



**Australian Government**

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**Department of Social Services**

**Home Care Packages Programme Guidelines**

**July 2014**

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## Foreword

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

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

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

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

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

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

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

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

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

## Terminology

### Consumer

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

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

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

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

### **Home care provider**

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

The term “approved provider” is used in the legislation.

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

### **Glossary of terms**

There is a glossary of terms at Part K.

## Part A – Introduction

### Covered in this part

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

## 1. Home Care Packages Programme

### 1.1 Programme objectives

The objectives of the Home Care Packages Programme are:

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

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

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

### 1.2 Package levels

There are four levels of Home Care Packages:

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

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

Transitional arrangements are explained in Part B, Section 2.

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

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

Further information on the supplements is at Part H.

### **1.3 Target population**

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

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

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

### **1.4 Special needs groups**

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

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

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<sup>1</sup> [Aged Care Assessment Programme Policy webpage](#).

<sup>2</sup> Section 11.3 of the *Aged Care Act 1997*.

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

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

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

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

## **1.5 People with dementia**

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

## **2. Consumer Directed Care (CDC)**

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

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

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

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



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

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

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

## **2.2 CDC principles**

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

### **2.2.1 Consumer choice and control**

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

### **2.2.2 Rights**

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

### **2.2.3 Respectful and balanced partnerships**

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

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

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<sup>3</sup> Care and services must be within the scope of the Home Care Packages Program.

### **2.2.4 Participation**

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

### **2.2.5 Wellness and re-ablement**

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

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

### **2.2.6 Transparency**

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

## **3. Use of innovative and digital technology**

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

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

## **4. Evaluation**

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

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<sup>4</sup> Care and services must be within the scope of the Home Care Packages Program.

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

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

The evaluation will also consider:

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

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

## **5. Legal framework**

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

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

## **6. Pathway for the consumer**

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

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

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

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

## Step 1: Finding information about the Home care Packages Programme

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

## Step 2: Assessing eligibility for a Home Care Package

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

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

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

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

#### Step 4.1: Care planning

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

#### Step 4.2: Service delivery, monitoring and re-assessment

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

#### Step 4.3: Early conversion to CDC

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

## Step 5: Moving or exiting

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

### CDC Home Care Package

#### Step 4.1: Setting goals, care planning

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

#### Step 4.2: Understanding the funding

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

#### Step 4.3: Service delivery, monitoring and re-assessment

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

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

### Covered in this part

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

### 1. Summary of changes

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

### 2. Transitional arrangements

#### 2.1 Existing allocations of packages

From 1 August 2013, all existing allocations of:

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

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

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

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

## **2.2 Continuing consumers**

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

## **2.3 Existing ACAT approvals**

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

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

## **2.4 Changes to approved provider arrangements**

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

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

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

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

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<sup>5</sup> Division 8 of the *Aged Care Act 1997*.

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



## Part C – Accessing a Home Care Package

### Covered in this part

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

### 1. Finding information about Home Care Packages

For information about the aged care system and services go to the [My Aged Care website](#) at [www.myagedcare.gov.au](http://www.myagedcare.gov.au) or call the national contact centre on **1800 200 422**.

### 2. Eligibility for a Home Care Package

#### 2.1 Age

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

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

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<sup>6</sup> [Aged Care Assessment Programme Policy webpage](#).

## **2.2 Residency or citizenship**

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

## **2.3 Assessment by an Aged Care Assessment Team**

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

## **2.4 Broadbanded assessments**

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

The two assessment bands for eligibility are:

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

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

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

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

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

## **3. Issues to be considered by ACATs in determining eligibility**

### **3.1 Eligibility criteria**

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

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<sup>7</sup> In Victoria, ACATs are known as Aged Care Assessment Services (ACAS).

The requirements of the legislation<sup>8</sup> mean that, for a person to be eligible for a Home Care Package, the person must:

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

### **3.2 Aged Care Client Record and information about the ACAT decision**

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

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

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

## **4. ACAT approvals**

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

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

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<sup>8</sup> Part 2, section 7 and Part 3, section 11 of the *Approval of Care Recipient Principles 2014*.

This means that:

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

#### **4.2 Removal of automatic lapsing of approvals**

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

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

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

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

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

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

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

### **6. Being offered a package by a home care provider**

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

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

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

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

### **6.1 Moving between package levels or bands**

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

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

### **6.2 Waiting lists**

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

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

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

## Part D – Making use of a Home Care Package

### Covered in this part

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

### 1. Being offered a package by a home care provider

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

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

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

### 2. Home Care Agreement

#### 2.1 Overview

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

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<sup>9</sup> Division 4, section 22 of the *User Rights Principles 2014*.

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

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

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

Once the Home Care Agreement is entered into, care and services can formally commence under the package and the home care provider is able to commence claiming the government subsidy for the package (see Part I, Section 5).

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

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

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

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

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

Home care providers are able to use TIS to provide interpreting services to assist home care consumers to understand their Home Care Package, including the Home Care Agreement, the individualised budget and monthly statements. Home care providers have been given a unique code that can be quoted to access TIS interpreting services. This arrangement is also in place for residential aged care providers.

## 2.2 Items to be included in the Home Care Agreement

Under the legislation<sup>10</sup>, the following information must be included as part of the Home Care Agreement:

Check	Item
<input type="checkbox"/>	Start date for the care
<input type="checkbox"/>	The level of the Home Care Package to be provided (Level 1, 2, 3 or 4)
<input type="checkbox"/>	Whether the Home Care Package will be provided on a CDC basis
<input type="checkbox"/>	The care and services the consumer will receive
<input type="checkbox"/>	Details outlining how the consumer can suspend care
<input type="checkbox"/>	An explanation of security of tenure
<input type="checkbox"/>	Conditions under which either party may terminate care
<input type="checkbox"/>	An explanation that any variation must be by mutual consent, following consultation between the consumer and the home care provider, and may only be made after the provider has given reasonable notice in writing to the consumer
<input type="checkbox"/>	A copy of the consumer's care plan, plus any subsequent changes to the care plan
<input type="checkbox"/>	Details of the consumer's rights about the service they are to receive. A copy of the 'Charter of Care Recipients' Rights and Responsibilities – Home Care' must also be provided to the consumer
<input type="checkbox"/>	A statement that the consumer is entitled to make, without fear of reprisal, any complaint about the Home Care Package, and an explanation of how to make a complaint. This refers to both internal complaint mechanisms and the Aged Care Complaints Scheme
<input type="checkbox"/>	A guarantee of the confidentiality, as far as legally permissible, of information provided by the consumer and the use to be made of the information
<input type="checkbox"/>	A clear itemised statement of the fees payable (if any) by the consumer and how they were calculated. (Note: providers must include a statement that an income tested care fee may be payable. The exact amount of income tested care fee payable, if any, is not necessarily required)
<input type="checkbox"/>	Other financial information relevant to the care and services provided to the consumer
<input type="checkbox"/>	An explanation that a consumer is entitled to request a statement of the home care service's financial position, including a copy of the most recent version of the home care provider's audited financial accounts. This must be provided within seven days of the request

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

<sup>10</sup> Section 23 of the *User Rights Principles 2014*.



For packages being delivered on a CDC basis, home care providers must provide an individualised budget and regular statement of the consumer’s Home Care Package income and expenditure.

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

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

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

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

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

### **2.4 When can the home care subsidy be claimed?**

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

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

## **3. Packages delivered on a CDC basis**

### **3.1 Care planning**

#### **3.1.1 Overview**

A key feature of a package being delivered on a CDC basis is that the consumer must have ownership of decision making. This requires the provider to ensure an independent empowering decision making framework, which supports the consumer

to make decisions about their needs and goals and determine the amount of control they want to exercise in relation to their package.

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

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

### **3.1.2 Goal setting**

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

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

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

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

### **3.1.3 Level of consumer control over the management of the package**

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

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

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

needs change. Any changes to the level of consumer involvement and control must also be documented in the care plan.

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

### **3.1.4 Determining who has authority to make decisions**

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

### **3.1.5 Case management**

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

- the initial assessment by the home care provider;
- identification of the consumer's goals;
- development of the Home Care Agreement, care plan and individualised budget;
- service coordination and referrals;
- ongoing monitoring and informal reviews of the consumer;
- formal re-assessment of the consumer's needs, and adjustment of the Home Care Agreement, care plan and individualised budget; and
- referral to an ACAT (e.g. if a reassessment is needed to move to a higher broad-banded level of package).

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

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

In some cases, a consumer may wish to have a specific person as a case manager. This can be negotiated between the consumer and the home care provider. If agreed, the home care provider will need to establish a contractual or employment

relationship with the case manager suggested by the consumer. The case manager should have appropriate skills and qualifications to perform this role.

