; or (ii) has not had an amount determined for the individual under section 195-3 during a period of effect for the classification level SAH restorative care pathway that includes a day in the previous 12 months
2	SAH end-of-life pathway	All of the following apply to the individual: (a) the individual: (i) has a prognosis of a life expectancy of 3 months or less; and (ii) has an AKPS score of 40 or less; (b) the individual has not previously had the classification level SAH end-of-life pathway in effect; (c) a notice in the approved form containing evidence of the matters referred to in paragraph (a) has been given to the System Governor

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Transitional classification levels

(2) The transitional classification levels for the classification type short-term for the service group home support are the following:

(a) STRC class;

(b) HSST NATSIFACP;

(c) HSST MPSP.

Note: The transitional classification levels for the classification type short-term for the service group home support are established for certain classes of individuals to whom subsection 2(2) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024* applies—see the *Aged Care (Consequential and Transitional Provisions) Determination 2025*.

81-17 Service group home support—classification type hospital transition

The following table sets out the classification levels for the classification type hospital transition for the service group home support and the criteria for the classification levels.

Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
1	HS HT class	The individual: (a) has an access approval that includes the service type assistance with transition care; and (b) is in the concluding stage of a hospital episode; and (c) is medically stable; and (d) has the potential to benefit from accessing funded aged care services delivered through the service group home support under the TCP; and (e) was admitted to a hospital at the time the aged care needs assessment was carried out

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81-20 Service group assistive technology—classification type ongoing

The following table sets out the classification levels for the classification type ongoing for the service group assistive technology and the criteria for the classification levels.

Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
1	Assistance dogs	The individual: (a) has an assistance dog; and (b) is unable to access assistance under the Assistance Dogs Australia program for people with physical disabilities

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81-25 Service group assistive technology—classification type short-term

Non-transitional classification levels and criteria

(1) The following table sets out the non-transitional classification levels for the classification type short-term for the service group assistive technology and the criteria for those classification levels.

Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
1	AT low	The individual: (a) needs low cost assistive technology to mitigate functional decline or impairment and enable them to safely live in their home and community; and (b) has had any of the following classification levels established for the individual: (i) for the classification type ongoing for the service group home support—SAH class 1, 2, 3, 4, 5, 6, 7 or 8; (ii) for the classification type short-term for the service group home support—SAH restorative care pathway or SAH end-of-life pathway
2	AT medium	The individual: (a) needs medium cost assistive technology to mitigate functional decline or impairment and enable them to safely live in their home and community; and (b) has had any of the following classification levels established for the individual: (i) for the classification type ongoing for the service group home support—SAH class 1, 2, 3, 4, 5, 6, 7 or 8; (ii) for the classification type short-term for the service group home support—SAH restorative care pathway or SAH end-of-life pathway
3	AT high	The individual: (a) needs high cost assistive technology to mitigate functional decline or impairment and enable them to safely live in their home and community; and (b) has had any of the following classification levels established for the individual: (i) for the classification type ongoing for the service group home support—SAH class 1, 2, 3, 4, 5, 6, 7 or 8; (ii) for the classification type short-term for the service group home support—SAH restorative care pathway or SAH end-of-life pathway
4	AT CHSP	The classification level CHSP class has been established for the individual for the classification type ongoing for the service group home support

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Transitional classification levels

(2) The transitional classification level for the classification type short-term for the service group assistive technology is AT transitional.

Note: The transitional classification level for the classification type short-term for the service group assistive technology is established for certain classes of individuals to whom subsection 2(2) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024* applies—see the *Aged Care (Consequential and Transitional Provisions) Determination 2025*.

81-27 Service group assistive technology—classification type hospital transition

The following table sets out the classification levels for the classification type hospital transition for the service group assistive technology and the criteria for the classification levels.

Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
1	AT HT class	The individual: (a) has an access approval that includes the service type assistance with transition care; and (b) is in the concluding stage of a hospital episode; and (c) is medically stable; and (d) has the potential to benefit from accessing funded aged care services delivered through the service group assistive technology under the TCP; and (e) was admitted to a hospital at the time the aged care needs assessment was carried out

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81-30 Service group home modifications—classification type short-term

Non-transitional classification levels and criteria

(1) The following table sets out the non-transitional classification levels for the classification type short-term for the service group home modifications and the criteria for those classification levels.

Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
1	HM low	The individual: (a) needs low cost home modifications to mitigate functional decline or impairment and enable them to safely live in their home and community; and (b) has had any of the following classification levels established for the individual: (i) for the classification type ongoing for the service group

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Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
		home support—SAH class 1, 2, 3, 4, 5, 6, 7 or 8; (ii) for the classification type short-term for the service group home support—SAH restorative care pathway
2	HM medium	The individual: (a) needs medium cost home modifications to mitigate functional decline or impairment and enable them to safely live in their home and community; and (b) has had any of the following classification levels established for the individual: (i) for the classification type ongoing for the service group home support—SAH class 1, 2, 3, 4, 5, 6, 7 or 8; (ii) for the classification type short-term for the service group home support—SAH restorative care pathway
3	HM high	The individual: (a) needs high cost home modifications to mitigate functional decline or impairment and enable them to safely live in their home and community; and (b) has had any of the classification levels SAH class 1, 2, 3, 4, 5, 6, 7 or 8 for the classification type ongoing for the service group home support established for the individual
4	HM CHSP	The classification level CHSP class has been established for the individual for the classification type ongoing for the service group home support

Transitional classification levels

(2) The transitional classification level for the classification type short-term for the service group home modifications is HM transitional.

Note: The transitional classification level for the classification type short-term for the service group home modifications is established for certain classes of individuals to whom subsection 2(2) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024* applies—see the *Aged Care (Consequential and Transitional Provisions) Determination 2025*.

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81-35 Service group residential care—classification type ongoing

Non-transitional classification levels and criteria

(1) The non-transitional classification levels for the classification type ongoing for the service group residential care are as follows:
(a) class 0; and
(b) the classification levels set out in the following table.

(2) The following table sets out the criteria for the classification levels set out in the table.

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Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
1	Class 1	The circumstances referred to in paragraph 76-15(10)(a) of this instrument (palliative care pathway) apply to the individual
2	Class 2	The individual: (a) is independently mobile; and (b) does not have significant compounding factors
3	Class 3	The individual: (a) is independently mobile; and (b) has significant compounding factors
4	Class 4	The individual: (a) is mobile only with assistance; and (b) has higher cognitive ability; and (c) does not have significant compounding factors
5	Class 5	The individual: (a) is mobile only with assistance; and (b) has higher cognitive ability; and (c) has significant compounding factors
6	Class 6	The individual: (a) is mobile only with assistance; and (b) has medium cognitive ability; and (c) does not have significant compounding factors
7	Class 7	The individual: (a) is mobile only with assistance; and (b) has medium cognitive ability; and (c) has significant compounding factors
8	Class 8	The individual: (a) is mobile only with assistance; and (b) has lower cognitive ability
9	Class 9	The individual: (a) is not mobile; and (b) has higher function; and (c) does not have significant compounding factors
10	Class 10	The individual: (a) is not mobile; and (b) has higher function; and (c) has significant compounding factors
11	Class 11	The individual: (a) is not mobile; and (b) has lower function; and (c) has lower pressure sore risk
12	Class 12	The individual:

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Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
		(a) is not mobile; and (b) has lower function; and (c) has higher pressure sore risk; and (d) does not have significant compounding factors
13	Class 13	The individual: (a) is not mobile; and (b) has lower function; and (c) has higher pressure sore risk; and (d) has significant compounding factors

Transitional classification levels and criteria

(3) The transitional classification levels for the classification type ongoing for the service group residential care are as follows:
(a) RCO MPSP;
(b) RCO NATSIFACP.

Note: Transitional classification levels for the classification type ongoing for the service group residential care are established for certain classes of individuals to whom subsection 3(2) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024* applies—see the *Aged Care (Consequential and Transitional Provisions) Determination 2025*.

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81-40 Service group residential care—classification type short-term

Non-transitional classification levels and criteria

(1) The non-transitional classification levels for the classification type short-term for the service group residential care are as follows:
(a) respite class 0; and
(b) the classification levels set out in the following table.

(2) The following table sets out the criteria for the classification levels set out in the table.

Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
1	Respite class 1	The individual is independently mobile
2	Respite class 2	The individual is mobile only with assistance
3	Respite class 3	The individual is not mobile

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Transitional classification levels

(3) The transitional classification level for the classification type short-term for the service group residential care are as follows:

(a) RCST MPSP;

(b) RCST NATSIFACP.

Note: Transitional classification levels for the classification type short-term for the service group residential care are established for certain classes of individuals to whom subsection 3(2) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024* applies—see the *Aged Care (Consequential and Transitional Provisions) Determination 2025*.

81-42 Procedure for deciding initial classification levels for individuals for the classification types ongoing and short-term for the service group residential care

Classification type ongoing

(1) The procedure for establishing a classification level for an individual to whom paragraph 78(1)(c) of the Act applies for the classification type ongoing for the service group residential care is to establish the classification level class 0 for the individual.

Classification type short-term

(2) The procedure for establishing a classification level for an individual to whom paragraph 78(1)(c) of the Act applies for the classification type short-term for the service group residential care is to establish the classification level respite class 0 for the individual.

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81-45 Service group residential care—classification type hospital transition

The following table sets out the classification levels for the classification type hospital transition for the service group residential care and the criteria for the classification levels.

Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
1	RC HT class	The individual: (a) has an access approval that includes the service type assistance with transition care; and (b) is in the concluding stage of a hospital episode; and (c) is medically stable; and (d) has the potential to benefit from accessing funded aged care services delivered through the service group residential care under the TCP; and (e) was admitted to a hospital at the time the aged care needs assessment was carried out

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Part 4—Prioritisation

Division 1—Prioritisation assessments

84-5 When prioritisation assessments not required for classification type ongoing for service group home support

For the purposes of paragraph 84(2)(b) of the Act, the circumstances for an individual are that the classification level CHSP class for the classification type ongoing for the service group home support has been established for the individual by a classification decision.

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Division 2—Priority category decisions

86-5 All service groups—period in which priority category decisions must be made

For the purposes of subsection 86(3) of the Act, the period of 14 days after the day on which the System Governor is given a prioritisation report under section 85 of the Act for an individual is prescribed.

86-10 Service group residential care—priority category 1—areas

For the purposes of subparagraph 86(5)(a)(ii) of the Act, an area with a 2023 MM category known as MM 5, MM 6 or MM 7 is prescribed.

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Division 3—Priority categories for classification types for service groups

Subdivision A—Service group home support

87-5 Priority categories and eligibility criteria for classification type ongoing

(1) For the purposes of subsection 87(1) of the Act:

(a) column 1 of the following table prescribes the priority categories for the classification type ongoing for the service group home support; and

(b) column 2 of the following table prescribes eligibility criteria for each of those priority categories.

Classification type ongoing for service group home support

Item	Column 1 Priority categories	Column 2 Eligibility criteria
1	Urgent	The individual has 5 or more points determined in accordance with subsection (2)
2	High	The individual has 4 points determined in accordance with subsection (2)
3	Medium	The individual has 2 or 3 points determined in accordance with subsection (2)
4	Standard	The individual has 1 point, or no points, determined in accordance with subsection (2)

Points

(2) For the purposes of column 2 of the table in subsection (1), an individual's points are determined by adding together the points specified in column 2 of each item of the following table in which column 1 specifies circumstances that apply to the individual (if any).

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Circumstances and points for eligibility criteria

Item	Column 1 Circumstances	Column 2 Points
1	The individual lives alone	1
2	The individual has a cognitive impairment	1
3	The individual is an Aboriginal or Torres Strait Islander person	1
4	The individual is homeless, or at risk of homelessness	1
5	The individual has a need for urgent access to ongoing funded aged care services through the service group home support	2
6	The individual: (a) has waited more than 6 months from: (i) the day on which the individual applied for access to funded aged	1

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Circumstances and points for eligibility criteria

Item	Column 1 Circumstances	Column 2 Points
	care services; or (ii) if the individual applied for the reassessment of the individual's need for funded aged care services—the day on which the individual applied for the reassessment; and (b) resides in an area with a 2023 MM category known as MM 5, MM6 or MM 7	
7	The individual had motor neurone disease at the time the individual's most recent aged care needs assessment was undertaken	5

Subdivision B—Service groups assistive technology and home modifications

87-7 Priority categories and eligibility criteria

Classification type ongoing or short-term for service group assistive technology

(1) For the purposes of subsection 87(1) of the Act:
(a) column 1 of the following table prescribes the priority categories for the classification types ongoing and short-term for the service group assistive technology; and
(b) column 2 of the following table prescribes eligibility criteria for each of those priority categories.

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Classification type ongoing or short-term for service group assistive technology

Item	Column 1 Priority categories	Column 2 Eligibility criteria
1	Immediate	Either of the following circumstances applies to the individual: (a) an approved needs assessor considers the classification type short-term for the service group home support should be approved for the individual; (b) the individual had motor neurone disease at the time the individual's most recent aged care needs assessment was undertaken
2	High	Two or more of the following circumstances apply to the individual: (a) the individual lives alone; (b) the individual has a mobility impairment; (c) the individual is an Aboriginal or Torres Strait Islander person; (d) the individual's current place of residence poses a moderate or severe risk to the individual's health or safety; (e) both of the following apply: (i) the individual has waited more than 6 months from the day on which the individual made the application to which the priority assessment relates; (ii) the individual resides in an area with a 2023 MM category

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Classification type ongoing or short-term for service group assistive technology

Item	Column 1 Priority categories	Column 2 Eligibility criteria
		known as MM 5, MM 6 or MM 7 Note: The application referred to in subparagraph (e)(i) could be an application for access to funded aged services under section 56 of the Act or an application for an aged care needs reassessment under section 64 of the Act.
3	Medium	One circumstance referred to in column 2 of item 2 applies to the individual
4	Standard	None of the circumstances referred to in column 2 of item 2 apply to the individual

Classification type short-term for service group home modifications

(2) For the purposes of subsection 87(1) of the Act:

(a) column 1 of the following table prescribes the priority categories for the classification type short-term for the service group home modifications; and

(b) column 2 of the following table prescribes eligibility criteria for each of those priority categories.

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Classification type short-term for service group home modifications

Item	Column 1 Priority categories	Column 2 Eligibility criteria
1	Immediate	Either of the following circumstances applies to the individual: (a) an approved needs assessor considers the classification type short-term for the service group home support should be approved for the individual; (b) the individual had motor neurone disease at the time the individual's most recent aged care needs assessment was undertaken
2	High	Two or more of the following circumstances apply to the individual: (a) the individual lives alone; (b) the individual has a mobility impairment; (c) the individual is an Aboriginal or Torres Strait Islander person; (d) the individual's current place of residence poses a moderate or severe risk to the individual's health or safety; (e) both of the following apply: (i) the individual has waited more than 6 months from the day on which the individual made the application to which the priority assessment relates; (ii) the individual resides in an area with a 2023 MM category known as MM 5, MM 6 or MM 7 Note: The application referred to in subparagraph (e)(i) could be an application for access to funded aged services under section 56 of the Act or an application for an aged care needs reassessment under section 64 of the Act.

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Section 87-7

Classification type short-term for service group home modifications

Item	Column 1 Priority categories	Column 2 Eligibility criteria
3	Medium	One circumstance referred to in column 2 of item 2 applies to the individual
4	Standard	None of the circumstances referred to in column 2 of item 2 apply to the individual

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Division 4—Circumstances for urgency ratings—service group residential care

87-10 Classification type ongoing

(1) For the purposes of subsection 87(2) of the Act, this section prescribes the circumstances in which an urgency rating of low, medium or high will apply to an individual in relation to the classification type ongoing for the service group residential care.

High

(2) An urgency rating of high will apply to the individual if the individual has a need for immediate access to ongoing funded aged care services delivered in an approved residential care home which, if not met, may place the individual's safety, health or wellbeing at risk.

Medium

(3) An urgency rating of medium will apply to the individual if:
  (a) the circumstances mentioned in subsection (2) do not apply to the individual; and
  (b) taking into account the individual's circumstances and preferences, the individual is expected to seek access to ongoing funded aged care services delivered in an approved residential care home within the next 6 months.

Low

(4) An urgency rating of low will apply to the individual if:
  (a) the circumstances mentioned in subsection (2) do not apply to the individual; and
  (b) the circumstances mentioned in paragraph (3)(b) do not apply to the individual.

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Part 5—Place allocation

Division 1—Allocation of places to individuals

Subdivision A—Allocation of places to individuals

92-5 When allocation of places to individuals does not apply for classification type ongoing for service group home support

For the purposes of paragraph 92(1A)(b) of the Act, the circumstances for an individual are that the classification level CHSP class for the classification type ongoing for the service group home support has been established for the individual by a classification decision.

92A-5 When a place is in effect—period for start day—service groups home support, assistive technology and home modifications

For the purposes of subsection 92A(2) of the Act, the period for a place allocated under subsection 92(1) of the Act to an individual is:

(a) 56 days from the day the place is allocated to the individual; or

(b) if, within the period referred to in paragraph (a), the individual notifies the System Governor that the individual needs an extension to that period—84 days from the day the place is allocated to the individual.

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92A-10 When a place ceases to have effect—service groups home support, assistive technology and home modifications

For the purposes of subsection 92A(4) of the Act, the time when a place allocated under subsection 92(1) of the Act to an individual for a classification type for the service group home support, assistive technology or home modifications ceases to have effect is the end of the earlier of the following (as applicable):

(a) for a place allocated to an individual for whom a classification level has been established for the classification type for the service group by a classification decision—the period of effect for the classification level;

(b) the day the individual dies.

Subdivision B—Method for allocation

93-5 Purpose of this Subdivision

For the purposes of subsection 93(2) of the Act, this Subdivision prescribes methods that the System Governor must follow in deciding the order of allocation under subsection 93(1) of the Act for:

(a) the classification type ongoing for the service group home support; and

(b) the classification types ongoing and short-term for the service group assistive technology; and

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(c) the classification type short-term for the service group home modifications.

93-10 Classification type ongoing for the service group home support—method for deciding order of allocation

The method for deciding the order of allocation of a place to an individual for the classification type ongoing for the service group home support is as follows.

Step 1:	Identify the individuals (if any) to whom the circumstances referred to in paragraph 64-10(d) of this instrument apply.
Step 2:	Allocate the place to the individual who has the longest current wait time.
Step 3.	Using the method in section 93-12, identify if a place is assigned to a priority category for the classification type for the service group.
Step 4.	Identify whether the place is a full place or an interim place.
Step 5.	Identify the individuals (if any) who have that priority category for the classification type for the service group and whether those individuals have an interim place in effect for the classification type for the service group.
Step 6.	If the place is a full place, allocate the place to the individual who, of the individuals to whom a place has not already been allocated under step 2, has the longest current wait time.
Step 7.	If the place is an interim place, allocate the place to the individual who, of the individuals who do not have an interim place in effect for the classification type for the service group and to whom a place has not already been allocated under step 2, has the longest current wait time.

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93-12 Classification type ongoing for the service group home support—method for assigning places to priority categories

The method for assigning a place to a priority category for the classification type ongoing for the service group home support on a day is as follows.

Step 1.	For each priority category for the classification type for the service group, identify the number of waiting individuals for whom the current wait time is equal to or greater than the target priority category wait time for that priority category on the day.
Step 2.	Add up the numbers identified for each priority category under Step 1.
Step 3.	Identify the number of places that are available to be allocated to individuals for that service group on the day (as worked out in

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accordance with the method determined under subsection 91(1) of the Act).

Step 4. If the number worked out under Step 2 is less than or equal to the number identified at Step 3, divide the number worked out under Step 2 by the number identified at Step 3.

Step 5. If the number worked out under Step 2 is greater than the number identified at Step 3, divide the number identified at Step 3 by the number worked out under Step 2.

Step 6. For each priority category:

(a) multiply the number identified under step 1 by the result of Step 4 or 5 (as applicable) and round down to the nearest whole number; and

(b) if the result under paragraph (a) is a number greater than zero, that number of places are assigned to that priority category on the day; and

(c) if the result under paragraph (a) is zero, no places are assigned to that priority category on the day.

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93-13 Classification type ongoing for the service group home support—method for working out wait time factor

The method for working out the ***wait time factor*** is as follows.

Step 1. Reduce the target classification type wait time most recently determined by the System Governor under section 93-14 by the priority category waiting proportion for the priority category urgent.

Step 2. For each remaining priority category, multiply the priority category waiting proportion by the queue rate.

Step 3. Add up the results of step 2 for each priority category.

Step 4. Divide the result of step 1 by the result of step 3.

93-14 Classification type ongoing for the service group home support—method for System Governor determination of target classification type wait time

The System Governor must, from time to time, determine the ***target classification type wait time*** (in months) for the classification type ongoing for the service group home support by considering:

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(a) on the first occasion the System Governor does so—the average of the old Act wait times; or

(b) on any subsequent occasion:

(i) the weighted average of the current wait times for individuals who have been assigned priority categories for the classification type for the service group; and

(ii) what change needs to be made to the previous target classification type wait time to ensure that, on and after 1 November 2027, the weighted average mentioned in subparagraph (i) is not more than 3 months.

93-15 Classification types ongoing and short-term for the service group assistive technology—method for deciding order of allocation

The method for deciding the order of allocation of a place to an individual for the classification type ongoing or short-term for the service group assistive technology is as follows.

Step 1.	Identify the individuals (if any) who have, or have had, the classification level SAH end-of-life pathway for the classification type short-term for the service group home support in effect.
Step 2:	Allocate the place to the individual who has the longest current wait time.
Step 3:	Identify the waiting individuals (if any) who have the priority category immediate for the classification type for the service group and to whom a place has not already been allocated under step 2.
Step 4.	Of those individuals, allocate the place to the individual who has the longest current wait time.
Step 5.	If no individuals are identified under step 3, identify the waiting individuals (if any) who have the priority category high for the classification type for the service group and to whom a place has not already been allocated under step 2.
Step 6.	Of those individuals, allocate the place to the individual who has the longest current wait time.
Step 7.	If no individuals are identified under step 5, identify the waiting individuals (if any) who have the priority category medium for the classification type for the service group and to whom a place has not already been allocated under step 2.
Step 8.	Of those individuals, allocate the place to the individual who has the longest current wait time.

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Step 9.	If no individuals are identified under step 7, identify the waiting individuals who have the priority category standard for the classification type for the service group and to whom a place has not already been allocated under step 2.
Step 8.	Of those individuals, allocate the place to the individual who has the longest current wait time.

93-20 Classification type short-term for the service group home modifications—method for deciding order of allocation

The method for deciding the order of allocation of a place to an individual for the classification type short-term for the service group home modifications is as follows.

Step 1:	Identify the individuals (if any) who have had the classification level SAH end-of-life pathway for the classification type short-term for the service group home support in effect.
Step 2:	Allocate the place to the individual who has the longest current wait time.
Step 3.	Identify the waiting individuals (if any) who have the priority category immediate for the classification type for the service group and to whom a place has not already been allocated under step 2.
Step 4.	Of those individuals, allocate the place to the individual who has the longest current wait time.
Step 5.	If no individuals are identified under step 3, identify the waiting individuals (if any) who have the priority category high for the classification type for the service group and to whom a place has not already been allocated under step 2.
Step 6.	Of those individuals, allocate the place to the individual who has the longest current wait time.
Step 7.	If no individuals are identified under step 5, identify the waiting individuals (if any) who have the priority category medium for the classification type for the service group and to whom a place has not already been allocated under step 2.
Step 8.	Of those individuals, allocate the place to the individual who has the longest current wait time.
Step 9.	If no individuals are identified under step 7, identify the waiting individuals who have the priority category standard for the classification type for the service group and to whom a place has not already been allocated under step 2.

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Step 10. Of those individuals, allocate the place to the individual who has the longest current wait time.

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Division 2—Allocation of a place to registered providers for certain specialist aged care programs

95-5 Allocation of a place—System Governor may invite application for allocation of TCP place

(1) For the purposes of subsection 95(2) of the Act, the System Governor may invite an entity to apply on its own behalf or on behalf of another entity (the ***nominated entity)*** for the allocation of a place for the delivery of funded aged care services under the TCP in a State or Territory.

(2) An application under subsection 95(2) of the Act may only be made in accordance with an invitation under subsection (1).

95-10 Allocation of a place—application for allocation of a TCP place

(1) An application under subsection 95(2) of the Act for the allocation of a place for delivering funded aged care services under the TCP in a State or Territory must specify the following:
  (a) whether the application is being made:
    (i) on an entity's own behalf; or
    (ii) on behalf of a nominated entity to which the place is to be allocated;
  (b) the number of places applied for;
  (c) the number of those places that will be used to prioritise delivery of funded aged care services to Aboriginal or Torres Strait Islander persons;
  (d) the area or areas in which the places will be used to deliver funded aged care services.

(2) For each area specified under paragraph (1)(d), the application must also specify the following:
  (a) the estimated number of persons residing in the area or areas who are aged at least 70, other than Aboriginal or Torres Strait Islander persons;
  (b) the estimated number of Aboriginal or Torres Strait Islander persons residing in the area or areas who are aged at least 50;
  (c) the estimated number of persons mentioned in paragraph (a) or (b) who are expected to be discharged from hospital;
  (d) the estimated number of persons expected to be discharged from hospital as mentioned in paragraph (c) annually, or within another relevant time period, who are expected to benefit from funded aged care services delivered under the TCP after discharge;
  (e) if the application is made on behalf of one or more nominated entities to which the places are to be allocated—the nominated entity or entities that will deliver funded aged care services under each place applied for.

(3) For the purposes of subsection (2), the number of persons for an area specified in an application is to be expressed as a whole number per thousand of the total number of persons residing in the area.

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(4) To avoid doubt:

(a) an area specified under paragraph (1)(d) may be the whole or a part of a State or Territory; and

(b) an application made on behalf of a nominated entity is made by the nominated entity for the purposes of the Act.

Note: The System Governor may request further information, which must be given within 14 days of the request (see section 588 of the Act and section 588-5 of this instrument).

95-15 Allocation of a place—matters of which System Governor must be satisfied before allocating TCP place

For the purposes of subparagraph 95(4)(a)(ii) of the Act, the System Governor must be satisfied of the following before allocating a place to an entity for the delivery of funded aged care services under the TCP in a State or Territory:

(a) that the place, if allocated, will be used by the entity to which the place is allocated to deliver funded aged care services in accordance with an agreement between the Commonwealth and the State or Territory made under paragraph 247(1)(b) of the Act;

(b) that, if the place is allocated to a nominated entity, the entity was nominated having regard to the community's needs.

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97-5 When a place is in effect—basic rules

When a place comes into effect

(1) For the purposes of subsection 97(1) of the Act, a place allocated under subsection 95(1) of the Act to an entity for a specialist aged care program comes into effect on the day after the first day on which the entity satisfies the following conditions:

(a) the entity is a registered provider that is registered for a registration category for one or more service groups through which the entity will deliver funded aged care services under the specialist aged care program;

(b) if the place is to be used to deliver funded aged care services under the MPSP—an agreement with the entity is in force under paragraph 247(1)(a) of the Act;

(c) if the place is to be used to deliver funded aged care services under the TCP in a State or Territory—an agreement with the State or Territory covering the arrangements for the delivery of those services is in force under paragraph 247(1)(b) of the Act;

(d) if the place is to be used to deliver funded aged care services in an approved residential care home—the System Governor is satisfied that a bed in the approved residential aged care home is ready to be used for the delivery of funded aged care services under the place.

Note: A place may, in certain circumstances, be allocated a second time under subsection 95(1) of the Act (see section 97-25).

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Period for which a place is in effect

(2) A place that comes into effect under subsection (1) is in effect for the period:
  (a) starting on the day on which the place comes into effect; and
  (b) ending on the day on which the place ceases to be in effect under section 97-15;

but is not in effect for any period for which it is temporarily not in effect under section 97-10.

Place cannot come into effect if 5 year delay

(3) A place allocated under subsection 95(1) of the Act to an entity for a specialist aged care program does not come into effect, and can never come into effect, if the place has not come into effect under subsection (1) of this section within 5 years after the day on which the place was allocated.

Entity may be required to complete application to confirm that a bed is ready to be used

(4) For the purposes of paragraph (1)(d), the System Governor may require an entity to complete an application process published on the Department's website.

97-10 When a place is in effect—temporary cessation

(1) For the purposes of subsection 97(1) of the Act, this section prescribes the circumstances in which a place that has been allocated under subsection 95(1) of the Act to an entity, and has come into effect, is temporarily not in effect.

Entity does not have capacity to deliver funded aged care services

(2) The place is not in effect for a period during which the System Governor and the entity agree that the entity does not have the capacity to deliver funded aged care services under the place.

Note: Section 167 of the Act, and rules made under that section, require certain registered providers to give notice of certain changes in circumstances to the System Governor.

Suspension of entity's registration

(3) The place is not in effect for any period of suspension, under subsection 129(1) of the Act, of the registration of the entity.

Condition makes it impracticable to deliver funded aged care services

(4) A place is not in effect for a period if:
  (a) a condition is placed on the entity; and
  (b) the condition makes it impracticable for the entity to deliver funded aged care services under the place for that period.

(5) A place that is not in effect for a period comes back into effect immediately after the end of the period.

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97-15 When a place is in effect—permanent cessation

(1) For the purposes of subsection 97(1) of the Act, a place that has been allocated under subsection 95(1) of the Act to an entity, and has come into effect, ceases to be in effect, and can never resume to have effect, if:

(a) the entity ceases to be a registered provider; or

(b) the System Governor and the entity agree, in accordance with subsection (2) of this section, that the entity may relinquish the place; or

(c) the System Governor revokes the place under subsection (3) of this section.

Note: A place allocated under subsection 95(1) of the Act may be brought back into effect for allocation to another entity in certain circumstances (see section 97-25).

(2) The System Governor must not agree to the relinquishment of a place under paragraph (1)(b) unless the System Governor is satisfied that the entity to which the place was allocated has complied with the requirements prescribed by Division 4 of Part 4 of Chapter 4 of this instrument (which deals with continuity of delivery of funded aged care services).

(3) The System Governor may revoke a place if the entity has not used the place to deliver funded aged care services for a period of 12 months or more.

97-25 When a place is in effect—reallocation of TCP place

(1) For the purposes of subsection 97(1) of the Act, if:

(a) the Minister determines under paragraph 94(1)(a) of the Act that a place is available for allocation for use in a specified State or Territory; and

(b) the place is allocated to an entity under subsection 95(1) of the Act; and

(c) the place would, apart from this section, cease permanently to be in effect under section 97-15;

the State or Territory specified in the determination may apply to the System Governor for the place to be allocated to another entity.

(2) If the State or Territory makes an application to the System Governor under subsection (1):

(a) the System Governor may decide to allocate the place to the other entity under subsection 95(1) of the Act; and

(b) if the System Governor so decides, the place comes into effect in accordance with section 97-5.

98-5 Transfer of places

(1) For the purposes of subsection 98(1) of the Act, this section prescribes circumstances in which a place allocated under subsection 95(1) of the Act to the first entity may be transferred to the second entity.

(2) One circumstance is that:

(a) the place is for delivering funded aged care services under the TCP in a State or Territory; and

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(b) the State or Territory makes an application to the System Governor for the place to be transferred to the second entity; and

(c) the second entity is a registered provider delivering funded aged care services under the TCP in the State or Territory.

(3) Another circumstance is that:

(a) the place is for delivering funded aged care services under the MPSP in a State or Territory; and

(b) the State or Territory makes an application to the System Governor for the place to be transferred to the second entity; and

(c) the second entity is a registered provider delivering funded aged care services under the MPSP in the State or Territory; and

(d) the first entity and second entity agree to the transfer.

99-5 Conditions that apply to an allocated place

For the purposes of paragraph 99(1)(f) of the Act, the following conditions are prescribed in relation to a place allocated by the System Governor to an entity under subsection 95(1) of the Act:

(a) the entity must notify the System Governor if the entity will not be able to, or does not intend to, use the place to deliver funded aged care services for a period of 12 months or more;

(b) for a place allocated for the MPSP:

(i) if the place is used for the delivery of funded aged care services through the service group residential care—the place must only be used by the entity at the approved residential care home specified in the notice given under subsection 96(1) of the Act in relation to the allocation of the place; and

(ii) if the place is used for the delivery of funded aged care services through a service group that is not the service group residential care—the place must only be used by the entity at a location specified in the notice given under subsection 96(1) of the Act in relation to the allocation of the place.

Note: Section 167 of the Act, and rules made under that section, have the effect that this condition of place allocation can be met by giving the Commissioner and the System Governor a notice under that section.

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101-5 System Governor decision on whether to vary a condition—matters to which System Governor must have regard

For the purposes of paragraph 101(2)(a) of the Act, the matters to which the System Governor must have regard in considering whether to vary a condition that applies to a place allocated to an entity under subsection 95(1) of the Act are the following:

(a) the objectives of the specialist aged care program for which the place is allocated;

(b) the needs of the communities of which individual members are expected to be able to access funded aged care services delivered under the place;

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(c) the Statement of Principles;
(d) any information or documents given by the entity in relation to the variation of the condition.

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Section 104-1

Chapter 3—Provider registration

Part 1—Introduction

104-1 Simplified outline of this Chapter

This Chapter relates to provider registration under Chapter 3 of the Act.

Part 2 of this Chapter relates to provider registration and residential care home approval process, and deals with:

(a) applications for registration as a registered provider and applications for renewal of registration; and

(b) requirements for audits or assessments of an entity's ability to conform with the Aged Care Quality Standards for a provider registration category; and

(c) applications for approval of a residential care home; and

(d) matters that must be included in a notice of a decision to register an entity as a registered provider or renew an entity's registration; and

(e) deeming certain classes of entities to be registered providers and matters that must be included in a determination that an entity is taken to be a registered provider.

Part 3 of this Chapter relates to variations, suspensions and revocations of the registration of a registered provider and variations of approvals of a residential care home, and deals with:

(a) the appointment by a registered provider of an eligible adviser to assist the provider to comply with the provider's conditions and obligations under Part 4 of Chapter 3 of the Act; and

(b) variations of approvals of residential care homes on the Commissioner's own initiative and on application by a registered provider; and

(c) matters that the Provider Register must include in relation to the registration of a registered provider.

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Part 2—Provider registration and residential care home approval process

Division 1—Applications for registration and registration decisions

Subdivision A—Application fees, information for applications and decision making periods

104-5 Application for registration—application fee

For the purposes of paragraph 104(2)(b) of the Act, the application fee for an application by an entity to be registered as a registered provider is the sum of:

(a) $3,270.00; and

(b) the sum of the amounts specified in column 2 of the following table for each provider registration category specified in the application as a provider registration category that the entity is applying to be registered in.

Note: Exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act.

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Amounts for provider registration categories

Item	Column 1 Provider registration category	Column 2 Amount ($)
1	Home and community services	1,270.00
2	Assistive technology and home modifications	1,270.00
3	Advisory and support services	1,270.00
4	Personal and care support in the home or community	3,800.00
5	Nursing and transition care	3,800.00
6	Residential care	5,070.00

104-15 Application for registration—other information

For the purposes of paragraph 104(3)(i) of the Act, the other information that must be specified in an application by an entity for registration is, for each provider registration category that the entity is applying to be registered in under which funded aged care services are delivered in a home or community setting—each local government area in which the entity intends to deliver funded aged care services.

Note: For provider registration categories, see subsection 11(3) of the Act and section 11-5 of this instrument.

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105-5 Application for registration—period for making decision

For the purposes of subsection 105(2) of the Act, the period within which the Commissioner must make a decision on an application by an entity for registration is 90 days from the later of the following:

(a) the day the Commissioner receives the application;

(b) if an audit finding referred to in subparagraph 109(2)(d)(i) of the Act is required in relation to one or more provider registration categories specified in the application—the day the Commissioner gives a copy of the final audit report to the entity under section 110-38 of this instrument.

Note: For provider registration categories prescribed for the purposes of paragraph 109(2)(d) of the Act, see section 109-5 of this instrument. For circumstances prescribed for the purposes of subparagraph 109(2)(d)(ii) of the Act, see section 109-10 of this instrument.

107-5 Application for renewal of registration—application fee

For the purposes of paragraph 107(2)(b) of the Act, the application fee for an application by a registered provider to renew the provider's registration is the sum of:

(a) $295.00; and

(b) the sum of the amounts specified in column 2 of the following table for each provider registration category specified in the application as a provider registration category that the registered provider is applying to be registered in.

Note: Exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act.

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Amounts for provider registration categories

Item	Column 1 Provider registration category	Column 2 Amount ($)
1	Home and community services	770.00
2	Assistive technology and home modifications	770.00
3	Advisory and support services	770.00
4	Personal and care support in the home or community	4,040.00
5	Nursing and transition care	4,040.00
6	Residential care	5,380.00

108-5 Application for renewal of registration—period for making decision

For the purposes of subsection 108(2) of the Act, the period within which the Commissioner must make a decision on an application by a registered provider for renewal of registration is 90 days from the later of the following:

(a) the day the Commissioner receives the application for renewal;

(b) if an audit finding referred to in subparagraph 109(2)(d)(i) of the Act is required in relation to one or more provider registration categories specified in the application—the day the Commissioner gives a copy of the

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final audit report to the registered provider under section 110-38 of this instrument.

Note: For provider registration categories prescribed for the purposes of paragraph 109(2)(d) of the Act, see section 109-5 of this instrument. For circumstances prescribed for the purposes of subparagraph 109(2)(d)(ii) of the Act, see section 109-10 of this instrument.

Subdivision B—Provider registration category specific requirements

109-5 Provider registration categories for which audit findings or prescribed circumstances are required

For the purposes of paragraph 109(2)(d) of the Act, the following provider registration categories are prescribed:

(a) personal and care support in the home or community;

(b) nursing and transition care;

(c) residential care.

109-10 Circumstances in which audit findings are not required—health service standards assessments

(1) For the purposes of subparagraph 109(2)(d)(ii) of the Act, the prescribed circumstances for an application by an entity for registration or renewal of registration in the following provider registration categories are:

(a) for residential care, in relation to the delivery, or proposed delivery, by the entity of funded aged care services through that provider registration category as part of an integrated service arrangement—that the entity satisfies subsection (2);

(b) for personal and care support in the home and community, and nursing or transition care, in relation to the delivery, or proposed delivery, by the entity of funded aged care services through those provider registration categories as part of an integrated service arrangement—that the entity satisfies subsection (3).

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Prescribed circumstances—residential care

(2) An entity satisfies this subsection if:

(a) during the 3 years immediately preceding the date of the entity's application, a health service standards assessment was conducted; and

(b) the health service standards assessment assessed the entity's ability to comply with the Australian Health Service Safety and Quality Accreditation Scheme requirements for:

(i) the National Safety and Quality Health Service Standards; and

(ii) the Integrated Health and Aged Care Services Module (or a substantially equivalent module that was in force before the transition time);

that are equivalent to the Aged Care Quality Standards that apply to the provider registration category residential care, in relation to each

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residential care home in which the entity delivers, or proposes to deliver, funded aged care services as part of an integrated service arrangement; and

(c) the assessment:

(i) covers all the residential care homes in which the entity delivers, or proposes to deliver, funded aged care services as part of an integrated service arrangement; and

(ii) found that the entity is able to comply with those Standards and that Module for each residential care home.

Note: The effect of this subsection is that an audit is not required for residential care homes of an entity in an integrated service arrangement for which a health service standards assessment has been conducted and has found that the entity is able to comply with those Standards and that Module.

Prescribed circumstances—personal and care support in the home or community and nursing or transition care

(3) An entity satisfies this subsection if:

(a) during the 3 years immediately preceding the date of the application, a health service standards assessment was conducted; and

(b) the assessment assessed the entity's ability to comply with the Australian Health Service Safety and Quality Accreditation Scheme requirements for:

(i) the National Safety and Quality Health Service Standards; and

(ii) the Integrated Health and Aged Care Services Module (or a substantially equivalent module that was in force before the transition time);

that are equivalent to the Aged Care Quality Standards that apply to the provider registration category personal and care support in the home or community, or nursing and transition care (as applicable); and

(c) the assessment covers the provider registration categories personal and care support in the home and community, or nursing or transition care, through which the entity delivers, or proposes to deliver funded aged care services as part of an integrated service arrangement; and

(d) the assessment found that the entity is able to comply with those Standards and that Module for all of the funded aged care services delivered, or proposed to be delivered, through those provider registration categories.

Note: The effect of this subsection is that an audit is not required for funded aged care services provided through the registration categories personal and care support in the home or community, or nursing and transition care, as part of an integrated service arrangement, for which a health service standards assessment has been conducted and has found that entity is able to comply with those Standards and that Module.

Meaning of health service standards assessment

(4) A ***health service standards assessment*** means an assessment conducted:

(a) in accordance with Australian Health Service Safety and Quality Accreditation Scheme formulated and coordinated by the Australian Commission on Quality and Safety in Health Care; and

(b) by an accrediting agency approved by the Australian Commission on Quality and Safety in Health Care to assess health service organisations

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against the National Safety and Quality Health Service Standards and the Integrated Health and Aged Care Services Module (or a substantially equivalent module that was in force before the transition time).

109-15 Circumstances if audit finds nonconformance

For the purposes of subparagraph 109(2)(d)(ii) of the Act, circumstances for an application by an entity for registration or renewal of registration are that:

(a) an audit referred to in subparagraph 109(2)(d)(i) of the Act has found that the entity has not conformed with one or more of the Aged Care Quality Standards that apply to a provider registration category specified in the application; and

(b) the nonconformance:

(i) has been addressed; or

(ii) can be addressed through an update to a continuous improvement plan that outlines how the nonconformance will be addressed within a specified period; or

(iii) can be addressed by the imposition of a condition under section 143 of the Act.

109-25 Other requirements for registration, renewal or variation of registration—delivery of funded aged care services in certain circumstances

(1) For the purposes of paragraph 109(2)(e) of the Act, this section prescribes other requirements for an application by an entity for registration, renewal of registration or variation of registration in a provider registration category other than residential care.

Delivery to certain individuals through the service group home support

(2) If the entity delivers, or intends to deliver, funded aged care services to an individual:

(a) who has an access approval in effect for the classification type ongoing for the service group home support; or

(b) who has the classification level SAH end-of-life pathway in effect for the classification type short-term for the service group home support;

another requirement is that the entity:

(c) also delivers, or intends to deliver, the service type care management to the individual; and

(d) has applied for, and satisfies the requirements for, registration in the provider registration category personal and care support in the home or community.

Delivery of services in service type restorative care management

(3) If the entity delivers, or intends to deliver, funded aged care services in the service type restorative care management, another requirement is that the entity

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delivers, or intends to deliver, funded aged care services in the service type allied health and therapy.

Section does not apply to specialist aged care programs

(4) This section does not apply if the entity delivers, or intends to deliver, funded aged services only under a specialist aged care program.

Section does not apply in respect of provider registration category subscription trial

(5) This section does not apply to an application to the extent that the application is for renewal of registration or variation of registration in the provider registration category subscription trial.

109-30 Other requirements for renewal or variation of registration—provider registration category subscription trial

(1) For the purposes of paragraph 109(2)(e) of the Act, this section prescribes other requirements for an application by a registered provider under subsection 107(1) (renewal of registration) or 124(1) (variation of registration) of the Act that specifies the provider registration category subscription trial.

(2) The following paragraphs must apply to the registered provider:

(a) the System Governor has invited the provider to be the recipient of a grant of financial assistance that would support the provider in delivering funded aged care services under the provider registration category subscription trial, and has not withdrawn the invitation;

(b) the registered provider's registration covers each non-subscription service that corresponds to a subscription service that the registered provider delivers, or proposes to deliver.

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109-35 Exemption from requirements for renewal or variation of registration—provider registration category subscription trial

For the purposes of subsection 109(4) of the Act, paragraphs 109(2)(a), (b) and (c) of the Act do not apply to an entity to the extent that the entity is applying for renewal of registration or variation of registration in the provider registration category subscription trial.

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Division 2—Audit requirements

Subdivision A—Purpose of this Division

110-5 Purpose of this Division

For the purposes of subsection 110(1) of the Act, this Division prescribes requirements relating to conducting an audit of an entity's ability to conform with the Aged Care Quality Standards for a provider registration category.

Subdivision B—How audits must be conducted—general

110-13 Audit must be conducted

(1) An audit of an entity's ability to conform with the Aged Care Quality Standards for a provider registration category must be conducted by the Commissioner.

(2) The Commissioner must gather evidence relevant to the scope of the audit being conducted and may be assisted by persons with the technical knowledge or skill required to collect and interpret information relevant to the scope of the audit.

(3) Before the audit is undertaken, the Commissioner must give a notice to the entity that includes the following information:

(a) a general description of the audit process;

(b) that an audit is proposed to be conducted in accordance with the audit process;

(c) the purpose of the audit, and the decision or decisions it will inform;

(d) the scope of the audit, including the applicable Aged Care Quality Standards;

(e) the period during which the audit is proposed to occur;

(f) the applicable fees for the proposed audit;

(g) advice on how individuals (if any) should be notified about opportunities to contribute to the audit;

(h) a copy of the audit methodology;

(i) any other information the Commissioner considers relevant.

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Subdivision C—How audits must be conducted—assessments of approved residential care homes

110-26 Assessments—approved residential care homes

(1) This section applies if an audit of a registered provider's ability to conform with the Aged Care Quality Standards relates to an application for renewal of the registered provider's registration in the provider registration category residential care.

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Assessments of approved residential care homes

(2) The Commissioner must, for each of the approved residential care homes included in the registered provider's registration, either:
  (a) conduct a home assessment of the residential care home; or
  (b) if the residential care home is covered by an integrated service arrangement—be satisfied that a health standards assessment has found it complies with the National Safety and Quality Health Service Standards and the Integrated Health and Aged Care Services Module (or a substantially equivalent module that was in force before the transition time).

Scope of home assessment

(3) A home assessment of an approved residential care home must assess whether the registered provider delivering funded aged care services in the approved residential care home conforms with the applicable Aged Care Quality Standards.

(4) A home assessment of an approved residential care home must, to the extent possible, consider the following matters as part of the home assessment:
  (a) the experience of individuals to whom funded aged care services are delivered in the approved residential care home;
  (b) documents and records relevant to the home assessment;
  (c) feedback from the following:
    (i) aged care workers of the registered provider;
    (ii) responsible persons of the registered provider;
    (iii) the governing body of the registered provider;
    (iv) third parties with relevant knowledge or experience;
  (d) observations at the approved residential care home;
  (e) care outcomes relating to the approved residential care home.

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Attendance at approved residential care homes

(5) A home assessment of an approved residential care home must include the following:
  (a) attendance by the Commissioner at the approved residential care home;
  (b) such other means of assessment as are appropriate.

Notice of home assessment

(6) Before a home assessment of an approved residential care home included in the registration of a registered provider is conducted, the Commissioner must give written notice to the registered provider:
  (a) specifying each approved residential care home included in the registered provider's registration, and stating that a home assessment of each approved residential care home is to be conducted; and
  (b) requiring the registered provider to notify each individual to whom funded aged care services are delivered in each approved residential care home:

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(i) that the home assessment is going to be conducted; and

(ii) that the person or persons conducting the home assessment will attend the approved residential care home as part of the home assessment, and the day or days on which this will occur; and

(iii) that the person or persons attending the approved residential care home will seek the individual's consent before engaging with the individual, or entering a part of the approved residential care home that comprises the individual's personal space (for example, the individual's room).

Rule if consent not obtained from individuals

(7) If an individual to whom funded aged care services are delivered at an approved residential care home does not give consent as mentioned in subparagraph (6)(b)(iii), the persons conducting the home assessment will not enter any part of the approved residential care home that comprises the individual's personal space.

Note: This means that if none of the individuals accessing funded aged care services in the approved residential care homes included in a registered provider's registration give consent, the person or persons conducting the home assessments will not enter any parts of the approved residential care homes that comprises the personal space of an individual.

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110-28 Preliminary assessment report of home assessment

(1) If a home assessment of an approved residential care home included in the registration of a registered provider is conducted, the Commissioner must prepare a preliminary assessment report setting out the findings of the home assessment.

(2) The preliminary assessment report must assign a grade for conformance with the Aged Care Quality Standards for the registered provider's delivery of funded aged care services in the approved residential care home as outlined in the audit methodology mentioned in paragraph 110-13(3)(h).

(3) The Commissioner must:

(a) give a copy of the preliminary assessment report to the registered provider within 14 days from the attendance at the approved residential care home for the home assessment; and

(b) give the registered provider the opportunity to respond in writing to the report within 14 days from the day the Commissioner gave the preliminary assessment report to the registered provider.

110-30 Final assessment report of home assessment

(1) If a home assessment of an approved residential care home included in the registration of a registered provider is conducted, the Commissioner must prepare a final assessment report setting out the findings of the home assessment.

(2) The final assessment report must assign a grade for conformance with the Aged Care Quality Standards for the registered provider's delivery of funded aged care

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services in the approved residential care home as outlined in the audit methodology mentioned in paragraph 110-13(3)(h).

(3) In preparing the final assessment report, the Commissioner must consider any response received from the registered provider as mentioned in paragraph 110-28(3)(b).

(4) The Commissioner must give a copy of the final assessment report to the registered provider within 28 days from:

(a) if the registered provider responded in writing to the preliminary report within the period mentioned in paragraph 110-28(3)(b)—the day the Commissioner received the response; or

(b) if the registered provider did not respond in writing to the preliminary report within the period mentioned in paragraph 110-28(3)(b)—the last day of that period.

(5) The registered provider must, within 14 days from receiving the final assessment report, notify the following of the findings of the home assessment (including the grade):

(a) responsible persons and aged care workers of the registered provider who deliver funded aged care services in the approved residential care home;

(b) individuals to whom funded aged care services are delivered in the approved residential care home.

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Subdivision D—How audits must be conducted—attendance at a service delivery location for home or community setting

110-32 Attendance at a service delivery location—home or community setting

(1) This section applies if:

(a) an audit of a registered provider's ability to conform with the Aged Care Quality Standards relates to an application for renewal of the registered provider's registration; and

(b) the scope of the audit includes funded aged care services delivered by the registered provider in a home or community setting.

Notice of attendance at a service delivery location

(2) If the scope of the audit includes attendance at a service delivery location, the Commissioner must give written notice to the registered provider:

(a) stating that attendance at the service delivery location is to be conducted; and

(b) stating whether or not one or more persons propose to attend individuals' residences or the premises of a community setting in conducting the attendance at the service delivery location; and

(c) if the Commissioner proposes to attend the residence of one of more individuals—requiring the registered provider to notify the individuals:

(i) that attendance at the service delivery location is going to be conducted; and

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(ii) that the Commissioner will attend individuals' residences as part of the attendance, and the day or days on which this will occur; and

(iii) that if the Commissioner proposes to attend the residence of a particular individual, the Commissioner will seek consent to enter the residence from the individual and any other person at their residence; and

(d) if the Commissioner proposes to attend the premises of a community setting—stating that the Commissioner will seek consent from the owner or occupier to enter the premises.

(3) If:

(a) an individual to whom funded aged care services are delivered at their residence does not give consent as mentioned in subparagraph (2)(c)(iii), attendance at the service delivery location must not include their residence; and

(b) if no such individuals give consent, attendance at the service delivery location must not be included in the scope of the audit.

(4) If it is not reasonably practicable to obtain consent from the owner or occupier of the premises where funded aged care services are delivered in a community setting, attendance at the service delivery location must not include those premises.

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Subdivision E—How audits must be conducted—final audit report

110-38 Final audit reports

(1) If an audit of an entity's ability to conform with the Aged Care Quality Standards is conducted, the Commissioner must prepare a final audit report.

(2) The final audit report must include the following:

(a) the period to which the audit relates;

(b) the scope of the audit;

(c) the audit outcomes;

(d) an assessment of the entity's conformance, or ability to conform, with the Aged Care Quality Standards;

(e) if the final audit report identifies nonconformance with the Aged Care Quality Standards—whether the entity has the ability to conform and the things the entity must do, or has done, to conform;

(f) the outcomes of the following (if any):

(i) each home assessment of an approved residential care home conducted in accordance with section 110-26 for the purposes of the audit;

(ii) each attendance at a service delivery location of residences or other premises conducted in accordance with section 110-32 for the purposes of the audit.

(3) The Commissioner must:

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(a) give a copy of the final audit report to the entity within 28 days of the completion of the audit; and

(b) give the entity the opportunity to respond in writing to the final audit report within 14 days from the day the final audit report was given to the entity, or such longer period as the Commissioner agrees with the entity.

(4) An entity that is a registered provider must, within 28 days from receiving the final audit report, notify the following of the outcomes of the audit:

(a) responsible persons and aged care workers of the registered provider;

(b) if the audit relates to an approved residential care home—any individuals to whom funded aged care services are delivered in the approved residential care home.

Subdivision F—Type and scope of audits and other matters

110-40 Type and scope of audits for provider registration categories

Provider registration categories

(1) This section prescribes the types and scope of audits that can be conducted for the following provider registration categories:

(a) personal and care support in the home or community;

(b) nursing and transition care;

(c) residential care.

Types of audit

(2) The types of audit that may be conducted in respect of the provider registration categories referred to in subsection (1) are as follows:

(a) registration of an entity;

(b) renewal of an entity's registration;

(c) variation of an entity's registration.

Scope of audit

(3) The scope of an audit is to include (as applicable):

(a) whether the audit relates to registration of an entity, or the renewal or variation of an entity's registration; and

(b) the applicable Aged Care Quality Standards in respect of:

(i) the provider registration category or categories for which the audit is being conducted; and

(ii) service types to which the audit relates; and

(c) whether or not the audit will include any home assessments or attendance at any service delivery locations.

Note 1: For the provider registration category residential care, a home assessment of all approved residential care homes must be conducted for renewal of registration (see subsection 110-26(2)), except in certain circumstances specified in subsection 109-10(2), where there has been a health service standards assessment in the previous 3 years.

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Note 2: For the provider registration categories personal and care support in the home or community, and nursing and transition care, attendance at a service delivery location on renewal of registration may be conducted (see subsection 110-32(2)).

(4) The Commissioner must consider the following when determining the scope of the audit:

(a) matters or risks that are identified as requiring specific examination;

(b) in the case of renewal or variation of an entity's registration:

(i) the time that has elapsed since the most recent audit of the entity was conducted; and

(ii) the scope of any previous audits of the entity; and

(iii) the outcomes of previous audits of the entity; and

(iv) the history of compliance with the Act of the entity;

(c) any guidelines relating to audit matters made for the purposes of subsection 348(2) of the Act.

Note: In considering the scope of an audit, the Commissioner may consider an audit undertaken by another person or body, which the Commissioner recognises as equivalent to meeting the Quality Standards, despite the audit not having been undertaken by the Commissioner.

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Subdivision G—Fees payable for an audit

110-45 Audit fee—audit in connection with registration

(1) This section applies to an audit, for one or more of the following provider registration categories, in connection with an entity applying to be registered as a registered provider under subsection 104(1) of the Act in the provider registration category or categories:

(a) personal and care support in the home or community;

(b) nursing and transition care;

(c) residential care.

(2) The fee payable by the entity for an audit for one or more of the provider registration categories is:

(a) unless subsection (3) applies to the entity—$14,870.00; or

(b) if subsection (3) applies to the entity—$0.

(3) This subsection applies to an entity if, at the time of the application:

(a) the entity intends to deliver funded aged care services under the MPSP or the TCP; or

(b) the entity intends that 85% of the individuals that the entity is to deliver services to will be located in an area with a 2023 MM category known as MM 6 or MM7; or

(c) the entity is known as an Aboriginal Community Controlled Organisation.

110-47 Audit fee—audit in connection with registration renewal

(1) This section applies to an audit, for one or more of the following provider registration categories, in connection with the renewal of the registration of a

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registered provider under subsection 107(1) of the Act in the provider registration category or categories:

(a) personal and care support in the home or community;

(b) nursing and transition care;

(c) residential care.

(2) The fee payable by the registered provider for an audit for one or more of the provider registration categories is the sum of:

(a) in any case:

(i) unless subsection (3) applies to the registered provider—$7,890.00; or

(ii) if subsection (3) applies to the registered provider—$0; and

(b) for either or both of the provider registration categories personal and care support in the home or community and nursing and transition care:

(i) unless subsection (3) applies to the registered provider—the amount that applies to the registered provider under subsection (5); or

(ii) if subsection (3) applies to the registered provider—$0; and

(c) for the provider registration category residential care:

(i) unless subsection (4) applies to the registered provider—the sum of the amounts applicable under subsection (6) or (7) (as the case may be) for each of the approved residential care homes included in the registered provider's registration at the time of the application and for which home assessments must be conducted under subsection 110-26(2); or

(ii) if subsection (4) applies to the registered provider—$0.

Circumstances in which a nil fee component is applicable

(3) For the purposes of paragraphs (2)(a) and (b), this subsection applies to a registered provider if, on the day the Commissioner invites the provider under section 106 of the Act to renew the registration:

(a) the entity is a registered provider delivering funded aged care services only under the MPSP or the TCP; or

(b) the entity intends that all of the individuals that the entity is to deliver services to will be located in an area with a 2023 MM category known as MM 5, MM6 or MM7; or

(c) the Commissioner considers, based on the information held by the Commissioner as at that day, that the provider is in the smallest 10% of all registered providers based on the number of individuals to whom funded aged care services are delivered by the provider.

(4) For the purposes of paragraph (2)(c), this subsection applies to a registered provider if, on the day the Commissioner invites the provider under section 106 of the Act to renew the registration:

(a) the registered provider is delivering funded aged care services only under the MPSP or the TCP; or

(b) both of the following apply:

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(i) an approved residential care home included in the provider's registration is located in an area in the 2023 MM category known as MM 4, MM 5, MM 6 or MM 7;

(ii) the average number of occupied beds per day over the quarter immediately preceding the day the invitation was given was fewer than 25; or

(c) both of the following apply:

(i) an approved residential care home included in the provider's registration has specialised Aboriginal or Torres Strait Islander status or has specialised homeless status;

(ii) the average number of occupied beds per day over the quarter immediately preceding the day the invitation was given was fewer than 25.

Personal and care support in the home or community and nursing and transition care

(5) For the purposes of paragraph (2)(b), the amount that applies to the registered provider is:

(a) if, on the day the Commissioner invites the provider under section 106 of the Act to renew the registration, the registered provider delivers funded aged care services only to fewer than 30 individuals in a single State or Territory—$9,800.00; or

(b) if, on that day, the registered provider delivers funded aged care services only to between 30 and 342 individuals in a single State or Territory—$15,550.00; or

(c) if, on that day, the registered provider delivers funded aged care services to:

(i) 343 or more individuals in a single State or Territory; or

(ii) any number of individuals in more than one State or Territory;

$17,950.00.

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Residential care—standard amounts

(6) For an approved residential care home to which subsection (8) does not apply, the amount is:

(a) for an approved residential care home with not more than 150 beds—$16,340.00; or

(b) for an approved residential care home with more than 150 beds but not more than 250 beds—$17,510.00; or

(c) for an approved residential care home with more than 250 beds—$18,670.00.

Residential care—reduced amounts

(7) For an approved residential care home to which subsection (8) applies, the amount is:

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(a) for an approved residential care home with not more than 150 beds—$8,170.00; or

(b) for an approved residential care home with more than 150 beds but not more than 250 beds—$8,760.00; or

(c) for an approved residential care home with more than 250 beds—$9,340.00.

(8) This subsection applies to an approved residential care home included in a registered provider's registration if:

(a) on the day the Commissioner invites the provider under section 106 of the Act to renew the registration, funded aged care services are delivered in the approved residential care home:

(i) in any case—to fewer than 25 individuals; or

(ii) if the approved residential care home is located in an area in the 2023 MM category known as MM category 4—to at least 25, and fewer than 30, individuals; or

(iii) if the approved residential care home is located in an area in the 2023 MM category known as MM category 5—to at least 25, and fewer than 39, individuals; or

(iv) if the approved residential care home is located in an area in the 2023 MM category known as MM category 6 or 7—to at least 25 individuals; or

(b) on the day the Commissioner invites the provider under section 106 of the Act to renew the registration:

(i) the approved residential care home has specialised Aboriginal and Torres Strait Islander status or specialised homeless status; and

(ii) funded aged care services are delivered in the approved residential care home to at least 25 individuals.

(9) For the purposes of paragraph (8)(b), the number of individuals is to be worked out by reference to the average number of occupied beds per day over the quarter immediately preceding the day the invitation was given.

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110-49 Audit fee—audit in connection with variation of registration

(1) This section applies to an audit, for one or more of the following provider registration categories, in connection with a registered provider applying to vary the provider's registration to register the provider in the provider registration category or categories:

(a) personal and care support in the home or community;

(b) nursing and transition care;

(c) residential care.

(2) The fee payable by the registered provider for an audit for one or more of the provider registration categories is:

(a) unless subsection (3) applies to the registered provider—$18,530.00; or

(b) if subsection (3) applies to the registered provider—$0.

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(3) This subsection applies to an entity if, at the time of the application:
  (a) the entity intends to deliver funded aged care services under the MPSP or the TCP; or
  (b) the entity intends that 85% of the individuals that the entity is to deliver services to will be located in an area with a 2023 MM category known as MM 6 or MM7; or
  (c) the entity is known as an Aboriginal Community Controlled Organisation.

110-51 Audit fee—refunds

(1) This section prescribes circumstances in which any of the following may be refunded to an entity:
  (a) an audit fee prescribed in section 110-45 of this instrument in connection with an application under section 104 of the Act;
  (b) an audit fee prescribed in section 110-47 of this instrument in connection with an application under section 107 of the Act;
  (c) an audit fee prescribed in section 110-49 of this instrument in connection with an application under section 124 of the Act.

(2) The circumstances are that:
  (a) the entity makes the application; and
  (b) the entity pays, in connection with the application (whether before or after making the application), the audit fee; and
  (c) an audit of the entity is not conducted under section 110 of the Act.

Subdivision H—Audit timeframes

110-53 Audit timeframes for provider registration categories

(1) Subsections (2) and (3) of this section prescribe the timeframes within which an audit must be conducted for the following provider registration categories:
  (a) personal and care support in the home or community;
  (b) nursing and transition care;
  (c) residential care.

(2) An audit in relation to an initial application for registration must be conducted during the period beginning on the date of the application and ending when the Commissioner makes a decision on the application.

(3) An audit in relation to a renewal of registration must be conducted during the period beginning on the date of the invitation to renew under subsection 106(1) of the Act and ending when the Commissioner makes a decision on the application.

(4) The Commissioner must not make a decision to register an entity, or renew a registration, until the final audit report is completed.

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Division 3—Applications for approval of residential care homes

111-5 Application fee

For the purposes of paragraph 111(2)(b) of the Act, the application fee for an application by an entity for approval of a residential care home in relation to the entity is $3,800.00 for each residential care home specified in the application.

Note: Exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act.

111-10 Information for residential care homes

For the purposes of subparagraph 111(3)(b)(ii) of the Act, the other information for each residential care home specified in an application is as follows:

(a) the name of the residential care home;
(b) the street address of the residential care home;
(c) the name of the responsible person in charge of the residential care home;
(d) a copy of the certificate of occupancy or equivalent certificate (however described) for the residential care home, or any other document that specifies or relates to the number of beds in the residential care home or the total number of individuals that may occupy or reside in the residential care home;
(e) documentary evidence demonstrating that the building or buildings that comprise the residential care home are permanent and will not present a risk to the delivery of quality and safe residential care, including but not limited to:
  (i) floor plans and bed layout; and
  (ii) fixtures, furnishings and design; and
  (iii) an explanation of the design of the residential care home.

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112-5 Period for making decision

For the purposes of subsection 112(2) of the Act, the period within which the Commissioner must make a decision on an application for approval of a residential care home in relation to an entity is:

(a) if the entity has made an application for registration under subsection 104(1) of the Act—the period that applies to that application under section 105-5 of this instrument; or
(b) if the entity is a registered provider—90 days from the day the Commissioner receives the application for approval of the residential care home.

113-5 Approval of residential care homes

For the purposes of subparagraph 113(b)(ii) of the Act, other requirements of which the Commissioner must be satisfied before approving a residential care home in relation to an entity are as follows:

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(a) either:
  (i) the entity owns the premises at which the residential care home is located; or
  (ii) if the entity does not own the premises at which the residential care home is located—the owner of the premises agrees to the entity using the premises as a residential care home;
(b) the building or buildings that comprise the residential care home are permanent; and
(c) the building or buildings that comprise the residential care home and its total number of beds will not present a risk to the delivery of quality and safe residential care.

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Division 4—Notice of decisions and other provisions

114-5 Other matters for notices of decisions to register or renew

For the purposes of paragraph 114(3)(f) of the Act, other matters that must be included in a notice of a decision given to an entity are the details of each residential care home (if any) that is approved in relation to the entity.

117-5 Deemed registration—classes of entity

For the purposes of subsection 117(1) of the Act, the following classes of entity are prescribed:

(a) hospitals (whether operated by government entities or non-government entities);

(b) entities that are not registered providers, but that:

(i) deliver services similar to funded aged care services that are delivered in an approved residential care home; or

(ii) deliver services similar to funded aged care services that are delivered in a home or community setting or in a similar sector;

(c) registered providers that are not registered in all of the provider registration categories.

117-10 Deemed registration—other matters for determinations of deemed registration

For the purposes of paragraph 117(2)(h) of the Act, other matters that must be specified in a determination that an entity is taken to be a registered provider are as follows:

(a) the ABN of the entity;

(b) each responsible person of the entity;

(c) the business location of the entity.

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Part 3—Variations, suspensions and revocations of registration

Division 1—Variations, suspensions and revocations

124-5 Application fee—variation to add provider registration categories

For the purposes of paragraph 124(2)(b) of the Act, the application fee for an application by a registered provider to vary the provider's registration to register the provider in a new provider registration category is the sum of the amounts specified in column 2 of the following table for each new provider registration category that the provider is applying to be registered in.

Note: Exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act.

Item	Column 1 Provider registration category	Column 2 Amount ($)
1	Home and community services	1,270.00
2	Assistive technology and home modifications	1,270.00
3	Advisory and support services	1,270.00
4	Personal and care support in the home or community	3,800.00
5	Nursing and transition care	3,800.00
6	Residential care	5,070.00

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124-10 Application fee—variation to remove provider registration categories

(1) For the purposes of paragraph 124(2)(b) of the Act, this section prescribes the application fee for an application by a registered provider to vary the provider's registration by removing the provider from being registered in a provider registration category.

(2) For an application to remove the provider from being registered in one or more of the following provider registration categories, the application fee is $545.00:

(a) home and community services;

(b) assistive technology and home modifications;

(c) advisory and support services.

(d) any of the following provider registration categories under which the registered provider is not delivering funded aged care services at the time of the application:

(i) personal and care support in the home or community;

(ii) nursing and transition care;

(iii) residential care.

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(3) For an application to remove the provider from being registered in one or more of the following provider registration categories under which the registered provider is delivering funded aged care services at the time of the application, the application fee is $4800.00 for each such category:

(a) personal and care support in the home or community;

(b) nursing and transition care;

(c) residential care.

Note: Exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act

133-5 Classes of persons who must not be appointed as eligible advisers

For the purposes of paragraph 133(4)(a) of the Act, classes of persons who must not be appointed by a registered provider as an eligible adviser are as follows:

(a) persons who are not independent of the registered provider;

(b) persons who are unsuitable having regard to the matters specified in subsection 13(1) of the Act;

(c) persons who have, or may be perceived to have, a conflict of interest between their duties as an eligible adviser and any other interests or duties.

133-10 Matters to be taken into account in specifying period within which eligible adviser must be appointed

(1) For the purposes of paragraph 133(4)(b) of the Act, this section prescribes matters that the Commissioner must take into account in specifying a period in a notice given under subsection 133(2) of the Act for the purposes of paragraph 133(3)(a) of the Act (requiring a registered provider to appoint an eligible adviser).

(2) The matters are as follows:

(a) the location where funded aged care services are delivered by the registered provider;

(b) the nature of any contravention, or proposed contravention, of the Act by the registered provider that the Commissioner is satisfied has occurred, is occurring or may occur;

(c) whether, as a result of any such contravention or proposed contravention of the Act by the registered provider, there is an immediate and severe risk to the safety, health and well-being of individuals to whom the registered provider is delivering funded aged care services;

(d) the availability of persons who have appropriate qualifications, skills or experience to assist the registered provider to comply with the conditions and obligations that apply to the registered provider under Part 4 of Chapter 3 of the Act in relation to the matters specified in subparagraphs 133(3)(a)(i) and (ii) of the Act (which relate to funded aged care services and governance and business operations);

(e) any other relevant matters.

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Division 2—Variations, suspensions and revocations of approvals of residential care homes

136-5 Variation of approval on Commissioner's own initiative—bed availability

For the purposes of paragraph 136(2)(a) of the Act, the period for which the Commissioner must be satisfied that the number of beds available in a residential care home is likely to be reduced is a period of at least 2 years.

137-10 Variation of approval on application by registered provider—bed availability

For the purposes of paragraph 137(3)(a) of the Act, the period for which the Commissioner must be satisfied that the number of beds available in a residential care home is likely to be reduced is a period of at least 2 years.

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Division 3—Provider Register

141-10 Other matters that must be included in the Provider Register—registered providers

For the purposes of paragraph 141(3)(p) of the Act, other matters that the Provider Register must include in relation to the registration of a registered provider are as follows:

(a) the name of each parent or holding company forming part of the registered provider's business structure;

(b) the ACN of the registered provider's business entity (if relevant);

(c) whether the registered provider is known as an Aboriginal Community Controlled Organisation or Aboriginal Community Controlled Health Organisation;

(d) the name of each associated provider that delivers funded aged care services on behalf of the registered provider in any of the following provider registration categories:

(i) personal and care support in the home or community;

(ii) nursing and transition care;

(iii) residential care;

(e) if the registered provider's registration has been suspended:

(i) the date of suspension; and

(ii) the period of suspension, including the expiry date (if known); and

(iii) whether the suspension was at the request of the Commissioner or at the request of the registered provider; and

(iv) any specified condition to which the suspension relates;

(f) if the registered provider delivers funded aged care services in one or more approved residential care homes:

(i) the name of the responsible person of the registered provider who is in charge of each approved residential care home; and

(ii) the total number of beds at each approved residential care home, updated in accordance with any variations to the registered provider's registration and any notification under subsection 167(1) of the Act;

(g) if a compliance notice has been given to the registered provider under section 481 or 482 of the Act:

(i) the date of the notice; and

(ii) whether the notice was given by the Commissioner or the System Governor; and

(iii) the details of the non-compliance or possible non-compliance with the Act; and

(iv) whether the notice was given under subparagraph 481(a)(i) or 482(a)(i) of the Act (non-compliance), or subparagraph 481(a)(ii) or 482(a)(ii) of the Act (possible non-compliance); and

(v) the action the provider must take or refrain from taking in response to the notice; and

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(vi) whether the notice was varied or revoked;

(h) if a banning order against the registered provider is in force under section 497 of the Act:

(i) the date of the banning order; and

(ii) a linking electronic reference to the detail of the banning order in the banning orders register.

141-15 Other matters that may be included in the Provider Register—former registered providers

For the purposes of paragraph 141(4)(e) of the Act, other matters that the Provider Register may include in relation to an entity that was a registered provider are as follows:

(a) if the entity's registration lapsed—the date the registration lapsed;

(b) if the entity's registration was revoked:

(i) whether the registration was revoked at the request of the provider, or on the Commissioner's initiative; and

(ii) the date of the revocation.

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141-20 Other matters that must be included in the Provider Register—responsible persons and aged care workers against whom banning orders are in force

For the purposes of paragraph 141(5)(d) of the Act, other matters that must be included in the Provider Register in relation to a responsible person, or an aged care worker, of a registered provider against whom a banning order is in force under section 498 are as follows:

(a) the date of the banning order;

(b) a linking electronic reference to the detail of the banning order in the banning orders register.

141-22 Other matters that may be included in the Provider Register—responsible persons and aged care workers against whom banning orders were in force

For the purposes of paragraph 141(6)(d) of the Act, other matters that may be included in the Provider Register in relation to a responsible person, or an aged care worker, of a registered provider against whom a banning order was in force under section 498 are as follows:

(a) the date of the banning order;

(b) a linking electronic reference to the detail of the banning order in the banning orders register.

141-25 Corrections of the Provider Register

(1) For the purposes of paragraph 141(8)(a) of the Act:

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(a) a person may request orally or in writing that the Commissioner make a correction to information relating to that person that is included in the Provider Register; and

(b) if the Commissioner considers information included in the Provider Register is inaccurate, incomplete, out-of-date, irrelevant or misleading, the Commissioner must correct the information (whether or not a person has made a request under paragraph (a) of this subsection).

(2) Despite subsection (1), the Commissioner must not make a correction to the Provider Register under this section if there is another process under the Act through which information included on the Provider Register can be updated or changed.

Note: For example, a change that can be made through a variation or change in circumstances notification is not a correction of the Provider Register.

141-30 Publication of the Provider Register

(1) For the purposes of paragraph 141(8)(b) of the Act, this section makes provision for and in relation to the publication of the Provider Register.

(2) In deciding whether to publish the Provider Register in whole or in part, or to publish specified information entered on the Provider Register on the Commission's website the Commissioner must have regard to:

(a) whether the Commissioner considers that publication would be contrary to the public interest; and

(b) whether the Commissioner considers that publication would be contrary to the interests of an individual accessing funded aged care services.

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Chapter 4—Conditions on provider registration

Part 1—Introduction

142-1 Simplified outline of this Chapter

This Chapter provides for matters relating to conditions on provider registration under Part 4 of Chapter 3 of the Act.

Part 3 of this Chapter relates to conditions relating to Rights, Principles and the Aged Care Code of Conduct.

Part 4 of this Chapter relates to the delivery of funded aged care services, and deals with conditions relating to:

(a) the Aged Care Quality Standards; and
(b) continuous improvement; and
(c) the delivery of funded aged care services; and
(d) requirements for starting and ceasing the provision of funded aged care services and continuity of those services.

Part 5 of this Chapter relates to conditions relating to financial matters.

Part 6 of this Chapter relates to aged care workers, and deals with conditions relating to:

(a) workforce and aged care worker requirements; and
(b) vaccinations.

Part 7 of this Chapter relates to information and access, and deals with conditions relating to:

(a) personal information and recordkeeping; and
(b) provision of information to individuals; and
(c) access by supporters.

Part 8 of this Chapter relates to governance, and deals with conditions relating to membership of governing bodies and advisory body requirements.

Part 9 of this Chapter relates to restrictive practices in approved residential care homes, and deals with conditions relating to:

(a) requirements relating to the use of restrictive practices; and
(b) requirements relating to behaviour support; and
(c) immunity from civil or criminal liability in relation to the use of restrictive practices in certain circumstances.

Part 10 of this Chapter relates to the management of incidents and complaints, and deals with conditions relating to:

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(a) implementing an incident management system and managing and preventing incidents; and
(b) implementing a complaints and feedback management system and managing complaints and feedback; and
(c) implementing a whistleblower system and maintaining a whistleblower policy.

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Part 3—Rights and principles

144-1 Kinds of providers to which the conditions apply

For the purposes of subsections 144(1) and (2) of the Act, every kind of registered provider is prescribed.

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Part 4—Delivery of funded aged care services

Division 1—Aged Care Quality Standards

146-5 Kinds of providers that must comply with Aged Care Quality Standards

For the purposes of section 146 of the Act:

(a) a registered provider registered in any of the following provider registration categories is prescribed:

(i) personal and care support in the home or community;

(ii) nursing and transition care;

(iii) residential care; and

(b) a registered provider registered in the provider registration category subscription trial is prescribed if the provider is also registered in a provider registration category referred to in subparagraph (a)(i) or (ii) of this section.

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Division 2—Continuous improvement

147-5 Kinds of providers that must demonstrate capability and commitment

For the purposes of subsection 147(1) of the Act, every kind of registered provider is prescribed.

147-10 Kinds of providers that must have a continuous improvement plan

For the purposes of subsection 147(2) of the Act:

(a) a registered provider registered in any of the following provider registration categories is prescribed:

(i) personal and care support in the home or community;

(ii) nursing and transition care;

(iii) residential care; and

(b) a registered provider registered in the provider registration category subscription trial is prescribed if the provider is also registered in a provider registration category referred to in subparagraph (a)(i) or (ii) of this section.

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Division 3—Delivery of funded aged care services

Subdivision A—Kinds of provider to which the condition applies

148-5 Kinds of providers to which the condition applies

For the purposes of section 148 of the Act, every kind of registered provider is prescribed.

Subdivision B—Requirements for delivering funded aged care services

148-10 Purpose of this Subdivision

For the purposes of paragraph 148(a) of the Act, this Subdivision prescribes requirements for delivery of funded aged care services.

148-15 All registered providers—preventing damage to an individual's property

A registered provider must take reasonable steps to prevent damage being caused to an individual's property by the provider, or an aged care worker of the provider, in delivering funded aged care services to the individual.

148-20 Providers delivering services under certain provider registration categories—requirements for meals, snacks and drinks

(1) This section applies to a registered provider that:

(a) is registered in any of the following provider registration categories:

(i) home and community services;

(ii) personal and care support in the home and community; and

(b) delivers any of the following funded aged care services to an individual on a day through the service group home support under one of the registration categories mentioned in paragraph (a):

(i) the service meal delivery;

(ii) the service community and centre-based respite;

(iii) a service in the service type community cottage respite.

(1A) This section also applies to a registered provider that:

(a) is registered in the provider registration category subscription trial; and

(b) is also registered in a provider registration category referred to in paragraph (1)(a); and

(c) delivers any of the following funded aged care services to an individual on a day through the service group home support under that provider registration category:

(i) the service subscription access to meal delivery;

(ii) the service subscription access to community and centre-based respite.

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(2) The provider must ensure any meals, snacks and drinks delivered to an individual through a funded aged care service referred to in paragraph (1)(b) or (1A)(c) are nutritious and appetising, having regard to the individual's needs and preferences.

Note: Providers have other statutory obligations in relation to food safety under the Australia New Zealand Food Standards Code.

(3) The provider must, at least annually, have a dietitian assess the meals, snacks and drinks delivered by the provider through a funded aged care service referred to in paragraph (1)(b) or (1A)(c) to ensure that any meals, snacks and drinks:

(a) are appetising; and

(b) are appropriate for the nutrition needs of individuals accessing funded aged care services, including individuals with specialised dietary needs; and

(c) reflect evidence-based guidelines and practice.

Note Examples of specialised dietary needs include medical needs, or religious or cultural preferences.

(4) The provider must implement a quality assurance framework to continuously improve the meals, snacks and drinks delivered to individuals through a funded aged care service referred to in paragraph (1)(b) or (1A)(c) by taking into account:

(a) the satisfaction of individuals with the meals, snacks and drinks they are provided; and

(b) the assessments undertaken and any recommendations made by a dietitian based on those assessments in accordance with subsection (3).

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148-25 Providers delivering services under certain provider registration categories—requirements for service delivery equipment

(1) This section applies to a registered provider that:

(a) is registered in any of the following provider registration categories:

(i) home and community services;

(ii) assistive technology and home modifications;

(iii) advisory and support services; and

(b) is delivering funded aged care services to an individual on a day under any of the registration categories referred to in paragraph (a).

(2) This section also applies to a registered provider that:

(a) is registered in the provider registration category subscription trial; and

(b) is also registered in a provider registration category referred to in subparagraph (1)(a)(i) or (iii); and

(c) is delivering funded aged care services to an individual on a day under the provider registration category subscription trial.

(3) If:

(a) the provider uses equipment in delivering the service; or

(b) delivery of the service involves the sourcing, supply and provision of equipment to the individual;

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the provider must ensure that the equipment is safe and meets the needs of the individual at the time the service is delivered to the individual.

148-30 Providers delivering services under certain provider registration categories—requirements for personal protective equipment, infection prevention and control

(1) This section applies to a registered provider that is registered in any of the following provider registration categories:

(a) home and community services;

(b) assistive technology and home modifications;

(c) advisory and support services.

(1A) This section also applies to a registered provider that is registered in the provider registration category subscription trial if the provider is also registered in a provider registration category referred to in subparagraph (1)(a) or (c).

(2) When delivering funded aged care services to an individual on a day under any of the registration categories referred to in subsection (1) or (1A), the provider must ensure that:

(a) personal protective equipment is available to the individual, the aged care workers of the provider delivering the services and any other persons who need it; and

(b) the persons mentioned in paragraph (a) are supported to correctly use the equipment.

(3) The provider must:

(a) have an appropriate infection prevention and control system for delivery of funded aged care services; and

(b) ensure that aged care workers of the provider use hygienic practices and take appropriate infection prevention and control precautions when delivering funded aged care services.

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148-33 Providers delivering services under provider registration category residential care—services that must be delivered

(1) This section applies to a registered provider that:

(a) is registered in the provider registration category residential care; and

(b) is delivering funded aged care services to an individual through the service group residential care.

(2) The services delivered to the individual by the provider must include the services listed and described in Division 8 (residential care service types) of Part 3 of Chapter 1.

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148-35 Providers delivering services under the TCP—services that must be delivered

(1) This section applies to a registered provider that is delivering funded aged care services to an individual under the TCP.

(2) The services delivered to the individual by the provider must include the service transition care management in the service type assistance with transition care.

148-40 Providers delivering short-term funded aged care services through the service group home support—services that must be delivered

(1) This section applies to a registered provider that is delivering short-term funded aged care services to an individual (other than under a specialist aged care program) for the classification level SAH restorative care pathway for the classification type short-term through the service group home support.

(2) The services delivered to the individual by the provider must comprise a multidisciplinary package of early intervention care that is designed to optimise the functioning and independence of the individual, and reverse or slow the individual's functional decline, to help delay the individual's need to access ongoing funded aged care services.

(3) Without limiting subsection (2), the services delivered to the individual must include the following:

(a) the service home support restorative care management in the service type restorative care management;

(b) other services in accordance with the individual's access approval which may include:

(i) a variety of services in the service type allied health and therapy; and

(ii) services in the service type nursing care.

(4) The provider must ensure an aged care worker of the provider who holds relevant health qualifications (a ***restorative care partner***) delivers the service mentioned in paragraph (3)(a) to the individual.

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148-45 Providers delivering certain funded aged care services through the service group home support—requirements for the service home support care management

(1) This section applies to a registered provider that:

(a) is delivering ongoing funded aged care services to an individual (other than under a specialist aged care program) through the service group home support; or

(b) is delivering short-term funded aged care services to an individual (other than under a specialist aged care program) for the classification level SAH end-of-life pathway through the service group home support.

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(2) The provider must deliver the service home support care management in the service type care management to the individual at least once in each month where the provider also delivers other services to the individual.

Subdivision C—Requirements for service agreements

148-60 Purpose of this Subdivision

For the purposes of paragraph 148(c) of the Act, this Subdivision prescribes requirements for service agreements.

148-65 Requirements for service agreements—general

Entry into service agreement

(1) A registered provider must enter into a service agreement with an individual:
  (a) unless paragraph (b) applies—on or before the individual's start day; or
  (b) if the individual is accessing funded aged care services in any of the circumstances specified in subsection 71(4) of the Act, or the registered provider is delivering funded aged care services to the individual under the MPSP or the NATSIFACP—within 28 days after the day the registered provider commences delivery of the services to the individual.

(2) A registered provider must ensure the following:
  (a) the individual is involved in the development and negotiation of the service agreement;
  (b) if requested by the individual, a supporter, family member, carer or advocate of the individual, or any other person significant to the individual, is present during the development and negotiation of the service agreement;
  (c) the service agreement is expressed in plain language and is readily understandable by the individual;
  (d) the individual is helped to understand the terms of the service agreement.

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Cooling-off period—other than for short-term funded aged care services delivered through the service group residential care

(3) A service agreement for the delivery of funded aged care services other than short-term funded aged care services delivered through the service group residential care must provide that if:
  (a) within 14 days after the date of entry into the service agreement; and
  (b) before the individual's start day;

the individual notifies (whether verbally or in writing) the registered provider that the individual wishes to withdraw from the service agreement, then:
  (c) the service agreement has no effect; and
  (d) the registered provider must refund any fees or contributions paid by the individual that are referred to in Part 3 of Chapter 4 of the Act.

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Cooling-off period and refunds of booking fees—short-term funded aged care services delivered through the service group residential care

(3A) A service agreement for the delivery of short-term funded aged care services through the service group residential care must:

(a) if the registered provider charges the individual a booking fee for or in connection with the delivery of those services under subsection 283(4) of the Act—set out the effect of subsections 283-15(3) to (7) of this instrument (which deal with refunds of booking fees); and

(b) provide that if:

(i) within 14 days after the date of entry into the service agreement; and

(ii) before the individual's start day;

the individual notifies (whether verbally or in writing) the registered provider that the individual wishes to withdraw from the service agreement, then:

(iii) the service agreement has no effect; and

(iv) the registered provider must refund any fees or contributions paid by the individual that are referred to in Division 2, 2A or 3 of Part 3 of Chapter 4 of the Act (other than a booking fee referred to in paragraph (a)).

Additional cooling-off period—ongoing aged care services delivered through the service group residential care

(4) A service agreement for an individual to whom the registered provider is to deliver funded aged care services under the classification type ongoing through the service group residential care must provide that, if the individual notifies (whether verbally or in writing) the registered provider that the individual wishes to withdraw from the service agreement within 28 days after the date of entry into the service agreement, the registered provider must refund any amount paid by the individual under the service agreement in relation to services that had not been delivered by the termination date.

Variation of service agreement

(5) A service agreement must provide that the agreement may be varied:

(a) by the registered provider if:

(i) the variation is necessary to implement the *A New Tax System (Goods and Services Tax) Act 1999*; and

(ii) the provider has given reasonable notice in writing about the variation to the individual; and

(iii) the variation is not inconsistent with the *A New Tax System (Goods and Services Tax) Act 1999* or the Act; or

(b) by mutual consent of the individual and the registered provider if:

(i) there has been adequate consultation about the variation between the individual and the provider; and

(ii) the provider has obtained consent from the individual to make the variation; and

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(iii) the variation is not inconsistent with the *A New Tax System (Goods and Services Tax) Act 1999* or the Act.

Review of service agreement

(6) A service agreement between a registered provider and an individual accessing ongoing funded aged care services must provide that the provider will review the service agreement:
(a) at least once every 12 months; and
(b) upon request from the individual.

(7) Without limiting the nature of the review, the provider must:
(a) give the individual an opportunity to participate in the review; and
(b) consider whether any updates need to be made to the service agreement; and
(c) if necessary, vary the service agreement in accordance with subsection (5).

148-70 Requirements for service agreements—contents

All registered providers

(1) A service agreement must not contain any provision that would have the effect of the individual being treated less favourably in relation to any matter than the individual would otherwise be treated, under any law of the Commonwealth, in relation to that matter.

(2) A service agreement entered into between a registered provider and an individual must contain the following:
(a) a statement setting out the parties to the agreement, including the following:
(i) the name of the individual;
(ii) the contact details of the individual;
(iii) the name of the provider;
(iv) the contact details of the provider;
(b) the contact details of the supporters of the individual (if any);
(c) a copy of the individual's access approval;
(d) the approved residential care home (if any) in or from which the provider will deliver funded aged care services to the individual;
(e) the date when the service agreement commences;
(f) the start day for the individual;
(g) if the individual is accessing short-term or hospital transition funded aged care services:
(i) when the provider will cease delivering short-term or hospital transition funded aged care services to the individual; and
(ii) the date when the service agreement ends;

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(h) if the individual is accessing ongoing funded aged care services, the date the service agreement is to be reviewed in accordance with subsection 148-65(6);

(i) how the individual will be involved in decisions relating to how, when and by whom funded aged care services are delivered to the individual.

(3) Despite subsection (2), a service agreement entered into between a registered provider and an individual does not have to contain the matters specified in paragraph (2)(i) if the provider is delivering funded aged care services to the individual under the TCP.

Certain registered providers delivering services through the service groups home support, assistive technology or home modifications (other than under a specialist aged care program)

(4) A service agreement entered into between a registered provider (to whom subsection (5) applies) and an individual must also contain the following:

(a) the funded aged care services the provider will deliver to the individual, including the following:

(i) the name of each service as provided in the service list under section 8-5 of this instrument;

(ii) if the provider intends for an associated provider to deliver any services to the individual, which services will be delivered by the associated provider;

(b) the prices the provider will charge the individual for each of the funded aged care services the provider will deliver to the individual;

(c) if the individual is to be charged a price for delivery of a funded aged care service that is higher than the price published on the provider's website or the department's website—the reason for the higher price;

(d) a statement that the prices mentioned in paragraphs (b) and (c) may be subject to regular price increases to account for indexation and the details of such increases, including:

(i) the date the prices will increase; and

(ii) the method for working out the increase; and

(iii) the reason for the matters specified at subparagraphs (i) and (ii);

(da) a statement that the individual agrees to pay any applicable fees or contributions referred to in Division 1 of Part 3 of Chapter 4 of the Act;

(e) a statement that the provider may only cease delivery of funded aged care services to the individual in the circumstances specified in subsection 149-35(2);

(f) if either of the circumstances in paragraphs 149-35(2)(e) or (f) arise, any other requirements for notifying the provider;

(g) how and when the service agreement may be terminated;

(h) a statement that the registered provider will not charge an individual contribution to the individual if the individual has made an application for a fee reduction supplement determination under subsection 197-20(1) and the System Governor has not decided on that application;

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(i) a statement that where, in relation to an application mentioned in paragraph (h), the System Governor makes a determination that the fee reduction supplement should not apply to the individual, the registered provider can collect the unpaid individual contributions for the period beginning on the day the application was made.

(4A) If the funded aged care services contained in a service agreement under paragraph (4)(a) include a subscription service, the service agreement must also contain the following:

(a) the parameters of the access provided by the subscription service, including (as applicable) the following:

(i) the days the access will be provided;

(ii) the periods on those days during which the access will be provided;

(iii) any limits on the number of times the access can be used during those periods;

(iv) whether the access is provided on a group basis;

(b) a statement of whether the individual consents to the collection of the individual's personal information for the purpose of evaluating the delivery of the subscription service;

(c) a statement that the individual may cease to access the subscription service by giving notice in writing to the provider stating the day that the individual wishes the cessation to take effect; and

(d) a statement of the effect of subsections 11A(2) to (4) of the Act and section 11A-5 of this instrument (dealing with when non-delivery of funded aged care services is taken to be delivery of funded aged care services).

(5) This subsection applies to a registered provider that is delivering funded aged care services to an individual through the service groups home support, assistive technology or home modifications (other than under a specialist aged care program).

Registered providers delivering services under the CHSP, MPSP or NATSIFACP

(6) A service agreement entered into between a registered provider (to whom subsection (9)) applies and an individual must also contain:

(a) the matters mentioned in paragraphs (4)(a), (e), (f) and (g); and

(b) the fees and contribution that the registered provider will charge the individual for each of the funded aged care services the provider will deliver to the individual.

(7) A service agreement entered into between a registered provider (to whom subsection (10) applies) and an individual must also contain the matters mentioned in paragraphs (4)(a), (e), (f) and (g).

(8) A service agreement entered into between a registered provider (to whom subsection (9) or (10) of this section applies) and an individual must also contain a statement that the individual agrees to pay any applicable fees referred to in Division 3 of Part 3 of Chapter 4 of the Act.

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(9) This subsection applies to a registered provider that is delivering funded aged care services to an individual under the CHSP.

(10) This subsection applies to a registered provider that is delivering funded aged care services to an individual under the MPSP or NATSIFACP.

Registered providers delivering services through the service group residential care

(11) A service agreement entered into between a registered provider (to whom subsection (13) or (14) of this section applies) and an individual must also contain which fees or contributions (if any), referred to in Division 2, 2A or 3 of Part 3 of Chapter 4 of the Act, the provider will charge the individual.

(12) A service agreement entered into between a registered provider (to whom subsection (13) of this section applies) and an individual must also contain the following:

(a) that the provider may only ask the individual to leave the approved residential care home in the circumstances specified in subsection 149-60(1);

(b) the assistance the provider will provide to the individual to obtain suitable alternative accommodation if the individual is asked to leave the approved residential care home;

(c) how and when the service agreement may be terminated;

(d) for any fees or contributions that the provider will charge the individual (as set out in the agreement under subsection (11))—the policies and practices the provider will follow in setting and updating the amounts of those fees and contributions.

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(13) This subsection applies to a registered provider that is delivering ongoing funded aged care services to an individual through the service group residential care.

(14) This subsection applies to a registered provider that:

(a) is delivering short-term funded aged care services to an individual through the service group residential care; or

(b) is delivering funded aged care services to an individual through the service group residential care under the TCP.

Subdivision D—Requirements for care and services plans

148-75 Purpose of this Subdivision

For the purposes of paragraph 148(e) of the Act, this Subdivision prescribes requirements for care and services plans.

148-80 Requirements for care and services plans—general

When a care and services plan must be developed—all registered providers

(1) A registered provider must develop a care and services plan for an individual:

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(a) unless paragraph (b) applies—on or before the individual's start day; or
(b) if the individual is accessing funded aged care services in any of the circumstances specified in subsection 71(4) of the Act, or the registered provider is delivering funded aged care services to the individual under the MPSP or the NATSIFACP—within 28 days after the day the registered provider commences delivery of the services to the individual.

How a care and services plan is developed—certain registered providers

(2) A registered provider to whom subsection (5) or (6) applies must actively engage with:
(a) the individual; and
(b) supporters of the individual (if any); and
(c) any other persons involved in the care of the individual;
in developing and reviewing the individual's care and services plan through ongoing communication.

Care and services plan to be in line with the individual's needs—certain registered providers

(3) A registered provider to whom subsection (5) or (6) applies must ensure an individual's care and services plan:
(a) describes the current care needs, goals and preferences of the individual; and
(b) includes strategies for risk management and preventative care; and
(c) where an individual is accessing ongoing funded aged care services, is reviewed at least once every 12 months.

Care and services plan to be accessible to individual—all registered providers

(4) A registered provider must provide a copy of an individual's care and services plan to the individual at the following times:
(a) once the plan is developed;
(b) any time the plan is updated;
(c) upon request from the individual.

Registered providers that are subject to subsections (2) and (3)

(5) This subsection applies to a registered provider that is delivering funded aged care services to an individual under any of the following registration categories:
(a) home and community services;
(b) assistive technology and home modifications;
(c) advisory and support services.

(6) This subsection applies to a registered provider that is registered in the provider registration category subscription trial if the provider is also registered in a provider registration category referred to in paragraph (5)(a) or (c).

Note 1: See subsections 15-20(1) to (3) for the Aged Care Quality Standards relating to care and services plans which apply to providers registered in provider registration

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categories personal and care support in the home and community, nursing and transition care, and residential care.

Note 2: For funded aged care services relating to care and services plans, see item 1 of the table in section 8-20 and items 1 and 4 in the table in section 8-155.

148-81 Requirements for care and services plans—restorative care partner to be responsible for care and services plans in certain circumstances

(1) This section applies to a registered provider that is delivering short-term funded aged care services to an individual (other than under a specialist aged care program) for the classification level SAH restorative care pathway through the service group home support.

(2) The provider must ensure the restorative care partner who will deliver the service mentioned in paragraph 148-40(3)(a) to the individual develops a care and services plan for the individual in accordance with any applicable requirements set out in this Subdivision.

(3) The provider must consider exit planning as part of the care and services plan and must ensure the plan complements any ongoing services the individual is also accessing.

148-85 Requirements for care and services plans—contents for all individuals (other than individuals accessing services through the service group residential care)

Application of this section

(1) This section applies to a registered provider that is delivering funded aged care services to an individual under any of the following registration categories:
- (a) home and community services;
- (b) assistive technology and home modifications;
- (c) advisory and support services;
- (d) personal and care support in the home or community;
- (e) nursing and transition care;
- (f) subscription trial.

Contents

(2) A care and services plan for an individual must include the following:
- (a) the funded aged care services that the provider will deliver to the individual, including:
  - (i) the frequency of the services; and
  - (ii) the volume or duration of the services;
- (b) when the care and services plan will be reviewed;
- (c) if the individual is accessing ongoing funded aged care services, the date the individual's service agreement is to be reviewed in accordance with subsection 148-65(6).

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Division 4—Starting and ceasing the provision of funded aged care services and continuity of those services

Subdivision A—Preliminary

149-5 Requirements relating to starting and ceasing the provision of funded aged care services and continuity of those services

For the purposes of section 149 of the Act, this Division prescribes requirements for the following:

(a) providing a start notification to the System Governor and the Commissioner;
(b) ceasing the delivery of funded aged care services to an individual;
(c) providing a cessation notification to the System Governor and the Commissioner;
(d) ceasing to deliver any funded aged care services;
(e) if the provider delivers funded aged care services in an approved residential care home—security of tenure for individuals accessing those services;
(f) continuity of funded aged care services for individuals.

Note: For requirements relating to a service agreement between an individual and a registered provider, see section 148-70 of this instrument.

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Subdivision B—Start notifications

149-10 Requirements for start notifications—general

(1) A registered provider must prepare a start notification for delivering funded aged care services to an individual in accordance with this section.

(2) Despite subsection (1), a registered provider does not have to prepare a start notification for an individual where the individual will access funded aged care services under a specialist aged care program other than the TCP.

(3) A start notification must be in an approved form.

Start notification for an individual accessing funded aged care services through the service groups home support, assistive technology or home modifications

(4) A start notification for an individual accessing funded aged care services through the service groups home support, assistive technology or home modifications must specify the following:

(a) the name of the individual;
(b) the start day for the individual;
(c) the service delivery branch through which funded aged care services will be delivered to the individual.

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Start notification for an individual accessing funded aged care services through the classification type ongoing for the service group residential care

(5) A start notification for an individual accessing funded aged care services through the classification type ongoing for the service group residential care must specify the following:

(a) the name of the individual;

(b) the start day for the individual;

(c) the approved residential care home at which funded aged care services will be delivered to the individual.

Start notification for an individual accessing funded aged care services through the classification type short-term or hospital transition for the service group residential care

(6) A start notification for an individual accessing funded aged care services through the classification type short-term or hospital transition for the service group residential care must specify the following:

(a) the name of the individual;

(b) the start day for the individual;

(c) the approved residential care home at which funded aged care services will be delivered to the individual.

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149-15 Requirements for start notifications—provision to System Governor and Commissioner

A registered provider must give a start notification for an individual to the System Governor and the Commissioner:

(a) for an individual mentioned in subsections 149-10(4) and (5)—within 28 days after the individual's start day; or

(b) for an individual mentioned in subsection 149-10(6)—within 14 days after the individual's start day.

Subdivision C—Cessation notifications

149-20 Requirements for cessation notifications—general

(1) A registered provider must prepare a cessation notification for ceasing the delivery of funded aged care services to an individual in accordance with this section.

(2) Despite subsection (1), a registered provider does not have to prepare a cessation notification for an individual where the individual is accessing funded aged care services under a specialist aged care program other than the TCP.

(3) A cessation notification must be in an approved form.

(4) A cessation notification for an individual must specify the following:

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(a) the name of the individual;
(b) the day the provider ceased to deliver funded aged care services to the individual;
(c) the reason for ceasing the delivery of funded aged care services to the individual.

149-25 Requirements for cessation notifications—provision to System Governor and Commissioner

A registered provider must give a cessation notification for an individual to the System Governor and the Commissioner:

(a) for an individual accessing funded aged care services through the classification type short-term for the service group residential care—within 14 days after the cessation of delivery of services through the approved residential care home of the provider; or
(b) for all other individuals—within 28 days after the cessation of delivery of services through the approved residential care home or service delivery branch of the provider.

Subdivision D—Ceasing delivery of funded aged care services (other than services delivered in an approved residential care home)

149-30 Application of this Subdivision

This Subdivision applies to a registered provider who is delivering funded aged care services to an individual for a classification type for the service groups home support, assistive technology or home modifications.

149-35 Requirements for ceasing delivery of funded aged care services - general

(1) A registered provider must not cease to deliver funded aged care services to an individual unless:
(a) one of the circumstances in subsection (2) applies; and
(b) the provider has given notice to the individual in accordance with section 149-40.

Circumstances where registered provider may cease delivery of funded aged care services to an individual

(2) The circumstances in which a registered provider may cease to deliver funded aged care services to an individual are:
(a) the individual cannot be cared for in the home or community with the resources available to the provider; or
(b) the individual's condition changes to the extent that:
(i) the individual no longer needs the funded aged care services delivered by the provider; or

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(ii) the individual's needs, as assessed by an approved needs assessor, can be more appropriately met by other types of funded aged care services; or

(c) the individual has:

(i) intentionally caused serious injury to an aged care worker of the provider; or

(ii) intentionally infringed the right of an aged care worker of the provider to work in a safe environment; or

(d) the individual:

(i) has not paid to the provider, for a reason within the individual's control, any applicable fee or contribution referred to in Division 1 of Part 3 of Chapter 4 of the Act as agreed in the service agreement between the individual and the provider; and

(ii) has not negotiated an alternative arrangement with the provider for payment of the fee or contribution; and

(iii) if the individual is accessing the services other than under a specialist aged care program—has no application for the fee reduction supplement in place; or

(e) the individual notifies the provider, in writing, that the individual wishes to move to a location where funded aged care services are not delivered by the provider; or

(f) the individual notifies the provider, in writing, that the individual no longer wishes to receive funded aged care services from the provider.

Note: The circumstances in which a registered provider may cease delivering funded aged care services to an individual must be specified in a service agreement between the individual and the registered provider made under section 148-70.

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149-40 Requirements for ceasing delivery of funded aged care services—notice to individual about cessation of services

Notice to be given if registered provider intends to cease delivery of funded aged care services

(1) If a registered provider intends to cease delivery of funded aged care services to an individual, the provider must give the individual a written notice which includes the following:

(a) the decision;

(b) the reasons for the decision;

(c) the date the provider intends to cease delivery of funded aged care services to the individual;

(d) the individual's rights in relation to cessation of the delivery of funded aged care services, including the right to access:

(i) the provider's complaints and feedback management system; and

(ii) any other mechanisms available to address complaints; and

(iii) independent aged care advocates.

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Note: For complaints and feedback management systems, see section 165 of the Act and Division 2 of Part 10 of Chapter 4 of this instrument.

(2) The registered provider must give the notice to the individual at least 14 days before the date the provider ceases delivery of funded aged care services to the individual.

Notice to be given if registered provider no longer intends to cease delivery of funded aged care services

(3) If:

(a) the decision to cease the delivery of funded aged care services was based on the individual's behaviour; and

(b) the registered provider has given the individual a notice under subsection (1); and

(c) after giving the notice, the provider has agreed with the individual that, because of a change in the behaviour, the delivery of funded aged care services will not cease;

the provider must give the individual a written notice stating that the provider no longer intends to cease delivery of funded aged care services to the individual.

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149-45 Requirements for ceasing delivery of funded aged care services—notice to individual about unspent portions

(1) This section applies if:

(a) a registered provider holds an unspent Commonwealth portion or unspent care recipient portion for an individual to whom the provider is delivering funded aged care services; and

(b) section 226C or 226D of the Act apply.

(2) The registered provider must give a notice relating to the individual's unspent Commonwealth portion or unspent care recipient portion in accordance with this section.

Note: See paragraphs 226C(2)(a) and 226D(2)(a) of the Act for requirements to give written notice to the System Governor about the unspent Commonwealth portion.

(3) The notice must:

(a) specify the following:

(i) the day the provider ceased to deliver funded aged care services to the individual;

(ii) the available balance (including a nil amount) of the unspent Commonwealth portion for the individual;

(iii) the balance (including a nil amount) of the unspent care recipient portion for the individual;

(iv) if the amount of the unspent care recipient portion for the individual was reduced by the individual contributions charged to the individual by the provider under paragraph 273A-20(a) of this instrument—the amount of those individual contributions; and

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(b) explain:
(i) the effect of paragraphs 226C(2)(b) and 226D(2)(b) of the Act; and
(ii) the effect of subsections 226A(7) to (9) and 226E(5) and (6) of the Act; and
(iii) the effect of paragraph 273A-20(b) of this instrument.

When notice must be given

(4) The notice must be given within 28 days after the cessation of delivery of services.

Who notice is given to

(5) The notice must be given to:
(a) the individual; or
(b) if the individual has died:
(i) the individual's legal representative; or
(ii) the individual's estate.

Note: A copy of the notice may also need to be given to another registered provider under section 149-80 of this instrument or a supporter of the individual under section 29 of the Act.

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149-46 Requirements for ceasing delivery of funded aged care services—notice to new registered provider about account balances

(1) This section applies if:
(a) a registered provider has ceased the delivery of funded aged care services to an individual through a service delivery branch of the provider; and
(b) within 60 days after the day the registered provider ceased to deliver funded aged care services to the individual, the provider is notified that the individual has entered into a service agreement with a new registered provider; and
(c) the new registered provider will deliver funded aged care services to the individual for a classification type for the service groups home support, assistive technology or home modifications through a service delivery branch of the new registered provider.

(2) The registered provider must give a notice to the individual's new registered provider specifying what the provider estimates will be the available balance of the individual's:
(a) notional ongoing home support account (if any); and
(b) notional short-term home support account (if any); and
(c) notional assistive technology account (if any); and
(d) notional home modifications account (if any); and
(e) notional home care account (if any);

after the provider gives a claim in accordance with section 251 of the Act for payment of subsidy for the delivery of funded aged care services to the

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individual for the relevant period where the provider ceased delivering services to the individual.

(3) The notice must be given within 28 days after the registered provider is notified that the individual has entered into a service agreement with the new registered provider.

149-48 Requirements for ceasing delivery of subscription services

A registered provider must not cease to deliver a particular subscription service to an individual unless:

(a) the provider ceases to deliver funded aged care services to the individual in accordance with section 149-35; or

(b) the individual has given the provider notice in writing in relation to the particular subscription service as referred to in paragraph 148-70(4A)(c).

Subdivision E—Security of tenure for individuals accessing funded aged care services in an approved residential care home

149-50 Application of this Subdivision

This Subdivision applies to a registered provider who is delivering funded aged care services to an individual for a classification type ongoing for the service group residential care in an approved residential care home of the registered provider.

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149-55 Security of tenure—general

A registered provider must not take action to make an individual accessing funded aged care services in an approved residential care home of the approved provider leave the home, or imply that the individual must leave the home, unless:

(a) one of the circumstances in subsection 149-60(1) apply; and

(b) suitable alternative accommodation is available for the individual that meets the requirements in subsection 149-60(2); and

(c) the provider has given notice to the individual in accordance with section 149-65.

149-60 Security of tenure—circumstances where registered provider may ask an individual to leave an approved residential care home

(1) A registered provider may only ask an individual accessing funded aged care services in an approved residential care home of the approved provider to leave the residential care home if:

(a) the approved residential care home is closing; or

(b) the provider can no longer provide accommodation and funded aged care services through the approved residential care home which are suitable for the individual, having regard to the individual's needs as assessed in

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accordance with subsection (4) and the provider has not agreed to deliver funded aged care services of the kind that the individual presently needs; or

(c) the individual no longer needs the funded aged care services delivered through the approved residential care home, as assessed by an approved needs assessor in accordance with subsection 64(2) of the Act; or

(d) the individual has been accessing funded aged care services under a specialist dementia care agreement and a clinical advisory committee constituted in accordance with the agreement has determined that the individual is not suitable to continue accessing those services; or

(e) the individual has not paid any agreed fee or contribution to the provider within 42 days after the day when it is payable, for a reason within the individual's control; or

(f) the individual has intentionally caused:

(i) serious damage to the approved residential care home; or

(ii) serious injury to an aged care worker of the provider, or to another individual accessing funded aged care services at the approved residential care home; or

(g) the individual is away from the approved residential care home for a continuous period of at least 7 days for a reason other than:

(i) emergency leave; or

(ii) hospital leave; or

(iii) hospital transition leave; or

(iv) extended hospital leave; or

(v) social leave.

Note: For when an individual is on leave, see section 244 of the Act.

Suitable accommodation to be available before individual can be required to leave approved residential care home

(2) If a registered provider intends to ask an individual to leave the approved residential care home, the provider must ensure suitable alternative accommodation is available:

(a) with an alternative registered provider that meets the individual's needs and is affordable by the individual; or

(b) in a place more suited to the individual's long term needs.

(3) Without limiting subsection (2), suitable alternative accommodation with an alternative registered provider will be available if the alternative registered provider has offered to enter into a service agreement with the individual under section 148-70 of this instrument for the delivery of funded aged care services to the individual.

Note: A registered provider is required to detail the steps taken to ensure any alternative accommodation meets the needs of the individual in a continuity of care plan for the individual prepared under section 149-75 of this instrument.

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Assessing the individual's needs

(4) For the purposes of paragraph (1)(b), the needs of the individual must be assessed by:
  (a) an approved needs assessor; or
  (b) at least 2 medical or other health practitioners who meet the following criteria:
    (i) one must be independent of the registered provider and the approved residential care home, and must be chosen by the individual;
    (ii) both must be competent to assess the aged care needs of the individual.

149-65 Security of tenure—notice requirements

Notice to be given if individual asked to leave residential care service

(1) If a registered provider of an approved residential care home decides to ask an individual to leave the approved residential care home, the provider must give the individual a written notice which includes the following:
  (a) the decision;
  (b) the reasons for the decision;
  (c) the date the individual is to leave;
  (d) the individual's rights in relation to being asked to leave the approved residential care home, including the right to access:
    (i) the provider's complaints and feedback management system; and
    (ii) any other mechanisms available to address complaints; and
    (iii) independent aged care advocates;
  (e) a copy of the continuity of care plan for the individual.

Note: For complaints and feedback management systems, see section 165 of the Act and Division 2 of Part 10 of Chapter 4 of this instrument.

(2) The registered provider must give the notice to the individual at least 14 days before the individual is to leave.

Notice to be given if individual no longer required to leave approved residential care home

(3) If:
  (a) the decision to require the individual to leave the approved residential care home was based on the individual's behaviour; and
  (b) the registered provider has given the individual a notice under subsection (1); and
  (c) after giving the notice, the provider has agreed with the individual that, because of a change in the behaviour, the individual should not be required to leave the residential care home;

the provider must give the individual a written notice stating that the individual is no longer required to leave the residential care home.

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149-70 Security of tenure—movement of individuals

(1) A registered provider must not move an individual from a room, or part of a room, in the approved residential care home to another room, or part of a room, in the home unless:

(a) the move is at the individual's request; or

(b) the individual agrees to the move after being fully consulted and without being subjected to any pressure; or

(c) the move is necessary on genuine medical grounds as assessed by one of the following:

(i) an approved needs assessor;

(ii) at least 2 medical or other health practitioners who meet the criteria in subparagraphs 149-60(4)(b)(i) and (ii) of this instrument; or

(d) the individual has been accessing funded aged care services under a specialist dementia care agreement and a clinical advisory committee constituted in accordance with the agreement has determined that the individual is not suitable to continue accessing those services in the individual's current room, or part of a room; or

(e) the move is necessary to carry out repairs or improvements to the home and the individual has the right to return to the room, or the part of the room, if it continues to exist as a room, or part of a room, for individuals when the repairs or improvements are finished; or

(f) the move is necessary due to an emergency, including (but not limited to) the following:

(i) during serious medical situations such as disease outbreak, viral pandemic and epidemic;

(ii) in circumstances in which the safety of the individual is compromised such as during a fire, natural disaster or flood;

(iii) the individual has been repeatedly violent towards another person in the same room or in close proximity to the individual.

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Subdivision F—Continuity of funded aged care services

149-75 Continuity of care plan

(1) A registered provider must prepare a plan for ensuring the continuity of funded aged care services for an individual (a ***continuity of care plan***) in accordance with this section if the provider intends to ask an individual to leave an approved residential care home of the provider in any of the circumstances prescribed in subsection 149-60(1) of this instrument.

Continuity of care plan for individuals accessing funded aged care services in an approved residential care home

(2) A continuity of care plan for an individual accessing funded aged care services through the classification type ongoing for the service group residential care in

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an approved residential care home of a registered provider must specify the following:

(a) details of any suitable alternative accommodation that is available that meet the requirements in subsection 149-60(2);

(b) the steps the registered provider has taken to ensure that any alternative accommodation meets the individual's needs;

(c) how any records relating to ensuring the continuity of funded aged care services for the individual will be transferred to a suitable alternative registered provider if required under section 149-80;

(d) the intended start date (if any) for the individual with a suitable alternative registered provider;

(e) where an individual will not continue accessing funded aged care services with an alternative registered provider, the reason for this;

(f) the way in which the registered provider proposes to help the individual move (with their personal possessions);

(g) the measures that the registered provider proposes to take to refund any fees or contributions to the individual as required by Part 3 of Chapter 4 of the Act;

(h) the measures that the registered provider proposes to take to deal with any refundable deposit balance paid by the individual as required by Division 7 of Part 4 of Chapter 4 of the Act.

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149-80 Transfer of records between registered providers

(1) This section applies if:

(a) a registered provider (the ***outgoing provider***) ceases to deliver funded aged care services to an individual; and

(b) another registered provider (the ***incoming provider***) starts the delivery of funded aged care services to the individual.

Records to be given to incoming provider on request

(2) The incoming provider may request the outgoing provider give records relating to the individual which are necessary to ensure the continuity of funded aged care services for the individual.

(3) If a request for records is made under subsection (2), the outgoing provider must give the incoming provider the records, or copies of such records, within 28 days after the request is made.

(4) Without limiting subsections (2) and (3), the outgoing provider must give the following records:

(a) any records relating to the individual the provider is required to keep under section 7 of the *Records Principles 2014*;

(b) any records relating to the individual the provider is required to keep under section 154-1000 of this instrument.

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Part 5—Conditions relating to financial matters

150A-1 Requirements for refundable deposit register

For the purposes of section 150A of the Act, a registered provider's refundable deposit register must:

(a) be able to produce the information prescribed under this Part (as applicable) in a single, itemised document; and

(b) require the collection of information prescribed under this Part that will enable the provider to provide information to the Commissioner, if required or requested to do so by the Commissioner.

150A-3 Kinds of providers to which the condition applies

For the purposes of section 150A of the Act, a registered provider registered in the category residential care that receives or has received payment of any of the following from an individual, wholly or partly as a lump sum:

(a) a refundable deposit;

(b) an accommodation bond;

(c) an entry contribution;

is prescribed.

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150A-5 Refundable deposit register to include information about refundable deposit paid and refundable deposit balances held

For the purposes of section 150A of the Act, a registered provider must include the following information in the refundable deposit register for each individual from whom a refundable deposit is paid to the provider, or in respect of whom the registered provider holds a refundable deposit balance:

(a) the name of the individual;

(b) the Aged Care Management Payment System number for the individual;

(c) the date on which the individual entered the approved residential care home through which the individual is provided with funded aged care services by the registered provider;

(d) the date on which the whole or each part of the refundable deposit paid by lump sum was paid to the registered provider for entry to the approved residential care home referred to in paragraph (c);

(e) the amount of each payment referred to in paragraph (d);

(f) the amount of each deduction made from the refundable deposit authorised under section 307 or section 308 of the Act;

(g) the date when each of the deduction referred to in paragraph (f) was made;

(h) for each deduction made under paragraph (f)—the provision that the deduction was authorised under and the reason for the deduction;

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(i) the refundable deposit balance as at the end of each calendar month in relation to the individual during which the registered provider held a refundable deposit balance;

(j) any amount refunded to the individual under subsection 304-5(1) of this instrument;

(k) the date when any amount was refunded to the individual under subsection 304-5(1) of this instrument;

(l) where the registered provider began delivering funded aged care services to the individual and the amount of accommodation payment charged to the individual is higher than the maximum accommodation payment amount prescribed by rules made for the purposes of section 289 of the Act—the Independent Health and Aged Care Pricing Authority approval number;

(m) any transfer of the refundable deposit made under section 312 of the Act, including any amount, the date of that transfer and the amount of retention period remaining.

150A-15 Refundable deposit register to include information about refundable deposit balances refunded

For the purposes of section 150A of the Act, a registered provider must include the following information in the refundable deposit register for each individual from whom a refundable deposit is paid to the provider, or in respect of whom the registered provider holds a refundable deposit balance:

(a) if the refundable deposit balance was refunded because the individual died;

(i) the date on which the individual died; and

(ii) if applicable, the date on which the registered provider is shown the probate of the will of the individual, letters of administration of the estate of the individual or other evidence that satisfied the provider that the refundable deposit is to be refunded to a person;

(b) if the refundable deposit balance was refunded because the individual ceased to be provided with ongoing funded aged care services in the service group residential care at the approved residential care home—the date on which the individual ceased to be provided with those ongoing funded aged care services;

(c) if paragraph (b) applies and the individual notified the registered provider, before the date referred to in that paragraph, that the individual intended to enter another approved residential care home to receive ongoing funded aged care services in the service group residential care—the date of notification by the individual;

(d) if the refundable deposit was refunded because of changes to the nature of delivery of funded aged care services to the individual whilst in the care of the registered provider, and those changes result in excess deposit being held by the registered provider—a description of those changes;

(e) if the refundable accommodation contribution amount is reduced because of changes to the daily means tested amount or the accommodation supplement applicable to the individual and that reduction results in excess deposit being held by the registered provider—the date the new daily

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means tested amount or new accommodation supplement applied and the date the provider refunded the excess refundable deposit.

(f) the date on which, or by which, the registered provider was required to refund the refundable deposit to the individual as worked out in accordance with section 311 of the Act;

(g) the date on which the refundable deposit was refunded to the individual or another person;

(h) the amount of the refundable deposit refunded;

(i) the amounts (if any) of interest paid, as required by section 313-5 of this instrument and worked out under section 313-10 of this instrument, broken down into amounts worked out using the base interest rate and amounts worked out using the maximum permissible interest rate, and the date or dates on which the amounts were paid.

150A-20 Refundable deposit register to include information about accommodation bond balances held by the registered provider

For the purposes of section 150A of the Act, a registered provider must include the following information in the refundable deposit register in relation to an individual in respect of whom an accommodation bond was paid to the registered provider on or after 1 July 2006, or in respect of whom the registered provider holds an accommodation bond balance on or after that date:

(a) the name of the individual;

(b) the Residential Identification Number allocated by the Department in respect of the individual;

(c) the date on which the individual entered the approved residential care home in which the individual is provided with funded aged care services by the registered provider on or after 1 July 2006;

(d) if, immediately before entering the approved residential care home referred to in paragraph (c), the individual was provided with care through an approved residential care home (the ***original approved residential care home***), and an accommodation bond was paid for the individual's entry to the original approved residential care home—the date on which the individual entered the original approved residential care home;

(e) the date on which the whole or each part of an accommodation bond paid by lump sum was paid for entry to the registered provider referred to in paragraph (c);

(f) the amount of each payment referred to in paragraph (e);

(g) the amount of each deduction made from the accommodation bond on or after 1 July 2006;

(h) the date of each deduction referred to in paragraph (g);

(i) the reason for each deduction referred to in paragraph (g);

(j) the accommodation bond balance as at 1 July 2006 (if applicable);

(k) the accommodation bond balance at the end of each calendar month commencing on or after 1 July 2006 during which the registered provider held the accommodation bond balance in respect of the individual.

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Section 150A-25

150A-25 Refundable deposit register to include information about accommodation bond balances refunded

For the purposes of section 150A of the Act, a registered provider must include the following information in the refundable deposit register in relation to an individual in respect of whom an accommodation bond balance is refunded on or after 1 July 2006:

(a) if accommodation bond balance was refunded because the individual died;
  (i) the date on which the individual died; and
  (ii) if applicable, the date on which the registered provider is shown the probate of the will of the individual, letters of administration of the estate of the individual or other evidence that satisfied the provider that the refundable deposit is to be refunded to a person;

(b) if the accommodation bond balance was refunded because the individual ceased to be provided with ongoing services in the services group residential care at the approved residential care home—the date on which the individual ceased to be provided with that care;

(c) if paragraph (b) applies and the individual notified the registered provider, before the date referred to in that paragraph, that the individual intended to enter another approved residential care home to receive residential care—the date of notification;

(d) the date on which, or by which, the registered provider was required to refund the accommodation bond balance to the individual, worked out in accordance with section 287-102 of this instrument;

(e) the date on which the accommodation bond payment balance was refunded;

(f) the amount of the accommodation bond balance refunded;

(g) the amounts (if any) of interest paid, as required by and worked out under section 287-103A of this instrument, broken down into amounts worked out using the base interest rate and amounts worked out using the pre-2014 maximum permissible interest rate, and the date or dates on which the amounts were paid.

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150A-30 Refundable deposit register to include information about entry contributions paid and entry contribution balances held

For the purposes of section 150A of the Act, a registered provider must include the following information in the refundable deposit register in relation to an individual who holds an entry contribution balance on or after 1 July 2006:

(a) the name of the individual;

(b) the Resident Identification Number allocated by the Department in respect of the individual;

(c) the date on which the entry contribution was paid;

(d) the amount of the entry contribution;

(e) the entry contribution balance at the end of each calendar month commencing on or after 1 July 2006 during which the registered provider held an entry contribution balance in respect of the individual.

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150A-35 Refundable deposit register to include information about entry contributions balances refunded

For the purposes of section 150A of the Act, a registered provider must include the following information in the refundable deposit register in relation to an individual of whom an entry contribution balance is refunded on or after 1 July 2006:

(a) the date on which the individual ceased to be provided with care;

(b) the date on which the registered provider was required to refund the entry contribution balance to the individual worked out in accordance with the formal agreement applying in respect of the entry contribution balance;

(c) the date on which the entry contribution balance was refunded;

(d) the amount of the entry contribution balance refunded;

(e) the amount (if any) of interest paid and the date when the interest was paid.

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Part 6—Aged care workers

Division 1—Workforce and aged care worker requirements

Subdivision A—Kinds of provider to which the condition applies

152-5 Kinds of provider to which the condition applies

For the purposes of subsection 152(1) of the Act, every kind of registered provider is prescribed.

Subdivision B—Worker screening requirements

152-10 Purpose of this Subdivision

For the purposes of paragraphs 152(1)(a) and (b) of the Act, this Subdivision prescribes worker screening requirements.

152-15 Responsible persons of registered providers delivering services other than under CHSP or NATSIFACP

Clearance requirements

(1) A registered provider (other than a registered provider to whom subsection (5) or (6) applies) must ensure that each responsible person of the provider is:
  (a) a person to whom subsection 152-25(1) (police certificates) applies; or
  (b) a person to whom subsection (2) of this section applies; or
  (c) a person in respect of whom an NDIS clearance decision is in force.

(2) This subsection applies to a person:
  (a) in respect of whom an NDIS screening application or a police certificate is pending; and
  (b) who is subject to appropriate supervision while that application or certificate is pending; and
  (c) who has made, and given to the registered provider, a statutory declaration stating the person:
    (i) has never been convicted of murder or sexual assault; and
    (ii) has never been convicted of, and sentenced to imprisonment for, any other form of assault.

Notification requirements

(3) A registered provider (other than a registered provider to whom subsection (5) or (6) applies) must take reasonable measures to require each responsible person of the provider to notify the provider if:
  (a) an NDIS exclusion decision is in force in respect of the person; or
  (b) an NDIS clearance decision in respect of the person is suspended; or

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(c) the person has been:
(i) convicted of murder or sexual assault; or
(ii) convicted of, and sentenced to imprisonment for, any other form of assault.

Continuation requirements

(4) A registered provider (other than a registered provider to whom subsection (5) or (6) applies) must ensure that a responsible person of the provider is not allowed to continue as a responsible person if the provider is satisfied on reasonable grounds that the person has been:
(a) convicted of murder or sexual assault; or
(b) convicted of, and sentenced to imprisonment for, any other form of assault.

Registered providers in relation to whom this section does not apply

(5) This subsection applies to a registered provider that:
(a) delivers funded aged care services under CHSP; and
(b) is registered in any of the following provider registration categories:
(i) home and community services;
(ii) assistive technology and home modifications;
(iii) advisory and support services;
(iv) personal and care support in the home or community;
(v) nursing and transition care.

(6) This subsection applies to a registered provider that delivers funded aged care services under NATSIFACP.

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152-16 Responsible persons of registered providers delivering services only under CHSP, NATSIFACP, or CHSP and NATSIFACP

Clearance requirements

(1) A registered provider to whom subsection (6), (7) or (8) applies must ensure that each responsible person of the provider is:
(a) a person to whom subsection 152-25(2), (3) or (5) (police certificates) applies; or
(b) a person to whom subsection (2) of this section applies; or
(c) a person in respect of whom an NDIS clearance decision is in force.

(2) This subsection applies to a person:
(a) in respect of whom an NDIS screening application or a police certificate is pending; and
(b) who is subject to appropriate supervision while that application or certificate is pending; and
(c) who has made, and given to the registered provider, a statutory declaration stating the person:

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(i) has never been convicted of an offence involving the death of a person; and
(ii) has never been convicted of, and sentenced to imprisonment for at least one year for, an offence referred to in subsection (3).

(3) For the purposes of subparagraph (2)(c)(ii), the offences are the following:
(a) a sex related offence, including sexual assault (whether against an adult or child), child abuse material offences, or an indecent act involving a child;
(b) an offence involving dishonesty.

Notification requirements

(4) A registered provider to whom subsection (6), (7) or (8) applies must take reasonable measures to require each responsible person of the provider to notify the provider if:
(a) an NDIS exclusion decision is in force in respect of the person; or
(b) an NDIS clearance decision in respect of the person is suspended; or
(c) the person is, after the commencement of this section:
(i) convicted of an offence involving the death of a person; or
(ii) convicted of, and sentenced to imprisonment for at least one year for, an offence referred to in subsection (3).

Continuation requirements

(5) A registered provider to whom subsection (6), (7) or (8) applies must ensure that a responsible person of the provider is not allowed to continue as a responsible person if the provider is satisfied on reasonable grounds that the responsible person is, after the commencement of this section:
(a) convicted of an offence involving the death of a person; or
(b) convicted of, and sentenced to imprisonment for at least one year for, an offence referred to in subsection (3).

Registered providers in relation to whom this section applies

(6) This subsection applies to a registered provider that:
(a) delivers funded aged care services only under CHSP; and
(b) is registered in any of the following provider registration categories:
(i) home and community services;
(ii) assistive technology and home modifications;
(iii) advisory and support services;
(iv) personal and care support in the home or community;
(v) nursing and transition care.

(7) This subsection applies to a registered provider that delivers funded aged care services only under NATSIFACP.

(8) This subsection applies to a registered provider that delivers funded aged care services only under CHSP and NATSIFACP.

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152-17 Responsible persons of other registered providers

(1) A registered provider:
  (a) to whom either or both subsection (2) or (3) applies; and
  (b) to whom subsection (4) applies;
must comply with each of the requirements mentioned in section 152-16.

(2) This subsection applies to a registered provider that:
  (a) delivers funded aged care services under CHSP; and
  (b) is registered in any of the following provider registration categories:
    (i) home and community services;
    (ii) assistive technology and home modifications;
    (iii) advisory and support services;
    (iv) personal and care support in the home or community;
    (v) nursing and transition care.

(3) This subsection applies to a registered provider that delivers funded aged care services under NATSIFACP.

(4) This subsection applies to a registered provider that delivers funded aged care services other than under CHSP or NATSIFACP.

152-20 Aged care workers delivering services other than under CHSP or NATSIFACP

Clearance requirements

(1) A registered provider must ensure that each aged care worker of the provider, other than a worker to whom subsection (5) or (6) applies, is:
  (a) a person to whom subsection 152-25(1) (police certificates) applies; or
  (b) a person to whom subsection (2) of this section applies; or
  (c) a person in respect of whom an NDIS clearance decision is in force; or
  (d) a secondary school student on a formal work experience placement with the provider and the worker is directly supervised by a person to whom paragraph (a) or (c) applies.

(2) This subsection applies to a person:
  (a) in respect of whom an NDIS screening application or a police certificate is pending; and
  (b) who is subject to appropriate supervision while that application or certificate is pending; and
  (c) who has made, and given to the registered provider, a statutory declaration stating the person:
    (i) has never been convicted of murder or sexual assault; and
    (ii) has never been convicted of, and sentenced to imprisonment for, any other form of assault.

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Notification requirements

(3) A registered provider must take reasonable measures to require each aged care worker of the provider, other than a worker to whom subsection (5) or (6) applies, to notify the provider if:
  (a) an NDIS exclusion decision is in force in respect of the worker; or
  (b) an NDIS clearance decision in respect of the worker is suspended; or
  (c) the worker has been:
    (i) convicted of murder or sexual assault; or
    (ii) convicted of, and sentenced to imprisonment for, any other form of assault.

Continuation requirements

(4) A registered provider must ensure that an aged care worker of the provider, other than a worker to whom subsection (5) or (6) applies, is not allowed to continue as an aged care worker if the provider is satisfied on reasonable grounds that the worker has been:
  (a) convicted of murder or sexual assault; or
  (b) convicted of, and sentenced to imprisonment for, any other form of assault.

Aged care workers in relation to whom this section does not apply

(5) This subsection applies to an aged care worker of a registered provider if the worker delivers funded aged care services under CHSP.

