Home Care Packages Program

Operational Manual

A guide for home care providers

Version 1.4 – August 2023

Contents

Reviews

Date	Summary of changes
March 2020	Manual (v1.0) first issued
February 2021	Manual revised (v1.1). Includes content about Improved Payment Arrangements, the Aged Care Provider Portal, addressing people receiving care and services under a package funded by the Australian Government as care recipients, updated web links and minor updates to wording.
September 2021	Manual revised (v1.2). Includes content about Improved Payment Arrangements.
January 2023	Manual revised (v1.3). Updates to Chapter 9: Inclusions and Exclusions including a decision tree and template providers can use to document agreed care and services with the care recipient; replaces all references to Department of Health with the Department of Health and Aged Care. Updates to Chapter 7 - Care Planning. Updates to Chapter 15: How does the HCP Program interact with other programs and schemes? Content updated to include information on price caps, pricing guidance, Serious Incident Response Scheme and unspent funds. All content has been revised and updated for currency.
August 2023	Manual revised (v1.4). Updated weblinks and contact details.

Disclaimer

The Home Care Packages Program is governed by the applicable legislation. Home care providers are responsible for understanding and complying with all legislation that is relevant to delivering home care.

If in doubt home care providers should consider the need to obtain their own appropriate legal advice relevant to their circumstances, especially in relation to the formulation of Home Care Agreements.

In addition to the legislation referred to in this Manual, other Australian Government portfolios and each state and territory may have its own separate legislation that is relevant to providers' operations as a home care provider. It is the provider's responsibility to understand and meet their obligations as they relate to all applicable legislation.

Any guidance released by the Department of Health and Aged Care is based on the policy intent of the program and a practical interpretation of the legislation.

In addition to this Manual, there are information resources that may further help providers understand their responsibilities and obligations as an approved provider. These Australian Government resources are available from:

- The Department of Health and Aged Care www.health.gov.au
- My Aged Care www.myagedcare.gov.au
- The Aged Care Quality and Safety Commission www.agedcarequality.gov.au
- Services Australia www.servicesaustralia.gov.au
- The Australian Competition and Consumer Commission www.accc.gov.au
- Australian Tax Office www.ato.gov.au

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1 Introduction

This section discusses management of the Home Care Packages (HCP) Program Provider Manual (this manual) including how it will be updated, and how to provide feedback on the manual.

1.1 What does this manual contain?

This manual provides guidance on the Australian Government's policy context and operational requirements for the HCP Program for approved home care providers.

A HCP Program consumer manual has also been developed and is available at www.myagedcare.gov.au. However, if you are looking for a high-level summary of the program, you can find information at:

- This link or by searching "Home Care Packages Program Operational Manual" at www.health.gov.au; or
- This link or by searching "Home Care Packages" at www.myagedcare.gov.au.

1.2 How will the manual be updated?

The Home Care Packages Program and the broader aged care system continue to operate in an environment of change.

The Department of Health and Aged Care ('the Department') will update the manual, as required, to ensure its currency and accuracy. The table at page five of this manual outlines the revisions that have been made since its release.

Please refer to the online version of the manual at this link or by searching "Home Care Packages Program Operational Manual" at www.health.gov.au to ensure that you have the most recent version. The footer of each page includes the issue date of the manual.

1.3 If I want to talk to someone about my questions, who can I contact?

To answer any questions you have, the My Aged Care contact centre is open Monday to Friday 8am-8pm and Saturday 10am-2pm. You can call the My Aged Care provider and assessor helpline on **1800 836 799**.

The My Aged Care contact centre is closed on Sundays and public holidays.

1.4 Who may I get additional assistance from?

Your state office will be able to assist you with program management enquiries that cannot be answered by My Aged Care.