### **3.1.6 Choosing care and services**

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

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

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

### **3.1.7 Care plan**

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

- the consumer's goals – what it is the consumer would like to achieve through their package;
- the care and services to be provided to support the consumer's assessed care needs and any identified goals;
- who will provide the care and services;
- when care and services will be provided, including the frequency of services and days/times when regular services are expected to be provided;
- the level of involvement and control the consumer will exercise over the management of the package;
- case management arrangements, including how ongoing monitoring and informal reviews will be managed; and
- the frequency of formal reassessments (which must be undertaken at least every 12 months).

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

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

### **3.1.8 Giving effect to the consumer’s choices and preferences**

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

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

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

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

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

- The proposed service may cause harm or pose a threat to the health and/or safety of the consumer or staff.
- The proposed service is outside the scope of the Home Care Packages Programme (see Part E, Section 3.6).
- The home care provider would not be able to comply with its responsibilities under aged care legislation or other Commonwealth or state/territory laws.
- The consumer’s choice of service provider is outside the home care provider’s preferred list of service providers and all reasonable effort has been made to broker an acceptable sub-contracting arrangement.
- The requested service provider will not enter into a contract with the home care provider.
- There have been previous difficulties or negative experiences with the consumer’s suggested service provider.
- Situations in which a consumer may want to go without necessary clinical services (resulting in a possible compromise of their health and/or wellbeing) in order to “save” for a more expensive non-clinical service.
- The cost of the service/item is beyond the scope of the available funds for the package.

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

### **3.1.9 Sub-contracted or brokered services**

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

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

Home care providers are encouraged to develop a list of “preferred service providers” to support consumers’ needs and choices.

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

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

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

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

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

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

### **3.1.11 Contracting to informal carers, family members or friends**

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

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

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

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

Carers may be eligible for support and assistance from the Australian Government through programmes such as the Carer Allowance or Carer Payment. These programmes are administered by the Department of Human Services and are not part of the Home Care Packages Programme. Further information is available at the [Department of Human Services' carers webpage](#).

## **3.2 Individualised budget**

### **3.2.1 Overview**

The government subsidy for a Home Care Package is paid to the home care provider, not directly to the consumer.

The home care provider is the fund holder and will administer the budget in a transparent manner, meeting quality and accountability requirements<sup>11</sup>.

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

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

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

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<sup>11</sup> Part 3, Divisions 1 and 2, and Schedules 3 and 4 of the *Quality of Care Principles 2014*.

### 3.2.2 What is an individualised budget?

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

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

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

#### Income

The budget should clearly identify the total funds available under the package, which would comprise:

- the government subsidy for the package level as indicated on the Department of Social Services website (including relevant supplements<sup>12</sup>, e.g. Dementia and Cognition, Veterans', Oxygen, Enteral Feeding and Top-up Supplements (where applicable);
- any consumer contribution/care fee; and
- any unexpended funds carried over from the prior periods.

For a consumer who commences their package on or after 1 July 2014, the minimum funds available will not vary irrespective of whether the income tested care fee is paid. The minimum funds will still be the amount of the government subsidy for the package level and the relevant supplements, e.g. Dementia and Cognition, Veterans', Oxygen, Enteral Feeding and Top-up supplements (where applicable).

In this way, the minimum funds available to a consumer who cannot be asked to pay an income tested care fee, will be the same as those of a consumer who could be asked to pay an income tested care fee.

It should be noted that the Department of Human Services only ever advises the maximum fees payable, however, the approved provider and the consumer are able to negotiate lower fees should they choose. Also providers cannot use the government subsidy to meet the consumer's income tested care fee. That is, the provider and consumer cannot select a lower level of care and services to match the value of the government subsidy paid.

If all or part of the basic daily care fee is paid, the budget should clearly identify these funds as included under the package.

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<sup>12</sup> Funding paid to the approved provider through the Viability Supplement (if applicable) does not have to be included in the individualised budget.



### Planned expenditure

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

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

These categories are explained below.

- **Administration costs** – reflect establishment costs for the organisation and would also include the costs of meeting government quality and accountability requirements. Administration costs may include expenses associated with:
  - insurance and government reporting
  - organisational overheads
  - capital costs
  - ongoing research and service improvement
  - CDC administrative overheads including staff and IT
  - developing statements and other consumer communication
  - establishing contracts with sub-contracted providers
  - setting up and cancelling appointments.
- **Core advisory and case management services** – this category will include the costs associated with:
  - care planning
  - set up costs for new consumers
  - periodic reviews or re-assessments
  - case co-ordination or case management
  - provision of support to consumers who elect to manage their package themselves.
- **Service and support provision and/or purchasing** – this category will include the costs of direct service provision. This part of the budget should confirm the decisions made in the care plan about what services have been chosen to be delivered or purchased (e.g. nursing, domestic assistance), the individual cost of those services and any additional surcharges applied.

### Balance remaining

The balance between Income and planned expenditure should be clearly demonstrated as funds may need to be carried over to a new period.

The budget should describe and quantify what tangible services will be provided to the consumer, e.g. costs are based on personal and phone contact of X hours per week at \$Y per hour (or appropriate service unit).

### **3.2.3 Contingency**

The budget may also include a small “contingency” to make provision for emergencies, unplanned events or increased care needs in the future, but this is not a requirement. Contingency amounts cannot be pooled across consumers.

If a contingency is set aside, it should be no more than 10 per cent of the total annual budget for the package. The contingency amount must be clearly identified in the individualised budget and in the monthly statement of income and expenditure provided to the consumer.

Contingency funds must be used before accessing additional home support programme services.

### **3.2.4 Income and expenditure statement to the consumer**

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

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

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

### **3.2.5 Unspent funds when a consumer leaves a package**

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

- If the consumer continues to receive a package from the home care provider (at a different package level), any unspent funds from the previous package must continue to be available under the consumer’s new package.
- If the consumer moves to a different home care provider (e.g. to take up a package with another home care provider) or to enter residential care, any

unspent funds can be retained by the previous home care provider to support service delivery for other consumers, or for infrastructure purposes.

- However, if the consumer returns to a package within 28 days, there is discretion for the home care provider to make available the unspent funds in a future package offered to the consumer.
- There is also the discretion for a home care provider to agree to transfer unspent funds to another home care provider to support the ongoing care needs of the consumer. This would need to be negotiated and agreed between the relevant providers, in consultation with the consumer.
- Any unspent funds remain with the home care provider on the cessation of the Home Care Package where the consumer is deceased. These funds should be used to support service delivery for other consumers, or for infrastructure purposes.
- Where the consumer has provided their own money to top-up or purchase additional services through the home care provider, or has paid any fees in advance, any unspent money provided by the consumer must be returned to the consumer when they leave the package, or to the consumer's estate if the consumer is deceased. See Section 5.

### **3.3 Monitoring, review and re-assessment**

#### **3.3.1 Ongoing monitoring and review by the home care provider**

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

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

#### **3.3.2 Re-assessment by the home care provider**

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

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

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

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

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

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

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

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

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

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

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

If the consumer's care needs have increased significantly so that the person potentially requires home care in a higher band (e.g. Level 3 or 4, rather than Level 1 or 2), or entry to residential care, the consumer will need another

assessment by an ACAT. The home care provider can assist in arranging the ACAT assessment, with the permission of the consumer.

## 4. Packages NOT being delivered on a CDC basis

### 4.1 Overview

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

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

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

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

- A consumer may choose to “top up” their package by purchasing additional care and services (i.e. paid for by the consumer). This would need to be negotiated and agreed between the consumer and the home care provider.

#### **4.2 Level of consumer control over the management of the package**

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

#### **4.3 Giving effect to the consumer’s choices and preferences**

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

#### **4.4 Individualised budget**

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

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

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

A consumer may choose to “top up” their package by purchasing additional care and services through their home care provider. This arrangement needs to be negotiated and agreed between the consumer and the provider.

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

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

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

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

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

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

Home care providers do not have to wait until 1 July 2015, but can elect to convert existing packages to a CDC basis once they are ready to make the transition. For home care providers wishing to transition their current non CDC packages, this can be undertaken through an informal or formal process.

### **6.1 Informal transition**

Home care providers can informally deliver their Home Care Packages on a CDC basis. There is nothing in the current conditions of allocation that prevent this. This can be done at the place, provider or the service level. This allows providers and consumers to begin the process of implementing CDC delivery within their service delivery operations and allow for a staged implementation in the lead up to 1 July 2015.

An informal conversion does not vary the conditions of allocation and does not in itself include any additional statutory protection around the CDC conditions of allocation.

### **6.2 Formal transition**

Home care providers are also able to formally convert their Home Care Packages to a CDC basis of delivery. Under the *Aged Care Act 1997*, Division 17, section 17-2, a home care provider can seek to vary the conditions of allocations for their non CDC place. See Part I, Section 2.

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<sup>13</sup> Packages allocated to providers before the 2012-13 ACAR were allocated as CACP, EACH or EACHD packages. These became Home Care Level 2 or 4 packages on 1 August 2013.