(6) This subsection applies to an aged care worker of a registered provider if the worker delivers funded aged care services under NATSIFACP.

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152-21 Aged care workers delivering services only under CHSP, NATSIFACP, or CHSP and NATSIFACP

Clearance requirements

(1) A registered provider must ensure that each aged care worker of the provider to whom subsection (5), (6) or (7) applies is:
  (a) a person to whom subsection 152-25(2), (3) or (5) (police certificates) applies; or
  (b) a person to whom subsection (2) of this section applies; or
  (c) a person in respect of whom an NDIS clearance decision is in force; or
  (d) a secondary school student on a formal work experience placement with the provider and the worker is directly supervised by a person to whom paragraph (a) or (c) applies.

(2) This subsection applies to a person:
  (a) in respect of whom an NDIS screening application or a police certificate is pending; and
  (b) who is subject to appropriate supervision while that application or certificate is pending; and

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(c) who has made, and given to the registered provider, a statutory declaration stating the person:

(i) has never been convicted of an offence involving the death of a person; and

(ii) has never been convicted of, and sentenced to imprisonment for at least one year for, an offence referred to in subsection 152-16(3).

Notification requirements

(3) A registered provider must take reasonable measures to require each aged care worker of the provider to whom subsection (5), (6) or (7) applies to notify the provider if:

(a) an NDIS exclusion decision is in force in respect of the worker; or

(b) an NDIS clearance decision in respect of the worker is suspended; or

(c) the worker is, after the commencement of this section:

(i) convicted of an offence involving the death of a person; or

(ii) convicted of, and sentenced to imprisonment for at least one year for, an offence referred to in subsection 152-16(3).

Continuation requirements

(4) A registered provider must ensure that an aged care worker of the provider to whom subsection (5), (6) or (7) applies is not allowed to continue as an aged care worker if the provider is satisfied on reasonable grounds that the worker is, after the commencement of this section:

(a) convicted of an offence involving the death of a person; or

(b) convicted of, and sentenced to imprisonment for at least one year for, an offence referred to in subsection 152-16(3).

Aged care workers in relation to whom this section applies

(5) This subsection applies to an aged care worker of a registered provider if the worker delivers funded aged care services only under CHSP.

(6) This subsection applies to an aged care worker of a registered provider if the worker delivers funded aged care services only under NATSIFACP.

(7) This subsection applies to an aged care worker of a registered provider if the worker delivers funded aged care services only under CHSP and NATSIFACP.

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152-22 Other aged care workers

(1) A registered provider in respect of an aged care worker of the provider:

(a) to whom either or both subsection (2) or (3) applies; and

(b) to whom subsection (4) applies;

must comply with each of the requirements mentioned in section 152-21.

(2) This subsection applies to an aged care worker of a registered provider if the worker delivers funded aged care services under CHSP.

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(3) This subsection applies to an aged care worker of a registered provider if the worker delivers funded aged care services under NATSIFACP.

(4) This subsection applies to an aged care worker of a registered provider if the worker delivers funded aged care services other than under CHSP or NATSIFACP.

152-25 Police certificates

Responsible persons or aged care workers of registered providers delivering services other than under CHSP or NATSIFACP

(1) This subsection applies to a person if:

(a) there is for the person a police certificate that is not more than 3 years old; and

(b) the police certificate does not record that the person has been:

(i) convicted of murder or sexual assault; or

(ii) convicted of, and sentenced to imprisonment for, any other form of assault; and

(c) for a person who has been, at any time after turning 16, a citizen or permanent resident of a country other than Australia—the person has made a statutory declaration stating that the person has never been:

(i) convicted of murder or sexual assault; or

(ii) convicted of, and sentenced to imprisonment for, any other form of assault.

Responsible persons or aged care workers of registered providers delivering services under CHSP

(2) This subsection applies to a person who is a responsible person or aged care worker of a registered provider to which subsection (4) applies if:

(a) there is for the person a police certificate that is not more than 3 years old; and

(b) either:

(i) the person was engaged as a responsible person or aged care worker of the registered provider on or after the commencement of this section; or

(ii) the police certificate was issued after the commencement of this section; and

(c) the police certificate does not record that the person has been convicted of an offence involving the death of a person; and

(d) the police certificate does not record that in the 5 years before the date of the certificate, the person has been convicted of, and sentenced to imprisonment for at least one year for, any of the following offences:

(i) a sex-related offence, including sexual assault (whether against an adult or child), child abuse material offences, or an indecent act involving a child;

(ii) an offence involving dishonesty; and

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(e) for a person who has been, at any time after turning 16, a citizen or permanent resident of a country other than Australia—the person has made a statutory declaration stating that the person has never been:

(i) convicted of an offence involving the death of a person; or

(ii) convicted of, and sentenced to imprisonment for at least one year for, a sex-related offence, including sexual assault (whether against an adult or child), child abuse material offences, or an indecent act involving a child; or

(iii) convicted of, and sentenced to imprisonment for at least one year for, an offence involving dishonesty.

(3) This subsection applies to a person who is a responsible person or aged care worker of a registered provider to which subsection (4) applies if:

(a) the person was engaged as a responsible person or aged care worker of the registered provider before the commencement of this section; and

(b) there is for the person a police certificate that:

(i) was issued before the commencement of this section; and

(ii) is not more than 3 years old.

(4) This subsection applies to a registered provider that:

(a) delivers funded aged care services under CHSP; and

(b) is registered in any of the following provider registration categories:

(i) home and community services;

(ii) assistive technology and home modifications;

(iii) advisory and support services;

(iv) personal and care support in the home or community;

(v) nursing and transition care.

Responsible persons or aged care workers of registered providers delivering services under NATSIFACP

(5) This subsection applies to a person who is a responsible person or aged care worker of a registered provider to which subsection (6) applies if:

(a) there is for the person a police certificate that is not more than 3 years old; and

(b) the police certificate does not record that the person has been convicted of an offence involving the death of a person; and

(c) the police certificate does not record that in the 5 years before the date of the certificate, the person has been convicted of, and sentenced to imprisonment for at least one year for, any of the following offences:

(i) a sex-related offence, including sexual assault (whether against an adult or child), child abuse material offences, or an indecent act involving a child;

(ii) an offence involving dishonesty; and

(d) for a person who has been, at any time after turning 16, a citizen or permanent resident of a country other than Australia—the person has made a statutory declaration stating that the person has never been:

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(i) convicted of an offence involving the death of a person; or
(ii) convicted of, and sentenced to imprisonment for at least one year for, a sex-related offence, including sexual assault (whether against an adult or child), child abuse material offences, or an indecent act involving a child; or
(iii) convicted of, and sentenced to imprisonment for at least one year for, an offence involving dishonesty.

(6) This subsection applies to a registered provider that:
(a) delivers funded aged care services under NATSIFACP; and
(b) is registered in any of the following provider registration categories:
(i) home and community services;
(ii) assistive technology and home modifications;
(iii) advisory and support services;
(iv) personal and care support in the home or community;
(v) nursing and transition care;
(vi) residential care.

Subdivision C—Qualifications and training requirements

152-35 Qualifications and training requirements

For the purposes of paragraph 152(c) of the Act, the requirements are that aged care workers of a registered provider must have appropriate qualifications, skills or experience to provide the funded aged care services that the provider delivers to individuals.

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Division 2—Vaccination

153-5 Kinds of provider to which the condition applies

For the purposes of subsection 153(1) of the Act, a registered provider registered in the registration category residential care is prescribed.

153-10 Requirements for providing access to vaccinations to individuals

For the purposes of subsection 153(1) of the Act, the requirement in accordance with which a registered provider must provide access to the vaccinations mentioned in subsection 153(2) of the Act for free to individuals to whom the provider is delivering funded aged care services is that the provider must do so in accordance with the National Immunisation Program Schedule, published by the Department, as existing from time to time.

Note: The National Immunisation Program Schedule could in 2026 be viewed on the Department's website (https://www.health.gov.au).

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Part 7—Information and access

Division 1—Personal information and record keeping

Subdivision A—Purpose of this Division

154-1 Purpose of this Division

For the purposes of paragraph 154(a) of the Act, this Division prescribes:

(a) the kinds of records that registered providers must keep and retain; and

(b) requirements for keeping and retaining those records.

Subdivision B—Information provided to an individual

154-2 Requirement to keep and retain information provided to an individual

(1) A registered provider must keep records demonstrating their compliance with their obligations and conditions of registration under Chapter 3.

(2) It is a requirement that a registered provider keep a record prescribed under this section for 7 years starting on the day the record is made.

154-3 Requirement to correct personal information

(1) This section applies to a registered provider that is not any of the following:

(a) an APP entity within the meaning of the *Privacy Act 1988*;

(b) a State or Territory; or

(c) a body established for a public purpose by or under a law of the State or Territory (other than a local government authority).

(2) It is a requirement that when a registered provider keeps and retains records, the registered provider must comply with Australian Privacy Principle 13 as set out in Schedule 1 of the *Privacy Act 1988*, as if it were an organisation for the purposes of that Act.

Note: A registered provider that is an APP entity remains subject to the *Privacy Act 1988*, including APP 13.

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Subdivision C—Vaccination

154-5 Application of this Subdivision to certain registered providers

This Subdivision applies to a registered provider registered in the provider registration category residential care.

154-10 Records about service staff—influenza vaccinations

(1) A registered provider must keep records, for each calendar year, of the following information:

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(a) the total number of service staff in relation to the approved residential care home;

(b) the number of those service staff who have informed the registered provider, whether voluntarily or as required under a law of a State or Territory, that they have received the annual seasonal influenza vaccination for that year (whether or not under the registered provider's influenza vaccination scheme (if any)).

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

154-15 Records about service staff—COVID-19 vaccinations

(1) A registered provider must keep records, for each calendar year, of the following information:

(a) the total number of service staff in relation to the approved residential care home;

(b) the number of those service staff who have voluntarily informed the registered provider that they have received a COVID-19 vaccination in that year.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

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154-20 Records about individuals receiving residential care—influenza vaccinations

(1) A registered provider must keep records, for each calendar year, of the following information:

(a) the total number of individuals accessing funded aged care services in the approved residential care home;

(b) the number of those individuals who have voluntarily informed the registered provider that they have received the annual seasonal influenza vaccination for that year.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

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154-25 Records about individuals receiving residential care—COVID-19 vaccinations

(1) A registered provider must keep records, for each calendar year, of the following information:

(a) the total number of individuals accessing funded aged care services in the approved residential care home;

(b) the number of those individuals who have voluntarily informed the registered provider that they had received one or more COVID-19 vaccinations in that year;

(c) the number of individuals covered by paragraph (b) who have informed the registered provider that they had received only one COVID-19 vaccination;

(d) the number of individuals covered by paragraph (b) who have informed the registered provider that they had received 2 COVID-19 vaccinations.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

Subdivision D—Quality indicators

154-105 Application of Subdivision to certain registered providers

This Subdivision applies to a registered provider that is required to give a quality indicators report under section 166-110.

154-110 Requirements for records on quality indicators

(1) Each of the following kinds of records are prescribed kinds of records that a registered provider must keep and retain:

(a) a quality indicators report;

(b) records relating to the collection and measurements of quality indicators.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

Subdivision E—Incidents

154-150 Records about details of incidents

A registered provider must keep and retain the details recorded in relation to an incident under section 164-25(1) of this instrument in written or electronic form for 7 years starting on the day the record is made or received.

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Subdivision F—Complaints and feedback

154-200 Application of Subdivision to feedback received

This Subdivision applies to feedback received by a registered provider:

(a) that is managed in accordance with section 165-30; and

(b) raises an issue as referred to in subsection 165-30(2).

154-205 Requirements for records of complaints and feedback

(1) Each of the following kinds of records are prescribed kinds of records that the registered provider must keep and retain:

(a) complaints and feedback received each year;

(b) the nature of complaints and feedback;

(c) the action taken to resolve complaints and feedback;

(d) responses provided to individuals about their complaints and feedback;

(e) any improvements made by the registered provider in relation to complaints and feedback;

(f) an evaluation of the effectiveness of the actions taken by the registered provider and their related outcome in relation to each complaint and feedback;

(g) a record of the number of days taken to resolve each complaint and feedback;

(h) the education and training that has been delivered to the aged care workers and responsible persons of the registered provider in relation to each complaint and feedback.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

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Subdivision G—Prudential and financial

154-300 Requirement to keep and retain financial and prudential reports

(1) Each of the following kinds of records are prescribed kinds of records that a registered provider must keep and retain:

(a) an aged care financial report;

(b) a quarterly financial report;

(c) a general purpose financial report;

(d) an annual prudential compliance statement.

Note: See Subdivision E of Division 3 of Part 2 of Chapter 5 of this instrument for requirements relating to each record prescribed.

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(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

Subdivision H—CHSP

154-400 Application of Subdivision

This Subdivision applies to a registered provider of a kind who is registered in one or more of the following provider registration categories:

(a) home and community services;
(b) assistive technology and home modifications;
(c) advisory and support services;
(d) personal and care support in the home or community;
(e) nursing and transition care;

and delivers funded aged care services under the CHSP.

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154-405 Requirements for records

(1) Each of the following kinds of records are prescribed kinds of records that the registered provider must keep and retain:

(a) the amount of financial assistance the System Governor, on behalf of the Commonwealth, has granted the registered provider within a particular financial year;
(b) any individual fees and contributions collected over the financial year;
(c) expenditure for the delivery of funded aged care services by the provider under the funding agreement;
(d) any surplus and uncommitted funds from the previous financial year;
(e) service types, and the duration of services, delivered to each individual;
(f) activity and performance data.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years, starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

Subdivision J—NATSIFACP

154-500 Application of Subdivision

This Subdivision applies to a registered provider of a kind who is registered in one or more of the following provider registration categories:

(a) home and community services;
(b) assistive technology and home modifications;

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(c) advisory and support services;
(d) personal and care support in the home or community;
(e) nursing and transition care;
(f) residential care;

and delivers funded aged care services under the NATSIFACP.

154-505 Requirements for records

(1) Each of the following kinds of records are prescribed kinds of records that the registered provider must keep and retain:
(a) the amount of financial assistance the System Governor, on behalf of the Commonwealth, has granted the registered provider under subsection 264(2) of the Act within a particular financial year;
(b) any individual fees and contributions collected over the financial year;
(c) expenditure for the delivery of funded aged care services by the provider under the funding agreement;
(d) any surplus and uncommitted funds from the previous financial year;
(e) service types, and the duration of services, delivered to each individual;
(f) individual care and services plans;
(g) progress in embedding a wellness and reablement approach to service delivery;
(h) individual service agreements;
(i) a summary of the activities undertaken to prevent disease outbreaks;
(j) the number of individuals who are waiting to access funded aged care services for the financial year and the reason for the waitlist.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

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Subdivision K—Multi-Purpose Service Program

154-605 Application of Subdivision to certain registered providers

This Subdivision applies to a registered provider delivering funded aged care services under the MPSP.

154-610 Requirements for records

(1) Each of the following kinds of records are prescribed kinds of records that the registered provider must keep and retain:
(a) records of the amount of subsidy received under Division 5 of Part 2 of Chapter 4 of the Act to deliver funded aged care services at each approved residential care home;

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(b) records of any individual fees or contributions paid to the provider under Part 3 of Chapter 4 of the Act by individuals accessing funded aged care services, in or from, each approved residential care home;

(c) records of expenditure by the provider for the delivery of funded aged care services at each approved residential care home for the financial year;

(d) records of the service types delivered for the financial year;

(e) records of the number of individuals who have accessed funded aged care services, or are waiting to access services, in, or from, the approved residential care home for the financial year, including:

(i) whether the individual had an access approval when they commenced accessing services; and

(ii) the service types the individual accessed, including the services where specified in the individual's access approval; and

(iii) the individual's classification type for a service group; and

(iv) when the individual commenced and ceased accessing services; and

(v) the reason the individual ceased accessing services;

(f) records of the demographic information about each individual who have accessed funded aged care services, or are waiting to access services for the financial year, including:

(i) the name of the individual; and

(ii) the gender of the individual; and

(iii) the date of birth of the individual; and

(iv) whether the individual is an Aboriginal or Torres Strait Islander person; and

(v) whether the individual has dementia or dementia symptoms;

(f) records of a summary of the activities undertaken to prevent disease outbreaks.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

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Subdivision L—Transition Care Program

154-650 Application of Subdivision to certain registered providers

This Subdivision applies to a registered provider delivering funded aged care services under the TCP.

154-665 Requirements for records

(1) Each of the following kinds of records are prescribed kinds of records that the registered provider must keep and retain:

(a) records of claims for payment of subsidy made by the provider under section 260 of the Act;

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(b) records of the amount of subsidy the Commonwealth has paid to the provider for the financial year;

(c) records of any individual fees or contributions paid to the provider under Part 3 of Chapter 4 of the Act by individuals accessing funded aged care services for the financial year;

(d) records of expenditure by the provider for the delivery of funded aged care services for the financial year;

(e) records of any System Governor approved unspent funds from previous financial years.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

Subdivision M—Governing bodies

154-700 Records about independent non-executive members of a governing body

(1) If, because of paragraph 157(2)(a) of the Act and section 157-5 of this instrument, a registered provider is required to ensure that a majority of the members of its governing body are independent non-executive members, the registered provider must keep and retain records of:

(a) the names of the members of its governing body; and

(b) which of those members are independent non-executive members.

(2) It is a requirement that a registered provider keep a record prescribed under this section for 7 years starting on the day the record is made.

(3) Despite subsection (2), if a record prescribed under subsection (1) relates to a specific member of the governing body, the registered provider must keep the record for a period of 7 years following the end of that member's engagement with the governing body.

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154-705 Records about members of a governing body with clinical care provision experience

(1) If, because of paragraph 157(2)(b) of the Act and section 157-10 of this instrument, a registered provider is required to ensure that at least one member of its governing body has experience in the provision of clinical care, the registered provider must keep and retain records of:

(a) the names of the members of its governing body who have experience in the provision of clinical care; and

(b) the details of those members' experience.

(2) It is a requirement that a registered provider keep a record prescribed under this section for 7 years starting on the day the record is made.

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(3) Despite subsection (2), if a record prescribed under subsection (1) relates to a specific member of the governing body, the registered provider must keep the record for a period of 7 years following the end of that member's engagement with the governing body.

Subdivision N—Advisory bodies

154-800 Records about the quality care advisory body

(1) If, because of paragraph 158(2)(a) of the Act and section 158-5 of this instrument, a registered provider is required to establish, and continue in existence, a quality care advisory body, the registered provider must keep and retain the following:

(a) records of the names of the members of the quality care advisory body and details of:

(i) the date each member was appointed to the quality care advisory body; and

(ii) the date (if any) a member resigned from the quality care advisory body;

(b) records of how the quality care advisory body satisfies the requirements of section 158-15 of this instrument (requirements for reports of quality care advisory bodies);

(c) a copy of the minutes of any meeting held by the quality care advisory body and the date on which the meeting was held;

(d) a copy of each written report given to the governing body of the provider by the quality care advisory body under subparagraph 158(2)(a)(ii) of the Act;

(e) records of any feedback given to the governing body of the provider by the quality care advisory body under subparagraph 158(2)(a)(iii) of the Act;

(f) a copy of any written advice given to the quality care advisory body by the governing body of the provider under subparagraph 158(2)(b)(ii) of the Act advising how the governing body has considered the report and feedback mentioned in paragraphs (d) and (e) of this subsection.

(2) It is a requirement that a registered provider keep a record prescribed under this section for 7 years starting on the day the record is made.

(3) Despite subsection (2), if a record prescribed under subsection (1) relates to a specific member of the quality care advisory body, the registered provider must keep the record for a period of 7 years following the end of that member's engagement with the quality care advisory body.

154-805 Records about the consumer advisory body

(1) If, because of paragraph 158(4)(a) of the Act and section 158-20 of this instrument, a registered provider is required to offer the opportunity to establish one or more consumer advisory bodies, the registered provider must keep and retain the following:

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(a) a copy of each written offer made to individuals to whom the provider delivers funded aged care services and the supporters of those individuals giving them the opportunity to establish a consumer advisory body;
(b) records of the date on which each offer was given to those individuals and supporters.

(2) If one or more consumer advisory bodies are established, the registered provider must also keep and retain the following in relation to each body:
(a) a copy of the minutes of each meeting of the consumer advisory body;
(b) records of any feedback given to the governing body of the provider by the consumer advisory body;
(c) a copy of any written advice given to the consumer advisory body by the governing body under subparagraph 158(4)(b)(ii) of the Act advising how the governing body has considered any such feedback.

(3) It is a requirement that a registered provider keep a record prescribed under this section for 7 years starting on the day the record is made.

Subdivision P—Worker screening

154-900 Records of responsible persons

(1) A registered provider must keep, and keep up-to-date, a record for each responsible person of the provider that includes the following information and documents:
(a) the person's full name, date of birth and address;
(b) if paragraph 152-15(1)(a) or 152-16(1)(a) applies to the person—a record of the person's police certificate;
(c) if paragraph 152-15(1)(b) or 152-16(1)(b) applies to the person—a record of the person's statutory declaration;
(d) if paragraph 152-15(1)(c) or 152-16(1)(c) applies to the person—a record of the person's NDIS clearance decision.

(2) Subject to subsection (3), the registered provider must also keep a record of:
(a) the name of the person who ensured that the responsible person has a police certificate, statutory declaration or NDIS clearance decision; and
(b) the date the person did so.

(3) Subsection (2) applies if the responsible person's police certificate, statutory declaration or NDIS clearance is received by the registered provider on or after the commencement of this section.

154-905 Records of aged care workers

(1) A registered provider must keep, and keep up-to-date, a record for each aged care worker of the provider that includes the following information and documents:
(a) the worker's full name, date of birth and address;
(b) how the provider has ensured that the worker:

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(i) has appropriate qualifications, skills or experience to provide the funded aged care services that the registered provider delivers to individuals (see section 152-35 of this instrument); and

(ii) is given opportunities to develop their capability to provide those services (see paragraph 152(d) of the Act);

(c) if paragraph 152-20(1)(a) or 152-21(1)(a) of this instrument applies to the worker—a record of the worker's police certificate;

(d) if paragraph 152-20(1)(b) or 152-21(1)(b) of this instrument applies to the worker—a record of the worker's statutory declaration;

(e) if paragraph 152-20(1)(c) or 152-21(1)(c) of this instrument applies to the worker—a record of the worker's NDIS clearance decision.

(2) Subject to subsection (3), the registered provider must also keep a record of:

(a) the name of the person who ensured that the worker has a police certificate, statutory declaration or NDIS clearance decision; and

(b) the date the person did so.

(3) Subsection (2) applies if the worker's police certificate, statutory declaration or NDIS clearance is received by the registered provider on or after the commencement of this section.

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154-910 How long records required by sections 154-900 and 154-905 to be kept

A registered provider must keep a record required by section 154-900 or 154-905 for 7 years starting on the later of the following:

(a) the day the record is first made;

(b) the day the latest update to the record is made.

154-915 Copies of records relating to allegations of misconduct

(1) This section applies if a registered provider has a copy of a record relating to:

(a) an allegation of misconduct against a responsible person or aged care worker of the provider; or

(b) any action taken, including any investigation, in response to such an allegation.

(2) The provider must keep the copy for 7 years starting on the first day the provider has the copy.

Subdivision Q—Delivery and continuity of funded aged care services

154-1000 Requirement to keep and retain records relating to continuity of funded aged care services

(1) A registered provider must keep the following kinds of records, or copies of such records, for an individual to whom the provider is delivering funded aged care services:

(a) any assessment and classification records of the individual that are not provided to the System Governor in electronic form;

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(b) the service agreement between the provider and the individual;
(c) the care and services plan for the individual;
(d) the medical records, progress notes and other clinical records of the individual;
(e) where the provider is delivering funded aged care services to the individual through the service group residential care, the accounts of the individual, including:
(i) the entry (if any) in the refundable deposit register of the provider that relates to the individual; and
(ii) amounts (if any) of daily accommodation payments, daily accommodation contributions or accommodation charge paid by the individual; and
(iii) entry and leave arrangements for the individual; and
(iv) the accommodation agreement between the provider and the individual; and
(f) where the provider is delivering funded aged care services to the individual through the service groups home support, assistive technology or home modifications, the accounts of the individual, including any notices provided to the individual in accordance with section 149-45;
(g) applicability of any fee reduction supplements to the individual under sections 197-5, 231-15 or 231-20;
(h) the name and contact details of any supporter registered in relation to the individual;
(i) measurements, assessments and information about the individual obtained in accordance with sections 154-110, 166-110 and 166-112 of this instrument;
(j) monthly statements prepared in accordance with section 155-40 of this instrument.

(2) It is a requirement that a registered provider keep a record made under this section for 7 years starting on the day the record is made.

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Subdivision R—Status of service delivery branches

154-1100 Requirement to keep and retain records about service delivery branches

(1) A registered provider must keep records of their compliance with the reporting requirements under Subdivision M of Division 3 of Part 2 of Chapter 5, including records of the following:
(a) any reports given under section 166-910;
(b) any reports given under section 166-915;
(c) any reports given under section 166-920;
(d) any reports given under section 166-925;
(e) any reports given under section 166-930.

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(2) It is a requirement that a registered provider keep a record prescribed under this section for 7 years starting on the day the record is made.

Subdivision S—Claims for subsidy

154-1200 Application of this Subdivision

(1) This Subdivision applies to a registered provider registered in any registration category.

(2) Despite subsection (1), this Subdivision does not apply to a registered provider only delivering funded aged care services under one of the following specialist aged care programs:
- (a) CHSP;
- (b) MPSP;
- (c) NATSIFACP.

154-1205 Requirement to keep and retain records which enable claims for payment of subsidy to be verified

(1) A kind of record that a registered provider must keep and retain under paragraph 154(a) of the Act is any record that enables claims for payments of subsidy to be properly verified.

(2) Without limiting subsection (1), a kind of record that enables claims for payments of subsidy to be properly verified includes the following:
- (a) the service agreement between the registered provider and the individual to whom the provider is delivering funded aged care services;
- (b) the medical records, progress notes and other clinical records of the individual to whom the provider is delivering funded aged care services;
- (c) invoices for the delivery of funded aged care services to an individual;
- (d) attendance records for an aged care worker of the provider.

(3) It is a requirement that a registered provider keep a record prescribed under subsection (1) for 7 years starting on the day the record is made.

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Subdivision T—Compliance

154-1300 Requirement to keep and retain records relating to compliance

(1) A kind of record that a registered provider must keep and retain under section 154 of the Act is any record that enables proper assessments to be made of whether a provider has complied, or is complying, with its obligations under Chapter 3 of the Act.

(2) It is a requirement that a registered provider keep a record prescribed under this section for 7 years starting on the day the record is made.

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Division 2—Provision of information to individuals

155-1 Purpose of this Division

For the purposes of section 155 of the Act, this Division prescribes the requirements for the following:

(a) the records and information that a registered provider must provide and explain to individuals accessing, or seeking to access, funded aged care services;

(b) the records and information (including personal information) held by the registered provider about the individual to whom the registered provider delivers funded aged care services that a registered provider must allow and facilitate access by an individual.

155-5 Kind of information to be provided and explained

For the purposes of subsection 155(1) of the Act, this Division prescribes requirements for the provision and explanation of the following kinds of information to individuals:

(a) the Statement of Rights;

(b) information to assist individuals to choose, in accordance with the individual's access approval, funded aged care services that best meet their needs;

(c) clear and understandable invoices;

(d) information about a registered provider's management and use of refundable deposits;

(e) information for prospective individuals;

(f) monthly statements;

(g) individualised budget;

(h) general information for individuals accessing any funded aged care services;

(i) general information for individuals accessing funded aged care services in a home or community setting;

(j) general information for individuals accessing funded aged care services in an approved residential care home;

(k) information about the financial position of the registered provider in a provider registration category other than residential care;

(l) pricing information.

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155-15 Information to be provided and explained—Statement of Rights

(1) For the purposes of subsection 155(1) of the Act, a registered provider must provide an individual accessing or seeking to access funded aged care services the following:

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(a) information about the individual's rights under the Statement of Rights set out in section 23 of the Act, in relation to the funded aged care services the individual accesses;

(b) a copy of the Statement of Rights.

Note: The registered provider must retain records relating to the Statement of Rights given under paragraph (1)(b) (see section 154-2).

(2) A registered provider must assist the individual to understand the information and the Statement of Rights given under subsection (1).

(3) A registered provider must comply with subsections (1) and (2) before, or when, the registered provider commences delivery of funded aged care services to that individual.

155-20 Information to be provided—information to assist individuals to choose funded aged care services that best meet their needs

(1) This section applies to a registered provider registered in any of the following provider registration categories:

(a) home and community services;

(b) assistive technology and home modifications;

(c) advisory and support services;

(d) personal and care support in the home or community;

(e) nursing and transition care;

(f) subscription trial.

(2) A registered provider must provide such information as is reasonably necessary to assist an individual to choose, in accordance with the individual's access approval, the funded aged care services that best meet the individual's goals and assessed needs and preferences within the limits of the resources available.

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155-25 Information to be provided—clear and understandable invoices

For the purposes of subsection 155(1) of the Act, a registered provider must provide an individual with invoices that are clear and in a format that is understandable.

155-30 Information to be provided—information about a registered provider's management and use of refundable deposits

(1) This section applies to a registered provider if the registered provider is prescribed under section 150A-3 of this instrument.

Notification by registered provider

(2) Within 7 days after an accommodation agreement is entered into between a registered provider and an individual, the registered provider must notify the individual, in writing, that the registered provider will give the individual, within 7 days of a request by the individual, the following information and documents:

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(a) a summary of the permitted uses for which refundable deposits and accommodation bonds have been used by the registered provider during the previous financial year;

(b) if, during the 2 years prior to the request, the registered provider has given the System Governor an aged care financial report for the registered provider that included a permitted uses reconciliation—a copy of the permitted uses reconciliation included in the most recent such report;

(c) information about whether the registered provider has, during the previous financial year, complied with:

(i) section 310 of the Act; and

(ii) the Financial and Prudential Standards;

(d) information about:

(i) the number (if any) of refundable deposit balances or accommodation bond balances that, in the previous financial year, were not refunded in accordance with section 311 of the Act or section 287-102 of this instrument; and

(ii) the number (if any) of entry contribution balances that, in the previous financial year, were not refunded in accordance with a formal agreement;

(e) if the registered provider is required to implement and maintain a written investment management strategy under the Financial and Prudential Standards—the registered provider's investment objectives as recorded in the registered provider's investment management strategy;

(f) a copy of the audit opinion referred to in paragraph 166-380(g) of this instrument for the previous financial year;

(g) a copy of either:

(i) the most recent statement of the audited accounts in relation to the registered provider; or

(ii) if the registered provider is operated as part of a broader organisation—the most recent statement of the audited accounts of the organisation's aged care component;

(h) a copy of the refundable deposit register entry that relates to the individual, as at the time of the request.

(3) A registered provider that is not required to prepare annual financial reports under Part 2M.3 of Chapter 2M of the *Corporations Act 2001* is not required to comply with paragraph (2)(g) of this section.

Disclosure of refundable deposit register entry relating to an individual

(4) A copy of the refundable deposit register entry that relates to the individual must be provided to the individual or another person in the following circumstances:

(a) when the individual ceases to access funded aged care services through the registered provider's approved residential care home, the record must be provided to the individual, or if the individual has died, the individual's legal representative or estate;

(b) when the individual moves to another approved residential care home of another approved provider, the record must be provided to the individual.

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Disclosure on request

(5) If an individual requests the registered provider of an approved residential care home in which the individual is accessing funded aged care services to give the individual the information and documents referred to in subsection (2) or (4), the registered provider must give the individual the information and documents requested within 7 days after receiving the request.

(6) Subsection (5) applies in relation to an individual who is accessing funded aged care services in an approved residential care home:

(a) whether or not the individual entered into an accommodation agreement with the registered provider of the approved residential care home; and

(b) whether or not the individual has paid a refundable deposit; an accommodation bond or an entry contribution to that registered provider.

(7) If:

(a) as a result of a request by an individual, a registered provider is required under subsection (5) to give the individual the summary referred to in paragraph (2)(a); and

(b) the registered provider has given the System Governor an aged care financial report for the registered provider for the previous financial year, and that report included a permitted uses reconciliation;

the registered provider may satisfy the requirement to give the individual the summary by giving the individual a copy of that permitted uses reconciliation.

Disclosure after end of financial year for registered provider

(8) Within 4 months after the end of each financial year for a registered provider, the registered provider must give each individual who has paid a refundable deposit, an accommodation bond or an entry contribution to the registered provider for entry to the approved residential care home operated by the registered provider:

(a) a copy of the refundable deposit record that relates to the individual as at the end of the financial year; and

(b) a written statement that the registered provider will provide, within 7 days of a request by the individual, the information and documents referred to in subsection (2).

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155-35 Information to be provided—to prospective individuals

(1) This section applies to a registered provider if the registered provider is prescribed under section 150A-3 of this instrument.

(2) Within 7 days of a request from a prospective individual, a registered provider must give the prospective individual the information and documents referred to in paragraphs 155-30(2)(a) to (g).

155-36 Information to be provided—statement of audited accounts

(1) Subject to subsection (2), if section 155-30 of this instrument does not apply to the registered provider that is registered in the provider registration category

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residential care, the provider must, if asked by an individual to whom the provider is delivering funded aged care services, give the individual, within 7 days of the request, a copy of either:

(a) the most recent statement of the audited accounts in relation to the registered provider; or

(b) if the registered provider is operated as part of a broader organisation—the most recent statement of the audited accounts of the organisation's aged care component; or

(c) the most recent audited general purpose financial report prepared under Subdivision E of Division 3 of Part 2 of Chapter 5 of this instrument.

(2) Despite subsection (1) of this section, a registered provider is not required to comply with this requirement if the registered provider:

(a) is not required to prepare annual financial reports under Part 2M.3 of the Chapter 2M of the *Corporations Act 2001*; and

(b) is not required to prepare a general purpose financial report under section 166-345 of this instrument.

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155-40 Information to be provided—monthly statement

(1) This section applies to a registered provider registered in any of the following provider registration categories:

(a) home and community services;

(b) assistive technology and home modifications;

(c) advisory and support services;

(d) personal and care support in the home or community;

(e) nursing and transition care;

(f) subscription trial.

(2) The requirements of this section do not apply in respect of the delivery of funded aged care services under a specialist aged care program.

(3) A registered provider that delivers funded aged care services to an individual through a service delivery branch in a calendar month must give the individual a written statement relating to the services delivered in that calendar month no later than the last day of the following month.

Monthly statement for an individual accessing care through the service group home support

(4) The monthly statement must contain the following:

(a) the amount of person-centred subsidy for the individual for the quarter in their ongoing home support account or the amount of person-centred subsidy for the individual for the episode in their short-term home support account;

(b) the amount of person-centred subsidy that was available for the individual in their ongoing or short-term home support account at the beginning of the calendar month;

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(c) the amount of person-centred subsidy for the individual remaining in their ongoing or short-term home support account at the end of the calendar month;

(d) the name and amount of the primary-centred supplements (if any) for the individual in their ongoing home support account for the quarter and the name and amount of the primary-centred supplements (if any) for the individual in their short-term home support account for the episode;

(e) rollover credits received in respect of the quarter;

(g) an itemised list of:

(i) each episode of services or items delivered to the individual during the calendar month; and

(ii) any adjustments, variations or refunds from previous calendar months, including the service name and delivery date if relating to a service; and

(iii) any adjustments, variations or refunds from previous calendar months, including the service name and delivery date if relating to individual contribution amounts;

(h) for each service or item delivered under the classification type ongoing or the classification type short-term:

(i) the name of the service or item as described in the service list under section 8-5 of this instrument; and

(ii) the price or cost that the registered provider charged the individual in respect of the calendar month; and

(iii) the date on which the service or item was delivered in respect of the calendar month; and

(iv) the contribution amount for the individual in respect of each service or item delivered in the calendar month; and

(v) the total amount of contribution paid by the individual for the calendar month; and

(vi) the amount of subsidy claimed by the registered provider in respect of each service or item delivered in the calendar month; and

(vii) the number of units or hours delivered in respect of the calendar month; and

(viii) if the service or item was delivered by an associated provider of the registered provider or by a third party, that fact;

(i) for each service delivered under the classification type ongoing or short-term:

(i) identify the individual contribution rate, which must be provided each time there is a change to the contribution rate arising from a new determination made under section 314 of the Act; and

(ii) the corresponding amount for which the individual is responsible to contribute for delivery of that service;

(j) for individuals with the classification type ongoing, information relating to the total number of units or hours delivered for the service type care management delivered in the relevant calendar month;

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(k) for individuals with the classification level SAH end-of-life pathway for the classification type short-term, information relating to:
  (i) the total number of units or hours delivered for the service type care management; and
  (ii) the price and cost of the service and amount of subsidy claimed by the provider in respect of that service;
(l) for individuals with the classification level SAH restorative care pathway for the classification type short-term, information relating to:
  (i) the total number of units or hours delivered for the service type restorative care management; and
  (ii) the price and cost of the service and amount of subsidy claim by the provider in respect of that service;
(m) for each service taken to be delivered in accordance with subsection 11A(2) of the Act:
  (i) the name of the service as provided in the list referred to in subsection 8(1) of the Act; and
  (ii) the amount that the registered provider charged the individual for the service; and
  (iii) the date on which the service was taken to be delivered; and
  (iv) if the registered provider charged an individual contribution for the service, the individual contribution rate used to work out the individual contribution; and
  (v) the amount of subsidy claimed by the registered provider for the service.

Monthly statement for an individual accessing care through the service groups assistive technology or home modifications

(5) The monthly statement must contain the following:
(a) the amount of person-centred subsidy for the individual for the account period;
(b) the available balance of the individual's notional assistive technology or home modifications account (if any) at the beginning of the calendar month;
(c) the available balance of the individual's notional assistive technology account or home modifications account at the end of the calendar month;
(d) the available balance of the individual's notional assistive technology account or notional home modifications account after taking into account any committed funds;
(e) any amount of the available balance that is no longer available to the individual due to the ceasing of the individual's notional assistive technology account or notional home modifications account in respect of the calendar month;
(f) the end date of the account period for the individual's notional assistive technology account or notional home modifications account in the following calendar month;

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(g) the name and amount of primary person-centred supplements (if any) for the individual for the account period;

(h) any additional approved amounts as specified in the determination made under subsection 211-20(5) of this instrument;

(i) an itemised list of:

(i) assistive technology or home modification items and services (if any), including administration or coordination, delivered to the individual during the calendar month; and

(ii) any adjustments, variations or refunds from previous calendar months;

(j) for each item or service delivered:

(i) the name of the item or service; and

(ii) the price that the registered provider charged the individual for the item or service in respect of the calendar month; and

(iii) the date on which the item or service was delivered in respect of the calendar month; and

(iv) the amount of contribution (if any) paid by the individual in respect of each item or service delivered in the calendar month; and

(v) the total amount of contribution paid by the individual for the calendar month; and

(vi) the amount of subsidy claimed by the registered provider in respect of each service or item delivered in the calendar month; and

(vii) the rate and number of item units or service hours delivered in respect of the calendar month; and

(viii) if the service or item was delivered by an associated provider of the registered provider or by a third party, that fact;

(k) any commitments to assistive technology or home modifications made during the calendar month, including those items, modifications or related services which are agreed to with the individual, but which have not yet been delivered within the calendar month;

(l) for each item or service committed to but not yet delivered:

(i) the name and price for each item or service agreed to; and

(ii) the amount of contribution in respect of each item or service that remains to be paid; and

(iii) the total amount of committed funds, including a breakdown of the total amount of subsidy to be claimed and the total amount of contribution to be paid;

(m) any assistive technology or home modification items charged through the assistive technology or home modifications account or through unspent Commonwealth portion;

(n) for each service taken to be delivered in accordance with subsection 11A(2) of the Act:

(i) the name of the service as provided in the service list under section 8-5 of this instrument; and

(ii) the amount that the registered provider charged the individual for the service; and

(iii) the date on which service was taken to be delivered; and

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(iv) if the registered provider charged an individual contribution for the service, the individual contribution rate used to work out the individual contribution; and

(v) the amount of subsidy claimed by the registered provider for the service.

Unspent portions and notional home care accounts

(6) If an individual has a notional home care account; or the registered provider holds an unspent Commonwealth portion or an unspent care recipient portion for the individual, the monthly statement must contain the following:

(a) the available balance of the individual's notional home care account at the beginning and end of the calendar month;

(b) the available balance of the individual's unspent Commonwealth portion at the beginning and end of the calendar month;

(c) the amount of the individual's unspent care recipient portion at the beginning and end of the calendar month.

Monthly statement for established account types

(7) The monthly statement must only contain information regarding the notional accounts established for the individual.

Monthly statement for a period in which no services are delivered

(8) If no service or item was delivered by registered provider to the individual during the calendar month, a statement must still be provided no later than the last day of the following calendar month.

When statement must be given

(9) A registered provider must give the statement to the individual no later than the last day of the following calendar month.

Informing the individual of, and helping the individual to understand, statement

(10) A registered provider must inform the individual of and help the individual to understand the monthly statement.

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155-41 Information to be provided with monthly statement—subscription services

(1) This section applies to a registered provider in respect of a calendar month if:

(a) the provider is registered in the provider registration category subscription trial; and

(b) the provider is required under subsection 155-40(3) to give an individual a written statement relating to the funded aged care services delivered to the individual by the provider in the month; and

(c) the services included a subscription service.

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(2) The registered provider must give the individual a statement, for each subscription service delivered to the individual in the month, of the use that the individual made of the service in the month, including the following:

(a) each day that the individual accessed the service made available to the individual by the subscription service;

(b) for each day referred to in paragraph (a):

(i) the number of hours on the day that the individual accessed the service made available to the individual by the subscription service; and

(ii) whether the service made available to the individual by the subscription service was delivered by an associated provider of the registered provider;

(c) for the month—the total number of hours that the individual accessed the service made available to the individual by the subscription service.

(3) The registered provider must give the statement under subsection (2) at the same time that the provider gives the statement under subsection 155-40(3).

155-45 Information to be given—final monthly statement

(1) This section applies to a registered provider registered in any of the following provider registration categories:

(a) home and community services;

(b) assistive technology and home modifications;

(c) advisory and support services;

(d) personal and care support in the home or community;

(e) nursing and transition care;

(f) subscription trial.

(2) The requirements of this section do not apply in respect of the delivery of funded aged care services under a specialist aged care program.

(3) If a registered provider ceases to deliver funded aged care services to the individual, the registered provider must give the individual or their supporter, after the final claim is made for the individual, a final monthly statement.

(4) The final monthly statement must be prepared in accordance with subsection 155-40(4) or (5).

(6) A registered provider must give the final monthly statement to the individual or their supporter no later than the last day of the calendar month after the last claim is made.

155-50 Information to be provided—individualised budget

(1) This section applies to a registered provider registered in any of the following provider registration categories:

(a) home and community services;

(b) assistive technology and home modifications;

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(c) advisory and support services;
(d) personal and care support in the home or community;
(e) nursing and transition care;
(f) subscription trial.

(2) The requirements of this section do not apply in respect of the delivery of funded aged care services under a specialist aged care program.

(3) A registered provider that delivers funded aged care services to an individual through one or more of the service groups home support, assistive technology and home modifications must give the individual a written individualised budget.

(4) The individualised budget for the individual must:
(a) be prepared in partnership with the individual; and
(b) cover a period agreed with the individual (the ***budget period***); and
(c) be prepared having regard to the individual's preferences, goals and assessed needs, the resources available and the funded aged care services selected by the individual for the budget period; and
(d) set out an itemised budget for the funded aged care services to be delivered to the individual in the budget period, as set out in the individual's care and services plan, including, for each service to be delivered to the individual on a day:
(i) if an individual contribution rate determination for the individual is in effect—the individual contribution rate for the service for the individual; and
(ii) if an individual contribution rate determination for the individual is not in effect—the maximum individual contribution rate that could apply to the service for the individual (when determined for each means testing category for the individual under section 314 of the Act); and
(iii) if known—the cost for the delivery of the service; and
(iv) if known—the amount that will be the individual contribution for the delivery of the service to the individual on the day; and
(v) if known—the amount of subsidy for which the provider will be eligible for the delivery of the service to the individual on the day; and
(e) for the service group assistive technology, the itemised budget must also specify the following (if known):
(i) the description and cost for assistive technology products and equipment;
(ii) the description and cost for assistive technology product and equipment repair or maintenance;
(iii) the prescription cost (if applicable) for assistive technology;
(iv) the description and cost of wraparound activities for assistive technology;
(v) administrative costs charged by the registered provider for assistive technology; and

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(f) for the service group home modifications, the itemised budget must also specify the following:
  (i) the description and cost of home modification supplies and services;
  (ii) the prescription cost (if applicable) for home modifications;
  (iii) the description and cost of wraparound activities for home modifications;
  (iv) coordination costs charged by the registered provider for home modifications; and
(g) if known—set out the amount of subsidy payable to the registered provider for the individual in respect of the period agreed between the individual and the registered provider.

(5) A registered provider must give the individualised budget to the individual as soon as practicable after the registered provider has all the necessary information to complete it.

(6) A registered provider must review and, if necessary, revise the individualised budget for the individual if:
(a) a change to the funded aged care services mentioned in paragraph (4)(d) is proposed; or
(b) there is a change to the costs for delivering those services; or
(c) the individual contribution rate for the individual changes; or
(d) the individual requests the registered provider to do so.

(7) If a registered provider reviews and revises the individualised budget for an individual, the registered provider must give the individual a copy of the revised individualised budget:
(a) if the review and revision was for a reason referred to in paragraph (6)(a), (b) or (c)—as soon as practicable after the registered provider has all the necessary information to complete it; or
(b) if the review and revision was in response to a request referred to in paragraph (6)(d)—within 14 days of the request being made.

(8) The registered provider must inform the individual of, and help the individual to understand, the individualised budget for the individual.

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155-55 Information to be provided—general information for individuals accessing any funded aged care services

(1) For the purposes of subsection 155(1) of the Act, a registered provider must give an individual accessing, or seeking to access, funded aged care services the following:
(a) a copy of the document mentioned in paragraph 165-20(1)(f) of this instrument, relating to giving complaints and feedback;
(b) an explanation of the effect of section 168 of the Act (which deals with the protection of personal information);
(c) a copy of the Aged Care Code of Conduct.

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(2) A registered provider must assist the individual to understand the information given under subsection (1) of this section.

(3) A registered provider must comply with subsections (1) and (2) before, or when, the registered provider commences delivery of funded aged care services to that individual.

155-60 Information to be provided—general information for individuals accessing funded aged care services in a home or community setting

(1) This section applies to a registered provider registered in any of the following provider registration categories:

(a) home and community services;
(b) assistive technology and home modifications;
(c) advisory and support services;
(d) personal and care support in the home or community;
(e) nursing and transition care;
(f) subscription trial.

(2) For the purposes of subsection 155(1) of the Act, a registered provider must give an individual accessing, or seeking to access, funded aged care services in a home or community setting the following:

(a) an explanation of the effect of Division 1 of Part 5 of Chapter 4 of the Act and Division 1 of Part 2 of Chapter 10 of this instrument (which deals with means testing in a home or community setting);
(b) information about the circumstances in which the provider may cease delivery of funded aged care services to the individual as specified in subsection 149-35(2) of this instrument, including an explanation of the effect of section 149-40 (which deals with notice requirements applicable to the provider);
(c) an explanation of the effect of subsection 148-80(1) of this instrument (which deals with the development of a care and services plan for the individual);
(d) information that the provider will give the individual a monthly statement in accordance with sections 155-40 and 155-45 of this instrument;
(e) for individuals accessing funded aged care services through the service group home support, other than under a specialist aged care program—a copy of the most recent version of the Support at Home Service List published by the Department.

Note: The Support at Home Service List could in 2026 be viewed on the Department's website (https://www.health.gov.au).

(3) A registered provider must assist the individual to understand the information given under subsection (2) of this section.

(4) A registered provider must comply with subsections (2) and (3) before, or when, the registered provider commences delivery of funded aged care services to that individual.

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(5) Despite subsection (2) of this section, the requirements of paragraphs (2)(a) and (2)(d) of this section do not apply in respect of the delivery of funded aged care services delivered under any specialist aged care program.

155-65 Information to be provided—general information for individuals accessing funded aged care services in an approved residential care home

(1) This section applies to a registered provider registered in the provider registration category residential care.

(2) For the purposes of subsection 155(1) of the Act, a registered provider must give an individual accessing, or seeking to access, funded aged care services in an approved residential care home the following:

(a) information about the circumstances in which the individual may be asked to leave the approved residential care home as specified in subsection 149-60(1) of this instrument, including an explanation of the effect of section 149-65 (which deals with notice requirements applicable to the provider);

(b) information about any policies or protocols of the approved residential care home that are relevant to the individual.

(3) A registered provider must assist the individual to understand the information given under subsection (2) of this section.

(4) A registered provider must comply with subsections (2) and (3) before, or when, the registered provider commences delivery of funded aged care services to that individual.

155-70 Information to be provided—information about the financial position of a registered provider registered in a provider registration category other than residential care

(1) Subject to subsection (2), this section applies to a registered provider registered in any of the following provider registration categories:

(a) home and community services;

(b) assistive technology and home modifications;

(c) advisory and support services;

(d) personal and care support in the home or community;

(e) nursing and transition care;

(f) subscription trial.

(2) This section does not apply to registered providers of services in the registration categories listed in subsection (1) which are government entities.

(3) For the purposes of subsection 155(1) of the Act, before or when a registered provider starts delivering funded aged care services to an individual the registered provider must notify the individual, in writing, that the registered

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provider will give the individual, within 7 days of a request by the individual, the following information and documents:

(a) a clear and simple presentation of the financial position of the registered provider;

(b) a copy of the most recent statement of the audited accounts of the service delivery branch or, if the service delivery branch is operated as part of a broader organisation, the most recent statement of the audited accounts of the organisation's aged care component (that includes the service delivery branch).

(4) If an individual requests the registered provider to give the individual the information and documents referred to in subsection (3), the registered provider must give the individual the information and documents requested within 7 days after receiving the request.

(5) A registered provider that is not required to prepare annual financial reports under Part 2M.3 of Chapter 2M of the *Corporations Act 2001* is not required to comply with paragraph (3)(b) of this section.

155-80 Information to be provided—pricing information (by way of publication)

(1) This section applies to a registered provider registered in any of the following provider registration categories:

(a) home and community services;

(b) assistive technology and home modifications;

(c) advisory and support services;

(d) personal and care support in the home or community;

(e) nursing and transition care.

Service group home support

(2) A registered provider delivering funded aged care services through the service group home support must publish on the registered provider's website the most common price that the registered provider charges individuals for each service in the following service types:

(a) allied health and therapy;

(b) care management;

(c) domestic assistance;

(d) home maintenance and repairs;

(e) home or community general respite;

(f) meals;

(g) nursing care;

(h) personal care;

(i) restorative care management;

(j) social support and community engagement;

(k) therapeutic services for independent living;

(l) transport.

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(3) The pricing information published for the purposes of subsection (2) of this section must:

(a) specify the most common price for delivery of the service during standard business hours; and

(b) specify the most common price for delivery of the service on weekdays outside standard business hours; and

(c) specify the most common price for delivery of the service on Saturdays; and

(d) specify the most common price for delivery of the service on Sundays; and

(e) specify the most common price for delivery of the service on public holidays.

(4) In this section:

most common price means the price for a service that the registered provider has most frequently charged during the previous 2 calendar months, calculated at the end of the following:

(a) August;

(b) October;

(c) December;

(d) February;

(e) April;

(f) June.

(5) A registered provider must update the pricing information on the registered provider's website for a service where the most common price for the service changes, within 30 days of the end of the calculation period mentioned in subsection (4).

(6) A registered provider is not required to publish a price for a service under subsection (2) if the registered provider is not currently delivering the service and has not delivered the service in the last 12 months.

(7) The requirements of this section do not apply to a registered provider in respect of the delivery of funded aged care services under a specialist aged care program.

Service group assistive technology

(8) A registered provider registered in the provider registration category assistive technology and home modifications delivering funded aged care services through the service group assistive technology must publish on the registered provider's website:

(a) whether the registered provider charges a provider administration fee for the provision of funded aged care services; and

(b) if the registered provider charges a provider administration fee, the amount of the provider administration fee as a percentage of the price for the provision of services.

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(9) A registered provider must update the pricing information on the registered provider's website where the information published under subsection (8) changes, within 30 days of the change.

Service group home modifications

(10) A registered provider registered in the provider registration category assistive technology and home modifications delivering funded aged care services through the service group home modifications must publish on the registered provider's website:

(a) whether the registered provider charges a provider coordination fee for the provision of funded aged care; and

(b) if the registered provider charges a provider coordination fee, the amount of the provider coordination fee as a percentage of the price for the provision of services.

(11) A registered provider must update the pricing information on the registered provider's website where the information published under subsection (10) changes, within 30 days of the change.

155-85 Requirements for allowing and facilitating access to information held about an individual

(1) For the purposes of subsection 155(2) of the Act, a registered provider that is not any of the following is prescribed:

(a) an APP entity within the meaning of the *Privacy Act 1988*;

(b) a State or Territory;

(c) body established for a public purpose by or under a law of the State or Territory (other than a local government authority).

(2) For the purposes of paragraph 155(2)(b) of the Act, it is a requirement when a registered provider is allowing and facilitating access by an individual to whom the registered provider delivers funded aged care services to records and information (including personal information) held by the registered provider about the individual, that the registered provider must comply with Australian Privacy Principle 12 as set out in Schedule 1 of the *Privacy Act 1988*, as if it were an organisation for the purposes of that Act.

Note: A registered provider that is an APP entity remains subject to the *Privacy Act 1988*, including APP 12.

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Division 3—Access by supporters etc.

156-5 Access to individuals

(1) For the purposes of subsection 156(1) of the Act, every kind of registered provider is prescribed.

Supporters

(2) For the purposes of subsection 156(1) of the Act, it is a requirement that a registered provider must allow and facilitate access (whether physically, by visual link or other reasonable means requested by the individual) by a supporter of an individual to whom the provider delivers funded aged care services to the individual at any time requested, or consented to, by the individual.

Note: See also subsection 156(4) of the Act, which relates to providers delivering services to an individual in a home or community setting, and access requirements only applying in relation to times during which those services are being delivered.

Legal advisors etc.

(3) For the purposes of subsection 156(1) of the Act, it is a requirement that a registered provider must allow and facilitate access (whether physically, by visual link or other reasonable means requested by the individual) to an individual to whom the provider delivers funded aged care services by a relevantly qualified person providing legal advice or another legal service to the individual at any time requested, or consented to, by the individual.

Note: See also subsection 156(4) of the Act, which relates to providers delivering services to an individual in a home or community setting, and access requirements only applying in relation to times during which those services are being delivered.

Independent aged care advocates

(4) For the purposes of subsection 156(1) of the Act, it is a requirement that a registered provider must allow and facilitate access (whether physically, by visual link or other reasonable means requested by the individual) by an independent aged care advocate to an individual to whom the provider delivers funded aged care services:

(a) unless paragraph (b) applies—at any time requested, or consented to, by the individual; or

(b) if the individual is unable to request or consent to the access—at any time.

Note: See also subsection 156(4) of the Act, which relates to providers delivering services to an individual in a home or community setting, and access requirements only applying in relation to times during which those services are being delivered.

Aged care volunteer visitor

(5) For the purposes of subsection 156(1) of the Act, it is a requirement that a registered provider must allow and facilitate access (whether physically, by visual link or other reasonable means requested by the individual) by an aged

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care volunteer visitor to an individual to whom the provider delivers funded aged care services at any time requested, or consented to, by the individual.

Note: See also subsection 156(4) of the Act, which relates to providers delivering services to an individual in a home or community setting, and access requirements only applying in relation to times during which those services are being delivered.

156-10 Access to settings

(1) For the purposes of subsection 156(2) of the Act:

(a) every kind of registered provider is prescribed; and

(b) it is a prescribed requirement that, if:

(i) a registered provider delivers funded aged care services to an individual in a setting; and

(ii) the individual requests, or consents to, access by an independent aged care advocate; and

(iii) the purpose of the access by the advocate is to provide information and education to the individual;

the registered provider must allow and facilitate the access to the individual, and any other individual who requests or consents to the access, in the setting.

Note 1: See also subsection 156(4) of the Act, which relates to providers delivering services to an individual in a home or community setting, and access requirements only applying in relation to times during which those services are being delivered.

Note 2: See also subsections 156(6) and (7) of the Act, which relate to access to settings.

(2) Without limiting paragraph (1)(b), a setting may include the following:

(a) a residential care home;

(b) a home or community setting.

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Part 8—Governance

Division 1—Membership of governing bodies

157-5 Kinds of provider to which the independent non-executive members requirement applies

(1) For the purposes of paragraph 157(2)(a) of the Act, a registered provider registered in any of the following provider registration categories is prescribed, unless the provider is covered by subsection (2):

(a) nursing and transition care;

(b) residential care.

(2) This subsection covers a registered provider that is:

(a) a kind of body known as an Aboriginal Community Controlled Organisation; or

(b) a body that is registered under the Co-operatives National Law or the *Co-operatives Act 2009* (WA) as a co-operative and has clauses in its rules to the effect that:

(i) an objective or primary activity of the registered provider is delivering quality funded aged care services to individuals in accordance with the Aged Care Quality Standards; and

(ii) distribution of assets to members upon winding-up are limited to the nominal value of the member's contribution to the co-operative, provided that such a limitation complies with the legislation under which the co-operative is registered.

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157-10 Kinds of provider to which the clinical care provision experience requirement applies

For the purposes of paragraph 157(2)(b) of the Act, a registered provider is prescribed if the provider:

(a) is registered in any of the following provider registration categories:

(i) nursing and transition care;

(ii) residential care; and

(b) is not a kind of body known as an Aboriginal Community Controlled Organisation.

157-15 Kinds of providers to which other governing body requirements apply

For the purposes of subsection 157(5) of the Act, a registered provider that is covered by paragraph 157-5(2)(b) of this instrument must ensure that the members of the provider's governing body undertake training on governance focused on co-operatives or includes course material on co-operatives within 6 months of the member's appointment as a member of the governing body.

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157-20 Application for determination that certain conditions do not apply—other matters that the Commissioner may take into account

For the purposes of paragraph 159(4)(h) of the Act, the matters are the following:

(a) subject to paragraph (b) of this section, the registered provider's history of compliance with the governance conditions set out in paragraphs 157(2)(a) and 157(2)(b) of the Act;

(b) any circumstances surrounding the registered provider's history of non-compliance with the governance conditions set out in paragraphs 157(2)(a) and 157(2)(b) of the Act, including steps (if any) that the provider has taken to become compliant;

(c) any other matter the Commissioner considers relevant.

Note: For paragraph (b), examples of circumstances include the following:

(a) where a member of a governing body has unexpectedly resigned, and recruitment of a new member is ongoing, which renders a provider non-compliant with a governance condition;

(b) where a person has accepted a role as a member of the governing body but is yet to commence in that role.

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Division 2—Advisory body requirements

158-5 Kinds of provider to which the quality care advisory body condition applies

For the purposes of subsection 158(2) of the Act, a registered provider registered in any of the following provider registration categories is prescribed:

(a) nursing and transition care;

(b) residential care.

158-10 Requirements for membership of quality care advisory body

For the purposes of subparagraph 158(2)(a)(i) of the Act, the requirements are that the membership of the quality care advisory body of a registered provider must include the following:

(a) a responsible person of the registered provider who has appropriate experience in the delivery of funded aged care services;

(b) if the registered provider is registered in the provider registration category residential care—a person who is directly involved in the provider's delivery of funded aged care services;

(c) if the registered provider is registered in the provider registration category nursing and transition care and delivers funded aged care services in the service type nursing care—a person who is directly involved in the delivery of those services;

(d) a person who represents the interests of individuals to whom the provider delivers funded aged care services.

Note: For paragraph (d), examples of such persons include the following:
(a) an individual to whom the provider is delivering funded aged care services;
(b) a member of a consumer advisory body (if established);
(c) a member of an organised consumer advisory service.

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158-15 Requirements for reports of quality care advisory body

For the purposes of subparagraph 158(2)(a)(ii) of the Act, the requirements for a written report given by the quality care advisory body of a registered provider to the governing body of the provider are that the report must include any concerns that the body has about the quality of funded aged care services delivered by the provider in the period covered by the report (the ***report period***), taking into account the following:

(a) feedback provided (if any) about the quality of funded aged care services delivered by the provider in the report period by:

(i) individuals to whom the provider delivered funded aged care services; and

(ii) responsible persons and aged care workers of the provider;

(b) complaints received (if any) in the report period by the provider about the quality of funded aged care services delivered by the provider and action taken by the provider to address the complaints;

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(c) the use of regulatory mechanisms (if any) under Chapter 6 of the Act by the Commissioner in relation to the quality of funded aged care services delivered by the provider;

(d) progress made in the report period in relation to the provider's continuous improvement plan, particularly improvements made in the delivery of funded aged care services by the provider;

(e) the results of any audits performed by the Commissioner under section 110-38;

(f) staffing arrangements of the provider during the report period, including details of the following, as applicable:

(i) the availability of allied health professionals or registered health practitioners;

(ii) the availability of registered nurses;

(iii) turnover of the aged care workers of the provider;

(g) reportable incidents (if any) in connection with the delivery of funded aged care services to an individual by the provider that occurred in the report period and any action taken by the provider in response to the reportable incidents;

(h) if the provider delivers funded aged care services in an approved residential care home:

(i) feedback received (if any) in the report period from individuals to whom the provider delivers funded aged care services about the quality of food provided by the provider; and

(ii) changes (if any) in the report period in the quality of food provided, and the food preparation model used, by the provider; and

(iii) menu assessments (if any) conducted by an accredited practising dietitian in the report period in relation to food and nutrition provided by the provider; and

(iv) information compiled or derived from a measurement or other assessment made by the provider in the report period in relation to the Quality Indicators in Subdivision B of Division 3 of Part 2 of Chapter 5 of this instrument.

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158-20 Kinds of provider to which the consumer advisory bodies condition applies

For the purposes of subsection 158(4) of the Act, a registered provider registered in any of the following provider registration categories is prescribed:

(a) nursing and transition care;

(b) residential care.

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Part 9—Restrictive practices—approved residential care homes

Division 1—Preliminary

162-5 Kinds of provider to which the condition applies

For the purposes of section 162 of the Act, a registered provider registered in the provider registration category residential care is prescribed.

162-10 Requirements relating to the use of restrictive practices

For the purposes of section 162 of the Act, this Part prescribes requirements relating to the use of restrictive practices in relation to an individual to whom a registered provider is delivering funded aged care services in an approved residential care home.

Note: See also sections 17 and 18 of the Act and Division 2 of Part 7 of Chapter 1 of this instrument.

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Division 2—Requirements relating to the use of restrictive practices

162-15 Requirements for the use of any restrictive practice

(1) The following requirements apply to the use of any restrictive practice in relation to an individual:

(a) the restrictive practice is used only:

(i) as a last resort to prevent harm to the individual or other persons; and

(ii) after consideration of the likely impact of the use of the restrictive practice on the individual;

(b) to the extent possible, best practice alternative strategies are used before the restrictive practice is used;

(c) the alternative strategies that have been considered or used have been documented in the behaviour support plan for the individual;

(d) the restrictive practice is used only to the extent that it is necessary and in proportion to the risk of harm to the individual or other persons;

(e) the restrictive practice is used in the least restrictive form, and for the shortest time, necessary to prevent harm to the individual or other persons;

(f) informed consent to the use of the restrictive practice, and how it is to be used (including its duration, frequency and intended outcome), has been given by:

(i) the individual; or

(ii) if the individual lacks the capacity to give that consent—the restrictive practices substitute decision-maker for the restrictive practice;

(g) the use of the restrictive practice is in accordance with the informed consent mentioned in paragraph (f);

(h) the use of the restrictive practice complies with any provisions of the behaviour support plan for the individual that relate to the use of the restrictive practice;

(i) the use of the restrictive practice complies with the Aged Care Quality Standards and the Aged Care Code of Conduct;

(j) the use of the restrictive practice is not inconsistent with the Statement of Rights;

(k) the use of the restrictive practice meets the requirements (if any) of the law of the State or Territory in which the restrictive practice is used.

(2) However, the requirements set out in paragraphs (1)(a), (b), (c), (f), (g) and (h) do not apply to the use of a restrictive practice in relation to an individual if the use of the restrictive practice in relation to the individual is necessary in an emergency.

(3) Subsection (2) applies only while the emergency exists.

Note: See section 162-35 for other responsibilities of registered providers that apply if the use of a restrictive practice in relation to an individual is necessary in an emergency.

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162-20 Additional requirements for the use of restrictive practices other than chemical restraint

(1) The following requirements apply to the use of a restrictive practice in relation to an individual that is not chemical restraint:

(a) an approved health practitioner who has day-to-day knowledge of the individual has:

(i) assessed the individual as posing a risk of harm to the individual or any other person; and

(ii) assessed that the use of the restrictive practice is necessary;

(b) the following matters have been documented in the behaviour support plan for the individual:

(i) the assessments;

(ii) a description of any engagement with persons other than the approved health practitioner in relation to the assessments;

(iii) a description of any engagement with external support services (for example, dementia support specialists) in relation to the assessments.

(2) However, the requirement set out in paragraph (1)(b) does not apply to the use of a restrictive practice in relation to an individual if the use of the restrictive practice in relation to the individual is necessary in an emergency.

(3) Subsection (2) applies only while the emergency exists.

Note: See section 162-35 for other responsibilities of registered providers that apply if the use of a restrictive practice in relation to an individual is necessary in an emergency.

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162-25 Additional requirements for the use of restrictive practices that are chemical restraint

(1) The following requirements apply to the use of a restrictive practice in relation to an individual that is chemical restraint:

(a) the registered provider is satisfied that a medical practitioner or nurse practitioner has:

(i) assessed the individual as posing a risk of harm to the individual or any other person; and

(ii) assessed that the use of the chemical restraint is necessary; and

(iii) prescribed medication for the purpose of using the chemical restraint; and

(iv) obtained informed consent to the prescribing of the medication for the purpose of using the chemical restraint;

(b) the following matters have been documented in the behaviour support plan for the individual:

(i) the assessments;

(ii) the practitioner's decision to use the chemical restraint;

(iii) the individual's behaviours that are relevant to the need for the chemical restraint;

(iv) the reasons the chemical restraint is necessary;

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(v) the information (if any) provided by the registered provider to the practitioner that informed the decision to prescribe the medication for the purpose of using the chemical restraint;

(vi) that the registered provider is satisfied that the practitioner obtained informed consent to the prescribing of the medication;

(vii) the details of the prescription for the prescribed medication, including its name, dosage and when it may be used;

(viii) a description of any engagement with persons other than the practitioner in relation to the use of the chemical restraint;

(ix) a description of any engagement with external support services (for example, dementia support specialists) in relation to the assessments;

(c) the use of the medication for the purpose of using the chemical restraint is in accordance with the prescription mentioned in subparagraph (b)(vii).

Note: Codes of appropriate professional practice for medical practitioners and nurse practitioners provide for the practitioners to obtain informed consent before prescribing medications. Those codes are approved under the National Law and are:

(a) for medical practitioners—*Good medical practice: a code of conduct for doctors in Australia* (which in 2025 could be viewed on the website of the Medical Board of Australia (www.medicalboard.gov.au)); and

(b) for nurse practitioners—*Code of conduct for nurses* (which in 2025 could be viewed on the website of the Nursing and Midwifery Board of Australia (www.nursingmidwiferyboard.gov.au)).

(2) However, the requirements set out in subparagraph (1)(a)(iv) and paragraph (1)(b) do not apply to the use of a restrictive practice in relation to an individual if the use of the restrictive practice in relation to the individual is necessary in an emergency.

(3) Subsection (2) applies only while the emergency exists.

Note: See section 162-35 for other responsibilities of registered providers that apply if the use of a restrictive practice in relation to an individual is necessary in an emergency.

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162-30 Requirements while restrictive practice being used

If a registered provider uses a restrictive practice in relation to an individual, the registered provider must ensure that while the restrictive practice is being used:

(a) the individual is monitored for the following:

(i) signs of distress or harm;

(ii) side effects and adverse events;

(iii) changes in mood or behaviour;

(iv) changes in well-being, including the individual's ability to engage in activities that enhance quality of life and are meaningful and pleasurable;

(v) changes in the individual's ability to maintain independent function (to the extent possible);

(vi) changes in the individual's ability to engage in activities of daily living (to the extent possible); and

(b) the necessity for the use of the restrictive practice is regularly monitored, reviewed and documented; and

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(c) the effectiveness of the use of the restrictive practice, and the effect of changes in the use of the restrictive practice, are monitored; and

(d) to the extent possible, changes are made to the individual's environment to reduce or remove the need for the use of the restrictive practice; and

(e) if the restrictive practice is chemical restraint—information about the effects and use of the chemical restraint is provided to the medical practitioner or nurse practitioner who prescribed the medication for the purpose of using the chemical restraint as mentioned in paragraph 162-25(1)(a).

162-35 Requirements following emergency use of restrictive practice

If a registered provider uses a restrictive practice in relation to an individual and the use of the restrictive practice in relation to the individual is necessary in an emergency, the registered provider must, as soon as practicable after the restrictive practice starts to be used:

(a) if the individual lacked capacity to consent to the use of the restrictive practice—inform the restrictive practices substitute decision-maker for the restrictive practice about the use of the restrictive practice; and

(b) ensure that the following matters are documented in the behaviour support plan for the individual:

(i) the individual's behaviours that were relevant to the need for the use of the restrictive practice;

(ii) the alternative strategies that were considered or used (if any) before the use of the restrictive practice;

(iii) the reasons the use of the restrictive practice was necessary;

(iv) the care to be provided to the individual in relation to the individual's behaviour;

(v) if the restrictive practices substitute decision-maker for the restrictive practice was informed about the use of the restrictive practice under paragraph (a)—a record of the restrictive practices substitute decision-maker being so informed; and

(c) if the restrictive practice is not chemical restraint—ensure that the assessments mentioned in paragraph 162-20(1)(a) are documented in the behaviour support plan for the individual; and

(d) if the restrictive practice is chemical restraint—ensure that the matters mentioned in subparagraphs 162-25(1)(b)(i) to (v) and (vii) to (ix) are documented in the behaviour support plan for the individual.

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162-40 Requirements relating to nominations of restrictive practices nominees

Preventing coercion and duress

(1) A registered provider must take reasonable steps to ensure that:

(a) an individual to whom the registered provider delivers funded aged care services is not subject to coercion or duress in making, varying or revoking a nomination under section 6-15; and

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(b) an individual nominated under section 6-15 (whether as an individual or as a member of a group) is not subject to coercion or duress in agreeing as mentioned in paragraph 6-15(2)(b) or (3)(b), or in withdrawing that agreement.

Assisting care individuals

(2) If an individual nominates an individual under section 6-15 (whether as an individual or as a member of a group), the registered provider delivering funded aged care services to the individual must assist the individual to:
(a) notify the individual of the nomination; and
(b) give the individual a copy of the nomination; and
(c) seek the individual's agreement as mentioned in paragraph 6-15(2)(b) or (3)(b).

Keeping records

(3) If an individual nominates an individual under section 6-15 (whether as an individual or as a member of a group), the registered provider delivering funded aged care services to the individual must keep a record of:
(a) the nomination; and
(b) whether the individual has agreed as mentioned in paragraph 6-15(2)(b) or (3)(b); and
(c) if the individual has agreed as mentioned in paragraph 6-15(2)(b) or (3)(b)—whether the individual has withdrawn that agreement.

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Division 3—Requirements relating to behaviour support

162-45 Requirement for behaviour support plans

(1) If:

(a) a registered provider delivers funded aged care services to an individual; and

(b) behaviour support is needed for the individual;

the registered provider must ensure that a behaviour support plan for the individual is included in the care and services plan for the individual.

(2) The registered provider must ensure that the behaviour support plan:

(a) is prepared, reviewed and revised in accordance with this Division; and

(b) sets out the matters required by this Division and Division 2.

(3) In preparing the behaviour support plan, the registered provider must take into account any previous assessment relating to the individual that is available to the registered provider.

162-50 Requirements for behaviour support plans—alternative strategies for addressing behaviours of concern

A behaviour support plan for an individual must set out the following matters:

(a) information about the individual that helps the registered provider to understand the individual and the individual's behaviour (such as information about the individual's past experience and background);

(b) any assessment of the individual that is relevant to understanding the individual's behaviour;

(c) information about behaviours of concern for which the individual may need support;

(d) the following information about each occurrence of behaviours of concern for which the individual has needed support:

(i) the date, time and duration of the occurrence;

(ii) any adverse consequences for the individual or other persons;

(iii) any related incidents;

(iv) any warning signs for, or triggers or causes of, the occurrence (including trauma, injury, illness or unmet needs such as pain, boredom or loneliness);

(e) alternative strategies for addressing the behaviours of concern that:

(i) are best practice alternatives to the use of restrictive practices in relation to the individual; and

(ii) take into account the individual's preferences (including preferences in relation to care delivery) and matters that might be meaningful or of interest to the individual; and

(iii) aim to improve the individual's quality of life and engagement;

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(f) any alternative strategies that have been considered for use, or have been used, in relation to the individual;

(g) for any alternative strategy that has been used in relation to the individual:

(i) the effectiveness of the strategy in addressing the behaviours of concern; and

(ii) records of the monitoring and evaluation of the strategies;

(h) a description of the registered provider's consultation about the use of alternative strategies in relation to the individual with the individual or a supporter of the individual (if any).

162-55 Requirements for behaviour support plans—if use of restrictive practice assessed as necessary

If the use of a restrictive practice in relation to an individual is assessed as necessary as mentioned in section 162-20 or 162-25, the behaviour support plan for the individual must set out the following matters:

(a) the individual's behaviours of concern that are relevant to the need for the use of the restrictive practice;

(b) the restrictive practice and how it is to be used, including its duration, frequency and intended outcome;

(c) the best practice alternative strategies that must be used (to the extent possible) before using the restrictive practice;

(d) how the use of the restrictive practice is to be monitored, including how the monitoring will be escalated if required, taking into account the nature of the restrictive practice and any care needs that arise from the use of the restrictive practice;

(e) how the use of the restrictive practice is to be reviewed, including consideration of the following:

(i) the outcome of its use and whether the intended outcome was achieved;

(ii) whether an alternative strategy could be used to address the individual's behaviours of concern;

(iii) whether a less restrictive form of the restrictive practice could be used to address the individual's behaviours of concern;

(iv) whether there is an ongoing need for its use;

(v) if the restrictive practice is chemical restraint—whether the medication prescribed for the purpose of using the chemical restraint can or should be reduced or stopped;

(f) if the individual lacks the capacity to give informed consent to the use of the restrictive practice:

(i) whether subsection 6-20(1), or an item of the table in subsection 6-20(2), applies for the restrictive practice in relation to the individual, and why that subsection or item applies; and

(ii) the name of the restrictive practices substitute decision-maker for the restrictive practice in relation to the individual;

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(g) a description of the registered provider's consultation about the use of the restrictive practice with:
  (i) the individual; or
  (ii) if the individual lacks the capacity to give informed consent to the use of the restrictive practice—the restrictive practices substitute decision-maker for the restrictive practice;

(h) a record of the giving of informed consent to the use of the restrictive practice, and how it is to be used (including its duration, frequency and intended outcome), by:
  (i) the individual; or
  (ii) if the individual lacks the capacity to give that consent—the restrictive practices substitute decision-maker for the restrictive practice.

Note: Sections 162-20 and 162-25 also require other matters to be documented in the behaviour support plan.

162-60 Requirements for behaviour support plans—if restrictive practice used

If a restrictive practice is used in relation to an individual, the behaviour support plan for the individual must set out the following matters:

(a) the restrictive practice and how it was used, including the following:
  (i) when it began to be used;
  (ii) the duration of each use;
  (iii) the frequency of its use;
  (iv) the outcome of its use and whether the intended outcome was achieved;
  (v) whether its use was in accordance with the informed consent set out under paragraph 162-55(h);

(b) if, under the plan, the restrictive practice is to be used only on an as-needed basis in response to particular behaviour, or in particular circumstances:
  (i) the individual's behaviours of concern that led to the use of the restrictive practice; and
  (ii) the actions (if any) taken leading up to the use of the restrictive practice, including any alternative strategies that were used before the restrictive practice was used;

(c) the details of the persons involved in the use of the restrictive practice;

(d) a description of any engagement with external support services (for example, dementia support specialists) in relation to the use of the restrictive practice;

(e) details of the monitoring of the use of the restrictive practice as required by the plan;

(f) the outcome of the review of the use of the restrictive practice as required by the plan.

Note 1: For paragraphs (e) and (f), see paragraphs 162-55(d) and (e) for the requirements for a behaviour support plan for an individual to require monitoring and review of the use of a restrictive practice in relation to the individual.

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Note 2: If the use of a restrictive practice in relation to an individual is necessary in an emergency, other matters must also be documented in the behaviour support plan for the individual (see section 162-35).

162-65 Requirements for behaviour support plans—if need for ongoing use of restrictive practice indicated

If a review of the use of a restrictive practice in relation to an individual (as required by the behaviour support plan for the individual) indicates a need for the ongoing use of the restrictive practice, the behaviour support plan for the individual must set out the following matters:

(a) the restrictive practice and how it is to be used, including its duration, frequency and intended outcome;

(b) how the ongoing use of the restrictive practice is to be monitored, including how the monitoring will be escalated if required, taking into account the nature of the restrictive practice and any care needs that arise from the use of the restrictive practice;

(c) how the ongoing use of the restrictive practice is to be reviewed, including consideration of the following:

(i) the outcome of the ongoing use of the restrictive practice and whether the intended outcome is being achieved;

(ii) whether an alternative strategy could be used to address the individual's behaviours of concern;

(iii) whether a less restrictive form of the restrictive practice could be used to address the individual's behaviours of concern;

(iv) whether there continues to be need for the ongoing use of the restrictive practice;

(v) if the restrictive practice is chemical restraint—whether the medication prescribed for the purpose of using the chemical restraint can or should be reduced or stopped;

(d) a description of the registered provider's consultation about the ongoing use of the restrictive practice, and how it is to be used (including its duration, frequency and intended outcome), with:

(i) the individual; or

(ii) if the individual lacks the capacity to give informed consent to the ongoing use of the restrictive practice—the restrictive practices substitute decision-maker for the restrictive practice;

(e) a record of the giving of informed consent to the ongoing use of the restrictive practice by:

(i) the individual; or

(ii) if the individual lacks capacity to give that consent—the restrictive practices substitute decision-maker for the restrictive practice.

162-70 Requirement to review and revise behaviour support plans

A registered provider must review a behaviour support plan for an individual and make any necessary revisions:

(a) on a regular basis; and

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(b) as soon as practicable after any change in the individual's circumstances.

162-75 Requirement to consult on behaviour support plans

(1) In preparing, reviewing or revising a behaviour support plan for an individual, a registered provider must consult the following:

(a) if the individual has the capacity to be consulted—the individual and a supporter of the individual (if any);

(b) if the individual lacks the capacity to be consulted—a person or body who, under the law of the State or Territory in which the individual accesses funded aged care services, can make decisions about that care;

(c) health practitioners with expertise relevant to the individual's behaviours of concern.

(2) If the use of a restrictive practice in relation to the individual is assessed as necessary as mentioned in section 162-20 or 162-25, the registered provider must also consult the following in preparing, reviewing or revising the behaviour support plan:

(a) the approved health practitioner who made the assessment;

(b) if the individual lacks the capacity to be consulted—the restrictive practices substitute decision-maker for the restrictive practice.

(3) In consulting under this section, the registered provider must provide the plan or revised plan, and any associated information, in an appropriately accessible format.

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Division 4—Immunity from civil or criminal liability in relation to the use of a restrictive practice in certain circumstances

163-5 Giving of informed consent by certain persons or bodies

For the purposes of paragraph 163(2)(a) of the Act (which refers to the giving of informed consent to the use of a restrictive practice in relation to an individual), a person or body that is a restrictive practices substitute decision-maker for the restrictive practice in relation to the individual is prescribed.

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Part 10—Management of incidents and complaints

Division 1—Incident management

Subdivision A—Preliminary

164-1 Kinds of provider to which the condition applies

For the purposes of section 164 of the Act, a registered provider registered in any of the following provider registration categories is prescribed:

(a) home and community services;
(b) advisory and support services;
(c) personal and care support in the home or community;
(d) nursing and transition care;
(e) residential care;
(f) subscription trial.

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164-5 Requirements relating to incident management

For the purposes of section 164 of the Act, this Division prescribes:

(a) requirements for implementing and maintaining an incident management system; and
(b) requirements for managing, and taking reasonable steps to prevent, incidents.

Note: For requirements for reporting reportable incidents to the Commissioner, see Division 2 of Part 2 of Chapter 5 of this instrument.

164-10 Incidents to which this Division applies

(1) This Division applies to incidents that consist of acts, omissions, events or circumstances that:

(a) occur, are alleged to have occurred, or are suspected of having occurred, in connection with the delivery of funded aged care services to an individual by a registered provider; and
(b) either:
(i) have caused harm to the individual or another person; or
(ii) could reasonably have been expected to have caused harm to an individual or another person.

(2) This Division also applies to incidents not covered by subsection (1) that consist of acts, omissions, events or circumstances that:

(a) a registered provider becomes aware of in connection with the delivery of funded aged care services to an individual in a residential care home of the registered provider; and
(b) have caused harm to the individual.

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Subdivision B—Implementing and maintaining an incident management system

164-15 Requirements for system—objects

The objects of a registered provider's incident management system must include the following:

(a) to promote the safety, health, well-being and quality of life of individuals to whom the provider delivers funded aged care services by:
  (i) detecting, addressing and remediating incidents; and
  (ii) preventing incidents; and
  (iii) ensuring the provider's incident management system facilitates the open disclosure and resolution of incidents between individuals and the provider;

(b) to promote continuous improvement of:
  (i) the provider's management and prevention of incidents; and
  (ii) the provider's delivery of funded aged care services.

164-20 Requirements for system—general

A registered provider's incident management system must:

(a) be able to identify, record, assess, respond to and report on incidents; and

(b) specify procedures for identifying, recording, assessing, responding to and reporting on incidents; and

(c) require that appropriate support and assistance (including access to advocates and language services) is provided to persons affected by an incident to ensure their safety, health, well-being and quality of life; and

(d) specify how persons affected by an incident will be appropriately involved in the management and resolution of the incident; and

(e) specify the roles and responsibilities of aged care workers and responsible persons of the provider in managing and responding to incidents; and

(f) specify the roles and responsibilities of aged care workers and responsible persons of the provider in notifying reportable incidents to the Commissioner; and

(g) require an aged care worker of the provider who becomes aware of a reportable incident to notify one of the following of that fact as soon as possible:
  (i) a responsible person of the provider;
  (ii) a supervisor or manager of the aged care worker;
  (iii) a person specified for the purposes of paragraph (e) or (f); and

(h) require reportable incidents to be reported to the Commissioner in accordance with Division 2 of Part 2 of Chapter 5 of this instrument; and

(i) specify when an investigation by the provider is required to establish:
  (i) the causes of a particular incident; and
  (ii) the harm caused by the incident; and

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(iii) any operational issues that may have contributed to the incident occurring; and

(j) specify the nature of investigations mentioned in paragraph (i); and

(k) specify when remedial action is required and the nature of that action; and

(l) set out procedures for ensuring that the requirements of sections 164-40 and 164-45 are complied with.

164-25 Requirements for system—recording details of incidents

(1) A registered provider's incident management system must require the following details, as a minimum, to be recorded in relation to each incident:

(a) a description of the incident, including:

(i) the harm that was caused, or that could reasonably have been expected to have been caused, to each person affected by the incident; and

(ii) if known—the consequences of that harm;

(b) whether the incident is a reportable incident;

(c) if known—the time, date and place at which the incident occurred or was alleged or suspected to have occurred;

(d) the time and date the incident was identified;

(e) the names and contact details of the persons directly involved in the incident;

(f) the names and contact details of any witnesses to the incident;

(g) details of the assessments undertaken in accordance with subparagraph 164-40(1)(b)(i) and subsection 164-45(1);

(h) the actions taken in response to the incident, including actions taken under sections 164-40 or 164-45;

(i) any consultations undertaken with the persons affected by the incident;

(j) whether persons affected by the incident have been provided with any reports or findings regarding the incident;

(k) if an investigation is undertaken by the provider in relation to the incident—the details and outcomes of the investigation;

(l) the name and contact details of the person recording the details of the incident;

(m) if the incident has been reported to the police—the details included in that report.

(2) A registered provider's incident management system must require details recorded in relation to an incident to be retained for 7 years after the date the record was made or received, in accordance with section 154-150 of this instrument.

164-30 Requirements for system—data collection and analysis

A registered provider's incident management system must:

(a) require the collection of data relating to incidents that will enable the provider to:

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(i) identify occurrences, or alleged or suspected occurrences, of similar incidents; and

(ii) identify and address systemic issues in the quality of funded aged care services delivered by the provider; and

(iii) provide feedback and training to the provider's aged care workers and responsible persons about managing and preventing incidents; and

(iv) provide information to the Commissioner, if required or requested to do so by the Commissioner; and

(v) provide information to the provider's quality care advisory body (if any) and consumer advisory bodies (if any) to assist the body or bodies to prepare reports or feedback about the quality of the funded aged care services delivered by the provider; and

(vi) continuously improve the provider's management and prevention of incidents; and

(b) require the regular analysis and review of data mentioned in paragraph (a) to assess:

(i) the effectiveness of the provider's management and prevention of incidents; and

(ii) what (if any) actions could be taken to improve the provider's management and prevention of incidents.

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164-35 Requirements for registered providers

(1) A registered provider must:

(a) prepare and keep up to date documents detailing:

(i) the provider's incident management system, including the objects mentioned in section 164-15 and the requirements mentioned in sections 164-20 to 164-30; and

(ii) the roles and responsibilities in the system of the provider's aged care workers and responsible persons in identifying, managing and resolving incidents and in preventing incidents from occurring; and

(b) give the documents to:

(i) the provider's aged care workers and responsible persons; and

(ii) to the Commissioner, if required or requested to do so by the Commissioner; and

(c) ensure that the provider's aged care workers and responsible persons are aware of, and understand, their roles and responsibilities in the system; and

(d) require the provider's aged care workers and responsible persons to comply with the system; and

(e) provide appropriate training to the provider's aged care workers and responsible persons on how the system works, including:

(i) how to recognise, respond to and report incidents; and

(ii) their roles and responsibilities in the system; and

(f) make the documents mentioned in paragraph (a) available, in an accessible form, to the following persons:

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(i) the individuals to whom the provider is delivering funded aged care services;

(ii) supporters, family members, carers and advocates of the individuals to whom the provider is delivering funded aged care services, and any other person significant to those individuals; and

(g) assist persons referred to in paragraph (f) to understand how the system works.

(2) Without limiting paragraph (1)(e), a provider provides appropriate training to a person who is an aged care worker or responsible person of the provider if the training is provided:

(a) at least annually; and

(b) at the following times:

(i) when the person becomes an aged care worker or responsible person of the provider;

(ii) when there is a change to how the system works that affects the person's roles and responsibilities in the system;

(iii) when there is a change to the person's role that affects the person's roles and responsibilities in the system.

Subdivision C—Managing and preventing incidents

164-40 Requirements for managing incidents

General

(1) A registered provider must manage an incident:

(a) in accordance with the provider's incident management system; and

(b) by doing the following:

(i) assessing the support and assistance required to ensure the safety, health, well-being and quality of life of persons affected by the incident;

(ii) providing that support and assistance to those persons;

(iii) assessing how to appropriately involve each person affected by the incident, or a supporter or advocate of the person, in the management and resolution of the incident;

(iv) involving each person or supporter or advocate in that way;

(v) using an open disclosure process.

Notifying police of incident where reasonable grounds to do so

(2) If there are reasonable grounds to report the incident to police, the provider must notify a police officer of the incident within 24 hours of becoming aware of the incident.

(3) If the provider later becomes aware of reasonable grounds to report the incident to police, the provider must notify a police officer of the incident within 24 hours of becoming aware of those grounds.

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164-45 Requirements for improving management of incidents and taking reasonable steps to prevent incidents

(1) The provider must assess the incident in relation to the following, taking into account the views of persons affected by the incident:

(a) whether the incident could have been prevented;

(b) what (if any) remedial action needs to be undertaken to prevent further similar incidents from occurring, or to minimise their harm;

(c) how well the incident was managed and resolved;

(d) what (if any) actions could be taken to improve the provider's management and resolution of similar incidents;

(e) whether other persons or bodies should be notified of the incident.

(2) The provider must notify the persons and bodies determined under paragraph (1)(e).

(3) The provider must:

(a) take any actions determined under paragraph (1)(b); and

(b) take any actions determined under paragraph (1)(d) of this section or subparagraph 164-30(b)(ii) that are reasonable in the circumstances.

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Division 2—Complaints, feedback and whistleblowers

Subdivision A—Preliminary

165-5 Purpose of this Part

For the purposes of section 165 of the Act, this Part prescribes requirements for the following:

(a) implementing and maintaining a complaints and feedback management system;

(b) managing complaints and feedback;

(c) implementing and maintaining a whistleblower system and maintaining a whistleblower policy;

(d) managing disclosures that qualify for protection under section 547 of the Act (whistleblower protections).

Subdivision B—Implementing and maintaining a complaints and feedback management system

165-10 Objects of this Subdivision

The objects of this Subdivision are:

(a) to promote quality care and the safety of individuals to whom a registered provider delivers funded aged care services by ensuring the provider's complaints and feedback management system facilitates the open disclosure and resolution of complaints between individuals and the provider; and

(b) to ensure that the provider's complaints and feedback management system acknowledges, assesses, manages and resolves matters relating to the provider's delivery of funded aged care services in a fair, transparent, accessible, safe, culturally safe and timely manner; and

(c) to ensure that:

(i) individuals to whom the provider delivers funded aged care services; and

(ii) supporters of those individuals, and other persons supporting those individuals; and

(iii) the provider's aged care workers; and

(iv) any other persons;

are encouraged and supported to make complaints and give feedback about the provider's delivery of funded aged care services; and

(d) to ensure that complaints and feedback contribute to the continuous improvement of the provider's delivery of funded aged care services.

165-15 Requirements for system—general

(1) A registered provider's complaints and feedback management system must:

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(a) be able to:
  (i) receive, record, assess, acknowledge, respond to and report on complaints and feedback; and
  (ii) securely store information relating to complaints and feedback; and
(b) enable any person to:
  (i) make a complaint or give feedback; and
  (ii) withdraw a complaint or feedback that the person has made or given; and
(c) enable complaints to be made and withdrawn, and feedback to be given and withdrawn, orally and in writing; and
(d) enable complaints to be made, and feedback to be given, anonymously; and
(e) require that there are to be no costs charged by the provider for making, withdrawing or managing a complaint or giving, withdrawing or managing feedback; and
(f) require that the process for making and resolving complaints and giving and responding to feedback is accessible to any person who wishes to make or give, or has made or given, a complaint or feedback; and
(g) require that appropriate support and assistance (including access to advocates and language services) is provided to:
  (i) any person who wishes to make or give, or has made or given, a complaint or feedback; and
  (ii) each individual to whom the provider delivers funded aged care services who is directly affected by an issue raised in a complaint or feedback; and
(h) require that the role of the independent aged care advocate is acknowledged and supported; and
(i) enable cooperation with, and facilitate arrangements for, the independent aged care advocate to support the following persons in making a complaint, giving feedback, or otherwise in relation to a complaint made or feedback given:
  (i) individuals to whom the provider delivers funded aged care services;
  (ii) supporters of those individuals, and other persons supporting those individuals; and
(j) require that, if a person who has made a complaint (other than anonymously), or an individual to whom the provider delivers funded aged care services who is directly affected by an issue raised in the complaint, wishes to be involved in the resolution of the complaint, the person or individual is:
  (i) involved in an appropriate way in the resolution of the complaint; and
  (ii) kept informed in an appropriate way of the progress and outcome of the complaint; and
(k) require that there are no reprisals for a person who makes a complaint or gives feedback; and
(l) require that information provided in a complaint or feedback is kept confidential and only disclosed if required by law or if the disclosure is otherwise appropriate in the circumstances; and

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(m) require that the provider must, in responding to a complaint or feedback, afford procedural fairness to:
  (i) the person who made the complaint or gave the feedback (other than anonymously); and
  (ii) the person (if any) against whom the complaint is made or who is the subject of the feedback; and
(n) require that the provider practise open disclosure and prioritise restorative practices; and
(o) ensure that any requirements for the referral or notification of complaints under Commonwealth, State or Territory laws (as applicable) are met; and
(p) provide for the system to be reviewed as required, and at least annually, to ensure that it is meeting the requirements mentioned in paragraphs (a) to (o).

(2) Without limiting paragraph (1)(l), a disclosure is appropriate if the person about whom the information relates has consented to the disclosure.

165-20 Requirements for registered providers

(1) A registered provider must:
(a) prepare and keep up to date documents detailing:
  (i) the provider's complaints and feedback management system, including the requirements mentioned in section 165-15; and
  (ii) the roles and responsibilities in the system of the provider's aged care workers and responsible persons in relation to complaints and feedback; and
(b) give the documents to the provider's aged care workers and responsible persons; and
(c) ensure that the provider's aged care workers and responsible persons are aware of, and understand, their roles and responsibilities in the system; and
(d) require the provider's aged care workers and responsible persons to comply with the system; and
(e) provide appropriate training to the provider's aged care workers and responsible persons on how the system works, including:
  (i) how to handle personal information and data; and
  (ii) how to recognise and respond to complaints and feedback; and
  (iii) managing relationships and clearly communicating with persons making complaints or giving feedback; and
  (iv) when and how to escalate complaints and feedback in the system; and
  (v) their roles and responsibilities in the system; and
  (vi) the roles and functions of independent aged care advocates in the system; and
(f) publish an accessible document that:
  (i) describes how a complaint can be made, or feedback can be given, to the provider; and

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(ii) describes what a person who makes a complaint or gives feedback to the provider can expect in relation to the provider's management of the complaint or feedback; and

(iii) includes information about how a complaint can be made, or feedback can be given, to the Complaints Commissioner; and

(iv) explains that the provider will not victimise or discriminate against anyone for making a complaint or giving feedback to the provider or the Complaints Commissioner; and

(v) includes information about how to contact an independent aged care advocate; and

(g) give the document mentioned in paragraph (f) to the following:

(i) individuals to whom the provider delivers funded aged care services;

(ii) any other person who requests the document; and

(h) if it is necessary, to enable a person to whom the document mentioned in paragraph (f) must be given under subparagraph (g)(i) to understand the document, to translate the document into another language or present the document in an alternative appropriate format—translate the document into that language, or present the document in that format, and give the translation or reformatted document to the person; and

(i) help the persons mentioned in subparagraph (g)(i) to understand how the provider's complaints and feedback management system works; and

(j) communicate regularly, and at least monthly, to the persons mentioned in paragraph (b) and subparagraph (g)(i) that complaints and feedback are welcome; and

(k) review the system as mentioned in paragraph 165-15(p).

(2) Without limiting paragraph (1)(e), the provider provides appropriate training to a person who is an aged care worker or responsible person of the provider if the training is provided:

(a) at regular intervals, which must be at least annually; and

(b) at the following times:

(i) when the person becomes an aged care worker or responsible person of the provider;

(ii) when there is a change to how the system works that affects the person's roles and responsibilities in the system;

(iii) when there is a change to the person's role that affects the person's roles and responsibilities in the system.

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Subdivision C—Managing complaints and feedback

165-25 Requirements for complaints management and resolution

If a registered provider receives a complaint, the provider must:

(a) manage the complaint in accordance with the provider's complaints and feedback management system; and

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(b) as soon as practicable after receiving the complaint, resolve each issue raised in the complaint by taking appropriate action in relation to the issue; and

(c) in resolving each issue raised in the complaint, use a resolution approach that:

(i) is consistent with the Statement of Rights; and

(ii) is appropriate given the nature of the issue; and

(iii) is centred around each individual to whom the provider delivers funded aged care services who is directly affected by the issue; and

(iv) seeks to address the issue as raised in the complaint; and

(v) will contribute to the continuous improvement of the provider's delivery of funded aged care services; and

(d) unless the complaint was made anonymously—take reasonable steps to notify the following persons of the outcome of the complaint, and the reasons for the outcome:

(i) the person who made the complaint;

(ii) if the complaint was made on behalf of an individual to whom the provider is delivering funded aged care services—the individual; and

(e) unless the complaint was made anonymously—take reasonable steps to tell the following persons how the complaint (the ***initial complaint***) can also be made to the Complaints Commissioner:

(i) the person who made the complaint;

(ii) if the complaint was made on behalf of an individual to whom the provider is delivering funded aged care services—the individual; and

(f) take reasonable steps to tell any other person involved in the resolution of the initial complaint how the complaint can also be made to the Complaints Commissioner; and

(g) take reasonable steps to tell the persons mentioned in paragraphs (d) and (e):

(i) how a new complaint about the resolution of the initial complaint can be made to the Complaints Commissioner;

(ii) information about the availability of independent aged care advocates to assist with making a new complaint to the Complaints Commissioner.

Note: See section 29 of the Act for provisions relating to giving information and documents to supporters.

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165-30 Requirements for feedback management and resolution

(1) If a registered provider receives feedback, the provider must manage the feedback in accordance with the provider's complaints and feedback management system.

(2) In resolving any issues raised in the feedback, the provider must:

(a) use a resolution approach that will contribute to the continuous improvement of the provider's delivery of funded aged care services; and

(b) unless the feedback was given anonymously—consult with:

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(i) the person who gave the feedback; and
(ii) if the feedback was given on behalf of an individual to whom the provider is delivering funded aged care services—the individual; and
(iii) if the person who gave the feedback is an individual to whom the provider is delivering funded aged care services and the individual has consented to the consultation—the individual's supporter (if any); and
(iv) if the feedback was given on behalf of an individual to whom the provider is delivering funded aged care services and the individual has consented to the consultation—the individual's supporter (if any).

(3) The provider must:
(a) unless the feedback was given anonymously—take reasonable steps to tell the persons mentioned in paragraph (2)(b) how the feedback (the ***initial feedback***) can also be given to the Complaints Commissioner; and
(b) take reasonable steps to tell any other person involved in the resolution of any issue raised by the initial feedback how the feedback can also be given to the Complaints Commissioner; and
(c) take reasonable steps to tell the persons mentioned in paragraph (2)(b) and paragraph (b) of this subsection how a complaint or new feedback about the resolution of any issue raised by the initial feedback can be made or given to the Complaints Commissioner.

165-35 Other requirements relating to complaints and feedback

(1) If a registered provider receives a complaint or feedback, the provider must:
(a) provide appropriate support and assistance (including access to advocates and language services), in relation to contacting the Complaints Commissioner, to the following persons:
(i) the person who made the complaint or gave the feedback (other than anonymously);
(ii) each individual to whom the provider delivers funded aged care services who is directly affected by an issue raised in the complaint or feedback; and
(b) take reasonable steps to ensure that:
(i) the person who made the complaint or gave the feedback, or on whose behalf the complaint was made or the feedback was given, is not adversely affected as a result of the making of the complaint or the giving of the feedback; and
(ii) no individual to whom the provider delivers funded aged care services who is affected by an issue raised in the complaint or feedback suffers any detriment, victimisation or reprisal as a result of the making of the complaint or the giving of the feedback.

(2) A registered provider must use an open disclosure process:
(a) in relation to a matter that is the subject of a complaint or feedback; and
(b) if things go wrong in managing a complaint or feedback or resolving an issue raised in a complaint or feedback.

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Handling whistleblower disclosures as complaints or feedback

(3) An individual who discloses information that qualifies for protection under section 547 of the Act (whistleblower protections) to a provider may elect to have the disclosure managed as a complaint or feedback under paragraph 165(1)(b) of the Act and this Division of this instrument.

(4) If an individual makes an election under subsection (3), the provider must manage the disclosure as a complaint or feedback in accordance with this Subdivision rather than in accordance with Subdivision E.

Subdivision D—Implementing and maintaining a whistleblower system and maintaining a whistleblower policy

165-40 Objects of this Subdivision

The objects of this Subdivision are:

(a) to promote quality care and the safety of individuals to whom a registered provider delivers funded aged care services by ensuring the provider's whistleblower system facilitates certain disclosures of information by individuals without fear of persecution, retribution or personal detriment; and

(b) to ensure that the confidentiality of such disclosures is maintained and, where relevant, the anonymity of the individual making the disclosure, and any other specified individual, is protected; and

(c) to ensure that the provider's whistleblower system acknowledges, assesses, manages and responds to concerns raised in such disclosures in a fair, transparent, accessible, safe, culturally safe and timely manner; and

(d) to ensure that such disclosures contribute to the continuous improvement of the provider's delivery of funded aged care services; and

(e) to ensure that aged care workers and any other persons are encouraged and supported to raise concerns about the provider's delivery of funded aged care services.

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165-45 Requirements for system—general

A registered provider's whistleblower system must:

(a) support the operation of Part 5 of Chapter 7 of the Act (whistleblower protections); and

(b) enable individuals to disclose information to the following:

(i) the provider;

(ii) a responsible person of the provider;

(iii) an aged care worker of the provider; and

(c) enable disclosures of information mentioned in paragraph (b) to be made:

(i) orally and in writing; and

(ii) anonymously; and

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(d) provide for the system to be reviewed as required, and at least annually, to ensure that it is meeting the requirements mentioned in paragraphs (a) to (c).

165-50 Requirements for registered providers—general

(1) A registered provider must:

(a) prepare and keep up to date documents detailing:

(i) the provider's whistleblower system, including the requirements mentioned in section 165-45; and

(ii) the roles and responsibilities in the system of the provider's aged care workers and responsible persons; and

(b) give the documents to the provider's aged care workers and responsible persons; and

(c) ensure that the provider's aged care workers and responsible persons are aware of, and understand, their roles and responsibilities in the system; and

(d) require the provider's aged care workers and responsible persons to comply with the system; and

(e) provide appropriate training to the provider's aged care workers and responsible persons on how the system works, including:

(i) how to handle personal information and data; and

(ii) how to recognise and respond to disclosures that qualify for protection under section 547 of the Act; and

(iii) managing relationships and communicating with disclosers; and

(iv) when and how to escalate disclosures in the system; and

(v) their roles and responsibilities in the system; and

(vi) the penalties for contravening subsection 550(1) of the Act (confidentiality of identity of disclosers); and

(f) communicate regularly, and at least monthly, to the provider's aged care workers and responsible persons that disclosures that qualify for protection under section 547 of the Act are welcome; and

(g) review the system as mentioned in paragraph 165-45(d).

(2) Without limiting paragraph (1)(e), the provider provides appropriate training to a person who is an aged care worker or responsible person of the provider if the training is provided:

(a) at regular intervals, which must be at least annually; and

(b) at the following times:

(i) when the person becomes an aged care worker or responsible person of the provider;

(ii) when there is a change to how the system works that affects the person's roles and responsibilities in the system;

(iii) when there is a change to the person's role that affects the person's roles and responsibilities in the system.

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Section 165-55

165-55 Requirements for registered providers—whistleblower policy

A registered provider must:

(a) prepare and keep up to date a whistleblower policy that sets out the following:
  (i) the effect of Part 5 of Chapter 7 of the Act;
  (ii) that individuals may disclose information to the provider or another person mentioned in section 547 of the Act, and how such disclosures may be made;
  (iii) how the provider will manage disclosures that qualify for protection under section 547 of the Act that are made to the provider or a responsible person or aged care worker of the provider;
  (iv) that individuals may also disclose information to the entities mentioned in subparagraphs 547(a)(i), (ii), (vi) and (vii) of the Act, and how such disclosures may be made;
  (v) how the provider will investigate disclosures;
  (vi) how the provider will comply with the requirements mentioned in paragraphs 165-60(c) and (d) of this instrument;
  (vii) how the provider will comply with the obligations in section 553 of the Act;
  (viii) what an individual who has made a disclosure that qualifies for protection under section 547 of the Act can do if they suspect that there has been a contravention of a provision of Part 5 of Chapter 7 of the Act; and
(b) publish the policy in an accessible document; and
(c) give the policy to the provider's aged care workers and responsible persons; and
(d) give the policy to the following:
  (i) individuals to whom the provider delivers funded aged care services;
  (ii) a person who requests the policy and is a supporter of an individual to whom the provider delivers funded aged care services;
  (iii) any other person who requests the policy; and
(e) if it is necessary, to enable a person to whom the policy must be given under subparagraph (d)(i) or (ii) to understand the policy, to translate the policy into another language or present the policy in an alternative appropriate format—translate the policy into that language, or present the policy in that format, and give the translation or reformatted policy to the person; and
(f) help the persons mentioned in subparagraphs (d)(i) and (ii) to understand how the whistleblower system works; and
(g) communicate regularly, and at least monthly, to the persons mentioned in paragraph (c) and subparagraphs (d)(i) and (ii) that disclosures that qualify for protection under section 547 of the Act are welcome.

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Subdivision E—Managing disclosures that qualify for protection under section 547 of the Act

165-60 Requirements for managing disclosures

If an individual makes a disclosure that qualifies for protection under section 547 of the Act to a registered provider or a responsible person or aged care worker of the provider, the provider must:

(a) manage the disclosure in accordance with the provider's whistleblower system; and

(b) as soon as practicable after the disclosure is made, take appropriate action in relation to the disclosure; and

(c) support:

(i) the individual (the ***first individual***) who made the disclosure; and

(ii) any other individual, or an entity, that employs or is otherwise associated with the first individual, and to which detriment might be caused, or a threat of detriment might be made, because of the disclosure; and

(d) ensure fair treatment of any responsible person or aged care worker of the provider who is mentioned in the disclosure or to whom the disclosure relates.

Note: See section 551 of the Act for civil penalties for victimisation relating to a disclosure that qualifies for protection under section 547 of the Act.

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Section 165A-1

Chapter 5—Registered provider, responsible person and aged care worker obligations

Part 1—Introduction

165A-1 Simplified outline of this Chapter

This Chapter provides for matters relating to registered provider, responsible person and aged care worker obligations under Part 4 of Chapter 3 of the Act.

Part 2 of this Chapter relates to obligations relating to reporting, notifications and information, and deals with requirements for reporting by certain registered providers to particular persons specified in subsection 166(2) of the Act on:

(a) vaccinations; and
(b) quality indicators; and
(c) complaints and feedback management; and
(d) complaints and feedback information on request; and
(e) prudential and financial matters; and
(f) reportable incidents; and
(g) the specialist aged care program CHSP; and
(h) the specialist aged care program NATSIFACP; and
(i) governing bodies; and
(j) registered nurses; and
(k) the status of service delivery branches; and
(l) the Multi-Purpose Service Program; and
(m) the transition care program; and
(n) pricing information.

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Part 3 of this Chapter relates to provider obligations in relation to notifying of changes in circumstances, and deals with:

(a) certain kinds of changes in relation to which certain kinds of registered providers must give notice to the Commissioner; and
(b) circumstances in relation to which a notice must also be given to the System Governor; and
(c) information that must be included in a notice given to the Commissioner or the System Governor.

Part 4 of this Chapter deals with the kinds of registered providers to which the obligation to notify of changes of circumstances relating to suitability applies.

Part 5 of this Chapter relates to obligations relating to suitability of responsible persons, and deals with the kind of registered providers to which the obligations apply and requirements for records of suitability matters.

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Part 6 of this Chapter relates to obligations relating to aged care workers, and deals with registered nurses and the delivery of direct care.

Part 7 of this Chapter relates to other obligations, and deals with requirements relating to cooperation by registered providers with the Pricing Authority.

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Part 2—Obligations relating to reporting, notifications and information

Division 1—Preliminary

165A-2 No limitation on other requests

Nothing in this Part limits or affects the System Governor, the Commissioner or the Complaints Commissioner from requesting information from a registered provider under any other provision of the Rules or the Act.

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Division 2—Reportable incidents

165A-5 Purpose of this Subdivision

For the purposes of paragraph 165A(2)(b) of the Act, this Subdivision prescribes requirements for reporting reportable incidents to the Commissioner.

165A-10 Application of Subdivision to registered providers

For the purposes of subsection 165A(1) of the Act, every kind of registered provider is prescribed.

165A-15 Registered provider must notify reportable incidents in accordance with this Subdivision

A registered provider must take all reasonable steps to ensure that reportable incidents are notified to the Commissioner in accordance with this Subdivision.

165A-20 Registered provider must ensure that aged care workers notify reportable incidents

A registered provider must ensure that an aged care worker of the provider who becomes aware of a reportable incident notifies one of the following of that fact as soon as possible:

(a) one of the provider's responsible persons;
(b) a supervisor or manager of the aged care worker;
(c) a person specified for the purposes of paragraph 164-20(e).

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165A-25 Priority 1 notice must be given within 24 hours

(1) If:

(a) a registered provider becomes aware of a reportable incident; and
(b) the provider has reasonable grounds to believe that the incident is a priority 1 reportable incident;

the provider must give the Commissioner a notice (a ***priority 1 notice***) in accordance with subsection (4) within 24 hours of becoming aware of the reportable incident.

Note: Notice about certain reportable incidents is not required to be given: see section 165A-35.

(2) A ***priority 1 reportable incident*** is a reportable incident:

(a) that has caused an individual physical or psychological injury or discomfort that requires medical or psychological treatment; or
(b) where there are reasonable grounds to report the incident to police; or
(c) of the kind covered by paragraph 16(1)(b) of the Act (about unlawful sexual contact or inappropriate sexual conduct, inflicted on an individual); or

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(d) of the kind covered by paragraph 16(1)(d) or (h) of the Act (about unexpected death or unexplained absence).

(3) For the purposes of paragraph (2)(a), in considering whether a reportable incident has caused an individual who has an impairment that directly affects their ability to recognise or communicate physical or psychological injury or discomfort (an ***impairment***), physical or psychological injury or discomfort that requires medical or psychological treatment, a registered provider:

(a) must not consider the impairment as:

(i) preventing the individual from being caused physical or psychological injury or discomfort; or

(ii) reducing the degree of physical or psychological injury or discomfort caused; and

(b) must recognise and consider that each individual's experience of an incident will be unique and that an impairment may contribute to causing the individual physical or psychological injury or discomfort.

Information to be included in notice

(4) Subject to subsection (5), the priority 1 notice must include the following information about the reportable incident:

(a) the name and contact details of the registered provider;

(b) a description of the reportable incident including:

(i) the kind of reportable incident; and

(ii) the harm that was caused, or that could reasonably have been expected to have been caused, to each person affected by the incident; and

(iii) if known—the consequences of that harm;

(c) the immediate actions taken in response to the reportable incident, including:

(i) actions taken to ensure the safety, health and well-being of each individual affected by the incident or the supporter of the individual; and

(ii) whether the incident has been reported to police or any other body;

(d) any further actions proposed to be taken in response to the reportable incident;

(e) the name, position and contact details of the person giving the notice;

(f) if known—the time, date and place at which the reportable incident occurred or was alleged or suspected to have occurred;

(g) the names of the persons directly involved in the reportable incident;

(h) if known—the level of cognition of the affected individuals directly involved in the reportable incident.

(5) The registered provider is not required to include information in the priority 1 notice if that information is not available within the 24 hours.

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Additional information

(6) The registered provider must give the Commissioner a notice including the following information about the reportable incident within 5 days after the start of the 24 hours, or within such other period as the Commissioner determines:
  (a) any information required by subsection (4) not provided in the priority 1 notice;
  (b) any further information specified by the Commissioner that is required to deal with the reportable incident.

(7) However, the registered provider is not required to give a notice under subsection (6) if the Commissioner decides otherwise.

Form of notices

(8) A notice given under this section must:
  (a) be in writing; and
  (b) be in the approved form.

Note: The Commissioner may approve forms for the purposes of this Division: see section 585 of the Act.

165A-30 Priority 2 notice must be given within 30 days

(1) If:
  (a) a registered provider becomes aware of a reportable incident; and
  (b) the provider has not given a notice under section 165A-25 about the incident;

the provider must give the Commissioner a notice (a ***priority 2 notice***) in accordance with subsection (2) within 30 days of becoming aware of the incident.

Note: Notice about certain reportable incidents is not required to be given: see section 165A-35.

(2) The priority 2 notice must include the following information about the reportable incident:
  (a) the name and contact details of the registered provider;
  (b) a description of the reportable incident including:
    (i) the kind of reportable incident; and
    (ii) the harm that was caused, or that could reasonably have been expected to have been caused to each person affected by the incident; and
    (iii) if known—the consequences of that harm;
  (c) the actions taken in response to the reportable incident, including:
    (i) actions taken to ensure the safety, health and well-being of each individual affected by the incident or the supporter of the individual; and
    (ii) whether the incident has been reported to police or any other body;

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(d) any further actions proposed to be taken in response to the reportable incident;
(e) the name, position and contact details of the person giving the notice;
(f) if known—the time, date and place at which the reportable incident occurred or was alleged or suspected to have occurred;
(g) the names of the persons directly involved in the reportable incident;
(h) if known—the level of cognition of the affected individuals directly involved in the reportable incident.

Additional information

(3) If the Commissioner requires the registered provider to give a notice including specified further information about the reportable incident within a specified period, the provider must give the Commissioner a notice including that information with the specified period.

Form of notices

(4) A notice given under this section must:
(a) be in writing; and
(b) be in the approved form.

Note: The Commissioner may approve forms for the purposes of this Division: see section 585 of the Act.

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165A-35 Reporting not required in certain circumstances

The Commissioner may decide that a registered provider is not required to give a notice under section 165A-25 or 165A-30 about a reportable incident if the Commissioner is satisfied that:
(a) the same incident has been repeatedly alleged by an individual accessing funded aged care services to have occurred; and
(b) the allegation is the result of a delusion of the individual.

165A-40 Significant new information must be notified

(1) A registered provider must notify the Commissioner of significant new information relating to a reportable incident as soon as reasonably practicable after becoming aware of the information if:
(a) the provider notifies the Commissioner of the reportable incident under section 165A-25 or 165A-30; and
(b) the provider later becomes aware of the significant new information.

(2) The notification must:
(a) be in writing; and
(b) be in the approved form.

Note: The Commissioner may approve forms for the purposes of this Division: see section 585 of the Act.

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165A-45 Final report about reportable incident must be given if required

(1) If required by the Commissioner, a registered provider must give the Commissioner a final report that includes specified information about a reportable incident.

(2) The final report must be given:

(a) within 84 days of the day a notice about the incident was first given to the Commissioner under section 165A-25 or 165A-30; or

(b) within such other period as is specified by the Commissioner.

(3) The final report must:

(a) be in writing; and

(b) be in the approved form; and

(c) contain the information specified by the Commissioner under subsection (1).

Note: The Commissioner may approve forms for the purposes of this Division: see section 585 of the Act.

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Division 3—Provider obligation—reporting to particular persons

Subdivision A—Vaccinations

166-5 Application of Subdivision to certain registered providers

This Subdivision applies to a registered provider registered in the provider registration category residential care.

166-10 Reports about service staff—influenza vaccinations

(1) For the purposes of paragraphs 166(1)(a) and (d) of the Act, this section prescribes that a registered provider must, on request by the System Governor or the Commissioner, give the System Governor or the Commissioner a report, in a form approved by the System Governor, that sets out the following information as at the reporting day specified in the request:

(a) the total number of service staff in relation to the approved residential care home;

(b) the number of those service staff who have informed the registered provider, whether voluntarily or as required under a law of a State or Territory, that they have received the annual seasonal influenza vaccination for the calendar year that includes the reporting day (whether or not under the registered provider's influenza vaccination scheme (if any)).

(2) The System Governor or the Commissioner may, at any time, request a registered provider to give to the System Governor or the Commissioner a report under subsection (1).

(3) A request under subsection (2) must:

(a) be in writing; and

(b) specify a reporting day that is not more than 3 years before the request is made.

(4) A registered provider must comply with a request under subsection (2) within 7 days after the request is made, or such longer period as is agreed, in writing, between the System Governor or the Commissioner and the registered provider.

166-15 Reports about service staff—COVID-19 vaccinations

(1) For the purposes of paragraphs 166(1)(a) and (d) of the Act, this section prescribes that a registered provider must, on request by the System Governor or the Commissioner, give the System Governor or the Commissioner a report, in a form approved by the System Governor, that sets out the following information as at the reporting day specified in the request:

(a) the total number of service staff in relation to the approved residential care home;

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(b) the number of those service staff who have voluntarily informed the registered provider that they have, in the period specified in the request before the reporting day, received a COVID-19 vaccination.

(2) The System Governor or the Commissioner may, at any time, request a registered provider to give to the System Governor or the Commissioner a report under subsection (1).

(3) A request under subsection (2) must:
(a) be in writing; and
(b) specify a reporting day that is not more than 3 years before the request is made.

(4) A registered provider must comply with a request under subsection (2) within 7 days after the request is made, or such longer period as is agreed, in writing, between the System Governor or the Commissioner and the registered provider.

166-25 Reports about individuals receiving residential care—COVID-19 vaccinations

(1) For the purposes of paragraphs 166(1)(a) and (d) of the Act, this section prescribes that a registered provider must, on request by the System Governor or the Commissioner, give the System Governor or the Commissioner a report, in a form approved by the System Governor, that sets out the following information, as at the reporting day specified in the request:
(a) the total number of individuals accessing funded aged care services in an approved residential care home;
(b) the number of those individuals who have voluntarily informed the registered provider, in the period specified in the request before the reporting day, that they had received one or more COVID-19 vaccinations;
(c) the number of individuals covered by paragraph (b) who have informed the registered provider that they had received only one COVID-19 vaccination;
(d) the number of individuals covered by paragraph (b) who have informed the registered provider that they had received 2 COVID-19 vaccinations.

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(2) The System Governor or the Commissioner may, at any time, request a registered provider to give to the System Governor or the Commissioner a report under subsection (1).

(3) A request under subsection (2) must:
(a) be in writing; and
(b) specify a reporting day that is not more than 3 years before the request is made.

(4) A registered provider must comply with a request under subsection (2) within 7 days after the request is made, or such longer period as is agreed, in writing, between the System Governor or the Commissioner and the registered provider.

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Subdivision B—Quality indicators

166-105 Application of Subdivision to certain registered providers

(1) Subject to subsection (2), this Subdivision applies to a registered provider registered in the provider registration category residential care.

(2) The requirements of this Subdivision do not apply to a registered provider in respect of the delivery of funded aged care services under a specialist aged care program.

166-110 Requirement to provide a quality indicators report

(1) For the purposes of paragraph 166(1)(d) of the Act, a registered provider must give a report (***the quality indicators report)*** on the quality indicators provided in this Subdivision to the System Governor each reporting period.

Note: For the reporting period for a quality indicators report, see section 166-115.

(2) To avoid doubt, if any individuals are excluded for any reason under this Subdivision, a registered provider is required to include information about the exclusion of those individuals in the report where required.

Example: If an individual is absent from the approved residential care home throughout the reporting period, as referred to in paragraph 166-135(1)(b) of this instrument, the registered provider is not required to include that individual in an assessment for falls and falls resulting in major injury, as referred to in paragraph 166-135(1)(a), but must include information about the exclusion of the individual under paragraph 166-135(1)(b).

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166-112 Requirements for the collection of information for quality indicators reports—measurements and assessments

(1) For the purposes of paragraph 166(4)(a) of the Act, a registered provider must:
(a) make measurements or other assessments relevant to indicating the quality of residential care; and
(b) compile or otherwise derive information from those measurements and assessments mentioned in paragraph (a); and
(c) give the information to the System Governor for the purposes of a quality indicator report.

(2) For paragraph (1)(a), measurements or assessments may include the collection or use of personal information and health information, within the meaning of the *Privacy Act 1988*, about the individual accessing funded aged care services.

(3) For paragraph (1)(b), the compiling or deriving of information must not include personal information about the individual accessing funded aged care services.

166-115 Timeframes for reporting under this Subdivision

For the purposes of subsection 166(4) of the Act:

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(a) the reporting period for a quality indicators report given to the System Governor under this Subdivision is a quarter, being a period of 3 months, beginning at the start of a financial year; and

(b) a registered provider must give a quality indicators report to the System Governor within 21 days after the end of the reporting period.

166-120 Quality indicator—pressure injuries

(1) A quality indicators report must include the following information on pressure injuries and the number of individuals accessing funded aged care services that:

(a) were assessed for pressure injuries;

(b) were excluded because of withholding consent to undergo an observational assessment for pressure injuries throughout the reporting period;

(c) were excluded because of an absence from accessing funded aged care services throughout the reporting period;

(d) have one or more pressure injuries;

(e) have one or more pressure injuries with each injury measured and reported against the following sub-categories:

(i) Stage 1 Pressure Injury;

(ii) Stage 2 Pressure Injury;

(iii) Stage 3 Pressure Injury;

(iv) Stage 4 Pressure Injury;

(v) Unstageable Pressure Injury;

(vi) Suspected Deep Tissue Pressure Injury;

(f) have one or more pressure injuries acquired outside the approved residential care home during the reporting period;

(g) have one or more pressure injuries acquired outside the approved residential care home during the reporting period with each injury measured and reported against the following sub-categories:

(i) Stage 1 Pressure Injury;

(ii) Stage 2 Pressure Injury;

(iii) Stage 3 Pressure Injury;

(iv) Stage 4 Pressure Injury;

(v) Unstageable Pressure Injury;

(vi) Suspected Deep Tissue Pressure Injury.

Note: For paragraphs (e) and (g), the relevant sub-category of pressure injury is determined by reference to the ICD-10 Australian Modified Pressure Injury Classification System.

(2) Registered providers, in preparing a quality indicators report for the purposes of subsection (1), must:

(a) identify a date once every reporting period when assessment for pressure injuries is to be carried out for each individual residing at the approved residential care home; and

(b) collect data relating to pressure injures for each individual during a single observation assessment at approximately the same time every reporting period; and

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(c) carry out assessment on or around the same time each reporting period and complete assessment as part of the individual's routine personal care (such as bathing and toileting).

(3) Registered providers, in assessing and reporting pressure injuries acquired by individuals, must inform the individual about the proposed assessment and must seek consent from the individual before the assessment takes place.

166-125 Quality indicator—restrictive practices

(1) A quality indicators report must include the following information on restrictive practices:

(a) the collection date in the reporting period;

(b) the number of individuals whose records were assessed for the use of restrictive practices other than chemical restraint throughout the collection period;

(c) the number of individuals excluded because of an absence from accessing funded aged care services throughout the collection period;

(d) the number of individuals subjected to the use of restrictive practices other than chemical restraint throughout the collection period:

(i) on any occasion;

(ii) on any occasion only in a secured area.

Note: See section 17-5 (Practices and interventions that are restrictive practices in relation to individuals). Restrictive practices covered by this section include environmental restraint, mechanical restraint, physical restraint and seclusion as defined in section 17-5.

(2) For the purposes of subsection (1), a collection period for this quality indicator is a 3-day period during the reporting period.

(3) Registered providers, in preparing a quality indicators report for the purposes of subsection (1), must:

(a) identify and record a collection date which is to take place during each reporting period; and

(b) ensure that the collection date is varied and unpredictable to staff directly involved in the care of an individual; and

(c) ensure that the 3-day collection period consists of the selected collection date and the 2 days before that date; and

(d) ensure that the 3-day collection period is the same for all individuals receiving funded aged care services at the approved residential care home.

(4) Registered providers, in preparing a quality indicators report for the purposes of subsection (1), must review an individual's existing record over the 3- day collection period and assess whether the individual was subject to the use of restrictive practices other than chemical restraint at any stage during the collection period.

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166-130 Quality indicator—unplanned weight loss

(1) A quality indicators report must include information on unplanned weight loss, with information reported under the following categories:
  (a) significant unplanned weight loss;
  (b) consecutive unplanned weight loss.

(2) For the purposes of paragraph (1)(a), a quality indicators report must include the following information on significant unplanned weight loss and the number of individuals accessing funded aged care services that:
  (a) were assessed for significant unplanned weight loss;
  (b) were excluded because of withholding consent to be weighed on the finishing weight collection date;
  (c) were excluded because of receiving end-of-life care;
  (d) were excluded because the previous or finishing weights were not recorded, including comments on why any such weights were not recorded;
  (e) experienced a 5% or higher decrease in weight between the finishing weight and the previous weight.

(3) Registered providers, in preparing the quality indicators report for the purposes of paragraph (1)(a), must:
  (a) identify each individual's previous weight using the approved residential care home's weight records of individuals in the residential care home; and
  (b) collect and record the finishing weight for each individual residing at the approved residential care home in the final month of the current reporting period using a calibrated scale; and
  (c) seek the consent of the individuals concerned before making the assessment required and must record any refusal to provide consent by an individual being assessed for their finishing weight; and
  (d) weigh individuals at or around the same time each month and at around the same time of the day and ensure that the individual is wearing clothing of a similar weight; and
  (e) for each individual who provided their consent for the making of the assessment, compare their finishing weight from the current reporting period with their previous weight and calculate the percentage weight loss.

(4) For the purposes of paragraph (1)(b), a quality indicators report must include the following information on consecutive unplanned weight loss and the number of individuals accessing funded aged care services that:
  (a) were assessed for consecutive unplanned weight loss;
  (b) were excluded because of withholding consent to be weighed on any weight collection date;
  (c) were excluded because of receiving end-of-life care;
  (d) were excluded because any of the required weights were not recorded, including comments on why any such weights were not recorded;
  (e) experienced any decrease in weight between the previous weight, starting weight, middle weight and finishing weight.

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(5) Registered providers, in preparing the quality indicators report for the purposes of paragraph (1)(b), must:

(a) measure consecutive unplanned weight loss as the weight loss of any amount measured every month over 3 consecutive months of a reporting period, and the 3 monthly weights are compared against each other and against the finishing weight from the previous reporting period; and

(b) use their approved residential care home's weight records in identifying each individual's previous weight; and

(c) in the first month of the reporting period, collect and record the starting weight of each individual residing at the approved residential care home using a calibrated scale; and

(d) in the second month of the reporting period collect and record the middle weight of each individual residing at the approved residential care home using a calibrated scale; and

(e) in the third and final month of the reporting period collect and record the finishing weight of each individual at the approved residential care home using a calibrated scale; and

(f) where previous weights and finishing weights may already have been collected and recorded for the individual as part of assessments and measurements made for significant unplanned weight loss, the previous weight and finishing weights recorded and collected can be used for assessing consecutive unplanned weight loss and do not need to be collected again; and

(g) seek the consent of the individuals concerned before making the assessment required and must record any refusal to provide consent by an individual being assessed for their finishing weight; and

(h) weigh individuals at or around the same time each month and at around the same time of the day and ensure that the individual is wearing clothing of a similar weight; and

(i) for each individual who provided their consent for the making of the assessment, compare their previous, starting, middle and finishing weight to determine whether there has been weight loss in every month over 3 consecutive months of a reporting period.

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(6) If an individual is assessed under one category of unplanned weight loss, this does not limit the ability to be assessed and reported under the other category.

166-135 Quality indicator—falls and major injury

(1) A quality indicators report must include the following information on falls and falls resulting in major injury, and the number of individuals accessing funded aged care services:

(a) whose records were assessed for falls and falls resulting in major injury;

(b) who were excluded because of an absence from accessing funded aged care services at the approved residential care home throughout the reporting period;

(c) who experienced one or more falls at the approved residential care home during the reporting period;

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(d) who experienced one or more falls at the approved residential care home resulting in major injury during the reporting period.

(2) Registered providers, in preparing a quality indicators report for the purposes of subsection (1), must:
(a) identify and record a collection date for the reporting period; and
(b) ensure that the collection date is in the 21 days after the end of the reporting period.

166-140 Quality indicator—medication management

(1) A quality indicators report must include information on medication management, with information reported under the following categories:
(a) polypharmacy;
(b) antipsychotics.

(2) For the purposes of paragraph (1)(a), a quality indicators report must include the following information on polypharmacy:
(a) the collection date in the reporting period;
(b) the number of individuals assessed for polypharmacy;
(c) the number of individuals excluded because they were admitted in hospital on the collection date;
(d) the number of individuals prescribed 9 or more medications based on a review of any of the following taken on the collection date:
(i) the individual's medication chart;
(ii) the individual's administration record.

(3) For the purposes of paragraph (1)(b), a quality indicators report must include the following information on antipsychotics:
(a) the collection date in the reporting period;
(b) the number of individuals assessed for antipsychotic medications;
(c) the number of individuals excluded because of they were admitted in hospital for at least 6 days prior to the collection date;
(d) the number of individuals that received an antipsychotic medication based on a review of any of the following taken on the collection date:
(i) the individual's medication chart;
(ii) the individual's administration record;
(e) the number of individuals that received an antipsychotic medication for a medically diagnosed condition of psychosis based on a review of any of the following taken on the collection date:
(i) the individual's medication chart;
(ii) the individual's administration record.

(4) For the purposes of paragraph (2)(a), the collection date is any date during the reporting period and the collection of data must involve a single review of medication charts and administration records for each individual on a particular collection date during the reporting period.