WA	WAPlaces@health.gov.au
NSW/ACT	NSWPlaces@health.gov.au
VIC	vic.office@health.gov.au

QLD	engagement.QLD@health.gov.au
SA	SAPlaces@health.gov.au
TAS	TAS.Office@health.gov.au
NT	NTPlaces@health.gov.au

The following peak bodies may be a further source of information and support for delivering aged care services generally:

Peak body	Website	Phone number
Aged & Community Care Providers Association (ACCPA)	www.accpa.asn.au	**1300 222 721**
COTA Australia	www.cota.org.au	**(02) 6154 9740**
Federation of Ethnic Communities Councils of Australia (FECCA)	fecca.org.au	**(02) 6282 5755**
National Aboriginal Communities Controlled Health Organisation (NACCHO) Affiliates	www.naccho.org.au	**(02) 6246 9300**
National Seniors	nationalseniors.com.au	**1300 765 050**
Older Persons' Advocacy Network (OPAN)	opan.com.au	**1800 700 600**
Australian Association of Gerontology	www.aag.asn.au	**03 8506 0525**

✓ Key points to remember

- If you are reading a printed copy of this manual, please make sure it is the most up to date version. You can find the most current version of the manual by going to https://www.health.gov.au/resources/publications/home-care-packages-program-operational-manual-a-guide-for-home-care-providers.
- Throughout this Manual older Australians who receive funding through the HCP Program are called 'care recipients' in line with the legislation. Information about the Aged Care Quality and Safety Commission will refer to older Australians as 'consumers' in line with governing legislation.

2 The Home Care Packages Program

This section provides an overview of the HCP Program, including the underlying philosophy and intent of the Program.

2.1 What is the philosophy underpinning Home Care?

The Australian Government seek to meet to the needs and preferences of older Australians by placing them at the centre of aged care services. Australians are living longer and healthier lives. It is important that, as people age, they have choice about their care. Reviews into aged care have found that older Australians do not want to be passive recipients of services.

Rather they want the opportunity to play an active role in where they live, which provider they choose to deliver their care and the ways in which services are provided. Feedback has also consistently shown that older Australians wish to remain living independently in their own homes for as long as possible. In response, the Australian Government has progressively implemented a number of reforms to the aged care sector in order to deliver a consumer directed care (CDC) approach to aged care services.

The Australian Government funds a range of aged care services from entry level home support to residential care for high needs.

Care recipients may also contribute to the cost of their Home Care Package depending on their financial situation and the provider they choose.

Three principles underpin these programs:

This is a diagram that lists the principles. The first is that older Australians should have access to care and services that support them to live in their own homes for as long as they can and choose to. The second is that older Australians can and should make decisions on the care and services they receive under Commonwealth Government subsidised aged care programs. The third is that the best care outcomes come from older Australians and home care providers working together.

2.2 What is the intent of the Home Care Packages Program?

The HCP Program supports older Australians with complex ageing related care needs to live independently in their own homes, using a consumer-directed care approach to maintain the care recipient's capabilities as they age. Home care packages ('packages') deliver co-ordinated packages of care and services to meet people's assessed ageing related care needs within the limits of their

individual home care budget and the scope of the Program. How care and services are identified and delivered should reflect and respect the individual, their ageing related care needs, personal situation and preferences.

All packages are delivered using a CDC model. The aim of this approach to planning and managing care and services is to give care recipients choice and flexibility in the supports they access, based on their ageing related needs, and how they are delivered.

The Aged Care Quality Standards require providers to deliver safe and effective services and supports for daily living that optimise the person's independence, health, well-being and quality of life. Services and supports for daily living include, but are not limited to domestic assistance, home maintenance, transport and recreational and social activities.

These may include services and supports to maintain care recipient's capabilities:

- well and independent – including personal care, nursing services, allied health
- safe in their home – including cleaning, home maintenance and modifications specific to ageing related capabilities, assistive technology
- connected to their community – including transport, social support services.

It is important to note that a Home Care Package is not a source of income that care recipients can use completely at their own discretion.