## Part E – What Home Care Packages provide

### Covered in this part

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

### 1. Home care subsidy

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

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

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

The basic subsidy amounts for 2014-15 are set out below.<sup>14</sup> Other supplement amounts may also apply – see Part H of these Guidelines.

Details of subsidy and supplement amounts are also published on the [Department of Social Services Aged Care Funding webpage](#). The information on the webpage is updated when subsidy and supplement amounts change.

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<sup>14</sup> Changes to subsidy amounts usually take effect from 1 July each year. Providers are advised about changes in subsidy amounts by the Department of Social Services, usually through a mailstream or faxstream notice.



Level of Home Care Package	Basic home care subsidy in 2014-15 (per day)	Basic home care subsidy in 2014-15 (per annum <sup>15</sup> )
Level 1	\$21.43	\$7,822
Level 2	\$38.99	\$14,231
Level 3	\$85.73	\$31,291
Level 4	\$130.32	\$47,567

## 2. Previous EACHD consumers

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

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

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

Home care	Total funding available in 2014-15 (per day)	Total funding available in 2014-15 (per annum)
Existing EACHD consumers only	\$145.93 (see note below)	\$53,264

Total funding for previous existing EACHD consumers comprises the Home Care Level 4 basic subsidy (\$130.32 per day), plus 10 per cent for the Dementia and Cognition Supplement or Veteran's Supplement (\$13.03 per day), plus the Top-up Supplement (\$2.58 per day).

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

## 3. Care and services

### 3.1 Overview

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

<sup>15</sup> Annual subsidy amounts have been rounded to the nearest dollar.

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

The list of care and services and the excluded items are set out in the following tables (Sections 3.5 and 3.6). These tables are based on the information contained in Schedule 3 to the *Quality of Care Principles 2014*.

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

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

The consumer and the home care provider can also negotiate other care and services required to support the consumer to live at home where this will assist the consumer to achieve his/her goals, consistent with the consumer's care needs.<sup>16</sup> The home care provider must also be able to provide the care and services within the limits of the resources available for the package, and the care and services must not be an excluded item (i.e. outside the scope of the Home Care Packages Programme).

This increased flexibility applies to **all** Home Care Packages, whether delivered on a CDC basis or not.

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

### **3.2 Nursing, allied health and other clinical services**

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

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

The home care provider is responsible for ensuring that all home care consumers receive quality care and services that are safe and appropriate to their assessed

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<sup>16</sup> The consumer's goals and care needs should be identified in the consumer's care plan.

needs.<sup>17</sup> This includes putting in place appropriate systems to support consumers in an emergency situation, including access to a person or service who can give emergency assistance when needed. If a consumer has been assessed as requiring nursing services, the home care provider should consider whether there is a need to include in the Home Care Package 24-hour on-call access to care provided by, or under the supervision of, a registered nurse.

### **3.3 Telehealth and digital technology**

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

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

### **3.4 Aids and equipment**

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

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

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

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

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<sup>17</sup> *Charter of Care Recipients' Rights and Responsibilities – Home Care.*

### 3.5 List of care and services

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

A. Care services	Care can include:
Personal services	Personal assistance, including individual attention, individual supervision and physical assistance, with: <ul style="list-style-type: none"> <li>• bathing, showering including providing shower chairs if necessary, personal hygiene and grooming, dressing and undressing, and using dressing aids</li> <li>• toileting</li> <li>• dressing and undressing</li> <li>• mobility</li> <li>• transfer (including in and out of bed)</li> </ul>
Activities of daily living	Personal assistance, including individual attention, individual supervision and physical assistance, with: <ul style="list-style-type: none"> <li>• communication including assistance to address difficulties arising from impaired hearing, sight or speech, or lack of common language, assistance with the fitting of sensory communication aids, checking hearing aid batteries, cleaning spectacles and assistance in using the telephone</li> </ul>
Nutrition, hydration, meal preparation and diet	Includes: <ul style="list-style-type: none"> <li>• assistance with preparing meals</li> <li>• assistance with special diet for health, religious, cultural or other reasons</li> <li>• assistance with using eating utensils and eating aids and assistance with actual feeding if necessary</li> <li>• providing enteral feeding formula and equipment</li> </ul>
Management of skin integrity	Includes: <ul style="list-style-type: none"> <li>• providing bandages, dressings, and skin emollients</li> </ul>
Continence management	Includes: <ul style="list-style-type: none"> <li>• assessment for and, if required, providing disposable pads and absorbent aids, commode chairs, bedpans and urinals, catheter and urinary drainage appliances and enemas</li> <li>• assistance in using continence aids and appliances and managing continence</li> </ul>
Mobility and dexterity	Includes: <ul style="list-style-type: none"> <li>• providing crutches, quadruped walkers, walking frames, walking sticks and wheelchairs</li> <li>• providing mechanical devices for lifting, bed rails, slide sheets, sheepskins, tri-pillows, and pressure relieving mattresses</li> <li>• assistance in using the above aids</li> </ul>

<b>B. Support services</b>	<b>Care can include:</b>
Support services	<p>Includes:</p> <ul style="list-style-type: none"> <li>• cleaning</li> <li>• personal laundry services, including laundering of the consumer’s clothing and bedding that can be machine-washed, and ironing</li> <li>• arranging for dry-cleaning of the consumer’s clothing and bedding that cannot be machine washed</li> <li>• gardening</li> <li>• medication management</li> <li>• rehabilitative support, or helping to access rehabilitative support, to meet a professionally determined therapeutic need</li> <li>• emotional support including ongoing support in adjusting to a lifestyle involving increased dependency and assistance for the consumer and carer if appropriate</li> <li>• support for consumers with cognitive impairment, including individual therapy, activities and access to specific programmes designed to prevent or manage a particular condition or behaviour, enhance quality of life and provide ongoing support</li> <li>• providing 24-hour on-call access to emergency assistance including access to an emergency call system if the consumer is assessed as requiring it</li> <li>• transport and personal assistance to help the consumer shop, visit health practitioners or attend social activities</li> <li>• respite care</li> <li>• home maintenance, reasonably required to maintain the home and garden in a condition of functional safety and provide an adequate level of security</li> <li>• modifications to the home, such as easy access taps, shower hose or bath rails</li> <li>• assisting the consumer, and the homeowner if the home owner is not the consumer, to access technical advice on major home modifications</li> <li>• advising the consumer on areas of concern in their home that pose safety risks and ways to mitigate the risks</li> <li>• arranging social activities and providing or coordinating transport to social functions, entertainment activities and other out-of-home services</li> <li>• assistance to access support services to maintain personal affairs</li> </ul>
Leisure, interests and activities	<p>Includes:</p> <ul style="list-style-type: none"> <li>• encouragement to take part in social and community activities that promote and protect the consumer’s lifestyle, interests and wellbeing</li> </ul>

<b>C. Clinical services</b>	<b>Can include:</b>
Clinical care	Includes: <ul style="list-style-type: none"> <li>nursing, allied health and therapy services such as speech therapy, podiatry, occupational or physiotherapy services</li> <li>other clinical services such as hearing and vision services</li> </ul>
Access to other health and related services	Includes: <ul style="list-style-type: none"> <li>referral to health practitioners or other service providers</li> </ul>

### 3.6 Excluded items

The following services or items are outside the scope of the Home Care Packages Programme and must not be included in a package (at any of the four levels of home care).<sup>18</sup>

<b>Excluded items</b>	<b>Items:</b>
Excluded items	<ul style="list-style-type: none"> <li>use of the package funds as a source of general income for the consumer</li> <li>purchase of food, except as part of enteral feeding requirements*</li> <li>payment for permanent accommodation, including assistance with home purchase, mortgage payments or rent</li> <li>payment of home care fees</li> <li>payment of fees or charges for other types of care funded or jointly funded by the Australian Government</li> <li>home modifications or capital items that are not related to the consumer's care needs</li> <li>travel and accommodation for holidays</li> <li>cost of entertainment activities, such as club memberships and tickets to sporting events</li> <li>payment for services and items covered by the Medicare Benefits Schedule or the Pharmaceutical Benefits Scheme</li> <li>gambling activities</li> <li>illegal activities</li> </ul>

#### Clarification

**\*Meals** – The government subsidy for a Home Care Package can be used to pay for the preparation and delivery of meals. This could be through the consumer's home care provider, a HACC service provider (for example, under a sub-contracting arrangement with the home care provider) or by a private service provider. However, the consumer is expected to cover, or to make a contribution towards, the cost of the food. The amount of the contribution or fee may be negotiated between the home care provider, the meals service provider and the consumer.

<sup>18</sup> These items are excluded under Part 2 of Schedule 3 to the *Quality of Care Principles 2014*.