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(5) Registered providers, in preparing a quality indicators report for the purposes of paragraph (1)(a), must:
  (a) identify and record a collection date for the reporting period;
  (b) use each individual's medication charts and administration records as at the identified collection date.

(6) For the purposes of paragraph (3)(a), the collection date is the final day in the collection period which for that subsection is a 7-day period during the reporting period.

(7) Registered providers, in preparing a quality indicators report for the purposes of paragraph (1)(b), must:
  (a) identify a collection date during the reporting period which is between the second week and the end of the reporting period;
  (b) assess and review all individual's medication charts and administration records during the assessment period which covers the collection date and the 6 days prior to that collection date;
  (c) ensure that the collection date is varied between reporting periods and must not be identified to staff directly involved in the care of individuals accessing funded aged care services;
  (d) ensure the assessment and review is not conducted by staff directly involved in the care of individuals receiving funded aged care services.

166-145 Quality indicator—activities of daily living

(1) A quality indicators report must include the following information on activities of daily living and the number of individuals receiving funded aged care services that:
  (a) were assessed for activities of daily living function;
  (b) were excluded because of receiving end-of-life care;
  (c) were excluded because of an absence from accessing funded aged care services throughout the entire reporting period;
  (d) were excluded because an assessment for activities of daily living function was not recorded for the previous reporting period, including comments on why any such previous assessment was not recorded;
  (e) were assessed for activities of daily living function and received a total score of zero in the previous reporting period;
  (f) were assessed for activities of daily living function and experienced a decline in the total score by one or more points.

(2) Registered providers, in preparing a quality indicators report for the purposes of subsection (1), must ensure the collection of information involves a single assessment of each individual, completed around the same time every reporting period, comparing the information to the activities of daily living assessment total score in the previous reporting period to determine decline.

(3) For the purposes of subsection (1), registered providers must:

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(a) identify each individual's activities for daily living assessment total score from the previous reporting period using their approved residential care home's care records;

(b) conduct activities for daily living assessment for each individual by completing the Barthel Index;

(c) compare the previous reporting period assessment total score with the current reporting period assessment total score in relation to an individual in order to determine if the individual experienced a decline of one or more points.

Note: Without limiting this section, activities of daily living includes fundamental skills typically needed to manage basic physical needs in the following areas:

(a) grooming and personal hygiene, such as oral care;
(b) dressing;
(c) toileting and continence;
(d) ambulating and movement;
(e) eating.

166-150 Quality indicator—incontinence care

(1) A quality indicators report must include the following information on incontinence care and the number of individuals receiving funded aged care services that:

(a) were assessed for incontinence care;

(b) were excluded because of an absence from accessing funded aged care services throughout the reporting period;

(c) were excluded from an Incontinence Associated Dermatitis assessment because they did not have incontinence;

(d) have incontinence and Incontinence Associated Dermatitis measured and reported against the following Ghent Global Incontinence Associated Dermatitis Categorisation Tool sub-categories:

(i) 1A: persistent redness without clinical signs of infection;

(ii) 1B: persistent redness with clinical signs of infection;

(iii) 2A: skin loss without clinical signs of infection;

(iv) 2B: skin loss with clinical signs of infection;

(e) have incontinence;

(f) have incontinence and Incontinence Associated Dermatitis.

(2) Registered providers, in preparing a quality indicators report for the purposes of subsection (1), must:

(a) identify a date once every reporting period to assess each individual residing at the approved residential care home for incontinence as part of routine care and carry out that assessment on or around the same time each reporting period; and

(b) ensure that the assessment of Incontinence Associated Dermatitis is conducted by staff who understand the Ghent Global Incontinence Associated Dermatitis Categorisation Tool and have the necessary skills and experience to do so accurately and safely; and

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(c) if personal care workers observe or identify signs of redness or skin loss during routine personal care, escalate to appropriately trained staff for further assessment; and

(d) consult with a suitably qualified health practitioner if there is uncertainty about the presence or severity of Incontinence Associated Dermatitis.

(3) For the purposes of subsection (1), registered providers must ensure that the collection of information involves a single assessment for each individual as part of routine care around the same time every reporting period.

166-155 Quality indicator—hospitalisation

(1) A quality indicators report must include the following information on hospitalisation and the number of individuals receiving funded aged care services that:

(a) were assessed for hospitalisation;

(b) were excluded because of an absence from accessing funded aged care services throughout the reporting period;

(c) had one or more emergency department presentations during the reporting period;

(d) had one or more emergency department presentations or hospital admissions during the reporting period.

(2) In preparing a quality indicators report for the purposes of subsection (1), registered providers must:

(a) ensure that the collection of information involves a single review of the care records for each individual for the entire reporting period;

(b) view the care records within 21 days after the end of the reporting period.

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166-160 Quality indicator—workforce

(1) A quality indicators report must include information on the workforce of a registered provider, reported against the following sub-categories of staff delivering funded aged care services:

(a) service managers;

(b) nurse practitioners and registered nurses;

(c) enrolled nurses;

(d) personal care workers and nursing assistants.

(2) A quality indicators report must include the following information reported against each sub-category specified in subsection (1):

(a) on the number of staff that have worked any number of hours in the previous reporting period;

(b) on the number of staff that:

(i) were employed at the start of the reporting period; and

(ii) have worked for at least 120 hours in the previous reporting period;

(c) on the number of staff that:

(i) were employed at the start of the reporting period; and

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(ii) did not work for at least 60 consecutive days in the reporting period.

(3) For the purposes of subsection (1), registered providers must review the records within 21 days after the end of the reporting period.

166-165 Quality indicator—Consumer Experience Assessment

(1) A quality indicators report must include the following information on an individual's experience obtained through a Consumer Experience Assessment and the number of individuals accessing funded aged care services that:

(a) were excluded because of an absence from accessing funded aged care services throughout the reporting period;

(b) were excluded because of choosing not to complete the Consumer Experience Assessment in the reporting period;

(c) were offered a Consumer Experience Assessment during the reporting period through any of the following means:

(i) a self-completion assessment;

(ii) an interviewer facilitated assessment;

(iii) a proxy assessment;

(d) undertook the Consumer Experience Assessment during the reporting period, the number of individuals who reported against the following sub-categories and the means of assessment mentioned in paragraph (a) for the individuals in each sub-category:

(i) excellent: for individuals who score between 22 and 24;

(ii) good: for individuals who score between 19 and 21;

(iii) moderate: for individuals who score between 14 and 18;

(iv) poor: for individuals who score between 8 and 13;

(v) very poor: for individuals who score between 0 and 7;

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(2) In preparing a quality indicators report for the purposes of subsection (1), registered providers must ensure that the collection of information for consumer experience assessment uses the Quality-of-Care Experience questions.

(3) In preparing a quality indicators report for the purposes of subsection (1), registered providers must collect information from each individual, once every reporting period.

(4) In preparing a quality indicators report for the purposes of subsection (1), registered providers must:

(a) in order to collect information, offer a copy of the QCE-ACC Self Complete Version document for self-completion by suitable individuals at the approved residential care home at around the same time every reporting period; and

(b) allow an individual with no or mild cognitive impairment to self-complete the QCE-ACC Self Complete Version document; and

(c) arrange interviewer facilitated completion for all individuals requiring assistance to complete the QCE-ACC document (such as where the individual requires support with reading the questions or writing their

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responses) at around the same time every reporting period using the QCE-ACC Interviewer Facilitated Version; and

(d) arrange proxy-completion for all individuals who cannot complete the QCE-ACC through self-completion or interviewer facilitated completion such as in circumstances where the individual has moderate or cognitive impairment at around the same time every reporting period using the QCE-ACC Proxy Version.

166-170 Quality indicator—Quality of Life Assessment

(1) A quality indicators report must include the following information on an individual's quality of life obtained through a Quality of Life Assessment and the number of individuals accessing funded aged care services that:

(a) were offered a Quality of Life Assessment during the reporting period through any of the following means:

(i) a self-completion assessment;

(ii) an interviewer facilitated assessment;

(iii) a proxy assessment;

(b) were excluded because of an absence from receiving funded aged care services throughout the reporting period;

(c) were excluded because of choosing not to complete the Quality of Life Assessment in the reporting period;

(d) undertook the Quality of Life Assessment, the number of individuals who reported against the following sub-categories and the means of assessment mentioned in paragraph (a) for the individuals in each sub-category:

(i) excellent: for individuals who score between 22 and 24;

(ii) good: for individuals who score between 19 and 21;

(iii) moderate: for individuals who score between 14 and 18;

(iv) poor: for individuals who score between 8 and 13;

(v) very poor: for individuals who score between 0 and 7.

(2) For the purposes of subsection (1), registered providers must ensure that the collection and assessment of information relating to quality of life must use the Quality of Life questions.

(3) For the purposes of subsection (1), registered providers must collect information from each individual, once every reporting period.

(4) In preparing a quality indicators report for the purposes of subsection (1), registered providers must:

(a) in order to collect information, offer a copy of the QOL-ACC Self Complete Version document for self-completion by suitable individuals at the approved residential care home at around the same time every reporting period; and

(b) allow an individual with no or mild cognitive impairment to self-complete the QOL-ACC Self Complete Version document; and

(c) arrange interviewer facilitated completion for all individuals requiring assistance to complete the QOL-ACC document (such as where the

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individual requires support with reading the questions or writing their responses) at around the same time every reporting period using the QOL-ACC Interviewer Facilitated Version; and

(d) arrange proxy-completion for all individuals who cannot complete the QOL-ACC through self-completion or interviewer facilitated completion such as in circumstances where the individual has moderate or cognitive impairment at around the same time every reporting period using the QOL-ACC Proxy Version.

166-175 Quality indicator—allied health

(1) A quality indicators report must include the following information on allied health:

(a) the number of individuals accessing funded aged care services in the residential care home that were assessed for services delivered by an allied health professional during the reporting period;

(b) the number of individuals who were excluded because of an absence from accessing funded aged care services throughout the reporting period;

(c) the number of funded aged care services in the service type allied health and therapy that were recommended to be delivered by an allied health professional (including through a care and services plan under paragraph 148(e) of the Act), reported against the sub-categories set out in subsection (3);

(d) the number of funded aged care services in the service type allied health and therapy that were recommended to be delivered by an allied health professional (including through a care and services plan under paragraph 148(e) of the Act) and which were received, reported against the sub-categories set out in subsection (3).

Note: See section 148 of the Act (Delivery of funded aged care services).

(2) A quality indicators report must include the number of allied health professional labour hours (represented as minutes of care and services delivered to individuals each day) and reported separately as:

(a) allied health professional employee labour hours;

(b) allied health professional agency labour hours.

(3) For the purposes of paragraphs (1)(c) and (d) and subsection (2), a registered provider must report against each of the following sub-categories of allied health professionals;

(a) physiotherapist;

(b) occupational therapist;

(c) speech pathologist;

(d) podiatrist;

(e) dietitian;

(f) allied health assistant;

(g) other allied health professionals.

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(4) For the purposes of paragraph (3)(g) other allied health professionals include the following:
  (a) art therapists;
  (b) audiologists;
  (c) exercise physiologists;
  (d) music therapists;
  (e) chiropractors;
  (f) counsellors;
  (g) osteopaths;
  (h) psychologists;
  (i) social workers.

(5) In preparing a quality indicators report for the purposes of subsection (1), registered providers must:
  (a) collect information as to recommended funded aged care services in the service type allied health and therapy by undertaking a single review of all individual's care records for the entire reporting period; and
  (b) only report once per allied health discipline.

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166-180 Quality indicator—lifestyle officers

(1) A quality indicators report must include the following information on lifestyle officers delivering funded aged care services:
  (a) the total labour hours worked in care minutes by lifestyle officers;
  (b) the total labour hours worked as agency staff by lifestyle officers.

Note: For subsection (1), a lifestyle officer includes any of the following roles:
  (a) diversional officer;
  (b) recreation officer;
  (c) activities officer.

(2) For the purposes of a quality indicators report and the quality indicator on lifestyle officers, a registered provider must also provide information on the number of occupied bed days for a provider for the reporting period.

166-185 Quality indicator—enrolled nursing

(1) A quality indicators report must include the following information on enrolled nursing with respect to direct care staff members that deliver funded aged care services:
  (a) enrolled nursing total number of care minutes (in hours);
  (b) registered nursing total number of care minutes (in hours);
  (c) personal care workers and nursing assistants total number of care minutes (in hours).

(2) For the purposes of subsection (1), direct care staff members covered under this section are those specified in paragraphs (a) to (d) of the definition of ***direct care staff member*** in section 7 of the Act.

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Subdivision C—Complaints and feedback management report

166-205 Application of Subdivision

(1) This Subdivision applies to registered providers registered in one or more of the following provider registration categories:
  (a) personal and care support in the home or community;
  (b) nursing and transition care;
  (c) residential care.

(1A) This Subdivision also applies to a registered provider registered in the provider registration category subscription trial if the provider is also registered in a provider registration category referred to in paragraph (1)(a) or (b).

(2) This Subdivision applies to feedback received by a registered provider:
  (a) that is managed in accordance with section 165-30; and
  (b) raises an issue as referred to in subsection 165-30(2).

166-210 Requirements for reporting information relating to complaints and feedback management

(1) For the purposes of paragraph 166(1)(a) of the Act this section prescribes that a registered provider to whom this Subdivision applies must give a report about the management of complaints and feedback (the ***complaints and feedback management report***) to the Commissioner within 4 months after the end of the reporting period for the registered provider.

(2) The reporting period for a registered provider is:
  (a) the period of 12 months starting on 1 July of a year; or
  (b) another 12 month period that starts on the first day of a month of a year that is determined for the registered provider by the System Governor in accordance with the rules.

(3) The report must:
  (a) be in the approved form; and
  (b) be signed by a governing body of the registered provider; and
  (c) include the information prescribed by subsection (4) of this section that is a summary of the management of complaints and feedback.

(4) For the purposes of paragraph 166(1)(a) of the Act, the following information is prescribed:
  (a) information about complaints and feedback received, including the number of complaints and feedback and the nature of the complaints and feedback;
  (b) information about the action taken to resolve complaints or in response to feedback received, including any subsequent improvements made by the registered provider in relation to complaints and feedback;
  (c) information about an evaluation of the effectiveness of the actions taken and their related outcome in relation to each complaint and feedback;

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(d) information about the number of days taken to resolve each complaint and feedback;
(e) information about the education and training that has been delivered to the staff of the registered provider in relation to each complaint and feedback;
(f) an analysis of the patterns of, and underlying reasons for, complaints.

Subdivision D—Complaints and feedback information on request

166-215 Application of Subdivision to all registered providers

(1) This Subdivision applies to every kind of registered provider.

(2) This Division applies to feedback received by a registered provider:
(a) that is managed in accordance with section 165-30; and
(b) raises an issue as referred to in subsection 165-30(2).

166-220 Requirements for reporting information on request relating to complaints and feedback management

(1) For the purposes of paragraphs 166(1)(a) and (d) of the Act this section prescribes that a registered provider to whom this Subdivision applies must on request by the System Governor or the Commissioner, give a report about the management of complaints and feedback (the ***complaints and feedback management report***) to the System Governor and the Commissioner.

(2) The System Governor or the Commissioner may, at any time, request a registered provider to give the System Governor and the Commissioner a report under subsection (1).

(3) A registered provider must comply with a request under subsection (1) within 14 days after the request is made, or such longer period as specified in the request.

(4) The report must:
(a) be in the approved form; and
(b) be signed by a governing body of the registered provider; and
(c) include the information prescribed by subsection (5) of this section.

(5) For the purposes of paragraphs 166(1)(a) and (d) of the Act, the following information is prescribed:
(a) information about complaints and feedback received, including the number of complaints and feedback and the nature of the complaints and feedback;
(b) information about the action taken to resolve complaints or in response to feedback received including any subsequent improvements made by the registered provider in relation to complaints and feedback;
(c) information about an evaluation of the effectiveness of the actions taken and their related outcome in relation to each complaint and feedback;
(d) information about the number of days taken to resolve each complaint and feedback;

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(e) information about the education and training that has been delivered to the staff of the registered provider in relation to each complaint and feedback;

(f) an analysis of the patterns of, and underlying reasons for, complaints.

Subdivision E—Prudential and financial

166-310 Aged care financial report—general

Scope of this section

(1) Subject to subsection (2), for the purposes of paragraph 166(1)(d) of the Act:

(a) every kind of registered provider is prescribed; and

(b) a registered provider must give a report about financial and prudential matters (the ***aged care financial report***) to the System Governor each reporting period for the registered provider.

Note: For the reporting period for an aged care financial report, see section 166-355 of this instrument.

(2) The requirements of this section do not apply in respect of the delivery of funded aged care services under any of the following specialist aged care programs:

(a) CHSP;

(b) NATSIFACP;

(c) TCP.

Note: For requirements relating to an annual prudential compliance statement, see section 166-360 of this instrument.

Requirements for an aged care financial report

(3) The aged care financial report must:

(a) be in the approved report form; and

(b) be signed by a member of the governing body of the registered provider; and

(c) be given to the System Governor within 4 months after the end of each reporting period for the registered provider; and

(d) if section 166-315 of this instrument applies—include a financial support statement; and

(e) if section 166-345 of this instrument applies—include a general purpose financial report; and

(f) if section 166-360 of this instrument applies—include an annual prudential compliance statement.

Note: The term ***governing body*** is defined in section 7 of the Act. The effect of this definition is that for registered providers who are not a body corporate with a board of directors (for example, State and Territory governments), the Aged Care Financial Report can be signed by a person or group of persons responsible for the executive decisions of the registered provider.

(4) To avoid doubt, the System Governor may, for the purposes of paragraph (3)(a), approve different forms in relation to specified provider registration categories or specified kinds of registered providers.

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Additional requirements if registered in provider registration category residential care

(5) For a registered provider registered in the provider registration category residential care, in addition to the requirements in subsection (3), an aged care financial report must also include the following:

(a) subject to section 166-335 of this instrument, a care minutes performance statement;

(b) the amount of accommodation payments and accommodation contributions paid to the registered provider;

(c) the amounts of those accommodation payments and accommodation contributions paid as refundable deposits and daily payments;

(d) the amounts of accommodation bonds and accommodation charges paid to the registered provider;

(e) the extent of building, upgrading and refurbishment of residential care homes.

Requirement to comply with a notice for further information

(6) A registered provider must comply with a notice under subsection (8) within the period specified in the notice or, if no period is specified in the notice, within 28 days after the day when the notice is given.

(7) A registered provider complies with a notice under subsection (8) only if the provider gives the information in a form (if any) approved by the System Governor for the purposes of that subsection.

System Governor may request further information

(8) The System Governor may, by notice in writing, require a registered provider to give the System Governor information about a matter, as specified in the notice, if the information is about a matter required under this section.

(9) A notice under subsection (8) may require a registered provider to give updated information about a matter in relation to a period that is:

(a) the same as the reporting period to which a report under this section relates; or

(b) different to the reporting period to which a report under this section relates.

Compliance with this section for part of reporting period

(10) If the registered provider:

(a) is registered as a registered provider for part of the reporting period for the provider; or

(b) expands its services to a new registration category for part of the reporting period;

the provider is taken to have complied with this section if the provider complies with this section for that part of the reporting period.

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166-315 Aged care financial report—provision of a financial support statement

Scope of this section

(1) Subject to subsection (2), for the purposes of paragraph 166(1)(d) of the Act, a registered provider is prescribed if the provider:

(a) is registered in the provider registration category residential care; and

(b) is part of or is financially reliant on a related corporate entity; and

(c) is not a government entity or a local government authority; and

(d) is required under section 166-310 of this instrument to give the System Governor an aged care financial report for the provider for a reporting period.

(2) This section does not apply to registered providers that deliver funded aged care services under the MPSP.

Financial support statement to be given with aged care financial report

(3) If a registered provider is required to give the System Governor an aged care financial report for the provider for a reporting period, then the provider must, when giving the report to the System Governor, also give the System Governor a financial support statement for the provider signed within the period of 4 months starting on the day after the end of the reporting period.

(4) However, subsection (3) does not apply to a registered provider in relation to a reporting period if the aged care financial report for the provider for the year includes an explanation of why the provider has not complied with subsection (3) in relation to that year.

Financial support statement to be given on request

(5) The System Governor may at any time, by notice in writing, require a registered provider to give the System Governor a financial support statement for the provider signed within the period for signing specified in the notice.

Note: For who must sign a financial support statement, see subsection 166-320(4) of this instrument.

(6) A registered provider must comply with a notice under subsection (5) within the period for complying specified in the notice or, if no such period is specified in the notice, within 28 days after the day when the notice is given.

(7) However, subsection (6) does not apply to a registered provider in relation to a notice under subsection (5) if at or before the end of the period within which the provider would (but for this subsection) be required to comply with the notice, the provider gives the System Governor a written explanation of why the provider is not able to comply with the notice.

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System Governor may request further information and documents

(8) The System Governor may at any time, by notice in writing, require a registered provider to give the System Governor information about a matter, as specified in the notice, if the information is about a matter required under this section.

(9) A registered provider must comply with a notice under subsection (8) within the period for complying specified in the notice or, if no such period is specified in the notice, within 28 days after the day when the notice is given.

166-320 Aged care financial report—what is a financial support statement

(1) A ***financial support statement***, for a registered provider of a kind prescribed under subsection 166-315(1) of this instrument, is a written statement by the ultimate holding company in relation to the provider that satisfies the requirements in subsections (2), (4) and (5).

(2) The statement must either:
  (a) state that the ultimate holding company is willing and able, while the provider remains a registered provider, to provide any financial support to the provider that is needed in order to enable the provider to pay the debts of the provider specified under subsection (3) in relation to the statement; or
  (b) state that the ultimate holding company is not willing and able, while the provider remains a registered provider, to provide such financial support to the provider.

(3) For the purposes of paragraph (2)(a), the following debts of the provider are specified in relation to the statement (whether or not the debts relate to the provision of aged care services by the provider):
  (a) any debts of the provider that are outstanding immediately before the start of the day (the ***giving day***) when the statement is given to the System Governor;
  (b) any debts of the provider that:
    (i) are debts that become due during the period that starts on the giving day and ends immediately before the start of the first day after the giving day when the provider gives the System Governor another financial support statement for the provider; or
    (ii) if the provider never gives the System Governor another financial support statement for the provider after the giving day—are debts that become due on or after the giving day.

(4) A financial support statement must be signed by:
  (a) if the ultimate holding company is a body corporate that is incorporated, or taken to be incorporated, under the *Corporations Act 2001*—a director of the body corporate for the purposes of that Act; or
  (b) otherwise—a member of the ultimate holding company's governing body.

(5) The statement must be in a form (if any) approved by the System Governor for the purposes of this subsection.

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166-325 Aged care financial report—permitted uses reconciliation

(1) A form approved by the System Governor for an aged care financial report for a registered provider may require such a report to include a statement (a ***permitted uses reconciliation***) that sets out information about reportable uses of funds by the registered provider during a reporting period or reporting periods for the registered provider.

(2) For the purposes of subsection (1), a reportable use of funds is any of the following:

(a) a permitted use of refundable deposits or accommodation bonds;

(b) a use of funds (other than refundable deposits or accommodation bonds) which was such that, if the funds had been refundable deposits or accommodation bonds, the use would have been a permitted use of refundable deposits or accommodation bonds.

Note: For the permitted uses of refundable deposits, see section 310 of the Act. For the permitted uses of accommodation bonds, see section 287-101 of this instrument.

(3) To avoid doubt, the System Governor may, for the purposes of subsection (1), approve different forms in relation to specified provider registration categories or specified kinds of registered providers.

166-335 Aged care financial report—care minutes performance statement

Scope of this section

(1) Subject to subsection (2), for the purposes of paragraph 166(1)(d) of the Act, a registered provider is prescribed if the provider:

(a) is registered in the provider registration category residential care; and

(b) is required under section 166-310 of this instrument to give the System Governor an aged care financial report for the provider for a reporting period.

(2) This section does not apply to registered providers that deliver funded aged care services under the MPSP.

(3) A registered provider of the kind prescribed under this section must provide a written statement that satisfies the requirements in subsections (4), (5) and (6) (a ***care minutes performance statement***).

Care minutes performance statement to be given with aged care financial report

(4) A registered provider must, when giving the aged care financial report to the System Governor, also give the System Governor a care minutes performance statement for the provider in accordance with the requirements prescribed by subsection (5).

Requirements for a care minutes performance statement

(5) A care minutes performance statement for a reporting period for a registered provider must:

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(a) be in writing; and
(b) be in a form approved by the System Governor; and
(c) not contain false or misleading information; and
(d) include the total number of care minutes (in hours) for each reporting period quarter as delivered by:
(i) registered nurses; and
(ii) enrolled nurses; and
(iii) personal care workers and nursing assistants; and
(e) include the total expenses for care minutes for each reporting period quarter as delivered by:
(i) registered nurses; and
(ii) enrolled nurses; and
(iii) personal care workers and nursing assistants; and
(f) include 24/7 registered nursing coverage across the reporting period by calendar month and expressed as a percentage; and
(g) if there is a variance in the data submitted under paragraph (f) throughout the reporting period—the registered provider must include an explanation for the variance; and
(h) if there is a variance between the care minutes reported in the care minutes performance statement and the care minutes reported in the previous quarterly financial reports—the registered provider must include an explanation for the variance; and
(i) subject to subsection (6), include a signed audit report for the submitted care minutes performance statement by an independent auditor.

Auditing of care minutes performance statement

(6) A care minutes performance statement must be audited in accordance with the following requirements:
(a) be audited by:
(i) a registered company auditor within the meaning of the *Corporations Act 2001*; or
(ii) a person approved by the System Governor under subsection (7);
(b) be audited in accordance with the Assurance Engagements Other than Audits or Reviews of Historical Financial Information Standard (ASAE 3000).

Note: For the purposes of paragraph (b), the Assurance Engagements Other than Audits or Reviews of Historical Financial Information Standard (ASAE 3000) is published by the Australian Auditing and Assurance Standards Board.

(7) The System Governor may approve a person to audit a care minutes performance statement if the System Governor is satisfied that the person has appropriate qualifications and experience.

(8) The System Governor may revoke an approval of a person under subsection (7) if the System Governor is satisfied that the person is no longer a fit and proper person to audit a care minutes performance statement.

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166-340 Quarterly financial report

Scope of this section

(1) Subject to subsections (2) and (3), for the purposes of paragraph 166(1)(d) of the Act, every kind of registered providers is prescribed.

(2) The requirements of this section do not apply in respect to the delivery of funded aged care services under any of the following specialist aged care programs:
  (a) CHSP;
  (b) TCP.

(3) The requirements of this section do not apply in respect of the delivery of funded aged care services under the NATSIFACP where the registered provider is not registered in the provider registration category residential care.

(4) A registered provider of the kind prescribed under this section must give a report about matters provided in subsection (5) (the ***quarterly financial report***) to the System Governor for each quarter of a reporting period for the registered provider.

Note: For the reporting period for a quarterly financial report, see section 166-355 of this instrument.

Requirements for a quarterly financial report

(5) The quarterly financial report must:
  (a) be in the approved report form; and
  (b) be signed by a member of the governing body of the registered provider.

Note: The term ***governing body*** is defined in section 7 of the Act.

(6) To avoid doubt, the System Governor may, for the purposes of paragraph (5)(a), approve different forms in relation to specified provider registration categories or specified kinds of registered providers.

Timeframes to give System Governor a quarterly financial report

(7) The quarterly financial report for a quarter of a reporting period for the registered provider must be given to the System Governor:
  (a) for a quarter ending at the end of 31 December—within 45 days after the end of the quarter; and
  (b) for any other quarter—within 35 days after the end of the quarter.

(8) Each of the following is a quarter of a reporting period for the registered provider:
  (a) the period of 3 months beginning on the first day of the reporting period for the registered provider;
  (b) each successive period of 3 months that occurs during the reporting period for the registered provider after the end of the period mentioned in paragraph (a).

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Requirement to comply with a notice for further information

(9) A registered provider must comply with a notice under subsection (11) within the period specified in the notice or, if no period is specified in the notice, within 28 days after the day when the notice is given.

(10) A registered provider complies with a notice under subsection (11) only if the provider gives the information in a form (if any) approved by the System Governor for the purposes of that subsection.

System Governor may request further information

(11) The System Governor may, by notice in writing, require a registered provider to give the System Governor information about a matter, as specified in the notice, if the information is about a matter required under this section.

(12) A notice under subsection (11) may require a registered provider to give updated information about a matter in relation to a period that is:
(a) the same as the reporting period to which a report under this section relates; or
(b) different to the reporting period to which a report under this section relates.

Compliance with this section for part of reporting period

(13) If the registered provider is registered as a registered provider for part of the reporting period for the registered provider or the registered provider expands its services to a new registration category for part of the reporting period, the registered provider is taken to have complied with this section if the registered provider complies with this section for that part of the reporting period.

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166-345 Aged care financial report—general purpose financial report

Scope of this section

(1) Subject to subsection (2), for the purposes of paragraph 166(1)(d) of the Act, a registered provider is prescribed if the provider is registered in the provider registration category residential care.

(2) The requirements of this section do not apply to a registered provider if the registered provider:
(a) is a government entity or a local government authority; or
(b) is delivering funded aged care services under a specialist aged care program.

(3) A registered provider of a kind prescribed under this section must give a report on matters provided in subsection (4) (the ***general purpose financial report***) to the System Governor each reporting period for the registered provider.

Note: For the reporting period for a general purpose financial report, see section 166-355 of this instrument.

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Requirements for a general purpose financial report

(4) The general purpose financial report must:

(a) be a general purpose financial report within the meaning given by section 6 of the Statement of Accounting Concepts SAC 1; and

(b) be in accordance with the Australian Accounting Standards in force at the time the report is prepared; and

(c) give a true and fair view of the financial position and performance of the registered provider for the reporting period for each residential care home approved in relation to the registered provider; and

(d) be written as if the registered provider were, so far as it provided those services, a distinct reporting entity within the meaning of the Statement of Accounting Concepts SAC 1; and

(e) be given to the System Governor at the same time the registered provider gives an aged care financial report under section 166-310 of this instrument to the System Governor.

(5) If a general purpose financial report deals with a matter other than funded aged care services delivered through the service group residential care, the report must be prepared as if the funded aged care services delivered through the service group residential care it relates to were a reportable segment for the purposes of the Australian accounting standards related to segment reporting in force at the time the report is prepared.

(6) Despite subsections (4) and (5), if all the information about each residential care home approved in relation to the registered provider is included in the provider's aged care financial report for the reporting period, none of that information need be included in the general purpose financial report for the reporting period.

(7) A registered provider must give a copy of its most recently audited general purpose financial report to each person who asks for a copy and is:

(a) an individual accessing funded aged care services at the approved residential care home; or

(b) an individual who has an access approval in effect for a residential care home and is considering accessing funded aged care services through the residential care home; or

(c) a supporter of an individual to whom paragraph (a) or (b) applies.

Requirement to comply with a notice for further information

(8) A registered provider must comply with a notice under subsection (10) within the period specified in the notice or, if no period is specified in the notice, within 28 days after the day when the notice is given.

(9) A registered provider complies with a notice under subsection (10) only if the provider gives the information in a form (if any) approved by the System Governor for the purposes of that subsection.

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System Governor may request further information

(10) The System Governor may, by notice in writing, require a registered provider to give the System Governor information about a matter, as specified in the notice, if the information is about a matter required under this section.

(11) A notice under subsection (10) may require a registered provider to give updated information about a matter in relation to a period that is:
  (a) the same as the reporting period to which a report under this section relates; or
  (b) different to the reporting period to which a report under this section relates.

Compliance with this section for part of reporting period

(12) If the registered provider is registered as a registered provider for part of the reporting period or the registered provider expands its services to a new registration category for part of the reporting period, the registered provider is taken to have complied with this section if the registered provider complies with this section for that part of the reporting period.

Requirement to publish reports

(13) A registered provider must ensure that a general purpose financial report for a reporting period is published, in a way that makes the report readily accessible to members of the public, on:
  (a) the registered provider's website; or
  (b) if the registered provider does not have a website—another website;
for a period of at least 3 years starting no later than 5 months after the end of the reporting period.

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166-350 Aged care financial report—general purpose financial report audit requirements

(1) A general purpose financial report must:
  (a) be audited by:
    (i) a registered company auditor within the meaning of the *Corporations Act 2001*; or
    (ii) a person approved by the System Governor under subsection (2); and
  (b) include each of the following:
    (i) an audit opinion about the general purpose financial report from a registered company auditor or a person approved under subsection (2);
    (ii) a statement from the registered company auditor or the person approved under subsection (2) as to whether the report complies with paragraphs 166-345(4)(b) and (c) of this instrument.

(2) The System Governor may approve a person to audit a general purpose financial report if the System Governor is satisfied that the person has appropriate qualifications and experience.

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(3) The System Governor may revoke an approval of a person under subsection (2) if the System Governor is satisfied that the person is no longer a fit and proper person to audit a general purpose financial report.

166-355 Financial and prudential reports—reporting period

(1) For the purposes of subsection 166(4) of the Act, the reporting period for all reports given to the System Governor by a registered provider under this Subdivision means:

(a) the financial year (the 12 month period beginning on 1 July and ending on 30 June); or

(b) if under subsection (3), the System Governor determines another period of 12 months (being a period that begins on the first day of a month)—that other period.

(2) A registered provider may apply to the System Governor to determine a period of 12 months, other than the financial year, to be the registered provider's reporting period.

(3) If the System Governor receives an application from a registered provider for a determination under subsection (2), the System Governor must:

(a) make, or refuse to make, the determination; and

(b) notify the registered provider, in writing, of the System Governor's decision:

(i) within 28 days; or

(ii) if the Secretary has requested further information in relation to the application—within 28 days, excluding the period within which the information is requested and received.

(4) The System Governor may determine another period to be the registered provider's reporting period under subsection (3) only if the System Governor is satisfied, on reasonable grounds, that it would be impracticable for the registered provider to comply with the requirements of this Subdivision in relation to a financial year.

(5) If the System Governor refuses to make a determination for the registered provider under subsection (3), the System Governor must also give the registered provider a written statement of the reasons for the decision.

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166-360 Aged care financial report—annual prudential compliance statement—general

Scope of this section

(1) For the purposes of paragraph 166(1)(d) of the Act, a registered provider is prescribed if the registered provider:

(a) is registered in the provider registration category residential care; and

(b) receives or has received payment of any of the following from an individual, wholly or partly as a lump sum:

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(i) a refundable deposit;
(ii) an accommodation bond;
(iii) an entry contribution.

(2) A registered provider of the kind prescribed under this section must give the System Governor a statement (the ***annual prudential compliance statement***) for a reporting period for the registered provider that includes the following:
(a) if the lump sum is a refundable deposit—information about refundable deposits and refundable deposit balances referred to in section 166-365 of this instrument;
(b) if the lump sum is an accommodation bond—information about the accommodation bond and accommodation bond balance referred to in section 166-365 of this instrument;
(c) if the lump sum is an entry contribution—information about entry contributions referred to in section 166-365 of this instrument;
(d) information about other fees referred to in section 166-375 of this instrument;
(e) the statements and other information referred to in section 166-380 of this instrument.

Requirements for an annual prudential compliance statement

(3) An annual prudential compliance statement for a reporting period for a registered provider must:
(a) be in writing; and
(b) be in a form approved by the System Governor; and
(c) further to subsection (2), include the information specified in that subsection; and
(d) not contain false or misleading information; and
(e) include a declaration that the registered provider has only charged the amount of refundable deposit the registered provider is permitted to charge; and
(f) if the registered provider has not complied with paragraph (e), include the number of times the provider has not complied with this requirement and the reasons for the non-compliance; and
(g) if the registered provider is required to prepare an aged care financial report for the reporting period—be included in the aged care financial report for the registered provider for the reporting period; and
(h) if paragraph (g) does not apply to the registered provider:
(i) be signed by a person who is one of the registered provider's responsible persons and is authorised by the registered provider to sign the statement; and
(ii) be given to the System Governor within 4 months after the end of the reporting period for the registered provider.

Note: The annual prudential compliance statement must be supported by an independent audit (see section 166-385 of this instrument).

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166-365 Annual prudential compliance statement—information about refundable deposits, accommodation bonds and entry contributions that must be included

(1) Further to section 166-360 of this instrument, this section prescribes the information to be included in an annual prudential compliance statement if the registered provider receives a refundable deposit, an accommodation bond or entry contribution from an individual.

(2) The information about a refundable deposit, an accommodation bond or entry contribution, a refundable deposit balance or an accommodation bond balance or entry contribution balance that must be included in a registered provider's annual prudential compliance statement for a reporting period is as follows:

(a) the total number of refundable deposit balances, or accommodation bond balances or entry contribution balances held by the registered provider as at the end of the reporting period;

(b) the total value of refundable deposit balances, or accommodation bond balances or entry contribution balances held by the registered provider as at the end of the reporting period;

(c) the total value of refundable deposits, accommodation bonds or entry contributions received by the registered provider during the reporting period;

(d) the total amount deducted by the registered provider during the reporting period from refundable deposit balances, accommodation bond balances or entry contribution balances, including:

(i) for refundable deposit balances or accommodation bond balances—any general deductions under section 307 of the Act or section 287-90 of this instrument; and

(ii) for refundable deposit balances only—any retention amounts deducted under section 308 of the Act by the registered provider during the reporting period from refundable deposit balances;

(iii) for accommodation bond balances only—any accommodation bond retention amounts deducted under section 287-95 of this instrument by the registered provider during the reporting period from accommodation bond balances;

(e) the total amount deducted by the registered provider during the reporting period from refundable deposits or accommodation bonds that were received during the year, including:

(i) for refundable deposit balances or accommodation bond balances—any general deductions under section 307 of the Act or section 287-90 of this instrument; and

(ii) for refundable deposit balances only—any retention amounts deducted under section 308 of the Act by the registered provider during the reporting period from refundable deposit balances received during the reporting period;

(iii) for accommodation bond balances only—any accommodation bond retention amounts deducted under section 287-95 of this instrument

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by the registered provider during the reporting period from accommodation bond balances;

(f) any transfer of a refundable deposit made under section 312 of the Act, a transfer of an accommodation bond made under section 287-103 of this instrument, or transfer of entry contribution balances, including the amount, the date of transfer and the amount left on retention;

(g) the total value of refundable deposit balances, accommodation bond balances and entry contribution balances refunded by the registered provider during the reporting period;

(h) if, during the reporting period, refundable deposit balances or accommodation bond balances or entry contribution balances were not refunded in accordance with subsection 311(3) of the Act, subsection 287-102(2) of this instrument or section 287-160 of this instrument (other than a refundable deposit balance, or accommodation bond balance or entry contribution balance in relation to which the registered provider has made an agreement as referred to in section 311-20(3) of this instrument)—the following information:

(i) the total number of refundable deposit balances, accommodation bond balances or entry contribution balances that were not refunded in accordance with subsection 311(3) of the Act, subsection 287-102(2) of this instrument or section 287-160 of this instrument;

(ii) where entry contribution balances were not refunded in accordance with an applicable formal agreement with an individual—the number of entry contributions that were refunded under the formal agreement applying in respect of the relevant entry contribution balance;

(iii) the reason or reasons for the delay in refunding the refundable deposit balances, accommodation bond balances or entry contribution balances;

(iv) in respect of each reason provided—the total number of instances of delay attributable to the reason;

(i) if, for the whole or a part of the reporting period, the registered provider was not permitted to charge a refundable deposit or accommodation bond for entry by an individual to any aged care service that the registered provider is responsible for operating:

(i) the period or periods during which the registered provider was not permitted to charge a refundable deposit or accommodation bond; and

(ii) the funded aged care service in respect of which each period specified applies;

(j) the use of refundable deposits and accommodation bonds by the registered provider during the reporting period;

(k) whether any use of refundable deposits, accommodation bonds by the registered provider during the reporting period was not permitted under section 310 of the Act or section 287-101 of this instrument;

(l) the total amount expended by the registered provider (whether or not obtained from refundable deposits or accommodation bonds) during the reporting period on capital expenditure for which use of a refundable

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deposit or an accommodation bond was permitted under section 310 of the Act or section 287-101 of this instrument;

(m) the total amount expended by the registered provider (whether or not obtained from refundable deposits or accommodation bonds) during the reporting period on investment in financial products for which use of a refundable deposit or an accommodation bond was permitted under section 310 of the Act or section 287-101 of this instrument;

(n) the total amount expended by the registered provider (whether or not obtained from refundable deposits or accommodation bonds) during the reporting period on loans for which use of a refundable deposit or an accommodation bond was permitted under section 310 of the Act or section 287-101 of this instrument;

(o) the total amount expended by the registered provider (whether or not obtained from refundable deposits or accommodation bonds) during the reporting period on repaying debt accrued for the purposes of:

(i) capital expenditure of the kind described in paragraph (l); or

(ii) refunding refundable deposit balances, accommodation bond balances or entry contribution balances;

(p) the total amount expended by the registered provider (whether or not obtained from refundable deposits or accommodation bonds) during the reporting period on repaying debt that accrued before 1 October 2011 if the debt was accrued for the purpose of delivering funded aged care services to individuals;

(q) the total amount expended by the registered provider (whether or not obtained from refundable deposits or accommodation bonds) during the reporting period on each of the uses of refundable deposits or accommodation bonds permitted under section 310 of the Act or section 287-101 of this instrument;

(r) the amount that has been returned to the registered provider during the reporting period from the sale, disposal or redemption of financial products covered by subsection 310(3) of the Act, or subsection 287-101(4) of this instrument, that the registered provider invested in after 1 October 2011, whether or not the investment was obtained from refundable deposits or accommodation bonds;

(s) for each accommodation agreement entered for a room priced above the maximum accommodation payment amount, whether the provider ensured they were permitted to charge the price, including having a current approval from the Pricing Authority at the time the individual agreed to the payment of the higher room price;

(t) where there is a decrease or reduction in the payable amount from each resident's daily accommodation contribution and refundable contribution held, information that the provider refunded the overpaid amount within 28 days of becoming aware of the reduced amount payable or paid by the individual;

(u) information regarding the overpayment of accommodation payments or contributions during prior reporting period that the provider has become aware of during the reporting period.

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Note: Paragraph (h) does not apply to a registered provider that has transferred their refundable deposit balance to another registered provider under section 312 of the Act.

166-375 Annual prudential compliance statement—information about other fees that must be included

The information about other fees that must be included in a registered provider's annual prudential compliance statement for a reporting period is as follows:

(a) the fees (if any) other than individual contributions, accommodation payments and accommodation contributions that the registered provider charged to individuals during the reporting period;

(b) the total value of each such fee charged by the registered provider during the reporting period;

(c) what each such fee purports to cover;

(d) for individuals accessing ongoing funded aged care services, whether the provider has conducted, in accordance with subsection 284-11(4) of this instrument, an annual review of each individual's higher everyday living agreement during the reporting period.

166-380 Annual prudential compliance statement—Financial and Prudential Standards

The statements and other information that must be included in a registered provider's annual prudential compliance statement for a reporting period are as follows:

(a) a statement about whether the registered provider has, during the reporting period, complied with the following:

(i) the Financial and Prudential Standards;

(ii) section 287-20 of this instrument and subsection 293(1), subsections 311(1) and (2) and section 313 of the Act;

(iii) Division 3 of Part 4 of Chapter 4 of the Act;

(iv) section 287-101 of this instrument subsection 310(1) of the Act;

(b) if the registered provider has not complied with any of the Standards in the Financial and Prudential Standards—a statement about why the registered provider has not complied with the Standard;

(ba) if the registered provider is of a kind prescribed by section 150A-3 of this instrument:

(i) a statement about whether the registered provider has, during the reporting period, complied with the condition under section 150A of the Act; and

(ii) if the provider has not complied with the condition—a statement about why the registered provider has not complied with the condition;

(c) if the registered provider has not complied with the conditions applicable to disclosure in section 155-30, 155-35, 166-365, 166-375, and 166-385 of this instrument—the following information:

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(i) the total number of occasions on which the registered provider did not comply;
(ii) the reason or reasons for the registered provider's failure to comply;
(iii) in respect of each reason provided—the total number of occasions of non-compliance attributable to the reason;

(d) the amount set out in the registered provider's liquidity management strategy, as at the end of the reporting period, as the registered provider's minimum liquidity amount for the end of the most recent quarter;

(e) the date on which the registered provider's liquidity management strategy was last reviewed and assessed;

(ea) the date on which the registered provider's investment management strategy was last reviewed and assessed;

(f) the date on which the registered provider's financial and prudential management system was last reviewed and assessed;

(g) an audit opinion, provided by the person who provides the independent audit referred to in section 166-385 of this instrument, on whether the registered provider has complied with the following in the reporting period:
(i) the Financial and Prudential Standards;
(ii) the condition under section 150A of the Act;
(iii) sections 155-30 and 155-35 of this instrument;
(iv) sections 166-360 to 166-385 of this instrument.

Note: The annual prudential compliance statement must be supported by an independent audit (see section 166-385 of this instrument).

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166-385 Annual prudential compliance statement—audit requirements

(1) An annual prudential compliance statement must be supported by an independent audit provided by:
(a) a registered company auditor within the meaning of the *Corporations Act 2001*; or
(b) a person approved by the System Governor under subsection (2).

(2) The System Governor may approve a person to audit an annual prudential compliance statement if the System Governor is satisfied that the person has appropriate qualifications and experience.

(3) The System Governor may revoke an approval of a person under subsection (2) if the System Governor is satisfied that the person is no longer a fit and proper person to audit an annual prudential compliance statement.

Subdivision F—CHSP

166-600 Application of Subdivision

This Subdivision applies to a registered provider of a kind who is registered in one or more of the following provider registration categories:
(a) home and community services;
(b) assistive technology and home modifications;

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(c) advisory and support services;
(d) personal and care support in the home or community;
(e) nursing and transition care;

and delivers funded aged care services under the CHSP.

166-605 Annual financial declaration statement

(1) For the purposes of paragraph 166(1)(d) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give the System Governor a statement (the ***annual financial declaration statement***) each financial year for the registered provider.

(2) The annual financial declaration statement for a financial year for the registered provider must be given to the System Governor by 31 August of that year.

(3) The annual financial declaration statement must be in a report form approved by the System Governor.

(4) The annual financial declaration statement must include the following information for the financial year:
(a) certification that all financial assistance granted by the System Governor was spent for the purposes specified in the grant agreement;
(b) the amount of financial assistance the System Governor has granted the registered provider under the grant agreement, excluding GST;
(c) the registered provider's expenditure for the delivery of funded aged care services, excluding GST;
(d) any surplus and uncommitted funds in the financial year;
(e) any surplus and uncommitted funds from the previous financial year.

Statement of compliance to be given with annual financial declaration statement

(5) If a registered provider is required under subsection (1) to give the System Governor an annual financial declaration statement for the financial year, then the provider must, when giving the report to the System Governor, also give the System Governor a statement of compliance that the financial assistance granted under the grant agreement was only spent on individuals with an assessment approval for funded aged care services in one or more service groups for the individuals and the classification types for the service groups under section 65 of the Act.

(6) The annual financial declaration statement must be certified by the registered provider's governing body.

(7) For the purposes of subsection (1), the annual financial declaration statement must not include information about the registered provider's:
(a) own funds; or
(b) funds from another aged care program.

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166-610 Monthly performance report

(1) For the purposes of paragraph 166(1)(d) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give the System Governor a report about activity and performance data matters (the ***monthly performance report***) each month.

(2) The monthly performance report must be in an approved report form approved by the System Governor.

(3) Without limiting subsection (2), the monthly performance report must include:
  (a) client level data and service delivery information for all activities described in Item B of the grant agreement, including:
    (i) the output measure as per the service type; and
    (ii) the My Aged Care ID for each individual; and
  (b) any individual fees or contributions paid to the registered provider under Part 3 of Chapter 4 of the Act.

(4) The monthly performance report for a registered provider must be given to the System Governor within 14 days after the end of the month.

166-615 Annual wellness and reablement report

(1) For the purposes of paragraph 166(1)(d) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give the System Governor a report about the registered provider's progress in embedding wellness and reablement in its service delivery (the ***annual wellness and reablement report***).

(2) The System Governor may, at any time, request a registered provider to give the System Governor a report under subsection (1).

(3) A registered provider must comply with a request under subsection (1) within 28 days after the request is made.

(4) The report must be in a report form approved by the System Governor.

166-620 Compliance report

(1) For the purposes of paragraph 166(1)(d) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give the System Governor a report about any matters related to the registered provider's management of a grant agreement under section 264 of the Act (the ***compliance report***).

(2) The System Governor may, at any time, request a registered provider to give the System Governor a report under subsection (1).

(3) The compliance report for a registered provider must be given to the System Governor within 14 days after the request is made.

(4) The report must be in a report form approved by the System Governor.

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166-625 Service delivery report

(1) For the purposes of paragraph 166(1)(d) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must, on request by the System Governor, give a report about service delivery (the ***service delivery report)***.

(2) The System Governor may, at any time, request a registered provider to give the System Governor a report under subsection (1).

(3) A registered provider must comply with a request under subsection (1) within 21 days after the request is made, or such longer period as specified in the request.

(4) The report must be in a report form approved by the System Governor.

166-627 Exemption process for certain reports

(1) For the purposes of paragraph 166(4)(b) of the Act, this section prescribes the exemption process in relation to the submission of the following:
  (a) annual financial declaration statement;
  (b) monthly performance report;
  (c) compliance report;
  (d) annual wellness and reablement report;

(2) A registered provider may apply to the System Governor for an exemption from subsections 166-605(1), 166-610(1), 166-615(1) or 166-620(1), if the provider is affected by extenuating circumstances.

(3) The application:
  (a) may be in a form approved by the System Governor; and
  (b) must be made to the System Governor at least 14 days before the due date for the report listed in subsection (1).

(4) The System Governor must decide to grant or refuse an exemption within:
  (a) if the registered provider is given a notice under subsection (5) and gives the System Governor the further information or documents requested within the 14-day period, or such longer period specified in the notice—14 days after receiving the further information or documents; or
  (b) if the registered provider is given a notice under subsection (5) but does not give the System Governor the further information or documents requested within the 14-day period, or such longer period specified in the notice—14 days after the end of that period; or
  (c) otherwise—14 days after receiving the request.

(5) If the System Governor receives an application under subsection (2) from a registered provider, the System Governor may, by notice in writing given to the provider, request further information or documents specified in the notice for the purposes of considering the application.

(6) If the registered provider does not provide the requested information or documents within 14 days after the day when the notice is given, or within such

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longer period specified in the notice, the application is taken to have been withdrawn. The notice must contain a statement setting out the effect of this subsection.

(7) If the System Governor receives an application under subsection (2) from a registered provider for an exemption under subsections 166-605(1), 166-610(1), 166-615(1) or 166-620(1), the System Governor may grant the exemption only if the System Governor is satisfied that the provider is affected by extenuating circumstances.

(8) If the System Governor decides to grant an exemption, the System Governor must decide the period for which the exemption is to be in force.

(9) The period may:
(a) be for the financial year; or
(b) be a duration no longer than 12 months.

(10) If the System Governor grants an exemption from subsections 166-605(1), 166-610(1), 166-615(1) or 166-620(1), to a registered provider, the System Governor must give the provider notice in writing of the decision that:
(a) states an exemption has been granted; and
(b) states the period for which the exemption is in force; and
(c) the reasons for the decision.

(11) If the System Governor refuses to grant an exemption from subsections 166-605(1), 166-610(1), 166-615(1) or 166-620(1), to a registered provider, the System Governor must give the provider notice in writing of the decision that:
(a) states an exemption has not been granted; and
(b) states the due date for the report; and
(c) the reasons for the decision.

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166-628 Child safety compliance statement

(1) For the purposes of paragraph 166(1)(d) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give a report on matters provided for in subsection (3) (the ***child safety compliance statement***) to the System Governor each year.

(2) The child safety compliance statement for the registered provider must be given to the System Governor by 31 March each year.

(3) The child safety compliance statement must include the following information:
(a) a declaration that the registered provider has delivered grant activities consistent with the Child Safety supplementary term in the registered provider's grant agreement;
(b) the activity name;
(c) the activity ID;
(d) the statement type in relation to the incidental contract term in the grant agreement;

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(e) the reporting start date;
(f) the reporting end date.

(4) If the registered provider has not complied with the Child Safety supplementary term in the registered provider's grant agreement, the registered provider must provide a description of the non-compliance and set out the reasons for the non-compliance in the child safety compliance statement.

(5) The child safety compliance statement must be in a report form approved by the System Governor.

Subdivision G—NATSIFACP

166-630 Application of Subdivision

This Subdivision applies to a registered provider of a kind who is registered in one or more of the following provider registration categories:
(a) home and community services;
(b) assistive technology and home modifications;
(c) personal and care support in the home or community;
(d) nursing and transition care;
(e) residential care;
(f) advisory and support services;
and delivers funded aged care services under the NATSIFACP.

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166-635 Annual financial declaration statement

(1) For the purposes of paragraph 166(1)(d) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give the System Governor a statement (the ***annual financial declaration statement***) each financial year for the registered provider.

(2) The annual financial declaration statement for a financial year for the registered provider must be given to the System Governor:
(a) annually; or
(b) at such other time as agreed between the System Governor and the registered provider.

(3) The annual financial declaration statement must be in a report form approved by the System Governor.

(4) The annual financial declaration statement must include the following information for the financial year:
(a) certification that the provider, in relation to the use of financial assistance granted by the System Governor under subsection 264(2) of the Act, complied with the statutory funding condition under subsection 267(1) of that Act;
(b) the amount of financial assistance the System Governor, on behalf of the Commonwealth, granted the registered provider;

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(c) the amount of expenditure for the delivery of funded aged care services by the provider;
(d) the amount, if any, of unspent grant funding in the financial year;
(e) any unspent funds approved by the System Governor from previous financial year.

Note: It is a statutory funding condition that the financial assistance granted to a registered provider is used only for the purpose of delivering funded aged care services to individuals in the circumstances mentioned in subsection 267(1) of the Act.

(5) The annual financial declaration statement must be signed by a member of the registered provider's governing body.

166-640 Audited income and expenditure report

(1) For the purposes of paragraph 166(1)(d) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give a report about financial matters (the ***audited income and expenditure report***) to the System Governor each financial year for the registered provider.

(2) The audited income and expenditure report must be prepared by:
(a) a registered company auditor within the meaning of the *Corporations Act 2001*; or
(b) a member of:
(i) the Institute of Public Accountants; or
(ii) the Institute of Chartered Accountants in Australia.

Audited income and expenditure statement to be given with audited income and expenditure report

(3) If a registered provider is required under this section to give the System Governor an audited income and expenditure report for the financial year, then the provider must, when giving the report to the System Governor, also give the System Governor an audited income and expenditure statement.

(4) The audited income and expenditure statement must:
(a) be in accordance with the Australian accounting standards in force at the time the report is prepared; and
(b) be based on proper accounts and records of the registered provider; and
(c) verify that the provider, in relation to the use of financial assistance granted by the System Governor under subsection 264(2) of the Act, complied with the statutory funding condition under subsection 267(1) of that Act; and
(d) include other matters as specified in the funding agreement; and
(e) include the audit opinion; and
(f) include the amount of financial assistance the System Governor, on behalf of the Commonwealth, has granted the registered provider under subsection 264(2) of the Act for the financial year; and
(g) include the amount of individual fees and contributions paid to the provider by individuals for the financial year; and

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(h) include salary expenditure; and
(i) include rent or lease expenditure; and
(j) include outbreak management expenditure; and
(k) include vehicle lease and maintenance cost; and
(l) include other expenditure; and
(m) include total expenditure.

166-645 Service activity report

(1) For the purposes of paragraph 166(1)(d) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give a report about the registered provider's progress in providing funded aged care services in accordance with the grant agreement (the ***service activity report***) to the System Governor every 6 months.

(2) The service activity report must be given to the System Governor:
(a) on 27 January for the 6 month period ending on 31 December; and
(b) on 27 July for the 6 month period ending on 30 June.

(3) The service activity report must:
(a) be in a report form approved by the System Governor; and
(b) include information about labour worked hours data for registered nurses, enrolled nurses, personal care workers and allied health professionals for the reporting period; and
(c) include information about labour cost for registered nurses, enrolled nurses, personal care workers and allied health professionals for the reporting period; and
(d) include information about the number of occupied beds for the reporting period; and
(e) include de-identified profiles of each aged care worker of the provider; and
(f) include the number of individuals accessing funded aged care services by service type; and
(g) include the number and type of health profession visits during the reporting period; and
(h) include the number and type of traditional or cultural events individuals accessing funded aged care services were supported to engage in during the reporting period.

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166-646 Child safety compliance statement

(1) For the purposes of paragraph 166(1)(d) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give a report on matters provided for in subsection (3) (***child safety compliance statement***) to the System Governor each year.

(2) The child safety compliance statement for the registered provider must be given to the System Governor by 31 March each year.

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(3) The child safety compliance statement must include the following information:
  (a) a declaration that the registered provider has delivered grant activities consistent with the Child Safety supplementary term in the registered provider's grant agreement;
  (b) the activity name;
  (c) the activity ID;
  (d) the statement type in relation to the incidental contract term in the grant agreement;
  (e) the reporting start date;
  (f) the reporting end date.

(4) If the registered provider has not complied with the Child Safety supplementary term in the registered provider's grant agreement, the registered provider must provide a description of the non-compliance and set out the reasons for the non-compliance in the child safety compliance statement.

(5) The child safety compliance statement must be in a report form approved by the System Governor.

Subdivision H—Multi-Purpose Service Program

166-720 Application of Subdivision to certain registered providers

This Subdivision applies to a registered provider delivering funded aged care services under the MPSP.

166-725 Annual activity report

(1) For the purposes of paragraph 166(1)(d) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give a report on matters provided for in subsection (4) (the ***annual activity report***) to the System Governor each financial year.

(2) The annual activity report for a financial year for the provider must be given to the System Governor:
  (a) by 31 July each year; or
  (b) at such other time as agreed between the System Governor and the registered provider.

(3) The annual activity report must be in a report form approved by the System Governor.

(4) The information that must be included in the annual activity report for the financial year is as follows:
  (a) the number of individuals who have accessed funded aged care services in, or from, the approved residential care home;
  (b) the number of individuals who commenced accessing funded aged care services without an access approval and were later approved through the alternative entry pathway under subsection 71(2) of the Act;

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(c) the number of individuals waiting to access such funded aged care services;
(d) any fees or contributions charged to individuals who accessed funded aged care services delivered in, or from, an approved residential care home;
(e) the service types delivered;
(f) the activities undertaken by the residential care home to prevent and manage disease outbreaks.

(5) A registered provider must provide the information prescribed in subsection (4) in respect of each residential care home operated by the registered provider.

166-730 Annual statement of financial compliance and income and expenditure

(1) For the purposes of paragraph 166(1)(d) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give a report on matters provided for in subsection (4) (the ***annual statement of financial compliance and income and expenditure***) to the System Governor each financial year.

(2) The annual statement of financial compliance and income and expenditure must be given to the System Governor:
(a) by 31 October each year; or
(b) at such other time as agreed between the System Governor and the registered provider.

(3) The annual statement of financial compliance and income and expenditure must be in a report form approved by the System Governor.

(4) The information that must be included in the annual statement of financial compliance and income and expenditure for the financial year is as follows:
(a) amount of subsidy received under Division 5 of Part 2 of Chapter 4 of the Act to deliver funded aged care services at each approved residential care home;
(b) individual fees or contributions paid to the provider under Part 3 of Chapter 4 of the Act by individuals accessing funded aged care services at each approved residential care home;
(c) the amount of expenditure on each of the following:
(i) salaries or wages of aged care workers and responsible persons;
(ii) any labour costs in addition to salaries in wages such as superannuation benefits, leave loadings, payroll tax, workers compensation and other liability insurance, cost of subsidised services to employees and training costs;
(iii) non-salary related other expenditure;
(iv) capital expenditure;
(v) disease outbreak management activities.

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166-735 Service demographics report

(1) For the purposes of paragraph 166(1)(d) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give a report on

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matters provided for in subsections (4) and (5) (***service demographics report***) to the System Governor each financial year.

(2) The service demographics report must be given to the System Governor:
  (a) by 31 July each year; or
  (b) at such other time as agreed between the System Governor and the registered provider.

(3) The service demographics report must be in a report form approved by the System Governor.

(4) The service demographics report must include a list of individuals who accessed funded aged care services delivered by the registered provider for the financial year.

(5) A report prepared for the purposes of subsection (1) of this section must also include the following information:
  (a) for each individual who accessed funded aged care service delivered by the provider, the service types, including the services where specified in the individual's access approval, delivered;
  (b) the classification type for the service group for each individual;
  (c) demographic information where requested in the report form approved by the System Governor, including:
    (i) the name of the individual; and
    (ii) the gender of the individual; and
    (iii) the date of birth of the individual; and
    (iv) whether the individual is an Aboriginal or Torres Strait Islander Person; and
    (v) whether the individual has been diagnosed with dementia or has suspected dementia symptoms;
  (d) whether the individual had an access approval when they commenced accessing services;
  (e) the date on which the individual commenced accessing funded aged care services;
  (f) the date on which the individual ceased accessing funded aged care services;
  (g) the reason for ceasing any funded aged care services.

(6) A registered provider must give the System Governor a service demographics report for each approved residential care home operated by the registered provider.

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Subdivision J—Transition Care Program

166-740 Application of Subdivision to certain registered providers

This Subdivision applies to a registered provider delivering funded aged care services under the TCP.

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166-745 Annual accountability report

(1) For the purposes of paragraph 166(1)(d) of the Act, this section prescribes that a provider to whom this Subdivision applies must give a report on matters provided for in subsection (4) (***annual accountability report***) to the System Governor each financial year.

(2) The annual accountability report for a financial year for the provider must be given to the System Governor:
  (a) annually; or
  (b) at such other time as agreed between the System Governor and the registered provider.

(3) The annual accountability report must be in a report form approved by the System Governor.

(4) The annual accountability report for the financial year must include the following information for the provider:
  (a) any subsidy received under section 249 of the Act;
  (b) any income derived from any individual fees and contributions under Part 3 or Chapter 4 of the Act;
  (c) State or Territory direct funding;
  (d) State or Territory in-kind contributions;
  (e) other income including;
    (i) donations; and
    (ii) interest; and
    (iii) expenditure recoveries and reimbursements; and
    (iv) client fees; and
    (v) any other income not specified in subparagraph (i) and (ii) of this paragraph or paragraph (a) to (d) of this subsection;
  (f) total income;
  (g) salary expenditure;
  (h) non-salary expenditure including:
    (i) office costs; and
    (ii) operating costs; and
    (iii) service agreements; and
    (iv) consumables and equipment for client use; and
    (v) travel; and
    (vi) capital costs;
  (i) other expenditure including:
    (i) asset related expenses including depreciation; and
    (ii) any other expenditure not specified in subparagraph (i) of this paragraph or paragraph (g) and (h) of this subsection;
  (j) total expenditure;
  (k) TCP activity for the financial year including;
    (i) total clients; and

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(ii) total care days; and
(iii) total residential care days; and
(iv) total home-based care days;

(l) surplus analysis and itemisation of surplus by income source including;
(i) Commonwealth government; and
(ii) State government; and
(iii) Territory government; and
(iv) client contributions; and
(v) any income specified in paragraph (e) of this subsection;

(m) the Commonwealth surplus expressed as a number of care days;

(n) any explanatory notes or commentary on the following;
(i) income;
(ii) expenditure;
(iii) activity for the financial year;
(iv) surplus analysis;
(v) additional activity;

(o) feedback, complaints and improvements including;
(i) the most common kinds of positive feedback; and
(ii) the most common kinds of complaints; and
(iii) improvements made by the provider;

(p) information in respect of whether the Fair Work Commission wage increase component of the Commonwealth subsidy has been passed on to any eligible workers;

(q) certification that the information provided in the report is true and correct.

Reporting period

(5) The reporting period for the provider is the period specified for a service activity report under section 166-645.

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Subdivision K—Governing bodies

166-800 Application of this Subdivision

(1) Subject to subsection (2), this Subdivision applies to registered providers registered in one or more of the following provider registration categories:
(a) nursing and transition care;
(b) residential care.

(2) This Subdivision does not apply to the delivery of funded aged care services provided under any of the following specialist aged care programs:
(a) MPSP;
(b) NATSIFACP.

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166-805 Governing bodies must prepare and provide statements

(1) Subject to subsection (2), for the purposes of paragraph 166(1)(d) of the Act, it is prescribed that a registered provider to whom this Subdivision applies must give a report of a kind referred to in this section to the System Governor within 4 months after the end of the reporting period.

(2) This section does not apply to registered providers that deliver funded aged care services under the MPSP.

(3) The reporting period for a registered provider to whom this Subdivision applies is:
  (a) the period of 12 months starting on 1 July of a year; or
  (b) another 12 month period that starts on the first day of a month of a year that is determined for the registered provider by the System Governor in accordance with the rules.

(4) The report must:
  (a) be in the approved form; and
  (b) be signed by a member of the provider's governing body on behalf of all members of the governing body; and
  (c) include the information prescribed by subsection (5) of this section; and
  (d) include any other statements or information required by the approved form.

(5) The following information is prescribed:
  (a) whether the governing body of the provider believes that the provider has complied with the conditions, obligations and requirements of the provider under the Act;
  (b) if the governing body of the provider believes that the provider has failed to comply with one or more conditions, obligations or requirements of the provider under the Act—the details of:
    (i) each condition, obligation or requirement that the governing body believes that the provider has failed to comply with; and
    (ii) the reasons why the provider has failed to comply with the condition, obligation or requirement; and
    (iii) the actions that the provider has taken, has started to take or will take to rectify the non-compliance.

Example: For subparagraph (b)(iii), under Chapter 6 of the Act a registered provider may:
  (a) give an enforceable undertaking about remedying non-compliance (see Part 8 of Chapter 6 of the Act); or
  (b) agree to certain matters if revocation of registration is being considered (see section 133 of the Act).

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166-810 Requirements for certain registered providers to give information relating to reporting periods

(1) For the purposes of paragraph 166(1)(d) of the Act, it is prescribed that a registered provider to whom this Subdivision applies must give the following additional information:

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(a) information about the kind of feedback and complaints received by the registered provider in the reporting period;

(b) information about improvements made by the registered provider in the reporting period in relation to quality of care;

(c) information about initiatives that the registered provider has implemented in the reporting period to support a diverse and inclusive environment for individuals accessing funded aged care services and aged care workers;

(d) information about the representation of different demographic groups in the membership of the governing body of the provider (but, for any group, only if a member of the governing body who is a member of that group consents to that information being provided);

(e) information on whether the registered provider was, in the reporting period, a government entity or a local government authority;

(f) for registered providers that are not government entities or local government authorities, whether the registered provider is a registered provider of a kind prescribed by the rules for the purposes of subsection 157(2) of the Act;

(g) for registered providers that are subject to the requirements of subsection 157(2) of the Act, whether the registered provider has complied during the reporting period with the requirements of subsection 157(2);

(h) whether subsection 157(3) or (4) of the Act applied to the registered provider during the reporting period.

(2) A registered provider registered in the registration category nursing and transition care must provide the information prescribed in subsections (1)(a) to (c) in respect of each service delivery branch operated by the registered provider.

(3) A registered provider registered in the registration category residential care must provide the information prescribed in subsections (1)(a) to (c) in respect of each residential care home operated by the registered provider.

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166-815 Service provided during part only of reporting period

If a registered provider registered in the residential care category was responsible for the operations of a residential care home during part of a reporting period for the registered provider, the registered provider is taken to have complied with sections 166-805 and 166-810 in relation to the home for the reporting period if the registered provider complied with 166-805 and 166-810 in relation to the home and that part of the reporting period.

Subdivision L—Registered nurses

166-850 Application of this Subdivision

(1) Subject to subsection (2), this Subdivision applies to a registered provider registered in the provider registration category residential care.

(2) The requirements of this Subdivision do not apply to a registered provider only delivering funded aged care services under a specialist aged care program.

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166-855 Reporting requirements relating to registered nurses

(1) For the purposes of paragraph 166(1)(d) of the Act, a registered provider must give the System Governor a report about the obligation in subsection 175(1) of the Act in relation to each approved residential care home of the provider within 7 days after the end of each calendar month, or within a longer period specified by the System Governor by notice in writing given to the provider.

(2) A registered provider is not required to provide a report under subsection (1) of this section in relation to an approved residential care home for a calendar month if, during that calendar month, the registered provider did not deliver funded aged care services to at least one individual in the home.

(3) To avoid doubt, it is a requirement that a registered provider provide a report under subsection (1) of this section in relation to an approved residential care home regardless of whether the registered provider has been granted an exemption under paragraph 175(2)(a) of the Act from the obligation in subsection 175(1) of the Act in relation to that home.

(4) The report must:
- (a) be in a form approved, in writing, by the System Governor; and
- (b) specify in relation to each approved residential care home, whether a registered nurse was on site and on duty at all times for each day during the calendar month on which at least one individual received funded aged care services in the home; and
- (c) if a registered nurse was not on site and on duty at all times on any such day—specify the following information:
  - (i) each period of 30 minutes or more that a registered nurse was not on site and on duty at the home;
  - (ii) for each such period, the reasons why a registered nurse was not on site or on duty (or both) during that period;
  - (iii) for each such period, the alternative arrangements that were made for the period to ensure the clinical needs of the individuals in the home were met, or a statement that no alternative arrangements were made.

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Subdivision M—Status of service delivery branches

166-900 Application of this Subdivision

This Subdivision applies to a registered provider registered in one or more of the following categories:
- (a) home and community services;
- (b) assistive technology and home modifications;
- (c) advisory and support services;
- (d) personal and care support in the home or community;
- (e) nursing and transition care.

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166-905 Reporting requirements relating to service delivery branches

For the purposes of paragraph 166(1)(d) of the Act, this Subdivision prescribes:

(a) the reports a registered provider must give to the System Governor in relation to a service delivery branch of the provider; and

(b) the requirements relating to those reports.

166-910 Report for opening of a service delivery branch

(1) A registered provider must give a report, in an approved form, to the System Governor in accordance with this section if:

(a) the provider intends to begin delivering funded aged care services through a service delivery branch; and

(b) either:

(i) the provider has not previously delivered any funded aged care services through this service delivery branch; or

(ii) the provider has previously given a report to the System Governor in accordance with section 166-925 in relation to closure of the service delivery branch.

Note: A separate notification must be given to the System Governor to establish a service delivery branch account for the service delivery branch: see subsection 203(1) of the Act.

Information to be included in the report

(2) The report must include the following information:

(a) the name of the service delivery branch;

(b) the date the provider proposes to begin delivering funded aged care services through the service delivery branch;

(c) the address of the service delivery branch;

(d) the contact details for the service delivery branch.

When report must be given

(3) The report must be given no later than the day the provider begins delivering funded aged care services through the service delivery branch.

166-915 Report for change to a service delivery branch

(1) A registered provider must give a report, in an approved form, to the System Governor in accordance with this section if:

(a) the provider has given a report to the System Governor in accordance with section 166-910 for a service delivery branch of the provider; and

(b) there has been a change to any information relating to the service delivery branch that was included in the report given to the System Governor in accordance with section 166-910.

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Information to be included in the report

(2) The report must include the following:
  (a) the name of the service delivery branch;
  (b) any updated information relating to the service delivery branch that was included in the report given under section 166-910.

When report must be given

(3) The report must be given within 28 days after the day the change in paragraph (1)(b) has occurred.

166-920 Report for merger of service delivery branches

(1) A registered provider must give a report, in an approved form, to the System Governor in accordance with this section if:
  (a) the provider has given a report to the System Governor in accordance with section 166-910 for 2 or more service delivery branches of the provider; and
  (b) the provider intends to merge 2 or more of these service delivery branches into a single service delivery branch of the provider.

Information to be included in the report

(2) The report must include the following information:
  (a) the names of the service delivery branches that the provider proposes to merge, specifying:
    (i) the name of the service delivery branch through which the provider proposes to continue delivering funded aged care services; and
    (ii) the name of each service delivery branch the provider intends to close;
  (b) the date the provider proposes to merge the service delivery branches;
  (c) in relation to the individuals (if any) accessing funded aged care services through the service delivery branches that the provider proposes to merge:
    (i) whether the provider has notified the individuals of the proposed merger; and
    (ii) whether the provider has given a cessation notification to the System Governor and the Commissioner for each individual accessing funded aged care services through each service delivery branch mentioned in subparagraph (a)(ii).

When report must be given

(3) The report must be given at least 90 days, or such smaller number of days as is agreed in writing between the System Governor and the registered provider, before the date of the proposed merger.

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166-925 Report for closure of a service delivery branch

(1) A registered provider must give a report, in an approved form, to the System Governor in accordance with this section if:

(a) the provider has given a report to the System Governor in accordance with section 166-910 for a service delivery branch of the provider; and

(b) the provider intends to close the service delivery branch.

(2) Despite subsection (1), a registered provider does not have to give a report in accordance with this section in relation to a service delivery branch if:

(a) the provider intends to merge the service delivery branch with one or more other service delivery branches of the provider; and

(b) a report under section 166-920 has been given in relation to the service delivery branch.

Information to be included in the report

(3) The report must include the following information:

(a) the name of the service delivery branch;

(b) the date the provider proposes to close the service delivery branch;

(c) in relation to the individuals (if any) accessing funded aged care services through the service delivery branch:

(i) whether the provider has notified the individuals of the proposed closure; and

(ii) whether the provider has given a cessation notification to the System Governor and the Commissioner for each individual.

When report must be given

(4) The report must be given at least 28 days before the date of the proposed closure.

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166-930 Report if provider no longer intends to open, merge or close service delivery branch

(1) A registered provider must give a report, in an approved form, to the System Governor in accordance with this section if:

(a) the provider has given a report (the ***original report***) to the System Governor in accordance with sections 166-910, 166-920 or 166-925; and

(b) the provider no longer intends to proceed with the opening, merger or closure described in the original report.

Information to be included in the report

(2) The report must include the following:

(a) a description of the original report, including:

(i) the name of each service delivery branch included in the original report; and

(ii) whether the original report was in relation to an opening, merger or closure; and

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(iii) the proposed date of the opening, merger or closure that was included in the original report;

(b) a statement that the provider no longer intends to proceed with the opening, merger or closure described in the original report;

(c) the reason why the provider no longer intends to proceed with the opening, merger or closure described in the original report.

When report must be given

(3) The report must be given no later than:

(a) for an opening or closure—the proposed date of the opening or closure; and

(b) for a merger—28 days before the proposed date of the merger.

Subdivision N—Pricing information

166-1000 Application of this Subdivision

(1) Subject to subsection (2), this Subdivision applies to a registered provider registered in one or more of the following provider registration categories:

(a) home and community services;

(b) assistive technology and home modifications;

(c) advisory and support services;

(d) personal and care support in the home or community;

(e) nursing and transition care.

(2) The requirements of this Subdivision do not apply in respect of the delivery of funded aged care services delivered under any specialist aged care program.

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166-1005 Pricing information

(1) For the purposes of paragraph 166(1)(d) of the Act, a registered provider must:

(a) give a report about the information specified in subsection (3) to the System Governor for each reporting period; and

(b) do so within 30 days of the end of the relevant reporting period; and

(c) do so in the approved form.

Reporting period

(2) For the purposes of this section, a ***reporting period*** is a period of 2 months commencing on 1 January, 1 March, 1 May, 1 July, 1 September or 1 November of a year.

Information to be included

(3) The information that must be included in a report given in accordance with subsection (1) is the most frequently charged price during standard business hours for the relevant reporting period that the provider charges individuals for each service in the following service types:

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(a) allied health and therapy;
(b) care management;
(c) domestic assistance;
(d) home maintenance and repairs;
(e) home or community general respite;
(f) meals;
(g) nursing care;
(h) personal care;
(i) restorative care management;
(j) social support and community engagement;
(k) therapeutic service for independent living;
(l) transport.

(4) A registered provider is not required to report on a price for a service in accordance with subsection (1) if:
(a) the registered provider is not currently delivering the service and has not delivered the service in the last 12 months; or
(b) the service is delivered under a specialist aged care program.

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Part 3—Provider obligation—notifying of change in circumstances

Division 1—Obligation to notify

167-5 Purpose of this Part

This Part is made for the purposes of section 167 of the Act and prescribes:

(a) changes of a kind in relation to which prescribed kinds of registered providers must give notice to the Commissioner under that section; and

(b) circumstances in relation to which a notice must also be given to the System Governor under that section; and

(c) information that must be included in a notice given to the Commissioner or the System Governor under that section.

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167-10 Notifying the Commissioner—kinds of registered providers and changes

The following table prescribes the kinds of registered providers and kinds of changes that those providers must give notice to the Commissioner under subsection 167(1) of the Act.

Kinds of registered providers and changes

Item	Column 1 Kind of registered providers	Column 2 Kinds of changes
1	every kind of registered provider	a change referred to in section 167-20 relating to the provider's suitability to be a registered provider
2	every kind of registered provider	a change referred to in section 167-25 relating to the suitability of a responsible person of the provider
3	every kind of registered provider	a change referred to in section 167-30 of responsible persons of the provider
4	every kind of registered provider	a significant change referred to in section 167-35 relating to the organisation arrangements of the provider
5	a registered provider to whom section 157 of the Act applies	a change referred to in section 167-40 relating to the governance arrangements of the provider
6	every kind of registered provider	a change referred to in section 167-45 relating to the scale of operations of the provider
7	a registered provider registered in any of the following provider registration categories: (a) home and community services;	a change referred to in section 167-50 relating to intended service types

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Kinds of registered providers and changes

Item	Column 1 Kind of registered providers	Column 2 Kinds of changes
	(b) assistive technology and home modifications; (c) advisory and support services; (d) personal and care support in the home or community; (e) nursing and transition care; (f) subscription trial.	
8	a registered provider registered in any of the following provider registration categories: (a) personal and care support in the home or community; (b) nursing and transition care; (c) residential care	a change referred to in section 167-55 relating to associated providers
8A	a registered provider registered in the provider registration category subscription trial that delivers funded aged care services in any of the following service types: (a) subscription allied health and therapy; (b) subscription home or community general respite; (c) subscription personal care; (d) subscription therapeutic services for independent living; (e) subscription nursing care	a change referred to in section 167-55 relating to associated providers
9	every kind of registered provider, except government entities	a change referred to in section 167-60 relating to financial and prudential matters, except a change prescribed in item 10 of this table
10	a registered provider that: (a) is registered in the provider registration category residential care; and (b) is not a government entity or a local government authority; and (c) is not delivering aged care services through the specialised aged care program NATSIFACP	a change referred to in section 167-65 relating to liquidity
11	a registered provider registered in the provider registration category residential care	a change referred to in section 167-70 relating to approved residential care homes

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167-15 Notifying the System Governor—circumstances

For the purposes of subsection 167(2) of the Act, the circumstances in which a notice must also be given to the System Governor under that subsection are the

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Section 167-15

circumstances in which a notice must be given to the Commissioner under subsection 167(1) of the Act relating to the following:

(a) the circumstances prescribed by item 4 of the table in section 167-10, to the extent that the circumstances relate to entering into administration;

(b) the circumstances prescribed by item 9 of the table in section 167-10 (relating to financial and prudential matters);

(c) the circumstances prescribed by item 10 of the table in section 167-10 (relating to liquidity);

(d) the circumstances prescribed by item 11 of the table in section 167-10 (relating to approved residential care homes).

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Division 2—Changes in circumstances

167-20 Suitability of a registered provider

(1) The change prescribed in item 1 of the table in section 167-10 is any change in circumstances for a registered provider that materially affects, or may materially affect, the provider's suitability to be a registered provider, taking into account the matters referred to in paragraph 109(1)(b) of the Act (which deals with suitability of registered providers).

Note: See section 167-10, which relates to notifying the Commissioner.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) the date on which a responsible person for the provider first became aware of the change of circumstances that materially affects the provider's suitability to be a registered provider; and

(b) how the provider became aware of the change of circumstances; and

(c) details about the change of circumstances.

167-25 Suitability of a responsible person of a registered provider

(1) The change prescribed in item 2 of the table in section 167-10 is any change in circumstances relating to a responsible person of a registered provider that materially affects, or could materially affect, the responsible person's suitability to be a responsible person of the provider, having regard to the matters referred to in subsection 13(1) of the Act (which deals with suitability matters in relation to an individual).

Note: See section 167-10, which relates to notifying the Commissioner.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) the name of the responsible person; and

(b) the date the provider first became aware of the change in circumstances; and

(c) how the provider became aware of the change in circumstances; and

(d) details of the change of circumstances; and

(e) whether, after considering those matters, the provider is reasonably satisfied that the responsible person continues to be suitable to be a responsible person of the provider; and

(f) what, if any, action the provider has taken, or proposes to take, in relation to the responsible person.

167-30 Change of responsible persons of a registered provider

(1) The change prescribed in item 3 of the table in section 167-10 is any change of responsible persons of a registered provider, including:

(a) an individual becoming a responsible person of the provider; and

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(b) an individual ceasing to be a responsible person of the provider.

Note: See section 167-10, which relates to notifying the Commissioner.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) for a change relating to an individual becoming a responsible person of the provider:

(i) the name and contact details of the individual; and

(ii) a description of the individual's responsibilities in their capacity as a responsible person of the provider; and

(iii) a statement to the effect that the provider has had regard to the suitability matters in relation to the individual, as referred to in subsection 13(1) of the Act, and that the provider is satisfied that the individual is suitable to be involved in the delivery of funded aged care services; and

(b) for a change relating to an individual ceasing to be a responsible person of the provider:

(i) the name of the individual ceasing to be a responsible person; and

(ii) the reason that the individual has ceased to be a responsible person of the provider; and

(iii) the name and contact details of another individual (if any) who is carrying out, or will carry out, the responsibilities of the individual ceasing to be a responsible person.

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167-35 Organisation arrangements of a registered provider

(1) The change prescribed in item 4 of the table in section 167-10 is any change of the following kind to the organisation of a registered provider:

(a) if the provider is not a government entity—any significant change to the provider's legal and business structure, including any of the following:

(i) a restructure of the organisation of the provider;

(ii) a sale, acquisition, or merger relating to the provider;

(b) for any registered provider (including a government entity)—the entering into of an agreement by the provider with another entity in which the other entity agrees to deliver services that support the management or governance function of the provider;

(c) for any registered provider (including a government entity)—any significant change to an agreement (including the cessation of a such an agreement) by the provider with another entity in which the other entity agrees to deliver services that support the management or governance of the provider;

(d) if the provider is not a government entity—any of the following events:

(i) the provider enters into administration;

(ii) the provider appoints a restructuring practitioner (within the meaning of the *Corporations Act 2001*);

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(iii) an insolvency event (within the meaning of the *Aged Care (Accommodation Payment Security) Act 2006*) occurs in relation to the provider.

Note 1: See section 167-10, which relates to notifying the Commissioner.

Note 2: See section 167-15, which relates to notifying the System Governor of matters relating to entering administration.

(2) To avoid doubt, the circumstances referred to in paragraph (1)(b) relating to the provider entering into an agreement do not include the entering into of an agreement for the delivery of funded aged care services.

(3) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) for a change to the provider's legal or business structure—details about the change to the provider's legal or business structure; and

(b) for an event referred to in paragraph (1)(b) or (c) (which relate to agreements):

(i) a detailed statement about the services that the other entity is to provide to the registered provider; and

(ii) the nature and duration of the agreement; and

(iii) if the notification is about the cessation of the agreement—the reason and date of cessation; and

(c) for an event set out in paragraph (1)(d) of this section (which relates to administration, restructuring and insolvency):

(i) the date on which the event occurred; and

(ii) the type of administration (where applicable); and

(iii) the name of the administrator or restructuring practitioner (where applicable).

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167-40 Governance arrangements of a registered provider

(1) The change prescribed in item 5 of the table in section 167-10 is any change to the governance of a registered provider that would result in the registered provider no longer complying with subsection 157(2) of the Act.

Note 1: See sections 157-5 and 157-10, which prescribe the kinds of registered providers to whom section 157 of the Act applies.

Note 2: See section 167-10, which relates to notifying the Commissioner.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) a statement that the provider no longer complies with a condition of registration set out in paragraph 157(2)(a) or (b) of the Act (whichever is relevant to the provider); and

(b) the names of incoming and outgoing members in relation to the non-compliance; and

(c) information on steps being taken to return to compliance, including whether an application under subsection 159(1) of the Act (which relates to

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determinations that certain conditions relating to the governing body of a registered provider do not apply) has been submitted, or will be submitted.

167-45 Change relating to the scale of operations of a provider

(1) The change prescribed in item 6 of the table in section 167-10 is any of the following changes:

(a) for a registered provider other than a registered provider registered in the provider registration category residential care—a change to the local government area in which the provider delivers a funded aged care service;

(b) for a registered provider (including a registered provider registered in the provider registration category residential care)—a significant increase or decrease in the number of aged care workers of the provider that materially affects the provider's ability to deliver funded aged care services.

Note: See section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) details of the change; and

(b) the aged care funded services that will be, or are likely to be, affected by the change; and

(c) any other anticipated effects of the change; and

(d) the reason for the change; and

(e) any actions that the provider has taken or will take to manage the effect on services, or other anticipated effects.

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167-50 Changes relating to intended service types

(1) The change prescribed in item 7 of the table in section 167-10 is any change relating to a registered provider's intended service types.

Note 1: See section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

Note 2: See Division 4 of Part 4 of Chapter 4 of this instrument for provisions relating to starting and ceasing the provision of funded aged care services to a particular individual and continuity of those services.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) the relevant service type; and

(b) the date on which the provider expects the change to take effect.

167-55 Changes relating to arrangements with associated providers

(1) Subject to subsections (2) and (2A), for the purposes of items 8 and 8A of the table in section 167-10, the changes are the following:

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(a) the commencement of a new arrangement between the registered provider and an associated provider for the delivery of funded aged care services by the associated provider on behalf of the registered provider;
(b) the variation or extension of an existing such arrangement between the registered provider and an associated provider;
(c) the cessation of an existing such arrangement between the registered provider and an associated provider.

Note: See section 167-10, which relates to notifying the Commissioner.

(2) Subsection (1) does not apply to circumstances where the registered provider has entered into an arrangement with an associated provider for:
(a) the supply of labour under a labour hire arrangement; or
(b) the delivery of services that support the management or governance function of the registered provider.

(2A) Subsection (1) applies only to arrangements for the delivery of the following services:
(a) services in service types that can be delivered under any of the following provider registration categories:
(i) residential care;
(ii) personal and care support in the home or community;
(iii) nursing and transition care;
(b) services in the following service types:
(i) subscription allied health and therapy;
(ii) subscription home or community general respite;
(iii) subscription personal care;
(iv) subscription therapeutic services for independent living;
(v) subscription nursing care.

(3) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:
(a) in all circumstances—information about the associated provider, including:
(i) the associated provider's business name; and
(ii) the associated provider's ABN; and
(iii) the associated provider's ACN (if any); and
(iv) the associated provider's business location; and
(b) in circumstances relating to the delivery of funded aged care services in a residential care home—information about the residential care home, including:
(i) the name of the residential care home; and
(ii) the address of the residential care home; and
(c) in circumstances relating to the commencement of a new arrangement:
(i) details of the services to be delivered under the new arrangement; and
(ii) the reasons for the new arrangement; and
(iii) the time period for the new arrangement (including the commencement date and expiry date of the arrangement); and

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(d) in circumstances relating to the variation or extension of an arrangement:
(i) details of the variation or extension, including any new commencement dates or expiry dates for the arrangement; and
(ii) the reason for the variation or extension; and
(e) in circumstances relating to the cessation of an arrangement:
(i) the date on which the arrangement ceased or will cease; and
(ii) the reason for the cessation.

167-60 Changes relating to financial and prudential matters

(1) The change prescribed in item 9 of the table in section 167-10 is any change to a registered provider's capacity to deliver funded aged care services that the provider is registered to deliver, including the following:
(a) the inability to pay the entitlements of the provider's aged care workers;
(b) any change that materially affects an existing or anticipated revenue source;
(c) any instance in which the provider is unable to pay the provider's debts as and when those debts become due and payable.

Note: See section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

(2) Subsection (1) does not apply to circumstances set out in section 167-65 (which relates to liquidity).

(3) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:
(a) details about the change; and
(b) the impact that the provider expects the change to have on the provider's ability to deliver funded aged care services; and
(c) details about any mitigating strategies the provider has attempted, or will attempt, to manage this impact.

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167-65 Changes relating to liquidity

(1) The change prescribed in item 10 of the table in section 167-10 is any circumstance where the registered provider is not maintaining, or is at risk of not maintaining, the provider's default minimum liquidity amount for a quarter or evaluated minimum liquidity amount for a quarter.

Note: See section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:
(a) the provider's current and expected liquidity for the relevant quarter; and
(b) the reason for the reduction, or expected reduction in liquidity; and
(c) the provider's Liquidity Management Strategy; and
(d) the provider's plan to increase liquidity to a level that is sufficient for the purposes set out in subsection (1).

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Note: The standards in relation to financial and prudential matters are set out in the Financial and Prudential Standards made by the Commissioner under subsection 376(1) of the Act.

167-70 Changes relating to approved residential care homes

(1) The change prescribed in item 11 of the table in section 167-10 is any of the following changes relating to an approved residential care home of a registered provider:

(a) a change that may affect whether the approved residential care home of the provider continues to meet the definition of residential care home in the Act;

(b) a change to a building or the premises that comprise the approved residential care home that presents a risk to the delivery of quality and safe residential care;

(c) a planned construction or renovation activity relating to the approved residential care home that the provider reasonably expects will affect the delivery of funded aged care services at the residential care home;

(d) an unplanned event relating to the approved residential care home that the provider reasonably expects will cause sustained disruption to the delivery of funded aged care services at the residential care home;

(e) a change in the ownership of the premises at which the residential care home is located or a change to any agreement between the owner of the premises and the registered provider to use the premises as a residential care home;

(f) for any provider other than a provider referred to in paragraph (g)—a reduction in the availability of the total number of beds covered by the approval of the approved residential care home that the provider expects will continue for a continuous period of at least 3 months, except where the approved residential care home only delivers funded aged care services under a specialist aged care program;

(g) for a registered provider in the 2023 MM category known as MM 6 or MM 7—a reduction in the availability of the total number of beds covered by the approval of the approved residential care home for any period of time, except where the approved residential care home only delivers funded aged care services under a specialist aged care program;

(h) a change in circumstances that causes beds that were unavailable as referred to in paragraph (1)(f) or (g) to become available.

Note 1: See section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

Note 2: See section 136 of the Act, which relates to varying the approval of a residential care home of a registered provider.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) the name of the approved residential care home; and

(b) the street address of the residential care home; and

(c) a description of the change of circumstances; and

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(d) for circumstances referred to in paragraph (1)(f) or (g):

(i) the number of beds in respect of which the registered provider is, or will be, unable to provide residential care; and

(ii) the period during which the registered provider is, or will be, unable to provide residential care for those beds; and

(iii) the reason for the change to the availability of beds; and

(e) details of the change in ownership, and in circumstances where the registered provider is not the owner of the premises used for the provision of services and there is a change in ownership, the information must include the date and details of the type of agreement under which permission to use the premises is given.

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Part 4—Responsible person obligation—change in circumstances relating to suitability

169-5 Kinds of registered provider to which the obligation applies

For the purposes of paragraph 169(1)(a) of the Act, every kind of registered provider is prescribed except a provider that is a sole trader.

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Part 5—Obligations relating to suitability of responsible persons

172-5 Kinds of registered provider to which the obligation applies

For the purposes of subsection 172(1) of the Act, every kind of registered provider is prescribed.

172-10 Requirements for records of suitability matters

For the purposes of paragraph 172(1)(b) of the Act, a registered provider must keep a record of its consideration of suitability matters in relation to a person that includes the following:

(a) the name of the person in relation to whom the suitability matters were considered;

(b) the date or dates on which the suitability matters were considered in relation to the person;

(c) the outcome of the provider's consideration of each suitability matter in relation to the person;

(d) the reasons for reaching that outcome.

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Part 6—Obligations relating to aged care workers etc.

Division 1—Registered nurses

Subdivision A—Preliminary

175-5 Exception to registered nurse requirement—approved residential care homes at which funded aged care services delivered only under TCP

For the purposes of paragraph 175(2)(b) of the Act, the TCP is prescribed.

175-10 Purpose of this Division

(1) For the purposes of subsection 175(3) of the Act, this Division provides for:
  (a) the circumstances in which an exemption from subsection 175(1) of the Act may be granted to a registered provider in relation to an approved residential care home; and
  (b) the period for which an exemption may be in force; and
  (c) the conditions that apply to that exemption.

(2) This Division also provides for the revocation of exemptions.

Subdivision B—Process for granting exemptions

175-15 Application for exemption

(1) A registered provider may apply to the System Governor for an exemption from subsection 175(1) of the Act in relation to an approved residential care home at which the provider delivers funded aged care services.

(2) An application under subsection (1) must be made in the approved form.

175-25 Decision whether to grant exemption

Criteria for granting exemption—approved residential care homes at which funded aged care services are not delivered only under the MPSP

(1) If the System Governor receives an application under section 175-15 of this instrument from a registered provider for an exemption from subsection 175(1) of the Act in relation to an approved residential care home, other than a home at which the provider delivers funded aged care services only under the MPSP, the System Governor may grant the exemption only if:
  (a) the home is located in the 2023 MM category known as MM 5, MM 6 or MM7; and
  (b) there are no more than 30 operational beds in the home on the day of the System Governor's decision; and

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(c) the System Governor is satisfied that the provider has taken reasonable steps to ensure that the clinical care needs of the individuals in the home will be met during the period for which the exemption is in force; and

(d) the registered provider has given to the System Governor the reports required under section 166-855 of this instrument in relation to the home for each calendar month.

Criteria for granting exemption—approved residential care homes at which funded aged care services are delivered only under the MPSP

(1A) If the System Governor receives an application under section 175-15 of this instrument from a registered provider for an exemption from subsection 175(1) of the Act in relation to an approved residential care home at which the provider delivers funded aged care services only under the MPSP, the System Governor may grant the exemption only if:

(a) the home is located in the 2023 MM category known as MM 5, MM 6 or MM7; and

(b) no more than 30 residential care places for the home are in effect under section 97-5 of this instrument on the day of the System Governor's decision; and

(c) the System Governor is satisfied that the provider has taken reasonable steps to ensure that the clinical care needs of the individuals in the home will be met during the period for which the exemption is in force; and

(d) for an application made on or after 1 November 2026—the registered provider has given to the System Governor the reports required under section 166-855 of this instrument in relation to the home for each calendar month beginning on or after 1 October 2026.

(2) In deciding whether to grant the exemption, the System Governor must have regard to:

(a) any variation to the registration of the registered provider by the Commissioner under paragraph 123(1)(a) of the Act to vary a condition to which the registration is subject to under section 143 of the Act; and

(b) any variation to the registration of the registered provider by the Commissioner under paragraph 123(1)(b) of the Act; and

(c) any notice given to the registered provider by the System Governor or Commissioner under:

(i) Division 2 of Part 10 of Chapter 6 of the Act; or

(ii) Part 11 of Chapter 6 of the Act; and

(d) any notice given to the registered provider under Part 5 of the Regulatory Powers Act (as applied by section 448 of the Act); and

(e) if the registered provider has given an undertaking under section 114 of the Regulatory Powers Act (as applied by section 458 of the Act); and

(f) if the registered provider has given an undertaking under section 463 of the Act; and

(g) whether the registered provider has been convicted of an offence against the Act; and

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(h) whether the registered provider has been found liable to pay a civil penalty under this Act.

(3) The System Governor may grant an exemption to a registered provider in relation to an approved residential care home for which the registered provider has previously been granted an exemption.

Period of exemption

(4) If the System Governor decides to grant an exemption, the System Governor must decide the period for which the exemption is to be in force.

(5) The period:
(a) must not be longer than 12 months; and
(b) must not begin before the day on which the System Governor grants the exemption.

Conditions that apply to exemption

(6) The following conditions apply to an exemption:
(a) the registered provider must give the System Governor notice in writing of any material change to the information given to the System Governor:
(i) in the application for the exemption; or
(ii) in response to a request by the System Governor under section 588 of the Act;
(b) any additional conditions that the System Governor decides to impose on the exemption.

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175-30 Notice of decision

(1) If the System Governor grants an exemption from subsection 175(1) of the Act to a registered provider in relation to an approved residential care home, the System Governor must give the provider notice in writing of the decision that:
(a) states the period for which the exemption is in force; and
(b) states the conditions that apply to the exemption.

(2) If the System Governor refuses to grant an exemption from subsection 175(1) of the Act to a registered provider in relation to an approved residential care home, the System Governor must give the provider notice in writing of the decision, including:
(a) the reasons for the decision; and
(b) the date of the decision; and
(c) how the registered provider may apply for reconsideration of the decision.

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Subdivision C—Revocation of exemptions

175-45 Revocation on request

(1) The System Governor must revoke a registered provider's exemption from subsection 175(1) of the Act in relation to a residential care home if the registered provider requests the revocation in writing.

(2) The System Governor must give the registered provider notice in writing of the date that the exemption ceases to have effect, which may be the date of the notice or a later date.

175-50 Revocation on System Governor's initiative

Grounds for revocation

(1) The System Governor may revoke a registered provider's exemption from subsection 175(1) of the Act in relation to an approved residential care home if:
- (a) the System Governor is satisfied the registered provider has breached a condition of the exemption; or
- (b) the System Governor is not satisfied that the clinical care needs of individuals in the home:
  - (i) are being met; or
  - (ii) will be met during the period the exemption would otherwise be in force; or
- (c) the registration of the registered provider has been varied by the Commissioner under paragraph 123(1)(a) of the Act to vary a condition to which the registration is subject to under section 143 of the Act; or
- (d) the registration of the registered provider has been varied by the Commissioner under paragraph 123(1)(b) of the Act; or
- (e) in relation to a home other than a home at which the provider delivers funded aged care services only under the MPSP—the System Governor becomes aware there are more than 30 operational beds in the home; or
- (f) in relation to a home at which the provider delivers funded aged care services only under the MPSP—the System Governor becomes aware there are more than 30 residential care places for the home in effect under section 97-5 of this instrument.

Notice before revocation

(2) Before the System Governor revokes a registered provider's exemption under this section, the System Governor must give the provider written notice that the System Governor is considering revoking the exemption.

(3) The notice must:
- (a) set out the reasons why the System Governor is considering revoking the exemption, and what the effect of the revocation would be; and

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(b) invite the provider to make a submission, in writing, to the System Governor in relation to the matter within the period specified in the notice (which must not be less than 28 days after giving the notice); and

(c) inform the provider that the System Governor may decide to revoke the exemption:

(i) if no submission is made within the specified period; or

(ii) after considering any submission made by the provider within the specified period.

Request for further information

(4) The System Governor may also request, in the notice given under subsection (2), that the provider give the System Governor the information specified in the notice, within the period specified in the notice for the purposes of paragraph (3)(b), to assist the System Governor to decide whether to revoke the exemption.

Note: The provider is not obliged to give the information.

(5) If the provider makes a submission in accordance with the invitation under paragraph (3)(b), the System Governor may, by written notice, request the provider to give the System Governor further information, within the period specified in the notice (which must not be less than 28 days after giving the notice), to assist the System Governor to decide whether to revoke the exemption.

Note 1: The System Governor may request further information under this subsection regardless of whether information was requested or given under subsection (4).

Note 2: The provider is not obliged to give the information.

(6) The System Governor may, at the request of the provider, extend the period specified for paragraph (3)(b) or subsection (5).

Deciding whether to revoke exemption

(7) The System Governor must:

(a) consider any submission made in accordance with the invitation under paragraph (3)(b) and any further information given in accordance with a request under subsection (4) or (5); and

(b) make a decision whether to revoke the exemption within 28 days from:

(i) if no submission is made in accordance with the invitation in the notice under paragraph (3)(b)—the end of the period specified in the notice (including that period as extended (if applicable) under subsection (6)); or

(ii) the later of:

(A) if a submission is made in accordance with the invitation in the notice under paragraph (3)(b) and no further information is requested under subsection (5)—the day the submission is made; and

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(B) if a submission is made in accordance with the invitation in the notice under paragraph (3)(b) and further information is requested under subsection (5)—the day the provider gives the System Governor the further information.

175-55 Notice of decision

If the System Governor decides under section 175-50 of this instrument to revoke a registered provider's exemption from subsection 175(1) of the Act in relation to an approved residential care home, the System Governor must give the registered provider notice in writing of the decision, including:

(a) the reasons for the decision; and

(b) the date that the exemption ceases to have effect, which may be the date of the decision or a later date; and

(c) how the registered provider may apply for reconsideration of the decision.

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Division 2—Delivery of direct care

Subdivision A—Delivery of direct care—mainstream providers

176-5 Kinds of provider to which the obligation applies, and requirements

For the purposes of section 176 of the Act:

(a) a registered provider registered in the provider registration category residential care is prescribed; and

(b) this Subdivision sets out the requirements for delivering direct care.

176-10 Application of this Subdivision

The requirements of this Subdivision do not apply in respect to the delivery of funded aged care services provided under any of the following specialist aged care programs:

(a) TCP;

(b) MPSP;

(c) NATSIFACP.

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176-15 Care minutes that must be delivered

(1) This section applies if the provider is delivering funded aged care services in an approved residential care home in a quarter.

Requirement—care minutes delivered by direct care staff members

(2) The provider must ensure that the average number of care minutes delivered in the home by direct care staff members of the provider per counted mainstream individual per day is at least the required combined staff average number of care minutes per individual per day worked out under subsection 176-20(1) in respect of the home for the quarter.

Note: Direct care staff members of the provider include registered nurse staff members of the provider (see the definition of ***direct care staff member*** in section 7 of the Act).

Requirement—care minutes delivered by registered nurse staff members

(3) The provider must ensure that the average number of care minutes delivered in the home by registered nurse staff members of the provider per counted mainstream individual per day is at least 90% of the required registered nurse average number of care minutes per individual per day worked out under subsection 176-20(2) in respect of the home for the quarter.

Responsibility—care minutes delivered by registered nurse staff members and enrolled nurse staff members

(4) The registered provider must ensure that the average number of care minutes delivered in the home by registered nurse staff members and enrolled nurse staff

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members of the provider per counted mainstream individual per day is at least the required registered nurse average number of care minutes per individual per day worked out under subsection 176-20(2) in respect of the home for the quarter.

Counted individuals

(5) An individual accessing funded aged care services in an approved residential care home on a day is a ***counted mainstream individual*** on the day unless:
  (a) the individual accesses the funded aged care services through a specialist aged care program referred to in section 176-10; or
  (b) the individual is on extended hospital leave, and the day is on or after the 29th day of the individual's leave.

176-20 Average numbers of care minutes

Required combined staff average number of care minutes

(1) The ***required combined staff average number of care minutes*** per individual per day in respect of an approved residential care home for a quarter is worked out by:
  (a) starting with the sum of the combined staff daily amounts for all of the days of recognised residential care provided in respect of individuals in the home during the reference period for the quarter; and
  (b) dividing that sum by the total number of days of recognised residential care provided in respect of individuals in the home during the reference period for the quarter; and
  (c) rounding the result of that division to 2 decimal places (rounding up if the third decimal place is 5 or more).

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Required registered nurse average number of care minutes

(2) The ***required registered nurse average number of care minutes*** per individual per day in respect of an approved residential care home for a quarter is worked out by:
  (a) starting with the sum of the registered nurse daily amounts for all of the days of recognised residential care provided in respect of individuals in the home during the reference period for the quarter; and
  (b) dividing that sum by the total number of days of recognised residential care provided in respect of individuals in the home during the reference period for the quarter; and
  (c) rounding the result of that division to 2 decimal places (rounding up if the third decimal place is 5 or more).

Daily amounts

(3) The following table sets out, for a day of recognised residential care provided in respect of an individual in an approved residential care home:
  (a) the combined staff daily amount for the day for the individual; and

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(b) the registered nurse daily amount for the day for the individual.

Daily amounts

Item	Column 1 For an individual classified as …	Column 2 the combined staff daily amount is … (minutes)	Column 3 and the registered nurse daily amount is … (minutes)
1	Class 1	268	51
2	Class 2	128	27
3	Class 3	178	36
4	Class 4	150	32
5	Class 5	185	41
6	Class 6	176	37
7	Class 7	215	46
8	Class 8	232	47
9	Class 9	214	44
10	Class 10	229	44
11	Class 11	253	48
12	Class 12	247	47
13	Class 13	268	51
14	Respite Class 1	176	37
15	Respite Class 2	223	48
16	Respite Class 3	262	51

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Day of recognised residential care

(4) A ***day of recognised residential care*** is provided in respect of an individual in an approved residential care home if funded aged care services are delivered to the individual in the home through the residential care service category on that day.

(5) Despite subsection (4), a ***day of recognised residential care*** does not include a day where:

(a) funded aged care services are delivered through a specialist aged care program referred to in section 176-10; or

(b) funded aged care services are provided to an individual classified as:

(i) Class 0; or

(ii) Respite Class 0.

Reference period

(6) The ***reference period*** for a quarter is the period of 3 months beginning on the day that is 4 months before the first day of the quarter.

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Information to be disregarded for calculations

(7) For the purposes of a calculation under this section for a quarter:
  (a) information about an individual entering or exiting an approved residential care home during the reference period for the quarter is to be disregarded if it is given to the System Governor on or after the calculation day for the quarter; and
  (b) a change to a classification decision for an individual that is made on or after the calculation day for the quarter but takes effect before the calculation day is to be disregarded.

Calculation if no days of recognised residential care provided during reference period

(8) If no days of recognised residential care were provided in respect of individuals in an approved residential care home during the reference period for a quarter, the result of the calculations in subsections (1) and (2) in relation to the quarter is taken to be zero minutes per individual per day.

Note: This subsection is to avoid an undefined result when dividing by zero.

Subdivision B—Delivery of direct care—NATSIFACP providers

176-25 Kinds of provider to which the obligation applies, and requirements

For the purposes of section 176 of the Act:
  (a) a registered provider registered in the provider registration category residential care is prescribed; and
  (b) this Subdivision sets out the requirements for delivering direct care.

176-30 Application of this Subdivision

The requirements of this Subdivision do not apply in respect to the delivery of funded aged care services provided under any of the following specialist aged care programs:
  (a) TCP;
  (b) MPSP.

176-35 Care minutes that must be delivered—NATSIFACP providers

(1) This section applies if the registered provider is delivering funded aged care services in an approved residential care home in a quarter under the specialist aged care program NATSIFACP.

Requirement—care minutes delivered by direct care staff members

(2) The provider must ensure that the average number of care minutes delivered in the home by direct care staff members of the provider per counted NATSIFACP individual per day is at least 215 minutes per individual per day in respect of the home for the reporting period for the provider.

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Note: Direct care staff members of the provider include registered nurse staff members of the provider (see the definition of ***direct care staff member*** in section 7 of the Act).

Requirement—care minutes delivered by registered nurse staff members

(3) The provider must ensure that the average number of care minutes delivered in the home by registered nurse staff members of the provider per counted NATSIFACP individual per day is at least 39.6 minutes per individual per day in respect of the home for the reporting period for the provider.

Responsibility—care minutes delivered by registered nurse staff members and enrolled nurse staff members

(4) The provider must ensure that the average number of care minutes delivered in the home by registered nurse staff members and enrolled nurse staff members of the provider per counted NATSIFACP individual per day is at least 44 minutes per individual per day in respect of the home for the reporting period for the provider.

Counted individuals

(5) An individual accessing funded aged care services in an approved residential care home on a day under the specialist aged care program NATSIFACP is a ***counted NATSIFACP individual*** on the day unless:
  (a) the individual is on extended hospital leave; and
  (b) the day is on or after the 29th day of the individual's leave.

Reporting period

(6) The reporting period for the provider is the period specified for a service activity report under section 166-645.

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Part 7—Other obligations—cooperation with other persons

177-10 Giving data or records to the Pricing Authority

Application of this section

(1) Subject to subsection (2), this section applies to every kind of registered provider.

(2) The requirements of this section do not apply to a registered provider in respect of the delivery of funded aged care services under the following specialist aged care programs:
  (a) CHSP;
  (b) TCP.

Requirement to comply with notice

(3) For the purposes of subsection 177(2) of the Act, it is a requirement that a registered provider must comply with a request made under subsection (4) or (6).

Notice to provide data or records

(4) The Pricing Authority may request, by written notice given to a registered provider, that the provider:
  (a) give the Pricing Authority data or records held by the provider, or copies of that data or records, that are necessary for the conduct of a Pricing Authority advice activity; and
  (b) do so in a form and manner specified in the notice; and
  (c) do so before or on a day specified in the notice.

(5) A notice given under subsection (4) must:
  (a) set out that the request is for the purposes of the Pricing Authority performing the function mentioned in paragraph 131A(1)(a) of the *National Health Reform Act 2011*; and
  (b) specify the details of the data or records that the registered provider is requested to give; and
  (c) specify a day by which the data or records must be given, which must be at least 14 days after the day on which the notice is given to the provider; and
  (d) set out the effect of subsection 177(4) of the Act.

Request for further data or records

(6) If:
  (a) a provider responds to a request to provide data or records made under subsection (4); and

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(b) the Pricing Authority considers that additional data or records are required before the Pricing Authority can carry out a function mentioned in paragraph 131A(1)(a) of the *National Health Reform Act 2011*;

the Pricing Authority may, by written notice given to the applicant, request the provider to give that additional data or records, or copies of that additional data or records, to the Pricing Authority.

177-15 Allowing access by the Pricing Authority to certain persons

Application of this section

(1) Subject to subsection (2), this section applies to every kind of registered provider.

(2) The requirements of this section do not apply to a registered provider in respect of the delivery of funded aged care services under the following specialist aged care programs:
(a) CHSP;
(b) TCP.

Requirement to comply with notice

(3) For the purposes of subsection 177(2) of the Act, it is a requirement that a registered provider must comply with a request made under subsection (4).

Notice to allow access to certain persons

(4) The Pricing Authority may request, by written notice given to a registered provider, that the provider:
(a) allow and facilitate access by an official of the Pricing Authority to a person referred to in subsection (6) for the purposes of undertaking a Pricing Authority advice activity; and
(b) make arrangements before or on a day specified in the notice to allow and facilitate the access within a reasonable timeframe.

(5) A notice given under subsection (4) must:
(a) specify the form of the access, which may be in person, by audio link, or by audio-visual link; and
(b) specify a day by which the provider must make arrangements for the access, which must be at least 14 days after the day on which the notice is given to the provider; and
(c) set out the effect of subsection 177(4) of the Act.

(6) For the purposes of paragraph (4)(a), the persons are the following:
(a) a specified responsible person of the provider;
(b) any responsible person of the provider who is responsible for a specified matter for the provider;
(c) a specified aged care worker of the provider;

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(d) any aged care worker of the provider who is responsible for a specified matter for the provider.

177-20 Allowing access by the Pricing Authority to residential care homes

Application of this section

(1) Subject to subsection (2), this section applies to a registered provider in the provider registration category residential care.

(2) The requirements of this section do not apply to a registered provider in respect of the delivery of funded aged care services under the following specialist aged care programs:
(a) CHSP;
(b) TCP.

Requirement to comply with notice

(3) For the purposes of subsection 177(2) of the Act, it is a requirement that a registered provider must comply with a request made under subsection (4).

Notice to allow access to residential care homes

(4) The Pricing Authority may request, by written notice given to a registered provider, that the provider:
(a) allow and facilitate access by an official of the Pricing Authority to a residential care home of the provider for the purposes of undertaking a Pricing Authority advice activity; and
(b) do so on a day specified in the notice.

(5) A notice given under subsection (4) must:
(a) specify a day on which the access must be facilitated, which must be at least 14 days after the day on which the notice is given to the provider; and
(b) set out the effect of subsection 177(4) of the Act.

(6) For the purposes of subsection 177(2) of the Act, it is a requirement that reasonable facilities and assistance provided by the registered provider to whom a notice has been given under subsection (4) must include:
(a) providing a site orientation to the official of the Pricing Authority undertaking the Pricing Authority advice activity to which the notice relates, including guidance on how to safely navigate the residential care home; and
(b) providing information in relation to the activity to any of the following:
(i) aged care workers of the provider;
(ii) individuals to whom the provider delivers funded aged care services;
(iii) supporters of the individuals; and
(c) providing the official with access to aged care workers of the provider who are at the residential care home; and

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(d) providing the official with access to individuals to whom the provider delivers funded aged care services who have consented to the access; and

(e) providing the official with access to all areas of the residential care home, excluding rooms and part rooms of individuals who have not consented to the access and private bathroom facilities; and

(f) providing the official with facilities (including a suitable workspace) for the purpose of undertaking the Pricing Authority advice activity; and

(g) providing the official with access to records held by the provider; and

(h) providing the official with instructions about how to access records held by the provider; and

(i) allowing the official to make copies of those records.

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Aged Care Act 2024

No. 104, 2024

Compilation No. 2

Compilation date: 1 July 2026

Includes amendments: Act No. 45, 2025

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Prepared by the Office of Parliamentary Counsel, Canberra

About this compilation

This compilation

This is a compilation of the *Aged Care Act 2024* that shows the text of the law as amended and in force on 1 July 2026 (the ***compilation date***).

The notes at the end of this compilation (the ***endnotes***) include information about amending laws and the amendment history of provisions of the compiled law.

Uncommenced amendments

The effect of uncommenced amendments is not shown in the text of the compiled law. The details of amendments made up to, but not commenced at, the compilation date are underlined in the endnotes. Any uncommenced amendments affecting the law are accessible on the Register (www.legislation.gov.au).

Application, saving and transitional provisions

If the operation of a provision or amendment of the compiled law is affected by an application, saving or transitional provision that is not included in this compilation, details are included in the endnotes.

Editorial changes

For more information about any editorial changes made in this compilation, see the endnotes.

Presentational changes

The *Legislation Act 2003* provides for First Parliamentary Counsel to make presentational changes to a compilation. Presentational changes are applied to give a more consistent look and feel to legislation published on the Register, and enable the user to more easily navigate those documents.

Modifications

If the compiled law is modified by another law, the compiled law operates as modified but the modification does not amend the text of the law. Accordingly, this compilation does not show the text of the compiled law as modified. Any modifications affecting the law are accessible on the Register.

Self-repealing provisions

If a provision of the compiled law has been repealed in accordance with a provision of the law, details are included in the endnotes.

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An Act about aged care, and for related purposes

Chapter 1—Introduction

Part 1—Preliminary

1 Short title

This Act is the *Aged Care Act 2024*.

2 Commencement

(1) Each provision of this Act specified in column 1 of the table commences, or is taken to have commenced, in accordance with column 2 of the table. Any other statement in column 2 has effect according to its terms.

Commencement information

Column 1	Column 2	Column 3
Provisions	**Commencement**	**Date/Details**
1. The whole of this Act	A single day to be fixed by Proclamation. However, if the commencement of the provisions is not fixed by Proclamation before 1 July 2025, the provisions commence on 1 July 2025.	1 November 2025 (F2025N00516)

Note: This table relates only to the provisions of this Act as originally enacted. It will not be amended to deal with any later amendments of this Act.

(2) Any information in column 3 of the table is not part of this Act. Information may be inserted in this column, or information in it may be edited, in any published version of this Act.

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Section 3

3 Act binds the Crown

(1) This Act binds the Crown in each of its capacities.

(2) This Act does not make the Crown liable to be prosecuted for an offence.

4 Extension to external Territories

This Act extends to the external Territories other than the Territory of Ashmore and Cartier Islands.

5 Objects of this Act

The objects of this Act are to:

(a) in conjunction with other laws, give effect to Australia's obligations under the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of Persons with Disabilities; and

(b) provide a forward-looking aged care system that is designed to:

(i) uphold the rights of individuals under the Statement of Rights; and

(ii) assist individuals accessing funded aged care services to live active, self-determined and meaningful lives; and

(iii) ensure equitable access to, and flexible delivery of, funded aged care services that put older people first and take into account the needs of individuals, regardless of their location, background and life experience; and

(iv) support individuals accessing funded aged care services to effectively participate in society on an equal basis with others, thereby promoting positive community attitudes to ageing; and

(v) facilitate access to integrated services in other sectors where required; and

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(c) enable individuals accessing funded aged care services to exercise choice and control in the planning and delivery of those services; and

(d) ensure individuals accessing funded aged care services are free from mistreatment, neglect and harm from poor quality or unsafe care; and

(e) provide a robust and risk-based regulatory framework for the delivery of funded aged care services, including accessible complaint mechanisms for individuals accessing those services, that will promote public confidence and trust in the Commonwealth aged care system; and

(f) provide and support education and advocacy arrangements that can assist individuals accessing funded aged care services to understand their rights, make decisions and provide feedback on the delivery of those services without reprisal; and

(g) provide for sustainable funding arrangements for the delivery of funded aged care services by a diverse, trained and appropriately skilled workforce; and

(h) promote innovation in the Commonwealth aged care system based on research and support continuous improvement in the Commonwealth aged care system.

6 Simplified outline of this Act

This Act provides for the delivery of funded aged care services to individuals under the Commonwealth aged care system. The services are included in the aged care service list and grouped into service types which are delivered through service groups.

The objects of the Act, the Statement of Rights and the Statement of Principles underpin the system and are aimed at ensuring quality and safe care for individuals.

Supporters may be registered to assist individuals with navigating the system and are required to act in accordance with principles that promote supported decision making.

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Section 6

Eligible individuals undergo an aged care needs assessment which identifies which funded aged care services are needed. Services are delivered in an approved residential care home, or a home or community setting, and are delivered by entities known as registered providers. For certain service groups, there are mechanisms for prioritisation and allocation of limited places.

The funding for services can be in the form of a subsidy or grant payable to the registered provider. The amount of funding available depends on various factors, including the classification type and classification level of individuals, the application of means testing and whether the service is being provided under a specialist aged care program, for example, for Aboriginal or Torres Strait Islander persons.

The system is governed by the Secretary (known as the System Governor), the Aged Care Quality and Safety Commissioner (the Commissioner), and the Complaints Commissioner.

A set of key obligations apply to registered providers and apply even where registered providers subcontract the delivery of services to associated providers. Separate obligations apply to aged care workers and responsible persons of registered providers.

Protections are provided for whistleblowers and statutory duties are imposed on registered providers, responsible persons and operators of aged care digital platforms that facilitate access to services. Criminal penalties and civil penalties apply for failures to meet requirements under this Act and compensation can be sought in cases of serious failures by registered providers.

The Commissioner and the System Governor have access to a suite of regulatory mechanisms to assist in the performance of their respective functions.

Arrangements for the protection of information and data obtained under this Act and the sharing of that information and data also apply.

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Part 2—Definitions and key concepts

Division 1—Definitions

7 Definitions

In this Act:

ABN has the same meaning as in the *A New Tax System (Australian Business Number) Act 1999*.

access approval, for an individual, means an approval under subsection 65(2).

accommodation agreement means an agreement between an individual and a registered provider that meets the requirements set out in section 294.

accommodation bond has the meaning prescribed by the rules.

accommodation bond balance has the meaning prescribed by the rules.

accommodation charge has the meaning prescribed by the rules.

accommodation contribution means a contribution paid by an individual to a registered provider for accommodation in an approved residential care home through which the provider delivers ongoing funded aged care services to the individual through the service group residential care.

Note: If an individual is not required to pay an accommodation payment, the individual may be required to pay an accommodation contribution. The amount (if any) of accommodation contribution payable depends, amongst other things, on the individual's daily means tested amount (see section 298).

accommodation payment means a payment paid by an individual to a registered provider for accommodation in an approved residential care home through which the provider delivers ongoing

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funded aged care services to the individual through the service group residential care.

Note: Whether or not an individual pays an accommodation payment depends, amongst other things, on the individual's daily means tested amount (see section 296).

account period:

(a) for a notional assistive technology account—see subsection 211(1); and

(b) for a notional home modifications account—see subsection 220(1).

ADI means an authorised deposit-taking institution within the meaning of the *Banking Act 1959*.

administrative action: see subsection 582(2).

Advisory Council means the Aged Care Quality and Safety Advisory Council established by section 382.

Advisory Council member means a member of the Advisory Council and includes the Chair and the Deputy Chair.

advocate includes an independent aged care advocate.

affected entity, for a reviewable decision: see sections 556, 557 and 558.

aged care clearance decision means a clearance decision within the meaning of paragraph 379(5)(c).

Aged Care Code of Conduct means the rules made for the purposes of section 14.

aged care digital platform: see section 187.

aged care exclusion decision means an exclusion decision within the meaning of paragraph 379(5)(e).

aged care needs assessment means an assessment undertaken under Division 2 of Part 2 of Chapter 2.

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Aged Care Quality Standards means the rules made for the purposes of subsection 15(1).

aged care volunteer visitor means a person who:

(a) volunteers for or is otherwise engaged by a person or body that receives financial assistance under section 265 for the purpose mentioned in paragraph 265(2)(d); and

(b) implements that purpose by visiting individuals accessing funded aged care services to provide companionship, social support or friendship to those individuals who are socially isolated or are at risk of social isolation.

aged care worker: see subsections 11(4) and (5).

aged care worker screening check means an assessment, under an aged care worker screening law, of whether a person who works, or seeks to work, with individuals accessing funded aged care services poses a risk to such individuals.

aged care worker screening database means the database established under section 379.

aged care worker screening law means a law of a State or Territory prescribed by the rules.

agreed accommodation payment amount, in relation to an individual and an approved residential care home: see paragraph 294(2)(b).

Appointed Commissioner means:

(a) the Commissioner; or

(b) the Complaints Commissioner.

approval period, in relation to an approved residential care home, means the period for which the approval of the home is in force.

approved form:

(a) in relation to a function of the System Governor—see section 584; or

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(b) in relation to a function of the Commissioner—see section 585; or
(c) in relation to a function of the Complaints Commissioner—see section 586.

approved needs assessor means a person who:
(a) is approved by an entity of a kind prescribed by the rules; and
(b) meets any criteria including training or qualification requirements prescribed by the rules.

approved provider means an approved provider within the meaning of the Commission Act as in force immediately before the commencement of this Act.

approved report form: see section 166A.

approved residential care home means a residential care home that is:
(a) approved in relation to a registered provider under paragraph 112(1)(a); or
(b) taken to be approved in relation to a registered provider under section 120.

assessment officer: see section 432.

asset determination, for an individual, means a determination made under subsection 329(1) in relation to the individual (including as varied).

asset free area: see subsection 319(3).

associated provider: see subsection 11(6).

Australian Business Register has the same meaning as in the *A New Tax System (Australian Business Number) Act 1999*.

authorised Commission officer means a person appointed as an authorised Commission officer under section 525.

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authorised officer means an authorised Commission officer or an authorised System Governor officer.

authorised System Governor officer means a person appointed as an authorised System Governor officer under section 526.

available balance, at a time, for any of the following notional accounts, or for an unspent Commonwealth portion, means the sum of the credits that have been made to the account or portion at or before that time reduced (but not below zero) by the sum of the debits that have been made to the account or portion at or before that time:

(a) a notional ongoing home support account;
(b) a notional short-term home support account;
(c) a notional service delivery branch account;
(d) a notional assistive technology account;
(e) a notional home modifications account;
(f) a notional home care account.

banning order means a banning order made under section 497 or 498.

base individual amount for the service group home support: see section 194.

base provider amount for a registered provider:

(a) for the service group home support—see section 204; and
(b) for the service group residential care—see subsection 238(1).

base rate for an individual for a classification type for the service group residential care for a day: see subsection 229(1).

basic age pension amount means the annual maximum basic rate under point 1064-B1 of the *Social Security Act 1991* that applies to a person who is not a member of a couple within the meaning of that section.

basic daily fee for an individual—see subsection 277(2).

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business location means the address shown in the Australian Business Register as an entity's address for service.

care and services plan: see paragraph 148(e).

care needs means one or both of the following that apply in relation to an individual:

(a) the individual has difficulty (whether physical, mental or social) undertaking any daily living activities;

(b) the individual requires help from another person, or the assistance of one or more aids, to maintain their physical, mental or social capacity to function independently.

carer means a person who:

(a) provides personal care, support and assistance to another individual who needs it because that other individual is an older individual; and

(b) does not provide the personal care, support and assistance to the individual:

(i) as an aged care worker of a registered provider; or

(ii) in the course of doing voluntary work for a charitable, welfare or community organisation, including as an aged care volunteer visitor; or

(iii) as part of the requirements of a course of education or training.

cessation notification: see paragraph 149(d).

Chair means the Chair of the Advisory Council.

Chief Executive Centrelink has the same meaning as in the *Human Services (Centrelink) Act 1997*.

Chief Executive Medicare has the same meaning as in the *Human Services (Medicare) Act 1973*.

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child, of an individual, includes:

(a) a stepchild or an adopted child of the individual; and

(b) someone who would be the stepchild of the individual except that the individual is not legally married to the individual's partner; and

(c) someone who is a child of the individual within the meaning of the *Family Law Act 1975*; and

(d) someone included in a class of persons prescribed by the rules.

civil penalty provision has the same meaning as in the Regulatory Powers Act.

classification assessment means an assessment of an individual undertaken in accordance with section 76 for the purposes of establishing a classification level for the individual under section 78.

classification decision means a decision under subsection 78(1) to establish a classification level for an individual for a classification type for a service group.

classification level: see subsection 81(1).

classification type: each of the following is a ***classification type***:

(a) ongoing;

(b) short-term;

(c) hospital transition.

close relation, of an individual, means:

(a) a parent of the individual; or

(b) a sibling, child or grandchild of the individual; or

(c) an individual included in a class of persons prescribed by the rules.

Commission means the Aged Care Quality and Safety Commission established by section 344.

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Commission Act means the *Aged Care Quality and Safety Commission Act 2018*.

Commissioner means the Commissioner of the Commission.

Commonwealth entity has the same meaning as in the *Public Governance, Performance and Accountability Act 2013*.

compensation payment fee for an individual for a day:

(a) for a funded aged care service delivered through the service group home support, assistive technology or home modifications—see subsection 274(2); or

(b) for a funded aged care service delivered through the service group residential care—see subsection 277(3).

compensation payment reduction for person-centred subsidy for an individual:

(a) for the service group home support—see section 199; and

(b) for the service group assistive technology—see section 216; and

(c) for the service group home modifications—see section 225; and

(d) for the service group residential care—see section 233.

compensation payment reduction for provider-based subsidy for an individual:

(a) for the service group home support—see section 207; and

(b) for the service group residential care—see section 241.

Complaints Commissioner means the Complaints Commissioner of the Commission.

complaints functions means the functions of the Complaints Commissioner under section 357.

compliance notice: see sections 481 and 482.

conduct means an act, an omission to perform an act or a state of affairs.

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conflict of interest, in relation to an individual accessing, or seeking to access, funded aged care services and a supporter of the individual, means any conflict between:

(a) the interests of the individual; and

(b) the interests of the supporter;

that would affect the supporter's ability to carry out the supporter's role.

constitutional corporation means a trading or financial corporation within the meaning of paragraph 51(xx) of the Constitution.

continuous improvement plan means a plan, in writing, which sets out:

(a) how a registered provider intends to improve the quality of funded aged care services delivered by the registered provider; and

(b) if the Commissioner imposed a condition on the registration of the registered provider under subsection 143(1) which relates to the quality of funded aged care services delivered by the registered provider—how the registered provider intends to comply with that condition.

Convention on the Rights of Persons with Disabilities means the Convention on the Rights of Persons with Disabilities done at New York on 13 December 2006.

Note: The Convention is in Australian Treaty Series 2008 No. 12 ([2008] ATS 12) and could in 2024 be viewed in the Australian Treaties Library on the AustLII website (http://www.austlii.edu.au).

cost, for the delivery of a funded aged care service, has the meaning prescribed by the rules.

Covenant on Economic, Social and Cultural Rights means the International Covenant on Economic, Social and Cultural Rights done at New York on 16 December 1966.

Note: The Covenant is in Australian Treaty Series 1976 No. 5 ([1976] ATS 5) and could in 2024 be viewed in the Australian Treaties Library on the AustLII website (http://www.austlii.edu.au).

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cover, a funded aged care service:

(a) in relation to a registered provider's registration—means the registered provider is registered in the registration category in which the service is included; or

(b) in relation to an individual's access approval—means the access approval:

(i) includes the classification type and service group through which the service is being delivered to the individual; and

(ii) if the service is in a service type that must be approved under subparagraph 65(2)(b)(i), or is a service that must be approved under subparagraph 65(2)(b)(ii)—includes the service type or service.

daily accommodation contribution means accommodation contribution that:

(a) accrues daily; and

(b) is paid by periodic payment.

daily accommodation payment means accommodation payment that:

(a) accrues daily; and

(b) is paid by periodic payment.

daily means tested amount, for an individual: see section 319.

daily payment means:

(a) a daily accommodation contribution; or

(b) a daily accommodation payment.

debtor: see section 514.

decision-maker, for a reviewable decision, means:

(a) for a decision by the Commissioner—the Commissioner; or

(b) for a decision by the System Governor—the System Governor; or

(c) for a decision by the Pricing Authority—the Pricing Authority; or

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(d) for a decision by the Complaints Commissioner—the Complaints Commissioner.

deliver, a funded aged care service, has a meaning affected by section 11A.

dependent child, of an individual, has the meaning given by subsection 22(1).

