Inclusion/Exclusion Framework for HCP services/purchases Form

Client's Name:……

Provider's Name: Daughterly Care Community Services Ltd

Care or Service requested :…….

The Department of Health requires this form to be completed.

Fill in with reference to the *Inclusions & Exclusions Framework Decision Tool*

Questions	**Document discussions and considerations**
Is the support Specifically Excluded under the Aged Care Legislation? Yes (Can't approve) / No / Ambiguous – need to ask Dept of Health	
Does the support directly align with the intent and scope of the HCP Program? Yes / No (Can't approve) / Ambiguous – need to Dept of Health	
Does the support pose a risk to the health and safety of our client? Yes / No	
Does the support pose a risk to the health and safety of DC staff or the community? Yes / No	
Is the support directly targeted for our client, or does it significantly benefit others, instead of our client? For client / Shared benefit / Significant benefit to others	
How does the support align with the *Assessed Ageing Related Care Needs* as documented in the ACAT Assessment, the providers' own assessment of the care recipient's needs or an assessment by a health care professional? Meets / Doesn't meet / Ambiguous	
How does the support assist our client to achieve their ageing related care goals, now and in the short to medium term? Is the support necessary to meet the care recipient's *ageing related Assessed Care Needs and care goals documented in the Care Plan?*	
Has the **evidence-base for the support** which addresses a particular *assessed ageing related care need* been considered? Yes / No evidence- base available (Not allowed to fund support where no evidence-base exists.)	

Does the support require maintenance to ensure the safe use of the item that represents a significant portion of the budget? Is it difficult to provide the maintenance required? Yes / No / Has sufficient in budget &/or Unspent Funds	
Is there an opportunity cost associated with the support? Will the care recipient miss out on a support identified in their assessment if package funding is used for a large purchase? e.g clinical care is first priority, followed by care & support. Yes (We can't approve) / No	
Can the support be provided informally through the community/family, if the budget can't afford it? Yes / No	
Does the support represent value for taxpayers' money to meet the care recipient's *assessed ageing related care needs?* No (We can't approve) / Yes	
Is the care support, service being provided by family or friends? Yes (HCP can't pay family/friends) / No	
Determination: The care or service type _____	Is an Inclusion / Exclusion (circle one) to the care plan

Care Manager Name: _____

Care Manager Signature: _____

Date: _____/2023

Home Care Package Program Manager Name:_____

Home Care Package Program Manager Signature:_____

Date: _____/2023

☐ Scanned into MCP