## 4. Security of tenure

### 4.1 Responsibilities for the provider

Under the legislation, home care providers are responsible for ensuring a consumer's security of tenure.<sup>19</sup>

The Home Care Agreement must specify how either party may terminate the Home Care Agreement<sup>20</sup> and must not contradict the security of tenure provisions set out in the *User Rights Principles 2014*.<sup>21</sup>

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

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

- the consumer cannot be cared for in the community with the resources<sup>22</sup> available to the home care provider;
- the consumer tells the home care provider, in writing, that they wish to move to a location where home care is not available through the home care provider;
- the consumer tells the home care provider, in writing, that they no longer wish to receive the care; or
- the consumer's condition changes so that:
  - they no longer need home care; or
  - the consumer's needs, as assessed by the ACAT, can be more appropriately met by other types of services or care.
- the consumer does not meet his/her responsibilities, as described in the 'Charter of Care Recipients' Rights and Responsibilities – Home Care', for a reason within the consumer's control, for example:
  - if a consumer does not pay the fees or negotiate an alternative with their provider, the provider may re-allocate the consumer's package to another person.

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

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<sup>19</sup> Section 56-2 of the *Aged Care Act 1997*.

<sup>20</sup> Division 4, paragraph 23(2)(g) of the *User Rights Principles 2014*.

<sup>21</sup> Division 2, section 17 of the *User Rights Principles 2014*.

<sup>22</sup> Resources available to the provider can include informal care and support provided by the consumer's family and/or other supports paid for by the consumer, in addition to the supports provided by the packages.

## 4.2 Consumers moving locality

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

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

Should a consumer move to another location, any unspent consumer contributions (e.g. advance monthly consumer payments and any top-up payments) paid by the consumer would have to be refunded. For information on the treatment of unexpended funds in the consumer's existing package, refer to Part D, Section 3.2.5.

## 5. Leave provisions

### 5.1 Overview

A consumer may choose or need to take temporary leave from their Home Care Package for various reasons – for a hospital stay which may sometimes be followed by transition care, to receive respite care, or for any other purpose, such as social leave. Previously there were different leave provisions between CACP and EACH/EACHD packages.

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

### 5.2 Suspension of home care agreement arrangements

Under section 46.2 of the *Aged Care Act 1997*, a home care recipient may suspend their home care agreement for any reason on a temporary basis. For this to occur, a home care provider must be informed in writing. The consumer must also advise the home care provider in writing of any extension to a planned episode of leave.

A consumer's tenure will not be affected while on leave (suspending services) as long as they advise the home care provider in writing they are taking leave. The provider continues to receive subsidy in respect of the consumer during a suspension period at a reduced rate after 28 days. Refer to the table below for the impact of suspension on subsidy payments.

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



the home care provider of the relevant dates for the proposed suspension of services.

Suspensions are calculated on a financial year basis from 1 July. If a consumer transfers to a different Home Care Package level, such as from Level 3 to Level 4, within the same financial year, the suspension subsidy balances are reset when the new package commences.

The following table provides information about how the subsidy is paid to providers in relation to suspending the home care agreement. This applies to all Home Care Package levels (1 to 4).

Types of suspension	Impact on payment of subsidy to approved provider
Hospital	<ul style="list-style-type: none"> <li>Home care subsidy is payable (at the full basic subsidy rate) for up to 28 <b>consecutive</b> days in a financial year, for each episode of hospitalisation.</li> <li>After 28 consecutive days, the subsidy is payable at 25 per cent of the basic subsidy rate.</li> </ul>
Transition care	<ul style="list-style-type: none"> <li>Home care subsidy is payable (at the full basic subsidy rate) for up to 28 <b>consecutive</b> days in a financial year, for each episode of transition care.</li> <li>After 28 consecutive days, the subsidy is payable at 25 per cent of the basic subsidy rate.</li> </ul>
Residential Respite care	<ul style="list-style-type: none"> <li>Home care subsidy is payable (at the full basic subsidy rate) for up to 28 <b>cumulative</b> days in a financial year.</li> <li>After 28 cumulative days, the subsidy is payable at 25 per cent of the basic subsidy rate.</li> </ul>
Social leave*	<ul style="list-style-type: none"> <li>Home care subsidy is payable (at the full basic subsidy rate) for up to 28 <b>cumulative</b> days in a financial year.</li> <li>After 28 cumulative days, the subsidy is payable at 25 per cent of the basic subsidy rate.</li> </ul>

\*all other suspension types

### 5.3 Impact of suspension on consumer fees (care fees)

A consumer may be required to pay an ongoing care fee to the home care provider while the consumer is on leave from their package<sup>23</sup>. This amount must be no more than the usual fee agreed between the consumer and the home care provider.

<sup>23</sup> Division 46, section 46-2 of the *Aged Care Act 1997* and *Aged Care (Transitional Provisions) Act 1997*; Division 2, section 72 of the *Subsidy Principles 2014*; section 108 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*; and Division 5, Part 4, subsection 130(5) of the *Aged Care (Transitional Provisions) Principles 2014*.

### **5.3.1 Consumers on a Home Care Package on or before 30 June 2014**

A consumer who was in receipt of a package on 30 June 2014, cannot be asked to pay a home care fee while the consumer's package has been suspended while the consumer is receiving transition care or residential respite care.<sup>24</sup>

### **5.3.2 Consumers on a Home Care Package on or after 1 July 2014**

For consumers who entered into a Home Care Agreement on or after 1 July 2014, the income tested care fee payable (if any) will remain payable while their package is suspended. The full fee will be paid for up to 28 days (see above table), after which the consumer will pay whichever is the lesser of:

- their income tested care fee, as previously advised; or
- the amount of the reduced home care subsidy, plus the primary supplements payable.

The Department of Human Services will notify the provider and consumer in writing of the amount payable.

A consumer who suspends their package to go into residential respite or transition care can apply for the financial hardship subsidy for the period of suspension if payment of the income tested care fee will put them into financial hardship.

However, for consumers who entered into a Home Care Agreement on or after 1 July 2014, the basic daily care fee must not be charged by the home care provider when the consumer takes leave for transition care or residential respite care<sup>25</sup>.

## **5.4 Impact of suspension on supplements**

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

- Dementia and Cognition Supplement and Veteran's Supplement
- Top-up Supplement
- Viability Supplement

However the following supplements will not be paid should the home care agreement be suspended:

- Enteral Feeding Supplement
- Oxygen Supplement

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<sup>24</sup> Subsection 130(5) of the *Aged Care (Transitional Provisions) Principles 2014*.

<sup>25</sup> Section 108 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

When the home care subsidy is paid at the reduced rate (25 per cent) after 28 consecutive days of suspension, payment of all supplements will cease, with the exception of the Viability Supplement. The amount of the Viability Supplement remains unchanged while the consumer is on leave.

### **5.5 Subsidy and care fees during suspension periods in packages delivered on a CDC basis**

For Home Care Packages being delivered on a CDC basis, any subsidy, relevant supplements<sup>26</sup> or care fees paid to the home care provider while the consumer is on leave must be included in the regular statement of income and expenditure provided to the consumer.

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<sup>26</sup> Dementia and Cognition, Veterans, Oxygen, Enteral Feeding and Top-Up Supplements (where applicable).

## Part F – Rights and responsibilities

### Covered in this part

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

### 1. Context

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

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

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

### 2. Consumers

#### 2.1 Rights and responsibilities

The rights and responsibilities of the consumer in relation to Home Care Packages are set out in the ‘Charter of Care Recipients’ Rights and Responsibilities – Home Care’ (the Charter).<sup>27</sup>

The Charter is contained in Schedule 2 to the *User Rights Principles 2014*. The full Charter will be available on the Department’s website.

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

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<sup>27</sup> The Charter was previously called the ‘Charter of Rights and Responsibilities for Community Care’.

## 2.2 Advocacy

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

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

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

The approved provider must allow an advocate acting for an authorised body access to the home care service if the consumer or their representative has requested the assistance of such a person.<sup>28</sup>

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

Should the consumer not have an advocate one may be made available through the National Aged Care Advocacy Programme.

### 2.2.1 National Aged Care Advocacy Programme

The National Aged Care Advocacy Programme (NACAP) is funded by the Australian Government under the *Aged Care Act 1997* and provides free, confidential advocacy support and information to consumers or potential consumers of Australian Government subsidised Home Care Packages.

There are nine community-based NACAP organisations operating nationally, one in each state and territory, and two in the Northern Territory. NACAP organisations provide information and support to consumers or potential consumers of aged care services, their carers and families about their rights and responsibilities when accessing services.

NACAP services:

- support consumers or people who are looking to receive residential aged care services or Home Care Packages to be involved in decisions that affect their life and their care needs;
- provide consumers receiving, or who are going to receive, residential aged care services or Home Care Packages with information and advice about their rights and responsibilities;

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<sup>28</sup> Division 2, section 18 of the *User Rights Principles 2014*.