Deputy Chair means the Deputy Chair of the Advisory Council.

direct care means any funded aged care services prescribed by the rules which are delivered to an individual by a direct care staff member.

direct care staff member means an aged care worker of a registered provider who is any of the following:

(a) a registered nurse;
(b) an enrolled nurse;
(c) a nursing assistant;
(d) a personal care worker;
(e) a person prescribed by the rules.

distinct part, in relation to an approved residential care home, means a specific area of the home that:

(a) is physically identifiable as separate from all the other parts of the home; and
(b) meets any other requirements prescribed by the rules.

efficient price, for the delivery of a funded aged care service, is the amount prescribed by the rules.

eligibility determination, for an aged care needs assessment for an individual, means a determination under subsection 57(1).

emergency leave: see subsection 244(3).

engage in conduct means:

(a) do an act; or

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(b) omit to perform an act.

engagement and education functions means the functions of the Commissioner under section 350.

enrolled nurse means a person who is registered under the National Law in the nursing profession as an enrolled nurse.

entity means any of the following:

(a) an individual;
(b) a body corporate;
(c) a body politic;
(d) a partnership;
(e) any other unincorporated association that has a governing body.

entrusted person means any of the following:

(a) the Minister;
(b) the System Governor;
(c) an APS employee in the Department;
(d) an official of the Commission under paragraph 344(2)(c);
(e) any other person employed or engaged by the Commonwealth to provide services to the Commonwealth in connection with the Department or the Commission;
(f) any other person employed or engaged (however described) by a person described in paragraph (e) to provide services in connection with the services mentioned in that paragraph;
(g) an Advisory Council member;
(h) a delegate of the System Governor or an Appointed Commissioner;
(i) an official of the Pricing Authority;
(j) an official of Services Australia;
(k) any other person employed or engaged by the Commonwealth to provide services to the Commonwealth in connection with Services Australia;

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(l) any other person employed or engaged (however described) by a person described in paragraph (k) to provide services in connection with the services mentioned in that paragraph;

(m) any other person in a class of persons prescribed by the rules and employed or engaged by the Commonwealth or a body corporate established by a law of the Commonwealth.

entry contribution has the meaning prescribed by the rules.

entry contribution balance has the meaning prescribed by the rules.

entry day, for a classification type for a service group—means the day, or the day worked out in accordance with a method, prescribed by the rules.

extended hospital leave: see subsection 244(6).

final efficient price, for the delivery of a funded aged care service, means the amount prescribed by the rules.

Finance Minister means the Minister who administers the *Public Governance, Performance and Accountability Act 2013*.

Financial and Prudential Standards means the standards made under subsection 376(1).

financial institution means a corporation that is an ADI for the purposes of the *Banking Act 1959*.

funded aged care service: see subsection 9(1).

governing body of a registered provider means:

(a) if the registered provider is a body corporate incorporated, or taken to be incorporated, under the *Corporations Act 2001*, that has a board of directors—the board of directors; or

(b) otherwise—the person or the group of persons responsible for the executive decisions of the registered provider.

government entity means:

(a) a Commonwealth entity; or

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(b) a State or Territory; or
(c) a body established for a public purpose by or under a law of a State or Territory (other than a local government authority).

Grantee Code of Conduct has the meaning given by subsection 268(3).

health service has the same meaning as in Article 25 of the Convention on the Rights of Persons with Disabilities.

high quality care: see section 20.

home care account, for an individual: see section 226E.

home or community setting: see subsections 10(6) and (7).

homeowner has the meaning prescribed by the rules.

hospital leave: see subsection 244(4).

hospital transition funded aged care service, a funded aged care service delivered by a registered provider to an individual is a hospital transition funded aged care service delivered through a service group if:

(a) the individual has an access approval in effect for the classification type hospital transition for the service group; and
(b) the provider has given the System Governor a start notification for delivering funded aged care services on that basis to the individual.

hospital transition leave: see subsection 244(5).

hotelling contribution: see section 278.

identity card, in relation to an authorised officer, means an identity card issued to the officer under section 35 or 76 of the Regulatory Powers Act.

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ILO Convention (No. 122) concerning Employment Policy means the ILO Convention (No. 122) concerning Employment Policy done at Geneva on 9 July 1964.

Note: The Convention is in Australian Treaty Series 1970 No. 17 ([1970] ATS 17) and could in 2024 be viewed in the Australian Treaties Library on the AustLII website (http://www.austlii.edu.au).

ILO Convention (No. 142) concerning Vocational Guidance and Vocational Training in the Development of Human Resources means the ILO Convention (No. 142) concerning Vocational Guidance and Vocational Training in the Development of Human Resources done at Geneva on 23 June 1975.

Note: The Convention is in Australian Treaty Series 1986 No. 2 ([1986] ATS 2) and could in 2024 be viewed in the Australian Treaties Library on the AustLII website (http://www.austlii.edu.au).

income determination, for an individual, means a determination made under subsection 322(1) in relation to the individual (including as varied).

income support payment has the meaning given by subsection 23(1) of the *Social Security Act 1991*.

income support supplement means an income support supplement under Part IIIA of the *Veterans' Entitlements Act 1986*.

independent aged care advocate means a person who:

(a) is independent of the System Governor, the Commission and any registered providers; and

(b) is employed or otherwise engaged by a person or body that receives financial assistance under section 265 for the purpose mentioned in paragraph 265(2)(e); and

(c) provides either or both of the following to individuals accessing, or seeking to access, funded aged care services:

(i) free, independent and confidential support, information and advocacy;

(ii) education about the rights of individuals under the Statement of Rights; and

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(d) if providing the services mentioned in subparagraph (c)(i) in relation to a particular individual—acts at the direction of the individual, reflecting the individual's expressed wishes, will, preferences, interests and rights.

individual contribution, for a registered provider for the delivery of a funded aged care service to an individual: see section 273.

individual contribution rate, for a funded aged care service delivered to an individual on a day, means the percentage specified in the individual contribution rate determination for the individual for the means testing category the service is in.

individual contribution rate determination, for an individual, means a determination made under section 314 in relation to the individual.

individual contribution reduction, for an individual:

(a) for person-centred subsidy for the service group home support—see section 200; and

(b) for provider-based subsidy for the service group home support—see section 208; and

(c) for person-centred subsidy for the service group assistive technology—see section 217; and

(d) for person-centred subsidy for the service group home modifications—see section 226.

in effect:

(a) for a place allocated under subsection 92(1): see section 92A; and

(b) for a place allocated under subsection 95(1): see section 97.

intended service types: see paragraph 104(3)(b).

internal decision reviewer, for a reviewable decision: see subsections 560(4) and 562(4).

leave, from an approved residential care home, has the meaning given by subsection 244(2).

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lifetime cap means the amount prescribed by the rules.

local government authority means a body established for the purposes of local government by or under a law of a State or Territory.

maximum accommodation payment amount: see subsection 289(1).

maximum accommodation supplement amount: see subsection 235(3).

maximum daily amount of the resident contribution: see section 277.

maximum hotelling supplement amount: see subsection 235(4).

maximum non-clinical care contribution: see subsection 279(3).

maximum period of effect for a classification level for a classification type for a service group: see subsection 80(4).

means not disclosed status:

(a) for an individual accessing funded aged care services in a home or community setting—see section 314A; and

(b) for an individual accessing funded aged care services in an approved residential care home—see section 320.

means testing category: see subsection 8(4).

member of a couple means:

(a) an individual who is legally married to another individual, and is not living separately and apart from the individual on a permanent basis; or

(b) an individual whose relationship with another individual (whether of the same sex or a different sex) is registered under a law of a State or Territory prescribed for the purposes of section 2E of the *Acts Interpretation Act 1901* as a kind of relationship prescribed for the purposes of that section, and

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who is not living separately and apart from the other individual on a permanent basis; or

(c) an individual who lives with another individual (whether of the same sex or a different sex) in a de facto relationship, although not legally married to the other individual.

minimum permissible asset value: see subsection 305(2).

Multi-Purpose Service Program means a specialist aged care program given effect through one or more agreements entered into by the Commonwealth under paragraph 247(1)(a) for the purpose of the delivery of funded aged care services at a place co-located with a hospital or other health service as a part of an integrated service arrangement.

National Disability Insurance Scheme has the meaning given by the NDIS Act.

National Law has the same meaning as in the *Health Insurance Act 1973*.

NDIS Act means the *National Disability Insurance Scheme Act 2013*.

NDIS banning order means a banning order made under section 73ZN of the NDIS Act.

NDIS clearance decision means a clearance decision within the meaning of paragraph 379(7)(c).

NDIS exclusion decision means an exclusion decision within the meaning of paragraph 379(7)(e).

NDIS worker screening law has the same meaning as in the NDIS Act.

nominated ART member: see paragraph 432(1)(b).

non-clinical care contribution: see section 279.

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notional assistive technology account means a notional account established for an individual under subsection 211(1).

notional home care account means a notional account established for an individual under subsection 226E(1).

notional home modifications account means a notional account established for an individual under subsection 220(1).

notional ongoing home support account means a notional account established for an individual under subsection 193(1).

notional service delivery branch account means a notional account established for a service delivery branch of a registered provider under subsection 203(1).

notional short-term home support account means a notional account established for an individual under subsection 195(1).

nursing means the provision of services by or under the supervision of a registered nurse acting within the registered nurse's scope of practice.

nursing assistant means a person:

(a) who is not a registered nurse or enrolled nurse; and
(b) who works under the direct control and supervision of a registered nurse; and
(c) whose work is solely to assist a registered nurse or enrolled nurse in the delivery of nursing.

official, of a Commonwealth entity, has the same meaning as in the *Public Governance, Performance and Accountability Act 2013*.

official of the Pricing Authority has the same meaning as in the *National Health Reform Act 2011*.

old Act means the *Aged Care Act 1997*.

ongoing funded aged care service, a funded aged care service delivered by a registered provider to an individual is an ongoing funded aged care service delivered through a service group if:

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(a) the individual has an access approval in effect for the classification type ongoing for the service group; and
(b) the provider has given the System Governor a start notification for delivering funded aged care services on that basis to the individual.

paid work means work for financial gain or reward (whether as an employee, a self-employed person or otherwise).

parent: without limiting who is a parent of an individual, a person is the ***parent*** of an individual if the individual is the person's child because of the definition of ***child*** in this section.

partner, in relation to an individual, means the other member of a couple of which the individual is also a member.

payment period, for the service group residential care: see section 255.

personal information has the same meaning as in the *Privacy Act 1988*.

person-centred subsidy:
(a) for the service group home support—see sections 191 and 192; and
(b) for the service group assistive technology—see sections 209 and 210; and
(c) for the service group home modifications—see sections 218 and 219; and
(d) for the service group residential care—see sections 227 and 228.

person-centred subsidy reduction: see section 235.

police officer means any of the following:
(a) a member of the Australian Federal Police (within the meaning of the *Australian Federal Police Act 1979*);
(b) a special member of the Australian Federal Police (within the meaning of that Act);

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(c) a member of the police force or police service of a State or Territory.

post-entry warrant: see paragraph 431(1)(a).

price charged, for the delivery of a funded aged care service, has the meaning prescribed by the rules.

Pricing Authority means the Independent Health and Aged Care Pricing Authority.

primary person-centred supplements:

(a) for the service group home support—see section 196; and

(b) for the service group residential care—see section 230.

protected entity: see subsection 163(3).

protected information: see section 21.

provider-based subsidy:

(a) for the service group home support—see sections 201 and 202; and

(b) for the service group residential care—see sections 236 and 237.

provider-based subsidy reduction: see section 242.

provider-based supplements:

(a) for a service delivery branch of a registered provider—see section 205; and

(b) for an approved residential care home of a registered provider—see section 239.

provider registration category: see subsection 11(3).

provisional subsidy amount, for a registered provider in relation to an individual:

(a) for person-centred subsidy for an ongoing or short-term funded aged care service delivered to the individual through the service group home support—see section 192; and

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(b) for provider-based subsidy for an ongoing funded aged care service delivered to the individual through the service group home support—see section 202; and

(c) for person-centred subsidy for an ongoing or short-term funded aged care service delivered to the individual through the service group assistive technology—see section 210; and

(d) for person-centred subsidy for a registered provider for a short-term funded aged care service delivered to an individual through the service group home modifications—see section 219.

published accommodation payment amount, for an approved residential care home or a distinct part of an approved residential care home: see subsection 291(5).

quarter means a period of 3 months beginning on 1 July, 1 October, 1 January or 1 April.

reasonably practicable in relation to a duty under Part 5 of Chapter 3: see subsection 179(2).

reconsideration decision: see subsections 564(2) and 565(2).

recoverable amount: see section 514.

refundable accommodation contribution means accommodation contribution that:

(a) does not accrue daily; and

(b) is paid as a lump sum.

refundable accommodation deposit means accommodation payment that:

(a) does not accrue daily; and

(b) is paid as a lump sum.

refundable deposit means:

(a) a refundable accommodation contribution; or

(b) a refundable accommodation deposit.

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refundable deposit balance, in relation to a refundable deposit, at a particular time, means the amount worked out by:

(a) taking the sum of:

(i) the refundable deposit; and

(ii) any amounts that, as at that time, have been paid as top up amounts (as mentioned in paragraphs 294(2)(g) and (h) and 294(3)(f) and (i)); and

(b) subtracting any amounts that, as at that time, have been deducted from the refundable deposit balance under this Act.

registered NDIS provider has the meaning given by the NDIS Act.

registered nurse has the same meaning as in the *Health Insurance Act 1973*.

registered provider: see subsection 11(2).

registration of providers functions means the functions of the Commissioner under section 351.

registration period, in relation to a registered provider, means the period for which the registration of the provider is in force.

Regulatory Powers Act means the *Regulatory Powers (Standard Provisions) Act 2014*.

relevant information means information obtained or generated by a person in the course of or for the purposes of:

(a) performing functions or duties, or exercising powers, under this Act; or

(b) assisting another person to perform functions or duties, or exercise powers, under this Act.

relevant period, in relation to a claim for person-centred subsidy or provider-based subsidy for the service group home support, assistive technology or home modifications—see subsection 251(2).

reportable incident: see section 16.

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required action notice: see sections 474 and 475.

residential care home: see subsections 10(2) to (4).

responsible person: see section 12.

restrictive practice: see section 17.

retention amount: see section 308.

Note: A retention amount is an amount that a registered provider must deduct from a refundable deposit balance.

retention period, for an individual: see subsection 308(1).

reviewable decision: see sections 556, 557 and 558.

RSA (short for retirement savings account) has the same meaning as in the *Retirement Savings Accounts Act 1997*.

rules means the rules made under section 602.

safeguarding functions means the functions of the Commissioner under section 349.

secondary person-centred supplements:

(a) for a classification type for the service group home support—see section 197; and
(b) for a classification type for the service group assistive technology—see section 214; and
(c) for a classification type for the service group home modifications—see section 223; and
(d) for a classification type for the service group residential care—see section 231.

serious failure:

(a) in relation to conduct of a registered provider—see subsection 179(4); and
(b) in relation to conduct of a responsible person—see subsection 180(5).

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serious injury or illness of an individual means an injury or illness requiring the individual to have:

(a) immediate treatment for:
  (i) the amputation of any part of the individual's body; or
  (ii) a serious head injury; or
  (iii) a serious eye injury; or
  (iv) a serious burn; or
  (v) the separation of the individual's skin from an underlying tissue (such as degloving or scalping); or
  (vi) a spinal injury; or
  (vii) the loss of a bodily function; or
  (viii) serious lacerations; or
  (ix) a serious wound or pressure injury; or

(b) medical treatment within 48 hours of exposure to a substance;

and includes any other injury or illness prescribed by the rules but does not include an illness or injury of a kind prescribed by the rules.

service includes the supply of goods.

service agreement means an agreement that meets any requirements prescribed by rules made for the purposes of paragraph 148(c).

service delivery branch has the meaning prescribed by the rules.

service group: see subsection 8(3).

service pension has the meaning given by subsection 5Q(1) of the *Veterans' Entitlements Act 1986*.

service type: see subsection 8(2).

SES office or position means an office or position that is held or occupied, or the duties of which are performed, by an SES employee or acting SES employee.

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setting means a residential care home or a home or community setting.

short-term funded aged care service, a funded aged care service delivered by a registered provider to an individual is a short-term funded aged care service delivered through a service group if:

(a) the individual has an access approval in effect for the classification type short-term for the service group; and

(b) the provider has given the System Governor a start notification for delivering funded aged care services on that basis to the individual.

sickness means an infirmity, illness, disease, incapacity or impairment.

significant failure, in relation to the conduct of a registered provider or responsible person of a registered provider: see subsection 19(1).

social leave: see subsection 244(7).

specialist aged care program, means a Government program for delivering funded aged care services that:

(a) is given effect through one or more agreements or arrangements entered into by the Commonwealth under subsection 247(1) or section 264 for the program; and

(b) meets any other requirements prescribed by the rules.

standard base provider amount: see subsection 242(2).

start day, for an individual:

(a) for a classification type for the service group home support, assistive technology or home modifications—means the day a registered provider starts delivering funded aged care services to the individual for the classification type for the service group through a service delivery branch of the registered provider; and

(b) for a classification type for the service group residential care—means the day a registered provider starts delivering

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funded aged care services to the individual for the classification type for the service group at an approved residential care home of the registered provider.

start notification: see paragraph 149(b).

Statement of Principles means the principles in section 25.

Statement of Rights means the rights in section 23.

statutory funding condition has the meaning given by section 267.

subsidy means any of the following:

(a) person-centred subsidy;
(b) provider-based subsidy;
(ba) subsidy referred to in section 242A;
(c) subsidy referred to in section 248.

subsidy basis, for the delivery of a funded aged care service, means any of the following:

(a) efficient price;
(b) unit price;
(c) cost.

suitability matter in relation to an individual: see section 13.

supporter, of an individual, means a person registered as a supporter of the individual under section 37.

systematic pattern of conduct, in relation to the conduct of a registered provider or responsible person of a registered provider: see subsection 19(2).

System Governor means the Secretary of the Department.

this Act includes:

(a) legislative instruments made under this Act; and
(b) the Regulatory Powers Act as it applies in relation to this Act.

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tier amount for an individual for an account period:

(a) for the service group assistive technology—see section 212; and

(b) for the service group home modifications—see section 221.

total assessable income free area: see subsection 319(2).

Transition Care Program means a specialist aged care program given effect through one or more agreements entered into by the Commonwealth under paragraph 247(1)(b) for the purpose of the delivery of funded aged care services to individuals with access approvals in effect for the classification type hospital transition for a service group.

transition time means the time this Act commences.

unit price, for the delivery of a funded aged care service, is the amount prescribed by the rules.

unspent care recipient portion, for an individual: see section 273A.

unspent Commonwealth portion, for an individual: see section 226A.

use, in relation to information, includes make a record of.

veteran payment has the meaning given by subsection 5Q(1) of the *Veterans' Entitlements Act 1986*.

visitor includes an aged care volunteer visitor.

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Division 2—Key concepts

8 Aged care service list

(1) The rules must prescribe a list of services for which funding may be payable under this Act. The rules must:

(a) list each service; and

(b) describe each service; and

(c) specify the service type that the service is in; and

(d) specify the service group that the service type is in; and

(e) specify, for the service groups home support, assistive technology and home modifications, that all service types in those service groups must be delivered in a home or community setting; and

(f) specify, for the service group residential care, that all service types in the service group must be delivered in a residential care home; and

(g) specify, for each service that is in a service type (other than a service type referred to in paragraph (i)) that is specified as a service type that is in the service group home support, assistive technology or home modifications:

(i) the means testing category for the service; and

(ii) the subsidy basis for the service; and

(iii) if the subsidy basis for the service is efficient price or unit price—the base efficient price or base unit price for the service; and

(iv) the loading type (if any) that applies to the service; and

(h) specify any specialist aged care program under which a service type can be delivered; and

(i) specify any service type that can only be delivered under a specialist aged care program; and

(j) specify each provider registration category under which a service type can be delivered.

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(2) For the purposes of paragraph (1)(c), a ***service type*** means a service type prescribed by the rules.

(3) For the purposes of paragraph (1)(d), a ***service group*** means any of the following:
  (a) home support;
  (b) residential care;
  (c) assistive technology;
  (d) home modifications.

(4) For the purposes of subparagraph (1)(g)(i), each of the following is a ***means testing category*** for a service type delivered in a home or community setting:
  (a) clinical supports;
  (b) independence;
  (c) everyday living.

Matters that must be considered before prescribing services

(5) The Minister must ensure that for the service group residential care nursing is a listed service that is in at least one service type that is in that group.

(6) The Minister must ensure that funded aged care services in a service type that is specified as a service type that is delivered in a residential care home for the purposes of paragraph (1)(f) are services of the following kind:
  (a) services for the care of persons who are experiencing sickness;
  (b) services incidental or conducive to the care of persons who are experiencing sickness.

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9 Funded aged care services and who they are delivered to

(1) A ***funded aged care service*** means a service included on the list referred to in subsection 8(1) delivered to an individual who can access the service through a service group as referred to in

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subsection (2) of this section and for which funding is paid under this Act.

(2) An individual can access a funded aged care service through a service group if:

(a) the individual makes an application for access to funded aged care services under section 56; and

(b) the System Governor makes an eligibility determination for the individual and that determination is in effect; and

(c) the individual undergoes an aged care needs assessment; and

(d) an access approval that covers the service is in effect for the individual; and

(e) if the individual is accessing the service other than under a specialist aged care program:

(i) a classification decision establishing a classification level in a classification type for the service group is in effect for the individual; and

(ii) if a priority category decision is required under section 86 for the classification type for the service group—such a decision under section 86 has been made for the individual for the classification type for the service group; and

(iii) if the classification type or classification level is one for which the System Governor may allocate the individual a place under section 92—a place has been allocated to the individual under that section for that classification type or classification level and is in effect; and

(f) if the individual is accessing the service under a specialist aged care program:

(i) a classification decision establishing a classification level in a classification type for the service group has been made for the individual; and

(ii) if the System Governor may allocate the registered provider a place under section 95—a place has been allocated to the registered provider under that section and is in effect.

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Note: Depending on what the funded aged care service is and the kind of registered provider that delivers the service, the Commonwealth funding of the service may be through a subsidy or grant under this Act.

10 Where funded aged care services are delivered

(1) A funded aged care service can be delivered in:
  (a) an approved residential care home; or
  (b) a home or community setting.

Residential care home

(2) A ***residential care home*** means a place that:
  (a) is the place of residence of individuals who, by reason of sickness, have a continuing need for aged care services, including nursing services; and
  (b) is fitted, furnished and staffed for the purpose of providing those services.

(3) To avoid doubt, a ***residential care home*** includes any of the following places:
  (a) a place within, or co-located with, a hospital or other health service that is covered by an agreement with the Commonwealth to deliver aged care services alongside health services as a part of an integrated service arrangement;
  (b) a place within a retirement village that is a place described by subsection (2);
  (c) a place which is a complex of buildings;
  (d) any other place prescribed by the rules.

(4) To avoid doubt, a ***residential care home*** does not include any of the following places:
  (a) a private home;
  (b) a retirement village (other than a place referred to in paragraph (3)(b));

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(c) a facility for which a declaration under subsection 121-5(6) of the *Private Health Insurance Act 2007* is in force (other than a place referred to in paragraph (3)(a));
(d) a hospice or facility that primarily provides palliative care;
(e) any other place prescribed by the rules.

(5) For the purposes of subsection (2), the rules may prescribe:
(a) circumstances where a place is taken to be 2 or more separate places; and
(b) circumstances where 2 or more separate places are taken to be a single place.

Home or community setting

(6) A ***home or community setting*** means a place in a home, or in the community, where funded aged care services are delivered.

(7) Despite subsection (6), a ***home or community setting*** does not include any of the following places:
(a) a group home funded under the National Disability Insurance Scheme;
(b) a hospital;
(c) a psychiatric facility;
(d) a prison or detention centre;
(e) a hospice or facility that primarily provides palliative care;
(f) any other place prescribed by the rules.

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11 Who delivers funded aged care services

(1) Funded aged care services are delivered by registered providers (and associated providers of registered providers) and the aged care workers of registered providers.

Registered providers

(2) A ***registered provider*** means an entity that is registered as a registered provider (whether under paragraph 105(1)(a), because of

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a renewal under paragraph 108(1)(a), or because of a determination made by the System Governor under subsection 117(1)), if:

(a) the registration period has not ended; and

(b) the registration has not been revoked under a provision of Part 3 of Chapter 3.

Note: A registered provider's registration is not in effect while suspended: see section 130. This means most provisions of this Act still apply to the registered provider unless a provision expressly requires that the registered provider's registration is in effect for the provision to apply.

(3) A registered provider is registered in one or more ***provider registration categories*** which are:

(a) the residential care category; and

(b) any other category prescribed by the rules.

Aged care workers

(4) An ***aged care worker*** of a registered provider means:

(a) an individual employed or otherwise engaged (including as a volunteer) by the registered provider to deliver funded aged care services; or

(b) an individual who:

(i) is employed or otherwise engaged (including as a volunteer) by an associated provider of the registered provider; and

(ii) is engaging in conduct under the associated provider's arrangement with the registered provider relating to the registered provider's delivery of funded aged care services; or

(c) an individual who is a registered provider.

Note: An individual engaged by a registered provider includes an independent contractor.

(5) An ***aged care worker*** of a registered provider does not include a responsible person of the provider unless the responsible person is an individual who is employed or otherwise engaged (including as a volunteer) by the registered provider, or by an associated

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provider of the registered provider, to deliver funded aged care services.

Associated providers

(6) If an entity (an ***associated provider***) engages in conduct under an arrangement with a registered provider relating to the registered provider's delivery of funded aged care services, this Act applies in relation to the registered provider as if the registered provider had engaged in the conduct.

Note: This means that a registered provider may contravene subsection 142(3) or (4) or another provision of this Act because of conduct engaged in by an associated provider.

11A Delivery of funded aged care services

Delivery not affected by involvement of associated providers

(1) To avoid doubt, a registered provider delivers a funded aged care service for the purposes of this Act even if some or all of the work involved in delivering the service to an individual is done by one or more associated providers of the registered provider.

Circumstances when non-delivery of funded aged care services is taken to be delivery of funded aged care services

(2) A service is taken to have been delivered by a registered provider to an individual for the purposes of this Act if:

(a) the service is included on the list referred to in subsection 8(1); and

(b) the service was scheduled to be delivered by the registered provider to the individual on a day; and

(c) had the service been delivered as scheduled, the individual could have accessed the service through a service group as referred to in subsection 9(2); and

(d) subsection (3) applies to the service.

(3) This subsection applies to the service if:

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(a) both:
(i) the service was scheduled to be delivered by the registered provider to the individual on the day at an agreed time and place; and
(ii) the only reason that the service was not delivered was because the individual cancelled the delivery of the service within the period, before that day, that is prescribed by the rules; or
(b) the circumstances prescribed by the rules apply.

(4) If subsection (2) applies in relation to a service:
(a) a reference in this Act to the number of hours or units of the service delivered to the individual on a day is taken to be a reference to the number of hours or units that were scheduled to be delivered to the individual on the day; and
(b) a reference in this Act to the service delivery branch through which the service was delivered is taken to be a reference to the service delivery branch through which the service was scheduled to be delivered.

(5) Subsection (2) does not apply:
(a) in circumstances prescribed by the rules; or
(b) for the purposes of a provision of this Act prescribed by the rules.

Certain reimbursements taken to be delivery of funded aged care services

(6) If:
(a) an individual incurs costs in acquiring a service that is included on the list referred to in subsection 8(1); and
(b) the registered provider reimburses, in accordance with any requirements prescribed by the rules, the individual for the whole or a part of the costs; and
(c) had the service been delivered to the individual by the registered provider, the individual could have accessed the

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service through a service group as referred to in subsection 9(2); and

(d) any other circumstances prescribed by the rules in relation to the individual, the acquisition or the service apply;

the reimbursement is taken, for the purposes of this Act, to be the delivery of the service by the registered provider to the individual.

(7) Subsection (6) does not apply:

(a) in circumstances prescribed by the rules; or

(b) for the purposes of a provision of this Act prescribed by the rules.

12 Meaning of *responsible person*

(1) Each of the following is a ***responsible person*** of a registered provider:

(a) if the registered provider is not a government entity—any person who is responsible for the executive decisions of the registered provider;

(b) if the registered provider is not a government entity—any other person who has authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the registered provider;

(c) for any registered provider (including a government entity)—if the registered provider delivers, or proposes to deliver, a funded aged care service:

(i) any person who has responsibility for overall management of the nursing services delivered by the registered provider, or overall management of the nursing services delivered at an approved residential care home of the registered provider, and who is a registered nurse; and

(ii) any person who is responsible for the day-to-day operations of an approved residential care home or service delivery branch of the registered provider.

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(2) Without limiting paragraph (1)(a), a person who is responsible for the executive decisions of a registered provider includes a member of the governing body of the provider.

13 Meaning of *suitability matters* in relation to an individual

(1) Each of the following matters is a ***suitability matter*** in relation to an individual:

(a) the individual's experience in providing, at any time, funded aged care services or other similar services;

(b) whether a banning order against the individual is, or has at any time been, in force;

(c) whether an NDIS banning order against the individual is, or has at any time been, in force;

(d) whether the individual has at any time been convicted of an indictable offence;

(e) whether a civil penalty order against the individual has been made at any time;

(f) whether the individual is, or has at any time been, an insolvent under administration;

(g) whether the individual is, or has at any time been, the subject of adverse findings or enforcement action by any of the following:

(i) a Department of the Commonwealth or of a State or Territory;

(ii) the Australian Securities and Investments Commission;

(iii) the Australian Charities and Not-for-profits Commission;

(iv) the Australian Competition and Consumer Commission;

(v) the Australian Prudential Regulation Authority;

(vi) the Australian Crime Commission;

(vii) AUSTRAC (within the meaning of the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006*);

(viii) the Australian Health Practitioner Regulation Agency;

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(ix) another body established for a public purpose by or under a law of the Commonwealth;

(x) a State or Territory authority (including, but not limited to, a body that is equivalent to a body mentioned in subparagraphs (ii) to (viii));

(xi) a local government authority;

(xii) a body responsible for maintaining standards of conduct in a profession that is involved in the delivery of funded aged care services;

(h) whether the individual:

(i) is, or has at any time been, the subject of any findings or judgment in relation to fraud, misrepresentation or dishonesty in any administrative, civil or criminal proceedings; or

(ii) is currently party to any proceedings that may result in the individual being the subject of such findings or judgment;

(i) whether the individual is, or has at any time been, disqualified from managing corporations under Part 2D.6 of the *Corporations Act 2001*;

(j) if circumstances prescribed by the rules apply in relation to the individual—the individual is a person in respect of whom the worker screening requirements prescribed for the purposes of section 152 are met;

(k) any other matter prescribed by the rules.

(2) This section does not affect the operation of Part VIIC of the *Crimes Act 1914* (which includes provisions that, in certain circumstances, relieve persons from the requirement to disclose spent convictions and require persons aware of such convictions to disregard them).

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14 Aged Care Code of Conduct

The rules may prescribe requirements relating to the conduct of the following:

(a) registered providers;

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(b) aged care workers of registered providers;
(c) responsible persons of registered providers.

Note: These requirements are the ***Aged Care Code of Conduct***: see section 7.

15 Aged Care Quality Standards

(1) The rules may prescribe standards relating to the quality of funded aged care services delivered by a registered provider.

Note 1: These standards are the ***Aged Care Quality Standards***: see section 7.

Note 2: Only registered providers in certain registration categories are required to be audited against these standards before registration: see paragraph 109(2)(d). Certain registered providers are required to comply with the standards as a condition of registration: see sections 142 and 146.

(2) Without limiting subsection (1), the rules may prescribe standards about the following matters:
(a) how registered providers must treat, and engage with, individuals seeking to access, or accessing, funded aged care services;
(b) how registered providers must deliver funded aged care services, including governance arrangements and arrangements for planning and delivery of palliative care;
(c) the physical environments in which funded aged care services are required to be delivered;
(d) how registered providers must deliver quality and safe clinical care to individuals, including infection prevention and control procedures and arrangements;
(e) how registered providers must deliver food and drink to meet the nutritional needs and preferences of individuals;
(f) how registered providers must support individuals accessing funded aged care services in approved residential care homes;
(g) how registered providers must manage and respond to feedback and complaints;

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(h) how registered providers must monitor and drive improvements to their delivery of funded aged care services.

(3) Without limiting subsection (1), the rules may provide that a provision of the Aged Care Quality Standards applies to the following:

(a) all registered providers;

(b) registered providers in specified provider registration categories;

(c) specified kinds of registered providers.

Periodic reviews of operation of Aged Care Quality Standards

(4) The System Governor must cause periodic reviews to be conducted of the operation of the Aged Care Quality Standards.

(5) The first review must be completed before the end of the period of 5 years starting on the day this Act commences.

(6) Each later review must be completed before the end of each subsequent 5 year period.

(7) The System Governor must give the Minister a written report of each review as soon as practicable after the review is completed.

(8) The System Governor must cause a copy of the report of each review to be published on the Department's website as soon as practicable after the Minister receives the report.

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16 Meaning of *reportable incident*

(1) A ***reportable incident*** is any of the following incidents that have occurred, are alleged to have occurred, or are suspected of having occurred, in connection with the delivery of funded aged care services to an individual by a registered provider:

(a) unreasonable use of force against the individual;

(b) unlawful sexual contact, or inappropriate sexual conduct, inflicted on the individual;

(c) psychological or emotional abuse of the individual;

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(d) unexpected death of the individual;
(e) stealing from, or financial coercion of, the individual by an aged care worker of the provider;
(f) neglect of the individual;
(g) use of a restrictive practice in relation to the individual (other than in accordance with any requirements prescribed by the rules);
(h) unexplained absence of the individual in the course of the delivery of funded aged care services to the individual.

(2) The rules may prescribe definitions or clarifications of an expression used in paragraph (1)(a), (b), (c), (d), (e), (f) or (h).

(3) Despite subsection (1), the rules may prescribe:
(a) that a specified act, omission or event involving an individual to whom a registered provider is delivering funded aged care services is a ***reportable incident***; or
(b) that a specified act, omission or event involving an individual to whom a registered provider is delivering funded aged care services is not a ***reportable incident***.

17 Restrictive practice in relation to an individual

(1) A ***restrictive practice*** in relation to an individual is any practice or intervention that has the effect of restricting the rights or freedom of movement of that individual.

(2) Without limiting subsection (1), the rules may provide that a practice or intervention is a ***restrictive practice*** in relation to an individual.

18 Restrictive practice requirements

(1) The rules made for the purposes of section 162 relating to the use of restrictive practices in relation to an individual to whom a registered provider is delivering funded aged care services must:
(a) require that a restrictive practice in relation to the individual is used only:

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(i) as a last resort to prevent harm to the individual or other persons; and

(ii) after consideration of the likely impact of the use of the practice on the individual; and

(b) require that, to the extent possible, alternative strategies are used before a restrictive practice in relation to the individual is used; and

(c) require that alternative strategies that have been considered or used in relation to the individual are documented; and

(d) require that a restrictive practice in relation to the individual is used only to the extent that it is necessary and in proportion to the risk of harm to the individual or other persons; and

(e) require that, if a restrictive practice in relation to the individual is used, it is used in the least restrictive form, and for the shortest time, necessary to prevent harm to the individual or other persons; and

(f) require that informed consent is given to the use of a restrictive practice in relation to the individual; and

(g) make provision for, or in relation to, the monitoring and review of the use of a restrictive practice in relation to the individual.

(2) The rules made for the purposes of section 162 may make provision for, or in relation to, the persons or bodies who may give informed consent to the use of a restrictive practice in relation to an individual to whom a registered provider is delivering funded aged care services if that individual lacks capacity to give that consent.

(3) The rules made for the purposes of section 162 may provide that a requirement prescribed by those rules does not apply if the use of a restrictive practice in relation to an individual to whom a registered provider is delivering funded aged care services is necessary in an emergency.

(4) Subsections (1), (2) and (3) do not limit the matters that may be prescribed by the rules made for the purposes of section 162.

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19 Meaning of *significant failure* and *systematic pattern of conduct*

(1) A registered provider's or responsible person of a registered provider's conduct involves a ***significant failure*** if the conduct represents a significant departure from the conduct that could reasonably be expected from a registered provider or responsible person, having regard to the requirements registered providers and responsible persons are subject to under this Act.

(2) In determining whether a registered provider's or responsible person of a registered provider's conduct is part of a ***systematic pattern of conduct***, regard must be had to the following:

(a) the number of times the provider's or responsible person's conduct has not complied with a provision of this Act (the ***relevant contraventions***);

(b) the period over which the relevant contraventions occurred;

(c) the number of individuals affected by the relevant contraventions;

(d) the provider's or responsible person's response, or failure to respond, to any complaints about the relevant contraventions.

20 Meaning of *high quality care*

The delivery of a funded aged care service by a registered provider to an individual is ***high quality care*** if the service is delivered in a manner that:

(a) puts the individual first; and

(b) upholds the rights of the individual under the Statement of Rights; and

(c) prioritises the following:

(i) kindness, compassion and respect for the life experiences, self-determination, dignity, quality of life, mental health and wellbeing of the individual;

(ii) the timely and responsive delivery of the service to the individual;

(iii) specific tailoring of care to the personal needs, aspirations and preferences of the individual, including

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preferences regarding the time when the service is delivered;

(iv) respecting the individual's preferences regarding privacy and time alone;

(v) supporting the improvement of the individual's wellbeing, independence, autonomy and physical and cognitive capacity through reablement approaches, where the individual chooses to, including by keeping the individual mobile and engaged if they are living in an approved residential care home;

(vi) supporting the individual to participate in meaningful and respectful activities and remain connected to friends, family, carers and the community, where the individual chooses to;

(vii) supporting the individual to remain connected to the natural environment, and animals and pets, where the individual chooses to;

(viii) implementing inclusive policies and procedures, in partnership with Aboriginal or Torres Strait Islander persons, family and community to ensure that culturally safe, culturally appropriate and accessible care is delivered to those persons at all times, which incorporates flexibility and recognises the unique experience of those persons;

(ix) adapting policy, practices and environments to ensure that services are culturally appropriate for the diverse life experiences of individuals, including by engaging workers with lived experience of diversity in the provider's workforce and governing body;

(x) bilingual aged care workers and interpreters being made available if required by the individual;

(xi) training of the aged care workers to facilitate the delivery of the service by well-skilled and empowered aged care workers who are able to develop and maintain a relationship with the individual;

(xii) recruitment and retention of aged care workers to ensure the needs of individuals are able to be met;

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(xiii) the delivery of high quality nursing services by sufficient numbers of qualified and experienced direct care staff members.

21 Meaning of *protected information*

Relevant information is ***protected information*** if:

(a) it is personal information; or

(b) it is information (including commercially sensitive information) the disclosure of which could reasonably be expected to found an action by an entity (other than the Commonwealth) for breach of a duty of confidence.

Note: Under the *Privacy Act 1988*, sensitive information (within the meaning of that Act) may be personal information. Information is not personal information if it is only about a person who has died.

22 Meaning of *dependent child*

(1) A young person (see subsection (2)) is a ***dependent child*** of an individual (the ***adult***) if:

(a) the adult:

(i) is legally responsible (whether alone or jointly with another individual) for the day-to-day care, welfare and development of the young person; or

(ii) is under a legal obligation to provide financial support in respect of the young person; and

(b) in a subparagraph (a)(ii) case—the adult is not included in a class of persons prescribed by the rules; and

(c) the young person is not:

(i) in full-time employment; or

(ii) in receipt of a social security pension (within the meaning of the *Social Security Act 1991*) or a social security benefit (within the meaning of that Act); or

(iii) included in a class of persons prescribed by the rules.

(2) A reference in subsection (1) to a ***young person*** is a reference to any of the following:

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(a) an individual under 16 years of age;
(b) an individual who:
  (i) has reached 16 years of age, but is under 25 years of age; and
  (ii) is receiving full-time education at a school, college or university;
(c) an individual included in a class of persons prescribed by the rules.

(3) For the purposes of paragraph (b) of the definition of ***close relation*** in section 7, if one individual is the child of another individual because of the definition of ***child*** in that section, relationships traced to or through the individual are to be determined on the basis that the individual is the child of the other individual.

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Part 3—Aged care rights and principles

Division 1—Aged care rights

23 Statement of Rights

Independence, autonomy, empowerment and freedom of choice

(1) An individual has a right to:

(a) exercise choice and make decisions that affect the individual's life, including in relation to the following:

(i) the funded aged care services the individual has been approved to access;

(ii) how, when and by whom those services are delivered to the individual;

(iii) the individual's financial affairs and personal possessions; and

(b) be supported (if necessary) to make those decisions, and have those decisions respected; and

(c) take personal risks, including in pursuit of the individual's quality of life, social participation and intimate and sexual relationships.

Equitable access

(2) An individual has a right to equitable access to:

(a) have the individual's need for funded aged care services assessed, or reassessed, in a manner which is:

(i) culturally safe, culturally appropriate, trauma-aware and healing-informed; and

(ii) accessible and suitable for individuals living with dementia or other cognitive impairment; and

(b) palliative care and end-of-life care when required.

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Quality and safe funded aged care services

(3) An individual has a right to:
  (a) be treated with dignity and respect; and
  (b) safe, fair, equitable and non-discriminatory treatment; and
  (c) have the individual's identity, culture, spirituality and diversity valued and supported; and
  (d) funded aged care services being delivered to the individual:
    (i) in a way that is culturally safe, culturally appropriate, trauma-aware and healing-informed; and
    (ii) in an accessible manner; and
    (iii) by aged care workers of registered providers who have appropriate qualifications, skills and experience.

(4) An individual has a right to:
  (a) be free from all forms of violence, degrading or inhumane treatment, exploitation, neglect, coercion, abuse or sexual misconduct; and
  (b) have quality and safe funded aged care services delivered consistently with the requirements imposed on registered providers under this Act.

Note: Division 1 of Part 4 of Chapter 3 deals with conditions on registered providers, including requirements in relation to the use of restrictive practices and management of incidents.

Respect for privacy and information

(5) An individual has a right to have the individual's:
  (a) personal privacy respected; and
  (b) personal information protected.

(6) An individual has a right to seek, and be provided with, records and information about the individual's rights under this section and the funded aged care services the individual accesses, including the costs of those services.

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Person-centred communication and ability to raise issues without reprisal

(7) An individual has a right to:
  (a) be informed, in a way the individual understands, about the funded aged care services the individual accesses; and
  (b) express opinions about the funded aged care services the individual accesses and be heard.

(8) An individual has a right to communicate in the individual's preferred language or method of communication, with access to interpreters and communication aids as required.

(9) An individual has a right to:
  (a) open communication and support from registered providers when issues arise in the delivery of funded aged care services; and
  (b) make complaints using an accessible mechanism, without fear of reprisal, about the delivery of funded aged care services to the individual; and
  (c) have the individual's complaints dealt with fairly and promptly.

Advocates, significant persons and social connections

(10) An individual has a right to be supported by an advocate or other person of the individual's choice, including when exercising or seeking to understand the individual's rights in this section, voicing the individual's opinions, making decisions that affect the individual's life and making complaints or giving feedback.

(11) An individual has a right to have the role of persons who are significant to the individual, including carers, visitors and volunteers, be acknowledged and respected.

(12) An individual has a right to opportunities, and assistance, to stay connected (if the individual so chooses) with:
  (a) significant persons in the individual's life and pets, including through safe visitation by family members, friends,

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volunteers or other visitors where the individual lives and visits to family members or friends; and

(b) the individual's community, including by participating in public life and leisure, cultural, spiritual and lifestyle activities; and

(c) if the individual is an Aboriginal or Torres Strait Islander person—community, Country and Island Home.

(13) An individual has a right to access, at any time the individual chooses, a person designated by the individual, or a person designated by an appropriate authority.

24 Effect of Statement of Rights

(1) An individual is entitled to the rights specified in section 23 when accessing, or seeking to access, funded aged care services.

(2) It is the intention of the Parliament that registered providers delivering funded aged care services to individuals must take all reasonable and proportionate steps to act compatibly with the rights specified in section 23 in the delivery of funded aged care services, taking into account that limits on rights may be necessary to balance the following:

(a) competing or conflicting rights;

(b) the rights and freedoms of other individuals, including aged care workers of the registered provider and other individuals accessing funded aged care services;

(c) compliance with other laws of the Commonwealth, or of a State or Territory, including the *Work Health and Safety Act 2011*.

(3) Nothing in this Division creates rights or duties that are enforceable by proceedings in a court or tribunal.

Note: However, it is a condition of registration for certain registered providers that a registered provider must demonstrate understanding of the Statement of Rights and have in place practices to ensure that the provider acts compatibly with the Statement of Rights: see subsection 144(1). A person may make a complaint to the Complaints

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Commissioner about a registered provider acting in a way that is incompatible with the Statement of Rights: see section 358.

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Division 2—Aged care principles

25 Statement of Principles

A person-centred aged care system

(1) The safety, health, wellbeing and quality of life of individuals is the primary consideration in the delivery of funded aged care services.

(2) The Commonwealth aged care system supports the delivery of funded aged care services by registered providers that:
  (a) puts older people first; and
  (b) treats older people as unique individuals; and
  (c) recognises the rights of individuals under the Statement of Rights.

(3) The Commonwealth aged care system supports individuals to:
  (a) be able to reside at the individual's home (if the individual so chooses) or, if that is not possible, in a setting that is appropriate given the individual's circumstances, needs and preferences; and
  (b) exercise individual responsibility and make decisions that enable the individual to lead an active and fulfilling life, including by engaging in the community and maintaining relationships with people (if the individual so chooses); and
  (c) be active and informed in decision-making, or be supported (if necessary) to make or communicate decisions, about the funded aged care services the individual accesses to ensure the individual's will and preferences are respected; and
  (d) maintain or improve the individual's physical, mental, cognitive and communication capabilities to the extent possible (if the individual so chooses), except where it is the individual's choice to access palliative care and end-of-life care; and

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(e) be aware of, understand and be empowered to exercise, their rights under the Statement of Rights when accessing, or seeking to access, funded aged care services; and

(f) engage with, and be supported by, independent aged care advocates (if the individual so chooses), including through receiving information, education and advocacy in relation to accessing, or seeking to access, funded aged care services.

(4) The Commonwealth aged care system offers accessible, culturally safe, culturally appropriate, trauma-aware and healing-informed funded aged care services, if required by an individual and based on the needs of the individual, regardless of the individual's location, background and life experiences.

Note: This may include individuals who:

(a) are Aboriginal or Torres Strait Islander persons, including those from stolen generations; or

(b) are veterans or war widows; or

(c) are from culturally, ethnically and linguistically diverse backgrounds; or

(d) are financially or socially disadvantaged; or

(e) are experiencing homelessness or at risk of experiencing homelessness; or

(f) are parents and children who are separated by forced adoption or removal; or

(g) are adult survivors of institutional child sexual abuse; or

(h) are care-leavers, including Forgotten Australians and former child migrants placed in out of home care; or

(i) are lesbian, gay, bisexual, trans/transgender or intersex or other sexual orientations or are gender diverse or bodily diverse; or

(j) are an individual with disability or mental ill-health; or

(k) are neurodivergent; or

(l) are deaf, deafblind, vision impaired or hard of hearing; or

(m) live in rural, remote or very remote areas.

(5) The Commonwealth aged care system builds the capacity of registered providers and connections with individuals in the community to support:

(a) continuity of funded aged care services; and

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(b) access to integrated services, including strong linkages with the health, mental health, veterans, disability and community services sectors.

An aged care system that values workers and carers

(6) The Commonwealth aged care system:

(a) supports funded aged care services being delivered by a diverse, trained and appropriately skilled workforce who are valued and respected; and

(b) supports aged care workers of registered providers being empowered, including through access to relevant information, to:

(i) provide feedback, suggest measures and take actions that support innovation, continuous improvement and the delivery of high quality care; and

(ii) participate in governance and accountability mechanisms related to the delivery of funded aged care services; and

(c) recognises and supports the important role of advocates, carers, volunteers and visitors in improving individuals' experiences of the Commonwealth aged care system.

(7) The Commonwealth aged care system recognises the valuable contribution carers make to society, consistent with the *Carer Recognition Act 2010*, and carers should be considered partners with registered providers who deliver funded aged care services.

A transparent and sustainable aged care system that represents value for money

(8) The Commonwealth aged care system is transparent and provides publicly available information, about funded aged care services, that is understandable, accessible and communicated through a variety of methods and languages.

(9) Funding by the Commonwealth for funded aged care services supports the delivery and regulation of those services to the

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individuals who have been prioritised on the basis of need for funded aged care services, taking into account the availability of resources and the needs of the individuals relative to other individuals.

(10) Individuals accessing funded aged care services are expected to meet some of the costs of those services if those individuals have the financial means to do so.

(11) The Commonwealth aged care system focusses on the needs of older people, and should not be used inappropriately to address service gaps in other care and support sectors preventing individuals from accessing the best available services to meet the needs, goals and preferences of those individuals.

(12) The Commonwealth aged care system is managed to ensure:
- (a) it is sustainable and resilient; and
- (b) the Commonwealth's investment in the system represents value for money, including by ensuring that public resources are used in the most efficient, effective, ethical and economic manner.

An aged care system that continues to improve

(13) The regulation of the Commonwealth aged care system:
- (a) promotes innovation, continuous improvement and contemporary evidence-based best practice in the Commonwealth aged care system; and
- (b) is responsive and proportionate to risk, with a focus on prevention and timely action; and
- (c) focusses on the safety, health, wellbeing and quality of life of individuals, and prioritises the areas of highest risk to individuals; and
- (d) promotes the provision of high quality care; and
- (e) strives for regulatory alignment (if appropriate) with other care and support sectors; and
- (f) is undertaken in collaboration with older people.

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(14) Feedback and complaints about the delivery and accessibility of funded aged care services are used to inform and promote continuous improvement in the Commonwealth aged care system.

26 Effect of Statement of Principles

(1) It is the intention of the Parliament that the Minister, the System Governor, the Commissioner, the Complaints Commissioner and any other person or body, performing functions or exercising powers under this Act, must have regard to the principles specified in section 25 when performing those functions or exercising those powers.

(2) Nothing in this Division creates rights or duties that are enforceable by proceedings in a court or tribunal.

(3) A failure to comply with this Division does not affect the validity of any decision, and is not a ground for the review or challenge of any decision.

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Part 4—Supporters

Division 1—Actions and duties of supporters

27 Actions of supporters

A supporter of an individual may, in line with the individual's will and preferences, do any of the following to support the individual to do a thing under, or for the purposes of, this Act (other than Part 5 of Chapter 4 of this Act):

(a) request, access or receive information or documents;

(b) communicate information, including the will, preferences and decisions of the individual;

(c) a thing, other than making a decision on behalf of the individual, prescribed by the rules.

Note 1: If there is more than one supporter of an individual, the supporters may do a thing jointly and severally: see subsection 37(3).

Note 2: For the provisions about how supporters are registered, see Division 3.

28 Role of guardians etc

(1) A person must not do any thing on behalf of an individual that may or must be done by the individual under, or for the purposes of, this Act unless the person is a person covered by subsection (2) who is, by reason of being such a person, authorised to do the thing on behalf of the individual.

(2) A person is covered by this subsection if the person:

(a) has guardianship of the individual under a law of the Commonwealth, a State or a Territory; or

(b) is appointed by a court, tribunal, board or panel (however described) under a law of the Commonwealth, a State or a Territory, and has power to make decisions for the individual; or

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(c) holds an enduring power of attorney or like power granted by the individual; or

(d) is included in a class of persons prescribed by the rules.

29 Giving information and documents to supporters

(1) Any information or document that is required or authorised under, or for the purposes of, this Act (other than Part 5 of Chapter 4 of this Act) to be given to an individual must also be given to the following persons:

(a) if the individual has consented to information or documents being given to a supporter of the individual—that supporter;

(b) regardless of whether the individual has consented—to a supporter of the individual if the supporter is a person covered by subsection 28(2).

(2) A person who receives information under subsection (1) may only use the information:

(a) under, or for the purposes of, this Act; and

(b) if the person is a person covered by subsection 28(2)—in a manner that is consistent with the person's duties and obligations as such a person.

30 Duties of supporters

(1) A supporter of an individual has:

(a) the duties set out in:

(i) subsection (2); and

(ii) section 31 (duty to inform of matters affecting ability or capacity to act as supporter); and

(b) the duty to act honestly, diligently and in good faith in discharging the supporter's other duties; and

(c) the duty to avoid or manage any conflict of interest in relation to the supporter and the individual, and to inform the System Governor of any such conflict as it arises; and

(e) any duty prescribed by the rules.

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(2) If the supporter is doing a thing under section 27 to support the individual to do a thing under, or for the purposes of, this Act, it is a duty of the supporter to:

(a) act in a manner that promotes the will, preferences and personal, cultural and social wellbeing of the individual; and

(b) act honestly, diligently and in good faith; and

(c) support the individual only to the extent necessary for the individual to do the thing, applying the supporter's best endeavours to maintain the ability of the individual to make the individual's own decisions.

31 Duty to inform of matters affecting ability or capacity to act as supporter

(1) For the purposes of subparagraph 30(1)(a)(ii), a supporter of an individual has a duty to inform the System Governor if:

(a) either:

(i) an event or change of circumstances happens; or

(ii) the supporter becomes aware that an event or change of circumstances is likely to happen; and

(b) the event or change of circumstances is likely to affect:

(i) the ability or capacity of the supporter to act as a supporter of the individual, including complying with the duties of supporters referred to in subsection 30(1); or

(ii) the ability of the System Governor to contact the supporter for the purposes of this Act; or

(iii) the ability or capacity of the supporter to comply with notices given to, and imposing requirements on, the supporter by the System Governor under, or for the purposes of, this Act.

(2) The supporter must inform the System Governor under subsection (1) as soon as reasonably practicable after the event or change of circumstances happens, or the supporter first becomes aware that the event or change of circumstances is likely to happen.

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(3) This section extends to:

(a) acts, omissions, matters and things outside Australia, whether or not in a foreign country; and

(b) all persons, irrespective of their nationality or citizenship.

32 When there is no breach of duty

(1) A supporter of an individual does not breach a duty of supporters referred to in subsection 30(1) by doing a thing if, when the thing is done, the supporter reasonably believes that the supporter is doing the thing to comply with the supporter's duties under that subsection.

(2) A supporter of an individual does not breach a duty of supporters referred to in subsection 30(1) by refraining from doing a thing if, at the relevant time, the supporter reasonably believes that the supporter is refraining from doing the thing to comply with the supporter's duties under that subsection.

33 Concurrent operation of State and Territory laws

This Part does not exclude or limit the operation of a law of a State or Territory that is capable of operating concurrently with this Part.

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Division 2—Protections relating to supporters

34 Protection of individual against liability for actions of supporter

An individual accessing, or seeking to access, funded aged care services does not commit an offence, and is not liable to a civil penalty, under this Act in relation to any act or omission of another person in that person's capacity as a supporter of the individual.

35 Protection of supporter against liability

A supporter of an individual accessing, or seeking to access, funded aged care services does not commit an offence, and is not liable to a civil penalty, under this Act in relation to:

(a) any act or omission of the individual; or

(b) anything done, in good faith, by the supporter in their capacity as a supporter of the individual.

36 Offence for abuse of position as supporter

Offence for current supporters

(1) A person commits an offence if:

(a) the person is a supporter of an individual accessing, or seeking to access, funded aged care services; and

(b) the person:

(i) exercises any influence that the person has in their capacity as a supporter of the individual; or

(ii) engages in any conduct when doing a thing under section 27 in the person's capacity as a supporter of the individual; or

(iii) uses any information that the person obtained in the person's capacity as a supporter of the individual; and

(c) the person does so with the intention of:

(i) dishonestly obtaining a benefit for the person or any other person; or

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(ii) dishonestly causing a detriment to another person.

Penalty: 60 penalty units.

(2) Strict liability applies to paragraph (1)(a).

Offence for former supporters

(3) A person commits an offence if:

(a) the person has ceased to be a supporter of an individual accessing, or seeking to access, funded aged care services; and

(b) the person obtained information in the person's capacity as a supporter of the individual; and

(c) the person uses the information with the intention of:

(i) dishonestly obtaining a benefit for the person or any other person; or

(ii) dishonestly causing a detriment to another person.

Penalty: 60 penalty units.

(4) Strict liability applies to paragraphs (3)(a) and (b).

Dishonesty

(5) In a prosecution for an offence against subsection (1) or (3), the determination of dishonesty is a matter for the trier of fact.

Definitions

(6) In this section:

dishonest means:

(a) dishonest according to the standards of ordinary people; and

(b) known by the defendant to be dishonest according to the standards of ordinary people.

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Division 3—Registration of supporters

37 Registration of supporters

(1) The System Governor may decide whether to register a person, for the purposes of this Act, to be a supporter of an individual accessing, or seeking to access, funded aged care services.

(2) The registration may be made on the request of a person (including the individual) or body.

(3) The System Governor may, under subsection (1):
  (a) register one person as a supporter of the individual; or
  (b) register 2 or more persons, jointly and severally, as supporters of the individual.

(4) The System Governor must, subject to subsection (6), register a person covered by subsection 28(2) (which deals with guardians and persons in other similar positions) under subsection (1) if:
  (a) there is such a person in relation to the individual; and
  (b) the person makes a request to be registered as a supporter of the individual.

(5) When considering whether to register a person under subsection (1) who is not a person covered by subsection 28(2) (which deals with guardians and persons in other similar positions), the System Governor must have regard to whether there is any person covered by that subsection in relation to the individual.

(6) The System Governor must not register a person under subsection (1) unless:
  (a) the System Governor is satisfied that the person is able to comply with the duties of supporters referred to in paragraphs 30(1)(a) to (c) and (e); and
  (b) one of the following applies:
    (i) if the registration is made on the request of the person who is a person covered by subsection 28(2)—the person has given consent to the registration;

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(ii) if the registration is made on the request of the person who is not a person covered by subsection 28(2)—both the person and the individual have given consent to the registration; and

(c) the System Governor has taken into consideration any other matters prescribed by the rules.

(7) A registration under subsection (1) may be made verbally or in writing.

Note: Written notice of the registration must be given under section 39 as soon as practicable after the registration is made.

38 Notice of decision not to register a person as a supporter

(1) If the System Governor decides not to register a person under subsection 37(1) to be a supporter of an individual, the System Governor must give notice of the decision to:

(a) any person who, or body which, made a request to the System Governor to register the person; and

(b) the individual.

(2) The notice under subsection (1) must:

(a) be given as soon as practicable after the decision is made; and

(b) include the reasons for the decision and how a person may apply for reconsideration of the decision.

39 Notification of registration of supporter in circumstances where individual has not consented to registration

(1) If the System Governor registers a person under subsection 37(1) to be a supporter of an individual in the circumstance set out in subparagraph 37(6)(b)(i), the System Governor must give written notice of the registration to the following:

(a) the supporter;

(b) the individual.

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Note: An individual is not required to consent to the registration of a person as a supporter of the individual in the circumstances set out in subparagraph 37(6)(b)(i).

(2) The notice under subsection (1) must:
(a) include the information specified in section 40; and
(b) be given as soon as practicable after the System Governor registers the supporter.

40 Content of notice of registration

(1) For the purposes of section 39, the information to be included in a notice given under that section is as follows:
(a) the name and contact details of the supporter registered in relation to an individual;
(b) the reasons for the decision to register the supporter;
(c) how a person may apply for reconsideration of that decision.

(2) The notice may specify the following:
(a) that the registration takes effect on a specified day;
(b) that the registration remains in effect until a specified day.

Note: A specified day could be the day a specified event occurs.

41 Effect of registration as a supporter

The registration of a person as a supporter of an individual does not prevent the individual from doing a thing that the individual may otherwise do under, or for the purposes of, this Act.

42 Period of effect of registration

(1) A registration of a supporter of an individual takes effect:
(a) at the time specified by the System Governor in relation to the registration; or
(b) if the System Governor does not specify a time for the purposes of paragraph (a)—at the time the registration is made under section 37.

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Note: A registration may be made verbally or in writing under section 37.

(2) Subject to subsection 49(4) (which provides that registrations have no effect while suspended), the registration remains in effect until the earliest of the following:

(a) the registration is cancelled under Division 5;

(b) the individual dies;

(c) the supporter dies;

(d) if the notice of registration given to the supporter under section 39 specifies that the registration remains in effect until a specified day—that day.

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Division 5—Suspensions and cancellations of registration

49 Suspension of registration

When a registration may be suspended

(1) The System Governor may suspend the registration of a person as a supporter of an individual if:

(a) the System Governor reasonably believes that the supporter has caused, or is likely to cause, physical, sexual, financial, psychological or emotional abuse or neglect to the individual; or

(b) the System Governor reasonably believes that the supporter has used information provided to the supporter under subsection 29(1) other than under, or for the purposes of, this Act; or

(c) the System Governor reasonably believes that the supporter has not complied with, or is not able to comply with a duty of supporters referred to in subsection 30(1) that applies to the supporter; or

(d) a circumstance set out in subsection (2) or (3) exists; or

(e) another circumstance prescribed by the rules exists in relation to the supporter.

(2) The circumstance is that:

(a) the supporter informs the System Governor under section 31 that:

(i) an event or change of circumstances has happened or is likely to happen; and

(ii) the event or change of circumstances is likely to have an effect as described in paragraph 31(1)(b); and

(b) the System Governor reasonably believes that the event or change of circumstances is likely to affect:

(i) the ability or capacity of the supporter to act as a supporter of the individual, including complying with

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the duties referred to in subsection 30(1) that apply to the supporter; or

(ii) the ability of the System Governor to contact the supporter for the purposes of this Act; or

(iii) the ability or capacity of the supporter to comply with notices given to, and imposing requirements on, the supporter by the System Governor under, or for the purposes of, this Act.

(3) The circumstance is that there is a change in relation to a person covered by subsection 28(2) (which deals with guardians and persons in other similar positions) in relation to the individual.

Note: Examples of changes include a change as to whether there is such a person in relation to the individual, or a change to who the person is.

Effect of suspension of registration

(4) While a person's registration as a supporter of an individual is suspended, the registration has no effect for the purposes of this Act.

50 Notice and decisions following suspension of registration

(1) If the System Governor suspends the registration of a person (the ***suspended person***) as a supporter of an individual, the System Governor must give written notice of the suspension to the following:

(a) the suspended person;

(b) the individual.

(2) The notice under subsection (1) must be given as soon as practicable after the System Governor suspends the registration.

(3) The notice given to the suspended person and the individual under subsection (1) must:

(a) include the reasons for the decision to suspend the registration; and

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(b) provide that the suspended person and individual may give the System Governor, within 28 days after the day the notice is given, a statement setting out the reasons why the person's registration should not be cancelled.

51 Cancellation of registration following suspension, or revoking suspension

(1) If the suspended person or individual (or both) gives the System Governor the statement referred to in paragraph 50(3)(b) within the 28-day period, the System Governor must, as soon as practicable after receiving the statement, consider the statement and decide whether to cancel the suspended person's registration.

Note: For notification requirements relating to cancellation of a registration, see section 54.

(2) If neither the suspended person nor the individual gives the System Governor the statement within the 28-day period, the System Governor may cancel the person's registration as soon as practicable after that period ends.

Note: For notification requirements relating to cancellation of a registration, see section 54.

(3) If the System Governor decides not to cancel the registration under subsection (1) or (2), the System Governor must:

(a) revoke the suspension of the person's registration; and

(b) give written notice of the System Governor's decision not to cancel the registration to the person and individual to whom notice was given under subsection 50(1).

Note: For notification requirements relating to cancellation of a registration, see section 54.

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52 Cancellation of registration of supporter on request by supporter

The System Governor must cancel the registration of a person as a supporter of an individual as soon as practicable if the supporter makes a written or verbal request to the System Governor to cancel the registration.

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Note: For notification requirements relating to cancellation of a registration, see section 54.

53 Cancellation of registration of supporter on request by individual

(1) If an individual makes a written or verbal request to the System Governor to cancel the registration of a person as a supporter of the individual, the System Governor must consider the request and decide:

(a) if the supporter is not a person covered by subsection 28(2)—to cancel the registration; and

(b) if the supporter is a person covered by subsection 28(2)—whether to cancel the registration.

(2) Before the System Governor decides whether to cancel the registration of a person as a supporter of an individual under paragraph (1)(b), the System Governor must give written notice of the individual's request to the supporter.

(3) The notice under subsection (2) must:

(a) be given as soon as practicable after the request is received by the System Governor; and

(b) provide that the supporter may give the System Governor, within 28 days after the day the notice is given, a statement setting out the reasons why the person's registration as a supporter of the individual should not be cancelled.

(3A) The System Governor must make the decision within:

(a) if the supporter is given a notice under subsection (2) and gives the System Governor a statement referred to in paragraph (3)(b) within the 28-day period—14 days after receiving the statement; or

(b) if the supporter is given a notice under subsection (2) but does not give the System Governor a statement referred to in paragraph (3)(b) within the 28-day period—14 days after the end of that 28-day period; or

(c) otherwise—28 days after receiving the request.

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(4) If the System Governor decides not to cancel the registration, the System Governor must give written notice of the System Governor's decision to the individual and the supporter.

Note: For notification requirements relating to cancellation of a registration, see section 54.

(5) The notice under subsection (4) must:

(a) be given as soon as practicable after the System Governor decides not to cancel the registration; and

(b) include:

(i) the reasons for the decision; and

(ii) how the individual may apply for reconsideration of the decision.

54 Notification of cancellation of registration

(1) If the System Governor cancels the registration of a person as a supporter of an individual under this Division, the System Governor must give written notice of the cancellation to the following:

(a) the person whose registration has been cancelled;

(b) the individual.

(2) The notice under subsection (1) must:

(a) be given as soon as practicable after the registration is cancelled; and

(b) include:

(i) the reasons for the cancellation; and

(ii) if the registration was cancelled under subsection 51(1) or (2)—how a person may apply for reconsideration of the decision to cancel the registration.

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Chapter 2—Entry to the Commonwealth aged care system

Part 1—Introduction

55 Simplified outline of this Chapter

Individuals can apply to the System Governor for access to funded aged care services and are assessed against a set of eligibility criteria. An individual with care needs who is age 65 or over (or age 50 or over and an Aboriginal or Torres Strait Islander person or homeless or at risk of homelessness) is eligible to undergo an aged care needs assessment by an approved needs assessor.

A report of the results of an aged care needs assessment is given to the System Governor who decides what funded aged care services are approved for the individual.

The approval may be in relation to all services in a service group, for example, as is the case for residential care where individuals generally need access to all the services in the group. For some service groups, such as home support, the approval may be limited to particular service types, or to particular services, in the service group. This reflects the wide range of different services available and varying needs of individuals accessing services in this group.

If an individual's circumstances change significantly, an application for reassessment can be made and a new approval decision is made, either on the basis of a new aged care needs assessment or information provided to the System Governor.

A classification assessment is generally undertaken at the same time as the aged care needs assessment (except in certain cases such as for ongoing residential care where it is undertaken once a

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registered provider has started delivering funded aged care services to the individual in an approved residential care home).

A classification decision is made by the System Governor in relation to any classification type (ongoing, short-term or hospital transition) for a service group the individual has been approved for. The classification decision generally affects the level of funding available under Chapter 4 to deliver funded aged care services to the individual. An individual may be approved and given a classification level for multiple service groups or multiple classification types in a service group, however, the individual can only have one classification level in effect for a classification type for a day, and there are rules about which classification types can be in effect on the same day.

For the service groups home support or residential care, a decision about the individual's priority category for that service group is made by the System Governor (where required). This decision may affect when the individual can access services in that service group. Individuals (or in certain circumstances the registered provider) must be allocated a place to access funded aged care services in these groups. The allocation is done on the basis of considerations such as the individual's priority category and when the individual's access approval was given.

Alternative allocation arrangements apply in relation to individuals accessing funded aged care services under specialist aged care programs.

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Part 2—Eligibility for entry

Division 1—Applying for access to funded aged care services

56 Requirements for applications

(1) An individual, or a person in a class of persons prescribed by the rules on behalf of the individual, may apply, in an approved form, to the System Governor for access to funded aged care services if the individual does not have an eligibility determination for an aged care needs assessment that is in effect.

Note: The application may be withdrawn: see section 590.

(2) If a person makes an application under subsection (1) on behalf of the individual, the person must notify the individual that the application has been made.

57 System Governor must decide whether to make determination

(1) The System Governor must consider the application for access to funded aged care services and decide whether to make an eligibility determination for an aged care needs assessment for the individual.

(2) The decision must be made within the period prescribed by the rules.

(3) If the System Governor decides not to make a determination under subsection (1), the individual's application for access to funded aged care services is taken to be withdrawn.

58 Eligibility determination for an aged care needs assessment

The System Governor must not make an eligibility determination for an aged care needs assessment for an individual unless the System Governor considers that:

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(a) the individual:
  (i) is aged 65 or over; or
  (ii) is an Aboriginal or Torres Strait Islander person and is aged at least 50; or
  (iii) is homeless, or at risk of homelessness, and is aged at least 50; and
(b) information of a kind prescribed by the rules has been provided relating to the individual's care needs; and
(c) if the individual is aged less than 65, the individual:
  (i) has elected, in the approved form, to be provided with funded aged care services before the individual turns 65; and
  (ii) has been informed of any other services that may be available to meet the care needs of the individual.

59 Notice of decision not to make a determination

(1) If the System Governor decides under section 57 not to make an eligibility determination for an aged care needs assessment for an individual, the System Governor must give notice of the decision to the individual within 14 days after the day the decision is made.

(2) The notice under subsection (1) must include:
  (a) the reasons for the decision; and
  (b) a statement that the effect of the decision is that the individual's application for access to funded aged care services is taken to be withdrawn; and
  (c) how the individual may apply for reconsideration of the decision.

(3) If the application for the eligibility determination was made by a person on behalf of the individual, the notice under subsection (1) must also be given to the person.

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60 Period of effect of determination

An eligibility determination for an aged care needs assessment takes effect at the time it is made and remains in effect until it is revoked under section 73 or 74.

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Division 2—Aged care needs assessments and reassessments

61 Aged care needs assessments

(1) The System Governor must arrange for an assessment of an individual's need for funded aged care services to be undertaken by an approved needs assessor if:

(a) an eligibility determination for an aged care needs assessment is made for the individual; or

(b) the System Governor decides that a reassessment of the individual's need for funded aged care services is required to be undertaken by an approved needs assessor in accordance with paragraph 64(2)(a).

(2) Despite subsection (1), the aged care needs assessment must not be undertaken, and the individual's application for funded aged care services, or application under paragraph 64(1)(b) for reassessment, is taken to be withdrawn, if:

(a) an eligibility determination for an aged care needs assessment is not in effect for the individual; or

(b) the System Governor is satisfied it is not reasonably possible for an approved needs assessor to undertake the assessment.

Note: Examples of circumstances in which it may not be reasonably possible to undertake an assessment include where the individual does not provide consent to the assessment.

62 Undertaking aged care needs assessments

(1) The aged care needs assessment must be undertaken by the approved needs assessor using an assessment tool prescribed by the rules and in accordance with any other requirements prescribed by the rules.

Note: An individual must have an eligibility determination for an aged care needs assessment under section 57 in effect before an aged care needs assessment can be undertaken for the individual.

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(2) The aged care needs assessment must include:

(a) a discussion with the individual about what the assessment has identified in terms of funded aged care services the individual may require access to and may assist the individual to maintain the individual's independence; and

(b) a discussion with the individual about the individual's preferences and goals, the next steps in terms of the individual's application for funded aged care services and how the individual will be informed of the outcome of the application; and

(c) any other thing prescribed by the rules.

(3) When undertaking the aged care needs assessment, the approved needs assessor must:

(a) consider the individual's rights mentioned in subsection 23(1) (independence, autonomy, empowerment and freedom of choice); and

(b) to the extent possible, make the individual aware of, support them to understand, and empower them to exercise, the individual's rights under the Statement of Rights; and

(c) involve the individual's carer, family member, advocate or other person in the discussions mentioned in subsection (2), if that is the individual's will and preference.

63 Aged care needs assessment reports

(1) The approved needs assessor must provide a report of the assessment to the System Governor as soon as practicable after the assessment is completed.

(2) The report must include information about:

(a) the funded aged care services the assessor considers the individual needs in order to meet the individual's care needs; and

(b) any service groups the assessor considers should be approved under subsection 65(2) for the individual; and

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(c) any service types the assessor considers should be approved under subparagraph 65(2)(b)(i) for the individual; and

(d) any funded aged care services the assessor considers should be approved under subparagraph 65(2)(b)(ii) for the individual; and

(e) whether the individual's approval for a particular service group should be for any or all of the classification types short-term, ongoing or hospital transition.

Note: A classification assessment report required under section 77 may be included with the report under this section.

64 Aged care needs reassessments

(1) The System Governor must decide whether a reassessment of an individual's need for funded aged care services is required if:

(a) an eligibility determination for an aged care needs assessment is in effect for the individual; and

(b) the individual makes an application for the reassessment in an approved form; and

(c) either:

(i) the System Governor is satisfied that a significant change in circumstances prescribed by the rules applies in relation to the individual; or

(ii) other circumstances prescribed by the rules apply in relation to the individual.

(2) If the System Governor decides under subsection (1) that a reassessment of an individual's need for funded aged care services is required, the System Governor must:

(a) if subparagraph (1)(c)(i) applies—arrange for a new assessment of the individual's need for funded aged care services to be undertaken by an approved needs assessor in accordance with section 61; or

(b) if subparagraph (1)(c)(ii) applies—make the reassessment on the basis of information of a kind prescribed by the rules being provided in relation to the individual.

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Note: Where the System Governor decides a reassessment of an individual's need for funded aged care services is required, the System Governor must make new decisions under subsections 65(1) and (2) (which deal with approving access to funded aged care services).

(3) If the System Governor decides under subsection (1) that a reassessment of an individual's need for funded aged care services is not required, the System Governor must, within 14 days after the decision is made, give notice to the individual of the decision.

(4) A notice under subsection (3) must include:

(a) the reasons for the decision; and

(b) how the individual may apply for reconsideration of the decision.

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Division 3—Approval of access to funded aged care services

65 Approval of access for funded aged care services

Approval for funded aged care services

(1) The System Governor must consider an assessment report for an individual provided under section 63, or information relating to an individual that is provided to the System Governor in accordance with paragraph 64(2)(b), and decide whether or not the individual requires access to funded aged care services.

Note 1: If the assessment report relates to a decision under subsection 64(1) to reassess the individual's need for funded aged care services, a new decision is made under this section.

Note 2: Paragraph 64(2)(b) allows the System Governor to make a reassessment of an individual's need for funded aged care services on the basis of certain kinds of information being provided to the System Governor (which results in a new decision being made under this section).

Access approval for service groups, classification types for service groups, service types and funded aged care services

(2) If the System Governor decides under subsection (1) that an individual requires access to funded aged care services, the System Governor must decide:

(a) whether to approve one or more service groups for the individual and the classification types for the service groups; and

(b) if the service group is home support, assistive technology or home modifications and the individual is not an Aboriginal or Torres Strait Islander person:

(i) whether to approve one or more service types in that group for the individual; and

(ii) if the service type is prescribed by the rules for the purposes of this paragraph—whether to approve one or

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more funded aged care services in that type for the individual.

Note: An individual may choose which funded aged care services covered by an approval they wish to access and when.

(3) However, the System Governor must not approve a service group, service type or funded aged care service under subsection (2) for an individual unless:

(a) section 66, 67 or 68 applies in relation to the individual and the service group, service type or service; and

(b) any eligibility requirements prescribed by the rules for the service group, or the service group in which the service type or service are included, are met.

Exceptional circumstances

(4) Despite an individual not having undergone an aged care needs assessment under section 62, the System Governor may make a decision under subsections (1) and (2) to approve access to funded aged care services for the individual if:

(a) the System Governor is satisfied that there are exceptional circumstances that justify making the decision without an assessment; and

(b) the individual, or a registered provider on behalf of the individual, makes an application to the System Governor in the approved form; and

(c) any circumstances prescribed by the rules do not apply.

Timing of decisions

(5) The decisions under subsections (1) and (2) must be made within the period prescribed by the rules.

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66 Aboriginal or Torres Strait Islander persons

This section applies in relation to an individual and any service group if the individual is an Aboriginal or Torres Strait Islander person.

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67 Individuals with an impairment or sickness

(1) This section applies in relation to an individual and a service type or funded aged care service if:

(a) the individual has a long-term physical, mental, sensory or intellectual impairment and the impairment may hinder the individual's participation in society on an equal basis with others as a result of the impairment's interaction with various barriers; and

(b) any of the following apply:

(i) each of the funded aged care services in the service type, or the funded aged care service, is an in-home, residential or other community support service and access to the funded aged care services in the service type, or the funded aged care service, is necessary to support the individual to live and be included in the community, and to prevent isolation or segregation of the individual from the community;

(ii) access to the funded aged care services in the service type, or the funded aged care service, will facilitate personal mobility of the individual in the manner and at the time of the individual's choice;

(iii) the funded aged care services in the service type each involve, or the funded aged care service involves, a mobility aid or device, or assistive technology, live assistance or intermediaries that will facilitate personal mobility of the individual;

(iv) the funded aged care services in the service type are each, or the funded aged care service is, a health service that the individual needs because of the individual's impairment or because of the interaction of the individual's impairment with various barriers;

(v) the funded aged care services in the service type are each, or the funded aged care service is, a habilitation or rehabilitation service;

(vi) the funded aged care services in the service type are each, or the funded aged care service is, a service that

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will assist the individual to access a service mentioned in subparagraph (iv) or (v);

(vii) the funded aged care services in the service type, or the funded aged care service, will minimise the prospects of the individual acquiring a further impairment or prevent the individual from acquiring a further impairment.

(2) This section applies in relation to an individual and a service type or funded aged care service if the funded aged care services in the service type are each, or the funded aged care service is, a medical service required by the individual because of sickness.

(3) This section applies in relation to an individual and the service group home support, assistive technology or home modifications but only to the extent to which this section applies to the service types or funded aged care services in the service group in accordance with subsections (1) and (2).

(4) For the purposes of paragraph (1)(a), an impairment may be long-term despite the fact it is episodic, fluctuating or varying in intensity over time.

68 Individuals with a sickness

This section applies in relation to an individual and the residential care service group if the individual has, by reason of sickness, a continuing need for funded aged care services (including nursing services) in the service group.

69 Conditions on approvals of service types or services in certain service groups

(1) The System Governor may include one or more conditions on the approval of a service type, or a funded aged care service, under paragraph 65(2)(b) for an individual.

(2) Without limiting subsection (1), conditions included on an approval of a service type or a funded aged care service for an individual may include any of the following:

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(a) that the individual must provide to a registered provider that will deliver funded aged care services in the service type, or the funded aged care service, information of a kind prescribed by the rules;

(b) that the individual can only access the funded aged care services in the service type, or the funded aged care service, through a registered provider of a kind prescribed by the rules;

(c) that a person of a kind prescribed by the rules has confirmed, in accordance with any requirements prescribed by the rules, that the individual requires access to the funded aged care services in the service type, or the funded aged care service.

70 Notice of decision

(1) The System Governor must give written notice of a decision under subsection 65(1) or (2) to the individual within 14 days after the decision is made.

(2) The notice under subsection (1) must include for each decision:

(a) the reasons for the decision; and

(b) how the individual may apply for reconsideration of the decision; and

(c) for a decision under subsection 65(2), all of the following:

(i) the day the access approval takes effect (see subsection 71(1));

(ii) any service groups approved under subsection 65(2) for the individual and the classification types approved for those service groups;

(iii) any service types approved under subparagraph 65(2)(b)(i) for the individual;

(iv) any funded aged care services approved under subparagraph 65(2)(b)(ii) for the individual;

(v) any conditions included, under section 69, on an approval referred to in subparagraph (iii) or (iv) of this paragraph.

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Note 1: The notice of the classification decision under section 79 for a service group may be included with the notice of approval under this section for the service group if the classification assessment is undertaken at the same time as the aged care needs assessment.

Note 2: The notice of an individual's priority category for a service group under section 88 may be included with the notice of approval under this section for the service group.

71 Period of effect of approval

General case

(1) An access approval takes effect on the day specified in the notice of the decision under section 70 and remains in effect until the earlier of the following:

(a) the individual's eligibility determination for an aged care needs assessment, or the access approval, is revoked under section 73 or 74;

(b) another decision is made for the individual under subsections 65(1) and (2).

Note: An access approval means an approval under subsection 65(2), see the definition of ***access approval*** in section 7.

Alternative entry

(2) For the purposes of subsection (1), the day specified in the notice of decision under section 70 for an individual may be a day that is earlier than the day the access approval is given if:

(a) the individual makes an application, in the approved form, within the period referred to in subsection (3); and

(b) the System Governor is satisfied that any of the circumstances set out in subsection (4) apply in relation to the individual; and

(c) the day is no earlier than the first day a funded aged care service was delivered to the individual.

(3) The period is:

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(a) the period of 5 days after the first day an aged care service covered by the approval was delivered to the individual; or

(b) if circumstances prescribed by the rules apply—the period prescribed by the rules; or

(c) if the System Governor determines a period for the individual under subsection (6)—that period.

(4) The circumstances are:

(a) the individual urgently needed access to funded aged care services and there was a significant risk of harm to the individual if those services were not delivered to the individual before the approval was given; or

(b) the individual is an Aboriginal or Torres Strait Islander person and at the time the individual was seeking to access funded aged care services there was a lack of availability of an approved needs assessor to undertake a culturally safe aged care needs assessment for the individual; or

(c) the individual commenced accessing funded aged care services under a specialist aged care program before the approval was given and at the time the individual was seeking to access funded aged care services there was a significant delay in the availability of an approved needs assessor to undertake an aged care needs assessment for the individual.

(5) For the purposes of paragraph (3)(c), an individual may apply, in the approved form, to the System Governor to determine a longer period than what would otherwise apply in relation to the individual under paragraph (3)(a) or (b).

(6) The System Governor must, by written notice given to the person decide to:

(a) determine the longer period for the individual; or

(b) reject the application.

(7) The notice under subsection (6) must:

(a) be given as soon as practicable after the decision is made; and

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(b) include the reasons for the decision and how a person may apply for reconsideration of the decision.

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Division 4—Revoking eligibility determinations and access approvals

72 Request for revocation

(1) An individual may request the System Governor revoke an eligibility determination for an aged care needs assessment that is in effect for the individual if the individual is under age 65 at the time of making the request.

(2) If an access approval is in effect for an individual, the individual may request the System Governor to revoke the approval.

(3) A request under this section must be in an approved form.

73 Revocation on request

(1) If a request for revocation is made under section 72, the System Governor must revoke the eligibility determination or access approval within 28 days after the day the request is made.

(2) The System Governor must, within 14 days after making the decision, give written notice of the revocation to the individual.

(3) If the System Governor revokes an eligibility determination or access approval under subsection (1), any pending application for the individual under section 56 or 64 is taken to be withdrawn.

74 Revocation on initiative of System Governor

(1) The System Governor may revoke an eligibility determination for an aged care needs assessment, or access approval, or both, for an individual if the System Governor is satisfied that:

(a) the individual gave information, or a document, in relation to the application for access to funded aged care services to which the determination or access approval relates; and

(b) either:

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(i) the information or document (as the case may be) was false or misleading; or

(ii) the information omitted any matter or thing without which the information is misleading.

(2) Before the System Governor makes a decision under subsection (1) for an individual, the System Governor must, by written notice, notify the individual that the System Governor is considering making that decision.

(3) The notice must:

(a) set out the reasons why the System Governor is considering making the decision; and

(b) invite the applicant to make submissions, in writing, to the System Governor in relation to the matter within 14 days after receiving the notice, or such longer period as is specified in the notice; and

(c) inform the individual that the System Governor may, after considering any submissions made by the individual, make the decision.

(4) The System Governor must consider any submissions made by an individual in accordance with a notice under subsection (3).

(5) If, after considering an individual's submissions under subsection (4), the System Governor decides to revoke the individual's eligibility determination, or access approval, or both, the System Governor must, within 14 days after the day the decision is made, give written notice of the following to the individual:

(a) the decision;

(b) the reasons for the decision;

(c) how the individual may apply for reconsideration of the decision.

(6) If the System Governor revokes an individual's eligibility determination, or access approval, or both under subsection (1),

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any pending application for the individual under section 56 or 64 is taken to be withdrawn.

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Part 3—Classification

Division 1—Classification assessments and decisions

75 Classification assessments

(1) A classification assessment for the purposes of determining a classification level for a classification type for a service group for an individual must be undertaken if:

(a) during an aged care needs assessment for the individual under section 62, the approved needs assessor considers the classification type for the service group should be approved for the individual under subsection 65(2); or

(b) an application for a classification reassessment for the classification type for the service group is made by the individual, or a registered provider on behalf of the individual, under section 82.

Note 1: Paragraph (a) also applies if a further aged care needs assessment is undertaken in accordance with paragraph 64(2)(a) (which deals with reassessments).

Note 2: A classification reassessment is also undertaken if a classification decision for an individual is reconsidered under section 560 or 562.

(2) Despite paragraph (1)(a), a classification assessment must be undertaken in accordance with subsection (3) if the approved needs assessor during the aged care needs assessment for the individual considers:

(a) the individual's access approval should include the classification type ongoing for the service group residential care; or

(b) both of the following apply:

(i) the individual's access approval should include the short-term classification type for the service group residential care;

(ii) it is not reasonably practicable to undertake the classification assessment for that classification type for

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that service group at the same time as the aged care needs assessment.

Note: An initial classification decision is made for the individual until the classification assessment can be undertaken: see paragraph 78(1)(c).

(3) The classification assessment must be instead undertaken at a time that is both:

(a) after the aged care needs assessment; and

(b) on or after the start date included in a start notification for delivering funded aged care services to the individual under that classification type at an approved residential care home of a registered provider.

(4) A classification assessment required under paragraph (1)(b) or subsection (2) must be arranged by the System Governor.

(5) Despite paragraph (1)(b) or subsection (2), a classification assessment otherwise required under that paragraph or subsection in relation to an individual for a classification type for a service group is not required to be undertaken if:

(a) circumstances prescribed by the rules apply; or

(b) the individual's access approval for the classification type for the service group is revoked; or

(c) if the classification assessment is for the classification type ongoing for the service group residential care—either of the following apply:

(i) a cessation notification for the individual is given to the System Governor by the registered provider referred to in subsection (3) or subsection 82(2);

(ii) a start notification is given to the System Governor by the registered provider, or another registered provider, to deliver funded aged care services in another approved residential care home to the individual.

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76 Undertaking classification assessments

(1) An assessment for an individual for a classification type for a service group must be carried out:

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(a) for a classification assessment required under paragraph 75(1)(a) or subsection 75(2):

(i) unless subparagraph (ii) applies—by an approved needs assessor using an assessment tool prescribed by the rules for the classification type for the service group and in accordance with any other requirements prescribed by the rules; or

(ii) if circumstances prescribed by the rules apply for the classification type for the service group and information of a kind prescribed by the rules for the classification type for the service group is given to the System Governor—by the System Governor in accordance with any requirements prescribed by the rules; or

(b) for a classification assessment required under paragraph 75(1)(b):

(i) unless subparagraph (ii) applies—by an approved needs assessor using an assessment tool prescribed by the rules for the classification type for the service group and in accordance with any other requirements prescribed by the rules; or

(ii) if circumstances prescribed by the rules apply for the classification type for the service group and information of a kind prescribed by the rules for the classification type for the service group is given to the System Governor—by the System Governor in accordance with any requirements prescribed by the rules.

(2) For a classification assessment for the classification type ongoing for the service group residential care, the approved needs assessor referred to in subparagraph (1)(a)(i) or (b)(i) must:

(a) have the skills and qualifications prescribed by the rules; and

(b) comply with any other requirements prescribed by the rules.

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77 Classification assessment reports

(1) If a classification assessment is undertaken for an individual in accordance with subparagraph 76(1)(a)(i) or (b)(i), the approved

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needs assessor must provide a report of the classification assessment to the System Governor as soon as practicable after the assessment is completed.

(2) The report must include the results for the individual against each relevant assessment item set out in the assessment tool referred to in that subparagraph.

Note: The report of the classification assessment may be included in an aged care needs assessment report for the individual under section 63 if the classification assessment is undertaken at the same time as the aged care needs assessment.

(3) Despite subsection (1), a report of a classification assessment for an individual for a classification type for a service group is not required to be provided to the System Governor if there is only one classification level prescribed for the service type for the service group by rules made for the purposes of subsection 81(1).

78 Classification decisions

(1) The System Governor must establish a classification level for an individual for a classification type for a service group in accordance with any criteria, methods or procedures prescribed by the rules for the purposes of section 81, if:

(a) the System Governor is given a report of a classification assessment for the individual for the classification type for the service group under section 77; or

(b) information is given to the System Governor as referred to in subparagraph 76(1)(a)(ii) or (b)(ii); or

(c) the System Governor makes an access decision for an individual under section 65 to approve a classification type for a service group for which the classification assessment will be undertaken in accordance with subsection 75(2).

Note: A decision required under paragraph (1)(c) is an initial decision made for the individual until the classification assessment can be undertaken and another classification decision is made under paragraph (1)(a) for the individual.

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(2) If subsection 77(3) applies in relation to an individual and a service group, the System Governor is taken to have established under subsection (1) the classification level for the individual for the classification type for the service group that is prescribed for the classification type for the service group by rules made for the purposes of subsection 81(1).

(3) Despite subsection (1), the System Governor is not required to make a decision under that subsection in relation to a classification type for a service group if the System Governor decides not to approve, under subsection 65(2), the classification type for the service group for the individual.

(4) The System Governor must make a decision under subsection (1) within the period prescribed by the rules.

79 Notice of decision

(1) The System Governor must give to an individual written notice of a classification decision under section 78 for the individual for a classification level for a classification type for a service group within 14 days after the decision is made.

(2) The notice under subsection (1) must include:
  (a) the classification level for the classification type for the service group; and
  (b) details about when the classification decision did, or will, come into effect; and
  (c) how the individual may apply for reconsideration of the decision.

Note: If the classification assessment is undertaken at the same time as the aged care needs assessment, the notice under this section may be included with the notice under section 70 of the individual's access approval for the service group.

(3) If the decision relates to a classification assessment undertaken in accordance with paragraph 75(1)(b) for the classification type ongoing or short-term for the service group residential care, or in accordance with subsection 75(2), the System Governor must also

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give a copy of the notice under subsection (1) to the registered provider that is delivering funded aged care services to the individual.

80 Period of effect of classification level

(1) A classification level for a classification type for a service group that has been established under section 78 for an individual has effect for the period prescribed by the rules.

(2) Rules made for the purposes of subsection (1) may prescribe:
  (a) that the first day of the period is a day before or after the classification decision was made for the individual under section 78; and
  (b) circumstances in which a classification level that has ceased being in effect resumes being in effect for a period; and
  (c) circumstances in which a classification level is not in effect on a day because:
    (i) another classification level in the same classification type for the service group is in effect on the day; or
    (ii) another classification level in a different classification type for the service group or any other service group is in effect on the day.

(3) Despite subsection (1), a classification level for a classification type for a service group for an individual is not in effect (and cannot resume being in effect) on or after any of the following days:
  (a) the day the individual's access approval for the classification type for the service group is revoked;
  (b) the day another classification decision made for the individual for the classification type for the service group under section 78 comes into effect.

(4) The rules may prescribe the ***maximum period of effect*** for a classification level for a classification type for a service group.

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81 Classification levels and procedures

(1) The rules must prescribe ***classification levels*** for each classification type for each service group.

(2) Without limiting subsection (1), the rules may:

(a) set out different classification levels for different classification types for different service groups; and

(b) set out criteria for each classification level that are to be used in establishing the classification level of an individual for a classification type for a service group; and

(c) set out for each service group which classification levels are in each classification type.

Note: A classification level in the short-term or hospital transition type will have a time-limited period of effect because of rules made for the purposes of subsection 80(4).

(3) Subject to subsection (4), rules made for the purposes of subsection (1) may specify methods or procedures that the System Governor must follow in deciding classification levels for an individual for a classification type for a service group.

(4) Rules made for the purposes of subsection (1) may:

(a) set out compounding factors (based on results against relevant assessment items mentioned in subsection 77(2)) that will be used to establish an individual's classification level; and

(b) prescribe the scientific population study that will be used by the System Governor to derive a method for establishing when these compounding factors, taken together, are significant because they indicate the individual has significantly higher care needs relative to the needs of other individuals.

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Division 2—Applying for a classification reassessment

82 Requirements for applications for classification reassessments

Ongoing or short-term funded aged care services delivered through service group home support or assistive technology

(1) An individual may make an application for a classification assessment for the individual for the classification type ongoing or short-term for the service group home support or assistive technology if:

(a) the individual has the classification type ongoing or short-term for the service group in effect; and

(b) the individual considers a different classification level in the classification type for the service group should be approved for the individual; and

(c) the funded aged care services are not being delivered under a specialist aged care program; and

(d) the System Governor considers circumstances (if any) prescribed by the rules apply.

Short-term funded aged care services delivered through service group home modifications

(1A) An individual may make an application for a classification assessment for the individual for the classification type short-term for the service group home modifications if:

(a) the individual has the classification type short-term for the service group in effect; and

(b) the individual considers a different classification level in the classification type for the service group should be approved for the individual; and

(c) the funded aged care services are not being delivered under a specialist aged care program; and

(d) the System Governor considers circumstances (if any) prescribed by the rules apply.

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Ongoing funded aged care services delivered through the service group residential care

(2) An individual, or a registered provider on behalf of the individual, may make an application for a classification assessment for the individual for the classification type ongoing for the service group residential care if:

(a) the registered provider is delivering ongoing funded aged care services to the individual through the service group in an approved residential care home; and

(b) the registered provider or the individual considers a different classification level in the classification type for the service group should be approved for the individual; and

(c) the funded aged care services are not being delivered under a specialist aged care program; and

(d) either of the following apply:

(i) if the rules prescribe a time period—not more than the number of applications prescribed by the rules have been made for the individual under this subsection in that time period;

(ii) the System Governor considers circumstances (if any) prescribed by the rules apply.

Short-term funded aged care services delivered through the service group residential care

(3) An individual, or a registered provider on behalf of the individual, may make an application for a classification assessment for the individual for the classification type short-term for the service group residential care if:

(a) the registered provider or the individual considers a different classification level in the classification type for the service group should be approved for the individual; and

(b) an access approval is in effect for the individual for the classification type for the service group; and

(c) if the application is made by the registered provider:

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(i) the registered provider is delivering short-term funded aged care services through the residential care service group to the individual in an approved residential care home; and

(ii) those funded aged care services are not being delivered under a specialist aged care program; and

(d) either of the following apply:

(i) if the rules prescribe a time period—not more than the number of applications prescribed by the rules have been made for the individual under this subsection in that time period;

(ii) the System Governor considers circumstances (if any) prescribed by the rules apply.

Hospital transition funded aged care services delivered through any service group

(4) A registered provider on behalf of an individual may make an application for a classification assessment for the classification type hospital transition for a service group if:

(a) the registered provider is delivering hospital transition funded aged care services to the individual through the service group; and

(b) the registered provider or the individual considers that an extension of the period of effect for the classification level that is in effect for the individual for the classification type for the service group should be approved for the individual.

Requirements for applications

(5) An application under this section must:

(a) be in an approved form; and

(b) be accompanied by the application fee (if any) prescribed by the rules.

Note 1: The System Governor does not have to make a decision on an application that does not meet the requirements of this section: see section 589.

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Note 2: The application may be withdrawn: see section 590.

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Division 3—Changing classifications

83 Changing classifications

(1) The System Governor must change a classification decision (the ***original decision***) for an individual under subsection 78(1) if the System Governor is satisfied that:

(a) the classification assessment for the original decision (see section 76) was incorrect or inaccurate; or

(b) the original decision was, for any other reason, incorrect.

(2) The original decision cannot be changed under this section in any other circumstances.

(3) Before changing the original decision, the System Governor must review the decision, having regard to:

(a) any material on which the original decision was based that the System Governor considers relevant; and

(b) any matters prescribed by the rules as matters to which the System Governor must have regard; and

(c) any other material or information that the System Governor considers relevant (including material or information that has become available since the original decision was made).

(4) If the System Governor changes the original decision:

(a) the change takes effect on the same day that the original decision took effect; and

(b) the System Governor must notify the individual for whom the original decision was made, and any registered provider that is providing funded aged care services to the individual, in writing, of the change.

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Part 4—Prioritisation

84 Prioritisation assessment

(1) A prioritisation assessment for the purposes of determining an individual's priority category for a classification type for a service group must be undertaken if:

(a) during an aged care needs assessment for the individual under section 62, the approved needs assessor considers the classification type for the service group should be approved for the individual under subsection 65(2); and

(b) the classification type for the service group is:

(i) ongoing for home support; or

(ii) ongoing or short-term for assistive technology; or

(iii) short-term for home modifications; or

(iv) ongoing for residential care.

(2) Despite subsection (1), a prioritisation assessment is not required to be undertaken in relation to an individual for a classification type for a service group if:

(a) the classification type for the service group is ongoing for home support; and

(b) the circumstances prescribed by the rules apply.

85 Prioritisation report

(1) If a prioritisation assessment for a classification type for a service group is carried out for an individual in accordance with section 84, the approved needs assessor must provide a report of the prioritisation assessment to the System Governor as soon as practicable after the assessment is completed.

(2) The report must include:

(a) for the classification type ongoing or short-term for the service group home support or assistive technology, or for

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the classification type short-term for the service group home modifications:

(i) the recommended priority category for the individual; and

(ii) how the individual meets the eligibility criteria for the recommended priority category; and

(b) for the classification type ongoing for the service group residential care:

(i) the recommended urgency rating for the individual; and

(ii) key reasons for the recommended urgency rating.

Note: The report of the prioritisation assessment may be included in an aged care needs assessment report for the individual under section 63.

86 Priority category decisions

General requirements

(1) If the System Governor is given a prioritisation report for an individual for a classification type for a service group under section 85, the System Governor must establish a priority category for the individual for the classification type for the service group in accordance with any criteria, methods or procedures prescribed by the rules for the purposes of section 87.

(3) A decision under subsection (1) must be made within the period prescribed by the rules.

(4) Despite subsection (1), the System Governor is not required to make a decision under that subsection in relation to a service group if the System Governor decides not to approve, under subsection 65(2), the classification type for the service group for the individual.

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Requirements for classification type ongoing for the service group residential care

(5) If the prioritisation report given to the System Governor under section 85 is for the classification type ongoing for the service group residential care, the System Governor must:

(a) assign the individual priority category 1 if:

(i) the individual has an urgency rating of high; or

(ii) the individual resides in an area prescribed by the rules; or

(iii) the individual is an Aboriginal or Torres Strait Islander person, homeless, or in a class of persons prescribed by the rules; or

(b) assign the individual priority category 2 if:

(i) the individual is not an individual to whom subparagraph (a)(ii) or (iii) applies; and

(ii) the individual has an urgency rating of medium; or

(c) assign the individual priority category 3 if:

(i) the individual is not an individual to whom subparagraph (a)(ii) or (iii) applies; and

(ii) the individual has an urgency rating of low.

87 Priority categories and urgency ratings

(1) The rules may prescribe, for the purposes of subsection 86(1):

(a) one or more priority categories for a classification type for a service group; and

(b) eligibility criteria for each of those priority categories.

(2) The rules may prescribe, for the purposes of subsection 86(1), the circumstances in which an urgency rating of low, medium or high will apply to an individual in relation to the classification type ongoing for the service group residential care.

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88 Notice of decision

(1) The System Governor must give written notice of a decision under subsection 86(1) to the individual within 14 days after the decision is made.

Note: A notice under this subsection relating to a classification type for a service group can be included with the notice under section 70 of the individual's access approval that includes the classification type for the service group.

(2) The notice under subsection (1) must include:

(a) the reasons for the decision; and

(b) how the individual may apply for reconsideration of the decision.

89 Period of effect of decision

A decision under subsection 86(1) about an individual's priority category for a classification type for a service group takes effect at the time it is made and remains in effect until the earliest of the following:

(a) for a classification type for the service group home support—the individual is allocated a full place under subsection 92(1) for that classification type for the service group;

(aa) for a classification type for any other service group—the individual is allocated a place for the classification type for the service group under subsection 92(1);

(b) another decision is made under subsection 86(1) for the classification type for the service group following an assessment of the individual undertaken in accordance with paragraph 61(1)(b) (which deals with reassessments).

Note: The effect of paragraph (a) is that an individual's priority category decision remains in effect if an interim place has been allocated for the classification type for the service group home support.

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90 Changing priority category for service group

(1) The System Governor may change a decision under subsection 86(1) (the ***original decision***) about an individual's priority category for a classification type for a service group if the System Governor is satisfied that:

(a) the assessment of the needs of the individual that was made for the purposes of the original decision was incorrect or inaccurate; or

(b) there has been a change in circumstances that may affect whether the person meets the eligibility criteria for a higher priority category for the classification type for the service group; or

(c) the original decision was, for any other reason, incorrect.

(2) The original decision cannot be changed under this section in any other circumstances.

(3) A decision under subsection (1) can be made:

(a) on application by the individual, in the approved form; or

(b) on the System Governor's own initiative.

(4) Before changing the original decision, the System Governor must review the decision, having regard to:

(a) any material on which the original decision was based that the System Governor considers relevant; and

(b) any matters prescribed by the rules as matters to which the System Governor must have regard; and

(c) any other material or information that the System Governor considers relevant (including material or information that has become available since the original decision was made).

(5) If the System Governor changes the original decision:

(a) the change takes effect on the same day that the original decision took effect; and

(b) the System Governor must notify the individual, in writing, of the change.

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Section 90

Note: In a situation where an individual's circumstances and need for funded aged care services have changed significantly, the individual can apply for a reassessment of the individual's need for aged care services under section 64.

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Part 5—Place allocation

Division 1—Allocation of places to individuals

91 Number of places available for allocation

(1) The Minister must, in writing, determine a method for a financial year, that may be used at any time during that year, for working out the following:

(a) the number of places available at that time to be allocated to individuals for each service group;

(b) how many of the places mentioned in paragraph (a) for a service group are for allocation for a particular classification type (other than hospital transition) for the service group;

(c) how many of the places mentioned in paragraph (b) for a particular classification type for a service group are for allocation for a particular classification level in the classification type;

(d) if the service group is home support—how many of the places mentioned in paragraph (b) or (c) are for allocation as interim places or full places for the classification type or classification level.

(2) Without limiting subsection (1), the method prescribed may be based on any of the following factors:

(a) forecast demand for funded aged care services at the time and the forecast cost of those services at that time;

(b) the appropriation for the financial year and how much of that appropriation is left at the time;

(c) target average wait times for individuals with access approvals for a classification type for a service group who are seeking to access funded aged care services through the service group.

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(3) A determination under subsection (1) for a financial year must be made before the end of the financial year and may be made before the start of the financial year.

(4) Before making a determination under subsection (1), the Minister must consult with the Finance Minister about the method to be included in the determination.

(5) A determination made under subsection (1) is a legislative instrument, but section 42 (disallowance) of the *Legislation Act 2003* does not apply to the determination.

(6) In making a determination under subsection (1) for the 2025-26 financial year, the Minister must ensure that the method makes available:

(a) a number of places equal to, or greater than, the guaranteed (tranche 1) number, for allocation to individuals for the service group home support by the end of 31 December 2025; and

(b) at least an additional 43,000 places, for allocation to individuals for the service group home support by the end of 30 June 2026.

Note: This guarantees at least 83,000 services (whether home care packages or home support places) for recipients.

(7) Nothing in subsection (6) limits the Minister's powers under any of paragraphs (1)(b) to (d) in respect of the places mentioned in that subsection.

(8) In this section:

guaranteed (tranche 1) number means the number worked out as follows:

(a) 40,000; less

(b) the following:

(i) if the difference between the number of home care packages immediately before the commencement of the *Aged Care Act 2024* and the number of home care

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packages immediately before the transition time is greater than or equal to 40,000—40,000;

(ii) if the difference between the number of home care packages immediately before the commencement of the *Aged Care Act 2024* and the number of home care packages immediately before the transition time is greater than zero but less than 40,000—that difference;

(iii) otherwise—zero.

number of home care packages, at a time, means the number of home care packages under the Australian Government framework known as the National Priority System that were available and released to recipients at that time in accordance with determinations under subsection 23B-1(1) of the *Aged Care Act 1997*.

transition time means the beginning of the day after the *Aged Care and Other Legislation Amendment Act 2025* receives the Royal Assent.

92 Allocation of places to individuals

(1) If the System Governor considers, at a time during a financial year, that a place for a service group is available in accordance with a determination made under subsection 91(1), the System Governor may allocate the place to an individual who:

(a) if the place is for a classification type for a service group for which an individual is required to have a priority category under subsection 86(1):

(i) if the System Governor considers, in accordance with paragraph 91(2)(a), that the place is for a particular classification type or particular classification level in a classification type for the service group—has been determined to have a priority category under subsection 86(1) for the classification type for the service group; or

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(ii) otherwise—has been determined to have a priority category under subsection 86(1) for any classification type for the service group; or

(b) if the place is for a classification type (other than hospital transition) for a service group for which an individual is not required to have a priority category under subsection 86(1)—has an access approval that includes the classification type for the service group.

(1A) However, subsection (1) does not apply in relation to an individual and a classification type for a service group if:

(a) the classification type for the service group is ongoing for home support; and

(b) the circumstances prescribed by the rules apply.

(2) If there is a method or procedure for allocating the place that is prescribed by rules made for the purposes of subsection 93(2), the System Governor must allocate the place using that method or procedure.

(3) The System Governor must give written notice of the allocation of a place under subsection (1) to the individual.

(4) A notice under subsection (3) must include:

(a) the classification type for the service group for which the individual has been allocated a place; and

(b) if the service group is residential care—the day the place is allocated; and

(c) if the service group is home support, assistive technology or home modifications:

(i) information about when the place takes effect or is taken to be withdrawn in accordance with section 92A; and

(ii) for the service group home support—whether the place is an interim place or a full place.

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(5) The System Governor's power to allocate places to an individual under subsection (1) must be exercised in the 2025-26 financial year so that:

(a) a number of places equal to, or greater than, the guaranteed (tranche 1) number (within the meaning of section 91) are allocated to individuals for the service group home support by the end of 31 December 2025; and

(b) at least an additional 43,000 places are allocated to individuals for the service group home support by the end of 30 June 2026.

Note: This ensures the 83,000 services (whether home care packages or home support places) guaranteed by subsection 91(6) are released.

(6) If the System Governor fails to comply with paragraph (5)(a) or (b), the System Governor must give the Minister a written statement that sets out the reasons for the failure.

(7) The System Governor must do so within 14 days of:

(a) for a failure to comply with paragraph (5)(a)—31 December 2025; or

(b) for a failure to comply with paragraph (5)(b)—30 June 2026.

(8) The Minister must cause a copy of the statement to be tabled in each House of the Parliament within 15 sitting days of that House after the statement is given to the Minister.

92A When a place is in effect

Home support, assistive technology or home modifications

(1) A place allocated under subsection 92(1) to an individual for a classification type for the service group home support, assistive technology or home modifications takes effect on the start day for the individual included in a start notification given by a registered provider for the classification type for the service group.

(2) Despite subsection (1), if the start day is not within the period prescribed by the rules, the place:

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(a) does not take effect; and
(b) is taken to be withdrawn.

(3) Despite subsection (1), if:
(a) the place allocated to the individual is a full place for a classification type for the service group home support; and
(b) an interim place is in effect for the individual for the classification type for the service group;
the full place takes effect on the day the System Governor gives notice to the individual of the allocation of the place under subsection 92(3).

(4) A place allocated under subsection 92(1) to an individual for a classification type for the service group home support, assistive technology or home modifications ceases to have effect at the time prescribed by the rules.

Residential care

(5) A place allocated under subsection 92(1) to an individual for a classification type for the service group residential care takes effect on the day the places is allocated to the individual and remains in effect until the individual dies.

93 Method for allocation

(1) The System Governor must determine in what order to allocate places to individuals under subsection 92(1) for a classification type for a service group or for a classification level for a classification type for a service group.

(2) The rules may prescribe a method that the System Governor must follow in deciding the order of allocation under subsection (1) for a classification type for a service group or for a classification level for a classification type for a service group.

(3) Without limiting subsection (1), a method prescribed for the purposes of subsection (2) for the allocation of a place to an individual for a classification type for a service group, or a

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classification level for a classification type for a service group, may be based on any of the following factors:

(a) the individual's priority category (if any) for the classification type;

(b) the day the individual's access approval for the classification type was given;

(c) whether the individual has an interim place in effect for the classification type or the classification level;

(d) the individual's wait time for the allocation of a place for the classification type or the classification level;

(e) whether the individual has informed the System Governor that the individual is not seeking access to funded aged care services for a specified period.

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Division 2—Allocation of a place to registered providers for certain specialist aged care programs

94 Number of places available for allocation

(1) The Minister may determine for a financial year:

(a) for the Transition Care Program:

(i) the number of places available to be allocated to entities for delivering funded aged care services through a service group under the program; and

(ii) how many of those places must be used to deliver funded aged care services in a specified State or Territory; and

(b) for the Multi-Purpose Service Program:

(i) the number of places available to be allocated to entities for delivering funded aged care services through a service group under the program; and

(ii) how many of those places are for a residential care home or home or community setting.

Note: For variation of a determination made under this section: see subsection 33(3) of the *Acts Interpretation Act 1901*.

(2) Before making a determination under paragraph (1)(a), the Minister must consider:

(a) relative community needs across the States and Territories; and

(b) any other matters prescribed by the rules.

(3) If the Minister determines under paragraph (1)(a) that places are available to be allocated for use in:

(a) Western Australia—those places are available to also be allocated for use within Christmas Island and the Territory of Cocos (Keeling) Islands; or

(b) Queensland—those places are available to also be allocated for use within Norfolk Island.

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(4) A determination under subsection (1) for a financial year must be made before the end of the financial year and may be made before the start of the financial year.

(5) A determination made under subsection (1) is a legislative instrument, but section 42 (disallowance) of the *Legislation Act 2003* does not apply to the determination.

95 System Governor may decide to allocate a place

(1) If the Minister determines that a place is available for allocation under subsection 94(1), the System Governor may decide whether to allocate the place to an entity.

(2) If the place is for delivering funded aged care services under the Transition Care Program, the entity must make an application for the allocation of the place in accordance with the application process and any other requirements prescribed by the rules.

(3) If the place is for delivering funded aged care services under the Multi-Purpose Service Program, the allocation may be made on the request of the entity or on the System Governor's own initiative.

(4) The System Governor must not allocate the place to the entity unless satisfied of the following:

(a) for the allocation of a place for the Transition Care Program:

(i) the allocation of the place is consistent with the terms and conditions of the specialist aged care program agreement under section 247 with the State or Territory in which the funded aged care services will be delivered under the place; and

(ii) any other requirements prescribed by the rules are met;

(b) for the allocation of a place for the Multi-Purpose Service Program:

(i) if the place is for delivering funded aged care services through the service group residential care at a specified location—the total number of beds at the location is equal to or greater than the number of places; and

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(ii) any other requirements prescribed by the rules are met;

(c) for the allocation of any place—the allocation of the place is likely to contribute to quality and safe funded aged care services being delivered to individuals.

(5) Before allocating the place to the entity, the System Governor must consider:

(a) the objectives of the specialist aged care program that the place is for and how many places are available under section 94 for allocation for that program; and

(b) the community needs in locations where individuals are expected to be able to access funded aged care services using the place; and

(c) the Statement of Principles; and

(d) any information or documents given by the entity in relation to the allocation of the place.

96 Notice of decision to allocate a place

(1) If the System Governor decides to allocate a place to an entity under subsection 95(1), the System Governor must give written notice of the decision to the entity within 14 days after making the decision.

(2) The notice under subsection (1) must include the following:

(a) the specialist aged care program and service groups for which the entity has been allocated a place;

(b) any condition on the allocation of the place;

(c) details about when the place takes effect;

(d) any other information prescribed by the rules.

97 When a place is in effect

(1) A place allocated under subsection 95(1) to an entity for a specialist aged care program is in effect for the period prescribed by the rules.

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(2) Without limiting subsection (1), rules made for the purposes of that subsection may provide for:

(a) a place to have a period of effect that is not continuous; and

(b) circumstances in which a place ceases to have effect and cannot ever resume to have effect.

98 Transfer of places

(1) The rules may prescribe circumstances in which a place allocated under subsection 95(1) to an entity (the ***first entity***) may be transferred to another entity (the ***second entity***) and requirements for the transfer of that place.

(2) If a transfer of a place occurs in accordance with rules made for the purposes of subsection (1), this Division applies, from the time the transfer is made, as if the place were allocated under subsection 95(1) to the second entity.

99 Conditions that apply to an allocated place

(1) A place allocated by the System Governor to an entity under subsection 95(1) is subject to the following conditions:

(a) the place must only be used by the entity once the entity has become a registered provider and the entity's registration is in effect and covers any funded aged care service delivered under the place;

(b) the place must only be used by the entity to deliver a funded aged care service to an individual when the place is in effect;

(c) the place must only be used by the entity to deliver a funded aged care service to an individual with an access approval in effect that:

(i) for the Transition Care Program—includes the classification type hospital transition for the service group in which the service is included and for which the place is allocated; or

(ii) for the Multi-Purpose Service Program—includes the classification type ongoing or short-term for the service

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group in which the service is included and for which the place is allocated;

(d) the place must only be used by the entity to deliver a funded aged care service to an individual in the State or Territory for which the place was allocated (if applicable);

(e) any conditions determined by the System Governor under subsection (2);

(f) any condition prescribed by the rules.

(2) The System Governor may determine, in accordance with any requirements prescribed by the rules, that an allocation of a place is subject to such conditions as specified by written notice given to the entity.

(3) The notice under subsection (2) may be given:

(a) on the day the System Governor gives notice of a decision, under subsection 95(1) to allocate the place; or

(b) on a later day.

(4) A determination by the System Governor that an allocation of a place to an entity is subject to such conditions as specified by a notice under subsection (2) takes effect:

(a) on the day the notice is given to the registered provider; or

(b) if the System Governor specifies a later day in the notice as the day the determination takes effect—that day.

(5) A notice given under subsection (2) is not a legislative instrument.

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100 Application to vary a condition relating to an allocated place

(1) An entity that has been allocated a place by the System Governor under subsection 95(1) may apply to the System Governor to vary a condition relating to the place.

(2) The application must be in an approved form.

(3) Without limiting subsection (2), the application must specify the following:

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(a) the day the variation is proposed to take effect;
(b) the condition the entity is seeking to vary;
(c) any other requirements prescribed by the rules.

Note: A registered provider of a kind prescribed by the rules must give notice under section 167 of any change of a kind prescribed by the rules in accordance with any requirements prescribed by the rules.

101 System Governor must decide whether to vary a condition

(1) If an entity makes an application under subsection 100(1) to vary a condition, the System Governor must decide whether to vary the condition.

(2) Before deciding to vary the condition, the System Governor must consider:
(a) any matters prescribed by the rules as matters to which the System Governor must have regard; and
(b) any other material or information that the System Governor considers relevant.

102 Notice of decision on whether to vary a condition

(1) Within 14 days after making a decision under subsection 101(1), the System Governor must give written notice of the decision to the entity.

(2) The notice under subsection (1) must specify:
(a) details of the System Governor's decision about whether to vary the condition; and
(b) the reasons for the decision.

(3) A decision to vary a condition relating to an allocated place takes effect:
(a) on the day notice of the decision is given; or
(b) if the System Governor specifies a later day the decision takes effect in the notice under subsection (1)—that day.

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Section 103

Chapter 3—Registered providers, aged care workers and aged care digital platform operators

Part 1—Introduction

103 Simplified outline of this Chapter

To deliver funded aged care services, an entity must be registered as a registered provider by the Commissioner.

The Commissioner must consider whether an entity meets key eligibility requirements before deciding to register an entity. These requirements include general requirements and also registration category specific requirements.

The registered provider is registered in one or more provider registration categories, depending on the service types the provider intends to deliver.

To be registered in certain categories, including the residential care category, entities need to have completed an audit against the Aged Care Quality Standards. Residential care homes are also required to be approved, and may be approved in conjunction with the registration process, for entities intending to deliver service types in the residential care category.

The registration period is generally 3 years, with providers needing to apply to have their registration re-assessed by the Commissioner and renewed in order to continue providing care after the expiration of a registration period. Providers can also apply to vary their registration where required during a registration period.

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Section 103

The Commissioner maintains a register of registered providers and former registered providers which may be published.

A registered provider must comply with key obligations, including conditions on their registration, when delivering funded aged care services. Civil penalties or offences generally apply for failure to meet these obligations. Statutory duties also apply to registered providers (and responsible persons of providers) with individuals able to seek compensation in cases resulting in serious illness or injury.

The Commissioner can revoke or suspend a provider's registration, or revoke a residential care home approval, in certain circumstances. The Commissioner can also vary a provider's registration or a residential care home approval in certain circumstances.

Separate obligations are also placed on responsible persons and aged care workers of registered providers, including to comply with the Aged Care Code of Conduct.

An aged care worker screening scheme is established which provides that NDIS clearance decisions are taken to be aged care clearance and exclusion decisions.

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Part 2—Provider registration and residential care home approval process

Division 1—Applications for registration and registration decisions

Subdivision A—Applications for registration

104 Registration of providers

(1) An entity may apply to the Commissioner to be registered as a registered provider.

(2) The application must:
(a) be in an approved form; and
(b) be accompanied by the application fee (if any) prescribed by the rules.

Note 1: The Commissioner is not required to make a decision on the application if this subsection is not complied with: see section 589.

Note 2: The application can be withdrawn: see section 590.

Note 3: The entity may, at the same time, make an application under section 111 to approve a residential care home in relation to the entity.

(3) Without limiting subsection (2), the application must specify:
(a) each provider registration category that the entity is applying to be registered in; and
(b) each service type (the ***intended service types***) that the funded aged care services which the entity intends to deliver are in; and
(c) each service group through which the entity intends to deliver those service types; and
(d) any specialist aged care program the entity intends to deliver those service types under; and

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(e) each residential care home (if any) that the entity is applying for approval of; and

(f) each approved residential care home (if any) of the entity; and

(g) each responsible person of the entity; and

(h) the legal and business structure of the entity, including the nature and extent of the relationship between the entity and any associated providers of the entity; and

(i) any other information prescribed by the rules.

(4) Despite subsection (1), an entity may not make an application under that subsection if the entity is already a registered provider.

Note: An entity that is already a registered provider may apply to renew the registration under Subdivision B.

105 Commissioner must decide whether to register the entity

(1) The Commissioner must consider an application made by an entity under subsection 104(1), and the requirements in section 109, and decide:

(a) whether to register the entity as a registered provider and in which registration categories; and

(b) if the Commissioner decides to register the entity in the residential care category—each approved residential care home to be covered by the entity's registration.

Note 1: The Commissioner may decide to register an entity in some, but not all, provider registration categories that the entity specifies in the entity's application: see subsection 109(2).

Note 2: If the Commissioner decides to register the entity as a registered provider of funded aged care services, the entity is subject to the conditions on registered providers set out in Part 4.

(2) A decision under subsection (1) must be made within the period prescribed by the rules, or the period worked out in accordance with a method prescribed by the rules.

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Subdivision B—Applications for renewal

106 Invitation to renew registration

(1) The Commissioner may invite a registered provider, within the period specified in the invitation, to make an application under subsection 107(1) if the remaining registration period is less than 18 months.

(2) The invitation must:

(a) request the registered provider to indicate, within the period specified in the invitation, whether the provider intends to make the application; and

(b) specify the period within which the application may be made (which must be a reasonable period after the invitation is given).

(3) The Commissioner may extend the period specified under paragraph (2)(b) on the request of the registered provider.

107 Renewal of registration

(1) A registered provider may apply to the Commissioner to renew the provider's registration if:

(a) the Commissioner has invited the provider under section 106 to make the application; and

(b) the provider has indicated, within the period specified in the invitation, that the provider intends to make the application.

(2) The application must:

(a) be in an approved form; and

(b) be accompanied by the application fee (if any) prescribed by the rules.

Note 1: The Commissioner is not required to make a decision on the application if this subsection is not complied with: see section 589.

Note 2: The application can be withdrawn: see section 590.

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(3) Subsection 104(3) applies in relation to an application under subsection (1) of this section in the same manner as it applies in relation to an application under subsection 104(1).

108 Commissioner must decide whether to renew the registration

(1) The Commissioner must consider an application made by a registered provider under subsection 107(1), and the requirements in section 109, and decide:

(a) whether to renew the provider's registration and in which provider registration categories; and

(b) whether to register the provider in any other provider registration categories.

Note 1: The Commissioner may decide to renew a registered provider's registration or register the provider in some, but not all, provider registration categories that the provider specifies in the provider's application: see subsection 109(2).

Note 2: If the Commissioner decides to renew the provider's registration, the provider continues to be subject to the conditions on registered providers set out in Part 4.

(2) A decision under subsection (1) must be made within the period prescribed by the rules, or the period worked out in accordance with a method prescribed by the rules.

Subdivision C—Registration and renewal requirements

109 Registration and renewal requirements

General requirements

(1) The Commissioner must not register, or renew the registration of, an entity as a registered provider unless the Commissioner is satisfied that:

(a) the entity has an ABN; and

(b) the entity is suitable to deliver funded aged care services having regard to the following:

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(i) the entity's compliance with any law of the Commonwealth or any law of a State or Territory in which the entity operates (including any history of non-compliance with such laws);

(ii) whether a banning order or an NDIS banning order against the entity is, or has at any time been, in force;

(iii) if the entity was previously a registered provider, an approved provider or a registered NDIS provider—whether that registration was revoked (other than on request by the entity);

(iv) if the entity is a registered provider or a registered NDIS provider—whether that registration is suspended;

(v) the entity's previous experience and performance in delivering funded aged care services in the entity's intended service types or other similar services;

(vi) the entity's legal and business structure, including whether the entity is an entity within the meaning of this Act;

(vii) any other matter prescribed by the rules; and

(c) if the entity is not a government entity—the entity:

(i) has a record of sound financial management; and

(ii) has systems that the entity uses, or proposes to use, in order to ensure sound financial management in relation to the delivery of the funded aged care services; and

(d) each responsible person of the entity is suitable to deliver funded aged care services having regard to the suitability matters; and

(e) the entity satisfies the requirements in subsection (2) for at least one of the provider registration categories specified in the entity's application for registration or renewal (as the case requires); and

(f) the entity satisfies any other requirements prescribed by the rules.

Note: For suitability matters in relation to individuals, see section 13.

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Provider registration category specific requirements

(2) For each provider registration category specified in an entity's application under subsection 104(1) (registration of providers) or 107(1) (renewal of registration), the Commissioner must be satisfied of the following before deciding to register, or renew the registration of, the entity in that provider registration category:

(a) the entity's intended service types include service types that are in the provider registration category and the entity intends to deliver those service types in the 3 year period after the application is made;

(b) the entity has the commitment, capability and capacity (including through any systems the entity has, or proposes to have) to deliver funded aged care services, having regard to the intended service types;

(c) if any of the funded aged care services in the intended service types are services delivered in a residential care home—either:

(i) the entity has made an application under section 111 (approval of residential care homes) and at least one residential care home specified in that application meets the requirements in paragraph 113(b); or

(ii) at least one approved residential care home of the entity meets the requirements in paragraph 113(b);

(d) for a provider registration category prescribed by the rules—either:

(i) an audit conducted in accordance with rules made for the purposes of section 110 has found the entity will be able to conform with the Aged Care Quality Standards that apply to the provider registration category; or

(ii) circumstances prescribed by the rules apply in relation to the entity and the provider registration category;

(e) any other requirements prescribed by the rules.

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Registration must not be inconsistent with banning order

(3) Despite subsections (1) and (2), if a banning order is in force in relation to an entity, the Commissioner must not register, or renew the registration of, the entity in a way that would be inconsistent with the banning order.

Rules may exempt certain providers

(4) The rules may prescribe that one or more of the paragraphs in subsection (1) or (2) (other than paragraph (2)(d)) do not apply in relation to an entity in a class of entities prescribed by the rules.

110 Audit requirements

(1) The rules may prescribe requirements relating to conducting an audit of an entity's ability to conform with the Aged Care Quality Standards for a provider registration category.

(2) Without limiting subsection (1), the rules may prescribe requirements about the following:
- (a) how an audit for a provider registration category must be conducted, including required audit activities;
- (b) the type and scope of audits that can be conducted for a provider registration category and the circumstances in which a particular type of audit is to be conducted;
- (c) fees payable by an entity for an audit for a provider registration category;
- (d) audit timeframes for a provider registration category;
- (e) requirements (including qualifications) that a person conducting an audit must meet.

Note: For the matters that can be dealt with in the Aged Care Quality Standards: see section 15.

(3) Without limiting subsection (1), the rules may prescribe different requirements for different kinds of registered providers.

Note: Examples of different kinds of registered providers include:

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(a) providers delivering funded aged care services under a specialist aged care program; and
(b) providers delivering funded aged care services at a specified number of residential care homes; and
(c) providers that have previously been registered providers in a provider registration category; and
(d) providers that have not previously been registered providers in a provider registration category.

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Division 2—Applications for approval of residential care homes

Subdivision A—Applications for approval

111 Approval of residential care homes

(1) An entity may apply to the Commissioner to approve a residential care home in relation to the entity if:
  (a) the entity is a registered provider; or
  (b) the entity has made an application under subsection 104(1).

(2) The application must:
  (a) be in an approved form; and
  (b) be accompanied by the application fee (if any) prescribed by the rules.

Note 1: The Commissioner is not required to make a decision on the application if this subsection is not complied with: see section 589.

Note 2: The application can be withdrawn: see section 590.

(3) Without limiting subsection (2), the application must specify:
  (a) each residential care home that the entity is applying for approval of; and
  (b) for each residential care home specified in the application in accordance with paragraph (a):
    (i) the total number of beds to be covered by the approval; and
    (ii) any other information prescribed by the rules.

112 Commissioner must decide whether to approve the home

(1) The Commissioner must consider an application made by an entity under subsection 111(1), and the approval requirements in section 113, and decide:

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(a) whether to approve any residential care home in relation to the entity; and

(b) the total number of beds to be covered by each approval.

Note: The Commissioner may decide to approve some, but not all, residential care homes that an entity specifies in the entity's application: see section 113.

(2) The decision under subsection (1) must be made within the period prescribed by the rules, or the period worked out in accordance with a method prescribed by the rules.

Subdivision B—Approval requirements

113 Approval requirements

The Commissioner must not approve a residential care home in relation to an entity unless the Commissioner is satisfied that:

(a) the entity is a registered provider registered in the residential care category; and

(b) both of the following apply:

(i) the residential care home meets the definition of a residential care home in section 10;

(ii) the entity and the residential care home meet any other requirements prescribed by the rules.

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Division 3—Notice of decisions and other provisions

Subdivision A—Registration and renewal decisions

114 Notice of decision to register or renew

(1) This section applies if the Commissioner:

(a) decides under subsection 105(1) to register an entity as a registered provider; or

(b) decides under subsection 108(1) to renew an entity's registration as a registered provider, or to register the provider in any other provider registration categories.

(2) The Commissioner must, within 14 days after the day the decision is made:

(a) give the entity written notice of the decision; and

(b) record or update the details of the entity's registration on the Provider Register.

(3) The notice must include:

(a) details of the decision, including each provider registration category that the Commissioner has decided to register, or renew the registration of, the entity in; and

(b) the reasons for the decision; and

(c) the registration period; and

(d) the conditions to which the registration is subject under section 142; and

(e) the conditions (if any) to which the registration is subject under section 143; and

(f) any other matter prescribed by the rules.

Note: If the Commissioner decides to not register the entity in all the provider registration categories specified in the entity's application, the Commissioner must also give a notice of refusal under section 122.

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115 Registration period

(1) The registration period for a registered provider is the period that:

(a) starts at:

(i) if subparagraph (ii) does not apply—the start of the day the decision is made to register the provider under subsection 105(1); or

(ii) if the provider's registration (the ***initial registration***) is renewed—the start of the day after the day the initial registration expired; and

(b) ends at:

(i) if subparagraphs (ii) and (iii) do not apply—the end of the period of 3 years; or

(ii) if the Commissioner determines a shorter or longer registration period under subsection (2) and subparagraph (iii) does not apply—the end of that period; or

(iii) if the provider's registration is revoked—the end of the day on which the registration is revoked.

(2) For the purposes of subparagraph (1)(b)(ii), the Commissioner may determine a shorter or longer registration period if the Commissioner is satisfied that it is appropriate to do so having regard to all of the circumstances.

(3) This section does not apply in relation to a registered provider that is taken to be registered under section 117.