Providers need to work with care recipients to ensure that funding is used appropriately and transparently. Care recipients should be actively involved in deciding how their package funds are spent. This includes due consideration of the legislated exclusions from a package. Care recipients will accrue unspent funds if their package funds are not fully expended each month.

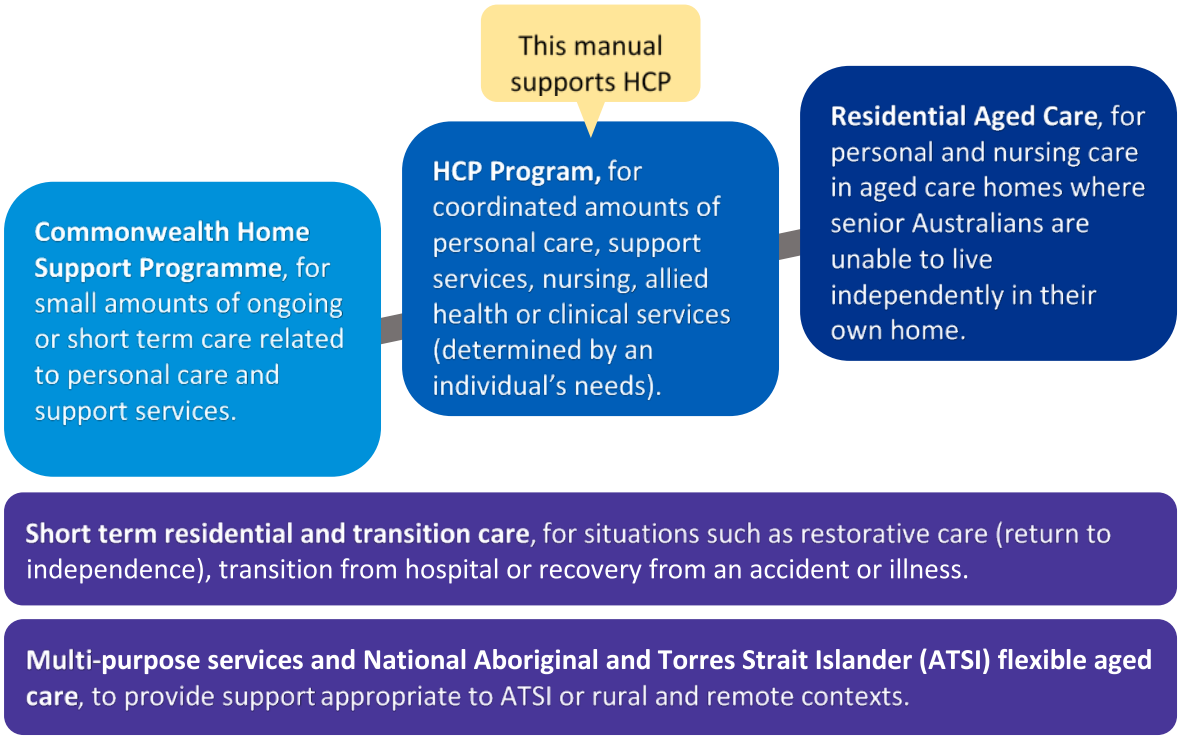
Different people, and their support networks, will want different levels of involvement in planning and managing their package, including self-management. At every level, providers will need to work with care recipients to balance their duty of care with an individual's right to make choices that take reasonable risks. This right is known as 'dignity of risk' and is discussed further at Section 9. An approved provider is responsible for the compliance and quality of all care and services provided under a package.

Changes introduced in September 2021 known as the Improved Payment Arrangements allow for greater transparency of unspent funds in the Program. These changes move the responsibility for holding the Commonwealth portion of unspent funds for care recipients from the provider to the Australian Government. This reduces the prudential risk in home care over time and improve protections for care recipients' home care funds as the program grows. The changes also reinforce the focus on delivering services to meet consumers needs and choices. See **Appendix F** for more information on Improved Payment Arrangements.