- assist consumers of residential aged care services or Home Care Packages and/or their representatives to resolve problems or complaints in relation to aged care services, through the provision of advocacy; and
- promote the rights of consumers receiving residential aged care services or Home Care Packages to aged care service providers.

To contact a NACAP provider in your area please call the National Aged Care Advocacy line on **1800 700 600**.

### 2.3 Complaints

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

Approved providers must have appropriate processes in place to receive, record and resolve complaints.<sup>29</sup> These processes are to include consideration of people with special needs such as people with vision or hearing impairments and people from culturally and linguistically diverse backgrounds. Approved providers are required to inform consumers about these mechanisms and they must be identified in the Home Care Agreement.

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

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

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

### 2.4 Aged Care Complaints Scheme

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

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

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<sup>29</sup> Section 56-4 of the *Aged Care Act 1997*.

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

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

The processes of the Complaints Scheme, including options for resolution, are governed by the *Complaints Principles 2014* under the Act.

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

- the 'Charter of Care Recipients' Rights and Responsibilities – Home Care'; and
- the Home Care Standards.

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

More information can be found on the [Aged Care Complaints Scheme webpage](#).

### **3. Approved providers**

#### **3.1 Responsibilities**

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

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

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

##### **3.1.1 Quality of care**

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

This includes providing care and services in accordance with the *Quality of Care Principles 2014* and complying with the Home Care Standards.

Through the Quality Reporting Programme, the Australian Aged Care Quality Agency undertakes reviews of approved providers against the Home Care Standards. The Quality Reporting Programme is explained below in Section 5 in this Part.

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

### **3.1.2 User rights**

Division 56 of the Act outlines the general responsibilities of approved providers in relation to consumers (users and proposed users) of Home Care Packages. These responsibilities are described in further detail in Part 4.2 of the Act and in the *User Rights Principles 2014*.

In summary, the responsibilities of approved providers include:

- charging fees in accordance with the Act;
- providing security of tenure;
- entering (or offering to enter) into a Home Care Agreement;
- protecting personal information;
- resolving complaints;
- the provision of information;
- access to home care service by advocates; and
- complying with any rights and responsibilities of consumers that are specified in the *Users Rights Principles 2014*.

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

### **3.1.3 Accountability**

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

- record keeping;
- complying with powers being exercised by authorised officers;
- complying with conditions of allocation;
- complying with responsibilities specified in the *Accountability Principles 2014* (includes police check/certificate requirements); and
- obligations in relation to key personnel.



## 4. Police check/certificate requirements

### 4.1 Overview

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

- all staff members who are reasonably likely to have access to care recipients; and
- volunteers who have, or are likely to have, unsupervised access to care recipients,

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

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

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

Volunteers provided by the Community Visitors Scheme (CVS) have a police certificate and have been assessed as meeting the requirement.

### 4.2 Staff member

A staff member is defined in section 4 of the *Accountability Principles 2014* as a person who:

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

### 4.3 Volunteer

Under Part 1, section 4 of the *Accountability Principles 2014*, a volunteer is defined as a person who:

- is not a staff member of the approved provider; and
- offers his or her services to the approved provider; and
- provides care or other services on the invitation of the approved provider and not solely on the express or implied invitation of a care recipient; and
- has, or is reasonably likely to have, unsupervised access to care recipients; and

- is at least 16 years old or, if the person is a full-time student, has turned 18 old.

#### **4.4 Key personnel**

Additional conditions apply to key personnel. Part 2 of the *Sanctions Principles 2014* outlines the reasonable steps to be taken by an approved provider to ensure none of its key personnel is a disqualified individual. Approved providers are required to obtain a signed statutory declaration from its key personnel stating whether he or she has been convicted of an indictable offence or is an insolvent under administration.

The approved provider must:

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

Part 6 of the *Accountability Principles 2014* and section 9 of the *Records Principles 2014* outline the responsibilities of approved providers in relation to police checks or police certificates (the names are used interchangeably) for staff members, contractors and volunteers.

#### **4.5 Contractors**

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

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

#### **4.6 Independent contractors**

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

generally do not require police checks. The policy intention is to allow for reasonable judgments to be made.

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

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

Visiting medical practitioners, pharmacists and other health professionals who have been requested by, or on behalf of, a consumer but are not under contract to the approved provider also do not require police checks.

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

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

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

The difference between a contractor and an independent contractor is generally decided on the basis of the degree of control that is exercised over the person's work. A precise determination of whether a contractor is under the control of an approved provider can be difficult, and whether someone is a staff member or an independent contractor is a matter that might ultimately be determined by the courts.

To assist employers to determine whether an individual is a staff member or an independent contractor, a Contractor Decision Tool is available at the [business.gov.au website](https://www.business.gov.au).

Further information about police checks is available:

- by phone: **1800 200 422**
- in writing to:
  - the Department’s inbox [agedcare.police.checks@dss.gov.au](mailto:agedcare.police.checks@dss.gov.au)
  - Aged Care Police Checks  
Aged Care Quality and Compliance Group  
Department of Social Services  
PO Box 7576  
CANBERRA BUSINESS CENTRE ACT 2610
- online: at the [Police Certificate Guidelines for Aged Care Providers webpage](#).

## 5. Quality Reporting Programme

The Home Care Standards apply to the delivery of Home Care Packages. The Standards are contained in Part 3, Division 2 of the *Quality of Care Principles 2014*.

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

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

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

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

The quality review process has been managed by the Department of Social Services. From 1 July 2014, this became one of the responsibilities of the Australian Aged Care Quality Agency.

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

## **6. Qualifications of staff and workers**

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

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

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

## Part G – Consumer care fees

### Covered in this part

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

## 1. Overview

### 1.1 Arrangements from 1 August 2013

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

These arrangements will continue to apply from 1 August 2013 under the Home Care Packages Programme – as set out in this Part, Sections 2 and 3 below.

### 1.2 Arrangements from 1 July 2014

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

The Department of Human Services advises the home care provider and the consumer on the maximum fees payable. However, the home care provider and the consumer are able to negotiate lower fees should they choose. It is important to note that the government subsidy cannot be used to meet the consumer's income tested care fee. That is, the provider and consumer cannot select a lower level of care and services to match the value of the government subsidy paid.

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

Further information about these changes is available from the [My Aged Care website](#) at [www.myagedcare.gov.au](http://www.myagedcare.gov.au) or the national contact centre on **1800 200 422**.

## 2. Determining care fees

### 2.1 Existing Home Care Package consumers at 30 June 2014

Where consumers are already receiving a Home Care Package before 1 July 2014, the changes to the income tested care fee that start on 1 July 2014 will not apply to them. These consumers may continue to be asked to pay a basic daily care fee and any fees calculated on income they receive above the basic pension. They will continue to receive the same package of care after 1 July 2014 and will not be affected by the new fee arrangements if they move between package levels.

If the consumer terminates their Home Care Agreement for more than 28 days, the new fee arrangements commencing on 1 July 2014 will apply if the consumer commences a new package.

The maximum fee that a consumer can be asked to pay in a care recipient contribution (referred to in these Guidelines as a basic daily care fee) is determined by the legislation.<sup>30</sup> For an existing Home Care Package consumer before 1 July 2014, their care fee will be calculated as follows:

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

**Example:** Where a consumer receives the single pension, for example \$766.00 per fortnight, the maximum fee they would pay is \$133.98 per fortnight. This example is based on the pension rates as at 20 March 2014. Pension rates are updated twice a year in March and September.

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

The maximum amount that a service provider can charge depends on the consumer's income but the provider must also consider other expenses such as high pharmaceutical bills, rent, utilities and other living expenses.

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

<sup>30</sup> Division 60 of the *Aged Care (Transitional Provisions) Act 1997* and Part 4, section 130 of the *Aged Care (Transitional Provisions) Principles 2014*.

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

However, a home care provider can ultimately withdraw the service for non-payment of fees, as detailed in the *User Rights Principles 2014*.<sup>31</sup> A consumer's responsibilities include paying the fees specified in the agreement. If a consumer does not pay the fees or negotiate an alternative with their provider, the provider may re-allocate the consumer's package to another person.

The legislation also requires that information about fees, including how fees are calculated and the fees payable, is included in the Home Care Agreement between the consumer and the home care provider.<sup>32</sup>

### 2.1.1 What constitutes income?

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

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

### 2.1.2 Review of care fees

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

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

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<sup>31</sup> Paragraph 17(2)(e) of the *User Rights Principles 2014* and clause 2(5) of the *Charter of Care Recipient's Rights and Responsibilities – Home Care*

<sup>32</sup> Section 23 of the *User Rights Principles 2014*.



## 2.2 New income testing arrangements from 1 July 2014

New consumers of home care services from 1 July 2014 can be asked to pay one or both of the following:

- a basic daily care fee, equivalent to 17.5 per cent of the single basic age pension; and
- an income tested care fee if their income is over a certain amount.