Note: If the System Governor determines that an entity is taken to be registered provider, the registration period is 3 months or such longer period as specified in the determination: see paragraph 117(2)(c).

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116 Extension of registration period—pending applications

(1) Subsection (2) applies if:

(a) the registration period for a registered provider will end on a particular day; and

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(b) the provider makes an application under subsection 107(1) within:
(i) the period specified in the invitation given to the provider under subsection 106(1); or
(ii) if the specified period has been extended under subsection 106(3)—the period as so extended.

(2) Despite paragraphs 114(3)(c) and 117(2)(c) (which relate to the registration period for a registered provider), the registration period ends immediately before the Commissioner makes a decision on the application under section 108.

117 Deemed registration

(1) The System Governor may determine, in writing, that an entity in a class of entities prescribed by the rules is taken to be registered as a registered provider.

(2) The determination must specify:
(a) the name of the entity; and
(b) the reasons for making the determination; and
(c) the registration period, being 3 months or such longer period as is specified in the determination; and
(d) the day on which the registration period starts; and
(e) each provider registration category in which the entity is taken to be registered under subsection 105(1); and
(f) if the entity is taken to be registered in the residential care category—each approved residential care home taken to be covered by the entity's registration; and
(g) the conditions to which the registration is subject under section 142; and
(h) any other matter prescribed by the rules.

(3) The System Governor must not make the determination unless the System Governor is satisfied that:
(a) any of the following applies:

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(i) a situation of emergency exists that could result in, or has resulted in, another entity being unable to deliver funded aged care services;

(ii) the determination would ensure that the delivery of certain funded aged care services does not cease, or will resume;

(iii) the determination would prevent a significant shortfall in the number of funded aged care services delivered in a locality or region; and

(b) any other requirements prescribed by the rules are met.

(4) The System Governor must give notice of the determination to the entity and the Commissioner.

(5) The Commissioner must record or update the details of the entity's registration on the Provider Register as soon as practicable after receiving the notice.

Determinations not legislative instruments

(6) A determination under subsection (1) is not a legislative instrument.

Subdivision B—Residential care home approval decisions

118 Notice of decision to approve residential care home

(1) If the Commissioner decides under subsection 112(1) to approve a residential care home in relation to a registered provider, the Commissioner must, within 14 days after the day the decision is made, give the provider written notice of the decision.

(2) The notice must include:

(a) details of the decision; and

(b) the reasons for the decision; and

(c) any other matter prescribed by the rules.

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Note: If the Commissioner decides to not approve all the residential care homes specified in the entity's application, the Commissioner must also give a notice of refusal under section 122.

119 Approval period

The approval period for an approved residential care home is the period that:

(a) starts on the day the decision is made to approve the home in relation to a registered provider under subsection 112(1); and

(b) ends at:

(i) if subparagraph (ii) does not apply—the end of the day on which the home is no longer covered by the registration of any registered provider; or

(ii) if the approval is revoked—the end of the day on which the approval is revoked.

120 Deemed approval

(1) The System Governor may determine, in writing, that a residential care home is taken to be approved in relation to a registered provider.

(2) The determination must specify:

(a) the name of the registered provider; and

(b) the name and address of the residential care home; and

(c) the total number of beds to be covered by the approval; and

(d) the reasons for making the determination; and

(e) the approval period, being 3 months or such longer period as is specified in the determination; and

(f) the day on which the approval period starts; and

(g) any other matter prescribed by the rules.

(3) The System Governor must not make the determination unless the System Governor is satisfied that:

(a) both of the following apply:

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(i) the home meets the definition of a residential care home in section 10;

(ii) the provider and the home meet any other requirements prescribed by the rules; and

(b) either of the following applies:

(i) a situation of emergency exists that could result in, or has resulted in, the provider being unable to deliver funded aged care services in another approved residential care home;

(ii) the provider is taken to be registered in the residential care category under section 117 and the approval is necessary for the provider to deliver a service type that is in that category; and

(c) any other requirements prescribed by the rules are met.

(4) The System Governor must give notice of the determination to the provider and the Commissioner.

(5) The Commissioner must update the details of the registered provider's registration on the Provider Register as soon as practicable after receiving the notice.

Determinations not legislative instruments

(6) A determination under subsection (1) is not a legislative instrument.

Subdivision C—Refusal decisions

121 Notice of possible refusal

(1) The Commissioner must give written notice to an entity:

(a) if the entity has made an application under subsection 104(1)—before the Commissioner decides to not register the entity in all of the provider registration categories specified in the entity's application; and

(b) if the entity has made an application under subsection 107(1)—before the Commissioner decides to not

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register, or not renew the registration of, the entity in all of the provider registration categories specified in the entity's application; and

(c) if the entity has made an application under subsection 111(1)—before the Commissioner decides to not approve all of the residential care homes specified in the entity's application.

(2) The notice must:

(a) set out the reasons why the Commissioner is considering making the decision; and

(b) invite the entity to make submissions, in writing, to the Commissioner in relation to the matter within 14 days after receiving the notice, or such longer period as is specified in the notice; and

(c) inform the entity that the Commissioner may, after considering any submissions made by the entity, still make the decision.

(3) The Commissioner must consider any submissions made by the entity in accordance with the notice.

122 Notice of refusal decisions

(1) The Commissioner must give written notice to an entity of any of the following decisions:

(a) a decision under subsection 105(1) to not register the entity in a provider registration category;

(b) a decision under subsection 105(1) to not register the entity in any provider registration category;

(c) a decision under subsection 108(1) to not register, or not renew the registration of, the entity in a provider registration category;

(d) a decision under subsection 108(1) to not register, or not renew the registration of, the entity in any provider registration category;

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(e) a decision under subsection 112(1) to not approve a residential care home.

(2) The notice must be given within 14 days after the day the decision is made.

(3) The notice must include:
(a) details of the decision; and
(b) the reasons for the decision; and
(c) how the entity may apply for reconsideration of the decision.

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Part 3—Variations, suspensions and revocations

Division 1—Variations, suspensions and revocations of registrations

123 Variation of registration on Commissioner's own initiative

(1) The Commissioner may, at any time and on the Commissioner's own initiative, vary the registration of a registered provider to:

(a) vary or revoke a condition to which the registration is subject under section 143; or

(b) impose a new condition to which the registration is subject under that section; or

(c) remove the provider from being registered in a provider registration category; or

(d) reduce or extend the registration period; or

(e) remove an approved residential care home from the approved residential care homes covered by the registration.

(2) However, the Commissioner must not vary the registration of a registered provider under subsection (1) unless the Commissioner considers it appropriate in all the circumstances to do so.

124 Variation of registration on application by registered provider

(1) The Commissioner may, on application by a registered provider, vary the registration of a registered provider to:

(a) register the provider in a new provider registration category; or

(b) remove the provider from being registered in a provider registration category; or

(c) vary or revoke a condition to which the registration is subject under section 143; or

(d) impose a new condition to which the registration is subject under that section; or

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(e) add a new approved residential care home in relation to the provider to be covered by the registration; or

(f) remove an approved residential care home from the approved residential care homes covered by the registration.

(2) The application must:

(a) be in the approved form; and

(b) be accompanied by the application fee (if any) prescribed by the rules.

Note: The Commissioner is not required to make a decision on the application if this subsection is not complied with (see section 589).

Requirements for variations

(3) However, the Commissioner must not vary the registration unless:

(a) the Commissioner considers it appropriate in all the circumstances to do so; and

(b) for a variation to register the provider in a new provider registration category—the Commissioner is satisfied of all the matters referred to in subsection 109(2) in relation to the provider and the category.

Additional considerations for adding or removing approved residential care homes

(4) In deciding whether to add a new approved residential care home to be covered by a registered provider's registration, the Commissioner must have regard to:

(a) whether the home is covered by another registered provider's registration; and

(b) if so—whether the other provider has put appropriate arrangements in place to ensure continuity of care for individuals at the home.

Note: A registered provider must comply with any requirements prescribed by the rules relating to continuity of funded aged care services for individuals: see section 149.

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(5) In deciding whether to remove an approved residential care home from the approved residential care homes covered by a registered provider's registration, the Commissioner must have regard to whether the provider has put appropriate arrangements in place to ensure continuity of care for individuals at the home.

Note: A registered provider must comply with any requirements prescribed by the rules relating to continuity of funded aged care services for individuals: see section 149.

125 Notice of possible variation of registration on Commissioner's own initiative

(1) Before the Commissioner decides to vary the registration of a registered provider under subsection 123(1) in a way that may have a significant adverse impact on the provider's delivery of funded aged care services, the Commissioner must, by written notice, notify the registered provider that the Commissioner is considering making that decision.

Note: An example of a variation that would have a significant adverse impact on the provider's delivery of funded aged care services includes the removal of an approved residential care home from the provider's registration.

(2) Subsection (1) does not apply if:

(a) the decision is to:

(i) vary or revoke a condition to which the registration is subject under section 143; or

(ii) impose a new condition to which the registration is subject under that section; and

(b) the Commissioner reasonably believes that, if the decision is not made, there will be an immediate and severe risk to the safety, health or well-being of one or more individuals to whom the registered provider is delivering funded aged care services.

(3) The notice must:

(a) set out the reasons why the Commissioner is considering making the decision; and

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(b) invite the registered provider to make submissions, in writing, to the Commissioner in relation to the matter within 14 days after receiving the notice, or such longer period as is specified in the notice; and

(c) inform the registered provider that the Commissioner may, after considering any submissions made by the registered provider, decide to vary the registration of the registered provider.

(4) The Commissioner must consider any submissions made by the registered provider in accordance with the notice.

126 Notice of possible refusal to vary registration on application by registered provider

(1) Before the Commissioner decides to not vary the registration of a registered provider under subsection 124(1), the Commissioner must, by written notice, notify the registered provider that the Commissioner is considering making that decision.

(2) The notice must:

(a) set out the reasons why the Commissioner is considering making the decision; and

(b) invite the registered provider to make submissions, in writing, to the Commissioner in relation to the matter within 14 days after receiving the notice, or such longer period as is specified in the notice; and

(c) inform the registered provider that the Commissioner may, after considering any submissions made by the registered provider, decide not to vary the registration of the registered provider.

(3) The Commissioner must consider any submissions made by the registered provider in accordance with the notice.

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Section 127

127 Notice of decision to vary

(1) If the Commissioner decides under subsection 123(1) or 124(1) to vary the registration of a registered provider, the Commissioner must, within 14 days after the day the decision is made:
  (a) give the provider notice of the decision; and
  (b) update the details of the provider's registration on the Provider Register.

(2) The notice must include:
  (a) details of the decision; and
  (b) the reasons for the decision; and
  (c) if the decision was made under subsection 123(1)—the following:
    (i) if the reason, or one of the reasons, for the decision is that the Commissioner was satisfied the registered provider has contravened, is contravening, or is proposing to contravene, this Act—a description of the contravention;
    (ii) if the reason, or one of the reasons, for the decision is that the Commissioner was satisfied it was necessary to prevent a risk to the safety, health or well-being of one or more individuals to whom the registered provider is delivering funded aged care services—a description of the risk; and
  (d) the day on which the decision takes effect; and
  (e) how the registered provider may apply for reconsideration of the decision.

(3) A variation of the registration of a registered provider takes effect on the day specified in the notice given under paragraph (1)(a).

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128 Notice of decision not to vary

(1) If the Commissioner decides under subsection 124(1) not to vary the registration of a registered provider, the Commissioner must

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give notice of the decision to the provider within 14 days after the day the decision is made.

(2) The notice must include:

(a) details of the decision; and

(b) the reasons for the decision; and

(c) how the registered provider may apply for reconsideration of the decision.

129 Suspension of registration

Suspension on Commissioner's own initiative

(1) The Commissioner may, in writing, suspend the registration of an entity as a registered provider for a specified period if:

(a) the Commissioner reasonably believes that the entity has contravened, is contravening, or is proposing to contravene, this Act; or

(b) the Commissioner reasonably believes that the application for registration by the entity contained information that was false or misleading in a material particular; or

(c) the entity is an insolvent under administration; or

(d) the Commissioner reasonably believes that the entity is no longer suitable to deliver funded aged care services, having regard to:

(i) the matters referred to in paragraph 109(1)(b); and

(ii) any other matters prescribed by the rules; or

(e) the Commissioner reasonably believes that the responsible persons of the entity are no longer suitable to be involved in the delivery of funded aged care services, having regard to:

(i) the suitability matters; and

(ii) any other matters prescribed by the rules; or

(f) a circumstance exists that is a circumstance prescribed by the rules.

Note 1: The conditions and obligations under Part 4 continue to apply to the entity during the suspension: see section 130.

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Note 2: For suitability matters in relation to individuals, see section 13.

(2) The period specified under subsection (1) must either:
  (a) not be longer than 90 days; or
  (b) be expressed to end upon the entity satisfying a specified condition.

(3) To avoid doubt, subsection (2) does not prevent the Commissioner suspending the registration of an entity as a registered provider more than once.

(4) In deciding whether to suspend the registration of an entity under subsection (1), the Commissioner must have regard to the following matters:
  (a) the nature, significance and persistence of any contravention, or proposed contravention, of this Act;
  (b) action that can be taken to address any contravention, or proposed contravention, of this Act;
  (c) the extent (if any) to which the entity is delivering funded aged care services in a way that may cause harm to, or jeopardise, public trust in the Commonwealth aged care system;
  (d) the safety, health or wellbeing of individuals accessing funded aged care services delivered by the entity;
  (e) any other matter the Commissioner considers relevant.

Suspension at the request of registered provider

(5) The Commissioner may, in writing, suspend the registration of an entity as a registered provider for a specified period if the entity requests the Commissioner, in writing, to suspend the registration.

Note: The conditions and obligations under Part 4 continue to apply to the entity during the suspension: see section 130.

(6) In deciding whether to suspend the registration of an entity under subsection (5), the Commissioner must consider whether appropriate arrangements are in place to ensure continuity of care

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for individuals to whom the provider is delivering funded aged care services.

130 Effect of registration while suspended

If an entity's registration as a registered provider is suspended for a period under section 129, the entity's registration is taken not to be in effect for that period.

Note: This means the registered provider will not be eligible for funding under Chapter 4.

131 Revocation of registration

Revocation on Commissioner's own initiative

(1) The Commissioner may, in writing, revoke the registration of an entity as a registered provider if:

(a) the Commissioner is satisfied that the entity has contravened, is contravening, or is proposing to contravene, this Act; or

(b) the application for registration by the entity contained information that was false or misleading in a material particular; or

(c) the entity is an insolvent under administration; or

(d) the Commissioner is satisfied that the entity is no longer suitable to deliver funded aged care services, having regard to:

(i) the matters referred to in paragraph 109(1)(b); and

(ii) any other matters prescribed by the rules; or

(e) the Commissioner is satisfied that the responsible persons of the entity are no longer suitable to deliver funded aged care services, having regard to:

(i) the suitability matters; and

(ii) any other matters prescribed by the rules; or

(f) a circumstance exists that is a circumstance prescribed by the rules.

Note: For suitability matters in relation to individuals, see section 13.

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(2) In deciding whether to revoke the registration of an entity under subsection (1), the Commissioner must have regard to the following matters:

(a) the nature, significance and persistence of any contravention, or proposed contravention, of this Act;

(b) action that can be taken to address any contravention, or proposed contravention, of this Act;

(c) the extent (if any) to which the entity is delivering funded aged care services in a way that may cause harm to, or jeopardise, public trust in the Commonwealth aged care system;

(d) the safety, health or wellbeing of individuals accessing funded aged care services delivered by the entity;

(e) any other matter the Commissioner considers relevant.

Revocation at the request of registered provider

(3) The Commissioner may, in writing, revoke the registration of an entity as a registered provider if the entity requests the Commissioner, in writing, to revoke the registration.

(4) In deciding whether to revoke the registration of an entity under subsection (3), the Commissioner must consider whether appropriate arrangements are in place to ensure continuity of care for individuals to whom the provider is delivering funded aged care services.

Note: The rules may provide that certain requirements under this Act continue to apply in relation to an entity that has ceased to be a registered provider: see subsections 602(8) and (9).

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132 Notice of possible suspension or revocation on Commissioner's own initiative

(1) Before the Commissioner decides to suspend or revoke the registration of a registered provider under subsection 129(1) or 131(1), the Commissioner must, by written notice, notify the provider that the Commissioner is considering making that decision.

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(2) The notice must:

(a) set out the reasons why the Commissioner is considering making the decision; and

(b) invite the registered provider to make submissions, in writing, to the Commissioner in relation to the matter within 14 days after receiving the notice, or such longer period as is specified in the notice; and

(c) inform the registered provider that if no submissions are made within the period specified in the notice, any suspension or revocation may take effect as early as 7 days after the end of that period.

(3) In deciding whether to suspend or revoke the registration, the Commissioner must consider any submissions made by the registered provider in accordance with the notice.

133 Registered provider may be required to agree to certain matters if revocation is being considered

(1) This section applies if the Commissioner:

(a) is considering revoking the registration of a registered provider under subsection 131(1); and

(b) has given the provider a notice under subsection 132(1); and

(c) has considered any submissions made by the provider in accordance with the notice.

(2) Before the Commissioner decides to revoke the registration, the Commissioner may, by written notice:

(a) require the provider to agree, in writing, to do any one or more things specified in the notice; and

(b) inform the provider that, if the provider does not agree to do those specified things in accordance with the notice, the Commissioner will revoke the registration.

Note: The Commissioner may also impose a condition on the provider under section 143 to comply with the agreement. Failure to comply with that condition may result in a contravention of subsection 142(3) or (4).

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(3) For the purposes of subsection (2), the following are the kinds of things that the Commissioner may require a registered provider to do in a notice given under that subsection:

(a) to appoint, within the period specified in the notice and with the agreement of the Commissioner, a person (an ***eligible adviser***) who has appropriate qualifications, skills or experience to assist the provider to comply with the provider's conditions and obligations under Part 4 in relation to either or both of the following matters:

(i) the funded aged care services delivered by the provider;

(ii) the governance and business operations of the provider;

(b) to give an eligible adviser appointed by the provider for that purpose all the necessary information required by the adviser to provide that assistance;

(c) to do any other things prescribed by the rules.

(4) The rules may:

(a) prescribe one or more classes of persons who must not be appointed by a registered provider as an eligible adviser; and

(b) specify matters that the Commissioner must take into account in specifying a period in a notice given under subsection (2) for the purposes of paragraph (3)(a).

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134 Notice of Commissioner initiated suspension or revocation

Notice of decision

(1) The Commissioner must notify a registered provider, in writing, of a decision to suspend or revoke the registration of the provider under subsection 129(1) or 131(1) within 14 days after the day the decision is made.

(2) The notice under subsection (1) must include:

(a) details of the decision; and

(b) the reasons for the decision; and

(c) how the registered provider may apply for reconsideration of the decision; and

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(d) if the decision is to suspend the registration of the registered provider:
  (i) the day the suspension takes effect (which must not be earlier than the day the notice is given); and
  (ii) the period for which the suspension is in force.

(3) The period specified under subparagraph (2)(d)(ii) must either:
  (a) not be longer than 90 days; or
  (b) be expressed to end upon the entity satisfying a specified condition.

Notice of revocation day

(4) Subject to subsection (6), if the decision is to revoke the registration of the registered provider, the Commissioner must also give the provider a written notice that specifies the day (the ***revocation day***) on which the revocation of the provider's registration takes effect.

(5) The notice under subsection (4):
  (a) must be given at least 7 days before the revocation day; and
  (b) may be given at the same time the notice under subsection (1) is given to the registered provider or at a later time.

(6) The Commissioner must not give a notice under subsection (4) to the registered provider unless the Commissioner is satisfied that appropriate arrangements are in place to ensure continuity of care for individuals to whom the provider is delivering funded aged care services.

Note: A registered provider must comply with any requirements prescribed by the rules relating to continuity of funded aged care services for individuals: see section 149.

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Section 135

135 Notice of suspension or revocation on request by registered provider

(1) The Commissioner must notify a registered provider, in writing, of a decision to suspend or revoke the registration of the provider under subsection 129(5) or 131(3) within 14 days after the day the decision is made.

(2) The notice must include:

(a) the day the suspension or revocation takes effect (which must not be earlier than the day the notice is given); and

(b) for a suspension—the period for which the suspension is in force.

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Division 2—Variations, suspensions and revocations of approvals of residential care homes

136 Variation of approval on Commissioner's own initiative

(1) The Commissioner may, at any time and on the Commissioner's own initiative, vary the approval of an approved residential care home by varying the total number of beds covered by the approval.

(2) However, the Commissioner must not vary the approval of an approved residential care home under subsection (1) by reducing the total number of beds covered by the approval unless:

(a) the Commissioner is satisfied that the number of beds available in the home is likely to be reduced for the period prescribed by the rules; and

(b) the Commissioner considers it appropriate in all the circumstances to do so, having regard to the number of beds in the home reserved by individuals on the day the variation is made.

137 Variation of approval on application by registered provider

(1) The Commissioner may, on application by a registered provider, vary the approval of an approved residential care home in relation to the provider by varying the total number of beds covered by the approval.

(2) The application must:

(a) be in the approved form; and

(b) be accompanied by the application fee (if any) prescribed by the rules.

Note: The Commissioner is not required to make a decision on the application if this subsection is not complied with (see section 589).

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(3) However, the Commissioner must not vary the approval of an approved residential care home under subsection (1) by reducing the total number of beds covered by the approval unless:

(a) the Commissioner is satisfied that the number of beds available in the home is likely to be reduced for the period prescribed by the rules; and

(b) the Commissioner considers it appropriate in all the circumstances to do so, having regard to the number of beds in the home reserved by individuals on the day the variation is made.

138 Revocation of approval

Revocation on Commissioner's own initiative

(1) The Commissioner may, in writing, revoke the approval of an approved residential care home in relation to a registered provider if the Commissioner is satisfied that the home no longer meets the requirements in paragraph 113(b).

Revocation at the request of registered provider

(2) The Commissioner may, in writing, revoke the approval of an approved residential care home in relation to a registered provider if the provider requests the Commissioner, in writing, to revoke the approval.

Continuity of care

(3) In deciding whether to revoke the approval of an approved residential care home under subsection (1) or (2), the Commissioner must consider whether appropriate arrangements are in place to ensure continuity of care for individuals at the home.

Note: A registered provider must comply with any requirements prescribed by the rules relating to continuity of funded aged care services for individuals: see section 149.

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139 Notice of possible variation or revocation of approval on Commissioner's own initiative

(1) Before the Commissioner decides to vary or revoke the approval of an approved residential care home in relation to a registered provider under subsection 136(1) or 138(1), the Commissioner must, by written notice, notify the provider that the Commissioner is considering making that decision.

(2) The notice must:

(a) set out the reasons why the Commissioner is considering making the decision; and

(b) invite the registered provider to make submissions, in writing, to the Commissioner in relation to the matter within 14 days after receiving the notice, or such longer period as is specified in the notice; and

(c) inform the registered provider that if no submissions are made within the period specified in the notice, any variation or revocation may take effect as early as 7 days after the end of that period.

(3) In deciding whether to vary or revoke the approval, the Commissioner must consider any submissions given to the Commissioner in accordance with the notice.

140 Notice of variation or revocation of approval

Commissioner initiated decisions

(1) The Commissioner must notify a registered provider, in writing, of a decision to vary or revoke the approval of an approved residential care home in relation to the provider under subsection 136(1) or 138(1) within 14 days after the day the decision is made.

(2) The notice under subsection (1) must include:

(a) details of the decision; and

(b) the reasons for the decision; and

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(c) how the provider may apply for reconsideration of the decision; and
(d) the day on which the decision takes effect.

Decisions on request by registered provider

(3) The Commissioner must notify a registered provider, in writing, of a decision to vary or revoke the approval of an approved residential care home in relation to the provider under subsection 137(1) or 138(2) within 14 days after the day the decision is made.

(4) The notice under subsection (3) must include the day on which the decision takes effect (which must not be earlier than the day the notice is given).

Effect of variation or revocation

(5) A variation or revocation of the approval of an approved residential care home takes effect on the day specified in the notice under subsection (1) or (3).

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Division 3—Provider Register

141 Provider Register

(1) The Commissioner must establish and maintain a register for the purposes of this Act, to be known as the Provider Register.

(2) The Provider Register may be kept in any form that the Commissioner considers appropriate.

(3) The Provider Register must include each of the following in relation to the registration of a registered provider:

(a) the name of the provider;

(b) the name of each responsible person of the provider;

(c) the ABN of the provider;

(d) the business location of the provider;

(e) the registration period;

(f) each provider registration category the provider is registered in;

(g) the provider's intended service types;

(h) any specialist aged care program under which the provider delivers funded aged care services;

(i) if the provider is registered in the residential care category—the name and address of each approved residential care home covered by the registration;

(j) if the provider delivers funded aged care services in a home or community setting—each local government area in which the provider delivers those services;

(k) the conditions (if any) to which the registration is subject under section 143;

(l) whether the registration is in force or is suspended;

(m) if the provider has given an undertaking under section 114 of the Regulatory Powers Act (as applied by section 458 of this Act)—information about the undertaking;

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(n) if a compliance notice has been given to the provider under section 481 or 482—information about the compliance notice;
(o) if a banning order against the provider is in force under section 497—information about the banning order;
(p) any other matter prescribed by the rules.

(4) The Provider Register may include any of the following in relation to an entity who was a registered provider:
(a) the name of the entity;
(b) the entity's ABN;
(c) the address of the entity;
(d) if the entity was a registered provider and the entity's registration was revoked on the Commissioner's own initiative—information about the revocation;
(e) any other matter prescribed by the rules.

(5) The Provider Register must include each of the following in relation to a responsible person, or an aged care worker, of a registered provider against whom a banning order is in force under section 498:
(a) the name of the person or worker;
(b) the person's or worker's ABN (if any);
(c) information about the banning order;
(d) any other matter prescribed by the rules.

(6) The Provider Register may include each of the following in relation to a responsible person, or an aged care worker, of a registered provider against whom a banning order was in force under section 498:
(a) the name of the person or worker;
(b) the person's or worker's ABN (if any);
(c) information about the banning order;
(d) any other matter prescribed by the rules.

(7) The Commissioner may publish on the Commission's website:

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(a) the Provider Register, in whole or in part; or
(b) any of the information entered on the Provider Register.

(8) The rules may make provision for and in relation to the following:
(a) the correction of entries in the Provider Register;
(b) the publication of the Provider Register in whole or in part, or of specified information entered on the Provider Register;
(c) certificates of registration, including procedures for issuing certificates of registration to registered providers;
(d) any other matter relating to the administration or operation of the Provider Register.

(9) The Provider Register is not a legislative instrument.

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Part 4—Obligations of registered providers etc. and conditions on registration of registered providers

Division 1—Conditions on provider registration

Subdivision A—Compliance with conditions

142 Conditions of registration

(1) The registration of a registered provider is subject to the following conditions:

(a) the conditions set out in this Division that apply in relation to the provider;

(b) any conditions prescribed by the rules that apply in relation to the provider;

(c) any conditions imposed on the registration by the Commissioner under section 143.

Note: The conditions set out in this Division may only apply to certain kinds of registered providers or certain provider registration categories.

(2) Without limiting paragraph (1)(b), the rules may prescribe different requirements for different kinds of registered providers.

Note: For example, the rules might prescribe different rules for registered providers in different provider registration categories or registered providers delivering funded aged care services under different specialist aged care programs.

(3) An entity contravenes this subsection if:

(a) the entity is a registered provider; and

(b) the entity engages in conduct; and

(c) the conduct breaches a condition to which the entity's registration is subject.

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Civil penalty: 250 penalty units.

(4) An entity contravenes this subsection if:
- (a) the entity is a registered provider; and
- (b) the entity engages in conduct; and
- (c) the conduct breaches a condition to which the entity's registration is subject; and
- (d) the conduct:
  - (i) involves a significant failure; or
  - (ii) is part of a systematic pattern of conduct.

Civil penalty: 500 penalty units.

143 Conditions imposed by the Commissioner

(1) The Commissioner may impose conditions on the registration of a registered provider.

(2) A condition may be imposed:
- (a) at the time of registration; or
- (b) at a later time in accordance with subsection 123(1) or 124(1).

(2A) The Commissioner must not impose a condition unless the condition is of a kind that is prescribed by the rules.

(2B) Subsection (2A) does not apply to a condition covered by subsection (3).

(3) The conditions covered by this subsection are conditions relating to the following matters:
- (a) the quality and safety of funded aged care services delivered by a registered provider;
- (b) the rules made for the purposes of subsection 110(1) (which deals with audit requirements);
- (c) any additional reporting requirements that a registered provider must comply with;

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(d) the Financial and Prudential Standards;
(e) the Aged Care Code of Conduct;
(f) requirements relating to the funded aged care services that a registered provider may or may not deliver;
(g) compliance with an agreement referred to in paragraph 133(3)(a) (eligible advisers).

Subdivision B—Conditions relating to Rights, Principles and Code of Conduct

144 Rights and principles

Rights

(1) It is a condition of registration that a registered provider of a kind prescribed by the rules must:
(a) demonstrate that the provider understands the rights of individuals under the Statement of Rights; and
(b) have in place practices to ensure that the provider acts compatibly with the Statement of Rights, in accordance with subsection 24(2) (acting compatibly with the Statement of Rights).

Principles—person-centred aged care system

(2) It is a condition of registration that a registered provider of a kind prescribed by the rules must demonstrate that the provider understands that the safety, health, wellbeing and quality of life of individuals is the primary consideration in the delivery of funded aged care services.

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145 Aged Care Code of Conduct

It is a condition of registration that a registered provider must:
(a) comply with the Aged Care Code of Conduct; and

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(b) take reasonable steps to ensure that the aged care workers, and the responsible persons, of the registered provider comply with the Aged Care Code of Conduct.

Subdivision C—Conditions relating to delivery of funded aged care services

146 Compliance with Aged Care Quality Standards

It is a condition of registration that a registered provider of a kind prescribed by the rules must comply with the Aged Care Quality Standards.

147 Continuous improvement

(1) It is a condition of registration that a registered provider of a kind prescribed by the rules must demonstrate the capability for, and commitment to, continuous improvement towards the delivery of high quality care.

(2) It is a condition of registration that a registered provider of a kind prescribed by the rules must have a continuous improvement plan.

148 Delivery of funded aged care services

It is a condition of registration that a registered provider of a kind prescribed by the rules must:

(a) deliver funded aged care services in accordance with any applicable requirements prescribed by the rules; and

(b) maintain and manage any residential care homes in accordance with any applicable requirements prescribed by the rules; and

(c) have an agreement with each individual accessing funded aged care services (a ***service agreement***) in accordance with any applicable requirements prescribed by the rules; and

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(d) deliver funded aged care services to each individual in accordance with that agreement; and

(e) have a plan about the delivery of funded aged care services to an individual (a ***care and services plan***) for each individual accessing funded aged care services in accordance with any applicable requirements prescribed by the rules; and

(f) deliver funded aged care services:

(i) in accordance with the description of each service in the list of services prescribed by the rules for the purposes of subsection 8(1); and

(ii) for a funded aged care service delivered through the residential care service group—in an approved residential care home.

149 Starting and ceasing the provision of funded aged care services and continuity of those services

It is a condition of registration that a registered provider must comply with any requirements prescribed by the rules relating to the following:

(a) starting the delivery of funded aged care services to an individual;

(b) providing a notification to the System Governor and the Commissioner about starting the delivery of funded aged care services to an individual (a ***start notification***);

(c) ceasing the delivery of funded aged care services to an individual;

(d) providing a notification to the System Governor and the Commissioner about ceasing the delivery of funded aged care services to an individual (a ***cessation notification***);

(e) ceasing to deliver any funded aged care services;

(f) if the provider delivers funded aged care services in an approved residential care home—security of tenure for individuals accessing those services;

(g) continuity of funded aged care services for individuals.

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Subdivision D—Conditions relating to financial matters

150 Compliance with Financial and Prudential Standards

(1) It is a condition of registration that a registered provider must comply with the provisions of the Financial and Prudential Standards that apply to the provider.

(2) It is a condition of registration that a registered provider of a kind prescribed by the rules must comply with any additional prudential requirements prescribed by the rules.

150A Refundable deposit register

(1) It is a condition of registration that a registered provider of a kind prescribed by the rules:

(a) establish and maintain, in accordance with any requirements prescribed by the rules, a register (a ***refundable deposit register***) that includes the information or records prescribed by the rules relating to refundable deposits, accommodation bonds or entry contributions paid to, or held by, the registered provider; and

(b) do so in a manner consistent with the requirements in section 168.

(2) Without limiting subsection (1), the rules may prescribe that information or records relating to the following be included in the refundable deposit register:

(a) information relating to the payment of a refundable deposit, accommodation bond or entry contribution;

(b) information relating to amounts deducted from a refundable deposit balance, accommodation bond balance or entry contribution balance;

(c) information relating to refunds of a refundable deposit balance, accommodation bond balance or entry contribution balance.

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Section 151

151 Fees, payments, contributions and subsidies

It is a condition of registration that a registered provider must comply with:

(a) Chapter 4 of this Act; and

(b) any requirements prescribed by the rules relating to matters dealt with in that Chapter.

Note: For example, there are requirements in Chapter 4 relating to prices and amounts that may be charged by providers to individuals accessing funded aged care services.

Subdivision E—Conditions relating to aged care workers

152 Workforce and aged care worker requirements

(1) It is a condition of registration that a registered provider of a kind prescribed by the rules must:

(a) comply with the worker screening requirements prescribed by the rules; and

(b) ensure that aged care workers and responsible persons of the provider comply with the worker screening requirements prescribed by the rules; and

(c) ensure that aged care workers meet any qualifications and training requirements prescribed by the rules; and

(d) ensure that aged care workers are given opportunities to develop their capability to provide funded aged care services; and

(e) ensure that aged care workers meet any other requirements prescribed by the rules.

(2) Without limiting subsection (1), worker screening requirements prescribed by rules made for the purposes of paragraph (1)(a) or (b) may include requirements relating to aged care workers whose normal duties include the direct delivery to an individual of a funded aged care service specified in an instrument in force under subsection (3).

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(3) The Commissioner may, by notifiable instrument, specify funded aged care services for the purposes of subsection (2).

153 Vaccination

(1) It is a condition of registration that a registered provider of a kind prescribed by the rules must, in accordance with any requirements prescribed by the rules:

(a) provide access to the vaccinations mentioned in subsection (2) for free to:

(i) individuals to whom the provider is delivering funded aged care services; and

(ii) aged care workers of the provider who access, or are reasonably likely to access, any premises where the delivery of funded aged care services occurs (***service staff***); and

(b) promote the benefits, for the individuals and service staff mentioned in paragraph (a), of those individuals and service staff receiving the vaccinations mentioned in subsection (2).

(2) For the purposes of subsection (1), the vaccinations are the following:

(a) an influenza vaccination;

(b) a COVID-19 vaccination;

(c) any other vaccination prescribed by the rules.

Subdivision F—Conditions relating to information and access

154 Personal information and record keeping

It is a condition of registration that a registered provider must:

(a) keep, and retain, the kinds of records prescribed by the rules, in accordance with any requirements prescribed by the rules; and

(b) do so, in a manner consistent with the requirements in section 168.

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Section 155

155 Provision of information to individuals

(1) It is a condition of registration that a registered provider must provide and explain records and information of a kind prescribed by the rules to individuals accessing, or seeking to access, funded aged care services, in accordance with any requirements prescribed by the rules.

Note: Information or documents may also be required to be given to a supporter of an individual: see section 29.

(2) It is a condition of registration that a registered provider of a kind prescribed by the rules must:

(a) allow and facilitate access by an individual to whom the registered provider delivers funded aged care services to records and information (including personal information) held by the registered provider about the individual; and

(b) do so in accordance with any requirements prescribed by the rules.

156 Access by supporters and independent aged care advocates etc.

Access to individuals

(1) It is a condition of registration that a registered provider of a kind prescribed by the rules must:

(a) allow and facilitate access by the following persons to an individual to whom the provider delivers funded aged care services:

(i) a supporter of the individual;

(ii) a relevantly qualified person providing legal advice or another legal service to the individual;

(iii) an independent aged care advocate;

(iv) an aged care volunteer visitor; and

(b) do so in accordance with any requirements prescribed by the rules.

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Note: For example, the rules might prescribe a requirement for a provider delivering services in a residential care home to allow a supporter of an individual access (whether physically, by video link or other means) to the individual at any time.

Access to settings

(2) It is a condition of registration that a registered provider of a kind prescribed by the rules must:

(a) allow and facilitate access by independent aged care advocates to a setting in which the provider delivers funded aged care services; and

(b) do so in accordance with any requirements prescribed by the rules.

Note: For example, the rules might prescribe a requirement for a registered provider delivering funded aged care services in a residential care home to allow independent aged care advocates access to the home to educate individuals accessing funded aged care services in the home about their rights and the availability of their advocacy services.

Access to records

(3) It is a condition of registration that a registered provider must:

(a) allow and facilitate access by an independent aged care advocate to records and information (including personal information) held by the registered provider about an individual to whom:

(i) the registered provider delivers funded aged care services; and

(ii) the independent aged care advocate provides advocacy;

if the individual has the right to access the records and information and consents to the independent aged care advocate being given access to the records and information; and

(b) do so in accordance with the requirements in section 168 and any requirements prescribed by the rules.

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Additional matters

(4) For the purposes of paragraphs (1)(a) and (2)(a), if the services are delivered to an individual in a home or community setting, the requirement to allow and facilitate access to the individual or setting (as applicable) only applies in relation to the times during which the provider delivers those services.

Note: For example, the rules might prescribe a requirement for a provider delivering services in a home or community setting to allow an independent aged care advocate to, with the consent of an individual, be present (whether physically, by video link or other means) when services are delivered to the individual.

(5) Without limiting paragraph (1)(b), (2)(b) or (3)(b), the rules may:
(a) prescribe different requirements for different kinds of registered providers; or
(b) different requirements for different kinds of settings.

(6) Subsections (1) and (2) do not limit each other.

(7) To avoid doubt, access to a setting may include access to one or more individuals accessing funded aged care services in that setting.

Subdivision G—Conditions relating to governance

157 Membership of governing bodies

(1) Subsection (2) applies to a registered provider other than a registered provider that is:
(a) a government entity; or
(b) a local government authority.

(2) Subject to subsections (3) and (4), it is a condition of registration that a registered provider must ensure that:
(a) if the provider is a registered provider of a kind prescribed by the rules—a majority of the members of the governing body of the provider are independent non-executive members; and

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(b) if the provider is a registered provider of a kind prescribed by the rules—at least one member of the governing body of the provider has experience in the provision of clinical care.

(3) Subsection (2) does not apply in relation to a registered provider at a particular time if both of the following apply at that time:
(a) the governing body of the provider has fewer than 5 members;
(b) the provider delivers funded aged care services to fewer than 40 individuals.

(4) Paragraph (2)(a) or (b) does not apply in relation to a registered provider at a particular time if a determination under section 159 that the requirement set out in that paragraph does not apply in relation to the provider is in force at that time.

(5) It is a condition of registration that a registered provider of a kind prescribed by the rules must comply with any requirements relating to membership of governing bodies prescribed by the rules.

158 Advisory body requirements

(1) This section applies to a registered provider other than a registered provider that is:
(a) a government entity; or
(b) a local government authority.

(2) It is a condition of registration that a registered provider of a kind prescribed by the rules must:
(a) establish, and continue in existence, a body (the ***quality care advisory body***) that:
(i) complies with the requirements about membership prescribed by the rules; and
(ii) is required, at least once every 6 months, to give the governing body of the provider a written report about the quality of the funded aged care services delivered by

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the provider in accordance with any requirements prescribed by the rules; and

(iii) is able, at any time, to give feedback to the governing body of the provider about the quality of the funded aged care services delivered by the provider; and

(b) require the governing body of the provider:

(i) to consider such a report, or any such feedback, when making decisions in relation to the quality of the funded aged care services delivered by the provider; and

(ii) to advise, in writing, the quality care advisory body how the governing body considered such a report or any such feedback.

(3) A registered provider must, if requested to do so by the quality care advisory body, give the body information about the quality of the funded aged care services delivered by the provider.

(4) It is a condition of registration that a registered provider of a kind prescribed by the rules must:

(a) offer, in writing, at least once every 12 months, individuals accessing funded aged care services and their supporters the opportunity to establish one or more bodies (the ***consumer advisory bodies***) to give the governing body of the provider feedback about the quality of the funded aged care services delivered by the provider; and

(b) if one or more consumer advisory bodies are established—require the governing body of the provider:

(i) to consider any such feedback given by the body or bodies when making decisions in relation to the quality of the funded aged care services delivered by the provider; and

(ii) to advise, in writing, the body or bodies how the governing body considered any such feedback.

(8) If an individual participates in a body established under this section (as a member of the body or otherwise):

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(a) the individual is not subject to any civil, criminal or administrative liability (including disciplinary action) for that participation; and

(b) no contractual or other remedy may be enforced, and no contractual or other right may be exercised, against the individual on the basis of that participation.

(9) Without limiting subsection (8), a contract to which the individual is a party may not be terminated on the basis that the participation constitutes a breach of the contract.

159 Determination that certain conditions relating to the governing body of a registered provider do not apply

Application for determination

(1) A registered provider may apply to the Commissioner for a determination that either or both of the following conditions (the ***governance conditions***) do not apply in relation to the provider:

(a) the condition set out in paragraph 157(2)(a);

(b) the condition set out in paragraph 157(2)(b).

(2) The application must:

(a) be in an approved form; and

(b) be accompanied by the application fee (if any) prescribed by the rules.

Note: The Commissioner is not required to make a decision on the application if this subsection is not complied with: see section 589.

Making of determination

(3) If a registered provider makes an application under subsection (1), the Commissioner may determine that either or both of the governance conditions do not apply in relation to the provider if the Commissioner is satisfied that it is reasonable to do so.

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(4) In deciding whether to make the determination in relation to the registered provider, the Commissioner may take into account the following matters:

(a) the number of funded aged care services that the provider delivers;

(b) the number of individuals to whom the provider delivers those services;

(c) the geographic area in which those services are delivered;

(d) the annual turnover in the provider's responsible persons;

(e) the membership of the governing body of the provider;

(f) any arrangements that the provider has made, or proposes to make, to assist:

(i) the members of the governing body of the provider to act objectively and independently in the best interests of the provider; or

(ii) the governing body of the provider to seek, when it considers it necessary to do so, advice from a person with experience in the provision of clinical care;

(g) any other requirements applying to the provider under a law of the Commonwealth or a law of a State or Territory in which the provider delivers funded aged care services;

(h) any other matter prescribed by the rules.

Notice of determination etc.

(5) If the Commissioner decides to make the determination in relation to the registered provider, the Commissioner must give the provider written notice of the following:

(a) the making of the determination;

(b) the governance condition to which the determination relates;

(c) the period for which the determination is in force.

Note: The determination may remain in force for a period specified by the Commissioner or until it is revoked under section 160.

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(6) If the Commissioner decides not to make the determination in relation to the registered provider, the Commissioner must give the provider written notice of the following:
  (a) the decision;
  (b) the reasons for the decision;
  (c) how the provider may apply for reconsideration of the decision.

160 Variation or revocation of determination on the Commissioner's own initiative

(1) The Commissioner may, on the Commissioner's own initiative, vary or revoke a determination made under subsection 159(3) in relation to a registered provider if the Commissioner is satisfied it is appropriate to do so.

(2) If the Commissioner decides to vary or revoke the determination in relation to the registered provider, the Commissioner must, as soon as is practicable, give the provider a written notice that:
  (a) sets out the decision; and
  (b) sets out the reasons for the decision; and
  (c) specifies the day on which the variation or revocation takes effect; and
  (d) states how the provider may apply for reconsideration of the decision.

161 Constitution of registered providers that are wholly-owned subsidiary corporations

Corporations under the Corporations Act 2001

(1) If:
  (a) a registered provider is a body corporate that is incorporated, or taken to be incorporated, under the *Corporations Act 2001*; and

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(b) the provider has a constitution (within the meaning of that Act); and

(c) the provider is a wholly-owned subsidiary (within the meaning of that Act) of another body corporate (the ***holding company***); and

(d) the holding company is not a registered provider;

it is a condition of registration that the registered provider must ensure that the constitution of the provider does not authorise a director of the provider to act in good faith in the best interests of the holding company.

Aboriginal and Torres Strait Islander corporations

(2) If:

(a) a registered provider is an Aboriginal and Torres Strait Islander corporation (within the meaning of the *Corporations (Aboriginal and Torres Strait Islander) Act 2006*); and

(b) the provider is a wholly-owned subsidiary (within the meaning of that Act) of another body corporate (the ***holding company***); and

(c) the holding company is not a registered provider;

it is a condition of registration that the registered provider must ensure that the constitution of the provider does not authorise a director of the provider to act in good faith in the best interests of the holding company.

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Subdivision H—Conditions relating to restrictive practices

162 Restrictive practices

It is a condition of registration that a registered provider of a kind prescribed by the rules must comply with any requirements prescribed by the rules relating to the use of restrictive practices in relation to an individual to whom the provider is delivering funded aged care services.

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163 Immunity from civil or criminal liability in relation to the use of a restrictive practice in certain circumstances

(1) This section applies if:

(a) an entity is a registered provider to whom section 162 applies; and

(b) a restrictive practice is used in relation to an individual; and

(c) the individual lacked capacity to give informed consent to the use of the restrictive practice.

(2) A protected entity is not subject to any civil or criminal liability for, or in relation to, the use of the restrictive practice in relation to the individual if, before 1 December 2026:

(a) informed consent to the use of the restrictive practice was given by a person or body prescribed by the rules made for the purposes of this paragraph; and

(b) the restrictive practice was used in accordance with any requirements prescribed by rules made for the purposes of section 162.

Note: This means a protected entity does not have immunity from liability if the restrictive practice was not used in accordance with the requirements prescribed by the rules.

(3) A ***protected entity*** means any of the following:

(a) the registered provider referred to in paragraph (1)(a);

(b) an individual who used, or assisted in the use of, the restrictive practice in relation to the individual referred to in paragraph (1)(b).

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Subdivision I—Conditions relating to management of incidents and complaints

164 Incident management

It is a condition of registration that a registered provider of a kind prescribed by the rules must:

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(a) implement and maintain an incident management system in accordance with any requirements prescribed by the rules; and

(b) manage, and take reasonable steps to prevent, incidents in accordance with any requirements prescribed by the rules; and

(c) not victimise or discriminate against anyone for reporting an incident.

165 Complaints, feedback and whistleblowers

(1) It is a condition of registration that a registered provider:

(a) implement and maintain a complaints and feedback management system in accordance with any requirements prescribed by the rules; and

(b) manage complaints and feedback in accordance with that system and any other requirements prescribed by the rules; and

(c) not victimise or discriminate against anyone for making a complaint or giving feedback; and

(d) implement and maintain a whistleblower system, and maintain a whistleblower policy, in accordance with any requirements prescribed by the rules; and

(e) manage disclosures that qualify for protection under section 547 (whistleblower protections) in accordance with any requirements prescribed by the rules; and

(f) if a complaint or feedback is also a disclosure that qualifies for protection under section 547—manage that disclosure in accordance with any requirements prescribed by the rules.

(2) Without limiting paragraph (1)(f), rules made for the purposes of that paragraph may provide that if a discloser (within the meaning of section 547) elects to have the disclosure managed as a complaint or feedback under paragraph (1)(b), the provider is required to manage the disclosure in accordance with that paragraph rather than paragraph (1)(e).

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Division 2—Registered provider, responsible person and aged care worker obligations

Subdivision A—Obligations relating to reporting, notifications and information

165A Reports about reportable incidents

Requirement to report

(1) A registered provider of a kind prescribed by the rules must, if the rules prescribe that reports relating to reportable incidents must be given to the Commissioner, report reportable incidents to the Commissioner in accordance with this section.

(2) A report under subsection (1) must:
  (a) be in the approved report form; and
  (b) be prepared, and given, in accordance with any other requirements prescribed by the rules.

Note: For ***approved report form***, see section 166A.

Civil penalty

(3) An entity contravenes this subsection if:
  (a) the entity is a registered provider; and
  (b) the entity fails to comply with subsection (1).

Note: A registered provider may commit an offence or contravene a civil penalty provision if the provider gives false or misleading information or documents (see Part 7.4 of the *Criminal Code* and section 591 of this Act).

Civil penalty: 250 penalty units.

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Section 166

166 Other reports by registered providers

Requirement to report

(1) A registered provider of a kind prescribed by the rules must, if the rules prescribe that a report must be given to one of the following persons, give a report to that person in accordance with this section:
  (a) the Commissioner;
  (b) the Complaints Commissioner;
  (c) the Inspector-General of Aged Care;
  (d) the System Governor;
  (e) the Pricing Authority.

(2) A report under subsection (1) must:
  (a) if the rules prescribe information that must be included in the report:
    (i) include that information; and
    (ii) be in the approved report form (if any); and
  (b) if paragraph (a) does not apply—be in the approved report form; and
  (c) in any case—be prepared, and given, in accordance with any other requirements prescribed by the rules.

Note: For ***approved report form***, see section 166A.

Prescribed information

(3) Without limiting paragraph (2)(a), the rules may prescribe information relating to any of the following:
  (a) complaints and feedback received by a registered provider;
  (b) the workforce, and governance, of a registered provider;
  (c) compliance by a registered provider with requirements relating to nursing services;
  (d) locations at which funded aged care services are delivered by a registered provider;

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(e) specified groups of individuals to whom a registered provider is delivering funded aged care services;

(f) how specified funded aged care services are delivered;

(g) specified financial and prudential matters.

Prescribed requirements relating to preparing and giving reports

(4) Without limiting paragraph (2)(c), the rules may prescribe requirements relating to either of the following:

(a) the collection or generation of information prescribed for the purposes of paragraph (2)(a) (including requirements relating to making particular measurements or assessments in connection with that collection or generation);

(b) reporting periods and the timeframes within which a report must be given in relation to those reporting periods (including by providing that a prescribed reporting period or timeframe is subject to an exemption determined by the System Governor in accordance with the rules).

Requirement to publish reports

(5) If the rules prescribe that a report given by a registered provider under subsection (1) must be published, the registered provider must publish the report in accordance with any requirements prescribed by the rules.

Civil penalty

(6) An entity contravenes this subsection if:

(a) the entity is a registered provider; and

(b) the entity fails to comply with subsection (1) or (5).

Note: A registered provider may commit an offence or contravene a civil penalty provision if the provider gives false or misleading information or documents (see Part 7.4 of the *Criminal Code* and section 591 of this Act).

Civil penalty: 250 penalty units.

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Section 166A

166A Approved report forms—section 165A and 166 reports

When a report is in the approved report form

(1) A report under section 165A or 166 is in the ***approved report form*** if:

(a) it is in a form approved under subsection (2) or (3) of this section for that kind of report by the person (the ***report recipient***) to whom the report is required to be given; and

(b) it contains the information that the form requires, and any further information, statement or document as the report recipient requires, whether in the form or otherwise; and

(c) it is given in the manner that the report recipient requires (which may include electronically).

Approval of forms

(2) The Commissioner may, in writing, approve a form for a kind of report under section 165A.

(3) Any of the following persons may, in writing, approve a form for a kind of report under section 166:

(a) the Commissioner;

(b) the Complaints Commissioner;

(c) the Inspector-General of Aged Care;

(d) the System Governor;

(e) the Pricing Authority.

(4) More than one kind of report may be combined in the same form approved under subsection (2) or (3).

(5) More than one form may be approved under subsection (2) or (3) for the same kind of report.

(6) A different form may be approved under subsection (2) or (3) for a kind of report for different circumstances.

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Publication of approved report forms and requirements

(7) If a form is approved under subsection (2) or (3), the person who approved the form must cause the following to be published on the Department's website:

(a) the form;

(b) any requirements mentioned in paragraphs (1)(b) and (c) relating to the kind of report that are not included in the form.

167 Change in circumstances

(1) A registered provider of a kind prescribed by the rules must give notice to the Commissioner of any change of a kind prescribed by the rules in accordance with any requirements prescribed by the rules.

(2) If circumstances prescribed by the rules apply, a notice under subsection (1) must also be given to the System Governor.

(3) Without limiting subsection (1), the rules may prescribe that a registered provider must give notice of a change in relation to the following:

(a) a change of circumstances or an event that materially affects the provider's suitability to be a registered provider taking into account the matters referred to in paragraph 109(1)(b) (which deals with suitability of registered providers);

(b) a change of circumstances that relates to a suitability matter in relation to a responsible person of the provider;

(c) a change in the responsible persons of the provider;

(d) a significant change in the organisation or governance arrangements of the provider;

(e) a significant change in the scale of the provider in relation to the funded aged care services delivered by the provider;

(f) a change in the service types delivered by the provider;

(g) specified changes relating to the associated providers of the provider;

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(h) specified changes to an approved residential care home;
(i) specified financial and prudential matters.

Note: See section 13 for the definition of ***suitability matter***.

(4) A notice under subsection (1) or (2) must:
(a) be given within 14 days after the registered provider becomes aware of the change in circumstances; and
(b) be in an approved form; and
(c) include any information prescribed by the rules in relation to a change of circumstances or event of a kind prescribed by the rules.

(5) An entity contravenes this subsection if:
(a) the entity is a registered provider; and
(b) the entity fails to comply with subsection (1) or (2).

Civil penalty: 30 penalty units.

168 Protection of personal information

(1) A registered provider must ensure the protection of personal information, relating to an individual to whom the registered provider delivers funded aged care services, including as follows:
(a) the personal information must not be used other than:
(i) for a purpose connected with the delivery of a funded aged care service to the individual by the registered provider; or
(ii) for a purpose for which the personal information was given by or on behalf of the individual to the registered provider;
(b) except with the consent of the individual, the personal information must not be disclosed to any other person other than:
(i) for a purpose connected with the delivery of a funded aged care service to the individual by the registered provider; or

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(ii) for a purpose connected with the delivery of a funded aged care service to the individual by an associated provider of the registered provider or another registered provider; or

(iii) for a purpose for which the personal information was given by or on behalf of the individual; or

(iv) for the purpose of complying with an obligation under this Act;

(c) the personal information must be protected by security safeguards that it is reasonable in the circumstances to take against the loss or misuse of the information.

(2) This section does not prevent personal information being given to a court, or to a tribunal, authority or person having the power to require the production of documents or the answering of questions, in accordance with a requirement of that court, tribunal, authority or person.

Subdivision B—Obligations relating to suitability of responsible persons

169 Responsible persons of a registered provider must notify of change of circumstances relating to suitability

(1) If:

(a) a person is one of the responsible persons of a registered provider of a kind prescribed by the rules; and

(b) the person becomes aware of a change of circumstances that relates to a suitability matter in relation to the person;

the person must notify the provider of the change.

(2) The notification must:

(a) be given in writing; and

(b) be given within 14 days after the person becomes aware of the change of circumstances; and

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(c) set out the details of the change of circumstances that relates to a suitability matter in relation to the person.

(3) A person commits an offence of strict liability if:

(a) the person is one of the responsible persons of a registered provider; and

(b) the person fails to comply with subsection (1).

Penalty: 30 penalty units.

170 Determination relating to suitability of responsible persons of a registered provider

Determination relating to suitability of responsible persons

(1) The Commissioner may, at any time, determine that a person who is one of the responsible persons of a registered provider is not suitable to be involved in the delivery of funded aged care services.

(2) In deciding whether to make the determination under subsection (1), the Commissioner must consider the suitability matters in relation to the person.

(3) Subsection (2) does not limit the matters the Commissioner may consider in deciding whether to make the determination under subsection (1) in relation the person.

Notice of intention to make determination

(4) Before the Commissioner makes the determination in relation to a person who is one of the responsible persons of the registered provider, the Commissioner must, by written notice, notify the person and the provider that the Commissioner is considering making such a determination.

(5) The notice must:

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(a) set out the reasons why the Commissioner is considering making the determination in relation to a person who is one of the responsible persons of the registered provider; and

(b) invite the person and the provider to make submissions, in writing, to the Commissioner in relation to the matter within:

(i) 14 days after receiving the notice; or

(ii) if a shorter period is specified in the notice—that shorter period; and

(c) inform the person and the provider that the Commissioner may, after considering any submissions made by them, decide to make the determination.

(6) The Commissioner must consider any submissions made by the person and the registered provider in accordance with the notice.

Notice of determination

(7) If the Commissioner decides to make the determination in relation to a person who is one of the responsible persons of the registered provider, the Commissioner must, within 14 days after making the decision, give the person and the provider a written notice that:

(a) sets out the decision; and

(b) sets out the reasons for the decision; and

(c) states that the provider must, within a specified period, take specified action to ensure that the person ceases to be one of the responsible persons of the provider; and

(d) sets out the effect of sections 171 and 172.

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171 Offence relating to failure to take action as required by determination

An entity commits an offence if:

(a) the entity is a registered provider; and

(b) the Commissioner makes a determination under subsection 170(1) in relation to a person who is one of the responsible persons of the registered provider; and

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(c) the entity fails to take the action specified in the notice of the determination within the period specified in that notice.

Note: Section 4K of the *Crimes Act 1914*, which deals with continuing and multiple offences, applies to this offence.

Penalty: 300 penalty units.

172 Offence relating to failure to comply with responsibility to consider suitability matters relating to responsible persons

(1) A registered provider of a kind prescribed by the rules must, in relation to a person who is one of the responsible persons of the registered provider:

(a) at least once every 12 months:

(i) consider the suitability matters in relation to the person in accordance with any requirements prescribed by the rules; and

(ii) be reasonably satisfied that the person is suitable to be involved in the delivery of funded aged care services; and

(b) keep a record of those matters that complies with any requirements prescribed by the rules; and

(c) comply with any other requirements prescribed by the rules.

(2) An entity commits an offence if:

(a) the entity is a registered provider; and

(b) the entity fails to comply with subparagraph (1)(a)(i).

Penalty: 300 penalty units.

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Subdivision C—Obligations relating to aged care workers etc.

173 Aged care workers of registered providers must comply with Aged Care Code of Conduct

(1) An aged care worker of a registered provider must comply with the Aged Care Code of Conduct.

(2) An aged care worker of a registered provider contravenes this subsection if the worker fails to comply with the Aged Care Code of Conduct.

Civil penalty: 250 penalty units.

174 Responsible persons of registered providers must comply with Aged Care Code of Conduct

(1) A responsible person of a registered provider must comply with the Aged Care Code of Conduct.

(2) A responsible person of a registered provider contravenes this subsection if the person fails to comply with the Aged Care Code of Conduct.

Civil penalty: 250 penalty units.

175 Registered nurses

(1) A registered provider must ensure that at least one registered nurse is on site, and on duty, at all times at an approved residential care home of the registered provider.

(2) Subsection (1) does not apply if:

(a) the System Governor grants the registered provider an exemption in accordance with any rules made for the purposes of subsection (3); or

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(b) the registered provider is delivering funded aged care services at the approved residential care home only under a specialist aged care program that is prescribed by the rules.

(3) The rules may make provision for, or in relation to, the granting of an exemption to the requirement in subsection (1).

(4) Without limiting subsection (3), rules made for the purposes of that subsection must:

(a) provide for the circumstances in which an exemption from subsection (1) may be granted (on application or otherwise) to a registered provider in relation to an approved residential care home; and

(b) provide that before granting such an exemption, the System Governor must be satisfied that the provider has taken reasonable steps to ensure that the clinical care needs of the individuals residing in the approved residential care home will be met during the period for which the exemption is in force; and

(c) provide that such an exemption that is granted to a registered provider in relation to an approved residential care home must not be in force for more than 12 months; and

(d) provide that more than one such exemption may be granted to a registered provider in relation to an approved residential care home; and

(e) provide for the conditions that may apply to such an exemption that is granted to a registered provider in relation to an approved residential care home.

(5) If an exemption from subsection (1) is granted to a registered provider in relation to an approved residential care home, the System Governor must make publicly available information about the exemption, including:

(a) the name of the registered provider and the approved residential care home; and

(b) the period for which the exemption is in force; and

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(c) any conditions that apply to the exemption; and
(d) any other information of a kind prescribed by the rules.

176 Delivery of direct care

A registered provider of a kind prescribed by the rules must deliver direct care in accordance with any requirements prescribed by the rules.

Subdivision D—Other obligations

177 Cooperation with other persons

(1) A registered provider must cooperate with any person who is performing functions, or exercising powers, under this Act.

Note: The expression ***this Act*** (see section 7) includes:
(a) legislative instruments made under this Act; and
(b) the Regulatory Powers Act as it applies in relation to this Act.

(2) A registered provider must cooperate with, and provide all reasonable facilities and assistance necessary to, any person who is undertaking activities mentioned in paragraph 131A(1)(c) of the *National Health Reform Act 2011* in accordance with any requirements prescribed by the rules, for the purposes of the Pricing Authority performing the function mentioned in paragraph 131A(1)(a) of that Act.

(3) Without limiting subsection (1) or (2), cooperating with a person includes providing access to any approved residential care home of the registered provider.

(4) An entity contravenes this subsection if:
(a) the entity is a registered provider; and
(b) the entity fails to comply with subsections (1) or (2).

Civil penalty: 30 penalty units.

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Section 178

178 Offences relating to non-permitted use of refundable deposits

Offence for registered provider

(1) An entity commits an offence if:
- (a) the entity is a registered provider; and
- (b) the entity uses a refundable deposit; and
- (c) the use of the refundable deposit is not permitted by section 310; and
- (d) at a particular time during the period of 5 years after the use of the refundable deposit, both of the following apply:
  - (i) an insolvency event (within the meaning of the *Aged Care (Accommodation Payment Security) Act 2006*) occurs in relation to the entity;
  - (ii) there is at least one outstanding accommodation payment balance (within the meaning of that Act) for the entity.

Penalty: 300 penalty units.

Offence for responsible persons

(2) A person commits an offence if:
- (a) the person is a responsible person of a registered provider (the ***entity***); and
- (b) the entity uses a refundable deposit; and
- (c) the use of the refundable deposit is not permitted by section 310; and
- (d) the person knew that, or was reckless or negligent as to whether:
  - (i) the refundable deposit would be used; and
  - (ii) the use of the refundable deposit was not permitted; and
- (e) the person was in a position to influence the conduct of the entity in relation to the use of the refundable deposit; and

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(f) the person failed to take all reasonable steps to prevent the use of the refundable deposit; and

(g) at a particular time during the period of 5 years after the use of the deposit, both of the following apply:

(i) an insolvency event (within the meaning of the *Aged Care (Accommodation Payment Security) Act 2006*) occurs in relation to the entity;

(ii) there is at least one outstanding accommodation payment balance (within the meaning of that Act) for the entity; and

(h) at the time the refundable deposit was used, the entity was a corporation.

Penalty: Imprisonment for 2 years.

Strict liability

(3) Strict liability applies to paragraphs (1)(d) and (2)(g) and (h).

178A Offences relating to non-permitted use of accommodation bonds

Offence for registered provider

(1) An entity commits an offence if:

(a) the entity is a registered provider; and

(b) the entity uses an accommodation bond; and

(c) the use of the accommodation bond is not permitted by rules made for the purposes of paragraph 287(3)(a); and

(d) at a particular time during the period of 5 years after the use of the accommodation bond, both of the following apply:

(i) an insolvency event (within the meaning of the *Aged Care (Accommodation Payment Security) Act 2006*) occurs in relation to the entity;

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(ii) there is at least one outstanding accommodation payment balance (within the meaning of that Act) for the entity.

Penalty: 300 penalty units.

Offence for responsible persons

(2) A person commits an offence if:

(a) the person is a responsible person of a registered provider (the ***entity***); and

(b) the entity uses an accommodation bond; and

(c) the use of the accommodation bond is not permitted by rules made for the purposes of paragraph 287(3)(a); and

(d) the person knew that, or was reckless or negligent as to whether:

(i) the accommodation bond would be used; and

(ii) the use of the accommodation bond was not permitted; and

(e) the person was in a position to influence the conduct of the entity in relation to the use of the accommodation bond; and

(f) the person failed to take all reasonable steps to prevent the use of the accommodation bond; and

(g) at a particular time during the period of 5 years after the use of the accommodation bond, both of the following apply:

(i) an insolvency event (within the meaning of the *Aged Care (Accommodation Payment Security) Act 2006*) occurs in relation to the entity;

(ii) there is at least one outstanding accommodation payment balance (within the meaning of that Act) for the entity; and

(h) at the time the accommodation bond was used, the entity was a corporation.

Penalty: Imprisonment for 2 years.

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Strict liability

(3) Strict liability applies to paragraphs (1)(d) and (2)(g) and (h).

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Part 5—Statutory duty and compensation

Division 1—Provider and responsible person duties

179 Registered provider duty

(1) A registered provider must ensure, so far as is reasonably practicable, that the conduct of the provider does not cause adverse effects to the health and safety of individuals to whom the provider is delivering funded aged care services while the provider is delivering those services.

(2) In this Act, ***reasonably practicable***, in relation to a duty imposed under this Part, means that which is, or was at a particular time, reasonably able to be done, taking into account and weighing up all relevant matters including:

(a) the likelihood of the adverse effect concerned occurring; and

(b) the likely degree of harm from the adverse effect; and

(c) what the person concerned knows, or ought reasonably to know, about ways of preventing the adverse effect; and

(d) the availability and suitability of ways to prevent the adverse effect; and

(e) the rights of individuals under the Statement of Rights.

Note: Under the Statement of Rights, an individual has a right to exercise choice and make decisions that affect the individual's life, including taking personal risks.

Serious failures

(3) A registered provider contravenes this subsection if:

(a) the provider has a duty under subsection (1); and

(b) the provider, without reasonable excuse, engages in conduct that does not comply with the duty; and

(c) the conduct amounts to a serious failure by the provider to comply with the duty.

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Civil penalty:

(a) in the case of a contravention by a registered provider that is an individual—150 penalty units; or

(b) in the case of a contravention by a registered provider other than an individual—1000 penalty units.

(4) Conduct of a registered provider amounts to a ***serious failure*** to comply with the duty in subsection (1) if:

(a) the conduct exposes an individual to whom the duty is owed a risk of death or serious injury or illness; and

(b) the conduct:

(i) involves a significant failure; or

(ii) is part of a systematic pattern of conduct.

Death or serious injury or illness

(5) A registered provider contravenes this subsection if:

(a) the provider has a duty under subsection (1); and

(b) the provider, without reasonable excuse, engages in conduct; and

(c) the conduct amounts to a serious failure by the provider to comply with the duty; and

(d) the conduct results in the death of, serious injury to or illness of an individual to whom the duty is owed.

Civil penalty:

(a) in the case of a contravention by a registered provider that is an individual—500 penalty units; or

(b) in the case of a contravention by a registered provider other than an individual—4,800 penalty units.

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180 Duty for certain responsible persons

(1) A person who is a responsible person of a registered provider under paragraph 12(1)(a) or (b) must exercise due diligence to ensure that the provider complies with the provider's duty under section 179.

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Section 180

(2) In this section, ***due diligence*** includes taking reasonable steps:

(a) to acquire and maintain knowledge of requirements applying to registered providers under this Act; and

(b) to gain an understanding of the nature of the funded aged care services the registered provider delivers and the potential adverse effects that can result to individuals when delivering those services; and

(c) to ensure that the registered provider has available for use, and uses, appropriate resources and processes to manage adverse effects to the health and safety of individuals accessing funded aged care services delivered by the provider; and

(d) to ensure that the registered provider has appropriate processes for receiving and considering information regarding incidents and risks and responding in a timely way to that information; and

(e) to ensure that the registered provider has, and implements, processes for complying with any duty or requirement of the registered provider under this Act.

(3) A person may be found liable to pay a civil penalty under this Act relating to a duty under this section whether or not the registered provider has been found liable to pay a civil penalty under section 179.

Serious failures

(4) A person contravenes this subsection if:

(a) the person has a duty under subsection (1); and

(b) the person, without reasonable excuse, engages in conduct that does not comply with the duty; and

(c) the conduct amounts to a serious failure by the person to comply with the duty.

Civil penalty: 150 penalty units.

(5) Conduct of a person amounts to a ***serious failure*** to comply with the duty in subsection (1) if:

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(a) the conduct exposes an individual to whom the duty is owed a risk of death or serious injury or illness; and

(b) the conduct:

(i) involves a significant failure; or

(ii) is part of a systematic pattern of conduct.

Death or serious injury or illness

(6) A person contravenes this subsection if:

(a) the person has a duty under subsection (1) in relation to a registered provider; and

(b) the person, without reasonable excuse, engages in conduct; and

(c) the conduct amounts to a serious failure by the person to comply with the duty; and

(d) the conduct results in the death of serious injury to or illness of an individual to whom the duty in section 179 is owed by the registered provider.

Civil penalty: 500 penalty units.

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Division 2—Other provisions that apply to duties

181 Duties not transferrable

A duty cannot be transferred to another entity.

182 Entity may have more than 1 duty

An entity can have more than 1 duty by virtue of being in more than 1 class of duty holder.

183 More than 1 entity can have a duty

(1) More than 1 entity can concurrently have the same duty.

(2) Each duty holder must comply with that duty to the standard required by this Act even if another duty holder has the same duty.

(3) If more than 1 entity has a duty for the same matter, each entity:
  (a) retains responsibility for the entity's duty in relation to the matter; and
  (b) must discharge the entity's duty to the extent to which the entity has the capacity to influence and control the matter or would have had that capacity but for an agreement or arrangement purporting to limit or remove that capacity.

184 Other duties not affected

This Part does not affect any duty imposed by, or under, any other law of the Commonwealth, or of a State or Territory, or under the common law.

185 Concurrent operation of State and Territory laws

This Part does not exclude or limit the operation of a law of a State or Territory that is capable of operating concurrently with this Part.

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Division 3—Compensation pathway

186 Compensation orders

(1) The Federal Court or the Federal Circuit and Family Court of Australia (Division 2) may order an entity to compensate an individual for serious injury or illness if:

(a) the entity is liable to a civil penalty for contravening subsection 179(3) or (5); and

(b) the serious injury or illness resulted from the contravention.

(2) The court may make the order only if:

(a) either:

(i) the Commissioner applies for an order under this section with the consent of the individual; or

(ii) the individual applies for an order under this section; and

(b) the application is made within 6 years after the day the contravention occurred.

(3) If the court makes the order, the amount of compensation specified in the order that is to be paid to the individual may be recovered as a debt due to the individual.

186A Protection of compensation

(1) For the purposes of any provision of this Act (other than section 186) and any other legislation of the Commonwealth or of a State or a Territory, a payment of compensation to an individual under section 186 is not to be treated as being a payment of compensation or damages.

Note: This subsection prevents a compensation payment affecting other payments that may be payable to the person under legislation.

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(2) Nothing in this Act prevents a liability insurance contract from treating a payment of compensation under section 186 as being a payment of compensation or damages.

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Part 6—Aged care digital platform operators

187 Meaning of *aged care digital platform*

(1) An ***aged care digital platform*** means an online enabled application, website or system operated to facilitate the delivery of services in the Commonwealth aged care system (whether funded aged care services or not), where:

(a) the operator of the application, website or system acts as an intermediary for entities seeking to access those services who interact with entities providing the services via the application, website or system; and

(b) any of the following requires, and processes, payments referable to that intermediary function:

(i) the operator of the application, website or system;

(ii) an associated entity (within the meaning of the *Corporations Act 2001*) of the operator;

(iii) a person contracted, whether directly or through one or more interposed entities, by the operator or an associated entity of the operator to process the payments.

(2) An ***aged care digital platform*** also means an online enabled application, website or system that is prescribed by the rules.

(3) An ***aged care digital platform*** does not include an online enabled application, website or system prescribed by the rules.

(4) For the purposes of subsection (2) or (3), the rules may:

(a) prescribe an online enabled application, website or system by name or by inclusion in a specified class or specified classes; or

(b) prescribe an online enabled application, website or system in respect of all services in the Commonwealth aged care

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system, or in respect of specified services in the Commonwealth aged care system.

188 Duty of operators of aged care digital platforms

(1) An operator of an aged care digital platform contravenes this subsection if:

(a) an entity represents via the platform that the entity can deliver a service in the Commonwealth aged care system; and

(b) the operator does not check and display on the platform:

(i) whether the entity is a registered provider or not; and

(ii) if the entity is a registered provider—the registration categories in which the entity is registered; and

(iii) whether a banning order against the entity is, or has at any time been, in force; and

(iv) whether an NDIS banning order against the entity is, or has at any time been, in force; and

(v) whether a banning order (within the meaning of the Commission Act as in force at any time before the commencement of this Act) against the entity has at any time been in force; and

(vi) any other information prescribed by the rules.

(2) An entity or person is liable to a civil penalty if the entity or person contravenes subsection (1).

Civil penalty: 500 penalty units.

189 Other obligations of certain operators of aged care digital platforms

(1) An entity that is a constitutional corporation and the operator of an aged care digital platform must:

(a) notify the Commissioner, in accordance with any requirements prescribed by the rules, that the entity operates the platform; and

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(b) implement a complaints management system and manage complaints in accordance with that system and any other requirements prescribed by the rules; and

(c) implement an incident management system and manage incidents in accordance with that system and any other requirements prescribed by the rules; and

(d) display on the platform a summary and explanation of the complaints management system referred to in paragraph (b) and the incident management system referred to in paragraph (c); and

(e) report to the Commissioner, the System Governor, the Complaints Commissioner or the Inspector-General of Aged Care, any information prescribed by the rules to be reported to that person; and

(f) display on the platform, in a way that is prominent to individuals using the platform to access funded aged care services, the Statement of Rights; and

(g) keep and retain the kinds of records prescribed by the rules, and disclose information contained in those records, in accordance with any requirements prescribed by the rules.

Note: Registered providers, as a condition of their registration, have obligations in relation to incident management, complaints management and reporting: see sections 164, 165, 165A and 166.

(2) An entity is liable to a civil penalty if the entity contravenes subsection (1).

Civil penalty: 250 penalty units.

Requirements relating to rules

(3) The rules may prescribe requirements for the purposes of paragraph (1)(b) or (c) only for the purpose of ensuring that the systems implemented by operators of aged care digital platforms support compliance by registered providers with their obligations in relation to reporting, incident management and complaints management.

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Chapter 4—Funding of aged care services

Part 1—Introduction

190 Simplified outline of this Chapter

Individuals accessing funded aged care services will have the funded aged care services funded through Commonwealth contributions and, in some cases depending on the individual's means, individual contributions and fees.

The Commonwealth contribution for funded aged care services is generally in the form of a subsidy paid for the delivery of a service to an individual. The amount of the subsidy differs depending on the classification type and service group through which the funded aged care service is delivered and whether the funded aged care service is delivered under certain specialist aged care programs. Various supplements can increase the amount of subsidy payable.

Means testing rules apply for all service groups to determine what individual contributions and fees are payable by the individual for funded aged care services. If individual contributions and fees are payable, the subsidy amount paid to the registered provider for the delivery of the funded aged care service is reduced commensurately.

An individual accessing ongoing funded aged care services through the service group residential care in an approved residential care home, or under a specialist aged care program, may be required to pay for, or contribute to the cost of, accommodation in the home. Whether an individual pays an accommodation payment or an accommodation contribution depends on the individual's daily means tested amount on the individual's start day.

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Accommodation payments and accommodation contributions may be paid by daily payments, a lump sum (known as a refundable deposit) or a combination of refundable deposit and daily payments.

Part 4 of this Chapter contains rules about registered providers entering into accommodation agreements with individuals, the charging of accommodation payments and accommodation contributions, the circumstances in which a registered provider may use, or deduct an amount from, a refundable deposit and when a refundable deposit must be refunded or transferred.

Part 4 makes provision for that Part not applying in relation to individuals included in a class of individuals prescribed by the rules. The rules may, in relation to the delivery of certain funded aged care services to these individuals, prescribe different requirements that relate to accommodation bonds, accommodation charges or entry contributions.

As an alternative to subsidies, the Commonwealth contribution for some funded aged care services delivered to individuals is by way of a grant of financial assistance to a registered provider. Certain specialist aged care programs are funded this way, including programs for the benefit of Aboriginal and Torres Strait Islander persons.

The Commonwealth also has power to enter into arrangements with entities to make a grant of financial assistance for other purposes related to the Commonwealth aged care system and the aged care system more broadly.

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Part 2—Commonwealth contributions

Division 1—Subsidy for home support

Subdivision A—Person-centred subsidy

191 Eligibility for person-centred subsidy

(1) The System Governor must determine that a registered provider is eligible for ***person-centred subsidy*** for a funded aged care service delivered by the registered provider to an individual through the service group home support on a day if the requirements in subsections (2), (3) and (4) are met.

(2) The requirements are that on the day:

(a) the registered provider's registration is in effect and covers the funded aged care service; and

(b) the individual has an access approval that is in effect that covers the funded aged care service; and

(c) the individual has been allocated a place for the classification type for the service group under section 92 and the place is in effect; and

(d) the individual has a classification level in effect for the service group:

(i) that is in the classification type ongoing or short-term for the service group; and

(ii) is not prescribed by the rules; and

(f) the funded aged care service is not prescribed by the rules; and

(g) the funded aged care service is not being delivered to the individual under a specialist aged care program; and

(h) the day is not a day after the day the individual dies; and

(i) the registered provider has agreed to deal with the individual's unspent Commonwealth portion (if any) in accordance with Division 3A.

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(3) The requirement is that the price charged by the registered provider for the delivery of the funded aged care service is not more than the final efficient price (if any) for the funded aged care service that applied on the day.

(4) The requirement is that:

(a) unless paragraph (b) applies—the day is on or after the start day specified in a start notification given by the registered provider for delivering ongoing or short-term funded aged care services to the individual for the service group through a service delivery branch of the provider; or

(b) if the rules prescribe circumstances for the purposes of this paragraph—those circumstances apply.

192 Amount of person-centred subsidy

Ongoing home support

(1) The amount of ***person-centred subsidy*** a registered provider is eligible for under subsection 191(1) for an ongoing funded aged care service delivered to an individual through the service group home support on a day in a quarter is worked out as follows:

Method statement

Step 1. Work out the following:

(a) if the subsidy basis for the service is efficient price or unit price—multiply the price charged by the provider to the individual for an hour or unit of the service (whichever is applicable) by the number of hours or units of the service delivered to the individual on the day;

(b) if the subsidy basis for the service is cost—the cost.

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Step 2. Reduce the amount worked out under Step 1 by the sum of any reduction amounts for the classification type for the service group that apply to the individual. This is the ***provisional subsidy amount***.

Step 3. Work out the sum of:

(a) the provisional subsidy amount; and

(b) any secondary person-centred supplements for the classification type ongoing for the service group home support that apply to the individual for the day.

The result is the amount of subsidy for which the registered provider is eligible for the individual for the service for the day.

Short-term home support

(2) The amount of ***person-centred subsidy*** a registered provider is eligible for under subsection 191(1) for a short-term funded aged care service delivered to an individual through the service group home support on a day is worked out as follows:

Method statement

Step 1. Work out the following:

(a) if the subsidy basis for the service is efficient price or unit price—multiply the price charged by the provider to the individual for an hour or unit of the service (whichever is applicable) by the number of hours or units of the service delivered to the individual on the day;

(b) if the subsidy basis for the service is cost—the cost.

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Step 2. Reduce the amount worked out under Step 1 by the sum of any reduction amounts for the classification type for the service group that apply to the individual. This is the ***provisional subsidy amount***.

Step 3. Work out the sum of:

(a) the provisional subsidy amount; and

(b) any secondary person-centred supplements for the classification type short-term for the service group home support that apply to the individual for the day.

The result is the amount of subsidy for which the registered provider is eligible for the individual for the service for the day.

193 Available ongoing home support quarterly account balance

Quarterly ongoing home support accounts

(1) A notional ongoing home support account is established for an individual for the quarter (the ***first quarter***) in which an entry day for the individual occurs for the classification type ongoing for the service group home support, and each subsequent quarter, unless circumstances prescribed by the rules apply.

Initial credit for account for first quarter

(2) The following is credited to the account for the first quarter at the start of the individual's entry day:

(a) the base individual amount for the individual for the classification type for the service group for the individual for that day multiplied by the remaining days in the quarter (including that day);

(b) the sum of any primary person-centred supplements for the classification type for the service group that apply to the

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individual on that day multiplied by the remaining days in the quarter (including that day).

Initial credit for accounts for subsequent quarters

(3) For an account for a quarter other than the first quarter, the following is credited to the account at the start of the first day of that quarter:

(a) the base individual amount for the individual for the classification type for the service group for that day multiplied by the days in the quarter;

(b) the sum of any primary person-centred supplements for the classification type for the service group that apply to the individual on the day multiplied by the days in the quarter.

Rollover credits

(4) For an account for a quarter other than the first quarter, the amount prescribed by the rules is credited to the account at the earlier of the following:

(a) if the registered provider gives the System Governor notice that the provider has made the provider's final claim for subsidy for the previous quarter—the day that claim is approved under subsection 251(4);

(b) the day that is 61 days after the last day of the previous quarter.

Credit due to change in classification or full place coming into effect

(5) If:

(a) either:

(i) a decision by the System Governor comes into effect for the individual for the classification type ongoing for the service group home support on a day in a quarter that is after the entry day for the individual; or

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(ii) a full place comes into effect for the individual for that classification type and service group on a day in a quarter that is after that entry day; and

(b) the base individual amount (the ***new base individual amount***) for the individual for the classification type for the service group is higher as a result of that decision or that place coming into effect;

the account for that quarter is credited with the amount that is the difference between the new base individual amount and the base individual amount for the individual for the classification type ongoing for the service group home support that applied before the decision or place came into effect multiplied by the remaining days in the quarter (including that day).

Credit due to primary person-centred supplement applying

(6) If a primary person-centred supplement for the classification type ongoing for the service group home support starts to apply to the individual on a day in a quarter that is after the entry day for the individual, the amount of that person-centred supplement for the day multiplied by the remaining days in the quarter (including that day) is credited to the account for the quarter.

Debits

(7) If a claim is made under section 251 for person-centred subsidy for the delivery of an ongoing funded aged care service to the individual on a day, the account is debited in accordance with section 251B immediately after the claim is approved under subsection 251(4).

(8) To avoid doubt, the time at which the account is debited may be a time after the end of the quarter to which the claim relates.

Rules may prescribe circumstances for no credits

(9) Despite subsection (3), (4), (5) or (6), the rules may prescribe circumstances in which a credit which would otherwise be required under that subsection is not to be made.

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Ceasing of accounts

(10) A notional ongoing home support account for a quarter ceases in the circumstances prescribed by the rules.

194 Base individual amount

The ***base individual amount*** for a classification type for the service group home support is the amount prescribed by the rules for the classification type for the service group.

195 Available short-term home support account balance

Short-term home support account

(1) A notional short-term home support account is established for an individual if an entry day for the individual occurs for the classification type short-term for the service group home support.

Initial credit

(3) At the start of the day the account is established, the following is credited to the account:

(a) the base individual amount for the individual for the classification type for the service group for that day multiplied by the number of days in the period prescribed by the rules (which must not be longer than the maximum period of effect for the individual's classification level for the classification type for the service group);

(b) the sum of any primary person-centred supplements for the classification type for the service group that apply to the individual on that day multiplied by the number of days in the period prescribed by the rules (which must not be longer than the maximum period of effect for the individual's classification level for the classification type for the service group).

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Credit due to circumstances prescribed by the rules applying

(3A) If the circumstances prescribed by the rules apply in relation to the individual, at the start of a day prescribed by the rules the amount prescribed by the rules is credited to the account.

(3B) Without limiting subsection (3A), rules made for the purposes of that subsection may provide that the System Governor may determine the amount for the individual in accordance with the rules.

(3C) If a determination made by the System Governor under rules made for the purposes of subsection (3A) is made in writing, the determination is not a legislative instrument.

Credit due to primary person-centred supplement applying

(4) If a primary person-centred supplement for the classification type for the service group starts to apply to the individual on a day, the account is credited with the amount of that person-centred supplement for the day multiplied by the remaining days (including that day) in the maximum period of effect for the classification level for the classification type for the service group.

Debits

(5) If a claim is made under section 251 for person-centred subsidy for the delivery of a short-term funded aged care service to the individual, the account is debited in accordance with section 251B immediately after the claim is approved under subsection 251(4).

(6) To avoid doubt, the time the account is debited may be a time after the end of the relevant period to which the claim relates.

Ceasing of account

(7) The account ceases in circumstances prescribed by the rules.

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196 Primary person-centred supplements

(1) The ***primary person-centred supplements*** for an individual for a day for a classification type for the service group home support are the supplements prescribed by the rules.

(2) The rules may prescribe, for each primary person-centred supplement for a classification type for the service group:
  (a) the circumstances in which the supplement will apply to an individual; and
  (b) the amount of the supplement.

197 Secondary person-centred supplements

(1) The ***secondary person-centred supplements*** for an individual for a day for a classification type for the service group home support are:
  (a) for any classification type for the service group—the fee reduction supplement; and
  (b) any other supplement for the classification type for the service group prescribed by the rules.

(2) The rules may prescribe, for each secondary person-centred supplement for a classification type for the service group:
  (a) the circumstances in which the supplement will apply to an individual for a day; and
  (b) the amount of the supplement.

(3) Without limiting subsection (2), rules made for the purposes of that subsection in relation to the fee reduction supplement may prescribe:
  (aa) circumstances that include that the System Governor has made a determination about particular matters; and
  (a) that the fee reduction supplement reduces any of the fees or contributions under Division 1 of Part 3 for the individual; and
  (b) the method for determining the amount (if any) of the fee reduction supplement that must reduce each of the amounts

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mentioned in paragraph (a) of this subsection, including in which order to reduce those amounts; and

(c) that the fee reduction supplement and the matters set out in paragraphs (a) and (b) of this subsection may be set by a determination made by the System Governor, and that the determination may include a limited period for which the supplement is payable.

(4) Without limiting subsection (2), the circumstances prescribed by the rules as circumstances in which the fee reduction supplement will apply to an individual for a day must include circumstances that involve financial hardship.

(5) If a determination made by the System Governor under rules made for the purposes of subsection (2) is made in writing, the determination is not a legislative instrument.

Subdivision B—Reduction amounts for person-centred subsidy

198 Reduction amounts

The reductions in person-centred subsidy for the classification type ongoing or short-term for the service group home support for a day for step 2 of the method statement in subsection 192(1) or (2) are such of the following reductions as apply to the individual for the classification type for the service group for the day:

(a) the compensation payment reduction for person-centred subsidy (see section 199);

(b) the individual contribution reduction (see section 200).

199 The compensation payment reduction for person-centred subsidy

(1) For the purposes of paragraph 198(a), a ***compensation payment reduction for person-centred subsidy*** applies to an individual for a day if circumstances prescribed by the rules apply.

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(2) The amount of the compensation payment reduction for person-centred subsidy for the individual for the day is the amount prescribed by the rules.

(3) Without limiting subsection (1), circumstances prescribed by the rules for the purposes of that subsection may include that the System Governor has made a determination about particular matters.

(4) A determination made by the System Governor under rules made for the purposes of subsection (1) is not a legislative instrument.

200 The individual contribution reduction

For the purposes of paragraph 198(b), the ***individual contribution reduction*** is the amount worked out under section 273 for the individual for the service (disregarding step 4 of the method statement in that section).

Subdivision C—Provider-based subsidy

201 Eligibility for provider-based subsidy

A registered provider is eligible for ***provider-based subsidy*** for an ongoing funded aged care service delivered by the registered provider to an individual on a day if:

(a) the requirements in paragraphs 191(2)(a), (b), (c), (d), (g), (h) and (i) are met in relation to the funded aged care service and the individual; and

(b) the requirements in subsection 191(3) are met in relation to the funded aged care service and the individual; and

(c) the funded aged care service is prescribed by the rules.

202 Amount of provider-based subsidy

The amount of provider-based subsidy a registered provider is eligible for under section 201 for the delivery of an ongoing funded

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aged care service to an individual on a day is worked out as follows:

Method statement

Step 1. Work out the following:

(a) if the subsidy basis for the service is efficient price or unit price—multiply the price charged by the provider to the individual for an hour or unit of the service (whichever is applicable) by the number of hours or units of the service delivered to the individual on the day;

(b) if the subsidy basis for the service is cost—the cost.

Step 2. Reduce the amount worked out under Step 1 by the sum of any reduction amounts for the classification type for the service group that apply to the individual. This is the ***provisional subsidy amount***.

The result is the amount of provider-based subsidy for which the registered provider is eligible for the individual for the service for the day.

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203 Available service delivery branch financial year account balance

Service delivery branch account

(1) A notional service delivery branch account for a registered provider for a service delivery branch of the provider is established:

(a) for the financial year (the ***first financial year***) for which the start day (the ***initial account start day***) included in the first start notification given for any individual (the ***first individual***) for the delivery of ongoing funded aged care

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services through the service group home support to the individual through the service branch occurs; and

(b) for each subsequent financial year (unless circumstances prescribed by the rules apply).

Credits—first and second quarters of active operation

(2) For the first quarter (the ***first quarter of operation***) in the first financial year or the subsequent quarter (the ***second quarter of operation***) the amount referred to in subsection (3) is credited to the account for the financial year in which the quarter occurs in relation to each individual (including the first individual) to whom both of the following apply on a day in the quarter:

(a) the registered provider gives a start notification for the individual for the classification type ongoing for the service group home support on that day;

(b) the individual's start day included in that notification is on or before that day.

(3) The amount is the sum of:

(a) the base provider amount for the individual, multiplied by the number of days prescribed by the rules; and

(b) the amount of any provider-based supplements that apply to the provider in relation to the individual, multiplied by the number of days prescribed by the rules.

Credits—subsequent quarters

(4) At the start of the first day of a quarter in a financial year (other than the first quarter of operation or second quarter of operation), the following is credited to the account:

(a) the sum of the base provider amount for each individual covered by subsection (5) for the quarter, multiplied by the number of days in the quarter;

(b) the sum of any provider-based supplements that apply to the provider in relation to an individual covered by subsection (5) for the quarter, multiplied by the number of days in the quarter.

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(5) An individual is covered by this subsection for a quarter (the ***relevant quarter***) if:

(a) the registered provider has given, at a time in any previous quarter during which the account has existed, a start notification for the individual for the classification type ongoing for the service group home support and that time is before the time (the ***test time***) prescribed by the rules in the quarter immediately before the relevant quarter; and

(b) the individual's start day included in that notification was on or before the day the notification was given; and

(c) any other requirements prescribed by the rules are met.

Credit due to change in classification, or change from interim to full place, of individual to whom services are being delivered through service delivery branch

(6) If:

(a) either of the following apply in relation to an individual for a day that is on or after the initial account start day:

(i) a new classification level for the classification type ongoing for the service group home support comes into effect for the individual on the day;

(ii) a full place comes into effect for the individual for the classification type ongoing for the service group home support on the day; and

(b) the base individual amount (the ***new base individual amount***) for the individual for the classification type for the service group is higher as a result of that classification level or place coming into effect;

the account for the financial year in which that day occurs is credited with the difference between the new base individual amount and the base individual amount for the individual for the classification type for the service group that applied before the classification level or full place came into effect, multiplied by the remaining days in the quarter in which the day occurs (including that day).

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Credit for provider-based supplement starting to apply

(7) If a provider-based supplement starts applying to the provider in relation to an individual:

(a) for an individual to whom subsection (2) applies—on a day in the first quarter of operation or second quarter of operation that is after the day the registered provider gives a start notification for the individual; or

(b) for an individual to whom subsection (4) applies for a quarter—on a day in that quarter;

the account for the financial year in which the quarter occurs is credited with the amount of that provider-based supplement for the day multiplied by the number of days prescribed by the rules.

Rollover credit

(8) For an account for a financial year other than the first financial year of operation, if the circumstances prescribed by the rules apply, then the amount prescribed by the rules for those circumstances is credited to the account at the earlier of the following:

(a) if the registered provider gives the System Governor notice that the provider has made the provider's final claim for subsidy for the previous financial year—the day that claim is approved under subsection 251(4);

(b) the day that is 61 days after the last day of the previous financial year.

Debits

(9) If a claim is made under section 251 for provider-based subsidy for the delivery of an ongoing funded aged care service to an individual through the service delivery branch on a day, the account is debited in accordance with section 251B immediately after the claim is approved under subsection 251(4).

(10) To avoid doubt, the time the account is debited may be a time after the end of the financial year to which the claim relates.

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Ceasing of accounts

(11) An account for a financial year ceases in circumstances prescribed by the rules.

204 Base provider amount

The ***base provider amount*** for a registered provider in relation to an individual covered by subsection 203(5) for a quarter is the amount prescribed by the rules.

205 Provider-based supplements

(1) The ***provider-based supplements*** that apply to a service delivery branch of a registered provider in relation to an individual on a day are the supplements prescribed by the rules.

(2) The rules may prescribe, for each provider-based supplement for a service delivery branch of a registered provider:

(a) the circumstances in which the supplement will apply to the branch on a day; and

(b) the amount of the supplement.

Subdivision D—Reduction amounts for provider-based subsidy

206 Reduction amounts

The reductions in provider-based subsidy for the classification type ongoing for the service group home support for a day for step 2 of the method statement in section 202 are such of the following reductions as apply to the individual for the classification type for the service group for the day:

(a) the compensation payment reduction for provider-based subsidy (see section 207);

(b) the individual contribution reduction (see section 208).

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207 The compensation payment reduction for provider-based subsidy

(1) For the purposes of paragraph 206(a), a ***compensation payment reduction for provider-based subsidy*** applies to an individual for a day if circumstances prescribed by the rules apply.

(2) The amount of the compensation payment reduction for provider-based subsidy for the individual for the day is the amount prescribed by the rules.

(3) Without limiting subsection (1), circumstances prescribed by the rules for the purposes of that subsection may include that the System Governor has made a determination about particular matters.

(4) A determination made by the System Governor under rules made for the purposes of subsection (1) is not a legislative instrument.

208 The individual contribution reduction

For the purposes of paragraph 206(b), the ***individual contribution reduction*** is the amount worked out under section 273 for the individual for the service (disregarding step 4 of the method statement in that section).

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Division 2—Subsidy for assistive technology

Subdivision A—Person-centred subsidy

209 Eligibility for person-centred subsidy

(1) The System Governor must determine that a registered provider is eligible for ***person-centred subsidy*** for a funded aged care service delivered by the registered provider to an individual through the service group assistive technology on a day if the requirements in subsections (2), (3) and (4) are met.

(2) The requirements are that on the day:

(a) the registered provider's registration is in effect and covers the funded aged care service; and

(b) the individual has an access approval that is in effect that covers the funded aged care service; and

(c) the individual has been allocated a place for the classification type for the service group under section 92 and the place is in effect; and

(d) the individual has a classification level in effect for the service group:

(i) that is in the classification type ongoing or short-term for the service group; and

(ii) is not prescribed by the rules; and

(f) the funded aged care service is not prescribed by the rules; and

(g) the funded aged care service is not being delivered to the individual under a specialist aged care program; and

(h) the day is not a day after the day the individual dies; and

(i) the registered provider has agreed to deal with the individual's unspent Commonwealth portion (if any) in accordance with Division 3A.

(3) The requirement is that the price charged by the registered provider for the delivery of the funded aged care service is not more than

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the final efficient price (if any) for the funded aged care service that applied on the day.

(4) The requirement is that:

(a) unless paragraph (b) applies—the day is on or after the start day specified in a start notification given by the registered provider for delivering ongoing or short-term funded aged care services to the individual for the service group through a service delivery branch of the provider; or

(b) if the rules prescribe circumstances for the purposes of this paragraph—those circumstances apply.

210 Amount of person-centred subsidy

The amount of ***person-centred subsidy*** a registered provider is eligible for under subsection 209(1) for an ongoing or short-term funded aged care service delivered to an individual through the service group assistive technology on a day is worked out as follows:

Method statement

Step 1. Work out the following:

(a) if the subsidy basis for the service is efficient price or unit price—multiply the price charged by the provider to the individual for an hour or unit of the service (whichever is applicable) by the number of hours or units of the service delivered to the individual on the day;

(b) if the subsidy basis for the service is cost—the cost.

Step 2. Reduce the amount worked out under Step 1 by the sum of any reduction amounts for the classification type for the service group that apply to the individual. This is the ***provisional subsidy amount***.

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Step 3. Work out the sum of:

(a) the provisional subsidy amount; and

(b) any secondary person-centred supplements for the classification type ongoing or short-term for the service group assistive technology that apply to the individual for the day.

The result is the amount of subsidy for which the registered provider is eligible for the individual for the service for the day.

211 Available assistive technology account balance

Assistive technology account

(1) A notional assistive technology account is established for the period (the ***account period***) prescribed by the rules for an individual if an entry day for the individual occurs for the classification type ongoing or short-term for the service group assistive technology.

(1A) Without limiting subsection (1), rules made for the purposes of that subsection may provide that the System Governor may determine the account period for the individual in accordance with the rules.

Credit to account

(3) At the start of the day the account is established, the account is credited with the individual's tier amount for the classification type for the service group for the account period.

(4) If the account was established for the individual for the classification type ongoing for the service group, at the start of a day prescribed by the rules the amount prescribed by the rules is credited to the account.

(4A) If the account was established for the individual for the classification type short-term for the service group, at the start of a

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day prescribed by the rules the amount prescribed by the rules is credited to the account.

(4B) Without limiting subsection (4A), rules made for the purposes of that subsection may provide that the System Governor may determine the amount for the individual in accordance with the rules.

Credit due to primary person-centred supplement applying

(5) If a primary person-centred supplement for the classification type for the service group applies to the individual on the day the account is established, the account is credited with the amount of that primary person-centred supplement for the individual for the account period.

Debits

(6) If a claim is made under section 251 for person-centred subsidy for the delivery of an ongoing or short-term funded aged care service through the service group to the individual on a day in the account period, the account is debited in accordance with section 251B immediately after the claim is approved under subsection 251(4).

Ceasing of account

(8) At the end of the account period the account ceases.

212 Tier amount for individual

The ***tier amount*** for an individual for an account period for a classification type for the service group assistive technology is the amount prescribed by the rules.

213 Primary person-centred supplements

(1) The ***primary person-centred supplements*** for an individual for a day for a classification type for the service group assistive technology are the supplements prescribed by the rules.

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(2) The rules may prescribe, for each primary person-centred supplement for a classification type for the service group:
  (a) the circumstances in which the supplement will apply to an individual; and
  (b) the amount of the supplement.

214 Secondary person-centred supplements

(1) The ***secondary person-centred supplements*** for an individual for a day for a classification type for the service group assistive technology are:
  (a) for any classification type for the service group—the fee reduction supplement; and
  (b) any other supplement for the classification type for the service group prescribed by the rules.

(2) The rules may prescribe, for each secondary person-centred supplement for a classification type for the service group:
  (a) the circumstances in which the supplement will apply to an individual; and
  (b) the amount of the supplement.

(3) Without limiting subsection (2), rules made for the purposes of that subsection in relation to the fee reduction supplement may prescribe:
  (aa) circumstances that include that the System Governor has made a determination about particular matters; and
  (a) that the fee reduction supplement reduces any of the fees or contributions under Division 1 of Part 3 for the individual; and
  (b) the method for determining the amount (if any) of the fee reduction supplement that must reduce each of the amounts mentioned in paragraph (a) of this subsection, including in which order to reduce those amounts; and
  (c) that the fee reduction supplement and the matters set out in paragraphs (a) and (b) of this subsection may be set by a determination made by the System Governor, and that the

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determination may include a limited period for which the supplement is payable.

(4) Without limiting subsection (2), the circumstances prescribed by the rules as circumstances in which the fee reduction supplement will apply to an individual for a day must include circumstances that involve financial hardship.

(5) If a determination made by the System Governor under rules made for the purposes of subsection (2) is made in writing, the determination is not a legislative instrument.

Subdivision B—Reduction amounts for person-centred subsidy

215 Reduction amounts

The reductions in person-centred subsidy for the classification type ongoing or short-term for the service group assistive technology for a day for step 2 of the method statement in section 210 are such of the following reductions as apply to the individual for the classification type for the service group for the day:

(a) the compensation payment reduction for person-centred subsidy (see section 216);

(b) the individual contribution reduction (see section 217).

216 The compensation payment reduction for person-centred subsidy

(1) For the purposes of paragraph 215(a), a ***compensation payment reduction for person-centred subsidy*** applies to an individual for a day if circumstances prescribed by the rules apply.

(2) The amount of the compensation payment reduction for person-centred subsidy for the individual for the day is the amount prescribed by the rules.

(3) Without limiting subsection (1), circumstances prescribed by the rules for the purposes of that subsection may include that the

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System Governor has made a determination about particular matters.

(4) A determination made by the System Governor under rules made for the purposes of subsection (1) is not a legislative instrument.

217 The individual contribution reduction

For the purposes of paragraph 215(b), the ***individual contribution reduction*** is the amount worked out under section 273 for the individual for the service (disregarding step 4 of the method statement in that section).

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Division 3—Subsidy for home modifications

Subdivision A—Person-centred subsidy

218 Eligibility for person-centred subsidy

(1) The System Governor must determine that a registered provider is eligible for ***person-centred subsidy*** for a funded aged care service delivered by the registered provider to an individual through the service group home modifications on a day if the requirements in subsections (2), (3) and (4) are met.

(2) The requirements are that on the day:

(a) the registered provider's registration is in effect and covers the funded aged care service; and

(b) the individual has an access approval that is in effect that covers the funded aged care service; and

(c) the individual has been allocated a place for the classification type for the service group under section 92 and the place is in effect; and

(d) the individual has a classification level in effect for the service group:

(i) that is in the classification type short-term for the service group; and

(ii) is not prescribed by the rules; and

(f) the funded aged care service is not prescribed by the rules; and

(g) the funded aged care service is not being delivered to the individual under a specialist aged care program; and

(h) the day is not a day after the day the individual dies; and

(i) the registered provider has agreed to deal with the individual's unspent Commonwealth portion (if any) in accordance with Division 3A.

(3) The requirement is that the price charged by the registered provider for the delivery of the funded aged care service is not more than

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the final efficient price (if any) for the funded aged care service that applied on the day.

(4) The requirement is that:

(a) unless paragraph (b) applies—the day is on or after the start day specified in a start notification given by the registered provider for delivering short-term funded aged care services to the individual for the service group through a service delivery branch of the provider; or

(b) if the rules prescribe circumstances for the purposes of this paragraph—those circumstances apply.

219 Amount of person-centred subsidy

The amount of ***person-centred subsidy*** a registered provider is eligible for under subsection 218(1) for a short-term funded aged care service delivered to an individual through the service group home modifications on a day is worked out as follows:

Method statement

Step 1. Work out the following:

(a) if the subsidy basis for the service is efficient price or unit price—multiply the price charged by the provider to the individual for an hour or unit of the service (whichever is applicable) by the number of hours or units of the service delivered to the individual on the day;

(b) if the subsidy basis for the service is cost—the cost.

Step 2. Reduce the amount worked out under Step 1 by the sum of any reduction amounts for the classification type for the service group that apply to the individual. This is the ***provisional subsidy amount***.

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Step 3. Work out the sum of:

(a) the provisional subsidy amount; and

(b) any secondary person-centred supplements for the classification type short-term for the service group home modifications that apply to the individual for the day.

The result is the amount of subsidy for which the registered provider is eligible for the individual for the service for the day.

220 Available home modifications account balance

(1) A notional home modifications account is established for the period (the ***account period***) prescribed by the rules for an individual if an entry day for the individual occurs for the short-term classification type for the service group home modifications.

(1A) Without limiting subsection (1), rules made for the purposes of that subsection may provide that the System Governor may determine the account period for the individual in accordance with the rules.

Credit to account

(3) At the start of the day the account is established, the account is credited with the individual's tier amount for the account period.

Credit due to primary person-centred supplement applying

(4) If a primary person-centred supplement for the classification type for the service group applies to the individual on the day the account is established, the account is credited with the amount of that primary person-centred supplement for the individual for the account period.

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Debits

(5) If a claim is made under section 251 for person-centred subsidy for the delivery of a short-term funded aged care service through the service group home modifications to the individual on a day in the account period, the account is debited in accordance with section 251B immediately after the claim is approved under subsection 251(4).

Ceasing of account

(7) At the end of the account period, the account ceases.

221 Tier amount for individual

The ***tier amount*** for an individual for an account period for a classification type for the service group home modifications is the amount prescribed by the rules.

222 Primary person-centred supplements

(1) The ***primary person-centred supplements*** for an individual for a day for a classification type for the service group home modifications are the supplements prescribed by the rules.

(2) The rules may prescribe, for each primary person-centred supplement for a classification type for the service group:
(a) the circumstances in which the supplement will apply to an individual; and
(b) the amount of the supplement.

223 Secondary person-centred supplements

(1) The ***secondary person-centred supplements*** for an individual for a classification type for the service group home modifications are:
(a) for any classification type for the service group—the fee reduction supplement; and
(b) any other supplement for the classification type for the service group prescribed by the rules.

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(2) The rules may prescribe, for each secondary person-centred supplement for a classification type for the service group:
  (a) the circumstances in which the supplement will apply to the individual; and
  (b) the amount of the supplement.

(3) Without limiting subsection (2), rules made for the purposes of that subsection in relation to the fee reduction supplement may prescribe:
  (aa) circumstances that include that the System Governor has made a determination about particular matters; and
  (a) that the fee reduction supplement reduces any of the fees or contributions under Division 1 of Part 3 for the individual; and
  (b) the method for determining the amount (if any) of the fee reduction supplement that must reduce each of the amounts mentioned in paragraph (a), including in which order to reduce those amounts; and
  (c) that the fee reduction supplement and the matters set out in paragraphs (a) and (b) of this subsection may be set by a determination made by the System Governor, and that the determination may include a limited period for which the supplement is payable.

(4) Without limiting subsection (2), the circumstances prescribed by the rules as circumstances in which the fee reduction supplement will apply to an individual for a day must include circumstances that involve financial hardship.

(5) If a determination made by the System Governor under rules made for the purposes of subsection (2) is made in writing, the determination is not a legislative instrument.

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Subdivision B—Reduction amounts for person-centred subsidy

224 Reduction amounts

The reductions in person-centred subsidy for the classification type short-term for the service group home modifications for a day for step 2 of the method statement in section 219 are such of the following reductions as apply to the individual for the classification type for the service group for the day:

(a) the compensation payment reduction for person-centred subsidy (see section 225);

(b) the individual contribution reduction (see section 226).

225 The compensation payment reduction for person-centred subsidy

(1) For the purposes of paragraph 224(a), a ***compensation payment reduction for person-centred subsidy*** applies to an individual for a day if circumstances prescribed by the rules apply.

(2) The amount of the compensation payment reduction for person-centred subsidy for the individual for the day is the amount prescribed by the rules.

(3) Without limiting subsection (1), circumstances prescribed by the rules for the purposes of that subsection may include that the System Governor has made a determination about particular matters.

(4) A determination made by the System Governor under rules made for the purposes of subsection (1) is not a legislative instrument.

226 The individual contribution reduction

For the purposes of paragraph 224(b), the ***individual contribution reduction*** is the amount worked out under section 273 for the individual for the service (disregarding step 4 of the method statement in that section).

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Division 3A—Unspent Commonwealth portions and home care accounts

226A Unspent Commonwealth portion

(1) A registered provider starts to hold an ***unspent Commonwealth portion*** for an individual at the transition time if, immediately before the transition time:

(a) the registered provider was an approved provider that held an unspent home care amount in relation to the individual as mentioned in the *User Rights Principles 2014*; and

(b) the amount of the Commonwealth portion of that amount under section 21CA of those Principles was not zero; and

(c) neither section 21F nor section 21JB of those Principles applied in relation to the Commonwealth portion of that amount (whether or not the Commonwealth portion had become due and payable to the Commonwealth).

Initial credit

(3) At the transition time, the amount of the Commonwealth portion of the individual's unspent home care amount under section 21CA of the *User Rights Principles 2014* immediately before the transition time is credited to the portion.

Debits for claims

(4) If a claim is made under section 251 for person-centred subsidy for the delivery of a funded aged care service to the individual on a day, the unspent Commonwealth portion is debited (if at all) in accordance with section 251B immediately after the claim is approved under subsection 251(4).

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Debit for return of unspent Commonwealth portion—provider election

(6) If the registered provider elects to return the available balance of an unspent Commonwealth portion for the individual to the Commonwealth under section 226B, the portion is reduced, at the start of a day prescribed by the rules (which may be a day before the day the election is made), by the amount of that balance at the start of that day.

Debit for return of unspent Commonwealth portion—individual transfers between provider service delivery branches

(7) If a registered provider returns the available balance of an unspent Commonwealth portion for the individual to the Commonwealth under section 226C, the portion is reduced, at the start of a day prescribed by the rules, by the amount of that balance at the start of that day.

Debit for return of unspent Commonwealth portion—provider ceases to deliver services

(8) If a registered provider returns the available balance of an unspent Commonwealth portion for the individual to the Commonwealth under section 226D, the portion is reduced, at the start of a day prescribed by the rules, by the amount of that balance at the start of that day.

Ceasing of portion

(9) The registered provider ceases to hold an unspent Commonwealth portion for an individual when the available balance of the portion is reduced to zero.

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226B Return of unspent Commonwealth portion—provider election

(1) A registered provider may, by written notice given to the System Governor and in accordance with the rules, elect to return the

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available balance of an unspent Commonwealth portion for an individual to the Commonwealth.

(2) Before making the election, the registered provider must obtain the individual's written agreement to the making of the election.

(3) The election is irrevocable.

(4) The provider must return the available balance of the unspent Commonwealth portion for the individual to the Commonwealth:

(a) within the period prescribed by the rules after the day the notice of the election is given to the System Governor; and

(b) in accordance with any other requirements prescribed by the rules.

Note: If the available balance is not returned to the Commonwealth in accordance with this section, it may be a recoverable amount: see subsection 514(3).

226C Return of unspent Commonwealth portion—individual transfers between provider service delivery branches

(1) This section applies if:

(a) a registered provider holds an unspent Commonwealth portion for an individual to whom the provider is delivering funded aged care services through a particular service delivery branch of the provider; and

(b) the provider ceases to deliver those services to the individual through that service delivery branch and starts to deliver those services to the individual through another service delivery branch of the provider; and

(c) there is continuity of the delivery of those services to the individual by that provider.

(2) The provider must:

(a) give the System Governor written notice of the matters mentioned in subsection (1); and

(b) return the available balance of the unspent Commonwealth portion for the individual to the Commonwealth:

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(i) within the period prescribed by the rules after the cessation; and

(ii) in accordance with any other requirements prescribed by the rules.

Note: If the available balance is not returned to the Commonwealth in accordance with this section, it may be a recoverable amount: see subsection 514(3).

226D Return of unspent Commonwealth portion—provider ceases to deliver services

(1) This section applies if:

(a) a registered provider holds an unspent Commonwealth portion for an individual to whom the provider is delivering funded aged care services; and

(b) the provider ceases to deliver funded aged care services to the individual.

(2) The provider must:

(a) give the System Governor written notice of the matters mentioned in subsection (1); and

(b) return the available balance of the unspent Commonwealth portion for the individual to the Commonwealth:

(i) within the period prescribed by the rules after the cessation; and

(ii) in accordance with any other requirements prescribed by the rules.

Note: If the available balance is not returned to the Commonwealth in accordance with this section, it may be a recoverable amount: see subsection 514(3).

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226E Home care account balance

Home care account

(1) A notional home care account is established for an individual at the transition time if:

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(a) immediately before the transition time:
(i) the individual had a home care account under the old Act; and
(ii) the home care account balance of that account under the old Act was not zero; or
(b) at the transition time, a registered provider holds an unspent Commonwealth portion for the individual under section 226A.

Initial credit

(3) At the transition time, the amount that, immediately before the transition time, is recorded in the information technology system relating to aged care payments operated by Services Australia as the amount of the individual's home care account balance is credited to the account.

Credit for return of unspent Commonwealth portion—provider election

(4) If a registered provider elects to return the available balance of an unspent Commonwealth portion for the individual to the Commonwealth under section 226B, the account is credited, at the start of a day prescribed by the rules (which may be a day before the day the election is made), by the amount of that balance at the start of that day.

Credit for return of unspent Commonwealth portion—individual transfers between provider service delivery branches

(5) If a registered provider returns the available balance of an unspent Commonwealth portion for the individual to the Commonwealth under section 226C, the account is credited, at the start of a day prescribed by the rules, by the amount of that balance at the start of that day.

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Credit for return of unspent Commonwealth portion—provider ceases to deliver services

(6) If a registered provider returns the available balance of an unspent Commonwealth portion for the individual to the Commonwealth under section 226D, the account is credited, at the start of a day prescribed by the rules, by the amount of that balance at the start of that day.

Debits for claims

(7) If a claim is made under section 251 for person-centred subsidy for the delivery of a funded aged care service to the individual on a day, the account is debited (if at all) in accordance with section 251B immediately after the claim is approved under subsection 251(4).

Debit to zero in prescribed circumstances

(8) If circumstances prescribed by the rules apply to the individual on a day, the account is reduced to zero on that day.

Ceasing of account

(9) The account ceases in the circumstances prescribed by the rules.

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Division 4—Subsidy for residential care—general

Subdivision AA—When this Division does not apply

227A Division (other than section 227) not to apply to individuals in prescribed classes

This Division (other than section 227) does not apply in relation to an individual accessing ongoing funded aged care services through the service group residential care if the individual is in a class of individuals prescribed by the rules.

Note: For the amount of subsidy for residential care for these individuals, see Division 4A.

Subdivision A—Person-centred subsidy

227 Eligibility for person-centred subsidy

(1) Subject to subsections (3) and (4), the System Governor must determine that a registered provider is eligible for ***person-centred subsidy*** for a funded aged care service delivered by the registered provider to an individual through the service group residential care on a day if the requirements in subsections (2) and (2A) are met.

General requirements

(2) The requirements are that on the day:

(a) the registered provider's registration is in effect and covers the funded aged care service; and

(b) the individual has an access approval that is in effect that covers the funded aged care service; and

(c) the individual has been allocated a place for the classification type for the service group under section 92 and the place is in effect; and

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(d) the individual has a classification level in effect for the classification type ongoing or short-term for the service group; and

(f) the funded aged care service is not being delivered to the individual under a specialist aged care program; and

(g) the individual is not excluded (see subsection (5)).

(2A) The requirement is that:

(a) unless paragraph (b) applies—the day is on or after the start day specified in a start notification given by the registered provider for delivering ongoing or short-term funded aged care services to the individual for the service group at an approved residential care home of the provider; or

(b) if the rules prescribe circumstances for the purposes of this paragraph—those circumstances apply.

Circumstances where registered provider not eligible

(3) The System Governor must determine that a registered provider is not eligible for person-centred subsidy for a day for the service group residential care for an individual if:

(a) the registered provider ceased delivering funded aged care services through the service group to the individual in an approved residential care home on that day (and that day is a different day to the day the provider started delivering those services); and

(b) no other registered provider subsequently started delivering funded aged care services through the service group to the individual in another approved residential care home on that day.

(4) The System Governor must determine that a registered provider is not eligible for person-centred subsidy for a day for the service group residential care for an individual if:

(a) the provider started delivering funded aged care services though the service group to the individual in an approved residential care home on the day; and

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(b) the provider was not the first registered provider to start delivering funded aged care services through the service group to the individual in an approved residential care home on the day.

Excluded individuals

(5) For the purposes of paragraph (2)(g), an individual is ***excluded*** in relation to funded aged care services delivered to the individual by a registered provider through the service group residential care in an approved residential care home on the day if:

(a) the number of individuals to whom the registered provider delivered funded aged care services through that service group in that home during that day exceeds the total number of beds covered by the registered provider's registration for that home (as reduced by any offline beds for that home); and

(b) the individual is in the group of one or more individuals who comprise the excess based on working back from the most recent individual to enter the approved residential care home.

228 Amount of person-centred subsidy

Ongoing residential care

(1) The amount of ***person-centred subsidy*** a registered provider is eligible for under subsection 227(1) for an ongoing funded aged care service delivered to an individual through the service group residential care on a day is worked out as follows:

Method statement

Step 1. Work out the amount that is the base rate for a day for the individual for the classification type ongoing for the service group.

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Step 2.	Add to the amount worked out under Step 1, the sum of the amounts of any primary person-centred supplements for the classification type ongoing for the service group for the day that apply in relation to the individual.
Step 3.	Subtract (but not below zero) from the amount worked out under Step 2, the sum of any reduction amounts for the service group for the day that apply to the individual.
Step 4.	Add the amounts of any secondary person-centred supplements for the classification type ongoing for the service group for the day that apply to the individual.

Short-term residential care

(2) The amount of ***person-centred subsidy*** a registered provider is eligible for under subsection 227(1) for a short-term funded aged care service delivered to an individual through the service group residential care on a day is worked out as follows:

Method statement

Step 1.	Work out the amount that is the base rate for a day for the individual for the classification type short-term for the service group.
Step 2.	Add to the amount worked out under Step 1, the sum of the amounts of any primary person-centred supplements for the classification type short-term for the service group for the day that apply to the individual.
Step 3.	Add the amounts of any secondary person-centred supplements for the classification type short-term for the service group for the day that apply to the individual.

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229 Base rates

(1) The ***base rate*** for an individual for a classification type for the service group residential care for a day is the amount prescribed by the rules.

(2) Without limiting subsection (1), the rules may prescribe different amounts based on any one or more of the following:
  (a) the classification level of an individual for the classification type;
  (b) whether the classification type is ongoing or short-term;
  (c) whether an individual is on leave from an approved residential care home and the type of that leave.

230 Primary person-centred supplements

(1) The ***primary person-centred supplements*** for an individual for the classification type ongoing or short-term for the service group residential care are:
  (a) for the ongoing classification type:
    (i) the accommodation supplement; and
    (ii) the hotelling supplement; and
  (aa) for the short-term classification type—the hotelling supplement; and
  (b) any other supplement for the classification type for the service group prescribed by the rules.

(2) The rules may prescribe, for each primary person-centred supplement for a classification type for the service group:
  (a) the circumstances in which the supplement will apply to an individual for a day; and
  (b) the amount of the supplement.

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231 Secondary person-centred supplements

(1) The ***secondary person-centred supplements*** for an individual for a day for the classification type ongoing or short-term for the service group residential care are:

(a) for any classification type for the service group—the fee reduction supplement; and

(b) any other supplement for the classification type for the service group prescribed by the rules.

(2) The rules may prescribe, for each secondary person-centred supplement for a classification type for the service group:

(a) the circumstances in which the supplement will apply to an individual for a day; and

(b) the amount of the supplement.

(3) Without limiting subsection (2), rules made for the purposes of that subsection in relation to the fee reduction supplement may prescribe:

(aa) circumstances that include that the System Governor has made a determination about particular matters; and

(a) that the fee reduction supplement reduces any of the following:

(i) fees or contributions under Division 2 of Part 3 for the individual;

(ii) an accommodation payment or accommodation contribution under Part 4 of Chapter 4 for the individual; and

(b) the method for determining the amount (if any) of the fee reduction supplement that must be applied to reduce each of the amounts mentioned in paragraph (a), including in which order to reduce the amounts; and

(c) that the fee reduction supplement and the matters set out in paragraphs (a) and (b) of this subsection may be set by a determination made by the System Governor, and that the determination may include a limited period for which the supplement is payable.

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(4) Without limiting subsection (2), the circumstances prescribed by the rules as circumstances in which the fee reduction supplement will apply to an individual for a day must include circumstances that involve financial hardship.

(5) If a determination made by the System Governor under rules made for the purposes of subsection (2) is made in writing, the determination is not a legislative instrument.

Subdivision B—Reduction amounts for person-centred subsidy for ongoing residential care

232 Reduction amounts

The reductions in person-centred subsidy for the classification type ongoing for the service group residential care for a day for step 3 of the method statement in subsection 228(1) are such of the following reductions as apply to the individual for the classification type for the service group for the day:

(a) the compensation payment reduction for person-centred subsidy (see section 233);

(b) the person-centred subsidy reduction (see section 235).

233 The compensation payment reduction for person-centred subsidy

(1) For the purposes of paragraph 232(a), a ***compensation payment reduction for person-centred subsidy*** applies to an individual for a day if circumstances prescribed by the rules apply.

(2) The amount of the compensation payment reduction for person-centred subsidy for the individual for the day is the amount prescribed by the rules.

(3) Without limiting subsection (1), circumstances prescribed by the rules for the purposes of that subsection may include that the System Governor has made a determination about particular matters.

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(4) A determination made by the System Governor under rules made for the purposes of subsection (1) is not a legislative instrument.

234 System Governor's powers if compensation information is not given

(1) This section applies if the System Governor believes on reasonable grounds that:

(a) an individual is entitled to a compensation payment reduction in accordance with any of sections 199, 207, 216, 225, 233 or 241; and

(b) the System Governor does not have sufficient information to work out the compensation payment reduction for the purposes of that section.

(2) The System Governor may, by notice in writing given to a person, require the person to give information or produce a document that is in the person's custody, or under the person's control, if the System Governor believes on reasonable grounds that the information or document may be relevant to the working out of the compensation payment reduction.

(3) The notice must specify:

(a) how the person is to give the information or produce the document; and

(b) the period within which the person is to give the information or produce the document; and

(c) the effect of subsection (4).

Note: Sections 28A and 29 of the *Acts Interpretation Act 1901* (which deal with service of documents) apply to notice given under this section.

(4) If the information or document is not given or produced within the specified period, the System Governor may determine compensation payment reductions for the individual.

(5) The compensation payment reductions determined under subsection (4) must be determined in accordance with any requirements prescribed by the rules.

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235 The person-centred subsidy reduction

(1) The ***person-centred subsidy reduction*** for an individual for the classification type ongoing for the service group residential care for a day is worked out as follows:

Method statement

Step 1. Work out the daily means tested amount for the individual for the day (see section 319).

Step 2. Subtract the maximum accommodation supplement amount for the day (see subsection (3)) from the daily means tested amount.

Step 3. If the Step 2 amount does not exceed zero, the person-centred subsidy reduction is zero.

Step 4. If the Step 2 amount exceeds zero, the person-centred subsidy reduction is the lesser of the following:

(a) the Step 2 amount;

(b) the maximum hotelling supplement amount for the day (see subsection (4)).

(2) Despite subsection (1), if the individual has means not disclosed status for a day, the ***person-centred subsidy reduction*** for the day is the maximum hotelling supplement amount for that day.

(3) The ***maximum accommodation supplement amount*** for a day is the highest of the amounts prescribed by the rules as the amounts of accommodation supplement payable for funded aged care services delivered in an approved residential care home for that day.

(4) The ***maximum hotelling supplement amount*** for a day is the highest of the amounts prescribed by the rules as the amount of

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hotelling supplement payable for funded aged care services delivered in an approved residential care home for that day.

(5) Despite subsection (1), the ***person-centred subsidy reduction*** for an individual for a day is zero if the hotelling contribution and non-clinical care contribution for the individual for the day is taken to be zero under section 280.

Subdivision C—Provider-based subsidy

236 Eligibility for provider-based subsidy

A registered provider is eligible for provider-based subsidy for a day for an ongoing or short-term funded aged care service delivered by the registered provider to an individual in an approved residential care home if the provider is eligible to claim a person-centred subsidy for the individual under section 227.

237 Amount of provider-based subsidy

(1) The amount of provider-based subsidy a registered provider is eligible for under section 236 for a day for an individual for the classification type ongoing for the service group residential care is worked out as follows:

Method statement

Step 1: Work out the sum of the following:

(a) the base provider amount for the classification type for the service group for the individual for the day;

(b) any provider-based supplements for the classification type for the service group for the individual for the day that the provider is eligible for under section 239.

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Step 2.	Subtract (but not below zero) from the amount worked out under Step 1, the sum of any reduction amounts for the classification type for the service group for the day that apply to the provider.

(2) The amount of provider-based subsidy a registered provider is eligible for under section 236 for a day for an individual for the classification type short-term for the residential care service group is worked out as follows:

Method statement

Work out the sum of the following:

(a) the base provider amount for the classification type for the service group for the individual for the day;

(b) any provider-based supplements for the classification type for the service group for the individual for the day that the provider is eligible for under section 239.

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238 Base provider amount

(1) The ***base provider amount*** for a registered provider for the classification type ongoing or short-term for the service group residential care for a day is the amount prescribed by the rules.

(2) Without limiting subsection (1), the rules may prescribe different amounts of base provider amount for a classification type for the service group based on any of the following:

(a) whether the classification type is ongoing or short-term;

(b) whether funded aged care services are being delivered in an approved residential care home that has been determined to have specialised status under subsection 243(3).

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239 Provider-based supplements

(1) The ***provider-based supplements*** for an individual for the classification type ongoing or short-term for the service group residential care for a day are any provider-based supplement prescribed by the rules.

(2) The rules may prescribe, for each provider-based supplement:
  (a) the circumstances in which the supplement will apply in relation to an individual; and
  (b) the amount of the supplement.

(3) Without limiting subsection (2), circumstances prescribed for a provider-based supplement may include circumstances relating to any of the following:
  (a) characteristics of the approved residential care home in which the service was delivered (such as its location and number of beds);
  (b) the number of other individuals to whom the registered provider delivered funded aged care services at the approved residential care home during a particular period (whether or not that period includes the day, and whether or not the funded aged care services were provided during that period to the individual in relation to whom the supplement applies);
  (c) information provided to the System Governor in relation to the registered provider's compliance with one or more of the following in relation to the approved residential care home for a particular period (whether or not that period includes the day):
    (i) a condition of the registered provider's registration under Division 1 of Part 4 of Chapter 3;
    (ii) an obligation of the registered provider under Division 2 of that Part.

(4) Before the Minister makes rules prescribing circumstances for the purposes of paragraph (2)(a), the Minister must be reasonably satisfied that additional funding will assist those registered providers to improve, or maintain, compliance with any of the

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following in relation to the delivery of funded aged care services to individuals at the approved residential care home:

(a) a condition of registration under Division 1 of Part 4 of Chapter 3 that applies to those providers;

(b) an obligation under Division 2 of that Part that applies to those providers.

Subdivision D—Reduction amounts for provider-based subsidy for ongoing residential care

240 Reduction amounts

The reductions in provider-based subsidy for the classification type ongoing for the service group residential care for a day for step 2 of the method statement in subsection 237(1) are such of the following reductions as apply to the provider for the classification type for the service group for the day:

(a) the compensation payment reduction for provider-based subsidy (see section 241);

(b) the provider-based subsidy reduction (see section 242).

241 The compensation payment reduction for provider-based subsidy

(1) For the purposes of paragraph 240(a), a ***compensation payment reduction for provider-based subsidy*** applies to an individual for a day if circumstances prescribed by the rules apply.

(2) The amount of the compensation payment reduction for provider-based subsidy for the individual for the day is the amount prescribed by the rules.

(3) Without limiting subsection (1), circumstances prescribed by the rules for the purposes of that subsection may include that the System Governor has made a determination about particular matters.

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(4) A determination made by the System Governor under rules made for the purposes of subsection (1) is not a legislative instrument.

242 Provider-based reduction amount

(1) The ***provider-based subsidy reduction*** for a registered provider for the classification types ongoing for the service group residential care for an individual for a day is worked out as follows:

Method statement

Step 1: Work out the daily means tested amount for the individual for the day (see section 319).

Step 2: Subtract the sum of the following from the daily means tested amount:

(a) the maximum accommodation supplement amount (see subsection 235(3));

(b) the maximum hotelling supplement amount (see subsection 235(4)).

Step 3. If the Step 2 amount does not exceed zero, the ***provider-based subsidy reduction*** is zero.

Step 4. If the Step 2 amount exceeds zero, the ***provider-based subsidy reduction*** is the lesser of the following:

(a) the Step 2 amount;

(b) the maximum non-clinical care contribution (see subsection 279(3));

(c) the standard base provider amount (see subsection (2)).

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(2) The ***standard base provider amount*** for a day for an individual is the amount prescribed by the rules.

(3) If the individual has means not disclosed status for a day, the provider-based subsidy reduction for the day is the lesser of the following:

(a) the maximum non-clinical care contribution for the day;

(b) the standard base provider amount for that day.

(4) Despite subsection (1), the ***provider-based subsidy reduction*** for a registered provider for the classification type ongoing for the service group residential care for an individual for a day is zero if:

(a) the hotelling contribution and non-clinical care contribution for the individual for the day is taken to be zero under section 280; or

(b) the non-clinical care contribution for the individual for the day is zero under subsection 279(4) or (5).

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Division 4A—Amount of subsidy for residential care—individuals in prescribed classes

242A Eligibility for subsidy

(1) A registered provider is eligible for subsidy for a funded aged care service delivered by the registered provider to an individual in a class of individuals prescribed by rules made for the purposes of section 227A through the service group residential care on a day if the System Governor is reasonably satisfied the requirements in subsections (2) to (4) are met.