The Australian Government will reduce the amount of subsidy it pays a service provider, based on the amount the consumer can be asked to pay as an income tested care fee.

The basic daily care fee does not impact the amount of government subsidy payable.

### 2.2.1 Basic daily care fee

Every consumer taking up a Home Care Package can be asked by their service provider to pay the basic daily care fee.

The maximum basic daily care fee is 17.5 per cent of the single person rate of the basic age pension. This is \$133.98 per person, per fortnight (from 20 March 2014 to 19 September 2014).

This rate increases on 20 March and 20 September each year in line with changes to the age pension. This applies to each person receiving a Home Care package, even if they are a member of a couple.

### 2.2.2 Income tested care fee

Depending on a consumer's income, they may be asked by their service provider to contribute more to the cost of their care. This extra amount is known as an 'income tested care fee'.

A consumer **cannot** be asked to pay an income tested care fee if they have a yearly income below the maximum income for a full age pensioner. The maximum income amount for a full age pensioner at July 2014 rates is:

- individual person – \$24,835.20;
- member of a couple but now separated due to illness (individual income) – \$24,367.20; or
- member of a couple living together (combined income) – \$38,552.80.

Consumers who are not currently in receipt of a means tested income support payment will need to complete and lodge an income assessment form. If the consumer is asked to complete and lodge this form but fails to do so, they can be asked to pay the maximum income tested care fee.

The Department of Human Services or the Department of Veterans' Affairs will work out the maximum income tested care fee payable based on an assessment of the consumer's income information, including the income deemed from their financial assets. The assessment does not include the value of the family home or any other assets.

More information on the income tested care fee is available on the [My Aged Care website](#).

### **2.2.3 Caps on care fees**

There is a limit to how much a consumer has to pay in income tested care fees. For part pensioners, this is **\$5,000** per year. For self-funded retirees, this is **\$10,000** per year. Once a consumer has reached this cap, the Australian Government will pay the consumer's share of the income tested care fee to the provider until the next anniversary of their start date into aged care.

There is a lifetime limit on income tested care fees (in home care) and means-tested care fees (in residential care) of **\$60,000**. Once a consumer has reached this cap, they will not have to pay any further income or means tested care fees during their lifetime.

The annual and lifetime caps are indexed biannually. The current value of the caps is included in the 'Schedule of Fees and Charges for Residential and Home Care: From 1 July 2014', which is available on the [Department of Social Services website](#).

### **2.2.4 How does a consumer work out what costs they may be asked to pay?**

A consumer who is in receipt of a means tested income support payment does not need to complete the income assessment form. The Department of Human Services or Department of Veterans' Affairs will have the information needed to calculate the income tested care fee payable, if any. Once the Department of Human Services is notified that a consumer has commenced a package, the consumer and provider will be sent a letter from the Department of Human Services advising of the maximum fees payable.

However, a consumer in receipt of a means tested income support payment can seek fee advice from the Department of Human Services before commencing care. To do this the consumer can either call the Department of Human Services on **1800 227 475** or complete their contact details and sign the income assessment form.

In all cases a self-funded retiree will need to complete the income assessment form. This can be done either before or shortly after commencing a package. The Department of Human Services will send the consumer and provider a letter advising of the maximum fees payable.

Where an assessment is done prior to the consumer commencing care, the fee advice will be valid for 120 days unless there is a significant change in the consumer's circumstances.

If a consumer is simply seeking an indication of the fees that may be payable they can use the Fee Estimator available on the [My Aged Care website](#). If the consumer does not have access to a computer they can call the national contact centre on **1800 200 422**. The contact centre will use the same fee estimator that is available on line to estimate the consumer's fees and charges.

The actual fees the consumer will pay will depend on the assessment undertaken by the Department of Human Services or the Department of Veterans' Affairs.

### **2.2.5 What constitutes income?**

Income for aged care purposes is assessed in the same way as it is for the age pension. Unlike taxable income, income from superannuation and government income support payments is included in determining overall income.

For a member of a couple, it is half of the couple's combined income which is attributed to each member of the couple and considered against the applicable income threshold. This applies no matter who earned the income.

### **2.2.6 Review of fees**

Once a consumer has commenced a Home Care Package the basic daily care fee and income tested care fee may change as a result of changes to the age pension, and in the case of the income tested care fee, the consumer's income.

Changes to the age pension will affect the basic daily care fee and the income free area and income thresholds which are used to determine the income tested fee.

The income tested care fee may also change if the care recipient's financial circumstances, marital status or home ownership change.

The basic daily care fee increases in March and September each year in line with age pension increases.

Income tested fees are generally set for four periods per year and reviewed in March, July, September and November/December each year. However, fees can also be reviewed and adjusted at other times including upon the request of a consumer or by the Department of Human Services where there has been a significant change to a consumer's circumstances.

The consumer and provider will be notified by letter if there is a change in the income tested care fee. Providers should refer to the 'Schedule of Fees and Charges

for Residential and Home Care: From 1 July 2014' for changes in the rate of the basic daily care fee, available on the [Department of Social Service's website](#).

### **2.3 Financial advice**

Consumers may want to consult with a financial adviser about their finances. There are various government services and resources that can help consumers obtain appropriate financial advice. It is suggested consumers do some research to see what options work best for them.

### **2.4 Provisions for financial hardship**

A consumer commencing a Home Care Package under the new fee arrangements, after 1 July 2014, is eligible to seek financial hardship assistance with their home care fees.

Financial hardship assistance is available for the basic daily care fee and/or income tested care fee.

For Home Care Packages, the value of the consumer's assets will be taken into account as part of the assessment process for financial hardship assistance.

During periods of residential respite or transition care, consumers who pay an income tested care fee can also apply for the Hardship Supplement if payment of the income tested care fee will put them into financial hardship.

The basic daily care fee cannot be charged when a consumer takes leave for transition care or residential respite care.

The consumer, their representative or the provider may apply for financial hardship assistance in respect of the fees payable by the consumer. To apply for financial hardship assistance, the consumer or their representative will need to complete an application for financial hardship assistance and submit the form to the Department of Human Services. To obtain a copy of the application form a consumer should call the Department of Human Services on **1800 227 475** or the provider can call the Department of Human Services on **1800 195 206**.

If financial hardship is granted, the Government will pay a hardship supplement of an amount determined in each individual case. The home care fees payable will be reduced by the amount of hardship supplement.

## **3. Payment of care fees in advance**

Home care providers may ask for fees to be paid up to one month in advance. If a consumer leaves the programme, any payment in advance beyond the date of leaving must be refunded to the consumer or their representative within 30 days of ceasing the package.

## Part H – Supplements

### Covered in this part

- Eligibility for supplements
  - Dementia and Cognition Supplement and Veterans’ Supplement
  - Oxygen Supplement
  - Enteral Feeding Supplement
  - Viability Supplement
  - Top-up Supplement
  - Hardship Supplement

### 1. Eligibility for Supplements

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

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

#### 1.1 Dementia and Cognition Supplement and Veterans’ Supplement

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

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

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

Guidelines for these supplements are available on the [Department of Social Services webpage](#).

Supplements amounts for 2014-15 are outlined in the following table.

Home Care Package	Level 1	Level 2	Level 3	Level 4
Home Care Package basic subsidy	\$21.43	\$38.99	\$85.73	\$130.32
Dementia and Cognition Supplement (10 per cent)	\$2.14	\$3.90	\$8.57	\$13.03
Veterans' Supplement (10 per cent)	\$2.14	\$3.90	\$8.57	\$13.03

## 1.2 Oxygen Supplement

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

The Oxygen Supplement is paid to the home care provider for a consumer who has an ongoing medical need. The oxygen supplement covers the cost of oxygen, oxygen equipment and other costs associated with the administration of continual oxygen therapy. There is no supplement available for episodic or short-term illnesses such as bronchitis.

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

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

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

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

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

The rates for the Oxygen Supplement are the same as the Residential Aged Care Supplements (Care Related) rates. The rates are available on the [Department of Social Services aged care funding webpage](#).

### **1.3 Enteral Feeding Supplement**

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

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

A higher supplement may be approved when, for example:

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

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

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

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

The rates for the Enteral Feeding Supplements are the same as the Residential Aged Care Supplements (Care Related) rates. The rates are available on the [Department of Social Services aged care funding webpage](#).

#### **1.4 Viability Supplement**

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

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

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

Information about the Viability Supplement including the subsidy rates is available on the [Department of Social Services Aged Care Funding webpage](#).

#### **1.5 Top-up Supplement (for continuing EACHD consumers)**

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

#### **1.6 Hardship Supplement**

A consumer commencing a Home Care Package under the new fee arrangements on or after 1 July 2014, is eligible to seek financial hardship assistance with their home care fees. The Hardship Supplement is paid to the home care provider for consumers who have been granted financial hardship assistance as a result of experiencing difficulty in paying fees and charges for Home Care Packages. Provisions for financial hardship assistance are outlined in Part G, Section 2.4.

Further information on financial hardship assistance is also available on the [My Aged Care website](#).



## Part I – Administrative arrangements for approved providers

### Covered in this part

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

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

### 1. Conditions of allocation to replace agreements

From 1 August 2013, there is no requirement for approved providers to enter into an agreement with the Commonwealth in respect of allocations of new home care places. This came into effect when Schedule 1 to the *Aged Care (Living Longer Living Better) Act 2013* and the transitional provisions in the *Allocation Principles 1997* commenced.

For all places, including those allocated to providers in the 2012-13 ACAR, the conditions of allocation will include a requirement that the places must be delivered on a CDC basis.

For those existing home care packages delivering on a non CDC basis, the transition to CDC will not come into effect until 1 July 2015.

#### 1.1 Conditions of allocation

The conditions of allocation for home care places form part of the Notice of Allocation issued to the approved provider under section 14-8 of the *Aged Care Act 1997*.

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

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

Additional conditions of allocation may be issued from time to time under section 14-6 of the *Aged Care Act 1997*.

## **1.2 Commencement of places**

An allocation of places to an approved provider takes effect when the Secretary of the Department (or delegate) determines that the approved provider is in a position to provide care in respect of those places. The approved provider will be advised of this through a Notice of Allocation from the Department issued under section 14-8 of the *Aged Care Act 1997*.

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

If the place has been allocated on a provisional basis, the approved provider must advise the Department in writing when they are able to commence providing services. An approved provider must apply in writing to the Secretary using the form titled 'Application for a Determination that an Approved Provider is in a Position to Provide Care – Home Care'. This application form will be available on the Department's website.

Once this information has been considered by the Department, the delegate will make a determination under section 15-1 of the *Aged Care Act 1997*, and once approved, this will enable the approved provider to commence claiming a subsidy for the place. Such determinations cannot be backdated.

## **2. Variations, transfers and surrender or relinquishment of places**

### **2.1 Variations of places**

An approved provider can apply to the Secretary of the Department to vary an allocation of places (Home Care Packages) in certain circumstances, for example, to change conditions of allocation relating to geographic locations or special needs groups. This process can also be used to add a condition of allocation to deliver packages on a CDC basis. See Part D Section 6.

There are separate application forms for the variation of places that have taken effect (operational places) and places that are yet to take effect (provisionally allocated places). These forms will be available on the Department's website from mid 2014.

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

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

- Where an approved provider is seeking to change the name of a service, the approved provider should advise the Department in writing. However, this does not have to be done via an application form.
- There is no capacity under the legislation to approve a variation in the level of the home care place that has been allocated to an approved provider, for example, from a Level 1 or 2 place to a Level 3 or 4 place. Providers seeking to obtain places at a different level should apply through the Aged Care Approvals Round.

### **2.2 Transfer of places**

An approved provider may apply in writing to the Secretary of the Department to transfer operational places under sections 16-1 and 16-2 of the *Aged Care Act 1997*.

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

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

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

### 2.3 Surrender or relinquishment of places

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

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

## 3. Financial reporting to the Department

The *Accountability Principles 2014*<sup>33</sup> outline the financial reporting responsibilities of home care providers.

For the 2013-14 financial year, the Financial Accountability Report process will continue to apply. There will be a requirement for a non-audited statement stating the information given is a true account. This will need to be signed by the CFO or CEO of the home care provider.

The Financial Accountability Report for the reporting period 1 July 2013 to 30 June 2014, must be provided to the Department no later than **31 October 2014**.

The Aged Care Financing Authority (ACFA) has been asked to provide advice to the Assistant Minister for Social Services by 30 September 2014 on cost effective options for improving the collection of appropriate financial data from aged care providers.

Any new requirements are likely to apply from July 2015 for the 2015-16 financial year.

## 4. Reporting of new consumers

Providers need to lodge an Aged Care Entry Record (ACER) with the Department of Human Services for every client who commences a new Home Care Package from 1 July 2014.

The ACER is required to be completed within 28 days of home care commencing.

The ACER form can be downloaded from the [Department of Human Services website](#), or accessed at the [Medicare forms webpage](#).

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<sup>33</sup> Part 4, Division 4 of the *Accountability Principles 2014*.

The completed ACER can be submitted to the Department of Human Services via the [Aged Care Online Claiming webpage](#). Alternatively a paper form can be scanned and either:

- emailed to: [aged.care.liaison@humanservices.gov.au](mailto:aged.care.liaison@humanservices.gov.au); or
- mailed to:
  - Department of Human Services
  - Aged Care Payments
  - GPO Box 9923
  - SYDNEY NSW 2001

## 5. Claims process

### 5.1 Home care subsidy payments

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

There is information on the subsidy amounts for the Home Care Packages at Part E, Section 1 and on the [Department of Social Services aged care funding webpage](#).

Subsidy payments are made by the Department of Human Services on behalf of the Department of Social Services. An approved provider's initial payment claim form covers the payment period from the date when the home care places become operational.

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

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

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

The current provider statement is valid for the period 1 July 2014 to 30 June 2017. The next statement is due 30 June 2017 and will be sent to providers with services

not registered for Aged Care Online Claiming from the Department of Human Services in April 2017.

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

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

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

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

The form is titled 'Register or Amend Access for Aged Care Online Claiming Viewing electronic Aged Care Client Records'. Further information about claiming for Home Care Packages is available at the [Department of Human Services aged care webpage](#).

Additionally, information about online claiming is available at the [Department of Human Services online claiming webpage](#).

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

## **5.2 Home care subsidy is GST free**

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

## **5.3 Other taxation matters**

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

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

## Part J – Interface with other programmes

### Covered in this part

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

### 1. Interface with other programmes

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

This Part provides a short overview of these programmes, including the nature of the interface between each programme and the Home Care Packages Programme.

More detailed information about the individual programmes is available on the [My Aged Care website](http://www.myagedcare.gov.au) at [www.myagedcare.gov.au](http://www.myagedcare.gov.au) or the national contact centre on **1800 200 422**.

### 2. Commonwealth Home Support Programme

#### 2.1 Overview of programme

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

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

(ACHA) Programme is being considered for inclusion in the Home Support Programme.

## **2.2 Interface with the Home Care Packages Programme**

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

## **3. Home and Community Care (HACC)**

### **3.1 Overview of programme**

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

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

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

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

### **3.2 Interface with the Home Care Packages Programme**

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



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

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

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

### **3.2.2 Accessing HACC services in addition to a Home Care Package**

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

- As much as possible, a home care consumer's care needs should be addressed through their Home Care Package. A consumer may, however, access additional HACC services (funded by the HACC Programme rather than out of the budget for the Home Care Package) in an emergency, or when a carer is not able to maintain their caring role. These instances should be time limited, monitored and reviewed.
- A home care consumer receiving a Level 1 or 2 package may also access additional nursing or allied health services funded through the HACC Programme, where the budget for the Home Care Package has been fully allocated for care needs identified in the consumer's care plan and additional nursing or allied health services are required to support the consumer to remain living at home.
- When a HACC service provider is assessing a home care consumer's eligibility for services under the HACC Programme, the service provider must consider any other services that the consumer is already receiving. Priority for HACC services may be given to people who are not receiving any other services.

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

- Yes, where a home care consumer is accessing additional services through the HACC Programme, the consumer would be expected to pay any consumer fees charged for the HACC service (as applicable).
- The home care subsidy cannot be used to pay consumer fees charged for the HACC service.

## **4. National Respite for Carers Programme (NRCP)**

### **4.1 Overview of programme**

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

### **4.2 Interface with the Home Care Packages Programme**

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

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

## **5. Residential respite**

### **5.1 Overview of programme**

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

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

### **5.2 Interface with the Home Care Packages Programme**

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

The home care subsidy cannot be used to pay the consumer contribution for residential respite care. If the consumer is unable to afford the respite care contribution, this should be negotiated with the respite facility. Hardship assistance is available for those who cannot afford to contribute to the cost of their care. There are criteria which need to be met in order to receive financial hardship assistance and these are assessed on an individual basis.

Under the legislation, a basic daily care fee must not be charged by the home care provider where the consumer takes leave for residential respite care.<sup>34</sup>

## 6. Day Therapy Centres programme

### 6.1 Overview of programme

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

\* From 1 July 2014, the distinction between “low care” and “high care” in permanent residential aged care has been removed. The DTC Programme has replaced “low care” with equivalent Aged Care Funding Instrument (ACFI) classification ranges in the programme’s eligibility criteria.