General requirements

(2) The requirements are:

(a) the registered provider's registration is in effect and covers the funded aged care service; and

(b) the individual has an access approval that is in effect that covers the funded aged care service; and

(c) the individual has been allocated a place for the classification type for the service group under section 92; and

(d) the individual has a classification level in effect for the classification type ongoing or short-term for the service group; and

(e) either:

(i) the registered provider has given a start notification for delivering ongoing or short-term funded aged care services to the individual through the service group at an approved residential care home of the provider; or

(ii) circumstances prescribed by the rules apply; and

(f) the funded aged care service is not being delivered to the individual under a specialist aged care program; and

(g) the individual is not excluded (see subsection (5)).

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Circumstances where registered provider not eligible

(3) Despite subsection (1), a registered provider is not eligible for subsidy for a day for the service group residential care for an individual if the System Governor is reasonably satisfied that:

(a) the registered provider ceased delivering funded aged care services through the service group to the individual in an approved residential care home on that day (and that day is a different day to the day the provider started delivering those services); and

(b) no other registered provider subsequently started delivering funded aged care services through the service group to the individual in another approved residential care home on that day.

(4) Despite subsection (1), a registered provider is not eligible for subsidy for a day for the service group residential care for an individual if the System Governor is reasonably satisfied that:

(a) the provider started delivering funded aged care services though the service group to the individual in an approved residential care home on the day; and

(b) the provider was not the first registered provider to start delivering funded aged care services through the service group to the individual in an approved residential care home on the day.

Excluded individuals

(5) For the purposes of paragraph (2)(g), an individual is ***excluded*** in relation to funded aged care services delivered to the individual by a registered provider through the service group residential care in an approved residential care home on a particular day if:

(a) the number of individuals to whom the registered provider delivered funded aged care services through that service group in that home during that day exceeds the total number of beds covered by the registered provider's registration for that home (as reduced by any offline beds for that home); and

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(b) the individual is in the group of one or more individuals who comprise the excess based on working back from the most recent individual to enter the approved residential care home.

242B Amount of subsidy

The amount of subsidy a registered provider is eligible for under section 242A for an ongoing funded aged care service delivered to an individual in a class of individuals prescribed by rules made for the purposes of section 227A through the service group residential care on a day is the amount prescribed by the rules for that class of individuals.

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Division 4B—Approved residential care homes with specialised status and leave from approved residential care homes

243 Approved residential care homes with specialised status

(1) A registered provider that delivers funded aged care services in an approved residential care home may apply to the System Governor for a determination under subsection (3) that the approved residential care home has specialised status.

(2) The application must be in the approved form.

(3) The System Governor must consider an application made by a registered provider under subsection (1) and decide:
  (a) whether to determine that the approved residential care home has specialised status; and
  (b) if determining that the approved residential care home has specialised status—the period, not exceeding the period referred to in paragraph (5)(c), for which the determination has effect.

(4) Within 14 days after making a decision under subsection (3), the System Governor must give written notice of the decision to the registered provider that includes:
  (a) details of the decision, including the period of effect for the determination; and
  (b) reasons for the decision; and
  (c) details about how the registered provider may apply for the reconsideration of the decision.

(5) The rules may prescribe:
  (a) different kinds of specialised status; and
  (b) criteria that the System Governor must consider when deciding whether to determine an approved residential care home has a particular specialised status; and

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(c) the maximum period of effect for such a determination.

243A Revoking specialised status determinations

Revocation on initiative of System Governor

(1) The System Governor may, by written notice given to a registered provider, revoke a determination made under subsection 243(3) in relation to the registered provider and an approved residential care home if circumstances prescribed by the rules apply.

Revocation on request

(2) A registered provider may, by written notice given to the System Governor, request the System Governor to revoke a determination made under subsection 243(3) in relation to the registered provider and an approved residential care home.

(3) The System Governor must revoke a determination for which a request is given under subsection (2) and give written notice to the registered provider of the revocation.

Notice requirements

(4) A notice given under subsection (1) or (3) must specify the day the revocation takes effect (which must not be earlier than the day the notice is given).

244 When an individual is on leave

(1) This section applies if a registered provider is delivering ongoing funded aged care services through the service group residential care in an approved residential care home to an individual.

(2) On each day during which an individual is on any type of ***leave*** mentioned in subsections (3) to (7) from the approved residential care home, the individual is taken, for the purposes of this Act (other than section 246) to have been delivered ongoing funded

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aged care services through the service group residential care by the registered provider in the approved residential care home.

Note: Section 246 deals with how to work out periods of leave under this section.

Emergency leave

(3) Despite subsections (4) to (7), the individual is on ***emergency leave*** from an approved residential care home (the ***affected home***) on a day if:

(a) during the whole of that day, the individual is absent from the affected home; and

(b) the Minister determines under subsection 245(1) that there is a situation of emergency for that day for the affected home, or a class of approved residential care homes that includes the affected home.

Hospital leave

(4) The individual is on ***hospital leave*** from the approved residential care home on each day of any period during which the individual attends a hospital for the purpose of receiving hospital treatment.

Hospital transition leave

(5) The individual is on ***hospital transition leave*** from the approved residential care home on each day of any period during which the individual has a hospital transition classification in effect.

Extended hospital leave

(6) The individual is on ***extended hospital leave*** if the individual is on any combination of hospital leave and hospital transition leave for a continuous period of 30 days or more.

Social leave

(7) The individual is on ***social leave*** from the approved residential care home on a day if:

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(a) during the whole of that day, the individual is absent from the approved residential care home; and

(b) the individual is not on leave under any of subsections (3), (4), (5) or (6) on that day; and

(c) the number of days on which the individual has previously been on leave under this subsection, during the current financial year, is less than 52.

Note: If an individual is taken not to have been delivered funded aged care services because the maximum number of days has been exceeded, subsidy will not be payable in respect of those excess days. However, the individual may agree to pay a fee to the registered provider to reserve the individual's bed in the approved residential care home. The maximum amount in such a case is set by section 282.

245 Determining situations of emergency to enable additional leave

(1) The Minister may determine, in writing, that there is a situation of emergency for a specified day for an approved residential care home, or a class of approved residential care homes, if the Minister is satisfied that an emergency is affecting or has affected:

(a) the home or homes for that day; or

(b) the community in which the home or homes are located for that day.

Note: An emergency affecting an approved residential care home or community may include a disaster (whether natural or otherwise), an epidemic or a pandemic.

(2) For the purposes of subsection (1):

(a) a class of approved residential care homes may include all approved residential care homes in Australia; and

(b) a day for which a situation of emergency is determined may be a day that is before, on or after the day the determination is made.

(3) A determination made under subsection (1) for a class of approved residential care homes is a legislative instrument.

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(4) A determination made under subsection (1) for a particular approved residential care home is not a legislative instrument, but must be published on the Department's website.

(5) The Minister may, in writing, delegate to the System Governor the power to make a determination under subsection (1). In exercising the power, the System Governor must comply with any directions of the Minister.

Note: Sections 34AA to 34A of the *Acts Interpretation Act 1901* contain provisions relating to delegations.

246 Working out periods of leave

In working out the days on which an individual is on leave under section 244:

(a) subject to paragraph (b), include the day the individual was first absent for the period; and

(b) do not include the day on which the registered provider recommenced delivering funded aged care services to the individual.

Note 1: Absences that do not include an overnight absence from an approved residential care home are not counted as leave because of paragraph (b).

Note 2: An individual is taken to be on leave for the whole day on which the individual was first absent, regardless of what time on that day the individual was first absent.

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Division 5—Subsidy for certain specialist aged care programs

247 Power to enter into agreements for delivery of funded aged care services under specialist aged care programs

(1) The System Governor may, on behalf of the Commonwealth, enter into a written agreement with:

(a) for the Multi-Purpose Service Program—an entity for the entity (once registered as a registered provider) to deliver funded aged care services to individuals through one or more specified service groups under the program; or

(b) for the Transition Care Program—a State or Territory to cover the arrangement in the State or Territory for the delivery of funded aged care services to individuals through one or more specified service groups under the program.

(1A) To avoid doubt, paragraph (1)(a) does not prevent there being one or more other parties to the agreement.

(2) The agreement is to be entered into by the System Governor on behalf of the Commonwealth.

(3) The System Governor must not enter an agreement under subsection (1)(a) unless circumstances prescribed by the rules apply.

(4) An agreement under subsection (1):

(a) may include terms and conditions relating to the registered provider's or State or Territory's involvement in the specialist aged care program; and

(b) must meet any other requirements prescribed by the rules.

(5) To avoid doubt, if a term or condition included in a written agreement under subsection (1) is inconsistent with a provision of this Act, the provision prevails and the term or condition, to the extent of the inconsistency, is of no effect.

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248 Eligibility for subsidy

A registered provider is eligible for subsidy on a day in relation to the delivery of funded aged care services to individuals through a service group under a specialist aged care program if, on that day:

(a) either:

(i) the registered provider has an agreement under subsection 247(1) with the Commonwealth that includes the service group; or

(ii) the registered provider is in a State or Territory that has an agreement under subsection 247(1) with the Commonwealth; and

(b) one or more places have been allocated to the registered provider for the service group for the program under section 95 and are being, or are able to be, used to deliver funded aged care services to those individuals; and

(c) those places are in effect and all the conditions that apply to those places under section 99 have been met for the delivery of any funded aged care services to those individuals.

Note: A registered provider may be eligible for subsidy for a day under this provision even if the registered provider did not deliver any funded aged care services to individuals on that day.

249 Amount of subsidy

(1) The amount of subsidy a registered provider is eligible for under section 248 on a day in relation to funded aged care services delivered through a service group under a specialist aged care program is the amount prescribed by the rules.

(2) To avoid doubt, and without limiting subsection (1) a subsidy amount prescribed by the rules under that subsection may:

(b) disregard the classification level for a classification type for a service group for an individual; and

(c) be based on factors other than the actual delivery of a funded aged care service to an individual on the day.

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Division 6—Subsidy claims and payment

Subdivision A—Claims and payment for home support, assistive technology and home modifications

250 Payment of subsidy

(1) Subsidy is payable by the Commonwealth to a registered provider if:

(a) the registered provider is eligible for subsidy under section 191, 201, 209 or 218 for a funded aged care service delivered to an individual on a day; and

(b) the registered provider gives the System Governor a claim for that subsidy in accordance with section 251.

Note: Subsidy is not payable to the extent that there are insufficient funds in an individual's relevant notional account: see section 251A.

(2) Subsidy payable in relation to individuals to whom funded aged care services were delivered through each service delivery branch of a registered provider is separately payable by the Commonwealth.

(3) If the full amount of subsidy for which a registered provider is eligible under section 191, 201, 209 or 218 for a funded aged care service delivered to an individual on a day is not payable because of the previous operation of section 251A in relation to the subsidy, the registered provider remains eligible for so much of the full amount of subsidy as remains unpaid.

Note: If additional credits are made to the individual's relevant notional account or the registered provider's relevant notional service delivery branch account, the unpaid amount may become payable in accordance with subsection (1) if an additional claim is made for that unpaid amount.

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251 Claims for subsidy

(1) For the purposes of obtaining payment, a registered provider must give to the System Governor a claim, in an approved form, for any subsidy that is payable, for the relevant period for the subsidy, to the registered provider under section 250 for a funded aged care service delivered to an individual through a service delivery branch of the registered provider during the relevant period.

(2) The ***relevant period*** is:

(a) for person-centred subsidy for an ongoing funded aged care service delivered to an individual through the service group home support—a quarter; and

(b) for provider-based subsidy for an ongoing funded aged care service delivered to an individual through the service group home support—a financial year; and

(c) for subsidy for a short-term funded aged care service delivered to an individual through the service group home support—the maximum period of effect for the individual's classification level for the classification type for the service group; and

(d) for subsidy for ongoing funded aged care services delivered to an individual through the service group assistive technology—the period prescribed by the rules; and

(e) for subsidy for short-term funded aged care services delivered to an individual through the service group assistive technology or home modifications—the maximum period of effect for the individual's classification level for the classification type for the service group.

(3) The claim must be given to the System Governor before the end of:

(a) whichever of the following periods ends first:

(i) the period of 60 days after the end of the relevant period;

(ii) the period of 60 days after an event prescribed by the rules occurs; or

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(b) if the System Governor determines a longer period for the claim than would otherwise apply under paragraph (a)—that longer period.

Note: Because the claim must be given before the end of the period applicable under this subsection, it can be given at any time before the end of that period, including during the relevant period.

(4) The System Governor must approve the claim for any subsidy that is payable to the registered provider, and give the registered provider a payment summary relating to the claim, as soon as reasonably practicable after the claim is given to the System Governor under subsection (1), unless the System Governor gives a written notice under section 252 to the registered provider in relation to the claim (which deals with registered providers who are not eligible).

(5) To avoid doubt, for the purposes of this section:
(a) multiple claims can be made for a single relevant period; and
(b) claims for multiple days in the same relevant period can be included in a single claim; and
(c) a further claim may be made for an unpaid amount referred to in subsection 250(3).

251A Subsidy amounts not payable to the extent of insufficient funds

Person-centred subsidy for home support

(1) Despite subsection 250(1), subsidy for which a registered provider is eligible under section 191 for the delivery of a funded aged care service to an individual on day is payable only to the extent that, immediately before the claim for the subsidy is approved, the amount worked out at Step 1 of the method statement in subsection 192(1) or 192(2) (the ***debit amount***) in relation to the subsidy does not exceed:
(a) the available balance of the individual's notional ongoing home support account or notional short-term home support

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account (as applicable) for the quarter or account period (as applicable) in which the day occurs; or

(b) if there is an excess amount—the excess amount (as reduced (but not below zero) by the sum of any reduction amounts referred to in Step 2 of the method statement in subsection 192(1) or 192(2) and the available balance of any unspent Commonwealth portion held by the provider for the individual) does not exceed the available balance of any notional home care account for the individual.

Provider-based subsidy for home support

(2) Despite subsection 250(1), subsidy for which a registered provider is eligible under section 201 for the delivery of a funded aged care service to an individual on a day is only payable to the extent that, immediately before the claim for the subsidy is approved, the amount worked out at Step 1 of the method statement in section 202 (the ***debit amount***) in relation to the subsidy does not exceed the available balance of the registered provider's notional service delivery branch account for the service branch through which the service was delivered for the financial year in which the day occurs.

Person-centred subsidy for assistive technology or home modifications

(3) Despite subsection 250(1), subsidy for which a registered provider is eligible under section 209 or 218 for the delivery of a funded aged care service to an individual on a day is only payable to the extent that, immediately before the claim for the subsidy is approved, the amount worked out at Step 1 of the method statement in section 210 and 219 (the ***debit amount***) in relation to the subsidy as reduced (but not below zero) by the available balance of any unspent Commonwealth portion held by the registered provider for the individual:

(a) does not exceed the available balance of any notional home care account for the individual; or

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(b) if there is an excess amount—the excess amount (as reduced (but not below zero) by the sum of any reduction amounts referred to in step 2 of the method statement in section 210 or 219) does not exceed the available balance of the individual's notional assistive technology account or notional home modifications account.

251B Debiting of notional accounts and unspent Commonwealth portions

Person-centred subsidy for home support

(1) If the System Governor approves a claim relating to subsidy for which the registered provider is eligible under section 191 for the delivery of a funded aged care service to an individual on a day, the following must be debited, in the following order, to cover so much of the debit amount referred to in subsection 251A(1) that is payable under that subsection:

(a) the individual's notional ongoing home support account or notional short-term home support account for the quarter or account period in which the day occurs;

(b) any unspent Commonwealth portion held by the provider for the individual;

(c) the individual's notional home care account (if any).

Provider-based subsidy for home support

(2) If the System Governor approves a claim relating to subsidy for which the registered provider is eligible under section 201 for the delivery of a funded aged care service to an individual on a day, the registered provider's notional service delivery branch account for the service delivery branch through which the service was delivered for the financial year in which the day occurs must be debited to cover so much of the debit amount referred to in subsection 251A(2) that is payable under that subsection.

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Person-centred subsidy for assistive technology or home modifications

(3) If the System Governor approves a claim relating to subsidy for which the registered provider is eligible under section 209 or 218 for the delivery of a funded aged care service to an individual on a day, the following must be debited, in the following order, to cover so much of the debit amount referred to in subsection 251A(3) that is payable under that subsection:

(a) any unspent Commonwealth portion held by the provider for the individual;

(b) the individual's notional home care account (if any);

(c) the individual's notional assistive technology account or notional home modifications account.

Debiting of unspent Commonwealth portions

(4) To avoid doubt, an unspent Commonwealth portion held by a registered provider for an individual is required to be debited under this section if the portion has reduced an excess amount referred to in paragraph 251A(1)(b) or the debit amount as referred to in subsection 251A(3).

Note: If additional credits are made to the individual's relevant notional account or the provider's relevant notional service delivery branch account, the unpaid amount may become payable in accordance with subsection 250(1) if an additional claim is made for that unpaid amount.

252 Notice of refusal

The System Governor must give written notice to a registered provider if:

(a) the registered provider has a made a claim under section 251 for subsidy for the delivery of a funded aged care service to an individual on a day; and

(b) the registered provider is not eligible for that subsidy.

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253 Variations of claims

(1) A registered provider may vary a claim made for a relevant period referred to in subsection 251(2) at any time before:

(a) the end of the period applicable for the claim under subsection 251(3); or

(b) such longer period as is determined for the claim by the System Governor.

(2) In determining a longer period for the purposes of paragraph (1)(b), the System Governor must be satisfied that a variation is required:

(a) due to an administrative error made by the Commonwealth; or

(b) because the Commonwealth considers that the circumstances of an individual are different from those on the basis of which subsidy was claimed.

Subdivision B—Claims and payment for residential care

254 Payment of subsidy

(1) Subsidy is payable by the Commonwealth to a registered provider for each day in a payment period for which the registered provider is eligible for an individual under section 227, 236 or 242A.

(2) The sum of subsidy payable for a payment period in relation to individuals to whom funded aged care services were delivered in each approved residential care home of the registered provider is separately payable by the Commonwealth.

255 Meaning of *payment period*

A ***payment period*** for the service group residential care is a calendar month.

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256 Timing of payments

Payment of subsidy

(1) Subsidy payable under section 254 to a registered provider in relation to an approved residential care home is payable by the Commonwealth for a payment period at such times as the System Governor thinks fit.

Advances

(2) If the System Governor pays an amount of subsidy in advance under subsection (1), the System Governor must work out the amount of the advance for the approved residential care home by:

(a) for the first payment period or the second payment period for the registered provider for the home—estimating the amount of subsidy that will be payable under section 254 in relation to the home for the days in that period; and

(b) for subsequent payment periods for the registered provider for the home by:

(i) estimating the amount of subsidy that will be payable under section 254 in relation to that home (taking into account any deductions under subsection 261(1)) for the days in the period; and

(ii) increasing or reducing that amount to make any adjustments that are necessary to take account of any underpayments or overpayments in respect of advances previously paid under this section.

(3) The amounts of advances under subsection (2) must be worked out in accordance with any requirements prescribed by the rules.

(4) The System Governor may, in deciding whether to reduce the amount of an advance under paragraph (2)(b), take into account the likelihood of the Commonwealth's right to recover a particular overpayment being written-off or waived under section 520 or 521.

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257 Claims for subsidy

(1) A registered provider must, for each payment period and each residential care home of the registered provider, give to the System Governor a claim, in the approved form, for any subsidy that is payable to the registered provider in relation to that home for that period under section 254.

(2) The claim must be given to the System Governor as soon as practicable after the end of the payment period.

258 Notice of refusal

The System Governor must give written notice to a registered provider if:

(a) the registered provider has made a claim under section 257 for subsidy in relation to an individual; and

(b) the registered provider is not eligible for that subsidy.

259 Variations of claims

(1) A registered provider may vary a claim made for a payment period within:

(a) 2 years after the end of the payment period; or

(b) such longer period as is determined for the claim by the System Governor.

(2) In determining a longer period for the purposes of paragraph (1)(b), the System Governor must be satisfied that a variation is required:

(a) due to an administrative error made by the Commonwealth; or

(b) because the Commonwealth considers that the circumstances of an individual are different from those on the basis of which subsidy was claimed.

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Subdivision C—Claims and payment for specialist aged care programs

260 Claims and payment of subsidy

(1) Subsidy is payable by the Commonwealth to a registered provider for each day the registered provider is eligible under section 248 in relation to the delivery of funded aged care services to individuals through a service group under a specialist aged care program.

(2) The rules may prescribe requirements relating to claims for, and payment of, subsidy under subsection (1).

(3) It is a condition on which subsidy is paid to a registered provider under this section that the subsidy is used by the registered provider only for the purpose of delivering funded aged care services to individuals in circumstances where all of the following apply:

(a) the services are delivered to the individual by the registered provider under a place that is in effect under section 97 for the program and service group;

(b) all conditions on those places under section 99 have been complied with;

(c) the registered provider's registration is in effect and covers the delivery of each of those services;

(d) each of those individuals has an access approval in effect that covers each of the services being delivered to the individual.

Note: Amounts are recoverable by the Commonwealth in circumstances where a registered provider breaches this condition: see paragraph 514(2)(c).

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Subdivision D—Miscellaneous provisions

261 Deduction for fees

(1) The System Governor may deduct from the total amount of person-centred subsidy and provider-based subsidy otherwise payable to a registered provider for a service delivery branch or

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approved residential care home under section 250 or 254, deductions for fees covered by an agreement referred to in subsection (2).

(2) The System Governor may, on behalf of the Commonwealth, enter into an agreement with a registered provider, under which:

(a) amounts equal to the fees payable by the registered provider for applications made under this Act are to be deducted from amounts of person-centred subsidy and provider-based subsidy otherwise payable to the registered provider for the service delivery branch or approved residential care home specified in the agreement; and

(b) so far as amounts are so deducted, the registered provider ceases to be liable to the Commonwealth for payment of the fees.

262 Multiple claims

(1) Subsection (2) applies if the System Governor is given for a day for an individual, by one or more registered providers:

(a) one or more claims for subsidy for a classification type for a service group; and

(b) either or both of the following:

(i) one or more claims for subsidy for any other classification type for the service group;

(ii) one or more claims for any classification type for another service group.

(2) The System Governor may accept any of the claims for one classification type for one service group and refuse the claims made for any other classification type for that service group or a classification type for another service group.

(3) If the System Governor refuses under subsection (2) one or more claims for subsidy for an individual, the individual is taken not to be eligible under this Act for the subsidy.

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(4) Subsection (2) does not apply in circumstances prescribed by the rules.

(5) This section has effect despite anything else in this Act.

263 Transfers of service delivery branches and approved residential care homes

(1) The rules may make provision for, or in relation to, the following matters:

(a) the transfer of a service delivery branch of a registered provider to another registered provider;

(b) the transfer of an approved residential care home of a registered provider to another registered provider.

(2) Without limiting subsection (1), the rules may make provision for, or in relation to, any one or more of the following matters:

(a) the entitlement of the transferor to an amount of subsidy that is payable immediately before the transfer takes effect;

(b) any other rights, obligations or responsibilities of the transferor under this Chapter as they exist immediately before the transfer takes effect;

(c) any other matter that is reasonably necessary to deal with the matter specified in paragraph (a) or (b).

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263A Mergers of service delivery branches

(1) The rules may make provision for, or in relation to, the merger of 2 or more service delivery branches of a registered provider into a single service delivery branch of the provider.

(2) Without limiting subsection (1), the rules may make provision for, or in relation to, any one or more of the following matters:

(a) the consolidation of the notional service delivery branch accounts for those branches;

(b) any other rights, obligations or responsibilities of the registered provider in relation to each of those service

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delivery branches under this Chapter as they exist immediately before the merger takes effect;

(c) any other matter that is reasonably necessary to deal with the matter specified in paragraph (a) or (b).

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Division 7—Grants

264 Power to enter into arrangements for delivery of funded aged care services

Services delivered in a home or community setting

(1) The System Governor may, on behalf of the Commonwealth, make, vary or administer a grant of financial assistance to a registered provider for the delivery of funded aged care services to individuals through one or more of the following service groups (with certain classification levels established for classification types ongoing or short-term for these groups):

(a) home support;

(b) assistive technology;

(c) home modifications.

Services delivered to Aboriginal or Torres Strait Islander persons

(2) The System Governor may, on behalf of the Commonwealth, make, vary or administer a grant of financial assistance to a registered provider for the delivery of funded aged care services to Aboriginal or Torres Strait Islander persons through one or more service groups.

Grants can be made on condition that entity becomes registered provider

(3) The System Governor may, on behalf of the Commonwealth, make a conditional offer of a grant of financial assistance under subsection (1) or (2) to an entity on the basis that the grant of financial assistance will be made if and when the entity becomes a registered provider.

Power does not limit other powers

(4) This section does not, by implication, limit section 265.

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265 Power to enter into other arrangements

(1) The System Governor may, on behalf of the Commonwealth, make, vary or administer a grant of financial assistance to any person or body in relation to the carrying out of activities by the person or body for a purpose referred to in subsection (2).

(2) The purposes are the following:

(a) to initiate, sustain, support or increase the delivery of services to individuals in relation to the Commonwealth aged care system and the aged care system more broadly, including during times of emergency;

(b) to strengthen the capability of, and raise awareness among, registered providers and aged care workers and responsible persons of registered providers about the specialised complex needs of individuals accessing funded aged care services;

(c) to provide additional support to address such specialised complex needs of individuals accessing those services;

(d) to support and uphold the rights and entitlements of individuals accessing services in the aged care system;

(e) to provide free, independent and confidential information, advocacy and education to individuals accessing, or seeking to access, funded aged care services;

(f) to address aged care worker shortages and retention issues, including by addressing capability and qualification gaps in relation to the delivery of funded aged care services;

(g) any other purpose prescribed by the rules.

266 Terms and conditions relating to grants

(1) The terms and conditions on which financial assistance is granted under section 264 or 265 are the following:

(a) the statutory funding conditions;

(b) any other terms and conditions set out in a written agreement (the ***funding agreement***) between the Commonwealth and the grant recipient.

Note 1: For the statutory funding conditions, see section 267.

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Note 2: See also section 270 (constitutional limits).

(2) The grant recipient must comply with the statutory funding conditions and the terms and conditions set out in the funding agreement.

Terms and conditions in funding agreement

(3) The terms and conditions set out in the funding agreement:
  (a) must provide for the circumstances in which the grant recipient must repay amounts to the Commonwealth; and
  (b) may deal with matters covered by the statutory funding conditions; and
  (c) may deal with the consequences for a breach of a term or condition of the funding agreement.

(4) Subsection (3) does not limit the terms and conditions that may be set out in the funding agreement.

(5) To avoid doubt, if a term or condition included in the funding agreement is inconsistent with a provision of this Act, the provision prevails and the term or condition, to the extent of the inconsistency, is of no effect.

Funding agreement to be entered into by System Governor

(6) The funding agreement is to be entered into by the System Governor on behalf of the Commonwealth.

267 Statutory funding conditions

Grants for delivery of funded aged care services

(1) The ***statutory funding condition*** that applies to financial assistance granted to a registered provider under subsection 264(1) or (2) is the condition that the financial assistance is used by the registered provider only for the purpose of delivering funded aged care services to individuals in circumstances where all of the following apply:

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(a) the registered provider's registration is in effect and covers each of those services;

(b) each of those individuals has an access approval in effect that covers each of the services being to delivered to the individual;

(c) for a grant under subsection 264(1)—each of those individuals has a classification level prescribed by the rules for each service group prescribed by the rules through which funded aged care services are being delivered to the individual.

Note: Amounts are recoverable by the Commonwealth in circumstances where a registered provider breaches this condition: see paragraph 514(2)(c).

Grants for carrying out activities for certain purposes

(2) The ***statutory funding condition*** that applies to financial assistance granted to a person or body under subsection 265(1) is the condition that the person or body complies with the Grantee Code of Conduct.

Note 1: Amounts are recoverable by the Commonwealth in circumstances where a person or body breaches this condition: see paragraph 514(2)(c).

Note 2: For the Grantee Code of Conduct, see section 268.

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268 Grantee Code of Conduct

(1) The rules may make provision for, or in relation to, a code of conduct that applies to persons or bodies:

(a) to whom money may be payable under an arrangement made under subsection 265(1); or

(b) who receive a grant of financial assistance made under subsection 265(1).

(2) Without limiting subsection (1), rules made for the purposes of that subsection may provide for the circumstances in which a person or body breaches the code of conduct because of an act, or an

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omission to perform an act, by another person who is employed, or otherwise engaged, by the person or body.

(3) The rules made for the purposes of subsection (1) are the ***Grantee Code of Conduct***.

269 System Governor has powers etc. of the Commonwealth

(1) The System Governor, on behalf of the Commonwealth, has all the rights, responsibilities, duties and powers of the Commonwealth in relation to the Commonwealth's capacity as the grantor of a grant made under section 264 or 265.

(2) Without limiting subsection (1):

(a) a grant made under section 264 or 265 is to be paid by the System Governor on behalf of the Commonwealth; and

(b) an amount payable to the Commonwealth by way of the repayment of the whole or a part of a grant made under section 264 or 265 is to be paid to the System Governor on behalf of the Commonwealth; and

(c) the System Governor may institute an action or proceeding on behalf of the Commonwealth in relation to a matter that concerns a grant made under section 264 or 265.

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270 Constitutional limits

The System Governor may exercise a power conferred on the System Governor by section 265 only:

(a) with respect to the executive power of the Commonwealth; or

(b) with respect to the provision of unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services and family allowances within the meaning of paragraph 51(xxiiiA) of the Constitution; or

(c) with respect to the people of any race for whom it is deemed necessary to make special laws; or

(d) with respect to aliens within the meaning of paragraph 51(xix) of the Constitution; or

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(e) with respect to the use of a postal, telegraphic, telephonic or other like service within the meaning of paragraph 51(v) of the Constitution; or

(f) with respect to the granting of financial assistance to a State or Territory; or

(g) with respect to implementing any of Australia's international obligations under any of the following:

(i) Articles 2, 6 and 12(2) of the Covenant on Economic, Social and Cultural Rights;

(ii) Articles 4, 8, 9, 19, 20, 25, 26 and 27 of the Convention on the Rights of Persons with Disabilities;

(iii) Articles 1 and 2 of the ILO Convention (No. 122) concerning Employment Policy;

(iv) Article 1 of the ILO Convention (No. 142) concerning Vocational Guidance and Vocational Training in the Development of Human Resources; or

(h) with respect to census and statistics (within the meaning of paragraph 51(xi) of the Constitution); or

(i) with respect to the granting of financial assistance to a constitutional corporation for the purposes of carrying out the corporation's activities; or

(j) with respect to matters incidental to the execution of any of the legislative powers of the Parliament or the executive power of the Commonwealth.

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271 Executive power of the Commonwealth

This Part does not, by implication, limit the executive power of the Commonwealth.

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Part 3—Individual fees and contributions

Division 1—Fees and contributions payable in a home or community setting

272 Division not to apply to specialist aged care programs

This Division does not apply in relation to an individual accessing funded aged care services under a specialist aged care program.

Note: For individual contributions for accessing funded aged care services under a specialist aged care program, see Division 3.

273 Contributions for delivery of funded aged care services in a home or community setting

(1) A registered provider that delivers a funded aged care service through the service group home support, assistive technology or home modifications to an individual on a day may charge the individual an individual contribution for that service.

(2) The ***individual contribution*** for the delivery of the funded aged care service to the individual on the day is worked out as follows:

Method statement

Step 1. Work out:

(a) if the service group is home support—the individual's individual contribution rate under section 314 for the day referred to in subsection (1) of this section; or

(b) if the service group is assistive technology or home modifications—the lower of the individual's individual contribution rate under section 314 for

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the day referred to in subsection (1) of this section and the day prescribed by the rules.

Step 2. If the subsidy basis for the service is efficient price or unit price—multiply the number of hours or units of the service delivered to the individual on the day by the lesser of the following:

(a) the base efficient price or base unit price for the service on that day;

(b) the price charged by the provider for an hour or unit of the service on that day.

Step 3. Multiply the Step 1 amount:

(a) if the subsidy basis for the service is efficient price or unit price—by the Step 2 amount; or

(b) if the subsidy basis for the service is cost and circumstances prescribed by the rules apply—by the amount prescribed by the rules for those circumstances; or

(c) if the subsidy basis for the service is cost and paragraph (b) does not apply—by the cost.

Step 4. Reduce (but not below zero) the Step 3 amount by any fee reduction supplement applicable to the individual for the day.

(3) The registered provider must not require payment of the contribution before the funded aged care service is delivered to the individual.

(4) The registered provider must ensure the price charged by the provider to the individual for the delivery of the funded aged care service complies with any requirements prescribed by the rules.

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(5) Despite subsection (2), the ***individual contribution*** for the delivery of the funded aged care service to the individual on the day is zero if, on a previous day (the ***trigger day***), the total of the following exceeds the lifetime cap on the trigger day:

(a) the sum of any individual contributions charged to the individual under this section for the delivery of other funded aged care services;

(b) the sum of any non-clinical care contributions charged to the individual under section 279;

(c) any other contribution or fee prescribed by the rules.

273A Unspent care recipient portion

(1) A registered provider starts to hold an ***unspent care recipient portion*** for an individual at the transition time if, immediately before the transition time:

(a) the registered provider was an approved provider that held an unspent home care amount in relation to the individual as mentioned in the *User Rights Principles 2014*; and

(b) the amount of the care recipient portion of that amount under section 21CA of those Principles was not zero; and

(c) section 21F of those Principles did not apply in relation to the care recipient portion of that amount.

(2) The registered provider must comply with any requirements prescribed by the rules relating to unspent care recipient portions.

274 Compensation payment fee

(1) A registered provider may charge an individual a compensation payment fee for a day if:

(a) the registered provider delivers a funded aged care service through the service group home support, assistive technology or home modifications to the individual on the day; and

(b) a compensation payment reduction for person-centred subsidy or provider-based subsidy applies to the individual for the day under any of sections 199, 207, 216, 225 or 234.

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(2) The ***compensation payment fee*** for the individual for the day is the amount equal to the compensation payment reduction applicable to the individual for the day under the section.

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Division 2—Fees and contributions payable in an approved residential care home

275 Division not to apply to specialist aged care programs

This Division does not apply in relation to an individual accessing funded aged care services under a specialist aged care program.

Note: For individual contributions for accessing funded aged care services under a specialist aged care program, see Division 3.

275A Division not to apply to individuals in prescribed classes

This Division does not apply in relation to an individual accessing ongoing funded aged care services through the service group residential care if the individual is in a class of individuals prescribed by the rules.

Note: For fees and contributions for these individuals, see Division 2A.

276 Contributions for delivery of funded aged care services—ongoing residential care

(1) A registered provider delivering ongoing funded aged care services through the service group residential care to an individual on a day may charge the individual an amount (the ***resident contribution***) for or in connection with those services.

(2) Subject to section 284, the resident contribution charged to the individual for the day must not exceed the sum of:

(a) the maximum daily amount of the resident contribution worked out for the day under section 277; and

(b) such other amounts as are prescribed by, or worked out in accordance with, the rules.

(3) If the registered provider does not, or is taken not to, deliver funded aged care services to the individual on the day, the registered provider must not charge the individual a resident contribution under this section for the day.

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Note: The registered provider may charge an individual certain amounts for a day on which the provider does not deliver funded aged care services to the individual: see sections 281 and 282.

(4) Without limiting paragraph (2)(b), rules made for the purposes of that paragraph may provide that an amount may be charged for only a particular period.

277 Maximum daily amount of resident contribution

(1) The ***maximum daily amount of the resident contribution*** payable by an individual for a day is the amount worked out as follows:

Method statement

Step 1. Work out the basic daily fee for the individual (see subsections (2) and (4)).

Step 2. Add the compensation payment fee (if any) for the individual for the day (see subsection (3)).

Step 3. Add the hotelling contribution (if any) for the individual for the day worked out using section 278 and subsection (4) of this section.

Step 4. Add the non-clinical care contribution (if any) for the individual for the day worked out using section 279 and subsection (4) of this section.

(2) The ***basic daily fee*** for an individual is:

(a) the amount prescribed by, or worked out in accordance with, the rules; or

(b) if no rules are in force for the purposes of paragraph (a)—the amount obtained by rounding down to the nearest cent the amount equal to 85% of the basic age pension amount (worked out on a per day basis).

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(3) The ***compensation payment fee*** for an individual for a day is the amount equal to the compensation payment reduction applicable to the individual on that day (see sections 233, 234 and 241).

(4) Reduce the amounts worked out under each of Steps 1, 3 and 4 of the method statement in subsection (1) in accordance with rules made for the purposes of subsection 231(3).

278 Hotelling contribution

(1) Subject to subsection (2), the ***hotelling contribution*** for an individual for a day is worked out as follows:

Method statement

Step 1. Work out the daily means tested amount for the individual using section 319.

Step 2. If the individual's daily means tested amount exceeds the maximum accommodation supplement amount (see subsection 235(3)), the ***hotelling contribution*** is the lesser of:

(a) the daily means tested amount minus the maximum accommodation supplement amount; and

(b) the maximum hotelling supplement amount (see subsection 235(4)).

Step 3. If the individual's daily means tested amount does not exceed the maximum accommodation supplement amount, the ***hotelling contribution*** is zero.

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(2) If the individual has means not disclosed status for the day, the ***hotelling contribution*** for the individual for the day is the maximum hotelling supplement amount for the day (see subsection 235(4)).

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279 Non-clinical care contribution

(1) Subject to subsections (2) and (4), the ***non-clinical care contribution*** for an individual for a day is worked out as follows:

Method statement

Step 1. Work out the daily means tested amount for the individual using section 319.

Step 2. Work out the sum of:

(a) the maximum accommodation supplement amount (see subsection 235(3)); and

(b) the maximum hotelling supplement amount (see subsection 235(4)).

Step 3. If the individual's daily means tested amount exceeds the result of Step 2, the ***non-clinical care contribution*** is the lesser of:

(a) the daily means tested amount minus the result of Step 2; and

(b) the maximum non-clinical care contribution (see subsection (3)).

Step 4. If the individual's daily means tested amount does not exceed the result of Step 2, the ***non-clinical care contribution*** is zero.

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(2) If the individual has means not disclosed status for the day, the ***non-clinical care contribution*** for the individual for the day is the maximum non-clinical care contribution.

(3) The ***maximum non-clinical care contribution*** is the amount prescribed by the rules.

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(4) Despite subsection (1), if on a day there has been a total of the number of days prescribed by the rules (whether or not the days occurred consecutively) prior to that day on which a registered provider:

(a) could have charged the individual an amount as the non-clinical care contribution; or

(b) but for a fee reduction supplement applying to the individual, could have charged the individual an amount as the non-clinical care contribution;

the ***non-clinical care contribution*** for the individual for the day is zero.

(5) Despite subsection (1), the ***non-clinical care contribution*** for the individual for the day is zero if, on a prior day (the ***trigger day***), the total of the following exceeds the lifetime cap on the trigger day:

(a) the sum of any individual contributions charged to the individual under section 273 for the delivery of other funded aged care services;

(b) the sum of any non-clinical care contributions charged to the individual under this section;

(c) any other contribution or fee prescribed by the rules.

280 Hotelling contribution and non-clinical care contribution taken to be zero in some circumstances

(1) The hotelling contribution and non-clinical care contribution for an individual is taken to be zero for each day on which either of the following applies:

(a) a determination is in force under subsection (2) in relation to the individual;

(b) the individual is included in a class of persons prescribed by the rules.

(2) The System Governor may, in accordance with any requirements prescribed by the rules, determine that the hotelling contribution and non-clinical care contribution for the individual is to be taken to be zero.

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(3) The determination ceases to be in force at the end of the period (if any) specified in the determination.

(4) When deciding whether to make a determination under subsection (2), the System Governor must have regard to the matters prescribed by the rules.

(5) Application may be made to the System Governor, in an approved form, for a determination under subsection (2) for an individual. The application may be made by:

(a) the individual; or

(b) a registered provider that is delivering, or is to deliver, ongoing funded aged care services through the service group residential care to the individual.

(6) The System Governor must give written notice to the individual and the registered provider of the System Governor's decision on whether to make the determination, within:

(a) if an application for the determination was made under subsection (5)—28 days after the application was made, or, if the System Governor requested further information in relation to the application, within 28 days after receiving the information; or

(b) if such an application was not made—28 days after the decision is made.

(7) A determination under subsection (2) is not a legislative instrument.

281 Fees for pre-entry period—ongoing residential care

(1) This section applies in relation to an individual whose access approval includes the ongoing classification type for the service group residential care.

(2) A registered provider delivering funded aged care services through the service group residential care in an approved residential care home may charge the individual an amount (the ***pre-entry fee***) for each day in the period set out in subsection (3).

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(3) The period (the ***pre-entry period***) is the period:

(a) starting on the later of the following:

(i) the day the individual enters into a service agreement with the provider;

(ii) the day that is 7 days before the individual's start day; and

(b) ending at the end of the day before that start day.

Note: The registered provider is taken not to be delivering funded aged care services to the individual on a day in the pre-entry period, so section 276 does not apply to the day.

(4) The maximum amount of the pre-entry fee that the registered provider may charge the individual under this section for a day in the pre-entry period is:

(a) the amount prescribed by, or worked out in accordance with, the rules; or

(b) if no rules are in force for the purposes of paragraph (a)—the amount obtained by rounding down to the nearest cent the amount equal to 85% of the basic age pension amount (worked out on a per day basis).

282 Fees for reserving a bed—ongoing residential care

(1) A registered provider delivering ongoing funded aged care services through the service group residential care to an individual in an approved residential care home may charge the individual an amount (the ***bed reservation fee***) for a day to reserve a bed if subsection (2) applies to the individual on that day.

(2) This subsection applies to the individual on the day if the individual:

(a) is absent from the approved residential care home on the day; and

(b) is not on leave from the approved residential care home on the day (see section 244); and

(c) would have been on social leave from the approved residential care home on the day except that the individual

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has previously been on social leave during the current financial year for 52 days.

Note: The registered provider is taken not to be delivering funded aged care services to the individual on a day if subsection (2) applies to the individual on the day, so section 276 does not apply to the day.

(3) The maximum amount of the bed reservation fee that the registered provider may charge the individual under this section for the day is the amount worked out in accordance with the rules.

283 Fees for delivery of funded aged care services—short-term residential care

(1) A registered provider delivering short-term funded aged care services through the service group residential care to an individual on a day may charge the individual an amount (the ***resident respite fee***) for or in connection with those services.

(2) Subject to section 284, the resident respite fee charged to the individual for the day must not exceed the sum of:

(a) whichever of the following is applicable:

(i) the amount prescribed by, or worked out in accordance with, the rules;

(ii) if no rules are in force for the purposes of subparagraph (i)—the amount obtained by rounding down to the nearest cent the amount equal to 85% of the basic age pension amount (worked out on a per day basis); and

(b) such other amounts as are prescribed by, or worked out in accordance with, the rules.

(3) If the registered provider does not, or is taken not to, deliver funded aged care services to the individual on the day, the registered provider must not charge the individual a resident respite fee under subsection (1) for the day.

(4) The registered provider may, in accordance with the rules, charge the individual a booking fee for or in connection with the delivery of the funded aged care services mentioned in subsection (1).

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(5) Without limiting paragraph (2)(b), rules made for the purposes of that paragraph may provide that an amount may be charged for only a particular period.

284 Fees for higher everyday living

(1) A registered provider that delivers funded aged care services through the service group residential care to an individual may charge the individual an additional amount (the ***higher everyday living fee***) for or in connection with a particular funded aged care service.

(2) The higher everyday living fee for the individual for the service is the amount agreed (the ***agreed amount***) between the registered provider and the individual in an agreement (the ***higher everyday living agreement***):

(a) that is entered into in accordance with any requirements prescribed by the rules; and

(b) that otherwise complies with any requirements prescribed by the rules.

(3) Without limiting paragraph (2)(b), rules made for the purposes of that paragraph must include a requirement that the higher everyday living agreement state that the agreed amount is subject to indexation in accordance with the rules.

(4) The registered provider must not charge the individual the higher everyday living fee for a service delivered on a day that occurs prior to the day the registered provider and individual enter into the higher everyday living agreement.

(5) The registered provider must not, before the individual's start day:

(a) ask the individual to pay a higher everyday living fee for a service; or

(b) offer to enter a higher everyday living agreement with the individual.

(6) Despite subsection (1), the registered provider must not:

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(a) charge the individual a higher everyday living fee in circumstances prescribed by the rules; or

(b) enter into a higher everyday living agreement with the individual in circumstances prescribed by the rules.

(7) To avoid doubt, a higher everyday living fee may be charged in accordance with subsection (1) for a service that is not included on the list of services referred to in subsection 8(1) if the service is incidental to, or capable of enhancing the quality of, a particular funded aged care service that is included on that list.

285 Other matters

(1) This section sets out matters that apply in relation to an amount that an individual may be charged under this Division.

(2) The individual must not be required to pay an amount for a day more than 1 month in advance of the day.

(3) If an individual dies or stops accessing funded aged care services, any amount paid in advance for a day occurring after the individual dies or stops accessing those services must be refunded in accordance with the rules.

(4) A registered provider must comply with any other requirements prescribed by the rules in relation to an amount that an individual may be charged under this Division.

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Division 2A—Fees and contributions payable for delivery of funded aged care services to individuals in prescribed classes

285A Fees and contributions payable for delivery of funded aged care services to individuals in prescribed classes

(1) A registered provider delivering ongoing funded aged care services through the service group residential care to an individual in a class of individuals referred to in section 275A may charge the individual one or more amounts prescribed by the rules for a day for that class for or in connection with those services.

(2) The individual must not be required to pay an amount for a day more than 1 month in advance of the day.

(3) If the individual dies or stops accessing funded aged care services, any amounts paid in advance for a day occurring after the individual dies or stops accessing those services must be refunded in accordance with the rules.

(4) A registered provider must comply with any other requirements prescribed by the rules in relation to an amount that an individual may be charged under this section.

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Division 3—Fees and contributions for specialist aged care programs

286 Fees and contributions payable for delivery of funded aged care services under a specialist aged care program

(1) A registered provider delivering funded aged care services through a service group under a specialist aged care program on a day to an individual may charge the individual one or more amounts, for or in connection with those services, in accordance with the rules.

(2) Without limiting subsection (1), the rules may provide for:
  (a) the charging of different amounts in relation to different specialist aged care programs; and
  (b) the charging of different amounts in connection with the delivery of funded aged care services through different service groups under a specialist aged care program.

(3) The individual must not be required to pay an amount for a day more than 1 month in advance of the day.

(4) If the individual dies or stops accessing funded aged care services, any amounts paid in advance for a day occurring after the individual dies or stops accessing those services must be refunded in accordance with the rules.

(5) A registered provider must comply with any other requirements prescribed by the rules in relation to an amount that an individual may be charged under this section.

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Part 4—Accommodation payments and accommodation contributions etc.

Division 1—Application of this Part

287 Application of this Part

(1) This Part applies in relation to the delivery of ongoing funded aged care services to an individual through the service group residential care in an approved residential care home if:

(a) the individual has an ongoing classification level in effect for the service group; or

(b) subject to rules made for the purposes of subsection 288(1), the services are delivered to the individual under a specialist aged care program.

(2) The provisions of this Part do not apply in respect of the delivery of funded aged care services to an individual (other than under a specialist aged care program) if the individual is included in a class of individuals prescribed by the rules.

(3) If the provisions of this Part do not apply in respect of the delivery of funded aged care services to a class of individuals because of subsection (2), the rules may prescribe requirements in relation to the following:

(a) the entering of agreements for, and the charging, payment or use of, an accommodation bond for the delivery of those services;

(b) the retention of, deduction of amounts from, transfer of, refund of, or payment of interest in relation to the refund of, an accommodation bond balance;

(c) the entering of agreements for, and the charging or payment of, an accommodation charge for the delivery of those services;

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(d) the transfer of, or the payment of interest in relation to the refund of, an entry contribution balance.

288 Rules may deal with application to specialist aged care programs

(1) Provisions of this Part do not apply in respect of the delivery of funded aged care services to an individual if:

(a) the provisions are specified in the rules; and

(b) the services are delivered to the individual under a specialist aged care program; and

(c) the program is prescribed by the rules.

(2) If provisions of this Part do not apply in respect of the delivery of funded aged care services to an individual because of the operation of subsection (1), the rules may prescribe different requirements in relation to the delivery of services under the specialist aged care program to the individual relating to the following:

(a) accommodation agreements;

(b) charging of accommodation payments;

(c) charging of accommodation contributions;

(d) charging of daily payments;

(e) refundable deposits.

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Division 2—Maximum accommodation payment amounts and publication of certain amounts by the System Governor

289 Maximum accommodation payment amount

(1) The rules may prescribe a maximum amount of accommodation payment (the ***maximum accommodation payment amount***) that a registered provider may charge an individual for the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home.

Note 1: Whether or not an individual pays an accommodation payment depends on the individual's daily means tested amount, which might not be worked out before the individual's start day.

Note 2: The Pricing Authority may, on application by a registered provider, approve the registered provider agreeing to, and charging, a higher maximum accommodation payment amount: see section 290.

(2) The maximum accommodation payment amount must be expressed as a refundable accommodation deposit amount.

(3) The rules must prescribe a method for working out the maximum accommodation payment amount expressed as a daily accommodation payment amount.

(4) A registered provider may charge less than the prescribed maximum accommodation payment amount.

290 Pricing Authority may approve higher maximum accommodation payment amount

(1) A registered provider may apply to the Pricing Authority for approval for the provider to agree to, and charge, an accommodation payment that is higher than the maximum accommodation payment amount prescribed by rules made for the purposes of section 289.

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(2) The application may relate to:

(a) an approved residential care home of the provider, including a home that is being, or is proposed to be, refurbished; or

(b) a distinct part of an approved residential care home of the provider, including a distinct part that is being, or is proposed to be, constructed or refurbished; or

(c) a residential care home, or a proposed residential care home, that the provider has applied, or intends to apply, for approval of under section 111; or

(d) a distinct part of a residential care home, or a proposed residential care home, that the provider has applied, or intends to apply, for approval of under section 111.

Note: Although applications may be made under this section in relation to residential care homes that are not approved residential care homes, only a registered provider delivering funded aged care services through the service group residential care in an approved residential care home may charge, under this Part, an amount of accommodation payment.

(3) The application:

(a) must comply with the requirements prescribed by the rules; and

(b) must not be made:

(i) within the period prescribed by the rules after the Pricing Authority last made a decision under this section in relation to the residential care home, or the distinct part of the residential care home; or

(ii) if no period is prescribed—within 12 months after that last decision.

(4) If the Pricing Authority needs further information to determine the application, the Pricing Authority may give the registered provider a notice requiring the provider to give the further information:

(a) within 28 days after the notice is given; or

(b) within such other period as is specified in the notice.

(5) The application is taken to have been withdrawn if the information is not given within whichever of those periods applies. The notice

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under subsection (4) must contain a statement setting out the effect of this subsection.

(6) The Pricing Authority must, in accordance with the rules:

(a) consider an application made in accordance with subsection (3), and any further information given in accordance with the rules or a notice given under subsection (4); and

(b) make a decision to approve or not approve the higher maximum accommodation payment amount specified in the application; and

(c) notify the registered provider, in writing, of the decision.

Note: A decision not to approve a higher maximum accommodation payment amount is a reviewable decision.

(7) If the Pricing Authority approves a higher maximum accommodation payment amount specified in an application that relates to a residential care home, or a distinct part of a residential care home, that is being, or is proposed to be, constructed or refurbished, the Pricing Authority must include the conditions prescribed by the rules on the approval.

(8) Subject to subsection (9), if the Pricing Authority approves the higher maximum accommodation payment amount, the amount applies in relation to an individual only if:

(a) at the date of the approval, the individual had not entered into an accommodation agreement with the registered provider; and

(b) the provider starts delivering ongoing funded aged care services to the individual through the service group residential care in an approved residential care home on or after the date of the approval.

(9) The higher maximum accommodation payment amount approved by the Pricing Authority also applies in relation to an individual if:

(a) the individual's start day occurred before the date of the approval; and

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(b) the individual had entered into an accommodation agreement with the registered provider before the date of the approval; and

(c) the individual moves to another bed, whether in another room (the ***new room***) or another part of a room (the ***new part***), in the residential care home and the move is voluntary; and

(d) the higher maximum accommodation payment amount applies in relation to the part of the residential care home that includes the new room or the new part of a room.

(11) The rules must prescribe:

(a) when a higher maximum accommodation payment amount is to be indexed; and

(b) a method for the indexation of such a payment.

(12) Without limiting this section, the rules may:

(a) prescribe the period within which the Pricing Authority must make, and give notice of, a decision in relation to an application made under this section; and

(b) prescribe conditions, relating to particular circumstances, that must be met for an approval of a higher maximum accommodation payment amount to take effect; and

(c) make provision for and in relation to the time when, or the period during which, a decision of the Pricing Authority in relation to an approval of a higher maximum accommodation payment amount is to have effect.

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291 Registered provider must notify System Governor of accommodation payment amounts for purposes of publication

(1) A registered provider delivering funded aged care services through the service group residential care in an approved residential care home must, in accordance with the rules, notify the System Governor about the amounts of accommodation payment the provider will charge individuals accessing such services in the home.

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Section 291

Note: Whether or not an individual pays an accommodation payment depends on the individual's daily means tested amount.

(2) If the registered provider will charge different amounts of accommodation payment in relation to distinct parts of the home, the information provided to the System Governor must relate to the amounts for each of those distinct parts.

(3) An amount of accommodation payment charged in relation to an approved residential care home or a distinct part of an approved residential care home must not be more than:

(a) the maximum accommodation payment amount prescribed by the rules for the purposes of section 289; or

(b) if a higher maximum accommodation payment amount is approved by the Pricing Authority under section 290 in relation to the home or the distinct part of the home—that higher amount.

(4) If a notification is given to the System Governor under subsection (1), the System Governor must publish the following information in relation to the notification:

(a) the name of the registered provider;

(b) the location of the approved residential care home;

(c) the amounts of accommodation payment the provider will charge in relation to the home or a distinct part of the home;

(d) such other information that is prescribed by the rules.

(5) An amount published in accordance with paragraph (4)(c) is the ***published accommodation payment amount*** for the approved residential care home or the distinct part of the home (as applicable).

(6) The System Governor may correct or update information published under subsection (4).

(7) This section does not limit section 544, 545 or 546.

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Division 3—Accommodation agreements

292 Information to be given before provider enters into an accommodation agreement with an individual

Before a registered provider enters into an accommodation agreement with an individual in relation to the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home, the provider must:

(a) give the individual a copy of the proposed accommodation agreement that meets the requirements set out in section 294; and

(b) inform the individual, in writing, of the published accommodation payment amounts for the home, each of which must be expressed as:

(i) a refundable accommodation deposit amount; and

(ii) a daily accommodation payment amount worked out in accordance with a method prescribed by the rules; and

(c) give the individual such other information that is prescribed by the rules.

Note 1: Whether or not an individual pays an accommodation payment depends on the individual's daily means tested amount, which might not be worked out before the individual's start day.

Note 2: Daily accommodation payments are subject to indexation in accordance with the rules.

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293 Registered provider must enter accommodation agreement before delivering ongoing funded aged care services to an individual

(1) A registered provider must enter into an accommodation agreement with an individual in relation to an approved residential care home before the registered provider starts delivering ongoing funded aged care services to the individual in the home.

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(2) A registered provider must not require an individual to choose how to pay an accommodation payment or accommodation contribution before the individual's start day.

294 Accommodation agreements

(1) An accommodation agreement between a registered provider and an individual must set out the following:

(a) the individual's start day, or proposed start day;

(b) that the individual will pay an accommodation payment if:

(i) the individual's daily means tested amount at the individual's start day is equal to, or greater than, the maximum accommodation supplement amount for that day; or

(ii) the individual has means not disclosed status at the individual's start day; or

(iii) at the individual's start day, the individual's daily means tested amount has not been determined and the individual does not have means not disclosed status;

(c) that, if the individual's daily means tested amount for the individual's start day is less than the maximum accommodation supplement amount for that day, the individual may pay an accommodation contribution, depending on the individual's daily means tested amount;

(ca) that, if the individual pays an accommodation payment because of subparagraph (b)(iii) in the period (the ***interim period)*** between the individual's start day and the day the individual's daily means tested amount at the individual's start day is determined, the following will apply:

(i) the amount of accommodation payment charged by the registered provider for a day in the interim period must be equal to, or less than, the agreed accommodation payment amount, as expressed as a daily accommodation payment amount;

(ii) any accommodation payment paid during the interim period must be paid by daily payments;

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(iii) the individual is to be refunded the amount (if any) by which the accommodation payment paid during the interim period exceeds the amount that would have been payable if the individual's daily means tested amount for the individual's start day had been determined at the start day;

(d) that a fee reduction supplement may reduce the accommodation payment or accommodation contribution (if payable), including to nil;

(e) subject to paragraph (ca), that the individual may choose to pay the accommodation payment or accommodation contribution (if payable) by:

(i) daily payments; or

(ii) refundable deposit; or

(iii) a combination of refundable deposit and daily payments;

(f) that, if the individual does not choose how to pay the accommodation payment or accommodation contribution (if payable), the individual must pay by daily payments;

(g) that the individual must not pay the accommodation payment or accommodation contribution (if payable) by refundable deposit before the individual's start day;

(h) the amounts that are permitted to be deducted from a refundable deposit balance;

(i) that retention amounts must be deducted from a refundable deposit balance within a certain period;

(j) the circumstances in which a refundable deposit balance must be refunded;

(k) any other conditions relating to the payment of a refundable deposit;

(l) such other matters prescribed by the rules.

Note 1: An accommodation agreement for an individual may be included in another agreement the individual enters into with the registered provider under or for the purposes of this Act.

Note 2: An accommodation agreement relates to a bed in an approved residential care home through which ongoing funded aged care

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services are delivered through the service group residential care to an individual.

(2) The accommodation agreement must set out the following in relation to an accommodation payment:

(a) the published accommodation payment amounts for the approved residential care home on the day the agreement is entered into;

(b) the accommodation payment amount (the ***agreed accommodation payment amount***) agreed between the provider and the individual for an approved residential care home, which must be:

(i) equal to or less than the published accommodation payment amount applicable to the part of the approved residential care home where the individual's bed is located; and

(ii) expressed as a refundable accommodation deposit amount; and

(iii) expressed as a daily accommodation payment amount worked out in accordance with a method prescribed by the rules;

(c) the amount of refundable accommodation deposit that would be payable if no daily accommodation payments were paid;

(d) the method prescribed by the rules for working out amounts that would be payable as a combination of refundable accommodation deposit and daily accommodation payments;

(e) that, if the individual pays a combination of daily payments and refundable accommodation deposit, the registered provider must, at the individual's request, deduct daily accommodation payments for the individual from the refundable deposit balance;

(f) that, if the individual pays a refundable accommodation deposit, the registered provider may require the individual to maintain the agreed accommodation payment amount if the refundable accommodation deposit is reduced;

(g) that, if the individual is required to maintain the agreed accommodation payment amount because the refundable

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accommodation deposit has been reduced, the individual may do so by:

(i) paying daily accommodation payments or increased daily accommodation payments; or

(ii) topping up the refundable accommodation deposit; or

(iii) a combination of both;

(h) that, if the individual pays a refundable accommodation deposit, the individual may choose to top up the refundable accommodation deposit up to the agreed accommodation payment amount;

(i) that daily accommodation payments are subject to indexation in accordance with the rules.

Note 1: See section 296 for requirements registered providers are subject to in relation to the charging of an accommodation payment.

Note 2: Daily accommodation payments are subject to indexation in accordance with the rules.

(3) The accommodation agreement must set out the following in relation to an accommodation contribution:

(a) that the amount of daily accommodation contribution for a day will not exceed the amount assessed for the individual based on the individual's daily means tested amount;

(b) that the amount of accommodation contribution payable will vary from time to time depending on:

(i) the accommodation supplement applicable to the individual; and

(ii) the individual's daily means tested amount;

(c) the method prescribed by the rules for working out amounts that would be payable by:

(i) refundable accommodation contribution; or

(ii) a combination of refundable accommodation contribution and daily accommodation contributions;

(d) that, if the individual pays a combination of daily payments and a refundable accommodation contribution, the registered provider must, at the individual's request, deduct daily

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accommodation contributions for the individual from the refundable deposit balance;

(e) that, if the individual pays a refundable accommodation contribution, the registered provider may require the individual to maintain the accommodation contribution that is payable if the refundable accommodation contribution is reduced;

(f) that, if the individual is required to maintain the accommodation contribution because the refundable accommodation contribution has been reduced, the individual may do so by:

(i) paying daily accommodation contributions or increased daily accommodation contributions; or

(ii) paying or topping up a refundable accommodation contribution; or

(iii) a combination of both;

(g) that, if the amount of accommodation contribution that is payable increases, the registered provider may require the individual to pay the increase;

(h) that, if the individual is required to pay the increase, the individual may do so by:

(i) paying daily accommodation contributions or increased daily accommodation contributions; or

(ii) topping up a refundable accommodation contribution; or

(iii) a combination of both;

(i) that, if the individual pays a refundable accommodation contribution, the individual may choose to top up the refundable accommodation contribution up to the amount of accommodation contribution that is payable.

Note: See section 298 for requirements registered providers are subject to in relation to the charging of an accommodation contribution.

(4) For the purposes of paragraphs (2)(f) and (3)(e), the registered provider must not require the individual to maintain the agreed accommodation payment amount or the accommodation contribution that is payable (as applicable) to the extent the

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refundable deposit is reduced because of the deduction of a retention amount under section 308.

295 Effect of accommodation agreements

An accommodation agreement has effect subject to this Act and any other law of the Commonwealth.

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Division 4—Charging of accommodation payments

296 Charging of accommodation payments

A registered provider must comply with the following in relation to the charging of an accommodation payment to an individual for the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home:

(a) the individual must not be charged an accommodation payment unless:

(i) the individual's daily means tested amount, at the individual's start day, is equal to or greater than the individual's maximum accommodation supplement amount for that day; or

(ii) the individual has means not disclosed status at the individual's start day; or

(iii) at the individual's start day, the individual's daily means tested amount has not been determined and the individual does not have means not disclosed status;

(b) an amount of accommodation payment must not exceed the agreed accommodation payment amount for the individual and the home;

(c) an accommodation payment must not be charged by the registered provider if:

(i) a condition on the registration of the registered provider has been imposed under subsection 143(1); and

(ii) the condition prohibits the provider from charging an accommodation payment;

(d) the registered provider must comply with the requirements (if any) about charging accommodation payments prescribed by the rules.

Note: Daily accommodation payments are subject to indexation in accordance with the rules.

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297 Accommodation payments must not be greater than agreed accommodation payment amounts

A registered provider delivering ongoing funded aged care services to an individual through the service group residential care in an approved residential care home must not accept an accommodation payment from the individual that, at a particular time, would result in the individual paying an amount of accommodation payment that is greater than the agreed accommodation payment amount for the individual and the home (reduced by any deductions made to that amount in accordance with section 308).

Note: Daily accommodation payments are subject to indexation in accordance with the rules.

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Division 5—Charging of accommodation contributions

298 Charging accommodation contributions

A registered provider must comply with the following in relation to the charging of an accommodation contribution for the delivery of ongoing funded aged care services to an individual through the service group residential care in an approved residential care home:

(a) an individual must not be charged an accommodation contribution unless the individual's daily means tested amount, at the individual's start day, is less than the maximum accommodation supplement amount for that day;

(b) the amount of daily accommodation contribution for a day must not exceed:

(i) the maximum accommodation supplement amount for that day; or

(ii) the amount assessed for the individual based on the individual's daily means tested amount;

(c) unless circumstances prescribed by the rules apply—an individual must not be charged an amount of daily accommodation contribution for a day that is greater than the agreed accommodation payment amount for the individual and the home (as expressed as a daily accommodation payment amount under subparagraph 294(2)(b)(iii));

(d) an accommodation contribution must not be charged by a registered provider if:

(i) a condition on the registration of the registered provider has been imposed under subsection 143(1); and

(ii) the condition prohibits the provider from charging an accommodation payment;

(e) a registered provider must comply with the requirements (if any) about charging accommodation contributions prescribed by the rules.

Note 1: If an individual has means not disclosed status at the individual's start day, the individual will be charged an accommodation payment: see paragraph 296(a).

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Note 2: Daily accommodation payments are subject to indexation in accordance with the rules.

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Division 6—Charging of daily payments

299 Payment in advance

An individual must not be required to pay a daily payment more than one month in advance.

300 When daily payments do not accrue

A daily payment does not accrue for any day after the delivery of ongoing funded aged care services to an individual through the service group residential care in an approved residential care home ceases.

301 Charging interest

(1) An individual may be charged interest on the balance of any amount of daily payment that:
  (a) is payable by the individual; and
  (b) has been outstanding for more than one month.

(2) Subsection (1) does not apply unless the individual's accommodation agreement provides for the charging of such interest at a specified rate.

(3) However, the rate charged must not exceed the maximum rate prescribed by the rules.

302 Rules about daily payments

The rules may prescribe:
  (a) when daily payments are to be made; and
  (b) when daily accommodation payments are to be indexed; and
  (c) a method for the indexation of daily accommodation payments; and

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(ca) circumstances in which an individual's daily accommodation payment is not to be indexed in accordance with rules made for the purposes of paragraphs (b) and (c); and

(cb) circumstances in which an amount of daily payment may be refunded; and

(d) any other matter relating to the payment or refund of daily payments.

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Division 7—Refundable deposits

303 When refundable deposits can be paid

(1) Subject to paragraph 294(1)(ca), an individual may pay a refundable deposit at any time on or after the individual's start day.

(2) At any time after an individual has paid a refundable deposit in relation to the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home, the individual may top up the refundable deposit up to:

(a) if the refundable deposit is a refundable accommodation deposit—an amount equal to the agreed accommodation payment amount for the individual and the home, minus any retention amounts that have been deducted under section 308; or

(b) if the refundable deposit is a refundable accommodation contribution—the amount of accommodation contribution that is payable.

304 Rules about refundable deposits

The rules may prescribe:

(a) circumstances in which an amount of refundable deposit may be refunded; and

(b) any other matters relating to the payment or refund of refundable deposits.

305 Individual must be left with minimum assets

(1) A registered provider must not accept payment of an amount of refundable deposit from an individual if:

(a) the individual provides sufficient information to allow the individual's daily means tested amount to be worked out; and

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(b) the individual pays the amount within 28 days after the individual's start day; and

(c) payment of the amount would leave the value of the individual's remaining assets at less than the minimum permissible asset value.

(2) The ***minimum permissible asset value*** is:

(a) the amount obtained by rounding to the nearest $500.00 (rounding $250.00 upwards) the amount equal to 2.25 times the basic age pension amount at the time the registered provider starts delivering ongoing funded aged care services to the individual in an approved residential care home; or

(b) such higher amount as is prescribed by the rules.

(3) The value of an individual's assets is to be worked out in the same way as it would be worked out under section 330, but disregarding subsection 330(7).

306 Registered provider may retain income derived

A registered provider may retain income derived from a refundable deposit.

307 Amounts to be deducted from refundable deposit balances—general

(1) A registered provider must not deduct an amount from a refundable deposit balance unless the deduction is authorised by this section or section 308 (retention amounts).

(2) A registered provider must deduct a daily payment from an individual's refundable deposit balance if:

(a) the individual has requested the deduction in writing; and

(b) the daily payment is payable by the individual.

(3) A registered provider may deduct the following from an individual's refundable deposit balance:

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(a) the amounts prescribed by the rules that may be deducted when the registered provider ceases to deliver ongoing funded aged care services to the individual through the service group residential care in an approved residential care home;
(b) any amounts that the individual has agreed in writing may be deducted;
(c) such other amounts (if any) as are prescribed by the rules.

308 Amounts that must be deducted from refundable deposit balances—retention amounts

(1) Subject to rules made for the purposes of subsection (3), a registered provider must deduct one or more amounts (a ***retention amount***) from an individual's refundable deposit balance during the period (the ***retention period***) of 5 years beginning on the day a refundable deposit was first paid by the individual.

Rate of retention

(2) A retention amount is to be calculated at a rate of 2 per cent per annum:
(a) on a daily basis; and
(b) applied to the refundable deposit balance each day.

Timing of deductions etc.

(3) The rules may prescribe the following:
(a) when a registered provider may deduct retention amounts from a refundable deposit balance;
(b) any other matter relating to retention amounts.

(3A) Subject to subsection (4), a registered provider must deduct a retention amount from an individual's refundable deposit balance at least once in each 3-month period starting on the day the individual paid the refundable deposit.

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(4) A registered provider must not deduct a retention amount from a refundable deposit balance:

(a) more than once in any one month period; or

(b) after the end of the individual's retention period.

Calculating an individual's retention period

(5) A day is only to be counted for the purposes of calculating an individual's retention period if:

(a) on the day, a registered provider delivers ongoing funded aged care services to the individual through the service group residential care in an approved residential home; and

(b) the individual has paid a refundable deposit in relation to the delivery of those services in the approved residential care home (regardless of whether the refundable deposit balance is nil on the day).

Note: For paragraph (a), on each day during which an individual is on leave mentioned in subsections 244(3) to (7) from an approved residential care home, the individual is taken to have been delivered ongoing funded aged care services through the service group residential care by the registered provider in the approved residential care home: see subsection 244(2).

(6) For the purposes of subsection (5), an individual is also taken to have been delivered ongoing funded aged care services through the service group residential care by the registered provider in the approved residential care home on a day if the individual:

(a) is absent from the approved residential care home on the day; and

(b) is not on leave from the approved residential care home on the day (see section 244); and

(c) would have been on social leave from the approved residential care home on the day except that the individual has previously been on social leave during the current financial year for 52 days.

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Rules may exempt certain classes of individuals

(7) This section does not apply in respect of an individual's refundable deposit balance if the individual is in a class of individuals prescribed by the rules.

309 Rules about deductions

The rules may prescribe the order in which deductions are to be made.

310 Refundable deposits to be used only for permitted purposes

(1) A registered provider must not use a refundable deposit unless the use is permitted by this section.

Permitted uses

(2) A registered provider is permitted to use a refundable deposit for the following:

(a) for capital expenditure of a kind prescribed by the rules;

(b) to invest in a financial product (within the meaning of Division 3 of Part 7.1 of the *Corporations Act 2001*) covered by subsection (3);

(c) to make a loan in relation to which the following conditions are satisfied:

(i) the loan is not made to an individual;

(ii) the loan is made on a commercial basis;

(iii) there is a written agreement in relation to the loan;

(iv) it is a condition of the agreement that the money loaned will only be used as mentioned in paragraph (a), (b), (d) or (e) of this subsection;

(v) the agreement includes any other conditions prescribed by the rules;

(d) to refund, or to repay debt accrued for the purposes of refunding, refundable deposit balances, accommodation bond balances or entry contribution balances;

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(e) to repay debt accrued for the purposes of capital expenditure of a kind prescribed by the rules;

(f) for a use prescribed by the rules.

Note: A registered provider, and the responsible persons of the registered provider, may commit an offence if the registered provider uses a refundable deposit and the use is not permitted by this section (see section 178).

(3) For the purposes of paragraph (2)(b), the following financial products are covered by this subsection:

(a) any deposit-taking facility made available by an ADI in the course of its banking business (within the meaning of the *Banking Act 1959*), other than an RSA;

(b) a debenture, stock or bond issued, or proposed to be issued, by the Commonwealth, a State or a Territory;

(c) a security, other than a security of a kind prescribed by the rules;

(d) any of the following in relation to a registered scheme (within the meaning of the *Corporations Act 2001*):

(i) an interest in the scheme;

(ii) a legal or equitable right or interest in an interest covered by subparagraph (i);

(iii) an option to acquire, by way of issue, an interest or right covered by subparagraph (i) or (ii);

(e) a financial product prescribed by the rules.

Rules

(4) Without limiting paragraphs (2)(a) or (f), the rules may prescribe that a use of a refundable deposit is only permitted for the purposes of those paragraphs if:

(a) specified circumstances apply; or

(b) the registered provider complies with conditions prescribed by the rules.

Note: For example, the rules might prescribe that the use of a refundable deposit is only permitted if the registered provider has obtained the consent of the System Governor to the use of the deposit.

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311 Refund of refundable deposit balances

Circumstances in which refundable deposit balance must be refunded

(1) If a refundable deposit is paid to a registered provider, the provider must refund the refundable deposit balance if:

(a) the individual dies; or

(b) both of the following apply:

(i) the registered provider ceases to deliver ongoing funded aged care services to the individual through the service group residential care in the approved residential care home to which the deposit relates (other than because the individual is on leave);

(ii) the registered provider has not transferred, or is not required to transfer, the refundable deposit balance to another registered provider under section 312.

(2) The refundable deposit balance must be refunded in the manner prescribed by the rules.

Period within which refundable deposit balance must be refunded

(3) If paragraph (1)(a) applies, the refundable deposit balance must be refunded:

(a) if the registered provider is shown the probate of the will of the individual or letters of administration of the estate of the individual—within 14 days after the day on which the provider was so shown; or

(b) if the circumstances prescribed by the rules apply—within the period prescribed by the rules.

(4) If paragraph (1)(b) applies, the refundable deposit balance must be refunded in accordance with the following table.

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When a refundable deposit balance must be refunded if paragraph (1)(b) applies

Item	If…	the refundable deposit balance must be refunded…
1	both of the following apply: (a) the individual is to move to another approved residential care home to receive ongoing funded aged care services through the service group residential care; (b) the individual notified the registered provider of the move more than 14 days before the day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i)	on the day on which the registered provider ceased delivering the services mentioned in subparagraph (1)(b)(i)
2	both of the following apply: (a) the individual is to move to another approved residential care home to receive ongoing funded aged care services through the service group residential care; (b) the individual notified the registered provider of the move within 14 days before the day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i)	within 14 days after the day on which the notice was given to the provider
3	both of the following apply: (a) the individual is to move to another approved residential care home to receive ongoing funded aged care services through the service group residential care; (b) the individual did not notify the provider of the move before the	within 14 days after the day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i)

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When a refundable deposit balance must be refunded if paragraph (1)(b) applies		
Item	**If…**	**the refundable deposit balance must be refunded…**
	day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i)	
4	items 1, 2 and 3 of this table do not apply	either: (a) within 14 days after the day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i); or (b) if the circumstances prescribed by the rules apply—within the period prescribed by the rules

312 Transfer of refundable deposit balance to another registered provider

(1) This section applies if:

(a) a refundable deposit was paid by an individual to a registered provider (the ***outgoing provider***) for accommodation in an approved residential care home through which the provider delivers ongoing funded aged care services through the service group residential care to the individual; and

(b) the outgoing provider ceases to deliver ongoing funded aged care services through the service group residential care in the residential care home; and

(c) there is continuity of the delivery of those services to the individual through that service group in the same residential care home by another registered provider (the ***incoming provider***).

(2) The outgoing provider must transfer the refundable deposit balance to the incoming provider in accordance with the rules.

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(3) Without limiting subsection (2), the rules may prescribe the following:

(a) when refundable deposit balance transfers are to be made;

(b) the manner in which refundable deposit balances are to be transferred;

(c) any other matter relating to the transfer of refundable deposit balances.

(4) Subsection (2) does not apply in circumstances prescribed by the rules.

313 Payment of interest—refund of refundable deposit balances

(1) The rules may prescribe circumstances in which interest is to be paid in relation to the refund of a refundable deposit balance.

(2) The amount of interest is the amount:

(a) prescribed by the rules; or

(b) worked out in accordance with a method prescribed by the rules.

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Part 5—Means testing

Division 1—Means testing in a home or community setting

314 Determination of individual contribution rate

(1) The System Governor must determine the individual contribution rate (expressed as a percentage) for an individual for each means testing category:

(a) in accordance with any criteria or methods prescribed by the rules; and

(b) within the period prescribed by the rules.

Giving notice of determination

(2) The System Governor must give notice of a determination under subsection (1) to the individual within 14 days after the determination is made.

(3) The notice under subsection (2) must:

(a) state that the individual may be required to notify the System Governor of any events or changes in the individual's circumstances in accordance with rules made for the purposes of subsection 315(1); and

(b) specify the individual contribution rate for the individual for each means testing category; and

(c) set out the reasons for the determination; and

(d) state how the individual may apply for reconsideration of the determination; and

(e) include such other matters as are prescribed by the rules.

Date of effect of determination

(4) The determination takes effect at the start of the day prescribed by the rules.

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314A Means not disclosed status

Means not disclosed status

(1) An individual accessing funded aged care services in a home or community setting has ***means not disclosed status*** if:

(a) the System Governor determines that the individual has that status in accordance with subsection (2); or

(b) the individual makes an election in accordance with section 314B.

(2) For the purposes of paragraph (1)(a), the System Governor must determine that the individual has means not disclosed status if the individual is asked to provide specified information prescribed by the rules, within a specified period prescribed by the rules, and the individual fails to do so.

Determining means not disclosed status

(3) A determination under paragraph (1)(a) takes effect on the day specified by the System Governor in the notice under subsection (5). The day may be before the day on which the determination is made but must be in accordance with the rules.

Note: For example, the means not disclosed status may take effect on the individual's start day.

(4) If, after that determination is made, the individual provides the information required as requested under subsection (2), the System Governor must:

(a) revoke the determination that the individual has means not disclosed status; and

(b) determine the day the revocation takes effect (which may be before the day that determination is made).

Giving notice of determination

(5) Within 14 days after making a determination under paragraph (1)(a) or (4)(b), the System Governor must give written notice of the decision to make that determination to the individual.

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(6) The notice under subsection (5) must:

(a) if the decision is to make a determination under paragraph (1)(a):

(i) explain the consequences of the individual having means not disclosed status and the steps the individual must take if the individual wants the determination to be revoked; and

(ii) specify the day the determination takes effect (see subsection (3)); and

(iii) set out the reasons for both the decision to make the determination and the decision as to the day the determination takes effect; and

(b) if the decision is to make a determination under paragraph (4)(b):

(i) specify the day the revocation takes effect; and

(ii) set out the reasons for the decision as to the day the revocation takes effect; and

(c) state how the individual may apply for reconsideration of the decisions mentioned in the notice; and

(d) include such other matters as are prescribed by the rules.

Determinations not legislative instruments

(7) If a determination under paragraph (1)(a) or (4)(b) is in writing, it is not a legislative instrument.

314B Electing to have means not disclosed status

(1) An individual may, by written notice given to the System Governor, elect not to give any information prescribed by the rules for the purposes of subsection 314A(2) to the System Governor.

(2) The individual may make the election during the period:

(a) starting on the individual's start day; and

(b) ending on the day immediately before the day the System Governor determines, in accordance with the rules, that the individual has means not disclosed status.

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(3) If the individual makes an election under subsection (1), the individual's means not disclosed status takes effect on the individual's start day and remains in effect until the day the individual withdraws the election in accordance with subsection (5).

(4) While the election is in effect, the System Governor must not request the individual to give any information prescribed by the rules for the purposes of subsection 314A(2).

(5) The individual may, by written notice given to the System Governor, withdraw the election.

315 Requirement to notify event or change in circumstances

(1) The rules may prescribe circumstances in which an individual, for whom an individual contribution rate determination is in force, must notify the System Governor of the occurrence of an event or a change in the individual's circumstances.

(2) The individual must notify the System Governor:
  (a) within the period prescribed by the rules; and
  (b) in the manner prescribed by the rules.

316 Varying or revoking an individual contribution rate determination

(1) The System Governor may:
  (a) vary an individual contribution rate determination (the ***old determination***) for an individual; or
  (b) revoke the old determination and make a new individual contribution rate determination for the individual.

Note: For when a variation or revocation of an income determination takes effect, see sections 317, 318 and 318A.

(2) The System Governor must vary the old determination:
  (a) following the making of certain social security decisions (see section 317); and

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(b) if an event or a change in the individual's circumstances occurs (see section 318).

(2A) The System Governor may revoke the old determination and make a new individual contribution rate determination for the individual if the System Governor is satisfied that the old determination is incorrect (see section 318A).

(2B) This section does not limit the application of subsection 33(3) of the *Acts Interpretation Act 1901* in relation to an individual contribution rate determination.

Giving notice of determination

(3) The System Governor must give notice of a decision under subsection (1) to the individual within 14 days after the decision is made.

(4) The notice under subsection (3) must:

(a) state that the individual may be required to notify the System Governor of any events or changes in the individual's circumstances in accordance with rules made for the purposes of subsection 315(1); and

(b) if the decision is to vary the old determination—include details of the variation (including specifying the individual contribution rate, as varied, for the individual for each means testing category); and

(c) if the decision is to revoke the old determination and make a new individual contribution rate determination—specify the day the new determination is in force; and

(d) set out the reasons for the decision; and

(e) state how the individual may apply for reconsideration of the decision; and

(f) include such other matters as are prescribed by the rules.

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317 Varying individual contribution rate determination following certain social security decisions

(1) This section applies if:

(a) an individual contribution rate determination is in force for an individual; and

(b) a decision under the social security law (within the meaning of the *Social Security Act 1991*) has been made; and

(c) any requirements prescribed by the rules are met.

(2) The System Governor must, within the period prescribed by the rules, vary the determination if the determination is no longer correct because of the decision.

Effect of decision

(4) Subject to subsection (5), the variation takes effect:

(a) if the variation results in an increase to the individual contribution rate—at the start of the day after the end of the quarter in which it is made; or

(b) if the variation results in a decrease to the individual contribution rate—at the start of the day on which it is made.

(5) The rules may prescribe that, in specified circumstances, the variation takes effect on a specified day (which must not be earlier than the day the decision mentioned in paragraph (1)(b) was made).

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318 Varying individual contribution rate determination following event or change in circumstances

(1) This section applies if:

(a) an individual contribution rate determination is in force for an individual; and

(b) the System Governor is notified of the occurrence of an event or a change in an individual's circumstances in accordance with rules made for the purposes of subsection 315(1).

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(2) The System Governor must, within the period prescribed by the rules, vary the determination.

Effect of decision

(5) Subject to subsection (6), the variation takes effect:
  (a) if the variation results in an increase to the individual contribution rate—at the start of the day after the end of the quarter in which it is made; or
  (b) if the variation results in a decrease to the individual contribution rate—at the start of the day on which it is made.

(6) The rules may prescribe that, in specified circumstances, the variation takes effect on a specified day (which must not be earlier than the day the System Governor is notified as mentioned in paragraph (1)(b)).

318A Revoking an incorrect individual contribution rate determination

(1) This section applies if:
  (a) an individual contribution rate determination is in force for an individual; and
  (b) the System Governor is satisfied that the determination is no longer correct; and
  (c) any requirements prescribed by the rules are met.

(2) The System Governor may, within the period prescribed by the rules, decide to revoke the determination and make a new individual contribution rate determination for the individual.

System Governor may request further information

(3) The System Governor may, by written notice, request the individual to give the System Governor further information, within the period specified in the notice (which must not be less than 28 days after giving the notice), to assist the System Governor to make the decision.

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Note: The individual is not obliged to give the information.

(4) The System Governor may, at the request of the individual, extend the specified period.

Effect of decision

(5) Subject to subsection (6), the new determination takes effect:

(a) if the new determination results in an increase to the individual contribution rate—at the start of the day after the end of the quarter in which it is made; or

(b) if the new determination results in a decrease to the individual contribution rate—at the start of the day on which it is made.

(6) The rules may prescribe that, in specified circumstances, the new determination takes effect on a specified day (which must not be earlier than the day the System Governor is satisfied as mentioned in paragraph (1)(b)).

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Division 2—Means testing in approved residential care home

Subdivision A—Daily means tested amounts

319 Working out the daily means tested amount

(1) The ***daily means tested amount*** for an individual is worked out as follows:

Work out the ***per day income tested amount*** using Steps 1 to 7:

Step 1. Work out the individual's total assessable income (which is determined under section 322).

Step 2. If the individual's total assessable income does not exceed the total assessable income free area (see subsection (2)), the ***per day income tested amount*** is zero.

Step 3. If the individual's total assessable income exceeds the total assessable income free area but not the first income threshold (see paragraph (4)(a)), the ***per day income tested amount*** is 50% of that excess, divided by 364.

Step 4. If the individual's total assessable income exceeds the first income threshold but not the second income threshold (see paragraph (4)(b)), the ***per day income tested amount*** is 50% of the difference between the total assessable income free area and the first income threshold, divided by 364.

Step 5. If the individual's total assessable income exceeds the second income threshold but not the third income threshold (see paragraph (4)(c)), the ***per day income***

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tested amount is the sum of the following, divided by 364:

(a) 50% of the difference between the total assessable income free area and the first income threshold;

(b) 50% of the excess above the second income threshold.

Step 6. If the individual's total assessable income exceeds the third income threshold but not the fourth income threshold (see paragraph (4)(d)), the ***per day income tested amount*** is the sum of the following, divided by 364:

(a) 50% of the difference between the total assessable income free area and the first income threshold;

(b) 50% of the difference between the second income threshold and the third income threshold.

Step 7. If the individual's total assessable income exceeds the fourth income threshold, the ***per day income tested amount*** is the sum of the following, divided by 364:

(a) 50% of the difference between the total assessable income free area and the first income threshold;

(b) 50% of the difference between the second income threshold and the third income threshold;

(c) 50% of the excess above the fourth income threshold.

Work out the ***per day asset tested amount*** using Steps 8 to 14:

Step 8. Work out the value of the individual's assets (which is determined under section 329).

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Step 9. If the value of the individual's assets does not exceed the asset free area (see subsection (3)), the ***per day asset tested amount*** is zero.

Step 10. If the value of the individual's assets exceeds the asset free area but not the first asset threshold (see paragraph (4)(e)), the ***per day asset tested amount*** is 17.5% of the excess, divided by 364.

Step 11. If the value of the individual's assets exceeds the first asset threshold but not the second asset threshold (see paragraph (4)(f)), the ***per day asset tested amount*** is 17.5% of the difference between the asset free area and the first asset threshold, divided by 364.

Step 12. If the value of the individual's assets exceeds the second asset threshold but not the third asset threshold (see paragraph (4)(g)), the ***per day asset tested amount*** is the sum of the following, divided by 364:

(a) 17.5% of the difference between the asset free area and the first asset threshold;

(b) 7.8% of the excess above the second asset threshold.

Step 13. If the value of the individual's assets exceeds the third asset threshold but not the fourth asset threshold (see paragraph (4)(h)), the ***per day asset tested amount*** is the sum of the following, divided by 364:

(a) 17.5% of the difference between the asset free area and the first asset threshold;

(b) 7.8% of the difference between the second asset threshold and the third asset threshold.

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Step 14. If the value of the individual's assets exceeds the fourth asset threshold, the ***per day asset tested amount*** is the sum of the following, divided by 364:

(a) 17.5% of the difference between the asset free area and the first asset threshold;

(b) 7.8% of the difference between the second asset threshold and the third asset threshold;

(c) 7.8% of the excess above the fourth asset threshold.

The ***daily means tested amount*** is the sum of the per day income tested amount and the per day asset tested amount.

Note: If either the per day income tested amount or the per day asset tested amount cannot be worked out, the daily means tested amount cannot be determined (see section 320 about an individual having means not disclosed status).

(2) The ***total assessable income free area*** is the sum of the following:

(a) the amount worked out by applying point 1064-B1 of Pension Rate Calculator A at the end of section 1064 of the *Social Security Act 1991*;

(b) the amount worked out under point 1064-BA4 of Pension Rate Calculator A at the end of section 1064 of the *Social Security Act 1991*;

(c) the amount worked out by applying point 1064-E4 of Pension Rate Calculator A at the end of section 1064 of the *Social Security Act 1991*.

(3) The ***asset free area*** is:

(a) unless paragraph (b) applies—the amount equal to 2.25 times the basic age pension amount; or

(b) if rules are in force for the purposes of this paragraph—such other amount as is calculated in accordance with the rules.

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(4) Each of the following terms have the meaning prescribed by the rules:
  (a) ***first income threshold***;
  (b) ***second income threshold***;
  (c) ***third income threshold***;
  (d) ***fourth income threshold***;
  (e) ***first asset threshold***;
  (f) ***second asset threshold***;
  (g) ***third asset threshold***;
  (h) ***fourth asset threshold***.

(5) Despite subsection (1), if the individual is in a class of individuals prescribed by the rules, the ***daily means tested amount*** for the individual is the amount prescribed by the rules.

(6) To avoid doubt, an amount prescribed by the rules under subsection (5) may refer to an individual's total assessable income, the value of an individual's assets, or both.

320 Means not disclosed status

Means not disclosed status

(1) An individual accessing funded aged care services in an approved residential care home has ***means not disclosed status*** if:
  (a) the System Governor determines that the individual has that status in accordance with subsection (2) or (2A); or
  (b) the individual makes an election in accordance with section 321.

(2) For the purposes of paragraph (1)(a) the System Governor must determine that the individual has means not disclosed status if the individual is asked to provide specified information prescribed by the rules within a specified period prescribed by the rules to assist the System Governor to determine the individual's daily means tested amount, and the individual fails to do so.

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(2A) For the purposes of paragraph (1)(a) the System Governor may determine that the individual has means not disclosed status if:

(a) the individual's income determination (if any) has been revoked under section 324 and a new income determination has not been made for the individual; or

(b) the individual's asset determination (if any) has been revoked under section 331 and a new asset determination has not been made for the individual.

Determining means not disclosed status

(3) A determination under paragraph (1)(a) takes effect on the day specified by the System Governor in the notice under subsection (5). The day may be before the day on which the determination is made but must be in accordance with the rules.

Note: For example, the means not disclosed status may take effect on the individual's start day, or when the revocation of the individual's income determination or asset determination takes effect.

(4) If, after that determination is made, the individual provides the information required for the individual's daily means tested amount to be determined, the System Governor must:

(a) revoke the determination that the individual has means not disclosed status; and

(b) determine the day the revocation takes effect (which may be before the day that determination is made).

Giving notice of determination

(5) Within 14 days after making a determination under paragraph (1)(a) or (4)(b), the System Governor must give written notice of the decision to make that determination to the individual.

(6) The notice under subsection (5) must:

(a) if the decision is to make a determination under paragraph (1)(a):

(i) explain the consequences of the individual having means not disclosed status and the steps the individual

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must take if the individual wants the determination to be revoked; and

(ii) specify the day the determination takes effect (see subsection (3)); and

(iii) set out the reasons for both the decision to make the determination and the decision as to the day the determination takes effect; and

(b) if the decision is to make a determination under paragraph (4)(b):

(i) specify the day the revocation takes effect; and

(ii) set out the reasons for the decision as to the day the revocation takes effect; and

(c) state how the individual may apply for reconsideration of the decisions mentioned in the notice; and

(d) include such other matters as are prescribed by the rules.

Determinations not legislative instruments

(7) If a determination under paragraph (1)(a) or (4)(b) is in writing, it is not a legislative instrument.

321 Electing to have means not disclosed status

(1) An individual may, by written notice given to the System Governor, elect not to give any information to the System Governor for the purposes of determining the individual's daily means tested amount.

(2) The individual may make the election during the period:

(a) starting on the individual's start day; and

(b) ending on the day immediately before the day the individual's daily means tested amount is determined.

(3) If the individual makes an election under subsection (1), the individual's means not disclosed status takes effect on the individual's start day and remains in effect until the day the individual withdraws the election in accordance with subsection (5).

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(4) While the election is in effect, the System Governor must not request the individual to give information for the purpose of determining:
  (a) the individual's total assessable income under section 322; or
  (b) the value of the individual's assets under section 329.

(5) The individual may, by written notice given to the System Governor, withdraw the election.

Subdivision B—An individual's total assessable income

322 Determination of individual's total assessable income

Making income determinations

(1) The System Governor must, within the period prescribed by the rules, determine an individual's total assessable income at a particular time (the ***income determination time***), worked out in accordance with section 323.

Note: A determination under this subsection is called an income determination.

(2) The System Governor is not required to make a determination under subsection (1) if the System Governor is not given the information required to make the determination.

(3) The income determination time must be at or before the time the determination is made.

Requesting further information

(4) The System Governor may, by written notice, request one or more of the following persons to give the System Governor, within the period specified in the notice (which must not be less than 28 days after giving the notice), the information specified in the notice for the purposes of making the determination:
  (a) the individual;
  (b) a person acting for or on behalf of the individual;

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(c) any other person whom the System Governor believes has information that would assist the System Governor in making the determination.

Note: A person is not obliged to give the information.

(5) The System Governor may, at the request of the person made before the end of the specified period, extend that specified period.

When determination takes effect

(6) The determination takes effect on the day specified by the System Governor in the notice under subsection (8). The day may be before the day on which the determination is made but must be in accordance with the rules.

Note: An income determination may be varied or revoked under section 324.

(7) However, if the determination is made after the individual withdraws an election under section 321, the determination can not take effect before the day after the election was withdrawn under subsection 321(5).

Giving notice of determination

(8) Within 14 days after making a determination under subsection (1), the System Governor must give written notice of the determination to the individual.

(9) The notice under subsection (8) must:

(a) state that the individual is required to notify the System Governor of any events or changes in the individual's circumstances in accordance with section 336; and

(b) specify the amount worked out as the individual's total assessable income; and

(c) specify the income determination time; and

(d) specify the day the determination takes effect (see subsection (6)); and

(e) set out the reasons for the following decisions:

(i) making the determination under subsection (1);

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(ii) the day the determination takes effect under subsection (6); and

(f) state how the individual may apply for reconsideration of either of those decisions; and

(g) include such other matters as are prescribed by the rules.

Determinations not legislative instruments

(10) If a determination under subsection (1) is in writing, it is not a legislative instrument.

323 Working out an individual's total assessable income

Total assessable income where no income support payment

(1) If an individual is not entitled to an income support payment, the individual's total assessable income is the amount the System Governor determines to be the amount that would be worked out as the individual's ordinary income for the purpose of applying Module E of Pension Rate Calculator A at the end of section 1064 of the *Social Security Act 1991*.

Total assessable income where service pension

(2) If an individual is entitled to a service pension, the individual's total assessable income is the sum of:

(a) the amount of the individual's service pension reduced by the amount worked out under subsection 5GA(3) of the *Veterans' Entitlements Act 1986* to be the individual's minimum pension supplement amount; and

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(b) the amount the System Governor determines to be the amount that would be worked out as the individual's ordinary/adjusted income for the purpose of applying Module E of the Rate Calculator in Schedule 6 to the *Veterans' Entitlements Act 1986*.

Total assessable income where income support supplement

(3) If an individual is entitled to an income support supplement, the individual's total assessable income is the sum of:

(a) the amount of the individual's income support supplement reduced by the amount worked out under subsection 5GA(3) of the *Veterans' Entitlements Act 1986* to be the individual's minimum pension supplement amount; and

(b) the amount the System Governor determines to be the amount that would be worked out as the individual's ordinary/adjusted income for the purpose of applying Module E of the Rate Calculator in Schedule 6 to the *Veterans' Entitlements Act 1986*.

Total assessable income where veteran payment

(4) If an individual is entitled to a veteran payment, the individual's total assessable income is the sum of:

(a) the amount of the individual's veteran payment reduced by the amount worked out under subsection 5GA(3) of the *Veterans' Entitlements Act 1986* to be the individual's minimum pension supplement amount; and

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(b) the amount the System Governor determines to be the amount that would be worked out as the individual's ordinary/adjusted income for the purpose of applying Module E of the Rate Calculator in Schedule 6 to the *Veterans' Entitlements Act 1986*.

Total assessable income where income support payment (other than service pension)

(5) If an individual is entitled to an income support payment (other than a service pension, an income support supplement or a veteran payment), the individual's total assessable income is the sum of:

(a) the amount of the individual's income support payment reduced by the amount worked out under subsection 20A(4) of the *Social Security Act 1991* to be the individual's minimum pension supplement amount; and

(b) the amount the System Governor determines to be the amount that would be worked out as the individual's ordinary income for the purpose of applying Module E of Pension Rate Calculator A at the end of section 1064 of the *Social Security Act 1991*.

(6) However, the reduction referred to in paragraph (5)(a) does not apply if:

(a) the individual's income support payment is special benefit or youth allowance under the *Social Security Act 1991*; or

(b) both:

(i) the individual has not reached pension age (within the meaning of subsections 23(5A), (5B), (5C) and (5D) of the *Social Security Act 1991*); and

(ii) the rate of the individual's income support payment is worked out in accordance with the Rate Calculator at the end of section 1066A, 1067L, 1068, 1068A or 1068B of that Act.

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Excluded amounts

(7) The rules may prescribe amounts that are to be taken, in relation to specified kinds of individuals, to be excluded from a determination under subsection (1) or paragraph (2)(b), (3)(b), (4)(b) or (5)(b).

Application of Social Security Act provisions

(8) For the purpose of making a determination under subsection (1) or paragraph (5)(b) of the amount that would be worked out as the individual's ordinary income for the purpose referred to in that subsection or paragraph, the relevant provisions of the *Social Security Act 1991* apply as if:

(a) paragraph 8(8)(zc) of that Act were omitted; and

(b) section 1176 of that Act were omitted; and

(c) any other provision of the social security law (within the meaning of the *Social Security Act 1991*) were omitted:

(i) that has the direct or indirect effect of excluding an amount from a person's ordinary income (within the meaning of that Act); and

(ii) that is prescribed by the rules.

Note: The effect of this subsection is that certain amounts that would not be included when working out an individual's ordinary income under the *Social Security Act 1991* will be included for the purposes of working out the individual's total assessable income under this section.

Application of Veterans' Entitlements Act provisions

(9) For the purpose of making a determination under paragraph (2)(b), (3)(b) or (4)(b) of the amount that would be worked out as the individual's ordinary/adjusted income for the purpose referred to in the relevant paragraph, the relevant provisions of the *Veterans' Entitlements Act 1986* apply as if:

(a) section 59X of that Act were omitted; and

(b) any other provision of the *Veterans' Entitlements Act 1986* were omitted:

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(i) that has the direct or indirect effect of excluding an amount from a person's ordinary/adjusted income (within the meaning of that Act); and

(ii) that is prescribed by the rules.

Note: The effect of this subsection is that certain amounts that would not be included when working out an individual's ordinary/adjusted income under the *Veterans' Entitlements Act 1986* will be included for the purposes of working out the individual's total assessable income under this section.

Determinations not legislative instruments

(10) If a determination under this section is in writing, it is not a legislative instrument.

324 Varying or revoking an income determination

Decision to vary or revoke income determination

(1) The System Governor may vary or revoke an income determination in relation to the individual.

Note 1: For requirements about giving notice of a variation or revocation of an income determination, see section 328.

Note 2: The amount of person-centred subsidy or provider-based subsidy payable for a day for an individual is calculated in accordance with any income determination in force for the individual for the day. If there is such an income determination, the amount payable will not change as a result of a change to the individual's income unless the income determination is varied or revoked or a new income determination is made.

(2) The income determination may be varied or revoked:

(b) on the application of the individual (see section 326); or

(c) on the System Governor's own initiative (see section 327).

(2A) The income determination must be varied if the System Governor has been notified of the occurrence of an event or a change in the individual's circumstances under Subdivision D (see also section 325).

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(3) Without limiting subsection (1), the income determination may be revoked if the System Governor is satisfied that the determination is incorrect.

(3A) This section does not limit the application of subsection 33(3) of the *Acts Interpretation Act 1901* in relation to an income determination.

Effect of decision

(4) If an income determination is varied or revoked, the variation or revocation takes effect on the day specified by the System Governor in the notice under subsection 328(1).

(5) The day specified may be before the day the notice is given but must be in accordance with the rules.

Variations and revocations not legislative instruments

(6) If a variation or revocation under subsection (1) is in writing, it is not a legislative instrument.

325 Varying or revoking income determination on notification of event or change in circumstances

(1) This section applies if the System Governor has been notified of the occurrence of an event or a change in an individual's circumstances under Subdivision D.

(2) The System Governor must, within the period specified in the rules, vary the income determination in force for the individual.

326 Varying or revoking income determination on application

(1) An application by an individual for the purposes of paragraph 324(2)(b) must be in the approved form.

(2) The System Governor must:

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(a) consider an application made in accordance with subsection (1) and any further information given in accordance with a request under section 588; and

(b) make a decision on the application within the period specified in the rules.

327 Varying or revoking income determination on System Governor's initiative

Notice before variation or revocation

(1) Before the System Governor varies or revokes an income determination under section 324 in relation to an individual on the System Governor's own initiative, the System Governor must give the individual written notice that the System Governor is considering varying or revoking the determination.

(2) The notice must:

(a) set out the reasons why the System Governor is considering varying or revoking the income determination, and what the effect of the variation or revocation would be; and

(b) invite the individual to make a submission, in writing, to the System Governor in relation to the matter within the period specified in the notice (which must not be less than 28 days after giving the notice); and

(c) inform the individual that the System Governor may decide to vary or revoke the income determination:

(i) if no submission is made within the specified period; or

(ii) after considering any submission made by the individual within the specified period.

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Request for further information

(3) The System Governor may also request, in the notice given under subsection (1), that the individual give the System Governor the information specified in the notice, within the period specified in the notice for the purposes of paragraph (2)(b), to assist the System

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Governor to decide whether to vary or revoke the income determination.

Note: The individual is not obliged to give the information.

(4) If the individual makes a submission in accordance with the invitation under paragraph (2)(b), the System Governor may, by written notice, request the individual to give the System Governor further information, within the period specified in the notice (which must not be less than 28 days after giving the notice), to assist the System Governor to decide whether to vary or revoke the income determination.

Note 1: The System Governor may request further information under this subsection regardless of whether information was requested or given under subsection (3).

Note 2: The individual is not obliged to give the information.

(5) The System Governor may, at the request of the individual, extend the period specified for paragraph (2)(b) or subsection (4).

Deciding whether to vary or revoke income determination

(6) The System Governor must:

(a) consider any submission made in accordance with the invitation under paragraph (2)(b) and any further information given in accordance with a request under subsection (3) or (4); and

(b) make a decision whether to vary or revoke the income determination within the period specified in the rules.

328 Notice of decision

Notice requirements—reviewable decisions

(1) The System Governor must give an individual written notice of any of the following decisions within 14 days after making the decision:

(a) a decision under subsection 324(1) to vary or revoke an income determination for the individual;

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(b) a decision under section 326 not to vary or revoke an income determination for the individual.

(2) The notice under subsection (1) must:

(a) state that the individual is required to notify the System Governor of any events or changes in the individual's circumstances in accordance with section 336; and

(b) if the decision is to vary the income determination:

(i) include details of the variation (including specifying the amount worked out as the individual's total assessable income); and

(ii) specify the day the variation takes effect (see subsection 324(4)); and

(c) if the decision is to revoke the income determination:

(i) explain the consequences of the revocation of the determination; and

(ii) specify the day the determination ceases to be in force (see subsection 324(4)); and

(d) set out the reasons for the following decisions:

(i) varying or revoking the income determination under subsection 324(1);

(ii) the day the variation or revocation takes effect under subsection 324(4); and

(e) state how the individual may apply for reconsideration of either of those decisions; and

(f) include such other matters as are prescribed by the rules.

Notice requirements—other decisions

(3) Within 14 days after making a decision under section 327 not to vary or revoke an income determination for an individual, the System Governor must give the individual written notice of the decision.

(4) The notice under subsection (3) must:

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(a) state that the individual is required to notify the System Governor of any events or changes in the individual's circumstances in accordance with section 336; and

(b) include such other matters as are prescribed by the rules.

Copies to registered provider

(5) If the System Governor is aware that the individual has given a registered provider a copy of the notice of the making of the income determination under section 322, the System Governor must also give the registered provider a copy of the notice referred to in subsection (1) or (3) of this section (as the case may be).

Subdivision C—The value of an individual's assets

329 Determination of value of individual's assets

Making asset determinations

(1) The System Governor must, within the period prescribed by the rules, determine the value at a particular time (the ***asset valuation time***) of an individual's assets, worked out in accordance with section 330.

Note: A determination under this subsection is called an asset determination.

(2) The System Governor is not required to make a determination under subsection (1) if the System Governor is not given the information required to make the determination.

(3) The asset valuation time must be at or before the time the determination is made.

Requesting further information

(4) The System Governor may, by written notice, request one or more of the following persons to give the System Governor, within the period specified in the notice (which must not be less than 28 days after giving the notice), the information specified in the notice for the purposes of making the determination:

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(a) the individual;
(b) a person acting for or on behalf of the individual;
(c) any other person whom the System Governor believes has information that would assist the System Governor in making the determination.

Note: A person is not obliged to give the information.

(5) The System Governor may, at the request of the person made before the end of the specified period, extend the specified period.

When determination takes effect

(6) The determination takes effect on the day specified by the System Governor in the notice under subsection (8). The day may be before the day on which the determination is made but must be in accordance with the rules.

Note: An asset determination may be varied or revoked under section 331.

(7) However, if the determination is made after the individual withdraws an election under section 321, the determination can not take effect before the day after the election was withdrawn under subsection 321(5).

Giving notice of determination

(8) Within 14 days after making a determination under subsection (1), the System Governor must give written notice of the determination to the individual.

(9) The notice under subsection (8) must:
(a) state that the individual is required to notify the System Governor of any events or changes in the individual's circumstances in accordance with section 336; and
(b) specify the amount worked out as the value of the individual's assets; and
(c) specify the asset valuation time; and
(d) specify the day the determination takes effect (see subsection (6)); and

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(e) set out the reasons for the following decisions:
(i) making the determination under subsection (1);
(ii) the day the determination takes effect under subsection (6); and
(f) state how the individual may apply for reconsideration of either of those decision; and
(g) include such other matters as are prescribed by the rules.

Determinations not legislative instruments

(10) If a determination under subsection (1) is in writing, it is not a legislative instrument.

330 Working out the value of an individual's assets

(1) Subject to this section, the value of an individual's assets is the value worked out in accordance with Division 1 of Part 3.12 of the *Social Security Act 1991*, reduced by any compensation payments received by the person under:
(a) the *Compensation (Japanese Internment) Act 2001*; or
(b) the *Veterans' Entitlements (Compensation—Japanese Internment) Regulations 2001*; or
(c) Part 2 of the *Veterans' Entitlements (Clarke Review) Act 2004*; or
(d) Schedule 5 to the *Social Security and Veterans' Affairs Legislation Amendment (One-off Payments and Other 2007 Budget Measures) Act 2007*.

Asset value where income stream and service pension, income support supplement or veteran payment

(2) If an individual who is receiving a service pension, an income support supplement or a veteran payment has an income stream (within the meaning of the *Veterans' Entitlements Act 1986*) that was purchased on or after 20 September 2007, the value of the individual's assets:

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(a) is taken to include the amount that the System Governor determines to be the value of that income stream that would be included in the value of the individual's assets if Subdivision A of Division 11 of Part IIIB of the *Veterans' Entitlements Act 1986* applied for the purposes of this Act; and

(b) is taken to exclude the amount that the System Governor determines to be the value of that income stream that would not be included in the value of the individual's assets if Subdivision A of Division 11 of Part IIIB of the *Veterans' Entitlements Act 1986* applied for the purposes of this Act.

Asset value where income stream and no service pension, income support supplement or veteran payment

(3) If an individual who is not receiving a service pension, an income support supplement or a veteran payment has an income stream (within the meaning of the *Social Security Act 1991*) that was purchased on or after 20 September 2007, the value of the individual's assets:

(a) is taken to include the amount that the System Governor determines to be the value of that income stream that would be included in the value of the individual's assets if Division 1 of Part 3.12 of the *Social Security Act 1991* applied for the purposes of this Act; and

(b) is taken to exclude the amount that the System Governor determines to be the value of that income stream that would not be included in the value of the individual's assets if Division 1 of Part 3.12 of the *Social Security Act 1991* applied for the purposes of this Act.

Other amounts included

(4) The value of an individual's assets is taken to include the amount that the System Governor determines to be the amount:

(a) if the individual is receiving a service pension, an income support supplement or a veteran payment—that would be included in the value of the individual's assets if

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Subdivisions B and BB of Division 11 and Subdivision H of Division 11A of Part IIIB of the *Veterans' Entitlements Act 1986* applied for the purposes of this Act; and

(b) otherwise—that would be included in the value of the individual's assets if Division 2 of Part 3.12 and Division 8 of Part 3.18 of the *Social Security Act 1991* applied for the purposes of this Act.

Note 1: Subdivisions B and BB of Division 11 of Part IIIB of the *Veterans' Entitlements Act 1986*, and Division 2 of Part 3.12 of the *Social Security Act 1991*, deal with disposal of assets.

Note 2: Subdivision H of Division 11A of Part IIIB of the *Veterans' Entitlements Act 1986*, and Division 8 of Part 3.18 of the *Social Security Act 1991*, deal with the attribution to individuals of assets of private companies and private trusts.

(5) If an individual has paid a refundable deposit, the value of the individual's assets is taken to include the amount of the refundable deposit balance.

Excluding value of home

(6) In working out the value at a particular time of the assets of an individual who is or was a homeowner, disregard the value of a home that, at the time, was occupied by:

(a) the partner or a dependent child of the individual; or

(b) a carer of the individual who:

(i) had occupied the home for the past 2 years; and

(ii) was eligible to receive an income support payment at the time; or

(c) another close relation of the individual who:

(i) had occupied the home for the past 5 years; and

(ii) was eligible to receive an income support payment at the time.

(7) In working out the value at a particular time of the assets of an individual who is or was a homeowner, disregard the value of a home to the extent that it exceeded the amount prescribed by the rules in force at that time.

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(8) For subsection (7), the value of a home is the value worked out after applying subsections (1), (12) and (13).

Other amounts excluded

(9) The rules may prescribe amounts that are to be taken, in relation to specified kinds of individuals, to be excluded from a determination under paragraph (2)(a) or (b) or (3)(a) or (b) or subsection (4).

Couples

(10) The value of the assets of an individual who is a member of a couple is taken to be 50% of the sum of:
  (a) the value of the individual's assets; and
  (b) the value of the assets of the individual's partner.

Joint ownership etc.

(11) A reference to the value of the assets of an individual is, in relation to an asset owned by the individual jointly or in common with one or more other people, a reference to the value of the individual's interest in the asset.

Application of Social Security Act provisions

(12) The following provisions of Division 1 of Part 3.12 of the *Social Security Act 1991* do not apply for the purposes of working out the value of the individual's assets:
  (a) paragraphs 1118(1)(a), (b) and (g), subparagraphs 1118(1)(ga)(ii) and (gb)(ii), paragraphs 1118(1)(u) and (v) and subsection 1118(4) (Certain assets to be disregarded in calculating the value of a person's assets);
  (b) section 1118AB (Value of person's assets reduced: certain transactions to do with aged care accommodation bonds);
  (c) section 1118AC (Value of person's assets reduced: refunds to charge exempt residents).

(13) Also, subsection 1121(1) of the *Social Security Act 1991* does not apply, for the purposes of working out the value of the individual's

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assets, to a charge or encumbrance over the amount of any refundable deposit balance in respect of a refundable deposit paid by the individual.

Determinations not legislative instruments

(14) If a determination under this section is in writing, it is not a legislative instrument.

331 Varying or revoking an asset determination

Decision to vary or revoke asset determination

(1) The System Governor may vary or revoke an asset determination in relation to the individual.

Note 1: For requirements about giving notice of a variation or revocation of an asset determination, see section 335.

Note 2: The amount of person-centred subsidy or provider-based subsidy payable for a day for an individual is calculated in accordance with any asset determination in force for the individual for the day. If there is such an asset determination, the amount payable will not change as a result of a change to the value of the individual's assets unless the asset determination is varied or revoked or a new asset determination is made.

(2) The asset determination may be varied or revoked:

(b) on the application of the individual (see section 333); or

(c) on the System Governor's own initiative (see section 334).

(2A) The asset determination must be varied if the System Governor has been notified of the occurrence of an event or a change in the individual's circumstances under Subdivision D (see also section 332).

(3) Without limiting subsection (1), the asset determination may be varied or revoked if the System Governor is satisfied that the determination is incorrect.

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(3A) This section does not limit the application of subsection 33(3) of the *Acts Interpretation Act 1901* in relation to an asset determination.

Effect of decision

(4) If an asset determination is varied or revoked, the variation or revocation takes effect on the day specified by the System Governor in the notice under subsection 335(1).

(5) The day specified may be before the day the notice is given but must be in accordance with the rules.

Variations and revocations not legislative instruments

(6) If a variation or revocation under subsection (1) is in writing, it is not a legislative instrument.

332 Varying or revoking asset determination on notification of event or change in circumstances

(1) This section applies if the System Governor has been notified of the occurrence of an event or a change in an individual's circumstances under Subdivision D.

(2) The System Governor must, within the period specified in the rules, vary the asset determination in force for the individual.

333 Varying or revoking asset determination on application

(1) An application by an individual for the purposes of paragraph 331(2)(b) must be in the approved form.

(2) The System Governor must:

(a) consider an application made in accordance with subsection (1) and any further information given in accordance with a request under section 588; and

(b) make a decision on the application within the period specified in the rules.

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334 Varying or revoking asset determination on System Governor's initiative

Notice before variation or revocation

(1) Before the System Governor varies or revokes an asset determination under section 331 in relation to an individual on the System Governor's own initiative, the System Governor must give the individual written notice that the System Governor is considering varying or revoking the determination.

(2) The notice must:

(a) set out the reasons why the System Governor is considering varying or revoking the asset determination, and what the effect of the variation or revocation would be; and

(b) invite the individual to make a submission, in writing, to the System Governor in relation to the matter within the period specified in the notice (which must not be less than 28 days after giving the notice); and

(c) inform the individual that the System Governor may decide to vary or revoke the asset determination:

(i) if no submission is made within the specified period; or

(ii) after considering any submission made by the individual within the specified period.

Request for further information

(3) The System Governor may also request, in the notice given under subsection (1), that the individual give the System Governor the information specified in the notice, within the period specified in the notice for the purposes of paragraph (2)(b), to assist the System Governor to decide whether to vary or revoke the asset determination.

Note: The individual is not obliged to give the information.

(4) If the individual makes a submission in accordance with the invitation under paragraph (2)(b), the System Governor may, by written notice, request the individual to give the System Governor

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further information, within the period specified in the notice (which must not be less than 28 days after giving the notice), to assist the System Governor to decide whether to vary or revoke the asset determination.

Note 1: The System Governor may request further information under this subsection regardless of whether information was requested or given under subsection (3).

Note 2: The individual is not obliged to give the information.

(5) The System Governor may, at the request of the individual, extend the period specified for paragraph (2)(b) or subsection (4).

Deciding whether to vary or revoke asset determination

(6) The System Governor must:

(a) consider any submission made in accordance with the invitation under paragraph (2)(b) and any further information given in accordance with a request under subsection (3) or (4); and

(b) make a decision whether to vary or revoke the asset determination within the period specified in the rules.

335 Notice of decision

Notice requirements—reviewable decisions

(1) The System Governor must give an individual written notice of any of the following decisions within 14 days after making the decision:

(a) a decision under section 331 to vary or revoke an asset determination for the individual;

(b) a decision under section 333 not to vary or revoke an asset determination for the individual.

(2) The notice under subsection (1) must:

(a) state that the individual is required to notify the System Governor of any events or changes in the individual's circumstances in accordance with section 336; and

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(b) if the decision is to vary the asset determination:
  (i) include details of the variation (including specifying the value worked out as the individual's assets); and
  (ii) specify the day the variation takes effect (see subsection 331(4)); and
(c) if the decision is to revoke the asset determination:
  (i) explain the consequences of the revocation of the determination; and
  (ii) specify the day the determination ceases to be in force (see subsection 331(4)); and
(d) set out the reasons for the following decisions:
  (i) varying or revoking the asset determination under subsection 331(1);
  (ii) the day the variation or revocation takes effect under subsection 331(4); and
(e) state how the individual may apply for reconsideration of either of those decision; and
(f) include such other matters as are prescribed by the rules.

Notice requirements—other decisions

(3) Within 14 days after making a decision under section 334 not to vary or revoke an asset determination for an individual, the System Governor must give the individual written notice of the decision.

(4) The notice under subsection (3) must:
(a) state that the individual is required to notify the System Governor of any events or changes in the individual's circumstances in accordance with section 336; and
(b) include such other matters as are prescribed by the rules.

Copies to registered provider

(5) If the System Governor is aware that the individual has given a registered provider a copy of the notice of the making of the asset determination under section 329, the System Governor must also

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give the registered provider a copy of the notice under subsection (1) or (3) of this section (as the case may be).

Subdivision D—Notifying of event or change in circumstances

336 Requirement to notify event or change in circumstances

(1) Subject to subsection (3), an individual accessing funded aged care services through the service group residential care must notify the System Governor of the occurrence of any event or a change in the individual's circumstances that might affect:

(a) the amount of subsidy, payable to a registered provider for the individual, worked out under Division 4 or Division 4A of Part 2; or

(b) the amount of fees or contributions that may be charged by a registered provider to the individual under Division 2 or Division 2A of Part 3.

Note: The events or changes in circumstances might affect the individual's total assessable income, the value of the individual's assets, or whether paying an amount would cause the individual financial hardship.

(2) The notification must be made in the manner, and within the period, prescribed by the rules.

(3) The individual is not required to notify the System Governor under subsection (1) if a registered provider delivering funded aged care services to the individual notifies the System Governor of the occurrence of the event or the change in the individual's circumstances under section 337.

337 Notification by the registered provider

(1) A registered provider delivering funded aged care services to the individual may notify the System Governor of the occurrence of any event or a change in the individual's circumstances that might affect:

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(a) the amount of subsidy, payable to a registered provider for the individual, worked out under Division 4 or Division 4A of Part 2; or

(b) the amount of fees or contributions that may be charged by a registered provider to the individual under Division 2 or Division 2A of Part 3.

(2) If a registered provider makes a notification under subsection (1), the notification must be made in the manner, and within the period, prescribed by the rules.

(3) If the registered provider notifies the System Governor of the occurrence of an event or a change in an individual's circumstances under subsection (1), the registered provider must notify the individual that the registered provider has done so.

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Part 6—Miscellaneous

337A Compensation for acquisition of property

(1) If the operation of:

(a) this Chapter; or

(b) a legislative instrument made under this Chapter;

would result in an acquisition of property (within the meaning of paragraph 51(xxxi) of the Constitution) from a person otherwise than on just terms (within the meaning of that paragraph), the Commonwealth is liable to pay a reasonable amount of compensation to the person.

(2) If the Commonwealth and the person do not agree on the amount of the compensation, the person may institute proceedings in:

(a) the Federal Court of Australia; or

(b) the Supreme Court of a State or Territory;

for the recovery from the Commonwealth of such reasonable amount of compensation as the court determines.

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Chapter 5—Governance of the aged care system

Part 1—Introduction

338 Simplified outline of this Chapter

The Commonwealth aged care system is governed by the Secretary (known as the System Governor), the Aged Care Quality and Safety Commissioner (the Commissioner), and the Complaints Commissioner. There is also an Aged Care Quality and Safety Advisory Council (the Advisory Council).

The System Governor has functions relating to the Commonwealth's administration of the aged care system, including:

(a) facilitating equitable access to funded aged care services; and

(b) providing stewardship of the Commonwealth's administration of the aged care system; and

(c) protecting and upholding the integrity of the Commonwealth's administration of the aged care system and the Commonwealth's investment in the system.

The System Governor must provide quarterly reports to the Minister on the duration of waiting periods for certain funded aged care services.

The Commissioner's functions include the following:

(a) safeguarding functions;

(b) engagement and education functions;

(c) registration of providers functions.

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The Commissioner may also make the Financial and Prudential Standards.

The Complaints Commissioner's functions include the complaints functions.

The Commission consists of the Commissioner, the Complaints Commissioner and the staff of the Commission. The Commission has the function of assisting the Commissioner and the Complaints Commissioner in the performance of their functions. The Commission may also be assisted by certain other officers and employees, and the Commissioner may engage consultants.

The Advisory Council consists of a Chair, a Deputy Chair and at least 7, but not more than 11, other members. The members are appointed by the Minister and must have substantial experience or knowledge in a specified field.

The Advisory Council's functions include the following:

(a) monitoring the performance of the Commissioner and the Complaints Commissioner's functions;

(b) providing advice to the Commissioner, the Complaints Commissioner and the Minister about matters arising in relation to those functions;

(c) supporting the development of the strategic objectives of the Commission and identifying systemic performance issues within the Commission.

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Part 2—System Governor

339 Functions of the System Governor

(1) The System Governor has the following functions:

(a) to facilitate equitable access to funded aged care services, including in respect of the location where services are delivered and individuals who identify with a number of diversity characteristics;

(b) to support the continuity of funded aged care services when the delivery of services by a registered provider is disrupted;

(c) to provide stewardship of the Commonwealth's administration of the aged care system and encourage the delivery of high quality care by:

(i) developing policy to make ongoing improvements to the Commonwealth's administration of the aged care system, including by consulting with individuals of diverse backgrounds and individuals who identify with a number of diversity characteristics; and

(ii) promoting the availability of funded aged care services in areas of unmet demand; and

(iii) promoting diversity of registered providers to enable individuals to choose between registered providers; and

(iv) providing education to build the capacity of registered providers to adopt best practice in the delivery of funded aged care services;

(d) to protect and uphold the integrity of the Commonwealth's administration of the aged care system and the Commonwealth's investment in the system, by:

(i) collecting, maintaining and providing accurate information about the Commonwealth's administration of the aged care system, including on expenditure by registered providers on the delivery of funded aged care services; and

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(ii) providing oversight of the Commonwealth's payments to registered providers, including ensuring compliance with this Act and other relevant requirements;

(e) to encourage the training and development of aged care workers of registered providers;

(f) to review the Commonwealth's administration of the aged care system, or a part of that system, including undertaking research, evaluation and analysis;

(g) any other functions conferred on the System Governor by this Act or any other law of the Commonwealth;

(h) to do anything incidental or conducive to the performance of any of the above functions.

(2) The System Governor may, by notifiable instrument, make guidelines relating to the performance of any of the functions mentioned in subsection (1).

340 Executive power of the Commonwealth

This Part does not limit the executive power of the Commonwealth.

341 Register of coroner's reports

System Governor to maintain register with certain information

(1) The System Governor is to maintain a register of reports that:

(a) are received by the Department from a coroner about the death of an individual accessing funded aged care services; and

(b) include a recommendation to the Department.

(2) Subject to subsections (4) and (5), the register must include, in relation to each report, the following information:

(a) subject to subsection (3), the circumstances of the death of the individual;

(b) the recommendations made to the Department;

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(c) a summary of any actions taken by the Department in response to those recommendations;
(d) any other information prescribed by the rules.

Certain information to be de-identified

(3) The System Governor must take such steps as are reasonable in the circumstances to ensure that information included on the register in accordance with paragraph (2)(a) is de-identified (within the meaning of the *Privacy Act 1988*).

Exceptions to information required to be included on register

(4) If information mentioned in subsection (2) is protected information, the System Governor must not include the information on the register unless the System Governor considers that it is appropriate in all the circumstances to do so.

(5) The System Governor must not include information mentioned in subsection (2) on the register if the System Governor is satisfied that it is not in the public interest to do so.

Other requirements for register

(6) The register is to be maintained by electronic means.

(7) The register is to be made available for public inspection on the internet.

Register not legislative instrument

(8) The register is not a legislative instrument.

342 Reporting relating to recommendations in coroner's reports

The System Governor must, as soon as practicable after the end of each financial year, prepare and give to the Inspector-General of Aged Care a report on the following matters in relation to each report mentioned in subsection 341(1) received by the Department in that year:

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(a) the recommendations made to the Department;
(b) a summary of any actions taken by the Department in response to those recommendations;
(c) an evaluation of the effectiveness of those actions.

342A Quarterly reporting on waiting periods for certain funded aged care services

(1) Subject to subsection (4), the System Governor must give the Minister a written report, within 28 days after the end of each quarter, on the duration of waiting periods for non-specialist funded aged care services.

(2) Without limiting subsection (1), the report must include the following information:
(a) the number of applications for funded aged care services made under subsection 56(1) for which a decision under subsection 57(1) has not been made, including applications made during that quarter and previous quarters;
(b) the average number of days between the date of an application for funded aged care services being made under subsection 56(1) and the commencement of the provision of non-specialist funded aged care services, where those services commenced in the quarter;
(c) the median number of days between the date of an application for funded aged care services being made under subsection 56(1) and the commencement of the provision of non-specialist funded aged care services, where those services commenced in the quarter;
(d) an assessment of the differences in the time taken between application and the commencement of services as a result of whether the non-specialist funded aged care service was delivered in an approved residential care home or a home or community setting;
(e) an assessment of the differences in the time taken between application and the commencement of services as a result of

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the State or Territory in which the non-specialist funded aged care service was delivered;

(f) an assessment of the differences in the time taken between application and the commencement of services as a result of the local region in which the non-specialist funded aged care service was delivered;

(g) any other matter prescribed by the rules.

(2A) Without limiting subsection (1), a report may include corrections or updates to information included in a previous report.

(3) The System Governor must publish the report on the Department's website as soon as practicable after it is given to the Minister.

(4) If this section commences during a quarter (but not on the first day of the quarter):

(a) no report is to be made at the end of the quarter; but

(b) the report made at the end of the next quarter is also to include the information about the duration of waiting periods for non-specialist funded aged care services that occurred in the previous quarter.

(5) In this section:

local region has the meaning prescribed by the rules.

non-specialist funded aged care service means a funded aged care service other than a service delivered under a specialist aged care program.

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343 System Governor may request information or documents from persons or bodies

(1) If the System Governor reasonably believes that a person or body has information or documents relevant to the System Governor's functions, the System Governor may request the person or body to give the System Governor any such information or documents (or copies of any such documents).

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(2) The person or body is not required to comply with the request.

Note: The System Governor may require a person to attend to answer questions or give information or documents under Division 3 of Part 10 of Chapter 6.

343A Identity cards for approved needs assessors

(1) The System Governor must issue an identity card to an approved needs assessor.

Form of identity card

(2) The identity card must:
(a) satisfy the requirements prescribed by the rules; and
(b) contain a photograph that is no more than 5 years old of the approved needs assessor.

Identity card to be carried and produced in accordance with rules

(3) An approved needs assessor must carry and produce the identity card as prescribed by the rules.

Strict liability offence

(4) A person commits an offence of strict liability if:
(a) the person has been issued with an identity card under subsection (1); and
(b) the person ceases to be an approved needs assessor; and
(c) the person does not return the identity card to the System Governor within 14 days after ceasing to be an approved needs assessor.

Penalty: 1 penalty unit.

(5) Subsection (4) does not apply if the identity card was lost or destroyed.

Note: A defendant bears an evidential burden in relation to the matter in subsection (5): see subsection 13.3(3) of the *Criminal Code*.

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Part 3—Aged Care Quality and Safety Commission

Division 1—Establishment and functions of the Aged Care Quality and Safety Commission

344 Aged Care Quality and Safety Commission

(1) The Aged Care Quality and Safety Commission is established by this section.

(2) For the purposes of the finance law (within the meaning of the *Public Governance, Performance and Accountability Act 2013*):
- (a) the Commission is a listed entity; and
- (b) the Commissioner is the accountable authority of the Commission; and
- (c) the following persons are officials of the Commission:
  - (i) the Commissioner;
  - (ii) the Complaints Commissioner;
  - (iii) the staff of the Commission;
  - (iv) persons assisting the Commission referred to in section 370;
  - (v) consultants engaged under section 371; and
- (d) the purposes of the Commission include:
  - (i) the functions of the Commission referred to in section 346; and
  - (ii) the functions of the Commissioner referred to in section 348; and
  - (iii) the functions of the Complaints Commissioner referred to in section 357.

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345 Constitution of the Commission

The Commission consists of:
- (a) the Commissioner; and

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(b) the Complaints Commissioner; and
(c) the staff of the Commission.

346 Functions of the Commission

The Commission has the following functions:

(a) to assist the Commissioner in the performance of the Commissioner's functions;
(b) to assist the Complaints Commissioner in the performance of the Complaint Commissioner's functions.

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Division 2—Establishment and functions of the Commissioner

347 Commissioner

(1) There is to be a Commissioner of the Aged Care Quality and Safety Commission.

(2) The Commissioner is to be appointed by the Minister by written instrument.

Note: The Commissioner may be reappointed: see section 33AA of the *Acts Interpretation Act 1901*.

(3) The Commissioner holds office for the period specified in the instrument of appointment. The period must not exceed 5 years.

348 Functions of the Commissioner

(1) The Commissioner has the following functions:
- (a) the safeguarding functions (see section 349);
- (b) the engagement and education functions (see section 350);
- (c) the registration of providers functions (see section 351);
- (d) any other functions conferred on the Commissioner by this Act or any other law of the Commonwealth;
- (e) to reconsider and review decisions relating to the above functions;
- (f) to do anything incidental or conducive to the performance of the above functions.

(2) The Commissioner may, by notifiable instrument, make guidelines relating to the performance of any of the functions mentioned in subsection (1).

(3) The Commissioner has power to do all things necessary or convenient to be done for or in connection with the performance of the functions mentioned in subsection (1).

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(4) In performing the functions mentioned in subsection (1), the Commissioner must:

(a) take reasonable steps to provide opportunities for individuals accessing funded aged care services to engage with the Commissioner; and

(b) take into consideration the rights under the Statement of Rights, wishes and views of individuals accessing funded aged care services.

(5) In performing the functions mentioned in subsection (1), the Commissioner may consult with the following:

(a) the System Governor;

(b) the Inspector-General of Aged Care;

(c) the Pricing Authority.