#### 6.1.1 Therapy and services

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

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

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

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<sup>34</sup> Section 130 of the *Aged Care (Transitional Provisions) Principles 2014* and section 108 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

## **6.2 Interface with the Home Care Packages Programme**

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

## **7. Transition Care Programme**

### **7.1 Overview of programme**

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

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

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

### **7.2 Interface with the Home Care Packages Programme**

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

Under the legislation, a home care fee must not be charged by the home care provider where the consumer takes leave for transition care.<sup>35</sup>

## **8. Community Visitors Scheme**

### **8.1 Overview of programme**

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

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<sup>35</sup> Section 130 of the *Aged Care (Transitional Provisions) Principles 2014* and section 108 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

The CVS funds community-based organisations (known as CVS auspices) to work with aged care providers in matching suitable volunteers with aged care recipients who have been identified by their aged care providers as being socially isolated, or at risk of becoming socially isolated due to lack of family contact, cultural reasons or disability. The CVS has a specific focus on targeting individuals who identify as being from one of the special needs groups under the *Aged Care Act 1997*.

The relationship between the CVS auspice and aged care providers is critical in ensuring those that would benefit from social contact are identified and matched appropriately.

The CVS auspices carry out the tasks of:

- recruiting, training and supporting volunteer community visitors;
- matching volunteers to aged care recipients; and
- supporting visitor-care recipient relationships.

The CVS is funded by the Australian Government and operates in every state and territory. To locate a CVS auspice operating in your area, contact My Aged Care on **1800 200 422**.

## **8.2 Interface with the Home Care Packages Programme**

From 1 August 2013, the CVS was expanded to home care. Consumers receiving a Home Care Package can access the CVS, but they must not be charged fees for visits provided through the CVS.

## **9. Disability programmes**

### **9.1 Overview of programme**

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

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

These arrangements came into place on 1 July 2012.

## 9.2 National Disability Insurance Scheme Australia

From 1 July 2013, the National Disability Insurance Scheme (NDIS) commenced in South Australia, Tasmania, the Hunter region in New South Wales, and the Barwon region in Victoria. The Australian Capital Territory, the Perth Hills region of Western Australia and the Barkly region of the Northern Territory joined the NDIS on 1 July 2014. Additionally, Queensland will begin to roll-out the scheme from July 2016.

The NDIS is expected to be fully rolled out nationally by 2019-20.

Further information about the NDIS is available at the [National Disability Insurance Scheme website](#).

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

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

Each of these requirements is specified in the *National Disability Insurance Scheme Act 2013* and the 'National Disability Insurance Scheme Rules'.

## 9.3 Interface with the Home Care Packages Programme

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

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

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

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

The final decision to offer a Home Care Package to a young person is made by the home care provider. The provider will need to consider the appropriateness of their

service, including what can be offered under a Home Care Package at the level available, to meet the care needs of the younger person.

## **10. Contenance Aids Payment Scheme**

### **10.1 Overview of programme**

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

Further information about the Scheme, including who is eligible to apply for a payment, is available on the [Department of Social Service's bladderbowel website](#).

### **10.2 Interface with the Home Care Packages Programme**

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

## **11. Palliative care**

### **11.1 Overview of palliative care**

The Australian Government provides:

- funding for national palliative care projects primarily focusing on education, training, quality improvement and advance care planning;
- financial support to state and territory governments to operate palliative care services, a form of subacute care, as part of their health and community service provision responsibilities. (State and territory governments are responsible for determining their palliative care funding priorities and required mix of services within their jurisdictions); and
- subsidies for palliative care medicines under the PBS and palliative care consultations under the MBS.

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

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

## **11.2 Interface with the Home Care Packages Programme**

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

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

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

## **12. Hospital in the Home**

### **12.1 Overview of programme**

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

### **12.2 Interface with the Home Care Packages Programme**

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

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



## **13. Department of Veterans' Affairs Programmes**

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

Through DVA, eligible veterans and war widows/widowers may also access a range of other services, for example the Coordinated Veterans' Care Programme, Veterans' Home Care, community nursing, allied health services such as physiotherapy and podiatry, counseling services and transport for health care. For further information on these programmes, refer to the [Department of Veterans' Affairs website](#).

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

### **13.1 Veterans' Home Care programme**

#### **13.1.1 Overview of programme**

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

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

#### **13.1.2 Interface with the Home Care Packages Programme**

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

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

The veteran or war widow/widower should not be accessing the same service tasks simultaneously from VHC and the Home Care Package, e.g. showering. In some instances, however, the veteran or war widow/widower may supplement the care provided under a Home Care Package with some VHC services, such as additional respite care, if the Home Care Package is not sufficient to meet the veteran's or war widow/widower's needs. As the Home Care Package remains the primary source of care, the selection of services under the Home Care Package utilising CDC should be focused on meeting the primary care needs from within the Home Care Package. It should not be expected that VHC will be able to provide additional services.

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

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

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

## **13.2 Coordinated Veterans' Care Programme**

### **13.2.1 Overview of programme**

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

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

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

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

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

### **13.2.2 Interface with the Home Care Packages Programme**

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

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

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

## **13.3 Department of Veterans’ Affairs Community Nursing Programme**

### **13.3.1 Overview of programme**

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

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

- general practitioner;
- treating doctor in a hospital;
- hospital discharge planner;
- nurse practitioner specializing in a relevant field; or
- Veterans’ Home Care (VHC) Assessment Agency.

DVA has criteria for access to community nursing services, as set out in the DVA Fact Sheets available on the [Department of Veterans' Affairs website](#).

### **13.3.2 Interface with the Home Care Packages Programme**

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

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

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

## **13.4 Department of Veterans' Affairs Rehabilitation Appliances Programme**

### **13.4.1 Overview of programme**

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

The programme provides aids and appliances:

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

The equipment should be:

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

### 13.4.2 Interface with the Home Care Packages Programme

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

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

## 13.5 Veterans' Transport for Treatment

### 13.5.1 Overview of programme

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

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

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

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

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

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

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

- they are aged 80 years or older;
- public, community or private transport are not available
- they have any of the following **medical conditions**:
  - legal blindness;
  - dementia;
  - psychosis;
  - hemiplegia;
  - ataxia;
  - respiratory insufficiency severely limiting independent activity;
  - cardiac failure severely limiting independence;
  - recent coronary occlusion severely limiting independence;
  - peripheral vascular disease severely limiting independence;
  - amputation severely limiting independence;
  - arthritis severely limiting independence;
  - recent surgery severely affecting your capacity to use public transport;
  - conditions that would cause you to be gravely embarrassed or that are unacceptable to other passengers on public transport e.g. incontinence of bladder or bowel, severe deformity or disfigurement;
  - significant trauma; or
  - frailty that severely limits your independence.

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

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

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

- former Repatriation General Hospitals;
- public and approved private hospitals;
- providers of prosthetics, surgical footwear and orthotics;

- Office of Hearing Services accredited providers;
- medical specialist rooms; or
- radiology, imaging and pathology services.

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

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

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

### **13.5.2 Interface with the Home Care Packages Programme**

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

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

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

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

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

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

## Part K – Appendices

### Appendix A – Glossary of terms

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



Term	Meaning
	<i>Care Act 1997 and Aged Care (Transitional Provisions) Act 1997</i>
home care consumer (or consumer)	A person who is receiving care and services under a Home Care Package funded by the Australian Government. In the <i>Aged Care Act 1997</i> , this person is referred to as a “care recipient”
home care provider (or approved provider)	An organisation approved by the Department of Social Services under Part 2.1 of the Act as suitable to provide home care. In the <i>Aged Care Act 1997</i> , this person or body is referred to as an “approved provider”
Home Care Agreement	An agreement entered into by a consumer and a home care provider outlining rights and responsibilities and what services will be provided to the consumer under the Home Care Package
Home Care Standards	The Home Care Standards means the ‘Home Care Common Standards’, as set out in Schedule 4 to the <i>Quality of Care Principles 2014</i>
Home Care Packages Programme	The Australian Government programme that provides funding for Home Care Packages aimed at supporting people to remain living at home
home care subsidy	The subsidy payable to a home care provider by the Australian Government under Part 3.2 of the <i>Aged Care Act 1997 and Aged Care (Transitional Provisions) Act 1997</i>
income tested care fee	Refers to the fee a consumer may be asked to pay for their home care, based on an income assessment.
NACAP	The National Aged Care Advocacy Programme is funded by the Australian Government and provides advocacy support and promotes the rights of people who are seeking or are receiving Australian Government funded aged care services
NRCP	National Respite for Carers Programme is one of several initiatives designed to support and assist relatives and friends caring at home for people who are unable to care for themselves because of disability or frailty.
Principles	Aged Care Principles made under section 96-1 of the <i>Aged Care Act 1997 and Aged Care</i>

Term	Meaning
	<i>(Transitional Provisions) Act 1997</i>
re-ablement	The use of timely assessment and targeted interventions to assist people to maximise their independence, choice and quality of life and minimise support required – to enable people to actively participate and remain engaged in their communities
suspension	Term used when a consumer takes a period of leave from their Home Care Package, and some or all services are suspended.
VHC	Veterans' Home Care