349 Safeguarding functions

The ***safeguarding functions*** of the Commissioner are the following:

(a) to uphold the rights under the Statement of Rights, and protect and enhance the safety, health, wellbeing and quality of life, of individuals accessing funded aged care services, including through encouraging the delivery of culturally safe, culturally appropriate, trauma aware and healing informed funded aged care services;

(b) to protect continuity of care through:

(i) monitoring the financial viability and sustainability of registered providers; and

(ii) monitoring the compliance of registered providers with their financial and prudential requirements under section 150 and taking proactive steps to prevent non-compliance with those requirements; and

(iii) taking proactive steps to mitigate prudential and financial risks;

(c) to promote:

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(i) continuous improvement for registered providers and aged care workers of registered providers; and

(ii) the delivery of high quality care by registered providers; and

(iii) the confidence and trust of individuals in the delivery of funded aged care services;

(d) to ensure registered providers and operators of aged care digital platforms comply with this Act, including through supervision and information gathering, and by using the regulatory mechanisms available to the Commissioner under Chapter 6;

(e) to ensure aged care workers and responsible persons of registered providers comply with their obligations under this Act (including the Aged Care Code of Conduct), including by using the regulatory mechanisms available to the Commissioner under Chapter 6;

(f) to support registered providers to develop and implement effective incident management systems;

(g) to build the capability of registered providers to prevent and manage reportable incidents;

(h) to oversee the notification and management of reportable incidents and respond where appropriate;

(i) to collect, correlate, analyse and disseminate information relating to reportable incidents to identify trends or systemic issues;

(j) if the Commissioner considers it appropriate to do so, to seek and consider clinical advice relevant to functions of the Commissioner;

(k) if the Commissioner considers it appropriate to do so, to seek and consider any professional advice (including financial advice) relevant to functions of the Commissioner.

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350 Engagement and education functions

The ***engagement and education functions*** of the Commissioner are the following:

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(a) to engage with individuals accessing funded aged care services and their supporters or other persons supporting those individuals, to learn about their experiences with aged care services;

(b) to develop, in consultation with individuals accessing funded aged care services and their supporters or other persons supporting those individuals, best practice models for the engagement of registered providers and aged care workers with the individuals accessing those services;

(c) to promote those best practice models to registered providers and responsible persons and aged care workers of registered providers;

(d) to engage and educate registered providers, responsible persons and aged care workers of registered providers, individuals accessing funded aged care services and their supporters or other persons supporting those individuals, and operators of aged care digital platforms, on the following:

(i) the rights of individuals under the Statement of Rights;

(ii) the functions of the Commissioner;

(iii) the functions of the Complaints Commissioner;

(iv) the obligations that apply to registered providers under Part 4 of Chapter 3;

(e) to build capability of registered providers, responsible persons and aged care workers of registered providers, individuals accessing funded aged care services and their supporters or other persons supporting those individuals, and operators of aged care digital platforms, to understand and promote the objectives of this Act;

(f) to collect, correlate, analyse and disseminate information relating to the Commissioner's functions.

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351 Registration of providers functions

The ***registration of providers functions*** of the Commissioner are the following:

(a) functions relating to the registration of registered providers by the Commissioner under Part 2 of Chapter 3;

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(b) functions relating to the variation, suspension and revocation of the registration of registered providers under Part 3 of Chapter 3, including monitoring the delivery of funded aged care services.

352 Commissioner may request information or documents from persons

(1) If the Commissioner reasonably believes that a person has information or documents relevant to the Commissioner's functions, the Commissioner may request the person to give the Commissioner any such information or documents (or copies of any such documents).

(2) The person is not required to comply with the request.

Note: The Commissioner may require a person to attend to answer questions or give information or documents under Division 3 of Part 10 of Chapter 6.

353 Deputy Commissioners

(1) The Commissioner may, in writing, appoint a person who is a member of the staff of the Commission as a Deputy Commissioner to assist the Commissioner in the performance of the Commissioner's functions.

(2) The Commissioner may appoint more than one person as a Deputy Commissioner under subsection (1).

354 Appointment of Chief Clinical Advisor

The Commissioner must, in writing, appoint a person who is a member of the staff of the Commission, or a consultant engaged under section 371, as the Chief Clinical Advisor to assist the Commissioner in the performance of the Commissioner's functions.

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355 Minister may give directions

(1) The Minister may, by legislative instrument, give written directions to the Commissioner about the performance of the Commissioner's functions.

Note: Section 42 (disallowance) and Part 4 of Chapter 3 (sunsetting) of the *Legislation Act 2003* do not apply to the directions (see regulations made for the purposes of paragraphs 44(2)(b) and 54(2)(b) of that Act).

(2) A direction given by the Minister under subsection (1):

(a) must be of a general nature only; and

(b) must not relate to a particular registered provider or individual accessing, or seeking to access, funded aged care services.

(3) The Commissioner must comply with a direction under subsection (1).

(4) Subsection (3) does not apply to the extent that the direction relates to the Commissioner's performance of functions or exercise of powers under the following Acts in relation to the Commission:

(a) the *Public Service Act 1999*;

(b) the *Public Governance, Performance and Accountability Act 2013*.

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Division 3—Establishment and functions of the Complaints Commissioner

356 Complaints Commissioner

(1) There is to be a Complaints Commissioner of the Aged Care Quality and Safety Commission.

(2) The Complaints Commissioner is to be appointed by the Minister by written instrument.

Note: The Complaints Commissioner may be reappointed: see section 33AA of the *Acts Interpretation Act 1901*.

(3) The Complaints Commissioner holds office for the period specified in the instrument of appointment. The period must not exceed 5 years.

357 Functions of the Complaints Commissioner

(1) The Complaints Commissioner has the following functions:
  (a) the complaints functions (see section 358);
  (b) any other functions conferred on the Complaints Commissioner by this Act or any other law of the Commonwealth;
  (c) to reconsider and review decisions relating to the above functions;
  (d) to do anything incidental or conducive to the performance of the above functions.

(2) The Complaints Commissioner may, by notifiable instrument, make guidelines relating to the performance of any of the functions mentioned in subsection (1).

(3) The Complaints Commissioner has power to do all things necessary or convenient to be done for or in connection with the performance of the functions mentioned in subsection (1).

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(4) In performing the functions mentioned in subsection (1), the Complaints Commissioner must:

(a) take reasonable steps to provide opportunities for individuals accessing funded aged care services to engage with the Complaints Commissioner; and

(b) take into consideration the rights under the Statement of Rights, wishes and views of individuals accessing funded aged care services.

(5) In performing the functions mentioned in subsection (1), the Complaints Commissioner may consult with the following:

(a) the System Governor;

(b) the Inspector-General of Aged Care;

(c) the Pricing Authority.

358 Complaints functions

The ***complaints functions*** of the Complaints Commissioner are the following:

(a) to uphold the rights under the Statement of Rights, and protect and enhance the safety, health, wellbeing and quality of life, of individuals accessing funded aged care services, by maintaining independent, transparent, accountable, accessible, safe and culturally safe processes for:

(i) making complaints about the compliance with this Act of a registered provider or a responsible person or aged care worker of a registered provider; and

(ii) making complaints about a registered provider acting in a way that is incompatible with the Statement of Rights; and

(iii) giving the Complaints Commissioner other feedback about a registered provider or a responsible person or aged care worker of a registered provider;

(b) to deal with complaints and feedback received by the Complaints Commissioner;

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(c) to acknowledge and engage with independent aged care advocates who provide support or advocacy to an individual in relation to making a complaint or giving feedback;

(d) to collect, correlate, analyse and disseminate information relating to complaints and feedback to identify trends or systemic issues;

(e) for complaints and feedback that is better dealt with by other persons or bodies—to refer the complaints and feedback to those persons or bodies;

(f) to promote a culture for registered providers, and responsible persons and aged care workers of registered providers, of raising concerns, open disclosure (including of complaints and feedback) and best practice in handling complaints and feedback, including by developing educational material and promoting the use of advocates;

(g) to promote a culture of continuous improvement for registered providers, including considering complaints and feedback and responding to complaints and feedback where appropriate;

(h) to build the capability of individuals to pursue complaints and give feedback;

(i) to build the capability of registered providers to develop a culture of learning and innovation to deliver quality funded aged care services and respond to complaints and feedback;

(j) to support registered providers to develop and implement effective complaints and feedback management systems;

(k) to seek and consider clinical advice, professional advice and advice in relation to complaints and feedback from other organisations;

(l) to provide analysis of complaints and feedback to the System Governor;

(m) to give the Minister written reports, in accordance with any requirements as prescribed by the rules, in relation to complaints and feedback received by the Complaints Commissioner.

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359 Complaints Commissioner may request information or documents from persons

(1) If the Complaints Commissioner reasonably believes that a person has information or documents relevant to the Complaints Commissioner's functions, the Complaints Commissioner may request the person to give the Complaints Commissioner any such information or documents (or copies of any such documents).

(2) The person is not required to comply with the request.

360 Minister may give directions

(1) The Minister may, by legislative instrument, give written directions to the Complaints Commissioner about the performance of the Complaints Commissioner's functions.

Note: Section 42 (disallowance) and Part 4 of Chapter 3 (sunsetting) of the *Legislation Act 2003* do not apply to the directions (see regulations made for the purposes of paragraphs 44(2)(b) and 54(2)(b) of that Act).

(2) A direction given by the Minister under subsection (1):

(a) must be of a general nature only; and

(b) must not relate to a particular registered provider or individual accessing, or seeking to access, funded aged care services.

(3) The Complaints Commissioner must comply with a direction under subsection (1).

(4) Subsection (3) does not apply to the extent that the direction relates to the Complaints Commissioner's performance of functions or exercise of powers under the following Acts in relation to the Commission:

(a) the *Public Service Act 1999*;

(b) the *Public Governance, Performance and Accountability Act 2013*.

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361 Dealing with complaints

(1) The rules may make provision in relation to dealing with complaints or feedback received by the Complaints Commissioner about an entity's compliance with this Act.

(1A) Without limiting subsection (1), the rules must provide that if a complaint is made to the Complaints Commissioner about:

(a) the compliance of a registered provider or a responsible person or aged care worker of a registered provider with this Act; or

(b) a registered provider acting in a way that is incompatible with the Statement of Rights;

the Complaints Commissioner must, by the end of the period specified in the rules:

(c) deal with and resolve the complaint; and

(d) prepare a written statement (a ***complaint determination***) setting out:

(i) what action (if any) the Complaints Commissioner took to deal with and resolve the complaint; and

(ii) what action (if any) should be taken by another person to deal with and resolve the complaint; and

(iii) information relating to the review or reconsideration of decisions made under the scheme; and

(e) give the person who made the complaint a copy of the complaint determination.

(2) Without limiting subsection (1), the rules may make provision in relation to the following:

(a) how complaints may be made to the Complaints Commissioner about:

(i) the compliance of a registered provider or a responsible person or aged care worker of a registered provider with this Act; and

(ii) a registered provider acting in a way that is incompatible with the Statement of Rights;

(b) how complaints may be dealt with and resolved;

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(c) the roles, rights and responsibilities of complainants, registered providers, aged care workers of registered providers and any other relevant persons;

(d) the processes for resolving complaints, including early resolution and restorative practices;

(e) the actions that may be taken to address complaints, which may include requiring a registered provider or aged care worker of a registered provider to do something;

(f) the review or reconsideration of decisions made under the scheme, including providing for procedural fairness;

(g) how a complaint that is also a disclosure that qualifies for protection under section 547 (whistleblower protections) may be dealt with.

(3) The Complaints Commissioner must, by notifiable instrument, make guidelines relating to the rules made for the purposes of subsection (1).

(4) In making the guidelines for the purposes of subsection (3), the Complaints Commissioner must have regard to the following principles:

(a) outcomes for individuals are improved when the processes for dealing with complaints made, or feedback provided, to the Complaints Commissioner:

(i) are person-centred, simple to access and easy to use; and

(ii) are able to resolve complaints in a timely way; and

(iii) promote use of restorative practices where appropriate;

(b) processes for dealing with complaints made, or feedback provided, to the Complaints Commissioner are most effective when the processes are:

(i) supported by clear guidelines; and

(ii) transparent about the effectiveness of those processes; and

(iii) subject to robust quality assurance and review processes.

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Division 4—Administration

362 Acting appointments

The Minister may, by written instrument, appoint a person to act as an Appointed Commissioner:

(a) during a vacancy in the office of the Appointed Commissioner (whether or not an appointment has previously been made to the office); or

(b) during any period, or during all periods, when the Appointed Commissioner:

(i) is absent from duty or from Australia; or

(ii) is, for any reason, unable to perform the duties of the office.

Note: For rules that apply to acting appointments, see sections 33AB and 33A of the *Acts Interpretation Act 1901*.

363 Remuneration and allowances

(1) An Appointed Commissioner is to be paid the remuneration that is determined by the Remuneration Tribunal. If no determination of that remuneration by the Tribunal is in operation, the Appointed Commissioner is to be paid the remuneration that is prescribed by the rules.

(2) An Appointed Commissioner is to be paid the allowances that are prescribed by the rules.

(3) This section has effect subject to the *Remuneration Tribunal Act 1973*.

364 Leave of absence

(1) An Appointed Commissioner has the recreation leave entitlements that are determined by the Remuneration Tribunal.

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(2) The Minister may grant an Appointed Commissioner leave of absence, other than recreation leave, on the terms and conditions as to remuneration or otherwise that the Minister determines.

365 Other paid work

An Appointed Commissioner must not engage in paid work outside the duties of the Appointed Commissioner's office without the Minister's approval.

366 Other terms and conditions

An Appointed Commissioner holds office on the terms and conditions (if any) in relation to matters not covered by this Act that are determined, in writing, by the Minister.

367 Resignation

(1) An Appointed Commissioner may resign the Appointed Commissioner's appointment by giving the Minister a written resignation.

(2) The resignation takes effect on the day it is received by the Minister or, if a later day is specified in the resignation, on that later day.

368 Termination of appointment

(1) The Minister may terminate the appointment of an Appointed Commissioner:

(a) for misbehaviour; or

(b) if the Appointed Commissioner is unable to perform the duties of the Appointed Commissioner's office because of physical or mental incapacity.

(2) The Minister may terminate the appointment of an Appointed Commissioner if:

(a) the Appointed Commissioner:

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(i) becomes bankrupt; or

(ii) applies to take the benefit of any law for the relief of bankrupt or insolvent debtors; or

(iii) compounds with the Appointed Commissioner's creditors; or

(iv) makes an assignment of the Appointed Commissioner's remuneration for the benefit of the Appointed Commissioner's creditors; or

(b) the Appointed Commissioner is absent, except on leave of absence, for 14 consecutive days or for 28 days in any 12 months; or

(c) the Appointed Commissioner engages, except with the Minister's approval, in paid work outside the duties of the Appointed Commissioner's office (see section 365); or

(d) the Appointed Commissioner fails, without reasonable excuse, to comply with section 29 of the *Public Governance, Performance and Accountability Act 2013* (which deals with the duty to disclose interests) or rules made for the purposes of that section.

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Division 5—Staff of the Commission

369 Staff

(1) The staff of the Commission must be persons engaged under the *Public Service Act 1999*.

(2) For the purposes of the *Public Service Act 1999*:
  (a) the Commissioner and the staff of the Commission together constitute a Statutory Agency; and
  (b) the Commissioner is the Head of that Statutory Agency.

370 Persons assisting the Commission

(1) The Commission may also be assisted by:
  (a) officers and employees of Agencies (within the meaning of the *Public Service Act 1999*), and of authorities of the Commonwealth, whose services are made available to the Commission in connection with the performance of any of the Commission's functions; and
  (b) persons whose services are made available under arrangements made under subsection (2).

(2) The Commissioner may, on behalf of the Commonwealth, make an arrangement with the appropriate authority or officer of:
  (a) a State or Territory government; or
  (b) a State or Territory government authority;
under which the government or authority makes officers or employees available to the Commission to perform services in connection with the performance of any of the Commission's functions.

(3) An arrangement under subsection (2) may provide for the Commonwealth to reimburse a State or Territory with respect to the services of a person or persons to whom the arrangement relates.

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(4) When performing services for the Commission under this section, a person is subject to the directions of an Appointed Commissioner.

371 Consultants

The Commissioner may, on behalf of the Commonwealth, engage consultants to assist in the performance of the Commission's functions.

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Division 6—Reporting and planning

372 Annual report

The annual report prepared by the Commissioner and given to the Minister under section 46 of the *Public Governance, Performance and Accountability Act 2013* for a period (the ***reporting period***) must include the following:

(a) an assessment of the extent to which the Commission's operations during the reporting period have contributed to the priorities set out in the corporate plan for the period;

(b) particulars of any variations of the corporate plan during the reporting period;

(c) an evaluation of the Commission's overall performance during the reporting period against the performance indicators set out in the corporate plan for the reporting period;

(d) a summary of activity undertaken in the reporting period for each of the functions mentioned in subsections 348(1) and 357(1);

(e) the key outcomes achieved by the Commissioner in the reporting period for individuals accessing funded aged care services;

(f) information about the use by the Commissioner of regulatory mechanisms under Chapter 6 in the reporting period;

(g) analysis of complaints and feedback received by the Complaints Commissioner in the reporting period;

(h) a summary of reports received by the Commissioner in relation to reportable incidents;

(i) any other matters prescribed by the rules.

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373 Minister may request report on matters relating to Commissioner's functions

(1) The Minister may, by notice in writing given to the Commissioner, request the Commissioner to inquire into and report to the Minister on a matter mentioned in section 348.

(2) When a request is made under subsection (1), the Commissioner must inquire into the matter and give the Minister a report in writing on that matter.

374 Minister may request report on matters relating to Complaints Commissioner's functions

(1) The Minister may, by notice in writing given to the Complaints Commissioner, request the Complaints Commissioner to inquire into and report to the Minister on a matter mentioned in section 357.

(2) When a request is made under subsection (1), the Complaints Commissioner must inquire into the matter and give the Minister a report in writing on that matter.

375 Consulting on corporate plans

In preparing a corporate plan under section 35 of the *Public Governance, Performance and Accountability Act 2013*, the Commissioner must consult the Minister, the Complaints Commissioner and the Advisory Council.

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Division 7—Financial and Prudential Standards

376 Commissioner may make Financial and Prudential Standards

(1) The Commissioner may, by legislative instrument, make standards in relation to financial and prudential matters.

Note 1: These standards are the ***Financial and Prudential Standards***: see section 7.

Note 2: It is a condition of registration that a registered provider must comply with the provisions of the Financial and Prudential Standards that apply to the provider: see section 150. If a registered provider breaches a condition of registration, the provider may be liable to a civil penalty: see subsection 142(3).

(2) The standards may only deal with the following:

(a) requirements in relation to the liquidity and capital adequacy of registered providers;

(b) requirements in relation to the keeping of financial records relating to the delivery of funded aged care services, including records about refundable deposits, accommodation bonds, accommodation charges, entry contributions, fees, payments and contributions;

(c) requirements in relation to governance systems and strategies that registered providers must have in place to ensure that they remain:

(i) financially viable and sustainable; and

(ii) able to comply with the other applicable requirements in the standards;

(d) requirements in relation to the disclosure and reporting, by registered providers, of information that may assist the Commissioner to:

(i) monitor the financial viability and sustainability of registered providers; and

(ii) monitor the compliance of registered providers with the other applicable requirements in the standards; and

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(iii) quantify prudential and financial risk relating to registered providers;

(e) requirements in relation to the management of investments by registered providers to ensure that they remain financially viable and sustainable;

(f) requirements in relation to any other prudential matter prescribed by the rules.

(3) Without limiting subsection (1), the standards may provide that a provision of the standards applies to the following:

(a) all registered providers;

(b) registered providers in specified provider registration categories;

(c) specified kinds of registered providers.

(4) Without limiting paragraph (2)(f), rules prescribing a prudential matter for the purposes of that paragraph may also prescribe that any standards made under subsection (1) dealing with that prudential matter only apply to registered providers in a specified provider registration category.

(5) Subsections (3) and (4) of this section do not limit subsection 33(3A) of the *Acts Interpretation Act 1901*.

377 Having regard to principles, and consultation, in making standards

(1) In making standards under subsection 376(1), the Commissioner must have regard to the Statement of Principles and the following principles:

(a) for a registered provider to deliver ongoing quality and safe care, the registered provider must remain financially viable and sustainable;

(b) safeguarding of the refundable deposits, accommodation bonds and entry contributions of individuals that are held by registered providers is helped by registered providers:

(i) remaining financially viable and sustainable; and

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(ii) having responsible management.

(2) The Commissioner must consult the System Governor before making standards under subsection 376(1).

378 Effect of Financial and Prudential Standards

Standards made under subsection 376(1) that are inconsistent with the rules have no effect to the extent of the inconsistency, but the standards are taken to be consistent with the rules to the extent that the standards are capable of operating concurrently with the rules.

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Division 8—Worker screening

Subdivision A—Aged care worker screening database

379 Aged care worker screening database

(1) The Commissioner must establish, operate and maintain a database for the purposes of this Act, to be known as the aged care worker screening database.

(2) The aged care worker screening database must be kept in electronic form.

Purposes of the database

(3) The purposes of the aged care worker screening database are the following:

(a) to maintain, for the purposes of this Act, an up-to-date record of persons who, under decisions made under aged care worker screening laws, have been found, in working, or seeking to work, with individuals accessing funded aged care services not to pose a risk, or to pose a risk, to such individuals;

(b) in relation to persons covered by paragraph (a)—to maintain an up-to-date record of other decisions that relate to the decisions covered by that paragraph;

(c) to share information in the database:

(i) with registered providers that are employers or potential employers of persons; and

(ii) with persons or bodies (whether the persons or bodies are registered providers or not) for the purposes of this Act or for the purposes of those persons or bodies facilitating the employment, engagement or training of other persons to work with individuals accessing funded aged care services; and

(iii) with the Commissioner of the NDIS Quality and Safeguards Commission for the purposes of that

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Commissioner performing that Commissioner's functions; and

(iv) with the Chief Executive Officer of the National Disability Insurance Agency for the purposes of performing the functions of the Agency; and

(v) with persons or bodies (including employers and potential employers) for the purposes of the National Disability Insurance Scheme;

(d) any other purpose prescribed by the rules.

(4) Paragraphs (3)(a) to (c) do not limit paragraph (3)(d).

Information in the database

(5) The aged care worker screening database may include the following information for the purposes of subsection (3):

(a) information relating to persons (each of whom is a ***screening applicant***) who have made applications (each of which is a ***screening application***) for an aged care worker screening check and information relating to those applications;

(b) information relating to each screening applicant in respect of whom a screening application is no longer being considered and the reasons for this;

(c) information relating to each screening applicant in respect of whom a decision (a ***clearance decision***) (however described) is in force, under an aged care worker screening law, to the effect that the person, in working, or seeking to work, with individuals accessing funded aged care services does not pose a risk to such individuals and information relating to the decision;

(d) information relating to any decisions made under an aged care worker screening law, in relation to each screening applicant, while the screening applicant's application is pending;

(e) information relating to each screening applicant in respect of whom a decision (an ***exclusion decision***) (however described) is in force, under an aged care worker screening

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law, to the effect that the person, in working, or seeking to work, with individuals accessing funded aged care services does pose a risk to such individuals and information relating to the decision;

(f) if a clearance decision or an exclusion decision specifies the period for which the decision is in force—information setting out that period;

(g) information relating to each person in respect of whom a decision (however described), under an aged care worker screening law, suspending a clearance decision has been made and information relating to the suspension;

(h) information relating to each person in respect of whom a decision (however described), under an aged care worker screening law, revoking a clearance decision or an exclusion decision has been made and information relating to the revocation;

(i) information relating to persons or bodies (whether the persons or bodies are registered providers or not) that employ, engage or train, or propose to employ, engage or train, persons who have made screening applications;

(j) any other information prescribed by the rules.

(6) Paragraphs (5)(a) to (i) do not limit paragraph (5)(j).

(7) The aged care worker screening database may also include the following information:

(a) information relating to persons (each of whom is a ***screening applicant***) who:

(i) have made applications (each of which is a ***screening application***) for an NDIS worker screening check (within the meaning of the NDIS Act); and

(ii) are identified (in screening applications or otherwise) as seeking to work with individuals accessing funded aged care services;

and information relating to those applications;

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(b) information relating to each screening applicant in respect of whom a screening application is no longer being considered and the reasons for this;

(c) information relating to each screening applicant in respect of whom a decision (a ***clearance decision***) (however described) is in force, under an NDIS worker screening law, to the effect that the person, in working, or seeking to work, with people with disability does not pose a risk to such people and information relating to the decision;

(d) information relating to any decisions made under an NDIS worker screening law, in relation to each screening applicant, while the screening applicant's application is pending;

(e) information relating to each screening applicant in respect of whom a decision (an ***exclusion decision***) (however described) is in force, under an NDIS worker screening law, to the effect that the person, in working, or seeking to work, with people with disability does pose a risk to such people and information relating to the decision;

(f) if a clearance decision or an exclusion decision specifies the period for which the decision is in force—information setting out that period;

(g) information relating to each person in respect of whom a decision (however described), under an NDIS worker screening law, suspending a clearance decision has been made and information relating to the suspension;

(h) information relating to each person in respect of whom a decision (however described), under an NDIS worker screening law, revoking a clearance decision or an exclusion decision has been made and information relating to the revocation;

(i) information relating to employers or potential employers of persons who have made screening applications.

Database may include personal information

(8) The information included under paragraphs (5)(a) to (j) and (7)(a) to (i) may include personal information.

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Database not a legislative instrument

(9) The aged care worker screening database is not a legislative instrument.

Subdivision B—NDIS screening decisions

380 NDIS clearance decision taken to be aged care clearance decision

(1) This section applies if an NDIS clearance decision is in force, under an NDIS worker screening law, in respect of a person in working, or seeking to work, with people with disability.

(2) The NDIS clearance decision in respect of the person is taken, for the purposes of this Act (other than this Division), to be an aged care clearance decision in force, under an aged care worker screening law, in respect of the person in working, or seeking to work, with individuals accessing funded aged care services.

381 NDIS exclusion decision taken to be aged care exclusion decision

(1) This section applies if an NDIS exclusion decision is in force, under an NDIS worker screening law, in respect of a person in working, or seeking to work, with people with disability.

(2) The NDIS exclusion decision in respect of the person is taken, for the purposes of this Act (other than this Division), to be an aged care exclusion decision in force, under an aged care worker screening law, in respect of the person in working, or seeking to work, with individuals accessing funded aged care services.

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Part 4—Aged Care Quality and Safety Advisory Council

Division 1—Establishment and functions of the Advisory Council

382 Establishment of the Aged Care Quality and Safety Advisory Council

The Aged Care Quality and Safety Advisory Council is established by this section.

383 Functions of the Advisory Council

The functions of the Advisory Council are the following:

(a) to monitor the performance of the Commission's functions;

(b) on its own initiative or at the request of the Commissioner, to provide advice to the Commissioner in relation to the Commissioner's functions, including by identifying current and emerging risks and making recommendations;

(c) on its own initiative or at the request of the Complaints Commissioner, to provide advice to the Complaints Commissioner in relation to the Complaints Commissioner's functions, including by identifying current and emerging risks and making recommendations;

(d) on its own initiative or at the request of the Minister, to provide advice to the Minister about matters arising in relation to the performance of the Commission's functions, including by identifying current and emerging risks and systemic performance issues, and making recommendations;

(e) to support the Commission in developing its strategic objectives;

(f) to collect (including through stakeholder engagement and consultation), correlate, analyse and disseminate data and

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other information for the purposes of, and relating to, the Advisory Council's functions.

384 Minister may give directions about the Advisory Council's functions

(1) The Minister may, by legislative instrument, give written directions to the Advisory Council in relation to the Advisory Council's functions.

Note: Section 42 (disallowance) and Part 4 of Chapter 3 (sunsetting) of the *Legislation Act 2003* do not apply to the directions (see regulations made for the purposes of paragraphs 44(2)(b) and 54(2)(b) of that Act).

(2) A direction given by the Minister under subsection (1):

(a) must be of a general nature only; and

(b) must not relate to a particular registered provider or individual accessing, or seeking to access, funded aged care services.

(3) The Advisory Council must comply with a direction under subsection (1).

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Division 2—Membership of Advisory Council

385 Membership of the Advisory Council

(1) The Advisory Council consists of the following members:

(a) a Chair;

(b) a Deputy Chair;

(c) at least 7, and not more than 11, other members.

(2) The members of the Advisory Council are not officials for the purposes of the *Public Governance, Performance and Accountability Act 2013*.

386 Appointment of Advisory Council members

(1) Each Advisory Council member is to be appointed by the Minister by written instrument, on a part-time basis.

Note 1: A reference to an Advisory Council member includes the Chair and the Deputy Chair: see section 7.

Note 2: An Advisory Council member may be reappointed: see section 33AA of the *Acts Interpretation Act 1901*.

(2) An Advisory Council member holds office for the period specified in the instrument of appointment. The period must not exceed 4 years.

(3) A person is not eligible for appointment to the Advisory Council unless the Minister is satisfied that the person has substantial experience or knowledge in at least one of the following fields:

(a) evaluation of quality management systems;

(b) delivery of funded aged care services to individuals;

(c) health consumer issues;

(d) geriatrics or gerontology;

(e) aged care nursing or an allied health profession;

(f) psychiatry of individuals likely to access, or seek to access, funded aged care services;

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(g) adult education;
(h) public administration;
(i) leadership and management;
(j) law;
(k) contemporary regulatory best practice;
(l) financial and prudential regulation;
(m) data analytics;
(n) any other appropriate field of expertise.

(4) When deciding whether to a appoint a person as an Advisory Council member, the Minister must take into account whether the person has any interests, pecuniary or otherwise, that conflict or could conflict with the proper performance of a member's functions.

387 Acting appointments

Chair

(1) The Minister may, by written instrument, appoint a person to act as the Chair:
(a) during a vacancy in the office of the Chair (whether or not an appointment has previously been made to the office); or
(b) during any period, or during all periods, when the Chair:
(i) is absent from duty or from Australia; or
(ii) is, for any reason, unable to perform the duties of the office.

Other Advisory Council members

(2) The Minister may, by written instrument, appoint a person to act as an Advisory Council member (other than the Chair):
(a) during a vacancy in the office of an Advisory Council member (other than the Chair), whether or not an appointment has previously been made to the office; or
(b) during any period, or during all periods, when an Advisory Council member (other than the Chair):

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(i) is absent from duty or from Australia; or

(ii) is, for any reason, unable to perform the duties of the office.

Eligibility

(3) A person is not eligible for appointment under subsection (1) or (2) unless the person is eligible for appointment as an Advisory Council member.

Note 1: For eligibility to be appointed as an Advisory Council member, see subsection 386(3).

Note 2: For rules that apply to acting appointments, see sections 33AB and 33A of the *Acts Interpretation Act 1901*.

Period of appointment

(4) An appointment under this section has effect for the period specified in the instrument of appointment. The period must not exceed 12 months.

388 Remuneration and allowances

(1) An Advisory Council member is to be paid the remuneration that is determined by the Remuneration Tribunal. If no determination of that remuneration by the Tribunal is in operation, the member is to be paid the remuneration that is prescribed by the rules.

(2) However, an Advisory Council member is not entitled to be paid remuneration if the member holds an office or appointment, or is otherwise employed, on a full-time basis in the service or employment of:

(a) a State; or

(b) a corporation (a ***public statutory corporation***) that:

(i) is established for a public purpose by a law of a State; and

(ii) is not a tertiary education institution; or

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(c) a company limited by guarantee, where the interests and rights of the members in or in relation to the company are beneficially owned by a State; or

(d) a company in which all the stock or shares are beneficially owned by a State or by a public statutory corporation.

Note: A similar rule applies to an Advisory Council member who has a similar relationship with the Commonwealth or a Territory: see subsection 7(11) of the *Remuneration Tribunal Act 1973*.

(3) An Advisory Council member is to be paid the allowances that are prescribed by the rules.

(4) This section has effect subject to the *Remuneration Tribunal Act 1973*.

389 Leave of absence

(1) The Minister may grant leave of absence to the Chair or the Deputy Chair on the terms and conditions that the Minister determines.

(2) The Chair may grant leave of absence to another Advisory Council member (other than the Deputy Chair) on the terms and conditions that the Chair determines.

390 Disclosure of interests to the Minister

An Advisory Council member must give written notice to the Minister of all interests, pecuniary or otherwise, that the member has or acquires and that conflict or could conflict with the proper performance of the member's functions.

391 Disclosure of interests to the Advisory Council

(1) An Advisory Council member who has an interest, pecuniary or otherwise, in a matter being considered or about to be considered by the Advisory Council must disclose the nature of the interest to a meeting of the Advisory Council.

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(2) The disclosure must be made as soon as possible after the relevant facts have come to the Advisory Council member's knowledge.

(3) The disclosure must be recorded in the minutes of the meeting of the Advisory Council.

(4) Unless the Advisory Council otherwise determines, the Advisory Council member:

(a) must not be present during any deliberation by the Advisory Council on the matter; and

(b) must not take part in any decision of the Advisory Council with respect to the matter.

(5) For the purposes of making a determination under subsection (4), the Advisory Council member:

(a) must not be present during any deliberation of the Advisory Council for the purpose of making the determination; and

(b) must not take part in making the determination.

(6) A determination under subsection (4) must be recorded in the minutes of the meeting of the Advisory Council.

392 Resignation

(1) An Advisory Council member may resign the member's appointment by giving the Minister a written resignation.

(2) The resignation takes effect on the day it is received by the Minister or, if a later day is specified in the resignation, on that later day.

393 Termination of appointment

(1) The Minister may terminate the appointment of an Advisory Council member:

(a) for misbehaviour; or

(b) if the Advisory Council member is unable to perform the duties of the member's office because of physical or mental incapacity.

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(2) The Minister may terminate the appointment of an Advisory Council member if:

(a) the member:

(i) becomes bankrupt; or

(ii) applies to take the benefit of any law for the relief of bankrupt or insolvent debtors; or

(iii) compounds with the member's creditors; or

(iv) makes an assignment of the member's remuneration for the benefit of the member's creditors; or

(b) the member is absent, except on leave of absence, from 3 consecutive meetings of the Advisory Council; or

(c) the member fails, without reasonable excuse, to comply with section 390 or 391 (which deal with the disclosure of interests); or

(d) the member is unable to properly perform the duties of the member's office because of interests, pecuniary or otherwise, that the member has and that conflict with the proper performance of the member's functions.

394 Other terms and conditions

An Advisory Council member holds office on the terms and conditions (if any) in relation to matters not covered by this Act that are determined, in writing, by the Minister.

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Division 3—Procedures of the Advisory Council

395 Procedures of the Advisory Council

(1) The Advisory Council may, subject to any direction given under subsection (2), determine its own procedures.

(2) The Minister may give the Advisory Council written directions about the procedures to be followed in relation to meetings of the Advisory Council.

(3) A direction given by the Minister under subsection (2):

(a) must be of a general nature only; and

(b) must not relate to a particular registered provider or individual accessing, or seeking to access, funded aged care services.

(4) A direction given under subsection (2) is not a legislative instrument.

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Chapter 6—Regulatory mechanisms

Part 1—Introduction

396 Simplified outline of this Chapter

This Chapter provides for a range of regulatory mechanisms that are available to the Commissioner, Complaints Commissioner and the System Governor in relation to their functions. These include powers under the Regulatory Powers Act and additional powers under this Chapter.

The additional powers include the following:

(a) powers for authorised Commission officers, acting under authorisation by the Commissioner, to enter and search approved residential care homes without a warrant or consent for the purposes of certain functions of the Commissioner;

(b) powers for the Commissioner, Complaints Commissioner and the System Governor to give required action notices and compliance notices to registered providers in relation to their functions;

(c) powers for the Commissioner to make banning orders prohibiting or restricting current and former registered providers, aged care workers and responsible persons from delivering (or being involved in delivering) funded aged care services;

(d) powers for the Commissioner, Complaints Commissioner and the System Governor to require persons to attend before authorised officers to answer questions or give information or documents in relation to their functions;

(e) a power for the System Governor to conduct assurance activities for the purposes of the System Governor's functions;

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(f) powers for the System Governor to recover amounts of subsidy or grants paid by the Commonwealth to entities that were not entitled to be paid those amounts.

This Chapter also deals with the appointment, functions and powers of authorised officers and miscellaneous matters.

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Part 2—Monitoring under Part 2 of the Regulatory Powers Act

Division 1—Triggering Part 2 of the Regulatory Powers Act

397 Provisions, information subject to monitoring

Provisions subject to monitoring

(1) A provision is subject to monitoring under Part 2 of the Regulatory Powers Act if it is:

(a) a provision of this Act; or

(b) an offence provision of the *Crimes Act 1914* or the *Criminal Code*, to the extent that it relates to this Act.

Note 1: The expression ***this Act*** (see section 7) includes:

(a) legislative instruments made under this Act; and

(b) the Regulatory Powers Act as it applies in relation to this Act.

Note 2: Part 2 of the Regulatory Powers Act creates a framework for monitoring whether a provision has been complied with. It includes powers of entry and inspection.

Information subject to monitoring

(2) Information given in compliance or purported compliance with a provision of this Act is subject to monitoring under Part 2 of the Regulatory Powers Act.

398 Related provisions, issuing officer and relevant court

For the purposes of Part 2 of the Regulatory Powers Act, as that Part applies in relation to the provisions mentioned in subsection 397(1) and the information mentioned in subsection 397(2) of this Act:

(a) there are no related provisions; and

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(b) each of the following is an issuing officer:
  (i) a magistrate;
  (ii) a Judge of a court of a State or Territory;
  (iii) a Judge of the Federal Court or the Federal Circuit and Family Court of Australia (Division 2); and
(c) each of the following is a relevant court:
  (i) the Federal Court;
  (ii) the Federal Circuit and Family Court of Australia (Division 2);
  (iii) a court of a State or Territory that has jurisdiction in relation to matters arising under this Act.

399 Authorised applicant, authorised person and relevant chief executive—Commissioner or Complaints Commissioner functions

For the purposes of Part 2 of the Regulatory Powers Act, as that Part applies in relation to the provisions mentioned in subsection 397(1) and the information mentioned in subsection 397(2) of this Act that relate to a function of the Commissioner or Complaints Commissioner (including a function which has been delegated to the Complaints Commissioner under section 575):

(a) an authorised Commission officer is an authorised applicant; and
(b) an authorised Commission officer is an authorised person; and
(c) the Commissioner is the relevant chief executive.

400 Authorised applicant, authorised person and relevant chief executive—System Governor functions

For the purposes of Part 2 of the Regulatory Powers Act, as that Part applies in relation to the provisions mentioned in subsection 397(1) and the information mentioned in

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subsection 397(2) of this Act that relate to a function of the System Governor:

(a) an authorised System Governor officer is an authorised applicant; and

(b) an authorised System Governor officer is an authorised person; and

(c) the System Governor is the relevant chief executive.

401 Persons assisting authorised persons

An authorised person may be assisted by other persons in exercising powers or performing functions or duties under Part 2 of the Regulatory Powers Act in relation to the provisions mentioned in subsection 397(1) and the information mentioned in subsection 397(2) of this Act.

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Division 2—Modifications of Part 2 of the Regulatory Powers Act

402 Application of this Division

This Division applies in relation to Part 2 of the Regulatory Powers Act as that Part applies in relation to the provisions mentioned in subsection 397(1) and the information mentioned in subsection 397(2) of this Act.

403 Use of force in executing monitoring warrants

In executing a monitoring warrant under Part 2 of the Regulatory Powers Act, as that Part applies in relation to the provisions mentioned in subsection 397(1) and the information mentioned in subsection 397(2) of this Act:

(a) an authorised person may use force against things only if all reasonable measures to execute the warrant effectively without the use of force have been exhausted; and

(b) a person assisting the authorised person may use force against things only if all reasonable measures to execute the warrant effectively without the use of force have been exhausted; and

(c) if paragraph (a) or (b) applies—the authorised person or person assisting the authorised person (as applicable) may use only such force against things as is necessary and reasonable in the circumstances.

404 Extension of Part 2 of the Regulatory Powers Act to external Territories

Part 2 of the Regulatory Powers Act, as that Part applies in relation to the provisions mentioned in subsection 397(1) and the information mentioned in subsection 397(2) of this Act, extends to the external Territories other than the Territory of Ashmore and Cartier Islands.

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406 Entry with consent—action before obtaining consent

Before obtaining the consent of an occupier of premises who is a registered provider for the purposes of paragraph 18(2)(a) of the Regulatory Powers Act, an authorised person must inform the registered provider that the registered provider has an obligation under section 177 of this Act to cooperate with a person who is performing functions, or exercising powers, under Part 2 of that Act.

Note: See section 25 of the Regulatory Powers Act for additional rules about consent.

407 Times for securing electronic equipment etc.

Sections 21, 22 and 33 of the Regulatory Powers Act are taken to apply as if:

(a) a reference to "24 hours" in sections 21 and 22 of that Act were a reference to "48 hours"; and

(b) a reference to a "24-hour period" in sections 21 and 22 of that Act were a reference to a "48-hour period".

408 Entry with consent—asking for answers to questions or production of documents

(1) The second reference to the occupier of premises in subsection 24(2) of the Regulatory Powers Act is taken to include a reference to any other person on the premises.

(2) Before requesting a person who is a registered provider to answer a question, or produce a document, under subsection 24(2) of the Regulatory Powers Act, an authorised person must inform the person that the registered provider has an obligation under section 177 of this Act to cooperate with a person who is performing functions, or exercising powers, under Part 2 of that Act.

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(3) If an authorised person requests a person to answer a question, or produce a document, under subsection 24(2) of the Regulatory Powers Act, the person is not required to comply with the request.

409 Exception to requirement to return identity card if authorised person continues to exercise other powers

Subsection 35(3) of the Regulatory Powers Act does not apply if a person who ceases to be an authorised person for the purposes of Part 2 of that Act, as that Part applies in relation to the provisions mentioned in subsection 397(1) and the information mentioned in subsection 397(2) of this Act, continues to be a person who exercises powers under this Act, or Part 3 of that Act as that Part applies in relation to this Act, for which the person is required to hold an identity card.

Note: A defendant bears an evidential burden in relation to the matter in this section: see subsection 13.3(3) of the Criminal Code.

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Division 3—Delegations by relevant chief executives

410 Delegation by relevant chief executive—Commission or Complaints Commissioner functions

(1) The relevant chief executive under section 399 may, in writing, delegate the powers and functions mentioned in subsection (3) of this section to a member of the staff of the Commission.

(2) However, the relevant chief executive under section 399 must not delegate a function or power to a person under subsection (1) of this section unless the relevant chief executive under section 399 is satisfied that the person has suitable training or experience to properly perform the function or exercise the power.

(3) The powers and functions that may be delegated are:

(a) powers and functions under Part 2 of the Regulatory Powers Act in relation to the provisions mentioned in subsection 397(1) and the information mentioned in subsection 397(2) of this Act that relate to a function of the Commissioner or Complaints Commissioner (including a function which has been delegated to the Complaints Commissioner under section 575); or

(b) powers and functions under the Regulatory Powers Act that are incidental to a power or function mentioned in paragraph (a).

(4) A person exercising powers or performing functions under a delegation under subsection (1) must comply with any written directions of the relevant chief executive under section 399.

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411 Delegation by relevant chief executive—System Governor functions

(1) The relevant chief executive under section 400 may, in writing, delegate the powers and functions mentioned in subsection (2) of

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this section to an SES employee, or an acting SES employee, in the Department.

(2) The powers and functions that may be delegated are:

(a) powers and functions under Part 2 of the Regulatory Powers Act in relation to the provisions mentioned in subsection 397(1) and the information mentioned in subsection 397(2) of this Act that relate to a function of the System Governor; and

(b) powers and functions under the Regulatory Powers Act that are incidental to a power or function mentioned in paragraph (a).

(3) A person exercising powers or performing functions under a delegation under subsection (1) must comply with any written directions of the relevant chief executive under section 400.

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Part 3—Investigating under Part 3 of the Regulatory Powers Act

Division 1—Triggering Part 3 of the Regulatory Powers Act

412 Provisions subject to investigation

A provision is subject to investigation under Part 3 of the Regulatory Powers Act if it is:

(a) an offence provision of this Act; or

(b) a civil penalty provision of this Act; or

(c) an offence provision of the *Crimes Act 1914* or the *Criminal Code*, to the extent that it relates to this Act.

Note 1: The expression ***this Act*** (see section 7) includes:
(a) legislative instruments made under this Act; and
(b) the Regulatory Powers Act as it applies in relation to this Act.

Note 2: Part 3 of the Regulatory Powers Act creates a framework for investigating whether a provision has been contravened. It includes powers of entry, search and seizure.

413 Related provisions, issuing officer and relevant court

For the purposes of Part 3 of the Regulatory Powers Act, as that Part applies in relation to evidential material that relates to a provision mentioned in section 412 of this Act:

(a) there are no related provisions; and

(b) each of the following is an issuing officer:

(i) a magistrate;

(ii) a Judge of a court of a State or Territory;

(iii) a Judge of the Federal Court or the Federal Circuit and Family Court of Australia (Division 2); and

(c) each of the following is a relevant court:

(i) the Federal Court;

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(ii) the Federal Circuit and Family Court of Australia (Division 2);

(iii) a court of a State or Territory that has jurisdiction in relation to matters arising under this Act.

414 Authorised applicant, authorised person and relevant chief executive—Commissioner or Complaints Commissioner functions

For the purposes of Part 3 of the Regulatory Powers Act, as that Part applies in relation to evidential material that relates to a provision mentioned in section 412 of this Act that relates to a function of the Commissioner or Complaints Commissioner (including a function which has been delegated to the Complaints Commissioner under section 575):

(a) an authorised Commission officer is an authorised applicant; and

(b) an authorised Commission officer is an authorised person; and

(c) the Commissioner is the relevant chief executive.

415 Authorised applicant, authorised person and relevant chief executive—System Governor functions

For the purposes of Part 3 of the Regulatory Powers Act, as that Part applies in relation to evidential material that relates to a provision mentioned in section 412 of this Act that relates to a function of the System Governor:

(a) an authorised System Governor officer is an authorised applicant; and

(b) an authorised System Governor officer is an authorised person; and

(c) the System Governor is the relevant chief executive.

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416 Persons assisting authorised persons

An authorised person may be assisted by other persons in exercising powers or performing functions or duties under Part 3 of the Regulatory Powers Act in relation to evidential material that relates to a provision mentioned in section 412 of this Act.

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Division 2—Modifications of Part 3 of the Regulatory Powers Act

417 Application of this Division

This Division applies in relation to Part 3 of the Regulatory Powers Act as that Part applies in relation to evidential material that relates to a provision mentioned in section 412 of this Act.

418 Use of force in executing investigation warrants

In executing an investigation warrant under Part 3 of the Regulatory Powers Act, as that Part applies in relation to evidential material that relates to a provision mentioned in section 412 of this Act:

(a) an authorised person may use force against things only if all reasonable measures to execute the warrant effectively without the use of force have been exhausted; and

(b) a person assisting the authorised person may use force against things only if all reasonable measures to execute the warrant effectively without the use of force have been exhausted; and

(c) if paragraph (a) or (b) applies—the authorised person or person assisting the authorised person (as applicable) may use only such force against things as is necessary and reasonable in the circumstances.

419 Extension of Part 3 of the Regulatory Powers Act to external Territories

Part 3 of the Regulatory Powers Act, as that Part applies in relation to a provision mentioned in section 412 of this Act, extends to the external Territories other than the Territory of Ashmore and Cartier Islands.

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420 Additional investigation powers

The additional powers mentioned in Part 5 of this Chapter are taken to be included in the investigation powers under Part 3 of the Regulatory Powers Act, as Part 3 of that Act applies in relation to evidential material that relates to a provision mentioned in section 412 of this Act.

421 Entry with consent—action before obtaining consent

Before obtaining the consent of an occupier of premises who is a registered provider for the purposes of paragraph 48(2)(a) of the Regulatory Powers Act, an authorised person must inform the registered provider that the registered provider has an obligation under section 177 of this Act to cooperate with a person who is performing functions, or exercising powers, under Part 3 of the Regulatory Powers Act.

Note: See section 55 of the Regulatory Powers Act for additional rules about consent.

422 Times for securing electronic equipment etc.

Sections 51 and 74 of the Regulatory Powers Act are taken to apply as if:

(a) a reference to "24 hours" in section 51 of that Act were a reference to "48 hours"; and

(b) a reference to a "24-hour period" in section 51 of that Act were a reference to a "48-hour period".

423 Entry with consent—asking for answers to questions or production of documents

(1) The second reference to the occupier of premises in subsection 54(2) of the Regulatory Powers Act is taken to include a reference to any other person on the premises.

(2) Before requesting a person who is a registered provider to answer a question, or produce a document, under subsection 54(2) of the

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Regulatory Powers Act, an authorised person must inform the person that the registered provider has an obligation under section 177 of this Act to cooperate with a person who is performing functions, or exercising powers, under Part 3 of the Regulatory Powers Act.

(3) If an authorised person requests a person to answer a question, or produce a document, under subsection 54(2) of the Regulatory Powers Act, the person is not required to comply with the request.

424 Exception to requirement to return identity card if authorised person continues to exercise other powers

Subsection 76(3) of the Regulatory Powers Act does not apply if the person who ceases to be an authorised person for the purposes of Part 3 of that Act, as that Part applies in relation to evidential material that relates to a provision mentioned in section 412 of this Act, continues to be a person who exercises powers under this Act, or Part 2 of that Act as it applies in relation to this Act, for which the person is required to hold an identity card.

Note: A defendant bears an evidential burden in relation to the matter in this section: see subsection 13.3(3) of the *Criminal Code*.

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Division 3—Delegations by relevant chief executives

425 Delegation by relevant chief executive—Commissioner or Complaints Commissioner functions

(1) The relevant chief executive under section 414 may, in writing:

(a) delegate the powers and functions mentioned in subsection (3) of this section to a member of the staff of the Commission who is:

(i) an SES employee or acting SES employee; or

(ii) an APS employee who holds, or is acting in, an Executive Level 2, or equivalent, position; and

(b) delegate the powers and functions mentioned in subsection (4) of this section to a member of the staff of the Commission.

(2) However, the relevant chief executive under section 414 must not delegate a function or power to a person under subparagraph (1)(a)(ii) or paragraph (1)(b) of this section unless the relevant chief executive under section 414 is satisfied that the person has suitable training or experience to properly perform the function or exercise the power.

(3) For the purposes of paragraph (1)(a), the powers and functions that may be delegated are:

(a) powers and functions under Part 3 of the Regulatory Powers Act in relation to evidential material that relates to a provision mentioned in section 412 of this Act that relates to a function of the Commissioner or Complaints Commissioner (including a function which has been delegated to the Complaints Commissioner under section 575); and

(b) powers and functions under the Regulatory Powers Act that are incidental to a power or function mentioned in paragraph (a).

(4) For the purposes of paragraph (1)(b), the powers and functions that may be delegated are:

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(a) the power under section 76 of the Regulatory Powers Act (to issue an identity card to an authorised person) that relates to a function of the Commissioner or Complaints Commissioner (including a function which has been delegated to the Complaints Commissioner under section 575); and

(b) powers and functions under the Regulatory Powers Act that are incidental to a power or function mentioned in paragraph (a).

(5) A person exercising powers or performing functions under a delegation under subsection (1) must comply with any written directions of the relevant chief executive under section 414.

426 Delegation by relevant chief executive—System Governor functions

(1) The relevant chief executive under section 415 may, in writing, delegate the powers and functions mentioned in subsection (2) of this section to an SES employee, or an acting SES employee, in the Department.

(2) The powers and functions that may be delegated are:

(a) powers and functions under Part 3 of the Regulatory Powers Act in relation to evidential material that relates to a provision mentioned in section 412 of this Act that relates to a function of the System Governor; and

(b) powers and functions under the Regulatory Powers Act that are incidental to a power or function mentioned in paragraph (a).

(3) A person exercising powers or performing functions under a delegation under subsection (1) must comply with any written directions of the relevant chief executive under section 415.

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Part 4—Access to premises where risk to safety etc. of individual

Division 1—Entry without warrant or consent

427 Entry without warrant or consent

Entry without warrant or consent

(1) An authorised Commission officer may enter and remain in a residential care home:

(a) at any time; and

(b) without a warrant or the consent of the occupier of the residential care home;

if the requirements in subsection (2) are satisfied.

(2) The requirements to be satisfied are:

(a) before the authorised Commission officer enters the residential care home, the Commissioner certifies, in writing, that the Commissioner is satisfied that:

(i) it is reasonably necessary for the authorised Commission officer to have access to the residential care home because there is an immediate and severe risk (the ***identified risk***) to the health, safety or wellbeing of an individual accessing funded aged care services; and

(ii) it is not practicable for the authorised Commission officer to apply for, and enter under, a monitoring warrant under section 32 of the Regulatory Powers Act or an investigation warrant under section 70 of the Regulatory Powers Act; and

(b) the certificate issued under paragraph (a) is in force; and

(c) the access is for the purposes of the performance of any of the Commissioner's safeguarding functions under paragraphs 349(a), (d) and (e).

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Notice and announcement of entry

(3) The authorised Commission officer may enter the residential care home under subsection (1) without prior notice to any person.

(4) However, before entering the residential care home, the authorised Commission officer must do the following:

(a) announce that the authorised Commission officer is authorised to enter the residential care home under this section;

(b) show the authorised Commission officer's identity card to the occupier of the residential care home, or a person apparently representing the occupier, if the occupier or other person is present at the residential care home;

(c) give any person at the residential care home an opportunity to allow entry to the residential care home.

(5) As soon as practicable after entering the residential care home, the authorised Commission officer must take reasonable steps to notify the occupier of the residential care home, or a person apparently representing the occupier, of the entry to the residential care home and the reason for that entry.

(6) The authorised Commission officer is not required to comply with paragraph (4)(a), (b) or (c) or subsection (5) if the authorised Commission officer reasonably believes that complying with that paragraph or subsection would frustrate the purpose for which access is necessary (including causing unreasonable delay).

Directions to address identified risk

(7) While remaining in the residential care home, the authorised Commission officer may give any directions necessary to the occupier of the residential care home, or a person apparently representing the occupier, to address the identified risk.

(8) A direction given under subsection (7) may be given orally or in writing.

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Securing things

(9) While remaining in the residential care home, the authorised Commission officer may secure a thing that the authorised Commission officer suspects, on reasonable grounds, to be relevant to:

(a) an offence provision of this Act; or

(b) a civil penalty provision of this Act; or

(c) an offence provision of the *Crimes Act 1914* or the *Criminal Code*, to the extent that it relates to this Act;

pending the obtaining of an investigation warrant under section 70 of the Regulatory Powers Act in relation to the residential care home. The thing may be secured by locking it up, placing a guard or any other means.

(10) The thing must not be secured under subsection (9) for longer than is reasonably necessary to obtain the investigation warrant.

(11) The authorised Commission officer must give notice to the occupier of the residential care home, or a person apparently representing the occupier, of:

(a) the authorised Commission officer's intention to secure the thing; and

(b) the fact that the thing may be secured for as long as it is reasonably necessary to obtain an investigation warrant under section 70 of the Regulatory Powers Act in relation to the residential care home.

Restriction on powers—failure to show identity card or proof of authority on request

(12) The authorised Commission officer is not entitled to enter or remain in the residential care home if:

(a) the occupier of the residential care home asks the authorised Commission officer to:

(i) show the officer's identity card; or

(ii) produce proof of the officer's authority to enter and remain in the residential care home; and

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(b) the authorised Commission officer fails:

(i) in the case of subparagraph (a)(i)—to present the officer's identity card; or

(ii) in the case of subparagraph (ii)—to produce the certificate issued by the Commissioner under paragraph (2)(a).

428 Use of force in entering premises

In entering a residential care home under section 427, and while at the residential care home, an authorised Commission officer, or a person assisting the officer, may use force against things as is necessary and reasonable in the circumstances.

429 Persons assisting

An authorised Commission officer may be assisted by other persons in exercising powers for the purposes of this Part, if that assistance is necessary and reasonable. A person giving such assistance is a ***person assisting*** the authorised Commission officer.

430 Responsibility to provide facilities and assistance etc.

(1) The occupier of a residential care home entered under section 427 must provide:

(a) an authorised Commission officer exercising powers; and

(b) any person assisting the officer;

with all reasonable facilities and assistance for the effective exercise of their powers while at the residential care home.

(2) A person to whom an authorised Commission officer gives a direction under subsection 427(7) must comply with the direction.

(3) A person commits an offence if:

(a) the person is subject to subsection (1) or (2); and

(b) the person fails to comply with that subsection.

Penalty: 30 penalty units or imprisonment for 6 months, or both.

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(4) A person is liable to a civil penalty if:

(a) the person is subject to subsection (1) or (2); and

(b) the person fails to comply with that subsection.

Penalty: 100 penalty units.

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Division 2—Post-entry warrants

431 Post-entry warrants

Requirement to apply for post-entry warrant

(1) If an authorised Commission officer enters a residential care home under, or purportedly under, section 427, the Commissioner must:

(a) apply to an assessment officer for a warrant (a ***post-entry warrant***) under this section in relation to the entry to the residential care home; and

(b) do so as soon as practicable after the exercise, or purported exercise, of powers under section 427 in relation to the residential care home.

(2) The application must:

(a) be in writing; and

(b) be accompanied by the certificate issued by the Commissioner under paragraph 427(2)(a); and

(c) set out the grounds on which the Commissioner was satisfied of the matters mentioned in paragraph 427(2)(a); and

(d) state the contact details for the Commissioner and the authorised Commission officer; and

(e) state how the assessment officer may give to the Commissioner the following:

(i) any request in writing under subsection (4) of this section for information or documents;

(ii) the post-entry warrant or a notice of refusal to issue the warrant; and

(f) set out any information that:

(i) is known to the Commissioner; and

(ii) the Commissioner considers may assist the assessment officer to give, to the occupier of the residential care home at the time of the entry, the post-entry warrant or a notice of refusal to issue the warrant; and

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(g) set out the time, date and place of the entry; and
(h) set out any other information, and be accompanied by any documents, the Commissioner considers relevant to the application.

(3) The information in the application must be sworn or affirmed by the Commissioner.

Requesting further information or documents

(4) The assessment officer may request, in writing, that the Commissioner or the authorised Commission officer provide further information or documents relating to the application, and that the Commissioner or authorised Commission officer do so in a particular way.

(5) If the Commissioner or the authorised Commission officer is unable to provide some or all of the further information or documents requested, the Commissioner or the authorised Commission officer must, within a reasonable period, notify the assessment officer:
(a) of the information or documents that cannot be provided; and
(b) of the reasons why the information or documents cannot be provided.

(6) If the assessment officer is notified in accordance with subsection (5) that some or all of the further information or documents cannot be provided, the assessment officer must (unless there is another reason not to) continue to consider the application despite having not received the further information or documents.

Issue of warrant

(7) The assessment officer must:
(a) issue the post-entry warrant if, and only if, the assessment officer is satisfied, on the balance of probabilities, that it was reasonable for the Commissioner to be satisfied of the matters mentioned in paragraph 427(2)(a); and
(b) otherwise, refuse to issue the post-entry warrant.

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(8) The issue of, or refusal to issue, the post-entry warrant does not affect whether or not the exercise, or purported exercise, of powers under section 427 was valid.

Content of warrant

(9) The post-entry warrant, if issued, must include the following:
- (a) the information mentioned in paragraph (2)(g);
- (b) a statement of the reasons for issuing the warrant;
- (c) a statement that the warrant has been issued under this section.

Notification requirements

(10) If the assessment officer issues the post-entry warrant, the assessment officer must give a copy of the warrant to the persons mentioned in subsection (12) as soon as reasonably practicable after issuing the warrant.

(11) If the assessment officer refuses to issue the post-entry warrant:
- (a) the assessment officer must give written notice of the refusal to the persons mentioned in subsection (12) as soon as reasonably practicable after refusing to issue the warrant; and
- (b) the notice must include a statement of reasons for refusing to issue the warrant; and
- (c) in the case of a notice given to a person mentioned in paragraph (12)(b)—the notice must also contain information about any right the person may have to:
  - (i) make a complaint to the Commonwealth Ombudsman under the *Ombudsman Act 1976*; or
  - (ii) take civil or other action;

  in relation to the entry to the residential care home or the exercise, or purported exercise, of powers under section 427 in relation to the residential care home.

(12) For the purposes of subsections (10) and (11), the persons are the following:
- (a) the Commissioner;

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(b) the occupier of the residential care home at the time of the entry;
(c) the authorised Commission officer.

432 Assessment officers

(1) An ***assessment officer*** is:
(a) a person:
(i) who is a Judge of the Federal Court of Australia, or a Judge of the Supreme Court of a State or Territory; and
(ii) in relation to whom a consent under subsection 433(1), and a declaration under subsection 433(2), are in force; or
(b) a person in relation to whom a nomination is in force under section 434 (a ***nominated ART member***).

(2) A function or power conferred on a Judge by this Division is conferred on the Judge in a personal capacity and not as a court or a member of a court.

(3) A Judge has, in relation to the performance or exercise of a function or power conferred on an assessment officer by this Division, the same protection and immunity as if the Judge were performing that function, or exercising that power, as, or as a member of, a court (being the court of which the Judge is a member).

(4) A nominated ART member has, in relation to the performance or exercise of a function or power conferred on an assessment officer by this Division, the same protection and immunity as a Justice of the High Court has in relation to proceedings in the High Court.

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433 Consent of Judges

(1) A Judge of the Federal Court of Australia, or of the Supreme Court of a State or Territory, may, by writing, consent to be declared an assessment officer by the Minister administering the *Judiciary Act 1903* under subsection (2).

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(2) The Minister administering the *Judiciary Act 1903* may, by writing, declare a Judge in relation to whom a consent under subsection (1) is in force to be an assessment officer for the purposes of this Division.

(3) A consent or declaration under this section is not a legislative instrument.

434 Nominated ART members

(1) The Minister administering the *Administrative Review Tribunal Act 2024* (the ***ART Minister***) may, by writing, nominate a person who holds one of the following appointments to the Administrative Review Tribunal to issue post-entry warrants and perform related functions under this Act:

(a) a Deputy President;

(b) a senior member appointed on a salaried basis.

(2) Despite subsection (1), the ART Minister must not nominate a person who holds an appointment as a senior member on a salaried basis unless the person:

(a) is enrolled as a legal practitioner of the High Court, of another federal court or of the Supreme Court of a State or of the Australian Capital Territory or the Northern Territory; and

(b) has been so enrolled for not less than 5 years.

(3) A nomination ceases to be in force if:

(a) the nominated ART member ceases to hold an appointment described in subsection (1); or

(b) the ART Minister, by writing, withdraws the nomination.

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Part 5—Additional investigation powers and compensation

435 Purpose of this Part

This Part:

(a) sets out additional powers for the purposes of section 420; and

(b) provides for compensation for damage to electronic equipment.

436 Use of equipment to examine or process things

(1A) This section applies if an authorised person exercises investigation powers under Part 3 of the Regulatory Powers Act in relation to premises entered under an investigation warrant for the purposes of this Act.

Equipment may be brought to premises

(1) An authorised person or a person assisting may bring to the premises any equipment reasonably necessary for the examination or processing of a thing found at the premises in order to determine whether the thing may be seized.

Thing may be moved for examination or processing

(2) A thing found at the premises may be moved to another place for examination or processing in order to determine whether the thing may be seized if:

(a) both of the following apply:

(i) it is significantly more practicable to do so having regard to the timeliness and cost of examining or processing the thing at another place and the availability of expert assistance;

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(ii) the authorised person or a person assisting suspects on reasonable grounds that the thing contains or constitutes evidential material; or

(b) the occupier of the premises consents in writing.

Notification of examination or processing and right to be present

(3) If the thing is moved to another place for the purpose of examination or processing under subsection (2), the authorised person must, if it is practicable to do so:

(a) inform the occupier of the premises of the address of the place and the time at which the examination or processing will be carried out; and

(b) allow the occupier or the occupier's representative to be present during the examination or processing.

(4) The authorised person need not comply with paragraph (3)(a) or (b) if the authorised person believes on reasonable grounds that to do so might:

(a) endanger the safety of a person; or

(b) prejudice an investigation or prosecution.

Time limit on moving the thing

(5) The thing may be moved to another place for examination or processing for no longer than 14 days.

(6) An authorised person may apply to an issuing officer for one or more extensions of that time if the authorised person believes on reasonable grounds that the thing cannot be examined or processed within 14 days or that time as previously extended.

(7) The authorised person must give notice of the application to the occupier of the premises, and that person is entitled to be heard in relation to the application.

(8) A single extension cannot exceed 7 days.

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Equipment at premises may be operated

(9) An authorised person or a person assisting may operate equipment already at the premises to carry out the examination or processing of a thing found at the premises in order to determine whether it is a thing that may be seized if the authorised person or person assisting believes on reasonable grounds that:

(a) the equipment is suitable for the examination or processing; and

(b) the examination or processing can be carried out without damage to the equipment or the thing.

437 Use of electronic equipment at other place

(1A) This section applies if an authorised person exercises investigation powers under Part 3 of the Regulatory Powers Act in relation to premises for the purposes of this Act.

(1) If electronic equipment is moved from the premises to another place under subsection 436(2), the authorised person or a person assisting may operate the equipment to access data (including data held at another place).

(2) If the authorised person or the person assisting suspects on reasonable grounds that any data accessed by operating the electronic equipment constitutes evidential material, the authorised person or the person assisting may copy any or all of the data accessed by operating the electronic equipment to a disk, tape or other associated device.

(3) If the relevant chief executive is satisfied that the data is not required (or is no longer required) for the purposes of this Act or for other judicial or administrative review proceedings, the relevant chief executive must arrange for:

(a) the removal of the data from any device in the control of the Commission or Department (as applicable); and

(b) the destruction of any other reproduction of the data in the control of the Commission or Department (as applicable).

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(4) If the authorised person or the person assisting, after operating the equipment, finds that evidential material is accessible by doing so, the authorised person or the person assisting may:

(a) seize the equipment and any disk, tape or other associated device; or

(b) if the material can be put in documentary form—put the material in that form and seize the documents so produced.

(5) An authorised person or a person assisting may seize equipment under paragraph (4)(a) only if:

(a) it is not practicable to copy the data as mentioned in subsection (2) or to put the material in documentary form as mentioned in paragraph (4)(b); or

(b) possession of the equipment by the occupier of the premises could constitute an offence.

438 Person with knowledge of a computer or a computer system to assist access etc.

(1A) This section applies if an authorised person exercises investigation powers under Part 3 of the Regulatory Powers Act in relation to premises for the purposes of this Act.

(1) An authorised person may apply to an issuing officer for an order requiring a specified person to provide any information or assistance that is reasonable and necessary to allow an authorised person or person assisting to do one or more of the following:

(a) access data held in, or accessible from, a computer or data storage device that:

(i) is on the premises; or

(ii) has been moved under subsection 436(2) and is at a place for examination or processing; or

(iii) has been seized under this Act or under the Regulatory Powers Act as it applies in relation to this Act;

(b) copy data held in, or accessible from, a computer, or data storage device, described in paragraph (a) to another data storage device;

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(c) convert into documentary form or another form intelligible to an authorised person or person assisting:

(i) data held in, or accessible from, a computer, or data storage device, described in paragraph (a); or

(ii) data held in a data storage device to which the data was copied as described in paragraph (b); or

(iii) data held in a data storage device removed from premises under the Regulatory Powers Act as it applies in relation to this Act.

(2) The issuing officer may grant the order if the issuing officer is satisfied that:

(a) there are reasonable grounds for suspecting that evidential material is held in, or is accessible from, the computer or data storage device; and

(b) the specified person is:

(i) if the premises were entered under an investigation warrant—reasonably suspected of having committed the offence or contravened the civil penalty provision stated in the warrant; or

(ii) the owner or lessee of the computer or device; or

(iii) an employee of the owner or lessee of the computer or device; or

(iv) a person engaged under a contract for services by the owner or lessee of the computer or device; or

(v) a person who uses or has used the computer or device; or

(vi) a person who is or was a system administrator for the system including the computer or device; and

(c) the specified person has relevant knowledge of:

(i) the computer or device or a computer network of which the computer or device forms or formed a part; or

(ii) measures applied to protect data held in, or accessible from, the computer or device.

(3) If:

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(a) the computer or data storage device that is the subject of the order is seized under this Act or under the Regulatory Powers Act as it applies in relation to this Act; and

(b) the order was granted on the basis of an application made before the seizure;

the order does not have effect on or after the seizure.

Note: An application for another order under this section relating to the computer or data storage device may be made after the seizure.

(4) If the computer or data storage device is not on the premises, the order must:

(a) specify the period within which the person must provide the information or assistance; and

(b) specify the place at which the person must provide the information or assistance; and

(c) specify the conditions (if any) determined by the issuing officer as the conditions to which the requirement on the person to provide the information or assistance is subject.

(5) A person commits an offence if the person fails to comply with the order.

Penalty: Imprisonment for 2 years.

439 Compensation for damage to electronic equipment

(1) This section applies if:

(a) as a result of electronic equipment being operated as mentioned in section 436 or 437:

(i) damage is caused to the equipment; or

(ii) the data recorded on the equipment is damaged; or

(iii) programs associated with the use of the equipment, or with the use of the data, are damaged or corrupted; and

(b) the damage or corruption occurs because:

(i) insufficient care was exercised in selecting the person who was to operate the equipment; or

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(ii) insufficient care was exercised by the person operating the equipment.

(2) The Commonwealth must pay the owner of the equipment, or the user of the data or programs, such reasonable compensation for the damage or corruption as the Commonwealth and the owner or user agree on.

(3) However, if the owner or user and the Commonwealth fail to agree, the owner or user may institute proceedings in:

(a) the Federal Court of Australia; or

(b) the Federal Circuit and Family Court of Australia (Division 2); or

(c) a court of a State or Territory that has jurisdiction in relation to the matter;

for such reasonable amount of compensation as the court determines.

(4) In determining the amount of compensation payable, regard is to be had to whether the occupier of the premises, or the occupier's employees or agents, if they were available at the time, provided any appropriate warning or guidance on the operation of the equipment.

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Part 6—Civil penalties under Part 4 of the Regulatory Powers Act

Division 1—Triggering Part 4 of the Regulatory Powers Act

440 Enforceable civil penalty provisions

Each civil penalty provision of this Act is enforceable under Part 4 of the Regulatory Powers Act.

Note 1: The expression ***this Act*** (see section 7) includes:
(a) legislative instruments made under this Act; and
(b) the Regulatory Powers Act as it applies in relation to this Act.

Note 2: Part 4 of the Regulatory Powers Act allows a civil penalty provision to be enforced by obtaining an order for a person to pay a pecuniary penalty for the contravention of the provision.

441 Authorised applicant—Commissioner and Complaints Commissioner functions

For the purposes of Part 4 of the Regulatory Powers Act, the Commissioner is an authorised applicant in relation to the civil penalty provisions of this Act that relate to a function of the Commissioner or Complaints Commissioner (including a function which has been delegated to the Complaints Commissioner under section 575).

442 Authorised applicant—System Governor functions

For the purposes of Part 4 of the Regulatory Powers Act, the System Governor is an authorised applicant in relation to the civil penalty provisions of this Act that relate to a function of the System Governor.

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443 Relevant court

For the purposes of Part 4 of the Regulatory Powers Act, each of the following courts is a relevant court in relation to the civil penalty provisions of this Act:

(a) the Federal Court;

(b) the Federal Circuit and Family Court of Australia (Division 2);

(c) a court of a State or Territory that has jurisdiction in relation to the matter.

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Division 2—Modifications of Part 4 of the Regulatory Powers Act

444 Crown not liable to pecuniary penalty

Part 4 of the Regulatory Powers Act, as that Part applies in relation to the civil penalty provisions of this Act, does not make the Crown liable to a pecuniary penalty.

445 Extension of Part 4 of the Regulatory Powers Act to external Territories

Part 4 of the Regulatory Powers Act, as that Part applies in relation to the civil penalty provisions of this Act, extends to the external Territories other than the Territory of Ashmore and Cartier Islands.

445A Amount of penalty for serious failures to comply with registered provider duty

Despite subsection 82(5) of the Regulatory Powers Act:

(a) the pecuniary penalty for a contravention of subsection 179(3) of this Act must not be more than the applicable pecuniary penalty specified in that subsection; and

(b) the pecuniary penalty for a contravention of subsection 179(5) of this Act must not be more than the applicable pecuniary penalty specified in that subsection.

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Division 3—Delegations by authorised applicants

446 Delegation by authorised applicant—Commissioner functions

(1) The authorised applicant under section 441 may, in writing, delegate the authorised applicant's powers and functions under Part 4 of the Regulatory Powers Act in relation to the civil penalty provisions of this Act that relate to a function of the Commissioner or Complaints Commissioner (including a function which has been delegated to the Complaints Commissioner under section 575) to a member of the staff of the Commission who is an SES employee or an acting SES employee.

(2) A person exercising powers or performing functions under a delegation under subsection (1) must comply with any written directions of the authorised applicant under section 441.

447 Delegation by authorised applicant—System Governor functions

(1) The authorised applicant under section 442 may, in writing, delegate the authorised applicant's powers and functions under Part 4 of the Regulatory Powers Act in relation to the civil penalty provisions of this Act that relate to a function of the System Governor to an SES employee, or an acting SES employee, in the Department.

(2) A person exercising powers or performing functions under a delegation under subsection (1) must comply with any written directions of the authorised applicant under section 442.

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Part 7—Infringement notices under Part 5 of the Regulatory Powers Act

Division 1—Triggering Part 5 of the Regulatory Powers Act

448 Provisions subject to an infringement notice

The following provisions of this Act are subject to an infringement notice under Part 5 of the Regulatory Powers Act:

(a) subsections 165A(3) and 166(6) (failure to give or publish reports);

(b) subsections 167(5) and 169(3) (failure to give notice of change in circumstances);

(c) subsection 177(4) (failure to cooperate with other persons);

(d) sections 480 and 487, and subsections 490(2) and 495(1) and (2) (failure to comply with notices);

(e) section 512 (failure to provide reasonable facilities and assistance for assurance activities);

(f) a provision of this Act that is prescribed by the rules.

Note 1: Part 5 of the Regulatory Powers Act creates a framework for using infringement notices in relation to provisions.

449 Infringement officer and relevant chief executive—Commissioner functions

For the purposes of Part 5 of the Regulatory Powers Act, the Commissioner:

(a) is an infringement officer; and

(b) is the relevant chief executive;

in relation to the provisions mentioned in section 448 of this Act that relate to a function of the Commissioner or Complaints Commissioner (including a function which has been delegated to the Complaints Commissioner under section 575).

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450 Infringement officer and relevant chief executive—System Governor functions

For the purposes of Part 5 of the Regulatory Powers Act, the System Governor:

(a) is an infringement officer; and

(b) is the relevant chief executive;

in relation to the provisions mentioned in section 448 of this Act that relate to a function of the System Governor.

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Division 2—Modifications of Part 5 of the Regulatory Powers Act

451 Crown not liable to be given infringement notice

Despite section 3, the Crown is not liable to be given an infringement notice in relation to the provisions mentioned in section 448.

452 Extension to external Territories

Part 5 of the Regulatory Powers Act, as that Part applies in relation to the provisions mentioned in section 448 of this Act, extends to the external Territories other than the Territory of Ashmore and Cartier Islands.

453 Single infringement notice may deal with more than one contravention

Despite subsection 103(3) of the Regulatory Powers Act, a single infringement notice may be given to a person in respect of:

(a) 2 or more alleged contraventions of a provision mentioned in section 448 of this Act; or

(b) alleged contraventions of 2 or more provisions mentioned in section 448 of this Act.

However, the notice must not require the person to pay more than one amount in respect of the same conduct.

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Division 3—Delegations by infringement officers and relevant chief executives

454 Delegation by infringement officer—Commissioner functions

(1) An infringement officer under section 449 may, in writing, delegate the infringement officer's powers and functions under Part 5 of the Regulatory Powers Act in relation to the provisions mentioned in section 448 of this Act that relate to a function of the Commissioner or the Complaints Commissioner to a member of the staff of the Commission who is:

(a) an SES employee or acting SES employee; or

(b) an APS employee who holds, or is acting in, an Executive Level 2, or equivalent, position.

(2) However, an infringement officer under section 449 must not delegate a function or power to a person under paragraph (1)(b) of this section unless the infringement officer is satisfied that the person has suitable training or experience to properly perform the function or exercise the power.

(3) A person exercising powers or performing functions under a delegation under subsection (1) must comply with any written directions of the infringement officer.

455 Delegation by relevant chief executive—Commissioner functions

(1) The relevant chief executive under section 449 may, in writing, delegate the relevant chief executive's powers and functions under Part 5 of the Regulatory Powers Act in relation to the provisions mentioned in section 448 of this Act that relate to a function of the Commissioner or the Complaints Commissioner to a member of the staff of the Commission who is an SES employee or an acting SES employee.

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(2) A person exercising powers or performing functions under a delegation under subsection (1) must comply with any written directions of the relevant chief executive under section 449.

456 Delegation by infringement officer—System Governor functions

(1) An infringement officer under section 450 may, in writing, delegate the infringement officer's powers and functions under Part 5 of the Regulatory Powers Act in relation to the provisions mentioned in section 448 of this Act that relate to a function of the System Governor to an SES employee, or an acting SES employee, in the Department.

(2) A person exercising powers or performing functions under a delegation under subsection (1) must comply with any written directions of the infringement officer.

457 Delegation by relevant chief executive—System Governor functions

(1) The relevant chief executive under section 450 may, in writing, delegate the relevant chief executive's powers and functions under Part 5 of the Regulatory Powers Act in relation to the provisions mentioned in section 448 of this Act that relate to a function of the System Governor to an SES employee, or an acting SES employee, in the Department.

(2) A person exercising powers or performing functions under a delegation under subsection (1) must comply with any written directions of the relevant chief executive under section 450.

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Part 8—Enforceable undertakings under Part 6 of the Regulatory Powers Act

Division 1—Triggering Part 6 of the Regulatory Powers Act

458 Enforceable provisions

The following provisions are enforceable under Part 6 of the Regulatory Powers Act:

(a) a provision of Part 4 of Chapter 3 of this Act (obligations of registered providers);

(b) a provision of the rules made for the purposes of a provision mentioned in paragraph (a).

Note: Part 6 of the Regulatory Powers Act creates a framework for accepting and enforcing undertakings relating to compliance with provisions.

459 Authorised person—Commissioner functions

For the purposes of Part 6 of the Regulatory Powers Act, the Commissioner is an authorised person in relation to the provisions mentioned in section 458 of this Act that relate to a function of the Commissioner.

460 Authorised person—System Governor functions

For the purposes of Part 6 of the Regulatory Powers Act, the System Governor is an authorised person in relation to the provisions mentioned in section 458 of this Act that relate to a function of the System Governor.

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461 Relevant court

For the purposes of Part 6 of the Regulatory Powers Act, each of the following courts is a relevant court in relation to the provisions mentioned in section 458 of this Act:

(a) the Federal Court;

(b) the Federal Circuit and Family Court of Australia (Division 2);

(c) a court of a State or Territory that has jurisdiction in relation to matters arising under this Act.

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Division 2—Modifications of Part 6 of the Regulatory Powers Act

462 Extension to external Territories

Part 6 of the Regulatory Powers Act, as that Part applies in relation to the provisions mentioned in section 458 of this Act, extends to the external Territories other than the Territory of Ashmore and Cartier Islands.

463 Other undertakings

(1) An authorised person may accept any of the following undertakings:

(a) a written undertaking given by a person that the person will, in order to provide compensation for loss or damage suffered as a result of a contravention or alleged contravention by the person of a provision mentioned in section 458, pay another person an amount worked out in accordance with the undertaking;

(b) a written undertaking given by a person in connection with a matter relating to a contravention or alleged contravention by the person of a provision mentioned section 458.

(2) The undertaking must be expressed to be an undertaking under this section.

(3) The power in subsection (1) is in addition to the power of an authorised person under subsection 114(1) of the Regulatory Powers Act.

(4) Part 6 of the Regulatory Powers Act, other than subsections 114(1) and (2), applies to an undertaking accepted under subsection (1) of this section as if it were an undertaking accepted under subsection 114(1) of that Act.

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Division 3—Delegations by authorised persons

464 Delegation by authorised person—Commissioner functions

(1) The authorised person under section 459 may, in writing, delegate the authorised person's powers and functions under Part 6 of the Regulatory Powers Act in relation to the provisions mentioned in section 458 of this Act that relate to a function of the Commissioner to a member of the staff of the Commission who is:

(a) an SES employee or acting SES employee; or

(b) an APS employee who holds, or is acting in, an Executive Level 2, or equivalent, position.

(2) However, the authorised person under section 459 must not delegate a function or power to a person under subsection (1) of this section unless the authorised person under section 459 is satisfied that the person has suitable training or experience to properly perform the function or exercise the power.

(3) A person exercising powers or performing functions under a delegation under subsection (1) must comply with any written directions of the authorised person under section 459.

465 Delegation by authorised person—System Governor functions

(1) The authorised person under section 460 may, in writing, delegate the authorised person's powers and functions under Part 6 of the Regulatory Powers Act in relation to the provisions mentioned in section 458 of this Act that relate to a function of the System Governor to an SES employee, or acting SES employee, in the Department.

(2) A person exercising powers or performing functions under a delegation under subsection (1) must comply with any written directions of the authorised person under section 460.

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Part 9—Injunctions under Part 7 of the Regulatory Powers Act

Division 1—Triggering Part 7 of the Regulatory Powers Act

466 Enforceable provisions

The following provisions are enforceable under Part 7 of the Regulatory Powers Act:

(a) a provision of Part 4 of Chapter 3 of this Act (obligations of registered providers);

(b) a provision of the rules made for the purposes of a provision mentioned in paragraph (a).

Note: Part 7 of the Regulatory Powers Act creates a framework for using injunctions to enforce provisions.

467 Authorised person—Commissioner functions

For the purposes of Part 7 of the Regulatory Powers Act, the Commissioner is an authorised person in relation to the provisions mentioned in section 466 of this Act that relate to a function of the Commissioner.

468 Authorised person—System Governor functions

For the purposes of Part 7 of the Regulatory Powers Act, the System Governor is an authorised person in relation to the provisions mentioned in section 466 of this Act that relate to a function of the System Governor.

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469 Relevant court

For the purposes of Part 7 of the Regulatory Powers Act, each of the following courts is a relevant court in relation to the provisions mentioned in section 466 of this Act:

(a) the Federal Court;

(b) the Federal Circuit and Family Court of Australia (Division 2);

(c) a court of a State or Territory that has jurisdiction in relation to matters arising under this Act.

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Division 2—Modifications of Part 7 of the Regulatory Powers Act

470 Consent injunctions

A relevant court may grant an injunction under Part 7 of the Regulatory Powers Act in relation to a provision mentioned in section 466 of this Act by consent of all the parties to proceedings brought under that Part, whether or not the court is satisfied that section 121 of that Act applies.

471 Extension to external Territories

Part 7 of the Regulatory Powers Act, as that Part applies in relation to the provisions mentioned in section 466 of this Act, extends to the external Territories other than the Territory of Ashmore and Cartier Islands.

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Division 3—Delegations by authorised persons

472 Delegation by authorised person—Commissioner functions

(1) The authorised person under section 467 may, in writing, delegate the authorised person's powers and functions under Part 7 of the Regulatory Powers Act in relation to the provisions mentioned in section 466 of this Act that relate to a function of the Commissioner to a member of the staff of the Commission who is an SES employee or an acting SES employee.

(2) A person exercising powers or performing functions under a delegation under subsection (1) must comply with any written directions of the authorised person.

473 Delegation by authorised person—System Governor functions

(1) The authorised person under section 468 may, in writing, delegate the authorised person's powers and functions under Part 7 of the Regulatory Powers Act in relation to the provisions mentioned in section 466 of this Act that relate to a function of the System Governor to an SES employee, or an acting SES employee, in the Department.

(2) A person exercising powers or performing functions under a delegation under subsection (1) must comply with any written directions of the authorised person.

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Part 10—Notices requiring action

Division 1—Required action notices

Subdivision A—Giving required action notices

474 Commissioner or Complaints Commissioner may give required action notices relating to certain matters

The Commissioner or Complaints Commissioner may give a registered provider a written notice (a ***required action notice***) in relation to:

(a) a matter that relates to the registered provider that is raised in a complaint, notification or other information received or held by the Commission; or

(b) a matter relating to the rights of an individual, under the Statement of Rights, to whom the registered provider is delivering funded aged care services; or

(c) a matter relating to the registered provider's conditions of registration or obligations under Part 4 of Chapter 3.

475 System Governor may give required action notices relating to System Governor's functions

The System Governor may give a registered provider a written notice (a ***required action notice***) in relation to a matter that relates to the System Governor's functions if the System Governor reasonably suspects that the registered provider has not complied, or is not complying, with this Act.

476 Contents of required action notices

A required action notice given to a registered provider must set out the following:

(a) the name of the provider;

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(b) brief details of the matter in relation to which the notice is given;

(c) a requirement that the registered provider must, within a reasonable period specified in the notice:

(i) examine or investigate the matter; and

(ii) provide a report on the examination or investigation of the matter to the Commissioner, Complaints Commissioner or the System Governor (as applicable);

(d) whether the examination or investigation of the matter must be carried out by an appropriately qualified and independent expert engaged by the registered provider (at the registered provider's expense);

(e) that a failure to comply with the notice is subject to a civil penalty under section 480;

(f) the actions that the Commissioner, Complaints Commissioner or the System Governor (as applicable) may take under this Act in response to a failure to comply with the notice;

(g) any other matters prescribed by the rules.

Subdivision B—Varying or revoking required action notices

477 Commissioner may vary or revoke required action notices

(1) The Commissioner may, by written notice given to a registered provider, vary a required action notice given to the provider by the Commissioner if, at the time of the variation, the Commissioner considers that the variation is appropriate.

(2) The Commissioner may, by written notice given to a registered provider, revoke a required action notice given to the provider by the Commissioner if, at the time of the revocation, the Commissioner considers that the notice is no longer appropriate.

(3) In deciding whether to vary or revoke a required action notice given to a registered provider, the Commissioner must consider any report received from the provider within the period referred to in subparagraph 476(c)(ii).

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478 Complaints Commissioner may vary or revoke required action notices

(1) The Complaints Commissioner may, by written notice given to a registered provider, vary a required action notice given to the provider by the Complaints Commissioner if, at the time of the variation, the Complaints Commissioner considers that the variation is appropriate.

(2) The Complaints Commissioner may, by written notice given to a registered provider, revoke a required action notice given to the provider by the Complaints Commissioner if, at the time of the revocation, the Complaints Commissioner considers that the notice is no longer appropriate.

(3) In deciding whether to vary or revoke a required action notice given to a registered provider, the Complaints Commissioner must consider any report received from the provider within the period referred to in subparagraph 476(c)(ii).

479 System Governor may vary or revoke required action notices

(1) The System Governor may, by written notice given to a registered provider, vary a required action notice given to the provider by the System Governor if, at the time of the variation, the System Governor considers that the variation is appropriate.

(2) The System Governor may, by written notice given to a registered provider, revoke a required action notice given to the provider by the System Governor if, at the time of the revocation, the System Governor considers that the notice is no longer appropriate.

(3) In deciding whether to vary or revoke a required action notice given to a registered provider, the System Governor must consider any report received from the provider before the end of the period set out in the notice under paragraph 476(c).

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Subdivision C—Penalty for contravening required action notices

480 Penalty for contravening required action notices

A registered provider contravenes this section if the provider fails to comply with a required action notice given to the provider.

Civil penalty: 30 penalty units.

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Division 2—Compliance notices

Subdivision A—Giving compliance notices

481 Commissioner may give compliance notices relating to Commissioner's functions

The Commissioner may give a registered provider a written notice (a ***compliance notice***) if:

(a) the Commissioner:

(i) is satisfied that the provider has not complied, or is not complying, with this Act; or

(ii) is aware of information that suggests that the provider may not have complied, or may not be complying, with this Act; and

(b) the non-compliance or possible non-compliance relates to a matter that relates to the Commissioner's functions.

482 System Governor may give compliance notices relating to System Governor's functions

The System Governor may give a registered provider a written notice (a ***compliance notice***) if:

(a) the System Governor:

(i) is satisfied that the provider has not complied, or is not complying, with this Act; or

(ii) is aware of information that suggests that the provider may not have complied, or may not be complying, with this Act; and

(b) the non-compliance or possible non-compliance relates to a matter that relates to the System Governor's functions.

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483 Contents of compliance notices—general

A compliance notice given to a registered provider must set out the following:

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(a) the name of the provider;
(b) brief details of the non-compliance or possible non-compliance;
(c) action that the provider must take, or refrain from taking, to address the non-compliance or possible non-compliance;
(d) a reasonable period within which the provider must take, or refrain from taking, the action;
(e) a reasonable period within which the provider must give the Commissioner or the System Governor (as applicable) a written response in relation to the notice;
(f) that a failure to comply with the notice is subject to a civil penalty under section 487;
(g) the actions that the Commissioner or the System Governor (as applicable) may take under this Act in response to a failure to comply with the notice;
(h) any other matters prescribed by the rules.

484 Contents of compliance notices—additional content for notices given by Commissioner in relation to significant failures or systematic patterns of conduct

If the Commissioner is satisfied that non-compliance by a registered provider is conduct that:

(a) involves a significant failure; or
(b) is part of a systematic pattern of conduct;

a compliance notice given to the provider by the Commissioner in relation to the non-compliance must also set out that the Commissioner is so satisfied and brief reasons that the Commissioner is so satisfied.

Note: See the definitions of ***significant failure*** and ***systematic pattern of conduct*** in section 19. See also the registered provider and responsible person duties in sections 179 and 180.

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Subdivision B—Varying or revoking compliance notices

485 Commissioner may vary or revoke compliance notices

(1) The Commissioner may, by written notice given to a registered provider, vary or revoke a compliance notice given to the provider by the Commissioner if the Commissioner considers that it is appropriate in all the circumstances to do so.

(2) In deciding whether to vary or revoke a compliance notice given to a registered provider, the Commissioner must consider any written response received from the provider before the end of the period set out in the notice under paragraph 483(e).

486 System Governor may vary or revoke compliance notices

(1) The System Governor may, by written notice given to a registered provider, vary or revoke a compliance notice given to the provider by the System Governor if the System Governor considers that it is appropriate in all the circumstances to do so.

(2) In deciding whether to vary or revoke a compliance notice given to a registered provider, the System Governor must consider any written response received from the provider before the end of the period set out in the notice under paragraph 483(e).

Subdivision C—Penalty for contravening compliance notices

487 Penalty for contravening compliance notices

A registered provider contravenes this section if the provider fails to comply with a compliance notice.

Civil penalty: 60 penalty units.

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Division 3—Notices to attend to answer questions or give information or documents

Subdivision A—Notices to attend

488 Notice to attend to answer questions etc. relevant to Commissioner's or Complaints Commissioner's functions

(1) This section applies if the Commissioner or Complaints Commissioner reasonably believes that a person has information or documents relevant to:

(a) in the case of the Commissioner:

(i) whether a registered provider, or a former registered provider, is complying with this Act in relation to a matter that relates to the Commissioner's functions; or

(ii) whether an individual who is or was an aged care worker of a registered provider, or a former registered provider, is complying, or has complied, with a provision of this Act that applies or applied to the individual; or

(b) in the case of the Complaints Commissioner—whether a registered provider, or a former registered provider, is complying with this Act in relation to a matter that relates to the Complaints Commissioner's functions (including a function which has been delegated to the Complaints Commissioner under section 575).

(2) The Commissioner or Complaints Commissioner may, by written notice, require the person to attend before an authorised Commission officer to do either or both of the following:

(a) to answer questions relating to the matter;

(b) to give such information or documents (or copies of documents) as are specified in the notice.

(3) The notice must:

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(a) specify the authorised Commission officer before whom the person is required to attend; and

(b) specify the day on which, and the time and place at which, the person is required to attend; and

(c) if the person is a registered provider—inform the registered provider that the registered provider has an obligation under section 177 of this Act to cooperate with a person who is performing functions, or exercising powers, under this Act.

(4) The day specified under paragraph (3)(b) must be at least 14 days after the notice is given.

489 Notice to attend to answer questions etc. relevant to System Governor's functions

(1) This section applies if the System Governor reasonably believes that a person has information or documents relevant to a matter that relates to the System Governor's functions.

(2) The System Governor may, by written notice, require the person to attend before an authorised System Governor officer to do either or both of the following:

(a) to answer questions relating to the matter;

(b) to give such information or documents (or copies of documents) as are specified in the notice.

(3) The notice must:

(a) specify the authorised System Governor officer before whom the person is required to attend; and

(b) specify the day on which, and the time and place at which, the person is required to attend; and

(c) if the person is a registered provider—inform the registered provider that the registered provider has an obligation under section 177 of this Act to cooperate with a person who is performing functions, or exercising powers, under this Act.

(4) The day specified under paragraph (3)(b) must be at least 14 days after the notice is given.

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490 Failing to comply with notice

Fault-based offence

(1) A person commits an offence if:
  (a) the person is given a notice under subsection 488(2) or 489(2); and
  (b) the person fails to comply with a requirement of the notice.

Penalty: 30 penalty units.

Civil penalty provision

(2) A person is liable to a civil penalty if:
  (a) the person is given a notice under subsection 488(2) or 489(2); and
  (b) the person fails to comply with a requirement of the notice.

Civil penalty: 30 penalty units.

491 Attending before authorised officer to answer questions—making oath or affirmation

(1) This section applies if:
  (a) a person is given a notice under subsection 488(2) or 489(2); and
  (b) the notice requires the person to attend before an authorised officer to answer questions; and
  (c) the person attends before the authorised officer for that purpose.

(2) The authorised officer may question the person on oath or affirmation and may, for that purpose:
  (a) require the person to take an oath or make an affirmation; and
  (b) administer an oath or affirmation to the person.

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(3) The oath or affirmation to be taken or made by the person for the purposes of subsection (2) is an oath or affirmation that the statements that the person will make will be true.

Offence

(4) A person commits an offence if:
  (a) the person is required by an authorised officer to take an oath or make an affirmation for the purposes of answering questions; and
  (b) the person refuses or fails to comply with the requirement.

Penalty: 30 penalty units.

Subdivision B—Notices to give information or produce documents

492 Notices to give information or produce documents required for Commissioner's functions

(1) The Commissioner may, by notice in writing given to a person, require the person, within 14 days or another reasonable time stated in the notice, to:
  (a) give the Commissioner any information; or
  (b) produce to the Commissioner any documents (or copies of documents);

specified in the notice that the Commissioner requires for the performance of the Commissioner's functions.

(2) The Commissioner may, by notice in writing given to the person, extend the time within which the information must be given or documents or copies of documents must be produced in accordance with the notice under subsection (1).

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493 Notices to give information or produce documents required for Complaints Commissioner's functions

(1) The Complaints Commissioner may, by notice in writing given to a person, require the person, within 14 days or another reasonable time stated in the notice, to:

(a) give the Complaints Commissioner any information; or

(b) produce to the Complaints Commissioner any documents (or copies of documents);

specified in the notice that the Complaints Commissioner requires for the performance of the Complaints Commissioner's functions (including a function which has been delegated to the Complaints Commissioner under section 575).

(2) The Complaints Commissioner may, by notice in writing given to the person, extend the time within which the information must be given or documents or copies of documents must be produced in accordance with the notice under subsection (1).

494 Notices to give information or produce documents required for System Governor's functions

(1) The System Governor may, by notice in writing given to a person, require the person, within 14 days or another reasonable time stated in the notice, to:

(a) give the System Governor any information; or

(b) produce to the System Governor any documents (or copies of documents);

specified in the notice that the System Governor requires for the performance of the System Governor's functions.

(2) The System Governor may, by notice in writing given to the person, extend the time within which the information must be given or documents or copies of documents must be produced in accordance with the notice under subsection (1).

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495 Failing to comply with notice

Strict liability offence

(1) A person commits an offence of strict liability if:

(a) the person is required to give information, or produce documents or copies of documents, in accordance with a notice given to the person under subsection 492(1), 493(1) or 494(1); and

(b) the person fails to comply with the requirement.

Penalty: 30 penalty units.

Civil penalty provision

(2) A person is liable to a civil penalty if:

(a) the person is required to give information, or produce documents or copies of documents, in accordance with a notice given to the person under subsection 492(1), 493(1) or 494(1); and

(b) the person fails to comply with the requirement.

Civil penalty: 30 penalty units.

Subdivision C—Privilege against self-incrimination

496 Privilege against self-incrimination not abrogated

(1) Nothing in this Division affects the right of a person to refuse to answer a question, give information or give a document or a copy of a document on the ground that answering the question, giving the information or giving the document might tend to incriminate the person.

(2) The fact that this section is included in this Division does not imply that the privilege against self-incrimination is abrogated in any other Act.

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Part 11—Banning orders

Division 1—Making banning orders

497 Banning orders on current and former registered providers

(1) The Commissioner may, by written notice, make an order (the ***banning order***) prohibiting or restricting either of the following by an entity that is or was a registered provider:

(a) delivery of funded aged care services generally;

(b) delivery of funded aged care services in a specified service type.

Note: Before making the banning order, the Commissioner needs to give the entity notice of the intention to make the order and allow the entity to comment, except in certain circumstances: see section 499.

(2) However, the banning order cannot prohibit or restrict delivery of funded aged care services in a specified service type if the entity is registered as a registered provider in a provider registration category because the entity intended to deliver funded aged care services in that service type.

(3) Subsection (2) does not apply if the Commissioner imposes a condition on the registration of the registered provider which has the effect that the registered provider may not deliver the funded aged care services in the specified service type.

Grounds for banning order

(4) The Commissioner may make an order under subsection (1) only if:

(a) the Commissioner has revoked the registration of the entity as a registered provider; or

(b) the Commissioner reasonably believes that the entity has contravened, is contravening, or is likely to contravene this Act; or

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(c) the Commissioner reasonably believes that the entity has been involved in, or is likely to become involved in, a contravention of this Act by another entity; or

(d) if the order is to prohibit or restrict the delivery of funded aged care services generally by the entity—the Commissioner reasonably believes that the entity is unsuitable to deliver funded aged care services generally; or

(e) if the order is to prohibit or restrict the delivery of funded aged care services in a specified service type—the Commissioner reasonably believes that the entity is unsuitable to deliver funded aged care services in that service type; or

(f) if the entity is a registered provider—the Commissioner reasonably believes that there is a severe risk to the safety, health or wellbeing of an individual accessing funded aged care services if the entity continues to be a registered provider; or

(g) the entity is convicted of an offence involving fraud or dishonesty; or

(h) the entity becomes an insolvent under administration.

Matters affecting entity's suitability

(5) In considering whether an entity is unsuitable as described in paragraph (4)(d) or (e), the Commissioner must have regard to the matters referred to in paragraph 109(1)(b). This does not limit the matters to which the Commissioner may have regard in that consideration.

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498 Banning orders on individuals as aged care workers and responsible persons

(1) The Commissioner may make an order (the ***banning order***) prohibiting or restricting the involvement of an individual, as either an aged care worker, or a responsible person, of a registered provider, in:

(a) delivery of funded aged care services generally; or

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(b) delivery of funded aged care services in a specified service type; or

(c) a specified activity of a registered provider.

Note: Before making the banning order, the Commissioner needs to give the individual notice of the intention to make the order and allow the individual to comment, except in certain circumstances: see section 499.

Grounds for banning order

(2) The Commissioner may make an order under subsection (1) affecting an individual (the ***affected individual***) only if:

(a) if the order is to prohibit or restrict the involvement of the affected individual in the delivery of funded aged care services generally—the Commissioner reasonably believes that the individual is unsuitable to be involved in the delivery of funded aged care services generally; or

(b) if the order is to prohibit or restrict the involvement of the affected individual in the delivery of funded aged care services in a specified service type—the Commissioner reasonably believes that the individual is unsuitable to be involved in the delivery of funded aged care services in that type; or

(c) if the order is to prohibit or restrict the involvement of the affected individual in a specified activity of a registered provider—the Commissioner reasonably believes that the individual is unsuitable to be involved in the activity; or

(d) the affected individual is or was an aged care worker, or a responsible person, of a registered provider and any of the following applies:

(i) the Commissioner reasonably believes that the affected individual did not comply, is not complying or is not likely to comply with the Aged Care Code of Conduct that applies or applied to the individual;

(ii) the Commissioner reasonably believes there is a severe risk to the safety, health or wellbeing of one or more individuals accessing funded aged care services if the

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affected individual is involved, or continues to be involved, in a matter to which the order is to relate;

(iii) the individual has at any time been convicted of an indictable offence involving fraud or dishonesty;

(iv) the individual is an insolvent under administration.

Matters affecting individual's suitability

(3) In considering whether an individual is unsuitable as described in paragraph (2)(a), (b) or (c), the Commissioner must have regard to the suitability matters. This does not limit the matters to which the Commissioner may have regard in that consideration.

Note: For suitability matters in relation to individuals, see section 13.

499 Notice of intention to make a banning order

(1) Before the Commissioner makes a banning order under section 497 or 498 against an entity (whether an individual or not), the Commissioner must, by written notice, notify the entity that the Commissioner is considering making the order.

(2) Subsection (1) does not apply if:

(a) the Commissioner reasonably believes that there is an immediate and severe risk to the safety, health or wellbeing of one or more individuals accessing funded aged care services if the banning order is not made against the entity; or

(b) the Commissioner has revoked the registration of the entity as a registered provider.

(3) The notice must:

(a) set out the reasons why the Commissioner is considering making the banning order against the entity; and

(b) invite the entity to make submissions, in writing, to the Commissioner in relation to the matter within 14 days after receiving the notice; and

(c) inform the entity that the Commissioner may make the order against the entity after the end of that period and considering any submissions made by the entity within that period.

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(4) The Commissioner must consider any submissions made by the entity in accordance with the notice.

500 Penalty for contravening banning orders

(1) An entity contravenes this subsection if:
  (a) a banning order against the entity is in force; and
  (b) the entity engages in conduct; and
  (c) the conduct breaches the order or a condition to which the order is subject.

Civil penalty: 1,000 penalty units.

(2) An entity contravenes this subsection if:
  (a) the entity is a registered provider; and
  (b) an individual is an aged care worker, or a responsible person, of the registered provider; and
  (c) a banning order against the individual is in force; and
  (d) the entity fails to take reasonable steps to ensure that the individual does not engage in conduct that breaches the order or a condition to which the order is subject.

Civil penalty: 1,000 penalty units.

501 Scope of banning orders

A banning order may:
  (a) apply generally or be of limited application; and
  (b) be permanent or for a specified period; and
  (c) be made subject to specified conditions.

502 Notice of decision about banning order

(1) As soon as is practicable after deciding whether to make a banning order against an entity, the Commissioner must give the entity a written notice that:
  (a) sets out the decision; and

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(b) sets out the reasons for the decision; and

(c) if the decision is to make the order:

(i) specifies whether the order applies generally or the order is of limited application; and

(ii) if the order is of limited application—specifies that limited application; and

(iii) specifies the day on which the order takes effect; and

(iv) if the order is to cease to have effect on a particular day—specifies that day; and

(v) specifies any conditions to which the order is subject; and

(vi) states how the entity may apply for reconsideration of the decision.

(2) If the Commissioner gives a notice under subsection (1) of a decision to make a banning order against an aged care worker, or responsible person, of a registered provider, the Commissioner must give the provider a copy of the notice as soon as is practicable.

503 Banning orders are not legislative instruments

A banning order is not a legislative instrument.

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Division 2—Varying or revoking banning orders

504 Varying or revoking banning order on Commissioner's own initiative

(1) The Commissioner may, on the Commissioner's own initiative, vary or revoke a banning order made against an entity if the Commissioner considers that it is appropriate in all the circumstances to do so.

(2) Without limiting subsection (1), the Commissioner may in varying a banning order do either or both of the following:

(a) vary, or revoke, a condition to which the order is subject;

(b) specify one or more new conditions to which the order is to be subject.

(3) If the Commissioner decides to vary or revoke a banning order made against an entity, the Commissioner must, as soon as is practicable, give the entity a written notice that:

(a) sets out the decision; and

(b) sets out the reasons for the decision; and

(c) specifies the day on which the variation or revocation takes effect; and

(d) if a condition to which the order is subject is varied—sets out the condition as varied; and

(e) specifies any conditions to which the order was subject that have been revoked; and

(f) specifies any new conditions to which the order is subject; and

(g) states how the entity may apply for reconsideration of the decision.

(4) If the Commissioner gives a notice under subsection (3) to an aged care worker, or responsible person, of a registered provider, the Commissioner must give the provider a copy of the notice as soon as is practicable.

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505 Varying or revoking banning order on application

Application for variation or revocation

(1) An entity against which a banning order has been made may apply to the Commissioner for variation or revocation of either the order or a condition to which the order is subject.

(2) The application must:
  (a) be made in writing; and
  (b) be in a form approved by the Commissioner; and
  (c) be accompanied by any documents or information specified by the Commissioner.

Variation or revocation

(3) After receiving the application, the Commissioner may vary or revoke the banning order or condition, or specify one or more new conditions to which the order is subject, if the Commissioner considers that it is appropriate in all the circumstances to do so.

Notice of intention not to vary or revoke as requested

(4) If the Commissioner proposes not to vary or revoke the banning order or condition, or proposes to specify one or more new conditions to which the order is to be subject, the Commissioner must give the entity a written notice that:
  (a) sets out the reasons for the Commissioner's proposal; and
  (b) invites the entity to make written submissions on the proposal to the Commissioner within:
    (i) 14 days after receiving the notice; or
    (ii) if a shorter period is specified in the notice—that shorter period; and
  (c) informs the entity that the Commissioner may decide to proceed with the proposal after the end of that period and considering any submissions made by the entity in accordance with the invitation.

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(5) The Commissioner must consider any submissions made by the entity in accordance with the invitation.

Notice of decision

(6) As soon as practicable after deciding whether to vary or revoke the banning order or a condition to which the order is subject, the Commissioner must give the entity a written notice that:

(a) sets out the decision; and

(b) sets out the reasons for the decision; and

(c) if the order is varied or revoked—specifies the day on which the variation or revocation takes effect; and

(d) if a condition to which the order is subject is varied—sets out the condition as varied and specifies the day on which the variation takes effect; and

(e) if a condition to which the order is subject is revoked—specifies the day on which the revocation takes effect; and

(f) if the order is subject to new conditions—sets out the new conditions and specifies when they take effect; and

(g) states how the entity may apply for reconsideration of the decision.

506 Variations and revocations of banning orders are not legislative instruments

A variation or revocation of a banning order is not a legislative instrument.

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Division 3—Register of banning orders

507 Register of banning orders

(1) The Commissioner must establish and maintain a register that includes each of the following in relation to each entity against which a banning order has been made at any time:

(a) the name of the entity;

(b) the entity's ABN (if any);

(c) the business location (if any) of the entity;

(d) the details of the banning order made against the entity (including any conditions to which the order is subject);

(e) if an application has been made under subsection 505(1) for the revocation of the banning order, and the application has not been finally determined—a statement to that effect;

(f) if a request has been made under section 559 for the reconsideration of a decision to make the banning order or not to revoke the banning order, and a reconsideration decision has not yet been made—a statement to that effect;

(g) if a decision has been made under section 561 to reconsider a decision to make the banning order or not to revoke the banning order, and a reconsideration decision has not yet been made—a statement to that effect;

(h) if an application has been made to the Administrative Review Tribunal for review of a reconsideration decision that relates to a decision to make the banning order or not to revoke the banning order, and the application has not been finally determined—a statement to that effect;

(i) any other information prescribed by the rules.

Note: Other information about entities that are or were registered providers is published in the Provider Register: see section 141. Information about banning orders against those entities may also be included in that register.

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(2) Subsection (1) applies in relation to a banning order even if the banning order is no longer in force, unless it is no longer in force because:

(a) the banning order has been revoked under section 504 or 505; or

(b) the decision to make the banning order has been set aside on reconsideration under section 560 or 562 or on review.

(3) The Commissioner must ensure that the register is kept up to date.

(4) The register may be kept in any form that the Commissioner considers appropriate.

(5) The rules must make provision for, or in relation to, the correction of information that is included in the register, including how an entity may access information about the entity that is included in the register and seek the correction of such information.

(6) The rules may make provision for and in relation to the following:

(a) the publication of the register in whole or in part, or of specified information entered on the register;

(b) any other matter relating to the administration or operation of the register.

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Part 12—System Governor functions assurance activities

508 System Governor may conduct assurance activities

(1) The System Governor may conduct activities (***assurance activities***) for the purposes of the System Governor's functions.

(2) Without limiting subsection (1), matters that assurance activities could relate to include the following:

(a) how registered providers are using subsidy or grants and charging for funded aged care services, including justifications for amounts charged to individuals;

(b) how registered providers are structuring their financial accounting for delivering funded aged care services;

(c) how registered providers are delivering funded aged care services;

(d) the nature and type of dealings that registered providers have with individuals to whom they are delivering funded aged care services;

(e) information and documents provided by registered providers;

(f) the completeness, accuracy and reliability of information and documents mentioned in paragraph (e);

(g) the procedures and documentation of registered providers in relation to matters mentioned in any of the above paragraphs.

Note: Assurance activities may be conducted before or after, or in conjunction with, other actions that the System Governor may take under this Chapter, and may inform those other actions. Any findings, conclusions or recommendations made as a result of assurance activities may provide a basis for the System Governor to exercise other powers under this Chapter.

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509 Terms of reference for assurance activities

The System Governor may, in writing, specify terms of reference for an assurance activity, including:

(a) the registered provider or providers, or class or classes of registered providers, that the activity relates to; and

(b) the matter or matters that the activity relates to.

510 Reports by System Governor on assurance activities

Reports for publication

(1) The System Governor may prepare and publish reports on assurance activities, dealing with any findings, conclusions or recommendations made as a result of the activities.

(2) A report under subsection (1):

(a) may include personal information about a registered provider to which the report relates; but

(b) must not otherwise include personal information.

Other reports

(3) The System Governor may prepare a report on any particular assurance activity, dealing with any findings, conclusions or recommendations made as a result of the activity.

(4) If the System Governor is considering including a finding, conclusion or recommendation, in a report under subsection (3), that is critical (either expressly or impliedly) of a registered provider, the System Governor must give the registered provider:

(a) a statement setting out the finding, conclusion or recommendation; and

(b) a reasonable opportunity to respond to the finding, conclusion or recommendation.

(5) The response under paragraph (4)(b) must be given in the manner and form specified by the System Governor.

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(6) If the System Governor prepares a report under subsection (3), the System Governor may give a copy of the report to any registered provider to which the activity relates.

(7) If the report under subsection (3) includes a recommendation that a registered provider take certain action, the System Governor may, by written notice, require the registered provider to respond to the recommendation within the period specified in the notice (which must not be less than 28 days after the notice is given).

(8) The response:
  (a) must be given in writing; and
  (b) must set out:
    (i) whether the registered provider accepts the recommendation (in whole or in part); and
    (ii) if the registered provider accepts the recommendation (in whole or in part)—details of any action that the registered provider proposes to take to give effect to the recommendation (in whole or in part); and
    (iii) if the registered provider does not accept the recommendation (in whole or in part)—the reasons for not accepting the recommendation (in whole or in part).

511 Assistance to System Governor in conducting and reporting on assurance activities

(1) The System Governor may be assisted in the conduct of assurance activities and the preparation of any reports on the activities by:
  (a) APS employees in the Department; or
  (aa) APS employees in Services Australia; or
  (b) persons engaged under contract by the System Governor to provide that assistance; or
  (c) any persons employed or engaged (however described) by the persons referred to in paragraph (b).

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(2) However, the power to give a registered provider a notice under section 489 or 494 may not be exercised by a person assisting the System Governor under subsection (1) of this section unless:

(a) the power has been delegated to the person under subsection 567(1), 569(1) or 570(1); and

(b) the person is an APS employee.

512 Registered providers must provide facilities and assistance for assurance activities

(1) A registered provider to which an assurance activity relates must provide:

(a) the person conducting the activity; and

(b) any individuals assisting that person;

with all reasonable facilities and assistance necessary for the effective exercise of the person's functions and duties in relation to the activity.

(2) An entity is liable to a civil penalty if:

(a) the entity is subject to subsection (1); and

(b) the entity fails to comply with that subsection.

Civil penalty: 30 penalty units.

513 Requesting information and production of documents

(1) If the System Governor, or a person assisting under subsection 511(1), reasonably believes that a person has information or documents relevant to the subject matter of an assurance activity, the System Governor or person assisting may request the person to give the System Governor or person assisting such information or documents (or copies of documents).

(2) The person is not required to comply with the request.

(3) However, before a request is made to a person that is a registered provider, the System Governor or person assisting must inform the person that the registered provider has an obligation under

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section 177 to cooperate with a person who is performing functions, or exercising powers, under this Part.

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Part 13—Recoverable amounts

Division 1—Recoverable amounts

514 Recoverable amounts and debtors

Recoverable amounts—entity not entitled to payment

(1) If:

(a) the Commonwealth pays an amount to an entity by way of:

(i) subsidy; or

(ii) a grant under Division 7 of Part 2 of Chapter 4; and

(b) the entity was not entitled for any reason to the payment of the amount;

then:

(c) the amount is a ***recoverable amount***; and

(d) the entity is a ***debtor*** in relation to the recoverable amount.

(2) Without limiting paragraph (1)(b), an entity is taken not to have been entitled to the payment of an amount if the payment should not have been made for one or more of the following reasons:

(a) the payment was made as a result of:

(i) a computer error or an administrative error; or

(ii) a contravention of this Act; or

(iii) a false or misleading statement or a misrepresentation; or

(iv) incorrect information being provided in purported compliance with this Act;

(b) if the amount was paid by way of subsidy—the circumstances of an individual are different from those on the basis of which subsidy was claimed (including where incorrect information was provided in relation to the claim for the payment);

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(c) if the amount was paid by way of a grant—a statutory funding condition that applies to the grant is not met.

Recoverable amounts—unspent Commonwealth portion

(3) The available balance of an unspent Commonwealth portion for an individual that is held by an entity is a ***recoverable amount***, and the entity is a ***debtor*** in relation to the amount, if:

(a) the entity was required to return the available balance to the Commonwealth in accordance with section 226B, 226C or 226D; and

(b) the entity failed to comply with that requirement.

515 Recoverable amounts are debts due to the Commonwealth

A recoverable amount is a debt due to the Commonwealth.

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Division 2—Recovery of recoverable amounts

516 Legal proceedings

(1) A recoverable amount may be recovered by the Commonwealth in a court of competent jurisdiction.

(2) Subject to subsections (3), (4) and (5), legal proceedings for the recovery of a recoverable amount are not to be commenced after the end of the period (the ***recovery period***) of 6 years starting on the first day any of the following becomes aware, or could reasonably be expected to have become aware, of the circumstances that gave rise to the recoverable amount:

(a) the System Governor;

(b) an APS employee in any of the following:

(i) the Department;

(ii) Services Australia;

(iii) the Department administered by the Minister who administers the *Data-matching Program (Assistance and Tax) Act 1990*.

(3) If, within the recovery period, part of the recoverable amount is paid, legal proceedings for the recovery of the balance of the recoverable amount may be commenced within the period of 6 years starting on the day of payment.

(4) If, within the recovery period, a debtor in relation to the recoverable amount acknowledges that the debtor owes the recoverable amount, legal proceedings for the recovery of the recoverable amount may be commenced within the period of 6 years starting on the day of acknowledgement.

(5) If, within the recovery period, either of the following occurs:

(a) a review of a file relating to action for the recovery of the recoverable amount;

(b) other internal Departmental activity relating to action for the recovery of the recoverable amount;

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action under this section for the recovery of the recoverable amount may be commenced within the period of 6 years after the end of the activity.

517 Arrangements between System Governor and debtors

(1) The System Governor may, on behalf of the Commonwealth, enter into an arrangement in writing with a debtor in relation to a recoverable amount under which the debtor is to pay the recoverable amount, or the outstanding amount of the recoverable amount, in a way set out in the arrangement (including payment in instalments).

(2) An arrangement entered into under subsection (1) has effect, or is taken to have had effect, on and after the day specified in the arrangement as the day the arrangement commences (whether that day is before, on or after the day the arrangement is entered into).

(3) If an arrangement entered into under subsection (1) does not specify a day as mentioned in subsection (2), it has effect on and after the day on which it is entered into.

(4) The System Governor may, on behalf of the Commonwealth, in writing, terminate or alter an arrangement entered into under subsection (1):

(a) at the debtor's request; or

(b) after giving 28 days' notice, in writing, to the debtor of the proposed termination or alteration; or

(c) without notice, if the System Governor is satisfied that the debtor has failed to disclose material information about the debtor's true capacity to pay the recoverable amount, or the outstanding amount of the recoverable amount.

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518 Recovery of amounts from financial institutions

Notice about payment made to wrong account

(1) If:

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(a) a recoverable amount is paid to a financial institution for the credit of an account kept with the institution; and

(b) the System Governor is satisfied that the payment was intended to be made to someone who was not the person or one of the persons in whose name or names the account was kept;

the System Governor may give a written notice to the institution setting out the matters mentioned in paragraphs (a) and (b) and requiring the institution to pay to the Commonwealth, within a reasonable period stated in the notice, the lesser of the following amounts:

(c) an amount specified in the notice that is equal to the recoverable amount;

(d) the amount standing to the credit of the account when the notice is received by the institution.

Notice about payment made to account of deceased person after their death

(2) If:

(a) the payment of a recoverable amount that is intended to be made to or in respect of a person (the ***first person***) is made to a financial institution for the credit of an account that was kept with the institution by the first person or by the first person and one or more other persons; and

(b) the first person died before the payment or payments were made;

the System Governor may give a written notice to the institution setting out the matters mentioned in paragraphs (a) and (b) and requiring the institution to pay to the Commonwealth, within a reasonable period stated in the notice, the lesser of the following amounts:

(c) an amount specified in the notice that is equal to the recoverable amount;

(d) the amount standing to the credit of the account when the notice is received by the institution.

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Informing deceased estate

(3) As soon as possible after issuing a notice under subsection (2), the System Governor must inform the deceased estate in writing of:

(a) the amount sought to be recovered from the deceased person's account; and

(b) the reasons for the recovery action.

Offence

(4) A financial institution must comply with a notice given to it under subsection (1) or (2).

Penalty: 300 penalty units.

Defence

(5) It is a defence to a prosecution of a financial institution for failing to comply with a notice given to it under subsection (1) or (2) if the financial institution proves that it was incapable of complying with the notice.

Note: A defendant bears a legal burden in relation to the matter in subsection (5): see section 13.4 of the *Criminal Code*.

Reduction of recoverable amount by amount recovered

(6) If a financial institution pays an amount to the Commonwealth in compliance with a notice given to it under subsection (1) or (2) in respect of a recoverable amount, the recoverable amount is reduced by the amount paid to the Commonwealth by the institution.

519 Recovery by deductions from amounts payable to debtor

If a person is a debtor in relation to a recoverable amount, the amount (or part of it) may be deducted from one or more other amounts payable to the person under this Act.

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Division 3—Non-recovery of recoverable amounts

520 Write-off of recoverable amounts

(1) Subject to subsections (2) and (3), the System Governor may, on behalf of the Commonwealth, decide to write off a recoverable amount or class of recoverable amounts, for a stated period or otherwise.

(2) The System Governor may decide to write off a recoverable amount under subsection (1) if, and only if:

(a) the recoverable amount is irrecoverable at law under subsection (4); or

(b) a debtor in relation to the recoverable amount has no capacity to repay the recoverable amount; or

(c) the whereabouts of a debtor in relation to the recoverable amount are unknown after all reasonable efforts have been made to locate the debtor; or

(d) it is not cost effective for the Commonwealth to take action to recover the recoverable amount.

(3) The System Governor may decide to write off a class of recoverable amounts under subsection (1) if, and only if, a paragraph of subsection (2) applies to each recoverable amount in the class.

(4) For the purposes of paragraph (2)(a), a recoverable amount is irrecoverable at law if, and only if:

(a) both:

(i) the recoverable amount cannot be recovered by means of legal proceedings because the relevant 6 year period mentioned in section 516 has elapsed; and

(ii) the recoverable amount cannot be recovered by means of deductions under section 519; or

(b) there is no proof of the recoverable amount capable of sustaining legal proceedings for its recovery; or

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(c) all of the following apply:
(i) a debtor in relation to the recoverable amount is discharged from bankruptcy;
(ii) the recoverable amount was incurred before the debtor became bankrupt;
(iii) the recoverable amount was not incurred by fraud; or
(d) a debtor in relation to the recoverable amount has died, leaving:
(i) no estate; or
(ii) insufficient funds in the debtor's estate to repay the recoverable amount.

(5) A decision made under subsection (1) takes effect:
(a) if no day is specified in the decision—on the day the decision is made; or
(b) if a day is specified in the decision—on the day so specified (whether that day is before, on or after the day the decision is made).

(6) Nothing in this section prevents anything being done at any time to recover a recoverable amount that has been written off under this section.

521 Waiver of right to recover recoverable amount

(1) Subject to subsections (2) and (3), the System Governor may, on behalf of the Commonwealth, waive the right of the Commonwealth to recover:
(a) the whole or a part of a recoverable amount; or
(b) a class of recoverable amounts.

(2) The System Governor may, on behalf of the Commonwealth, waive the right of the Commonwealth to recover the whole or a part of a recoverable amount only in the circumstances described in section 522, 523 or 524.

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(3) The System Governor may, on behalf of the Commonwealth, waive the right of the Commonwealth to recover a class of recoverable amounts only if:

(a) circumstances described in section 522, 523 or 524 apply to each recoverable amount in the class; or

(b) circumstances described in section 524A apply to the class.

(4) A waiver takes effect:

(a) on the day specified in the waiver (whether that day is before, on or after the day the decision to waive is made); or

(b) if the waiver does not specify when it takes effect—on the day the decision to waive is made.

Note: If the System Governor waives the Commonwealth's right to recover all or part of a recoverable amount, this is a permanent bar to recovery of the recoverable amount or part of the recoverable amount and the recoverable amount or part of the recoverable amount effectively ceases to exist.

522 Circumstances for waiver—small amounts

The System Governor may waive the right to recover a recoverable amount if:

(a) the recoverable amount is, or is likely to be, less than $200; and

(b) it is not cost effective for the Commonwealth to take action to recover the recoverable amount.

523 Circumstances for waiver—settlements between Commonwealth and debtors

Civil actions

(1) If the Commonwealth has agreed to settle a civil action against a debtor in relation to a recoverable amount for recovery of an amount that is less than the full amount of the recoverable amount, the System Governor must waive the right to recover the difference between the recoverable amount and the amount that is the subject of the settlement.

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Proceedings before the Administrative Review Tribunal

(2) If the System Governor has agreed to settle proceedings before the Administrative Review Tribunal relating to recovery of a recoverable amount on the basis that a debtor in relation to the recoverable amount will pay less than the full amount of the recoverable amount, the System Governor must waive the right to recover the difference between the recoverable amount and the amount that is the subject of the settlement.

Agreement after recovery of at least 80% of recoverable amount

(3) If:

(a) the Commonwealth has recovered at least 80% of the original value of a recoverable amount from a debtor in relation to the recoverable amount; and

(b) the Commonwealth and the debtor agree that the recovery is in full satisfaction for the whole of the recoverable amount; and

(c) the debtor cannot repay a greater proportion of the recoverable amount;

the System Governor must waive the remaining 20% or less of the value of the original recoverable amount.

Agreement for payment of present value of unpaid amount

(4) If the System Governor and a debtor in relation to a recoverable amount agree that the recoverable amount will be fully satisfied if the debtor pays the Commonwealth an amount (the ***agreed amount***) that is less than the amount of the recoverable amount outstanding at the time of the agreement (the ***unpaid amount***), the System Governor must waive the right to recover the difference between the unpaid amount and the agreed amount.

(5) The System Governor must not make an agreement described in subsection (4) unless the System Governor is satisfied that the agreed amount is at least the present value of the unpaid amount if it is repaid in instalments of amounts, and at times, determined by the System Governor.

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(6) For the purposes of subsection (5), the present value of the unpaid amount is the amount worked out in accordance with the method prescribed by the rules.

524 Circumstances for waiver—special circumstances

The System Governor may waive the right to recover a recoverable amount if:

(a) the recoverable amount did not arise in whole or part as a result of:

(i) a contravention of this Act; or

(ii) a false or misleading statement or a misrepresentation; and

(b) there are special circumstances (other than financial hardship) that the System Governor is satisfied make waiver appropriate; and

(c) the System Governor is satisfied that waiver is more appropriate than writing off the recoverable amount.

524A Circumstances for waiver—determined classes

(1) The System Governor may waive the right to recover a recoverable amount that is included in a class of recoverable amounts determined by the Minister by legislative instrument.

(2) A determination under subsection (1) may state:

(a) any conditions to be met before the System Governor exercises the power to waive the recoverable amounts; and

(b) any limits on the amounts of the recoverable amounts to be waived.

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Part 14—Authorised Commission officers and authorised System Governor officers

Division 1—Appointment

525 Appointment of authorised Commission officers

(1) The Commissioner may, in writing, appoint a person as an authorised Commission officer for the purposes of this Act if:

(a) the person is:

(i) a member of the staff of the Commission; or

(ii) another person who the Commissioner considers it necessary to appoint as an authorised Commission officer; and

(b) the person satisfies the training and qualification requirements for authorised Commission officers determined under subsection (4).

(2) An appointment may specify the period during which it has effect.

(3) The Commissioner may, in writing, vary or revoke an appointment at any time.

(4) The Commissioner must determine, in writing, training and qualification requirements for authorised Commission officers.

(5) A determination made under subsection (4) is not a legislative instrument.

526 Appointment of authorised System Governor officers

(1) The System Governor may, in writing, appoint a person as an authorised System Governor officer for the purposes of this Act if:

(a) the person is:

(i) a member of the staff of the Department; or

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(ii) another person who the System Governor considers it necessary to appoint as an authorised System Governor officer; and

(b) the person satisfies the training and qualification requirements for authorised System Governor officers determined under subsection (4).

(2) An appointment may specify the period during which it has effect.

(3) The System Governor may, in writing, vary or revoke an appointment at any time.

(4) The System Governor must determine, in writing, training and qualification requirements for authorised System Governor officers.

(5) A determination made under subsection (4) is not a legislative instrument.

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Division 2—Functions and powers

527 Functions and powers of authorised Commission officers

(1) An authorised Commission officer has the functions and powers conferred on an authorised Commission officer by this Act.

(2) Subsection (1) has effect subject to any restrictions specified in the authorised Commission officer's instrument of appointment.

(3) In performing functions or exercising powers under this Act, an authorised Commission officer must comply with any written directions of the Commissioner.

(4) If a direction is given under subsection (3) in writing, the direction is not a legislative instrument.

528 Functions and powers of authorised System Governor officers

(1) An authorised System Governor officer has the functions and powers conferred on an authorised System Governor officer by this Act.

(2) Subsection (1) has effect subject to any restrictions specified in the authorised System Governor officer's instrument of appointment.

(3) In performing functions or exercising powers under this Act, an authorised System Governor officer must comply with any written directions of the System Governor.

(4) If a direction is given under subsection (3) in writing, the direction is not a legislative instrument.

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Part 15—Miscellaneous

Division 1—Civil penalty provisions for false or misleading information or documents

529 Civil penalty provision for false or misleading information

(1) An entity is liable to a civil penalty if:

(a) the entity gives information in compliance or purported compliance with this Act; and

(b) the entity does so knowing that the information:

(i) is false or misleading in a material particular; or

(ii) omits any matter or thing without which the information is misleading in a material particular.

Civil penalty: 100 penalty units.

(2) Subsection (1) does not apply if, before the information was given by an entity to another person (the ***official***) in compliance or purported compliance with this Act, the official did not take reasonable steps to inform the entity that the entity may be liable to a civil penalty for contravening subsection (1).

Note: A defendant bears an evidential burden in relation to the matter in this subsection: see section 96 of the Regulatory Powers Act.

(3) For the purposes of subsection (2), it is sufficient if the following form of words is used:

"You may be liable to a civil penalty for giving false or misleading information".

530 Civil penalty provision for false or misleading documents

(1) An entity is liable to a civil penalty if:

(a) the entity produces a document to another person; and

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(b) the entity does so knowing that the document is false or misleading in a material particular; and

(c) the document is produced in compliance or purported compliance with this Act.

Civil penalty: 100 penalty units.

(2) Subsection (1) does not apply to an entity that produces a document if the document is accompanied by a written statement signed by the person specified in subsection (3):

(a) stating that the document is, to the knowledge of the person, false or misleading in a material particular; and

(b) setting out, or referring to, the material particular in which the document is, to the knowledge of the person, false or misleading.

Note: A defendant bears an evidential burden in relation to the matter in this subsection: see section 96 of the Regulatory Powers Act.

(3) For the purposes of subsection (2), the statement must be signed by the following person:

(a) if the entity is an individual—the individual;

(b) if the entity is a body corporate—a competent officer of the body corporate;

(c) if the entity is a partnership—one of the partners;

(d) if the entity is an unincorporated association—a member of the association's governing body.

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Division 2—General rules about offences and civil penalty provisions

531 Physical elements of offences

(1) This section applies if a provision of this Act provides that a person contravening another provision of this Act (the ***conduct rule provision***) commits an offence.

(2) For the purposes of applying Chapter 2 of the *Criminal Code* to the offence, the physical elements of the offence are set out in the conduct rule provision.

Note: Chapter 2 of the *Criminal Code* sets out general principles of criminal responsibility.

532 Contravening offence and civil penalty provisions

(1) This section applies if a provision of this Act provides that a person contravening another provision of this Act (the ***conduct provision***) commits an offence or is liable to a civil penalty.

(2) For the purposes of this Act, a reference to a contravention of an offence provision or a civil penalty provision includes a reference to a contravention of the conduct provision.

Note: This also affects references in the Regulatory Powers Act to a contravention of an offence provision or a civil penalty provision: see the definition of ***this Act*** in section 7.

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Division 3—Immunity of officers and persons assisting

533 Protection from liability for authorised officers and persons assisting

(1) An authorised officer is not liable to civil proceedings for loss, damage or injury of any kind suffered by another person as a result of anything done, or omitted to be done, by the officer in good faith in the exercise or purported exercise of any power under this Chapter or the Regulatory Powers Act as it applies under this Chapter.

(2) A person assisting an authorised officer in the exercise or purported exercise of any power under this Chapter, or the Regulatory Powers Act as it applies under this Chapter, is not liable to civil proceedings for loss, damage or injury of any kind suffered by another person as a result of anything done, or omitted to be done, in good faith for the purpose of assisting the officer.

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Chapter 7—Information management

Part 1—Introduction

534 Simplified outline of this Chapter

The unauthorised use and disclosure of certain information (***protected information***) obtained or generated for the purposes of this Act, such as personal information, is subject to criminal penalties.

This Chapter authorises the use and disclosure of protected information in certain circumstances, and also authorises the use and disclosure of a broader class of information (***relevant information***).

Authorisations differ depending on whether the uses or disclosures concerned are by persons generally, by entrusted persons such as public servants, or by the System Governor or an Appointed Commissioner. There are more extensive authorisations for the System Governor and Appointed Commissioners.

Persons making certain disclosures of information indicating suspected contraventions of this Act are protected from having their identities revealed and from victimisation.

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Part 2—Secrecy of information

Division 1—Unauthorised use or disclosure of protected information

535 Unauthorised use or disclosure of protected information

(1) A person commits an offence if:

(a) the person is, or has been, an entrusted person; and

(b) the person has obtained or generated information in the person's capacity as an entrusted person; and

(c) the information is protected information; and

(d) the person uses or discloses the information.

Penalty: Imprisonment for 2 years or 120 penalty units, or both.

(2) A person commits an offence if:

(a) the person uses or discloses information; and

(b) the information is protected information; and

(c) the information was disclosed to the person; and

(d) the disclosure of the information to the person was authorised by or under any of the following provisions of this Act:

(i) subsection 537(8) (reasonable belief about threats to safety, etc.);

(ii) subsection 537(10) (functions under certain laws relating to worker screening);

(iii) subsection 538(1) (performance of Minister's functions);

(iv) subsection 538(4) (individual accessing funded aged care services);

(v) section 539 (use or disclosure by the System Governor or Appointed Commissioner);

(vi) subsection 540(1) (coronial inquiries, etc.);

(vii) subsection 540(2) (health complaints, etc.);

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(viii) subsection 541(1) (grants); and

(e) the person is not, and has never been, an entrusted person or, if the person is or has been an entrusted person, the information was not disclosed to the person in that capacity; and

(f) the purpose for which the person uses or discloses the information is not the purpose for which the information was disclosed to the person.

Penalty: Imprisonment for 2 years or 120 penalty units, or both.

(3) Subsections (1) and (2) do not apply to a use or disclosure authorised by a provision of Division 2.

Note 1: A defendant bears an evidential burden in relation to the matter in subsection (3): see subsection 13.3(3) of the *Criminal Code*.

Note 2: Division 2 authorises the use and disclosure of protected information and relevant information in various circumstances. As well as having effect for the purposes of subsection (3), these authorisations have effect for the purposes of the *Privacy Act 1988*.

(4) Subsection (2) does not apply to the following:

(a) conduct of individuals accessing, or seeking to access, funded aged care services;

(b) conduct of supporters of those individuals;

(c) conduct of registered providers.

Note: A defendant bears an evidential burden in relation to the matter in subsection (4): see subsection 13.3(3) of the *Criminal Code*.

536 Protection from liability etc.

Authorised use or disclosure not an offence under other laws

(1) Subject to subsection (2), a person does not commit an offence, and is not liable to any penalty, under any other enactment of the Commonwealth, or any enactment of a State or Territory, as a result of the person using or disclosing relevant information in accordance with Division 2.

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(2) Subsection (1) does not apply in relation to provisions of the *Australian Security Intelligence Organisation Act 1979* and the *Intelligence Services Act 2001*.

Authorised use or disclosure does not result in liability for civil proceedings

(3) A person is not liable to civil proceedings for loss, damage or injury of any kind suffered by an entity as a result of the person using or disclosing relevant information in accordance with Division 2.

Authorised use or disclosure does not contravene medical or other professional standards

(4) A person does not contravene medical standards, or any other relevant professional standards, as a result of the person using or disclosing relevant information in accordance with Division 2.

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Division 2—Authorisation of use or disclosure of relevant information

Subdivision A—Authorisation of entities generally

537 Authorisations to use or disclose information—general

Use or disclosure in performing functions or exercising powers under this Act

(1) A person may use or disclose relevant information:

(a) in the course of performing a function or duty, or exercising a power, under or in connection with this Act; or

(b) to assist another person to perform a function or duty, or exercise a power, under or in connection with this Act.

Note 1: A provision of this section constitutes an authorisation for the purposes of the *Privacy Act 1988* and other laws (including the common law).

Note 2: Use, in relation to information, includes make a record of (see the definition of ***use*** in section 7).

Use or disclosure for purposes of proceedings

(2) A person may disclose relevant information to a court, a Royal Commission or any other body or entity that has power to require the production of documents or the answering of questions:

(a) for the purpose of complying with such a requirement; or

(b) for the purpose of providing information to a Royal Commission, whether for the purpose of complying with such a requirement or otherwise.

Note 1: Section 542 limits the circumstances in which the court, Royal Commission, body or entity with such power may make such a requirement.

Note 2: For example, a Royal Commission under the *Royal Commissions Act 1902* is a body or entity that has power to require the production of documents or the answering of questions.

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Use or disclosure required or authorised by another Australian law

(3) A person may use or disclose relevant information if the use or disclosure is required or authorised under an Australian law other than this Act.

Disclosure to entity to whom information relates

(4) A person may disclose relevant information to the entity to which the information relates.

Use or disclosure with consent

(5) A person may use or disclose relevant information for a purpose if the entity to which the information relates has consented to the person using or disclosing the information for that purpose (whether the consent is express or implied).

Disclosure to entity that provided information

(6) A person may disclose relevant information to the entity that provided the information.

Use or disclosure of information that is already public

(7) A person may use relevant information, or disclose relevant information to another person, if the information has already been lawfully made available to the public.

Use or disclosure for purposes of preventing serious threat to safety, health or wellbeing, etc.

(8) A person may use or disclose relevant information if the person reasonably believes that the use or disclosure:

(a) is necessary to lessen or prevent a serious threat to the safety, health or wellbeing of an individual seeking to access, or accessing, funded aged care services; or

(b) is for the purpose of, or in relation to, reporting a past threat to an individual's life, health or safety to an entity:

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(i) that has regulatory, compliance or law enforcement functions; or

(ii) that is prescribed by the rules for the purposes of this paragraph.

Use or disclosure of information relating to fire safety

(8A) A person may use relevant information, or disclose relevant information to the chief executive officer (however described) of a State or Territory fire authority, if:

(a) the relevant information relates to fire safety; and

(b) the use or disclosure is for the purposes of assisting the State or Territory fire authority to perform its functions.

(8B) For the purposes of subsection (8A), a ***State or Territory fire authority*** means a State or Territory authority that has functions relating to fire safety under a law of the State or Territory (including a local by-law).

Use or disclosure for purpose for which information was disclosed

(9) Subject to subsection (9A), if relevant information is disclosed to a person, the person may use or disclose the information for the purpose for which it was disclosed to the person.

(9A) The relevant information used or disclosed by the person must be de-identified if:

(a) it is appropriate in the circumstances to de-identify the relevant information; and

(b) de-identifying the relevant information does not prevent the person from fulfilling the purpose for which the information was disclosed to the person.

Disclosure for worker screening

(10) A person may use or disclose relevant information:

(a) for the purpose of facilitating the performance of a function or duty, or the exercise of a power, under any of the following:

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(i) an aged care worker screening law;
(ii) the NDIS Act;
(iii) an NDIS worker screening law;
(b) for the purpose of the aged care worker screening database.

538 Authorisations to use or disclose information—entrusted persons

Disclosure to Minister

(1) An entrusted person may disclose relevant information to the Minister for the purposes of the Minister's performance of the Minister's functions.

(2) Subsection (1) does not authorise disclosure of personal information if the purposes mentioned in that subsection can be achieved by the disclosure of information that has been de-identified (within the meaning of the *Privacy Act 1988*).

Use or disclosure for obtaining legal advice or service

(3) An entrusted person may use or disclose relevant information for the purposes of providing or obtaining legal advice or another legal service.

Use or disclosure for provision of services to an individual

(4) An entrusted person may use or disclose, for any of the following purposes, relevant information relating to an individual accessing, or seeking to access, funded aged care services:
(a) delivery of funded aged care services or other community, health or social services to the individual;
(b) assessing the individual's needs for funded aged care services or other community, health or social services;
(c) if the individual is accessing funded aged care services—assessing the level of care the individual needs, relative to the needs of other individuals accessing such services.

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Subdivision B—Authorisation of System Governor and Appointed Commissioners

539 Authorisations of System Governor and Appointed Commissioners to use or disclose information

Disclosure to Chief Executive Centrelink or Chief Executive Medicare

(1) The System Governor or an Appointed Commissioner may disclose relevant information to the Chief Executive Centrelink for any of the following:

(a) a purpose relating to the payment of a subsidy or a grant (however described);

(b) for the purposes of a centrelink program.

Note: For ***centrelink program***, see section 40 of the *Human Services (Centrelink) Act 1997*.

(2) The System Governor or an Appointed Commissioner may disclose relevant information to the Chief Executive Medicare for any of the following:

(a) a purpose relating to the payment of a subsidy or a grant (however described);

(b) the purposes of a medicare program or the *Health and Other Services (Compensation) Care Charges Act 1995*.

Note: For ***medicare program***, see section 41G of the *Human Services (Medicare) Act 1973*.

Disclosure to Commonwealth bodies for facilitating functions, duties or powers

(3) The System Governor or an Appointed Commissioner may disclose relevant information to a body mentioned in subsection (4) for the purpose of facilitating the performance of the functions or duties, or the exercise of the powers, of the body or a member of the body.

(4) For the purposes of subsection (3), the bodies are:

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(a) the Office of the Inspector-General of Aged Care;
(b) the Department administered by the Minister administering the *Military Rehabilitation and Compensation Act 2004*;
(c) the Repatriation Commission;
(e) the Department administered by the Minister administering the *Disability Services and Inclusion Act 2023*;
(f) the National Disability Insurance Agency;
(g) the NDIS Quality and Safeguards Commission;
(h) the Department administered by the Minister administering the *Human Services (Centrelink) Act 1997*;
(i) Services Australia;
(j) Safe Work Australia;
(k) the Fair Work Commission;
(l) the Office of the Fair Work Ombudsman;
(m) the Office of the Commonwealth Ombudsman described in section 4A of the *Ombudsman Act 1976*;
(n) the Office of the Australian Information Commissioner;
(o) the Australian Prudential Regulation Authority;
(p) the Australian Securities and Investments Commission;
(q) the Australian Competition and Consumer Commission;
(r) the Independent Health and Aged Care Pricing Authority;
(s) the Australian Commission on Safety and Quality in Health Care;
(t) the Australian Institute of Health and Welfare;
(u) a Department of State, or other authority, of the Commonwealth that is prescribed by the rules and:
(i) has regulatory, compliance or enforcement functions relating to the provision of care, support, treatment or other related services or assistance (including care, support, treatment or other related services or assistance provided through a contractual or other arrangement); or
(ii) has functions of screening persons for suitability for work in a particular field or of occupational registration (however described) of persons.

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Disclosure to supporter of individual accessing, or seeking to access, funded aged care services

(5) The System Governor or an Appointed Commissioner may disclose relevant information about an individual accessing, or seeking access, to funded aged care services to a supporter of the individual, if the information is relevant to anything the supporter is required or permitted to do as a supporter of the individual.

Disclosure for continuation of funded aged care services

(6) If an entity has taken over (however described) the delivery of funded aged care services, the System Governor or an Appointed Commissioner may disclose relevant information to the entity for the purposes of enabling the proper delivery of those services by the entity.

Disclosure for research

(7) The System Governor or an Appointed Commissioner may disclose relevant information to an entity that is carrying out research into funded aged care services on behalf of the Commonwealth if the System Governor or Appointed Commissioner reasonably believes the information is necessary for the research.

Note: Disclosure of relevant information that is personal information is not necessary for the research if the research could be carried out with de-identified information.

Disclosure for law enforcement and revenue protection

(8) If the System Governor or an Appointed Commissioner reasonably believes that the use or disclosure of relevant information is necessary for:

(a) enforcement of the criminal law; or

(b) enforcement of a law imposing a pecuniary penalty; or

(c) protection of the public revenue; or

(d) an integrity purpose within the meaning of the *Crimes Act 1914*;

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the System Governor or Appointed Commissioner may each use or disclose the information, and may disclose the information to each other, and to any agency whose functions include that enforcement or protection, or that purpose, for the purposes of that enforcement, protection or purpose.

Disclosure for maintenance of professional standards

(9) If the System Governor or an Appointed Commissioner reasonably believes that:

(a) a person's conduct breaches, or may breach, the standards of professional conduct of a profession of which the entity is a member; and

(b) the person should be reported to a body responsible for standards of conduct in the profession;

the System Governor or Appointed Commissioner may disclose relevant information to that body for the purposes of maintaining standards of professional conduct in the profession.

Use or disclosure for certified purposes

(10) The System Governor may use relevant information, or disclose relevant information to specified persons, for a purpose specified by the System Governor, if the System Governor makes a written determination certifying that it is necessary in the public interest for the System Governor to use the relevant information, or to disclose the relevant information to those persons, for that purpose.

(11) An Appointed Commissioner may use relevant information, or disclose relevant information to specified persons, for a purpose specified by the Appointed Commissioner, if the Appointed Commissioner makes a written determination certifying that it is necessary in the public interest for the Appointed Commissioner to use the relevant information, or to disclose the relevant information to those persons, for that purpose.

(12) Subsections (10) and (11) have effect subject to the rules (if any).

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(13) A determination made under subsection (10) or (11) is not a legislative instrument.

540 Authorisations of the System Governor and Appointed Commissioners to use or disclose information for certain inquiries, etc.

Disclosure to coroner etc.

(1) The System Governor or an Appointed Commissioner may disclose relevant information for the purpose of assisting a coronial inquiry, coronial investigation or coronial inquest under a law of the Commonwealth, a State or a Territory.

Disclosure for State or Territory complaints process

(2) The System Governor or an Appointed Commissioner may disclose relevant information to an entity or body that has, under a law of a State or Territory, a function of dealing with complaints or information about the provision of health or community services, for the purpose of facilitating the performance of the function.

Subdivision C—Authorisation of System Governor for grants and quality related purposes

541 Authorisations of System Governor to use or disclose information for grants, etc.

Disclosure for grants

(1) The System Governor may disclose relevant information to an entity to which a grant has been made under section 264 or 265 for a purpose for which the grant was made.

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Disclosure for star ratings

(2) The System Governor must publish information about the following in relation to funded aged care services delivered by registered providers in approved residential care homes:
  (a) the quality of those services;
  (b) action taken under this Act:
    (i) to ensure the quality of those services; or
    (ii) to ensure compliance with this Act in relation to the delivery of those services; or
    (iii) because of a failure to comply with this Act in relation to the delivery of those services;
  (c) any other matter prescribed by the rules relating to:
    (i) those services; or
    (ii) registered providers in their delivery of those services.

(2A) Subsection (2) does not apply in relation to services delivered under specialist aged care programs unless the rules provide otherwise.

(3) The System Governor may publish information under subsection (2) in the form of one or more star ratings for an approved residential care home.

(3A) The System Governor may give an approved residential care home a low star rating for quality if the registered provider in relation to whom the approved residential care home is approved fails to comply with requirements under this Act to report on that quality.

(4) The System Governor may use or disclose relevant information for the purposes of:
  (a) creating information for publication under subsection (2); or
  (b) calculating star ratings for approved residential care homes.

(5) Information published under subsection (2) must not include personal information about an individual accessing, or seeking access, to funded aged care services.

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(6) The System Governor is not liable to civil proceedings for loss, damage or injury of any kind suffered by the registered provider in relation to whom an approved residential care home is approved, or another entity, as a result of the publication of information under subsection (2).

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Division 3—Limit on powers to require disclosure of protected information

542 Limit on requirements to produce documents or answer questions

A court, or any other body or person that has power to require the production of documents or the answering of questions, may require a person to disclose protected information only if one of the following applies:

(a) the disclosure is required for the purposes of this Act or the *Inspector-General of Aged Care Act 2023*;

(b) the information was originally disclosed to the person under Division 2, and the disclosure is required for the purpose for which the information was disclosed under that Division;

(c) the entity to which the information relates has consented, in writing, to the disclosure.

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Part 3—Record-keeping

543 Retention of records by former registered provider

(1) An entity commits an offence if:

(a) the entity has ceased to be a registered provider of a kind prescribed by the rules; and

(b) the entity fails to retain for 7 years after that cessation a record; and

(c) immediately before that cessation, it was a condition of the entity's registration as a registered provider that the entity retain the record; and

(d) the record relates to a funded aged care service the entity delivered as a registered provider.

Penalty: 60 penalty units.

(2) Subsection (1) does not apply in relation to a record the entity was required to transfer to someone else when or after the entity ceased to be a registered provider.

Note: A defendant bears an evidential burden in relation to the matter in subsection (2): see subsection 13.3(3) of the *Criminal Code*.

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Part 4—Information sharing

Division 1—Publication by System Governor

544 System Governor must publish information about funded aged care services generally

(1) The System Governor must publish in accordance with the rules information relating to funded aged care services.

(2) Without limiting subsection (1), the rules may provide for one or more of the following:

(a) information that must be published about:

(i) funded aged care services; or

(ii) registered providers delivering those services; or

(iii) responsible persons of those registered providers;

(b) the ways in which information must be published;

(c) the period within which information must be published.

(3) Information published under subsection (1) must not include personal information about an individual who is not a registered provider or a responsible person of a registered provider.

545 Information that System Governor may publish about particular funded aged care services

(1) The System Governor may publish information about any of the following matters relating to funded aged care services delivered in a particular residential care home or home or community setting by a particular registered provider:

(a) the name of the provider;

(b) the ABN of the provider;

(c) how the provider may be contacted;

(d) a description of the funded aged care services delivered by the provider;

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(e) the location where those services are delivered;
(f) the number of individuals accessing those services;
(g) the accommodation costs, fees and charges connected with those services;
(h) the facilities and activities available to individuals accessing those services;
(i) the names of responsible persons of the provider;
(j) the funding under this Act received by the provider in connection with those services;
(k) whether the provider's registration is in effect;
(l) the provider's performance relating to requirements of this Act;
(m) action taken, or intended to be taken, under this Act to protect the health and welfare of individuals accessing the services, and the reasons for that action;
(n) a matter specified by the rules for the purposes of this paragraph.

(2) Information published under subsection (1) must not include personal information about an individual who is not a registered provider or responsible person of a registered provider.

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Division 2—Publication by Commissioner

546 Information that Commissioner may publish

(1) The Commissioner may publish information about any of the following matters relating to funded aged care services delivered in a particular residential care home or home or community setting by a particular registered provider:

(a) the name of the provider;

(b) the ABN of the provider;

(c) how the provider may be contacted;

(d) a description of the funded aged care services delivered by the provider;

(e) the location where those services are delivered;

(f) the number of individuals accessing those services;

(g) the accommodation costs, fees and charges connected with those services;

(h) the facilities and activities available to individuals accessing those services;

(i) whether the provider's registration is in effect;

(j) the provider's performance relating to requirements of this Act;

(k) action taken, or intended to be taken, under this Act to protect the welfare of individuals accessing the services, and the reasons for that action;

(l) a matter specified by the rules for the purposes of this paragraph.

(2) Information published under subsection (1) must not include personal information about an individual who is not a registered provider.

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Part 5—Whistleblower protections

547 Disclosures qualifying for protection

A disclosure of information by an individual (***the discloser***) qualifies for protection under this section if:

(a) the disclosure is made to one of the following:
  (i) an Appointed Commissioner or a member of the staff of the Commission;
  (ii) the System Governor, or an official of the Department;
  (iii) a registered provider;
  (iv) a responsible person of the registered provider;
  (v) an aged care worker of a registered provider;
  (vi) a police officer;
  (vii) an independent aged care advocate; and

(b) the disclosure is made orally or in writing (and whether made anonymously or not); and

(c) the discloser has reasonable grounds to suspect that the information indicates that an entity may have contravened a provision of this Act.

548 Protections

(1) If an individual makes a disclosure that qualifies for protection under section 547:

(a) the individual is not subject to any civil, criminal or administrative liability (including disciplinary action) for making the disclosure; and

(b) no contractual or other remedy may be enforced, and no contractual or other right may be exercised, against the individual on the basis of the disclosure.

Note: The individual is still subject to any civil or criminal liability for conduct of the individual that may be revealed by the disclosure.

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(2) Without limiting subsection (1), a contract to which the individual is a party may not be terminated on the basis that the disclosure constitutes a breach of the contract.

549 Recipient to take steps to preserve anonymity

If:

(a) an individual makes a disclosure that qualifies for protection under section 547 to an entity (the ***recipient***); and

(b) the individual requests that the individual, or any other individual named in the request, remain anonymous;

the recipient must take such steps as are reasonable in the circumstances to preserve the anonymity of individuals named in the request.

Note 1: For example, if disclosing the name of an individual is necessary to lessen or prevent a serious threat to the health, safety or well-being of another individual, disclosing the identity of the first-mentioned individual may be reasonable in the circumstances.

However, if the serious threat could be lessened without naming the individual, then disclosing the name is unlikely to be reasonable in the circumstances.

Note 2: An entity may be liable to a civil penalty if the entity discloses certain information relating to the identity of an individual who makes a disclosure that qualifies for protection (see section 550).

550 Confidentiality of identity of disclosers

(1) An entity contravenes this subsection if:

(a) an individual (the ***discloser***) makes a disclosure of information (the ***qualifying disclosure***) that qualifies for protection under section 547; and

(b) the entity discloses any of the following (the ***confidential information***):

(i) the identity of the discloser;

(ii) information that is likely to lead to the identification of the discloser; and

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(c) the confidential information is information that the entity obtained directly or indirectly because of the qualifying disclosure; and

(d) the disclosure referred to in paragraph (b) is not authorised under subsection (2).

Civil penalty: 30 penalty units.

(2) A disclosure referred to in paragraph (1)(b) is authorised under this subsection if:

(a) the disclosure is made to an Appointed Commissioner or a member of the staff of the Commission; or

(b) the disclosure is made to the System Governor, or an official of the Department; or

(c) the disclosure is made to the Inspector-General of Aged Care; or

(d) the disclosure is made to a police officer; or

(e) the disclosure is made to a legal practitioner for the purpose of obtaining legal advice or legal representation in relation to the operation of this Part; or

(f) the disclosure is made with the consent of the discloser; or

(g) the disclosure is necessary to lessen or prevent a serious threat to the safety, health or wellbeing of one or more individuals; or

(h) the disclosure is made to a court, tribunal or a Royal Commission (within the meaning of the *Royal Commissions Act 1902*); or

(i) the discloser elects to have the qualifying disclosure managed or dealt with as:

(i) a complaint under section 361; or

(ii) a complaint or feedback under paragraph 165(1)(b); or

(j) both of the following apply:

(i) the confidential information is in the public domain before the disclosure is made;

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(ii) the original disclosure of the confidential information into the public domain (before the disclosure is made) was not in contravention of subsection (1).

(3) Subsection (1) does not apply if:

(a) the confidential information disclosed by the entity (as mentioned in paragraph (1)(b)):

(i) is not the identity of the discloser; and

(ii) is reasonably necessary for the purposes of dealing with the matter referred to in paragraph 547(c) to which the qualifying disclosure relates; and

(b) the entity takes all reasonable steps to reduce the risk that the discloser will be identified as a result of the disclosure of the confidential information referred to in paragraph (1)(b).

551 Victimisation prohibited

Actually causing detriment

(1) An entity contravenes this subsection if:

(a) the entity engages in conduct; and

(b) the entity's conduct causes any detriment to an individual (the ***first individual***) or to another individual or to another entity that employs or is otherwise associated with the first individual; and

(c) the entity engages in the conduct solely or partly because the entity believes or suspects that the first individual or another individual has, may have, or intends to make, a disclosure that qualifies for protection under section 547.

Civil penalty: 500 penalty units.

(2) In proceedings for a civil penalty order against an entity for a contravention of subsection (1), it is not necessary to prove that the first individual or other individual has done, may have done or intends to do a thing mentioned in paragraph (1)(c).

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Threatening to cause detriment

(3) An entity contravenes this subsection if:

(a) the entity makes to an individual (the ***first individual***) a threat to cause any detriment to the first individual or to another individual or to another entity that employs or is otherwise associated with the first individual; and

(b) the entity:

(i) intends the first individual to fear that the threat will be carried out; or

(ii) is reckless as to causing the first individual to fear that the threat will be carried out; and

(c) the entity engages in the conduct solely or partly because the entity believes or suspects that the first individual or another individual has, may have, or intends to make, a disclosure that qualifies for protection under section 547.

Civil penalty: 500 penalty units.

Threats

(4) For the purpose of subsection (3), a threat may be:

(a) express or implied; or

(b) conditional or unconditional.

(5) In proceedings for a civil penalty order against an entity for a contravention of subsection (3), it is not necessary to prove:

(a) that the first individual actually feared that the threat would be carried out; or

(b) that an individual has done, may have done or intends to do a thing mentioned in paragraph (3)(c).

Exception—reasonable administrative action

(6) Subsections (1) and (3) do not apply if the conduct engaged in by the entity is administrative action that is reasonable to protect the first individual from detriment.

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Note: A defendant bears an evidential burden in relation to the matter in this subsection (see section 96 of the Regulatory Powers Act).

552 Court orders

A court may make any order the court considers appropriate if the court is satisfied that an entity has contravened, or proposes to contravene, subsection 551(1) or (3), including any of the following orders:

(a) an order granting an injunction, or interim injunction, to prevent, stop or remedy the effects of a contravention;

(b) an order awarding compensation for loss, damage or injury that an entity has suffered because of the contravention;

(c) an order for reinstatement of an individual;

(d) an order for exemplary damages.

553 Registered providers' obligations in relation to disclosers

Ensuring aged care workers and responsible persons who make disclosures are not victimised

(1) A registered provider must ensure, as far as reasonably practicable, compliance with section 549, subsection 550(1) and subsections 551(1) and (3) in relation to an individual who:

(a) is an aged care worker or responsible person of the registered provider; and

(b) makes a disclosure that qualifies for protection under section 547.

Note: The obligation under subsection (1) covers not only compliance by the registered provider with those provisions but extends to the registered provider ensuring as far as reasonably practicable that there is also compliance by others, such as the provider's other aged care workers, responsible persons and associated providers.

Protecting discloser identities

(2) If an individual makes a disclosure that qualifies for protection under section 547 to a person (the ***recipient***) who is:

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(a) an aged care worker of a registered provider; or

(b) a responsible person of a registered provider;

the provider must take reasonable measures to ensure that the recipient does not disclose the fact that the individual was the maker of the disclosure, except as authorised by this Part.

554 Concurrent operation of State and Territory laws

This Part does not exclude or limit the operation of a law of a State or Territory that is capable of operating concurrently with this Part.

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Chapter 8—Miscellaneous

Part 1—Introduction

555 Simplified outline of this Chapter

This Chapter deals with the following matters:

(a) review of decisions;
(b) delegation of the functions and powers of the System Governor, Commissioner and Complaints Commissioner under this Act;
(d) the application of this Act to partnerships and unincorporated associations;
(e) automation of certain administrative action;
(f) processes for applications, claims and requests made to the System Governor, Commissioner and Complaints Commissioner;
(g) fees for applications and for services provided by the System Governor, Commissioner and Complaints Commissioner;
(h) appropriation of the Consolidated Revenue Fund;
(i) annual reporting and reviews;
(j) the making of rules.

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Part 2—Reconsideration and review of decisions

Division 1—Reviewable decisions and affected entities

556 Decisions by the Commissioner or Complaints Commissioner

Decisions by the Commissioner

(1) A decision by the Commissioner referred to in column 1 of an item of the following table is a ***reviewable decision***. An entity referred to in column 2 of the item is an ***affected entity*** for the decision.

Decisions by the Commissioner

Item	Column 1 Decision	Column 2 Entity
1	A decision under paragraph 105(1)(a) not to register an entity as a registered provider	The entity
2	A decision under paragraph 105(1)(a) not to register an entity in a provider registration category	The entity
3	A decision under paragraph 105(1)(b) not to cover an approved residential care home in an entity's registration	The entity
4	A decision under paragraph 108(1)(a) not to renew the registration of an entity as a registered provider	The entity
5	A decision under paragraph 108(1)(a) not to renew the registration of an entity in a provider registration category	The entity
6	A decision under paragraph 108(1)(b) not to register an entity in a provider registration category	The entity
7	A decision under paragraph 112(1)(a) not to approve a residential care home in relation to an entity	The entity

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Section 556

Decisions by the Commissioner		
Item	**Column 1** **Decision**	**Column 2** **Entity**
8	A decision under paragraph 112(1)(b) to determine a total number of beds covered by an approval of a residential care home in relation to an entity	The entity
9	A decision under subsection 123(1) to vary the registration of a registered provider	The registered provider
10	A decision under subsection 124(1) not to vary the registration of a registered provider	The registered provider
11	A decision under subsection 129(1) to suspend the registration of an entity as a registered provider for a specified period	The entity
12	A decision under subsection 129(5) not to suspend the registration of an entity that is registered as a registered provider for a specified period	The entity
13	A decision under subsection 131(1) to revoke the registration of an entity as a registered provider	The entity
14	A decision under subsection 131(3) not to revoke the registration of an entity that is registered as a registered provider	The entity
15	A decision under subsection 136(1) to vary the approval of an approved residential care home in relation to a registered provider	The registered provider
16	A decision under subsection 137(1) not to vary the approval of an approved residential care home in relation to a registered provider	The registered provider
17	A decision under subsection 138(1) to revoke the approval of an approved residential care home in relation to a registered provider	The registered provider
18	A decision under subsection 138(2) not to revoke the approval of an approved residential care home in relation to a registered provider	The registered provider
19	A decision under subsection 143(1) to impose	The registered provider

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Decisions by the Commissioner		
Item	**Column 1** **Decision**	**Column 2** **Entity**
	conditions on the registration of a registered provider	
20	A decision under subsection 159(3) not to determine that either or both of the governance conditions set out in subsection 157(2) do not apply in relation to a registered provider	The registered provider
21	A decision under subsection 160(1) to vary or revoke a determination made under subsection 159(3) (which deals with determinations that certain conditions relating to the governing body of a registered provider do not apply) in relation to a registered provider	The registered provider
22	A decision under subsection 170(1) to determine that a person who is one of the responsible persons of a registered provider is not suitable to be involved in the delivery of funded aged care services	Each of the following: (a) the person; (b) the registered provider
23	A decision under section 474 to give a registered provider a required action notice	The registered provider
24	A decision under section 477 to vary a required action notice given to a registered provider	The registered provider
25	A decision under section 481 to give a registered provider a compliance notice	The registered provider
26	A decision under section 485 to vary a compliance notice given to a registered provider	The registered provider
27	A decision under subsection 497(1) to make a banning order prohibiting or restricting the delivery of funded aged care services generally or in a specified service type by an entity that is or was a registered provider	The entity
28	A decision under subsection 498(1) to make a banning order prohibiting or restricting the involvement of an individual in the delivery of funded aged care services generally, or in a	The individual

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Decisions by the Commissioner		
Item	**Column 1** **Decision**	**Column 2** **Entity**
	specified service type, or in a specified activity of a registered provider	
29	A decision under subsection 504(1) to vary or revoke a banning order made against an entity	The entity
30	A decision under subsection 505(3) not to vary or revoke a banning order made against an entity, or a condition of the order	The entity
31	A decision under a provision of the rules prescribed by the rules	An entity prescribed by the rules

Decisions by the Complaints Commissioner

(2) A decision by the Complaints Commissioner referred to in column 1 of an item of the following table is a ***reviewable decision***. An entity referred to in column 2 of the item is an ***affected entity*** for the decision.

Decisions by the Complaints Commissioner		
Item	**Column 1** **Decision**	**Column 2** **Entity**
1	A decision under section 474 to give a registered provider a required action notice	The registered provider
2	A decision under section 478 to vary a required action notice given to a registered provider	The registered provider
3	A decision under a provision of the rules prescribed by the rules	An entity prescribed by the rules

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557 Decisions by the System Governor

A decision by the System Governor referred to in column 1 of an item of the following table is a ***reviewable decision***. An entity

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referred to in column 2 of the item is an ***affected entity*** for the decision.

Decisions by the System Governor

Item	Column 1 Decision	Column 2 Entity
1	A decision under subsection 37(1) not to register a person to be a supporter of an individual	Each of the following: (a) the individual; (b) the person
2	A decision under subsection 37(4) to register a person as a supporter of an individual	The individual
5	A decision under subsection 51(1) or (2) to cancel a suspended person's registration	The person
6	A decision under subsection 53(1) not to cancel the registration of a person as a supporter of an individual on request by the individual	The individual
7	A decision under subsection 57(1) not to make an eligibility determination for an aged care needs assessment for an individual	The individual
8	A decision under subsection 64(1) that a reassessment of an individual's need for funded aged care services is not required	The individual
9	A decision under subsection 65(1) that an individual does not require access to funded aged care services	The individual
10	A decision under subsection 65(2) not to approve a service group, or a classification type for a service group, a service type, or a funded aged care service, for an individual	The individual
11	A decision under subsection 65(4) that exceptional circumstances do not apply in relation to an individual	Each of the following: (a) the individual; (b) the registered provider
12	A decision under subsection 71(2) to not specify an earlier day in a notice of decision under	The individual

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Section 557

Decisions by the System Governor		
Item	**Column 1** **Decision**	**Column 2** **Entity**
	section 70	
13	A decision under subsection 71(6) to reject an application for a longer period for an individual to make an application	The individual
14	A decision under subsection 74(1) to revoke an eligibility determination for an aged care needs assessment for an individual	The individual
15	A decision under subsection 74(1) to revoke an access approval for an individual	The individual
16	A decision under subsection 78(1) to establish a classification level for an individual for a classification type for a service group	Each of the following: (a) the individual; (b) if a copy of the notice of the decision is required to be given to a registered provider under subsection 79(3)—the registered provider
17	A decision under subsection 83(1) to change a classification decision (the ***original decision***) for an individual	Each affected entity for the original decision
18	A decision under subsection 86(1) to assign a priority category for an individual for a classification type for a service group	The individual
19	A decision under subsection 90(1) to change a decision about an individual's priority category for a classification type for a service group	The individual
20	A decision under subsection 234(4) to determine compensation payment reductions for an individual	The individual
21	A decision under subsection 243(3) not to	The registered provider

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Decisions by the System Governor

Item	Column 1 Decision	Column 2 Entity
	determine that an approved residential care home in relation to a registered provider has specialised status	
21A	A decision under subsection 243A(1) to revoke a determination that an approved residential care home in relation to a registered provider has specialised status	The registered provider
22	A decision under paragraph 259(1)(b) not to determine a longer period for a registered provider to vary a claim for a payment period	The registered provider
23	A decision under subsection 314(1) to determine an individual's contribution rate for a means testing category	The individual
24	A decision under subsection 316(1) to vary or revoke an individual contribution rate determination in relation to an individual	The individual
25	A decision under subsection 316(1) not to vary or revoke an individual contribution rate determination in relation to an individual	The individual
26	A decision under paragraph 320(1)(a) to determine an individual has means not disclosed status	The individual
27	A decision under subsection 320(3) to determine the day that a determination under paragraph 320(1)(a) in relation to an individual takes effect	The individual
28	A decision under paragraph 320(4)(b) to determine the day that revocation of an individual's means not disclosed status takes effect	The individual
29	A decision under subsection 322(1) to determine an individual's total assessable income	The individual
30	A decision under subsection 322(6) to determine	The individual

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Section 557

Decisions by the System Governor		
Item	**Column 1** **Decision**	**Column 2** **Entity**
	the day that a determination under subsection 322(1) in relation to an individual takes effect	
31	A decision under subsection 324(1) to vary or revoke an income determination in relation to an individual	The individual
32	A decision under subsection 324(4) to determine the day that a determination under subsection 324(1) in relation to an individual takes effect	The individual
33	A decision under subsection 326(2) not to vary or revoke an income determination in relation to an individual	The individual
34	A decision under subsection 329(1) to determine the value of an individual's assets	The individual
35	A decision under subsection 329(6) to determine the day that a determination under subsection 329(1) in relation to an individual takes effect	The individual
36	A decision under subsection 331(1) to vary or revoke an asset determination in relation to an individual	The individual
37	A decision under subsection 331(4) to determine the day that a determination under subsection 331(1) in relation to an individual takes effect	The individual
38	A decision under subsection 333(2) not to vary or revoke an asset determination in relation to an individual	The individual
39	A decision under section 475 to give a registered provider a required action notice	The registered provider
40	A decision under section 479 to vary a required action notice given to a registered provider	The registered provider

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Decisions by the System Governor		
Item	**Column 1** **Decision**	**Column 2** **Entity**
41	A decision under section 482 to give a registered provider a compliance notice	The registered provider
42	A decision under section 486 to vary a compliance notice given to a registered provider	The registered provider
43	A decision under subsection 582(4) to substitute a decision (the ***original decision***) the System Governor is treated as having taken under subsection 582(3) if the original decision is a reviewable decision	Each affected entity for the original decision
44	A decision under a provision of the rules prescribed by the rules	An entity prescribed by the rules

558 Decisions by the Pricing Authority

A decision by the Pricing Authority referred to in column 1 of an item of the following table is a ***reviewable decision***. An entity referred to in column 2 of the item is an ***affected entity*** for the decision.

Decisions by the Pricing Authority		
Item	**Column 1** **Decision**	**Column 2** **Entity**
1	A decision under subsection 290(6) not to approve a higher maximum accommodation payment amount in relation to a registered provider	The registered provider
2	A decision under a provision of the rules prescribed by the rules	An entity prescribed by the rules

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Division 2—Reconsideration of reviewable decisions

559 Affected entity may request reconsideration of reviewable decision

(1) An affected entity for a reviewable decision may request the decision-maker for the decision to reconsider the decision.

(2) The request must:
  (a) be made in writing; and
  (b) set out the reasons for the request; and
  (c) for a request to reconsider a reviewable decision made under subsection 78(1) to establish a classification level for an individual for a classification type for a service group—be accompanied by the application fee (if any) prescribed by the rules.

(3) The request must be given to the decision-maker within the following period after the day the affected entity is notified of the reviewable decision:
  (a) 28 days;
  (b) for a request to reconsider a reviewable decision made under subsection 322(1) to determine an individual's total assessable income—90 days;
  (c) if the System Governor, the Commissioner or the Complaints Commissioner determines a longer period for the request than would otherwise apply under paragraph (a) or (b)—that period.

(4) The System Governor, the Commissioner or the Complaints Commissioner may, at the request of the affected entity, extend the period under subsection (3).

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560 Reconsideration of reviewable decision on request

(1) This section applies if a request is made by an affected entity for a reviewable decision under subsection 559(1) to the decision-maker for the decision to reconsider the decision.

(2) The decision-maker must, within 14 days after receiving the request, give the affected entity written notice that:
  (a) states that the request has been received; and
  (b) specifies the day the request was received; and
  (c) sets out the effect of section 565.

(3) The decision-maker must:
  (a) personally reconsider the reviewable decision; or
  (b) cause the reviewable decision to be reconsidered by a delegate of the decision-maker who:
    (i) was not involved in making the decision; and
    (ii) occupies a position that is at least the same level as that occupied by the person who made the decision.

(4) The person who reconsiders the reviewable decision is the ***internal decision reviewer***.

(5) The internal decision reviewer must:
  (a) have due regard to procedural fairness; and
  (b) for reconsideration of a reviewable decision made under subsection 78(1) to establish a classification level for an individual for a classification type for a service group—consider:
    (i) any report of a classification assessment for the individual for the service group given to the System Governor under section 77; and
    (ii) any information given to the System Governor as referred to in subparagraph 76(1)(a)(ii) or (b)(ii); and
  (c) within 90 days after receiving the request, reconsider the reviewable decision.

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(6) In reconsidering a decision made under subsection 78(1) or 83(1) for the classification type ongoing or short-term for the service group residential care:

(a) the System Governor must arrange a new classification assessment for the individual to be undertaken as if paragraph 75(1)(b) applies in relation to the individual; and

(b) the internal decision reviewer must take that assessment into account before making a reconsideration decision.

(7) If the individual cannot be assessed for the purposes of the reconsideration:

(a) the internal decision reviewer must not make a reconsideration decision; and

(b) the request for reconsideration of the decision is taken to be withdrawn.

561 Initiation of reconsideration by decision-maker

A decision-maker for a reviewable decision may reconsider the decision if satisfied that there is sufficient reason to do so.

562 Reconsideration of reviewable decision on initiative of decision-maker

(1) This section applies if the decision-maker for a reviewable decision decides under section 561 to reconsider the decision.

(2) The decision-maker must, within 14 days after commencing reconsideration of the reviewable decision, give each affected entity for the decision written notice that:

(a) states that the decision is being reconsidered; and

(b) specifies the day the reconsideration commenced; and

(c) sets out the effect of section 565.

(3) The decision-maker must:

(a) personally reconsider the decision; or

(b) cause the decision to be reconsidered by a delegate of the decision-maker who:

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(i) was not involved in making the decision; and
(ii) occupies a position that is at least the same level as that occupied by the person who made the decision.

(4) The person who reconsiders the decision is the ***internal decision reviewer***.

(5) The internal decision reviewer must:
(a) have due regard to procedural fairness; and
(b) for reconsideration of a reviewable decision made under subsection 78(1) to establish a classification level for an individual for a classification type for a service group—consider:
(i) any report of a classification assessment for the individual for the service group given to the System Governor under section 77; and
(ii) any information given to the System Governor as referred to in subparagraph 76(1)(a)(ii) or (b)(ii); and
(c) within 90 days after deciding to reconsider the decision, reconsider the reviewable decision.

(6) In reconsidering a decision made under subsection 78(1) or 83(1) for the classification type ongoing or short-term for the service group residential care:
(a) the System Governor must arrange a new classification assessment for the individual to be undertaken as if paragraph 75(1)(b) applies in relation to the individual; and
(b) the internal decision reviewer must take that assessment into account before making a reconsideration decision.

(7) If the individual cannot be assessed for the purposes of the reconsideration, the internal decision reviewer must not make a reconsideration decision.

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563 Requests for further information or documents for reconsideration on initiative of decision-maker

(1) If an internal decision reviewer for a reviewable decision needs further information or a document to reconsider the decision under section 562, the internal decision reviewer may, by written notice, request any affected entity for the decision give the further information or document to the internal decision reviewer.

(2) The affected entity must give the requested further information or document to the internal decision reviewer within the following period:

(a) 28 days after the notice is given under subsection (1);

(b) if the internal decision reviewer specifies a longer period in the notice—that period.

(3) If the affected entity does not give the requested further information or document within the period mentioned in subsection (2), the internal decision reviewer may:

(a) extend the period under subsection (2); or

(b) make a reconsideration decision.

(4) If the affected entity gives the requested further information or document within the period mentioned in subsection (2), the period for the internal decision reviewer to reconsider the decision specified in paragraph 562(5)(c) does not include a day in the period:

(a) starting on the day the notice is given under subsection (1) of this section; and

(b) ending at the end of the day the affected entity gives the requested further information or document.

(5) A notice given under subsection (1) must set out the effect of subsections (3) and (4).

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564 Reconsideration decision etc.

(1) After reconsidering a reviewable decision under section 560 or 562, an internal decision reviewer must:
  (a) affirm the reviewable decision; or
  (b) vary the reviewable decision; or
  (c) set the reviewable decision aside and substitute a new decision.

(2) The decision made by the internal decision reviewer is the ***reconsideration decision***.

(3) After the internal decision reviewer makes the reconsideration decision, the internal decision reviewer must give written notice of the following to each affected entity for the reviewable decision:
  (a) the reconsideration decision;
  (b) the day the reconsideration decision was made;
  (c) the reasons for the reconsideration decision;
  (d) details of the affected entity's right to apply to the Administrative Review Tribunal for review of the reconsideration decision.

(4) The reconsideration decision takes effect:
  (a) on the day the reconsideration decision was made; or
  (b) if the notice given under subsection (3) specifies a day as the day the reconsideration decision takes effect—that day.

(5) If the internal decision reviewer is the Commissioner or Complaints Commissioner, or a delegate of the Commissioner or Complaints Commissioner, the internal decision reviewer must, as soon as practicable, give the System Governor a copy of the notice under subsection (3).

(6) The reconsideration decision has effect (except for the purposes of section 556, 557 and 558) as if it had been made under the provision under which the reviewable decision was made.

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565 Deemed reconsideration decision

(1) A decision-maker for a reviewable decision is taken to affirm the decision if:

(a) either of the following apply:

(i) an affected entity for the reviewable decision makes a request under subsection 559(1) for the decision-maker to reconsider the decision;

(ii) the decision-maker gives written notice under subsection 562(2) to each affected entity for the reviewable decision stating that the decision is being reconsidered; and

(b) a notice of the reconsideration decision is not given to each affected entity for the decision under subsection 564(3) within the specified period under paragraph 560(5)(c) or 562(5)(c) (whichever applies).

(2) The reviewable decision which is taken to have been affirmed by the decision-maker under subsection (1) is the ***reconsideration decision***.

(3) The reconsideration has effect (except for the purposes of section 556, 557 and 558) as if it had been made under the provision under which the reviewable decision was made.

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Division 3—Review of reconsideration decisions

566 Review by the Administrative Review Tribunal

(1) An affected entity for a reviewable decision may apply to the Administrative Review Tribunal for the review of a reconsideration decision to which the reviewable decision relates.

(2) Subsection (1) has effect despite section 17 of the *Administrative Review Tribunal Act 2024*.

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Part 3—Delegation provisions

Division 1—Delegation by System Governor

567 Delegation by System Governor—general

Delegation to persons engaged by Commonwealth entities etc.

(1) Subject to subsection (4), the System Governor may, in writing, delegate all or any of the System Governor's functions or powers under this Act, other than Parts 2 to 9 of Chapter 6 (regulatory mechanisms), to a person engaged (whether as an employee or otherwise) by:

(a) a Commonwealth entity; or

(b) an organisation that performs services for a Commonwealth entity.

Note: Sections 34AA to 34A of the *Acts Interpretation Act 1901* contain provisions relating to delegations.

(1A) To avoid doubt, an organisation performs services for a Commonwealth entity even if that organisation performs those services in accordance with a contract or other arrangement with another organisation that performs services for the Commonwealth entity.

Delegation to holders of specified non-SES offices or positions

(2) Before delegating a function or power under subsection (1) to an APS employee holding, occupying, or performing the duties of a specified office or position that is not an SES office or position, the System Governor must have regard to whether the office or position is sufficiently senior for the employee to perform the function or exercise the power.

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Delegation to persons who are not APS employees

(3) Before delegating a function or power under subsection (1) to a person who is not an APS employee, the System Governor must have regard to whether the person has appropriate qualifications or expertise to perform the function or exercise the power.

Limitation—automation of administrative action

(4) The System Governor may only delegate the System Governor's function or power under subsection 582(1) (which deals with automation of administrative action) to an APS employee in the Department who is holding, occupying, or performing the duties of an SES office or position.

568 Delegation to Pricing Authority

(1) The System Governor may, in writing, delegate to the Pricing Authority the powers and functions of the System Governor under this Act that the System Governor considers necessary for the Pricing Authority to perform the Pricing Authority's functions under this Act.

Subdelegation

(2) If, under subsection (1), the System Governor delegates a power or function to the Pricing Authority, the Pricing Authority may, in writing, subdelegate the power or function to a person covered by paragraph 161(1)(c) or subsection 161(2) of the *National Health Reform Act 2011*.

569 Delegation to Chief Executive Centrelink

(1) The System Governor may, in writing, delegate all or any of the System Governor's functions or powers under this Act, other than Parts 2 to 9 of Chapter 6 (regulatory mechanisms), to the Chief Executive Centrelink.

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Subdelegation

(2) Subject to subsection (5), if the System Governor delegates a power or function to the Chief Executive Centrelink under subsection (1), the Chief Executive Centrelink may, in writing, subdelegate the power or function to a person engaged (whether as an employee or otherwise) by Services Australia.

Subdelegation to holders of specified non-SES offices or positions

(3) Before subdelegating a function or power under subsection (2) to an APS employee in Services Australia holding, occupying, or performing the duties of a specified office or position that is not an SES office or position, the Chief Executive Centrelink must have regard to whether the office or position is sufficiently senior for the employee to perform the function or exercise the power.

Subdelegation to persons who are not APS employees

(4) Before subdelegating a function or power under subsection (2) to a person who is not an APS employee in Services Australia, the Chief Executive Centrelink must have regard to whether the person has appropriate qualifications or expertise to perform the function or exercise the power.

Limitation—automation of administrative action

(5) The Chief Executive Centrelink may only subdelegate a function or power under subsection 582(1) (which deals with automation of administrative action) to an APS employee who is holding, occupying, or performing the duties of an SES office or position in Services Australia.

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570 Delegation to Chief Executive Medicare

(1) The System Governor may, in writing, delegate all or any of the System Governor's functions or powers under this Act, other than Parts 2 to 9 of Chapter 6 (regulatory mechanisms), to the Chief Executive Medicare.

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Subdelegation

(2) Subject to subsection (5), if the System Governor delegates a power or function to the Chief Executive Medicare under subsection (1), the Chief Executive Medicare may, in writing, subdelegate the power or function to a person engaged (whether as an employee or otherwise) by Services Australia.

Subdelegation to holders of specified non-SES offices or positions

(3) Before subdelegating a function or power under subsection (2) to an APS employee in Services Australia holding, occupying, or performing the duties of a specified office or position that is not an SES office or position, the Chief Executive Medicare must have regard to whether the office or position is sufficiently senior for the employee to perform the function or exercise the power.

Subdelegation to persons who are not APS employees

(4) Before subdelegating a function or power under subsection (2) to a person who is not an APS employee in Services Australia, the Chief Executive Medicare must have regard to whether the person has appropriate qualifications or expertise to perform the function or exercise the power.

Limitation—automation of administrative action

(5) The Chief Executive Medicare may only subdelegate a function or power under subsection 582(1) (which deals with automation of administrative action) to an APS employee who is holding, occupying, or performing the duties of an SES office or position in Services Australia.

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571 Delegation to Veterans' Affairs Secretary

(1) The System Governor may, in writing, delegate to the Secretary of the Department administered by the Minister who administers the *Veterans' Entitlements Act 1986*:

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(aa) the System Governor's powers and functions under Division 1 of Part 5 of Chapter 4 (means testing in a home or community setting); or

(a) the System Governor's powers and functions under Subdivision C of Division 2 of Part 5 of Chapter 4 (value of an individual's assets); or

(b) the System Governor's powers and functions under Part 2 of this Chapter relating to reconsidering decisions under:

(i) Division 1 of Part 5 of Chapter 4; or

(ii) Subdivision C of Division 2 of Part 5 of Chapter 4; or

(c) the System Governor's powers and functions under section 582 (automation of administrative action).

Subdelegation

(2) Subject to subsection (4), if, under subsection (1), the System Governor delegates a power or function to the Secretary of the Department administered by the Minister who administers the *Veterans' Entitlements Act 1986*, the Secretary of that Department may, in writing, subdelegate the power or function to an APS employee in that Department.

Subdelegation to holders of specified non-SES offices or positions

(3) Before subdelegating a function or power under subsection (2) to an APS employee holding, occupying, or performing the duties of a specified office or position that is not an SES office or position, the Secretary must have regard to whether the office or position is sufficiently senior for the employee to perform the function or exercise the power.

Limitation—automation of administrative action

(4) The Secretary of the Department administered by the Minister who administers the *Veterans' Entitlements Act 1986* may only subdelegate a function or power under subsection 582(1) (which deals with automation of administrative action) to an APS

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employee holding, occupying, or performing the duties of an SES office or position in that Department.

572 Delegation to Repatriation Commission

(1) The System Governor may, in writing, delegate to the Repatriation Commission:

(aa) the System Governor's powers and functions under Division 1 of Part 5 of Chapter 4 (means testing in a home or community setting); or

(a) the System Governor's powers and functions under Subdivision B of Division 2 of Part 5 of Chapter 4 (individual's total assessable income); or

(b) the System Governor's powers and functions under Part 2 of this Chapter relating to reconsidering decisions under:

(i) Division 1 of Part 5 of Chapter 4; or

(ii) Subdivision B of Division 2 of Part 5 of Chapter 4.

Subdelegation

(2) If, under subsection (1), the System Governor delegates a power or function to the Repatriation Commission, the Repatriation Commission may, in writing, subdelegate the power or function to any person to whom, under section 360DB of the *Military Rehabilitation and Compensation Act 2004*, it may delegate powers under that Act.

Delegation to holders of specified non-SES offices or positions

(3) Before subdelegating a function or power under subsection (2) to an APS employee holding, occupying, or performing the duties of a specified office or position that is not an SES office or position, the Repatriation Commission must have regard to whether the office or position is sufficiently senior for the employee to perform the function or exercise the power.

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Delegation to persons who are not APS employees

(4) Before subdelegating a function or power under subsection (2) to a person who is not an APS employee, the Repatriation Commission must have regard to whether the person has appropriate qualifications or expertise to perform the function or exercise the power.

573 Delegation to Social Services Secretary

(1) The System Governor may, in writing, delegate to the Secretary of the Department administered by the Minister who administers the *Data-matching Program (Assistance and Tax) Act 1990*:

(aaa) the System Governor's powers and functions under Subdivision A of Division 2 of Part 4 of Chapter 3 (obligations relating to reporting, notifications and information); or

(aa) the System Governor's powers and functions under Division 1 of Part 5 of Chapter 4 (means testing in a home or community setting); or

(a) the System Governor's powers and functions under Subdivision B of Division 2 of Part 5 of Chapter 4 (individual's total assessable income); or

(b) the System Governor's powers and functions under Division 7 of Part 2 of Chapter 4 (grants); or

(c) the System Governor's powers and functions under Part 2 of this Chapter relating to reconsidering decisions under the following:

(ia) Division 1 of Part 5 of Chapter 4;

(i) Subdivision B of Division 2 of Part 5 of Chapter 4;

(ii) Division 7 of Part 2 of Chapter 4.

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Subdelegation

(2) If, under subsection (1), the System Governor delegates a power or function to the Secretary of the Department administered by the Minister who administers the *Data-matching Program (Assistance*

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and Tax) Act 1990, the Secretary of that Department may, in writing, subdelegate the power or function to an APS employee in that Department.

Subdelegation to holders of specified non-SES offices or positions

(3) Before subdelegating a function or power under subsection (2) to an APS employee holding, occupying, or performing the duties of a specified office or position that is not an SES office or position, the Secretary must have regard to whether the office or position is sufficiently senior for the employee to perform the function or exercise the power.

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Division 2—Delegation by Commissioner

574 Delegation by Commissioner to staff or consultants

Delegation to staff of the Commission

(1) The Commissioner may, in writing, delegate all or any of the Commissioner's functions or powers under this Act, other than Parts 2 to 9 of Chapter 6 (regulatory mechanisms), to a member of the staff of the Commission.

Note: Sections 34AA to 34A of the *Acts Interpretation Act 1901* contain provisions relating to delegations.

Delegation to holders of specified non-SES offices or positions

(2) Before delegating a function or power under subsection (1) to an APS employee holding, occupying, or performing the duties of a specified office or position that is not an SES office or position, the Commissioner must have regard to whether the office or position is sufficiently senior for the employee to perform the function or exercise the power.

Delegation to consultants

(3) The Commissioner may, in writing, delegate all or any of the Commissioner's functions or powers under this Act, other than:
(a) Parts 2 to 9 of Chapter 6 (regulatory mechanisms); or
(b) a provision referred to in section 556 (reviewable decisions of the Commissioner);
to a consultant engaged under section 371.

(4) Before delegating a function or power under subsection (3) to a person, the Commissioner must have regard to whether the person has appropriate qualifications or expertise to perform the function or exercise the power.

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575 Delegation by Commissioner to Complaints Commissioner

(1) The Commissioner may, in writing, delegate all or any of the Commissioner's functions or powers under this Act, other than Parts 2 to 9 of Chapter 6 (regulatory mechanisms), to the Complaints Commissioner.

Subdelegation to staff of the Commission

(2) If, under subsection (1), the Commissioner delegates a power or function to the Complaints Commissioner, the Complaints Commissioner may, in writing, subdelegate the power or function to a member of the staff of the Commission.

Subdelegation to holders of specified non-SES offices or positions

(3) Before subdelegating a function or power under subsection (2) to an APS employee holding, occupying, or performing the duties of a specified office or position that is not an SES office or position, the Complaints Commissioner must have regard to whether the office or position is sufficiently senior for the employee to perform the function or exercise the power.

Subdelegation to consultants

(4) If, under subsection (1), the Commissioner delegates a power or function to the Complaints Commissioner, the Complaints Commissioner may, in writing, subdelegate the power or function to a consultant engaged under section 371.

(5) Before subdelegating a function or power under subsection (4) to a person, the Complaints Commissioner must have regard to whether the person has appropriate qualifications or expertise to perform the function or exercise the power.

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Division 3—Delegation by Complaints Commissioner

576 Delegation by Complaints Commissioner

Delegation to staff of the Commission

(1) The Complaints Commissioner may, in writing, delegate all or any of the Complaints Commissioner's functions or powers under this Act, other than Parts 2 to 9 of Chapter 6 (regulatory mechanisms), to a member of the staff of the Commission.

Note: Sections 34AA to 34A of the *Acts Interpretation Act 1901* contain provisions relating to delegations.

Delegation to holders of specified non-SES offices or positions

(2) Before delegating a function or power under subsection (1) to an APS employee holding, occupying, or performing the duties of a specified office or position that is not an SES office or position, the Complaints Commissioner must have regard to whether the office or position is sufficiently senior for the employee to perform the function or exercise the power.

Delegation to consultants

(3) The Complaints Commissioner may, in writing, delegate all or any of the Complaints Commissioner's functions or powers under this Act, other than Parts 2 to 9 of Chapter 6 (regulatory mechanisms), to a consultant engaged under section 371.

(4) Before delegating a function or power under subsection (3) to a person, the Complaints Commissioner must have regard to whether the person has appropriate qualifications or expertise to perform the function or exercise the power.

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Division 4—General

577 Delegations in relation to specified kinds of matters

Without limiting this Part or subsection 33(3A) of the *Acts Interpretation Act 1901*, a power or function may be delegated or subdelegated generally or only in relation to specified kinds of matters.

578 Subdelegation

Sections 34AA, 34AB and 34A of the *Acts Interpretation Act 1901* apply in relation to a subdelegation in the same way to the way in which they apply to a delegation.

579 Complying with directions

In exercising powers or performing functions delegated or subdelegated by a person under this Part, the delegate or subdelegate must comply with any directions of the person.

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Part 4—Application of this Act to certain entities

580 Partnerships

(1) This Act applies to a partnership as if it were a person, but with the changes set out in this section.

(2) An obligation that would otherwise be imposed on the partnership by this Act is imposed on each partner instead, but may be discharged by any of the partners.

(3) An offence against this Act that would otherwise have been committed by the partnership is taken to have been committed by each partner in the partnership, at the time the offence was committed, who:

(a) did the relevant act or made the relevant omission; or

(b) aided, abetted, counselled or procured the relevant act or omission; or

(c) was in any way knowingly concerned in, or party to, the relevant act or omission (whether directly or indirectly and whether by any act or omission of the partner).

(4) This section applies to a contravention of a civil penalty provision in a corresponding way to the way in which it applies to an offence.

(5) For the purposes of this Act, a change in the composition of a partnership does not affect the continuity of the partnership.

581 Unincorporated associations

(1) This Act applies to an unincorporated association as if it were a person, but with the changes set out in this section.

(2) An obligation that would otherwise be imposed on the association by this Act is imposed on each member of the association's

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governing body instead, but may be discharged by any of the members.

(3) An offence against this Act that would otherwise have been committed by the unincorporated association is taken to have been committed by each member of the governing body of the association at the time the offence was committed, who:

(a) did the relevant act or made the relevant omission; or

(b) aided, abetted, counselled or procured the relevant act or omission; or

(c) was in any way knowingly concerned in, or party to, the relevant act or omission (whether directly or indirectly and whether by any act or omission of the member).

(4) This section applies to a contravention of a civil penalty provision in a corresponding way to the way in which it applies to an offence.

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Part 5—Automation of administrative action

582 Automation of administrative action

(1) The System Governor may, in writing, arrange for the use, under the System Governor's oversight, of computer programs to take administrative action that must be taken by the System Governor under this Act.

(2) ***Administrative action*** is any of the following:

(a) making, or refusing or failing to make, a decision under a provision mentioned in subsection (2A);

(b) exercising, or refusing or failing to exercise, a power under a provision mentioned in subsection (2A);

(c) performing, or refusing or failing to perform, a function or duty under a provision mentioned in subsection (2A);

(d) doing, or refusing or failing to do, anything (including giving a notice) related to making a decision, exercising a power or performing a function or duty under a provision mentioned in subsection (2A).

(2A) For the purposes of subsection (2), the provisions are the following provisions of this Act:

(a) subsection 78(1) (which deals with classification levels);

(b) subsection 86(1) (which deals with priority category decisions);

(c) subsection 92(1) (which deals with allocation of places to individuals);

(d) subsection 93(1) (which deals with deciding the order of allocation of places to individuals);

(e) Parts 2 to 5 of Chapter 4 (which deal with funding of aged care services);

(f) section 541 (which deals with star ratings);

(g) a provision of this Act prescribed by the rules.

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System Governor is treated as having taken administrative action

(3) Administrative action taken by the operation of a computer program under an arrangement under subsection (1) is treated, for all purposes, as administrative action taken by the System Governor.

Substituted actions

(4) The System Governor may take administrative action (the ***substituted action***) in substitution for administrative action the System Governor is treated as having taken under subsection (3) if the System Governor is satisfied that the administrative action taken by the operation of the computer program is not correct.

(5) The substituted action takes effect on:

(a) if the System Governor specifies the day on which the substituted action takes effect (which may be earlier than the day the substituted action is taken)—that specified day; or

(b) otherwise—the day of the administrative action taken by the operation of the computer program.

(5A) The day specified under paragraph (5)(a) may be earlier than the day the substituted action is taken, but not earlier than the day of the administrative action taken by the operation of the computer program.

System Governor may still take administrative action

(5B) An arrangement under subsection (1) does not prevent the System Governor from taking administrative action under the provisions referred to in subsection (2A).

Substituted action does not limit right to review or reconsideration of administrative action

(6) Subsection (4) does not limit any other provision of this Act that provides for the review or reconsideration of an administrative action.

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Arrangement not a legislative instrument

(7) An arrangement under subsection (1) is not a legislative instrument.

583 Oversight and safeguards for automation of administrative action

System Governor to ensure administrative action is action that could be validly taken

(1) The System Governor must take all reasonable steps to ensure that administrative action taken by the operation of a computer program under an arrangement under subsection 582(1) is administrative action that the System Governor could validly take under this Act.

(2) Without limiting subsection (1), the System Governor must do the things (if any) prescribed by the rules for the purposes of this subsection.

Note: Administrative action may still be invalid even if subsections (1) and (2) are complied with.

(3) A failure to comply with subsection (1) or (2) does not affect the validity of the administrative action taken by the operation of a computer program under an arrangement under subsection 582(1).

Notice to entities of substituted decisions

(4) If, under subsection 582(4), the System Governor makes a decision in substitution for a decision the System Governor is treated as having taken under subsection 582(3), the System Governor must, within 14 days of the making of the substituted decision, give the entity that is the subject of the substituted decision written notice of the substituted decision.

(5) The notice must include how the entity may apply for reconsideration of the substituted decision.

(5A) A failure to comply with subsection (4) or (5) does not affect the validity of the substituted decision.

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Publication

(6) If the System Governor makes an arrangement under subsection 582(1) in relation to particular provisions of this Act, the System Governor must cause a statement to be published on the Department's website:

(a) to the effect that the System Governor has made such an arrangement; and

(b) setting out those particular provisions.

Details in annual report

(7) The System Governor, when preparing the Department's annual report under section 46 of the *Public Governance, Performance and Accountability Act 2013* for a period, must include the following information in that report:

(a) the total number of substituted actions taken by the System Governor under subsection 582(4) of this Act in that period;

(b) the kinds of substituted actions so taken;

(c) the kinds of administrative action taken by the operation of the computer program that the System Governor was satisfied were not correct.

(8) The System Governor may also include in the report any other information (other than personal information within the meaning of the *Privacy Act 1988*) about the operation of section 582 and this section in that period that the System Governor considers appropriate.

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Part 6—Applications, requests and notifications etc.

584 Approved forms for documents—System Governor functions

When a document is in the approved form

(1) A document (such as an application, claim, election, request or notice) under this Act that relates to a function of the System Governor is in the ***approved form*** if:

(a) it is in a form approved by the System Governor for that kind of document; and

(b) it contains the information that the form requires, and any further information, statement or document as the System Governor requires, whether in the form or otherwise; and

(c) for a kind of document that is required to be given to the System Governor—it is given in the manner that the System Governor requires (which may include electronically).

Approval of forms

(2) The System Governor may, in writing, approve a form for a kind of document under this Act that relates to a function of the System Governor.

(3) The System Governor may combine in the same approved form more than one kind of document.

(4) The System Governor may approve:

(a) more than one approved form for a kind of document; or

(b) a different approved form for a kind of document for different circumstances.

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Publication of approved forms and requirements

(5) If the System Governor approves a form for a kind of document, the System Governor must publish the form, and any requirements mentioned in paragraphs (1)(b) and (c) relating to the kind of document that are not included in the form, on the Department's website.

585 Approved forms—Commissioner functions

When a document is in the approved form

(1) A document (such as an application, election, request or notice) under this Act that relates to a function of the Commissioner is in the ***approved form*** if:

(a) it is in a form approved by the Commissioner for that kind of document; and

(b) it contains the information that the form requires, and any further information, statement or document as the Commissioner requires, whether in the form or otherwise; and

(c) for a kind of document that is required to be given to the Commissioner—it is given in the manner that the Commissioner requires (which may include electronically).

Approval of forms

(2) The Commissioner may, in writing, approve a form for a kind of document under this Act that relates to a function of the Commissioner.

(3) The Commissioner may combine in the same approved form more than one kind of document.

(4) The Commissioner may approve:

(a) more than one approved form for a kind of document; or

(b) a different approved form for a kind of document for different circumstances.

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Section 586

586 Approved forms—Complaints Commissioner functions

When a document is in the approved form

(1) A document (such as an application, election, request or notice) under this Act that relates to a function of the Complaints Commissioner is in the ***approved form*** if:

(a) it is in a form approved by the Complaints Commissioner for that kind of document; and

(b) it contains the information that the form requires, and any further information, statement or document as the Complaints Commissioner requires, whether in the form or otherwise; and

(c) for a kind of document that is required to be given to the Complaints Commissioner—it is given in the manner that the Complaints Commissioner requires (which may include electronically).

Approval of forms

(2) The Complaints Commissioner may, in writing, approve a form for a kind of document under this Act that relates to a function of the Complaints Commissioner.

(3) The Complaints Commissioner may combine in the same approved form more than one kind of document.

(4) The Complaints Commissioner may approve:

(a) more than one approved form for a kind of document; or

(b) a different approved form for a kind of document for different circumstances.

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587 When oral communications taken to be in the approved form

(1) This section applies if a person makes an oral communication under this Act (such as an application, election, request or notice) of a kind for which there is an approved form for a document.

(2) The person receiving the communication must:

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(a) make a written record of the details of the communication; and

(b) note on the record the day on which the communication is made.

(3) This Part has effect as if the written record was a document in the approved form given on the day the communication was made.

588 Requests for further information or documents by System Governor, Commissioner or Complaints Commissioner for decisions on applications, claims and requests

Notice requesting further information or documents

(1) If the System Governor, Commissioner or Complaints Commissioner (the ***decision-maker***) needs further information or a document to make a decision on an application, claim or request made by an entity under this Act, the decision-maker may, by written notice, request the entity to give the further information or document to the decision-maker within a reasonable period specified in the notice.

Period for providing further information or documents

(2) The specified period must not be shorter than:

(a) if paragraph (b) does not apply—28 days after the notice is given; or

(b) if circumstances prescribed by the rules apply in relation to the application or request—7 days after the notice is given.

(3) The decision-maker may, at the request of the entity, extend the specified period.

Consequence if further information or documents not provided in time

(4) If the entity does not give the requested further information or document within:

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(a) if the specified period has been extended under subsection (3)—the period as so extended; or

(b) otherwise—the specified period;

the application, claim or request is taken to be withdrawn at the end of the period.

Decision-making period extended if further information or documents provided in time

(5) If:

(a) this Act requires a decision to be made on the application, claim or request within a particular period (the ***decision-making period***); and

(b) the entity gives the requested further information or document within the period mentioned in subsection (4);

the decision-making period does not include a day in the period:

(c) starting on the day the notice is given under subsection (1); and

(d) ending at the end of the day the entity gives the requested further information or document.

Requirement for notice

(6) A notice given under subsection (1) must set out the effect of subsections (4) and (5).

589 When System Governor, Commissioner or Complaints Commissioner not required to make a decision or do a thing

Application, claim or request not in approved form

(1) If this Act requires an application, claim or request made to the System Governor, Commissioner or Complaints Commissioner (the ***decision-maker***) to be in the approved form, the decision-maker is not required to make a decision on the application, claim or request if it is not in that form.

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Requested information or documents not provided

(2) If this Act permits the System Governor, Commissioner or Complaints Commissioner (the ***decision-maker***) to request or require information or documents for the purposes of, or for purposes relating to, making a decision or doing a thing, the decision-maker is not required to make the decision or do the thing until the information or documents are provided.

Application fee not paid

(3) If this Act requires a fee to be paid in relation to an application or request made by an entity to the System Governor, Commissioner or Complaints Commissioner (the ***decision-maker***), the decision-maker is not required to make a decision on the application or request if:

(a) the fee has not been paid; and

(b) the entity is not exempt from paying the fee; and

(c) the decision-maker has not waived the fee.

590 Withdrawal of applications, claims and requests

An entity who has made an application, claim or request to the System Governor, Commissioner or Complaints Commissioner (the ***decision-maker***) under this Act may withdraw the application, claim or request at any time before the decision-maker makes a decision on the application, claim or request.

591 False or misleading information or documents in applications, claims and requests

An entity contravenes this section if the entity:

(a) provides information or a document in, or in connection with, an application, claim or request made under this Act; and

(b) the entity knows the information or document is false or misleading in a material particular.

Note: Part 7.4 of the *Criminal Code* provides offences in relation to false or misleading statements, information and documents.

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Civil penalty: 60 penalty units.

592 Method of notification by System Governor, Commissioner or Complaints Commissioner

If this Act requires or permits the System Governor, Commissioner or Complaints Commissioner (the ***notifier***) to notify an entity, the notifier may notify the entity:

(a) by sending the notice by prepaid post addressed to the entity at the entity's postal address last known to the notifier; or

(b) if the entity is an individual—by giving the notice to the entity personally; or

(c) in any other way the notifier considers appropriate (including electronically).

Note: See also section 28A of the *Acts Interpretation Act 1901* in relation to the service of documents and the *Electronic Transactions Act 1999* in relation to giving information in writing by means of an electronic communication.

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Part 7—Application fees and fees for services provided by the System Governor, Commissioner and Complaints Commissioner

593 Fees for services provided by the System Governor

(1) The System Governor may, on behalf of the Commonwealth, charge fees prescribed by the rules for services prescribed by the rules that are provided by the System Governor in performing the System Governor's functions.

(2) However, the System Governor must not charge an individual accessing, or seeking to access, funded aged care services, a supporter of the individual or another person supporting the individual, a fee for a service provided by the System Governor in performing the System Governor's functions.

(3) A fee charged under subsection (1):
  (a) is a debt due to the System Governor, on behalf of the Commonwealth; and
  (b) is recoverable by the System Governor, on behalf of the Commonwealth, in a court of competent jurisdiction.

594 Fees for services provided by the Commissioner

(1) The Commissioner may, on behalf of the Commonwealth, charge fees prescribed by the rules for services prescribed by the rules that are provided by the Commissioner in performing the Commissioner's functions.

(2) However, the Commissioner must not charge an individual accessing, or seeking to access, funded aged care services, a supporter of the individual or another person supporting the

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individual, a fee for a service provided by the Commissioner in performing the engagement and education functions.

(3) A fee charged under subsection (1):
  (a) is a debt due to the Commissioner, on behalf of the Commonwealth; and
  (b) is recoverable by the Commissioner, on behalf of the Commonwealth, in a court of competent jurisdiction.

595 Fees for services provided by the Complaints Commissioner

(1) The Complaints Commissioner may, on behalf of the Commonwealth, charge fees prescribed by the rules for services prescribed by the rules that are provided by the Complaints Commissioner in performing the Complaints Commissioner's functions.

(2) However, the Complaints Commissioner must not charge a complainant fees for services provided by the Complaints Commissioner in performing the complaints functions.

(3) A fee charged under subsection (1):
  (a) is a debt due to the Complaints Commissioner, on behalf of the Commonwealth; and
  (b) is recoverable by the Complaints Commissioner, on behalf of the Commonwealth, in a court of competent jurisdiction.

596 Fees must not amount to taxation

(1) This section applies to:
  (a) a fee that, under this Act, must accompany an application or request made to the System Governor, Commissioner or Complaints Commissioner; and
  (b) a fee that may be charged under sections 593 to 595.

(2) The fee must not be such as to amount to taxation.

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597 Fees—exemptions, waivers and refunds

The rules may make provision in relation to the following:

(a) for a fee mentioned in section 593, or an application fee for an application made to the System Governor—the circumstances in which the System Governor may waive the fee;

(b) for a fee mentioned in section 594, or an application fee for an application made to the Commissioner—the circumstances in which the Commissioner may waive the fee;

(c) for a fee mentioned in section 595, or an application fee for an application made to the Complaints Commissioner—the circumstances in which the Complaints Commissioner may waive the fee;

(d) for a fee that, under this Act, must accompany an application or request made to the System Governor, Commissioner or Complaints Commissioner:

(i) the circumstances in which an entity is exempt from paying the fee; and

(ii) the circumstances in which the fee may be refunded, in whole or in part.

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Part 8—Appropriation

598 Appropriation

(1) Subject to subsection (2), amounts payable by the Commonwealth under Divisions 1 to 6 of Part 2 of Chapter 4 are to be paid out of the Consolidated Revenue Fund, which is appropriated accordingly.

(2) Subsection (1) does not apply to an amount to the extent that:

(a) the Repatriation Commission has accepted financial responsibility for the amount as mentioned in subsection 84(3A) of the *Veterans' Entitlements Act 1986*; or

(b) the Repatriation Commission has accepted financial responsibility for the amount as mentioned in subsection 287(2A) of the *Military Rehabilitation and Compensation Act 2004*; or

(c) the Repatriation Commission has accepted financial responsibility for the amount as mentioned in section 13A of the *Australian Participants in British Nuclear Tests and British Commonwealth Occupation Force (Treatment) Act 2006*; or

(d) the Repatriation Commission has accepted financial responsibility for the amount as mentioned in section 15 of the *Treatment Benefits (Special Access) Act 2019*.

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Part 9—Reports on and review of this Act

599 Annual report on the operation of the Act

(1) The System Governor must give the Minister, for presentation to each House of the Parliament, a report on the performance of the System Governor's functions during each financial year.

(2) Without limiting subsection (1), the report must include information about the following matters:

(a) the extent of unmet demand for funded aged care services;

(aa) the extent of funded aged care services accessed by individuals from different locations and with different backgrounds and life experience;

(b) the duration of waiting periods for funded aged care services;

(c) the number of registered providers entering and exiting the market for the delivery of funded aged care services;

(d) the financial viability of registered providers in that market;

(e) usage of the bond guarantee scheme;

(f) the amounts of contributions paid;

(g) the amounts of those contributions paid as refundable deposits;

(h) the extent of building, upgrading and refurbishment of residential care homes.

Note: For reporting and planning by the Commissioner, see Division 5 of Part 3 of Chapter 5.

600 Review of operation of refundable deposits under this Act

(1) The Minister must cause an independent review of the use of refundable deposits under this Act to commence no later than 31 January 2029.

(2) The persons who conduct the review must give the Minister a written report of the review.

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(3) The Minister must cause a copy of the report to be tabled in each House of the Parliament no later than 31 March 2030.

600A Review of accommodation pricing

(1) The Minister must cause an independent review of accommodation pricing under this Act to be conducted.

(2) The persons who conduct the review must give the Minister a written report of the review.

(3) The Minister must cause a copy of the report to be tabled in each House of the Parliament no later than 1 July 2026.

601 Review of operation of this Act

(1) The Minister must cause an independent review of the operation of this Act to be conducted within 6 months after the third anniversary of the commencement of this Act.

(1A) Without limiting the matters to be covered by the review, the review must:

(a) have regard to the objects of the Act; and

(b) consider the following matters:

(i) the operation of the Statement of Rights and the Statement of Principles;

(ii) the effectiveness of the Act in delivering the objects, including enabling individuals to exercise choice and control;

(iii) the effectiveness of the Act in embedding the role of supporters in the aged care system;

(iv) the extent of unmet demand for funded aged care services in a home or community setting;

(v) the duration of waiting periods from application to service commencement for funded aged care services in a home or community setting;

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(va) the expansion of regular reporting on the duration of waiting periods for funded aged care services to cover specialist aged care programs;

(vi) the effectiveness of the governance (under Chapter 5) and regulatory mechanisms (under Chapter 6) of the aged care system in overseeing and ensuring the quality of funded aged care services;

(vii) the effectiveness of the Act in ensuring equitable access to funded aged care services for individuals, regardless of their location, background and life experience;

(viii) the effect of Part 3 of Chapter 4 (about individual fees and contributions) on the sustainability of the aged care system, service usage and outcomes for individuals accessing funded aged care services;

(ix) the use of refundable accommodation deposits and daily accommodation payments;

(x) the proportion of aged care accommodation payments being charged at the maximum accommodation payment amounts;

(xi) the proportion of registered providers who charge an accommodation payment approved under section 290 (that is, an approved accommodation payment that is higher than the maximum accommodation payment amount);

(xii) the quality and timeliness of data published about the performance of the aged care system.

(2) The persons who conduct the review must give the Minister a written report of the review.

(3) The Minister must cause a copy of the report to be tabled in each House of the Parliament within 15 sitting days of that House after the report is given to the Minister.

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Part 10—Rules

602 Rules

(1) The Minister may, by legislative instrument, make rules prescribing matters:

(a) required or permitted by this Act to be prescribed by the rules; or

(b) necessary or convenient to be prescribed for carrying out or giving effect to this Act.

(2) To avoid doubt, the rules may not do the following:

(a) create an offence or civil penalty;

(b) provide powers of:

(i) arrest or detention; or

(ii) entry, search or seizure;

(c) impose a tax;

(d) set an amount to be appropriated from the Consolidated Revenue Fund under an appropriation in this Act;

(e) directly amend the text of this Act.

(3) Without limiting subsection (1), the rules may:

(a) make different provision in relation to different classes of registered providers, including by providing for certain matters to apply only to registered providers of a certain class; and

(b) provide for the making of applications, requests and decisions in relation to matters dealt with by the rules and require the payment of fees prescribed by the rules for making such requests and applications.

(4) Subsection (3) of this section does not limit subsection 33(3A) of the *Acts Interpretation Act 1901*.

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(5) Despite subsection 14(2) of the *Legislation Act 2003*, the rules may make provision in relation to a matter by applying, adopting or incorporating, with or without modification, any matter contained in any other instrument or other writing as in force or existing from time to time.

Prerequisites for rules prescribing aged care worker screening laws

(6) Before the Minister makes rules prescribing a law of a State or Territory for the purposes of the definition of ***aged care worker screening law*** in section 7, the Minister must be satisfied that:

(a) the law establishes a scheme for the screening of workers for purposes including the purposes of this Act; and

(b) the State or Territory agrees to the law being prescribed.

Amounts and methods for working out amounts

(7) The rules may prescribe an amount by:

(a) specifying the amount; or

(b) specifying a method for working out the amount; or

(ba) specifying that the amount or period may be set by a determination made by the System Governor in accordance with the rules; or

(c) specifying a nil amount.

Rules about transitional cohorts

(7A) Without limiting subsections (1) and (7), the rules may make different provision for an amount (including in any of the ways provided for in subsection (7)) for different classes of individuals, including classes of individuals (***transitional cohorts***) identified by reference to the individual being approved as a recipient of a kind of care under any of the following as in force or existing immediately before the commencement of this section:

(a) the *Aged Care Act 1997*;

(b) the *Aged Care (Transitional Provisions) Act 1997*;

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(c) the program manual for the Commonwealth Home Support Program or the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

(7B) Without limiting subsection (1), the rules may prescribe the following:

(a) arrangements for individuals in a transitional cohort to elect to cease to be included in the cohort;

(b) circumstances in which an individual will cease to be included in a transitional cohort.

Rules about former registered providers

(8) Without limiting subsection (1), the rules may provide that a provision of this Act continues to apply in relation to an entity that has ceased to be a registered provider in circumstances prescribed by the rules.

Constitutional limits for rules made for the purposes of subsidy calculations

(9) Rules made for the purposes of a provision of Division 1, 2 or 3 of Part 2 of Chapter 4 that affect the amount of subsidy payable under that Division must:

(a) be with respect to implementing Australia's international obligations under Articles 4, 19, 20, 25 and 26 of the Convention on the Rights of Persons with Disabilities; or

(b) be with respect to implementing Australia's international obligations under Articles 2 and 12(2) of the International Covenant on Economic, Social and Cultural Rights; or

(c) be with respect to the provision of be a right or benefit conferred upon Aboriginal or Torres Strait Islander persons.

(10) Rules made for the purposes of a provision of Division 4 or Division 4A of Part 2 of Chapter 4 that affect the amount of subsidy payable under that Division must:

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(a) be with respect to the provision of sickness and hospital benefits within the meaning of paragraph 51(xxiiiA) of the Constitution; or

(b) be with respect to implementing Australia's international obligations under Articles 2 and 12(2) of the International Covenant on Economic, Social and Cultural Rights; or

(c) be with respect to the provision of a right or benefit conferred upon Aboriginal or Torres Strait Islander persons.

(11) Rules made for the purposes of a provision of Division 5 of Part 2 of Chapter 4 that affect the amount of subsidy payable under that Division must:

(a) be with respect to implementing Australia's international obligations under Articles 4, 19, 20, 25 and 26 of the Convention on the Rights of Persons with Disabilities; or

(b) be with respect to implementing Australia's international obligations under Articles 2 and 12(2) of the International Covenant on Economic, Social and Cultural Rights; or

(c) be with respect to the provision of a right or benefit conferred upon Aboriginal or Torres Strait Islander persons.

Review by Senate Committee

(12) The Senate Community Affairs Legislation Committee, or such other committee constituted under a resolution of the Senate, must:

(a) begin a review of any rules made for the purposes of a provision specified in subsection (13) within 3 months after the day the rules are tabled in the Senate; and

(b) report the Committee's findings to the Senate as soon as practicable after completing each review.

(13) The following provisions are specified:

(a) section 14 (Aged Care Code of Conduct);

(b) section 15 (Aged Care Quality Standards);

(c) section 16 (meaning of *reportable incident*);

(d) section 17 (restrictive practice in relation to an individual);

(e) section 141 (Provider Register);

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(f) section 154 (personal information and record keeping);
(g) section 162 (restrictive practices);
(h) section 163 (immunity from civil or criminal liability in relation to the use of a restrictive practice in certain circumstances);
(i) Chapter 4 (funding of aged care services);
(j) section 379 (aged care worker screening database);
(k) section 507 (register of banning orders).

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Endnotes

Endnote 1—About the endnotes

The endnotes provide information about this compilation and the compiled law.

The following endnotes are included in every compilation:

Endnote 1—About the endnotes
Endnote 2—Abbreviation key
Endnote 3—Legislation history
Endnote 4—Amendment history

Abbreviation key—Endnote 2
The abbreviation key sets out abbreviations that may be used in the endnotes.

Legislation history and amendment history—Endnotes 3 and 4
Amending laws are annotated in the legislation history and amendment history.

The legislation history in endnote 3 provides information about each law that has amended (or will amend) the compiled law. The information includes commencement details for amending laws and details of any application, saving or transitional provisions that are not included in this compilation.

The amendment history in endnote 4 provides information about amendments at the provision (generally section or equivalent) level. It also includes information about any provision of the compiled law that has been repealed in accordance with a provision of the law.

Editorial changes
The *Legislation Act 2003* authorises First Parliamentary Counsel to make editorial and presentational changes to a compiled law in preparing a compilation of the law for registration. The changes must not change the effect of the law. Editorial changes take effect from the compilation registration date.

If the compilation includes editorial changes, the endnotes include a brief outline of the changes in general terms. Full details of any changes can be obtained from the Office of Parliamentary Counsel.

Misdescribed amendments
A misdescribed amendment is an amendment that does not accurately describe how an amendment is to be made. If, despite the misdescription, the amendment

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Endnote 1—About the endnotes

can be given effect as intended, then the misdescribed amendment can be incorporated through an editorial change made under section 15V of the *Legislation Act 2003*.

If a misdescribed amendment cannot be given effect as intended, the amendment is not incorporated and "(md not incorp)" is added to the amendment history.

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Endnote 2—Abbreviation key

ad = added or inserted

am = amended

amdt = amendment

C[x] = Compilation No. x

ch = Chapter(s)

cl = clause(s)

cont. = continued

def = definition(s)

Dict = Dictionary

disallowed = disallowed by Parliament

div = Division(s)

ed = editorial change

exp = expires/expired or ceases/ceased to have effect

gaz = gazette

LA = *Legislation Act 2003*

LIA = *Legislative Instruments Act 2003*

(md) = misdescribed amendment can be given effect

(md not incorp) = misdescribed amendment cannot be given effect

mod = modified/modification

No. = Number(s)

Ord = Ordinance

orig = original

p = page(s)

para = paragraph(s)/subparagraph(s)/sub-subparagraph(s)

pres = present

prev = previous

(prev…) = previously

pt = Part(s)

r = regulation(s)/Court rule(s)

reloc = relocated

renum = renumbered

rep = repealed

rs = repealed and substituted

s = section(s)/subsection(s)/rule(s)/subrule(s)/order(s)/suborder(s)

sch = Schedule(s)

SLI = Select Legislative Instrument

SR = Statutory Rules

sub ch = Sub-Chapter(s)

sub div = Subdivision(s)

sub pt = Subpart(s)

underlining = whole or part not commenced or to be commenced

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Endnote 3—Legislation history

Act (Register ID)	Number and year	Assent	Commencement	Application, saving and transitional provisions
Aged Care Act 2024 (C2024A00104)	104, 2024	2 Dec 2024	1 Nov 2025 (s 2(1) item 1)	
Aged Care and Other Legislation Amendment Act 2025 (C2025A00045)	45, 2025	19 Sept 2025	sch 1 (items 1-300): 1 Nov 2025 (s 2(1) item 2) sch 1 (items 301-304): 1 July 2026 (s 2(1) item 3)	—

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Endnote 4—Amendment history

Provision affected	How affected
Chapter 1	
Part 2	
Division 1	
s 7	am No 45, 2025
	ed C1; C2
Division 2	
s 8	am No 45, 2025
s 9	am No 45, 2025
s 11	am No 45, 2025
s 11A	ad No 45, 2025
s 15	am No 45, 2025
Part 4	
Division 1	
s 27	am No 45, 2025
s 28	am No 45, 2025
s 29	am No 45, 2025
s 30	am No 45, 2025
Division 5	
s 54	am No 45, 2025
Chapter 2	
Part 2	
Division 1	
s 58	am No 45, 2025
Part 3	
Division 1	
s 75	am No 45, 2025
s 81	am No 45, 2025

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Endnote 4—Amendment history

Provision affected	How affected
Division 2	
s 82	am No 45, 2025
Part 4	
s 84	am No 45, 2025
s 85	am No 45, 2025
s 86	am No 45, 2025
s 87	am No 45, 2025
s 89	am No 45, 2025
Part 5	
Division 1	
s 91	am No 45, 2025
s 92	am No 45, 2025
s 92A	ad No 45, 2025
s 93	rs No 45, 2025
Chapter 3	
Part 2	
Division 2	
Subdivision A	
s 111	am No 45, 2025
s 112	am No 45, 2025
Part 4	
Division 1	
Subdivision C	
s 146	am No 45, 2025
Subdivision D	
s 150A	ad No 45, 2025
Subdivision E	
s 152	am No 45, 2025
Division 2	
Subdivision A	
s 165A	ad No 45, 2025

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Endnote 4—Amendment history

Provision affected	How affected
s 166	rs No 45, 2025
s 166A	ad No 45, 2025
Subdivision C	
s 175	am No 45, 2025
Subdivision D	
s 178A	ad No 45, 2025
Part 6	
s 189	am No 45, 2025
Chapter 4	
Part 1	
s 190	am No 45, 2025
Part 2	
Division 1	
Subdivision A	
s 191	am No 45, 2025
s 192	am No 45, 2025
s 193	rs No 45, 2025
s 195	am No 45, 2025
s 197	am No 45, 2025
Subdivision C	
s 201	rs No 45, 2025
s 202	am No 45, 2025
s 203	rs No 45, 2025
s 204	am No 45, 2025
Division 2	
Subdivision A	
s 209	am No 45, 2025
s 210	am No 45, 2025
s 211	am No 45, 2025
s 214	am No 45, 2025

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Endnote 4—Amendment history

Provision affected	How affected
Division 3	
Subdivision A	
s 218	am No 45, 2025
s 219	am No 45, 2025
s 220	am No 45, 2025
s 223	am No 45, 2025
Subdivision B	
s 224	am No 45, 2025
Division 3A	
s 226A	am No 45, 2025
s 226B	am No 45, 2025
s 226C	am No 45, 2025
s 226D	am No 45, 2025
s 226E	am No 45, 2025
Division 4	
Division 4 heading	rs No 45, 2025
Subdivision AA	
Subdivision AA	ad No 45, 2025
s 227A	ad No 45, 2025
Subdivision A	
s 227	am No 45, 2025
s 230	am No 45, 2025
s 231	am No 45, 2025
Subdivision B	
s 234	am No 45, 2025
s 235	am No 45, 2025
Subdivision C	
s 239	am No 45, 2025
Subdivision D	
s 242	am No 45, 2025

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Endnote 4—Amendment history

Provision affected	How affected
Division 4A	
Division 4A	ad No 45, 2025
s 242A	ad No 45, 2025
s 242B	ad No 45, 2025
Division 4B	
Division 4B	ad No 45, 2025
Subdivision E heading	rep No 45, 2025
s 243	am No 45, 2025
s 243A	ad No 45, 2025
Subdivision F heading	rep No 45, 2025
s 244	am No 45, 2025
Division 5	
s 247	am No 45, 2025
s 249	am No 45, 2025
Division 6	
Subdivision A	
s 250	rs No 45, 2025
s 251	rs No 45, 2025 ed C1
s 251A	ad No 45, 2025
s 251B	ad No 45, 2025
s 252	am No 45, 2025
s 253	am No 45, 2025
Subdivision B	
s 254	am No 45, 2025
s 256	am No 45, 2025
s 257	am No 45, 2025
s 258	am No 45, 2025
Subdivision D	
s 263A	ad No 45, 2025

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Endnote 4—Amendment history

Provision affected	How affected
Division 7	
s 264	am No 45, 2025
Part 3	
Division 1	
s 273A	am No 45, 2025
Division 2	
s 275A	ad No 45, 2025
s 277	am No 45, 2025
s 278	am No 45, 2025
s 279	am No 45, 2025
s 284	am No 45, 2025
Division 2A	
Division 2A	ad No 45, 2025
s 285A	ad No 45, 2025
Part 4	
Part 4 heading	am No 45, 2025
Division 1	
s 287	am No 45, 2025
Division 2	
s 289	am No 45, 2025
s 290	am No 45, 2025
Division 3	
s 294	am No 45, 2025
Division 4	
s 296	am No 45, 2025
Division 5	
s 298	am No 45, 2025
Division 6	
s 302	am No 45, 2025
Division 7	
s 303	am No 45, 2025

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Endnote 4—Amendment history

Provision affected	How affected
s 304	rs No 45, 2025
s 308	am No 45, 2025
s 310	am No 45, 2025
s 312	am No 45, 2025
Part 5	
Division 1	
s 314A	am No 45, 2025
s 316	am No 45, 2025
s 317	am No 45, 2025
s 318	am No 45, 2025
s 318A	ad No 45, 2025
	ed C2
Division 2	
Subdivision A	
s 320	am No 45, 2025
Subdivision B	
s 322	am No 45, 2025
	ed C2
s 324	am No 45, 2025
s 325	am No 45, 2025
s 327	ed C2
s 328	am No 45, 2025
Subdivision C	
s 329	am No 45, 2025
	ed C2
s 331	am No 45, 2025
s 332	am No 45, 2025
s 334	ed C2
s 335	am No 45, 2025
Subdivision D	
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Endnote 4—Amendment history

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Part 2	
s 338	am No 45, 2025
s 342A	am No 45, 2025
s 343A	ad No 45, 2025
Part 3	
Division 7	
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s 377	am No 45, 2025
Chapter 6	
Part 7	
Division 1	
s 448	am No 45, 2025
Part 12	
s 511	am No 45, 2025
Part 13	
Division 1	
s 514	am No 45, 2025
Division 3	
s 521	am No 45, 2025
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Chapter 7	
Division 2	
Subdivision A	
s 537	am No 45, 2025
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Endnote 4—Amendment history

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s 573	am No 45, 2025
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s 583	am No 45, 2025
Part 8	
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Part 10	
s 602	am No 45, 2025 ed C1

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Endnote 5—Editorial changes

In preparing this compilation for registration, the following kinds of editorial change(s) were made under the *Legislation Act 2003*.

Section 7

Kind of editorial change

Reordering of definitions

Details of editorial change

This compilation was editorially changed to move the definition of ***personal information*** in section 7 to the correct alphabetical position.

Subsections 318A(4), 322(5), 327(5), 329(5) and 334(5)

Kind of editorial change

Correct typographical errors

Details of editorial change

Subsections 318A(4), 322(5), 327(5), 329(5) and 334(5) refer to "System-Governor" rather than "System Governor".

This compilation was editorially changed to omit "System-Governor" and substitute "System Governor" in subsections 318A(4), 322(5), 327(5), 329(5) and 334(5) to correct the typographical errors.

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Australian Government
Department of Health, Disability and Ageing



Aged Care Assessment Manual

Version 8.3

Published 29 June 2026

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FOI 27-3598 - Document 3

IMPORTANT

The *Aged Care Act 2024* governs the delivery of funded aged care services by registered providers. The information in this manual helps assessment teams to understand the laws around the government-funded aged care system and specifies mandatory and best practice guidance for aged care needs assessment teams to deliver high-quality assessment services.

Parts of this manual summarise multiple legal documents in accessible, simple language, so it doesn't contain every detail of the law. It is not intended as legal or professional advice on interpretation of the legislation or how it applies in individual circumstances.

Additional information and resources that may further support you to understand your responsibilities and obligations are available through the following Australian Government resources:

- Department of Health, Disability and Ageing https://www.health.gov.au
- My Aged Care www.myagedcare.gov.au
- Aged Care Quality and Safety Commission www.agedcarequality.gov.au
- Services Australia http://www.servicesaustralia.gov.au

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Document purpose

This Aged Care Assessment Manual specifies mandatory and best practice guidance for aged care needs assessment teams including assessors, team leaders, triage delegates and assessment delegates. To achieve the delivery of high-quality assessment services, assessment organisations are required to follow the guidance in this manual in the assessment of older people's support and aged care needs and eligibility for government funded aged care services under the *Aged Care Act 2024* (Cth).

In addition to the guidance in this manual, assessors are expected to also use the Aged Care Assessment Quality Framework to deliver a high-quality assessment experience and service for every older person. All assessors, delegates and team leaders are also required to complete the mandatory training outlined in the My Aged Care Workforce Learning Strategy v1.5.

The Department of Health, Disability and Ageing will regularly review and update this Manual as required to ensure it remains up to date in the context of system changes and enhancements to the My Aged Care operating model.

Guidance for undertaking residential aged care (RAC) funding assessments is provided in the Australian National Aged Care Classification (AN-ACC) RAC Funding Assessor Training Manual.

Key sources of information to complement this manual include:

- IAT User Guide
- Aged Care Assessment Quality Framework
- *Aged Care Act 2024*
- *Aged Care Rules 2025*
- My Aged Care website
- Fact sheets for Assessors
- My Aged Care Assessor Portal resources
- My Aged Care Workforce Learning Strategy
- Assessment Hub SharePoint Site
- Support at Home Program Manual
- Commonwealth Home Support Program (CHSP) Manual 2025-2027
- Multi-Purpose Service Program (MPSP) Fact Sheets
- National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) Manual
- Aboriginal and Torres Strait Islander Aged Care Framework
- Support at Home Assistive Technology and Home Modifications (AT-HM) scheme Fact Sheet
- Transition Care Program (TCP) Guidelines
- Support at Home Pricing Resources

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Terminology

Throughout this document:

- The terms 'individual,' 'older person', ‘client,’ ‘care recipient’ and 'participant' are used interchangeably to refer to a person who meets the eligibility criteria for an aged care assessment and government funded aged care services under the *Aged Care Act 2024 (the Act)*.
- The term ‘reassessment’ is used throughout this document to describe an assessment that occurs after an older person has already been assessed at least once.
- The terms ‘provider’ or ‘service provider’ are used throughout this document to refer to a ‘registered provider’ as outlined in the *Act*.
- The term ‘assessor’ or ‘needs assessor’ are used interchangeably throughout this document to refer to a person who conducts aged care assessments, for home support and comprehensive assessments.



This symbol displays throughout the document and denotes significant change in information and the assessment process from version 8.2 of the Aged Care Assessment Manual.



This symbol displays where there are links to further information and resources.

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Document Structure

Chapter	What you'll find in this chapter	Key Changes from v8.2 to v8.3
Chapter 1 *Aged Care Act 2024*	Key concepts under the *Aged Care Act 2024* that are important to understand. Eligibility requirements to access aged care services Service list and structure under *Aged Care Rules 2025* Approvals under *Aged Care Act 2024* Transition arrangements	• Updates to information about transition arrangements for RCP recipients (sections 1.5. and 1.5.8).
Chapter 2 Overview of My Aged Care and Single Assessment System	Provides information about My Aged Care and the Single Assessment System including: • Introduction of pilot of Aboriginal and Torres Strait Islander Assessment Organisations from August 2025 • Assessment Organisation roles and responsibilities • Assessment types • The Integrated Assessment Tool (IAT)	• Updates to information in business and system role descriptions for clinical and non-clinical assessors, and non-clinical assessment delegate (section 2.4). • Additional information has been included about training for Aboriginal and Torres Strait Islander Assessment Organisations (section 2.6.1).
Chapter 3 Referral, Registration and Screening	Details the referral, registration and screening stages of the assessment journey. Information includes: • Registered supporters • Entry into My Aged Care • Registering with My Aged Care • Screening • Alternative entry (urgent services pathway)	• Updates to information about CHSP Direct-to-Provider Referrals (section 3.2.1). • Additional information has been included to define an organisation agent (section 3.4.2).

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Chapter	What you'll find in this chapter	Key Changes from v8.2 to v8.3
	• Application for Care form	
Chapter 4 Referral for Assessment	Details the assessment referral process in the My Aged Care assessor portal including: • Managing and actioning referrals and assigning referral priority • Managing preference for Aboriginal and Torres Strait Islander assessments • Explaining how priority categories are assigned to different assessments including Home Support, Comprehensive and Hospital Assessments • Using the End-of-Life Pathway 'high priority' referrals in the system • Explaining how assessors can self-refer for eligible and (likely) ineligible individuals. • SPRs and reassessment requests	• Removal of instructions for delegates regarding use of the 'ineligible at triage' referral rejection reason (section 4.3.4). • Addition of instructions regarding minimum attempts to contact older person/supporters requirement (section 4.3.8).
Chapter 5 Assessment Activities	Includes important information about how to undertake an aged care needs assessment and complete a support plan for an older person. This chapter includes: • Consent for triage and assessment • Triaging Assessments and Triage Delegate role • Triage for SPRs • Revocation of Eligibility • Undertaking a needs assessment using the IAT • Assessment settings	• Clarification of presumption of capacity and obtaining consent (section 5.1). • Updates to Disability Support for Older Australians (DSOA) Program content (sections 5.1 and 5.7.7). • Details of the new system functionality that allows Triage Delegates to determine an older person is not eligible for an assessment without completing the triage process (section 5.3). • Updated guidance for Triage Delegates on completing triage after an SPR (section 5.3.3). • Updated guidance for assessors on discussing with a client their preference for an Aboriginal and Torres Strait Islander assessment organisation (section 5.6.1).

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Chapter	What you'll find in this chapter	Key Changes from v8.2 to v8.3
	• Clinical attendance • IAT Outcome • Recommending service types and services • Converting a home support assessment to comprehensive • Support Plan • Wellness & Reablement • Linking Supports • Assessment wrap-up	• New reminder for assessors to add a client's goals to the support plan before finalising the IAT (section 5.7). • Updates to multiple areas in section 5.7.7. This includes updates to the classification algorithm text, revisions to the DSOA note, a new note on returning the IAT to an assessor, a new note for Assessment Organisations on explaining IAT outcomes to older people (section 5.7.7.).
Chapter 6 Aged Care Programs	Includes important information about the aged care programs recommended by assessors to meet an older person's needs and goals.	• Addition of a caveat that budgets are indicative and will be subject to indexation (section 6.1). • Updates to reflect changes to the Support Home priority system (section 6.1.1). • Minor updates to the note regarding monitoring of RCP caps (section 6.2). • Additional guidance on system prompts regarding RCP (section 6.2.3). • Updated guidance on the interaction between RCP and AT-HM (section 6.2.4). • Updated guidance on selecting allied health and other therapeutic services, including interactions between RCP and AT-HM (section 6.3.7) • New guidance on AT reoccurring costs (section 6.4.4). • Updated guidance on uploading the completed AT-HM tier guide to the assessor portal (section 6.4.8). • Updated guidance on recording an older person's need for AT-HM and on recommending AT-HM services (section 6.4.9). • Updated guidance on interactions between CHSP and other funded aged care programs (section 6.5.5).

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Chapter	What you'll find in this chapter	Key Changes from v8.2 to v8.3
		• Updated guidance to remove manual steps when recording CHSP and SaH in the NoD (section 6.5.6). • Removal of guidance instructing assessors to override the algorithm outcome to recommend TCP for clients who are new to the aged care system (section 6.8.3). • Updated guidance for assessors on support programs through Dementia Support Australia (section 6.11.3). • Updated guidance and additional reminder that DSOA clients found eligible for ongoing SaH will have their DSOA funding capped (section 6.11.6).
Chapter 7 Delegations and approvals under the Act	Includes information about: • The powers under the Aged Care Act 2024 that are delegated to Triage Delegates and Clinical and Non-Clinical Assessment Delegates. • How approvals work under the Aged Care Act 2024, and the decisions that delegates make.	• New guidance for non-clinical assessment delegates on not appointing learner assessors until all mandatory training has been completed (section 7.4.1). • Updates to the reframed reasons for access under section 67 (section 7.6.3).
Chapter 8 Delegate decisions in practice	Includes guidance for assessment delegates covering: • How to make sound, evidence-based decisions • step-by-step processes for approving aged care services across the service groups • Other approvals (including giving approvals after a service has commenced and approving a service without an assessment).	• Significant updates to reflect new system functionality to return the IAT to the assessor (section 8.2.3). • New guidance on returning support plans to the assessor for amendments (section 8.2.4). • New guidance on the assessment delegate returning the IAT to the assessor for amendment (section 8.2.5). • Updated guidance to reflect changes to SaH priority system (section 8.3.4). • Updated guidance on home adjustments, equipment and products (section 8.5.1).
Chapter 9	Includes guidance about:	• Removal of guidance on system generated NoD letters for CHSP only (section 9.3.2).

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Chapter	What you'll find in this chapter	Key Changes from v8.2 to v8.3
Finalising the Assessment and Service Referral	• Finalising the assessment • Recording and communicating the assessment outcome • Referring the older person for services, • The single provider model for Support at Home (which includes a single referral code for all services/pathways) • Completing the Notice of Decision (approval/non-approval letter).	• Removal of guidance regarding manual language changes when completing the NoD (section 9.3.3). • Updates to guidance about reasons for decisions in the NoD (section 9.3.4). • New guidance about including Notice of Decision attachments (section 9.3.5). • Updated guidance on generating the notice of outcome of application for second concurrent unit of restorative care funding (section 9.3.6). • Removal of note regarding signature block in offline NoD templates (section 9.3.8). • Updates to guidance explaining separate CHSP referral codes must be generated for each service type and reissuing service codes (section 9.4.5).
Chapter 10 SPRs and Reassessments	Includes guidance on the circumstances for conducting a support plan review (SPR) or a reassessment for each aged care program.	• Additional note about limitation of system functionality for Support Plan Reviews (SPR) for the End-of-Life Pathway (section 10.1.1). • New guidance to assessors instructing them how to begin triage while conversing with a client during an SPR when the outcome is a reassessment (section 10.1.7). • Removal of note about use of unspent funds and AT/HM scheme data collection process (section 10.1.7). • New guidance on second unit of funding for the Restorative Care Pathway (RCP) and updates to monitoring of RCP units (section 10.1.8). • New guidance on transferring clients to ongoing services through SPR process not a new assessment (section 10.1.9).
Chapter 11 Reviewable Decisions, Revocations and Complaints	Provides information on assessment related reviewable decisions in accordance with the *Aged Care Act 2024*. It also details:	• No substantive changes have been made to this chapter.

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Chapter	What you'll find in this chapter	Key Changes from v8.2 to v8.3
	• The Review of Decisions process • Options for reviews and revocations • The complaints process.	
Chapter 12 Supporting Diverse Experiences and Needs	Outlines the ways in which the aged care system supports an older person's diverse needs by ensuring they have access to person-centred aged care assessments and services. This includes valuing older people, their identities, cultures, abilities, diversity, beliefs and life experiences.	• Additional note about working with organisations that support Stolen Generation survivors (section 12.3.1). • Updates to guidance on obtaining consent for an assessment for people living with mental health conditions (section 12.12.2).
Chapter 13 Operating Procedures	Includes information on privacy, information management and relevant legislation. Also included in this chapter is information about: • Applying to be a delegate • Clinical governance • Separation of assessment services and delivery of aged care services • Information management and privacy under the Aged Care Act 2024 • Framework for governance of Indigenous data • Branding • Resources for consumers • Reporting and performance	• Updated note on completing the non-clinical workflow in the system, including that learner assessors cannot be appointed as delegates until they have completed all mandatory training requirements; and that in exceptional circumstances, non-clinically qualified staff within Aboriginal and Torres Strait Islander Assessment Organisations can submit a business case to be considered for a clinical assessor and/or Triage Delegate role (section 13.1.1). • Updated list of Qlik reports that Assessment Organisations can access (section 13.7). • New section containing information on the requirement for Assessor ID Cards (section 13.8).
Chapter 14	Provides guidance on fees, payments and participant	• Updated guidance about fees for hoarding and squalor services and CHSP

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Chapter	What you'll find in this chapter	Key Changes from v8.2 to v8.3
Fees and Payments	contributions for funded aged care services.	contributions for SaH participants (section 14.2.1). • Updates to guidance on CHSP contributions for SaH participants (section 14.2.2). • New guidance about fees payable by older people accessing care under the MPSP (section 14.2.5).
Appendices	Appendices include: • Glossary • Contact Details • Clinical Governance Guidance for Aged Care Needs Assessment Organisations • Clinical attendance • Wellness and Reablement • Restorative Care Case Studies • Aged Care Assessment Workforce Credentials • Case studies of individuals experiencing homelessness or at risk of homelessness • IAT amendment guidance	• Updated definitions for: Active, appointed decision maker, Integrated Assessment Tool (IAT), and Single Assessment System workforce. New terms added: Clinical Assessment Delegate, Non-clinical Assessment Delegate, Residential Care (ongoing), Support at Home Program, and Triage Delegate (Appendix A). • Contact details for the right of review have been updated to include an email address. Updated details added for My Aged Care complaints (Appendix B). • Updates to training referenced in Element 2 (Appendix C). • Additional note advising a business case is not necessary for Aboriginal and Torres Strait Islander Health Practitioners with a cert iv to become a clinical assessor in Aboriginal and Torres Strait Islander Assessment Organisations (Appendix F). • New guidance regarding IAT amendments (Appendix I).

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1. Chapter 1: Aged Care Act 2024

What you'll find in this chapter

This chapter introduces some key concepts under the *Aged Care Act 2024* (the Act) that are important to understand. They include:

- The structure of the Act
- Statement of Rights and Principles
- Dignity of Risk
- Eligibility requirements to access government funded aged care services
- Service List and structure under the *Aged Care Rules 2025*
- Transition Arrangements for 1 November 2025

1.1. About the *Aged Care Act 2024*

The *Aged Care Act 2024* (the Act) is rights-based legislation designed to put older people at the heart of the aged care system. It includes a Statement of Rights and a Statement of Principles to ensure the focus remains on the needs and well-being of older people. The Act provides a framework to deliver high-quality, safe, and respectful funded aged care services while empowering those who receive them.

The Act upholds these rights through:

- **Strong Legal Foundations**: The Act establishes a person-centred aged care system, and the objects of the Act give effect to Australia's obligations under international human rights treaties, ensuring a robust legal basis.
- **Independent Oversight**: The Act introduces mechanisms for independent system oversight, promoting accountability and fairness within the aged care system.
- **Equitable Access**: It ensures that all individuals are assessed against a culturally safe and appropriate single assessment framework, facilitating fair access to aged care services.

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This structure is designed to ensure that aged care services are fair, accessible, and centred on the dignity and rights of older people.

The Act is structured into eight chapters, each focusing on different aspects of the aged care system. These are summarised below.

The most relevant areas of the Act for assessment organisations are in Chapter 2 which explains eligibility and assessment processes, and Chapter 8 which covers reconsiderations, decision reviews, and delegation provisions.

Chapter 1 – Introduction
This Chapter establishes the purpose, objectives, and scope of the Act. It introduces the key principles that underpin the Act, including the Statement of Rights and the Statement of Principles, which recognise the rights, dignity, and autonomy of older Australians. The Chapter also defines important concepts and terminology used throughout the Act, ensuring consistency in interpretation and application. This Chapter also includes the aged care service list (Prescribed in the *Aged Care Rules 2025* in Part 3).

Chapter 2 – Entry to the Australian Aged Care System

This Chapter includes the requirements for an individual to access government-funded aged care services. It details the eligibility criteria for aged care needs assessments, the aged care needs assessment process, and how individuals are approved for services. Additionally, it covers the approach to classifying the level of funding required, how priority for services is established, and the allocation of available aged care places to individuals and providers.

Chapter 3 – Registered providers, aged care workers, and digital platform operators

This Chapter focuses on aged care service providers, aged care workers, and the digital platforms that support aged care services. It sets out the registration process for providers, the approval process for residential care homes, and the conditions and obligations that registered providers must meet. It also outlines requirements for aged care workers, governance structures, and compliance responsibilities, ensuring service quality and accountability.

Chapter 4 – Funding of aged care services

This Chapter details how the Commonwealth funds aged care services, including whether that funding is through subsidies or grant based. This Chapter also sets out the individual fees and contributions that are payable for funded aged care services. It explains the funding structures for home support, assistive technology, home modifications, and residential care services. It also outlines means-testing rules, financial obligations of individuals accessing services, and mechanisms for subsidy payments to registered providers. This ensures a fair and sustainable funding model that aligns with individuals' financial circumstances.

Chapter 5 – Governance of the aged care system

This Chapter establishes the underlying governance of the broader aged care system. It establishes roles such as the System Governor, Aged Care Quality and Safety Commissioner, and Complaints Commissioner, detailing their responsibilities in ensuring compliance, investigating concerns, and enforcing the Aged Care Quality Standards. It also establishes the Aged Care Quality and Safety Advisory Council, who provides expert advice to improve aged care services and regulatory approaches.

Chapter 6 – Regulatory mechanisms

This Chapter outlines the enforcement measures in place to ensure aged care providers comply with legal and quality standards. It details the monitoring and investigation processes, including the use of compliance notices, banning orders, civil penalties, and enforceable undertakings. The Chapter also covers whistleblower protections and the legal mechanisms available to investigate and address regulatory breaches, ensuring transparency and accountability in the sector.

Chapter 7 – Information management

This Chapter establishes the rules for handling aged care data, privacy, and information sharing. It sets out record-keeping requirements for providers and government agencies and outlines protections against the misuse of sensitive personal information. The Chapter also introduces whistleblower protections and mechanisms for publishing key information about aged care providers and services, ensuring transparency and public trust in the system.

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Chapter 8 – Miscellaneous

The final Chapter covers additional provisions, including the reconsideration (review) and appeal processes available to individuals and providers regarding decisions made under the *Aged Care Act 2024 (the Act*). It details delegation powers, administrative automation, financial provisions, and the Minister's authority to make rules under the Act. This Chapter also mandates periodic reviews of the legislation to ensure it remains effective and responsive to the evolving needs of the aged care sector.

Subordinate legislation

The Act is supported by subordinate legislation the *Aged Care Rules 2025 (the Rules)*. The Rules sit underneath the Act and provide further detail and instruction on how the Act operates. There are two distinct bodies of Rules which will support the Act. Transitional Rules which deal with transitional matters not already addressed by the *Aged Care (Consequential Amendments and Transitional Provision) Act 2024* and the *Aged Care Rules 2025.*

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1.2. Statement of Rights and Principles

The Statement of Rights and the Statement of Principles support a person-centred aged care system, ensuring older people receive equitable, safe and quality care.

The Statement of Rights and the Statement of Principles are a reference point for the standard of conduct, duties and obligations for when assessment staff, registered providers and aged care workers deliver funded aged care services.



Figure 1 – Aged Care Act 2024 (Cth) Statement of Rights and Principles

1.2.1. The Statement of Rights

The Statement of Rights (section 23 of the *Aged Care Act 2024 (the Act)*) is a fundamental part of the person-centred Act and promotes the older person's right to receive safe, high-quality care in the Commonwealth aged care system.

All assessment staff should perform their functions and duties in a way that is compatible with the rights. Of importance, assessment organisations and their assessment staff should ensure that an individual's need for funded aged care services is assessed, or reassessed, in a way that is:

- culturally safe, culturally appropriate, trauma-aware and healing-informed, and
- accessible and suitable for individuals living with dementia or other cognitive impairment.

1.2.2. The Statement of Principles

The Statement of Principles (section 25 of the Act) provide guidance on how the aged care system should operate. It should be used to guide the decisions, actions and behaviours of everyone operating in the aged care system, including assessors, providers, aged care workers, registered supporters and government agencies.

The Statement of Principles also aims to guide government agencies and bodies to ensure that the whole aged care system is directed towards the safety, health, wellbeing, and quality of life of individuals accessing funded aged care services.

1.3. Dignity of risk

During an aged care needs assessment, assessors should work with older people to balance their responsibility for an individual's right to make choices, even if their choices include some risk to themselves. This right is known as 'dignity of risk' which involves:

- Assessors considering the older person's rights mentioned in the Statement of Rights when undertaking an assessment.
- Ensuring older people during an assessment can, where possible, make informed decisions for themselves, including in the setting of goals, including if those decisions involve risk
- The new role of a registered supporter under the *Aged Care Act 2024 (the Act)*, who can support an older person to make and communicate their own decisions regarding their care and preferences.

1.4. Eligibility requirements to access government funded aged care services

From 1 November 2025, all government funded aged care services can only be provided once an older person has been found eligible to undergo an aged care needs assessment by the System Governor (a Triage Delegate) and it has been decided that the individual requires access to aged care services by the System Governor (an Assessment Delegate) following an aged care needs assessment.

This means that all services are Act-based services under the Act from 1 November 2025, including services that an older person accesses through a specialist aged care program

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(e.g. Commonwealth Home Support Program, Multi-purpose Service Program, National Aboriginal and Torres Strait Islander Flexible Aged Care Program and Transition Care Program).

1.4.1. Age eligibility requirements

Under the *Aged Care Act 2024*, there are clear eligibility requirements that an individual will need to meet to have an aged care needs assessment. Section 58 of the Act outlines these eligibility requirements.

Note:

To be eligible for an aged care needs assessment an individual must be:

- aged 65 or over; or
- an Aboriginal or Torres Strait Islander person and is aged at least 50; or
- homeless, or at risk of homelessness, and is aged at least 50; and

Each of the above individuals must also provide information relating to the individual's care needs. Care needs are defined under the Act as one or both of the following:

- the individual has difficulty (whether physically, mentally or socially) undertaking any daily living activities;
- the individual needs help from another person, or the assistance of an aid, to maintain their physical, mental or social capacity to function independently.

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1.4.2. Informing the eligible younger person of other services

There are limited circumstances in which people under the age of 65 can access Australian government aged care services. Under subparagraph 58(c) if the individual is under the age of 65 and falls into one or more of the eligible cohorts, they must:

(i) be informed of any other services that may be available to meet their care needs (noting that it is not a requirement for a person under the age of 65 to take up other services in place of aged care services).
(ii) elect, in the approved form, to be provided with government funded aged care services before they turn 65.

For eligible younger people who make an application via My Aged Care, they will be informed of other services at this stage. However, for all other registration pathways, the Triage Delegate will need to inform the eligible younger person of other services. Further information about this process is at section 5.3.2 of this Manual.

Note:

The Principles and Guidelines for a younger person's access to Commonwealth funded aged care services is no longer relevant under the *Aged Care Act 2024*.

Definitions for 'homeless' and 'at risk of homelessness'

A person aged 50 years or older who is homeless or at risk of homelessness may be eligible for an aged care needs assessment and access funded aged care services. For Triage Delegates to determine if an individual aged 50 to 64 meets the eligibility criteria for a needs assessment under the homeless or risk of homelessness provision in the *Aged Care Act 2024*, the following definitions apply:

Homeless definition

The term 'homeless' in the context of aged care and for the purposes of receiving a needs assessment and funded aged care services refers to an individual who:

- is aged 50 or older, **and**
- has prematurely aged and requires services for their aged care needs, **and**
- has the following living arrangements:
  - lacks any adequate roof over their head, **or**
  - has no security of tenure, or moves between various forms of temporary or medium-term shelter, **or**
  - stays in accommodation that falls below minimum community standards, **and**
- does not have the means to change their living arrangements.

At risk of homelessness definition

The term 'at risk of homelessness' in the context of aged care and for the purposes of receiving a needs assessment and funded aged care services refers to an individual who:

- is aged 50 or older, **and**
- has prematurely aged and requires services for their aged care needs, **and**
- is at risk of experiencing the following living arrangements:
  - lacks any adequate roof over their head, **or**
  - has no security of tenure, or moves between various forms of temporary or medium-term shelter, **or**
  - stays in accommodation that falls below minimum community standards, **and**
- does not have the means to change their living arrangements.

Once an aged care needs assessment is undertaken, the assessment delegate must ensure that all eligibility requirements are met before approving any service group, service type, or specific funded aged care service.

This means that the older person's situation must meet the conditions outlined in sections 66 to 68 of the *Aged Care Act 2024 (the Act)*, and any additional eligibility criteria set by the relevant *Aged Care Rules 2025* must be satisfied. If these requirements are not met, the assessment delegate cannot approve the provision of aged care services.

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Any younger individual[1] who were already accessing services on 1 November will not be required to have a reassessment. Younger individuals currently accessing services will be able to continue to access these, even if they are below the minimum age requirements for the Act, subject to any actions required for that individual to transition to the Act.

1.5. Transition arrangements to the *Aged Care Act 2024*

As part of the commencement of the *Aged Care Act 2024 (the Act)* on 1 November 2025, different transitional arrangements have been put in place for existing clients and new clients being assessed as eligible for government funded aged care services.

Assessment staff should follow the procedures outlined in Table 1 when managing approvals for older people who transitioned from the *Aged Care Act 1997* to the *Aged Care Act 2024*.

Table 1: Transitional Arrangements from 1 November 2025

Cohort	Transitional Arrangements from 1 November 2025
Home Care Package (HCP)	• All HCP recipients transitioned to Support at Home. - Assigned one of four Transitioned HCP classifications based on their current HCP level. • No Support at Home classification (Levels 1–8) assigned at transition. • Transitional classification can be retained indefinitely, even after reassessment, if more beneficial.
Multi-Purpose Services Program (MPSP)	• Home/community services recipients (or those starting within 3 months) automatically approved for: - Ongoing/short-term home support - Assistive Technology (AT) - Home Modifications (HM) • Residential aged care recipients (or those starting within 3 months) approved for ongoing/short-term residential care.
NATSIFACP	• Individuals receiving NATSIFACP services in the 12 months before 1 Nov 2025 are automatically eligible under the Act. • No new assessment required unless care needs change.

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[1] A younger individual is a person who is under 50 years old for Aboriginal and Torres Strait Islander people or people who are homeless or at risk of homelessness or under 65 years old for all other persons.

Cohort	Transitional Arrangements from 1 November 2025
	• All new clients post 1 November are required to make an application for funded aged care services by registering with My Aged Care, undergo a needs assessment and obtain an access approval for one or more service groups in place to access services delivered under NATSIFACP. • However, they can receive NATSIFACP services before assessment if they meet the criteria for alternative entry.
Commonwealth Home Support Program (CHSP)	• Registered and assessed clients automatically transition and continue accessing services. • Unregistered and unassessed clients must have been assessed by 31 October 2025 to continue accessing services. • Grandfathered clients (from pre-2015 programs) who have never been assessed must undergo an assessment. • Under the transitional arrangements and under section 71 of the Act, CHSP clients who have accessed a CHSP service by 31 October 2025 and are awaiting assessment on or after 1 November can have their service approval backdated to 1 November if they are found eligible at assessment
Short-Term Restorative Care (STRC) ***(now known as Restorative Care Pathway RCP)***	• The STRC Programme changed to the 'Restorative Care Pathway' under Support at Home from 1 November 2025. Transition arrangements applied to two cohorts: ○ Participants who commenced their STRC care episode before 1 November 2025 and were still in progress on that date continued their care under transitional arrangements. ○ Participants approved for the STRC Programme who commenced their care on or after 1 November 2025 had their approval converted to the Restorative Care Pathway (RCP), with six months from the date of STRC approval to accept their RCP/AT-HM place. • All STRC approvals have now either concluded or transitioned to RCP. • If participants did not access their approval within the six-month period, they will need to be reassessed to access restorative care or AT-HM under the Support at Home program, if eligible
Younger People	• Younger people already accessing services on 1 November 2025 did not require a reassessment. • Younger people currently accessing services will be able to continue to access these services and also be eligible to be assessed for other aged care services in the future.

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Cohort	Transitional Arrangements from 1 November 2025
	• Younger people, who were in the process of applying for aged care services on 1 November, will be eligible to be assessed under relevant criteria within the *Approval of Care Recipients Principles 2014*.
Transition Care Program (TCP)	• Transition Care Program clients who continued to receive care across the transition from the *Aged Care Act 1997* to the *Aged Care Act 2024* had their eligibility and approval deemed across. • All new clients post 1 November 2025 are required to have a comprehensive assessment and receive delegate approval, before they are discharged from hospital, to be referred to a transition care service provider.
Residential Care	• Existing residents in care on 1 November 2025 were allocated a place to ensure no payment or continuity of care issues for the provider or older Australian. This cohort of older Australians did not need to do anything to facilitate this allocation. It happened as part of the transition to the Act. • Older Australians who were assessed and approved as requiring residential care, prior to 1 November 2025, were automatically allocated a place and can enter care when they choose to.

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1.5.1. Transitioned Home Care Package

All individuals who were receiving a Home Care Package (HCP) on 1 November 2025 were transitioned to the Support at Home program. At the point of transition, they were not assigned a Support at Home classification level (Levels 1–8). Instead, each person was allocated one of four Transitioned Home Care Package classifications, based on their HCP level prior to 1 November 2025.

Clients can remain on these transitional classifications indefinitely, unless assessed and approved for a Support at Home classification at a higher level. A transitional classification can be retained even if the client has a new assessment and the IAT Outcome results in a Support at Home classification level that would reduce their funding compared to their transitional level. When reassessing transitioned clients, assessors must ensure the transitional classification is retained when it is more beneficial to the client.

Table 2: Transitioned levels and recommended outcomes

Transition level	IAT Outcome	Recommended outcome
Transitioned HCP 1	CHSP Support at Home Classification 1	Retain Transitioned HCP 1
	Support at Home Classification 2-8	Use Support at Home 2-8 Class aligning with IAT Outcome.
Transitioned HCP 2	CHSP Support at Home Classification 1-2	Retain Transitioned HCP 2
	Support at Home Classification 3-8	Use Support at Home 3-8 Class aligning with IAT Outcome.
Transitioned HCP 3	CHSP Support at Home Classification 1-5	Retain Transitioned HCP 3
	Support at Home Classification 6-8	Use Support at Home 6-8 Class aligning with IAT Outcome.
Transitioned HCP 4	CHSP Support at Home Classification 1-7	Retain Transitioned HCP 4
	Support at Home Classification 8	Use Support at Home 8 Class aligning with IAT Outcome.

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Section 6.7 Classification of the Support at Home Manual.

1.5.2. Support plan reviews for transitioned Home Care Package (HCP) clients

Transitioned HCP clients will continue to be eligible for support plan reviews (SPRs) under the same process currently in place. However, in line with existing procedures, if it is determined that a client's circumstances have changed significantly, a reassessment will be required.

Under Support at Home a higher Support at Home classification level cannot be approved through an SPR — this can only occur following a reassessment and the IAT Outcome generates a higher classification level. When reassessing transitioned clients, assessors will need to ensure that they maintain the transitional classification where it is more beneficial for the older person. This will be flagged in the system on reassessment. If the IAT Outcome is a lower classification than the existing active ongoing classification, then a warning message will display to inform the assessor that they can retain the existing classification by clicking the accept button.

When completing an SPR to transition a client to the End-of-Life Pathway, assessors will have the option to convert the client's Transitioned HCP level to End-of-Life once the End-of-Life form has been uploaded and validated. Clients receiving services on the End-of-Life Pathway can also return to their Transitioned HCP level, just as clients in the Support at Home program can return to their previous classification level.

1.5.3. Transitioned Home Care Package recipients and access to the Assistive Technology and Home Modifications scheme

All Home Care Package (HCP) recipients transitioned over to Support at Home with approval for Assistive Technology (AT) transitional and Home Modifications (HM) transitional classifications. These approvals enable a transitioned HCP recipient who has not undergone a reassessment and does not have AT-HM funding, to use their HCP unspent funds to purchase equipment, products and home modifications from the AT-HM list. Providers must document and justify the need and reasoning for the purchase and retain all evidence to support the claim.

If a transitioned HCP recipient has no HCP unspent funds and requires AT-HM, the provider can, with consent from the participant, refer them for a support plan review.

Where a transitioned HCP recipient has been reassessed under Support at Home and receives approved AT-HM funding, the purchase of assistive technology and home modifications must be first drawn from any HCP unspent funds before the provider can claim from the AT-HM funding account.

All purchases of AT-HM items must align with the participant's needs, be agreed with the participant, be documented in their care plan and meet any prescription requirements, where applicable.

AT-HM List

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