Changes to management and administration charges were introduced in January 2023 to reduce excessive prices and improve price transparency for care recipients and their families. These changes include capping how much providers can charge for care and package management, eliminating exit amounts and charging separately for costs associated with third party services. This ensures more funds are available to meet the assessed needs of care recipients. See **Appendix C** for more information on price capping.

2.3 What is the scope of the Home Care Packages Program?

The HCP Program is part of the Australian Government's continuum of care for older Australians. It addresses the level of need between the CHSP (which offers a relatively small amount of care and support services) and residential aged care (a high level of care in a residential aged care home). The following diagram outlines where the HCP Program sits within the continuum:



Access to home services programs is determined by an independent assessment by an Aged Care Assessment Team (ACAT) or a Regional Assessment Service (RAS). My Aged Care will connect older Australians to the correct assessment service for their needs (see Section 6).

Some people will receive services through flexible care or CHSP and will then be assessed for the HCP Program; others will start their Government-supported aged care with the HCP Program. There is no requirement that anyone participates in programs earlier in the continuum of care to be eligible for the HCP Program. Further information on the interaction of these and other aged care programs is included at Section 16.

The HCP Program provides a subsidy and supplements (where an individual is eligible) towards a co-ordinated package of care, services and care management to meet each person's assessed ageing related care needs, care goals and preferences. There are four levels of packages to reflect the different levels of assessed ageing related care needs to support people to safely remain living at home as long as it is appropriate.

The types of care and services that can be subsidised by the Australian Government under the HCP Program should keep people well and independent, and maintain the capabilities of the older Australians as they age and keep them connected to their community. Primary categories of in-scope supports are set out in the table below:

Ageing related services to keep people well and independent	**Ageing related** services to keep people safe in their home	**Ageing related** services to keep people connected to their community
• Personal care • Nursing • Allied health and therapy services • Meal preparation and dietetics	• Domestic assistance • Home maintenance • Minor home modifications • Goods equipment and assistive technology • Respite	• Transport • Social support

The HCP Program **cannot** be used for types of care that are funded, or jointly funded, by the Australian Government through other initiatives such as the dental, pharmaceutical, or medical systems e.g., Medicare Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS), or be used to fund private dental, pharmaceutical, medical costs, or spectacles as these care types are out of scope for the policy intent of the program.

The HCP Program **is not** an income support program and cannot be used for general income expenses.

Further guidance on how to decide what can be included under a package is included at Section **9.**

2.4 How are a care recipient's ageing related care needs and goals established?

When a care recipient enters the HCP Program, their provider should ensure they understand that care recipient's assessed ageing related care needs and help them to establish goals for their care. The documentation from their ACAT assessment will record assessed care needs at the time of assessment, and providers will need to discuss these with them. In the time between the assessment and assignment of a package, assessed care needs may have changed. Providers are required to identify and assess, as per their obligations under the Aged Care Quality Standards, how these needs have changed and can be met within the framework of the HCP Program. This can be done when discussing which care and services to provide under a package.

As part of this conversation, providers and care recipients should consider any supports already in place or accessible through a carer, family members, friends, local community and other services should be considered. The package can be used to access complementary care and services, maximising the supports available.

Each care recipient's package should equally be directed by their personal goals. A wellness approach should be taken to delivering all care and services. Where possible and clinically appropriate, care and service should also align with reablement.

Wellness is an approach that involves the assessment, planning and delivery of supports that build on an individual's strengths, capacity and goals. This includes encouraging actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home.

Wellness as a philosophy is based on the premise that, even with frailty, chronic illness or disability, people generally have the desire and capacity to make gains in their physical, social and emotional wellbeing to live autonomously and as independently as possible.

Reablement involves short-term or time-limited interventions that are targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities. Like wellness, reablement aims to assist people to reach their goals and

maximise their independence and autonomy. Supports could include training in a new skill or re-learning a lost skill, minor modification to a person's home environment or having access to equipment or assistive technology.

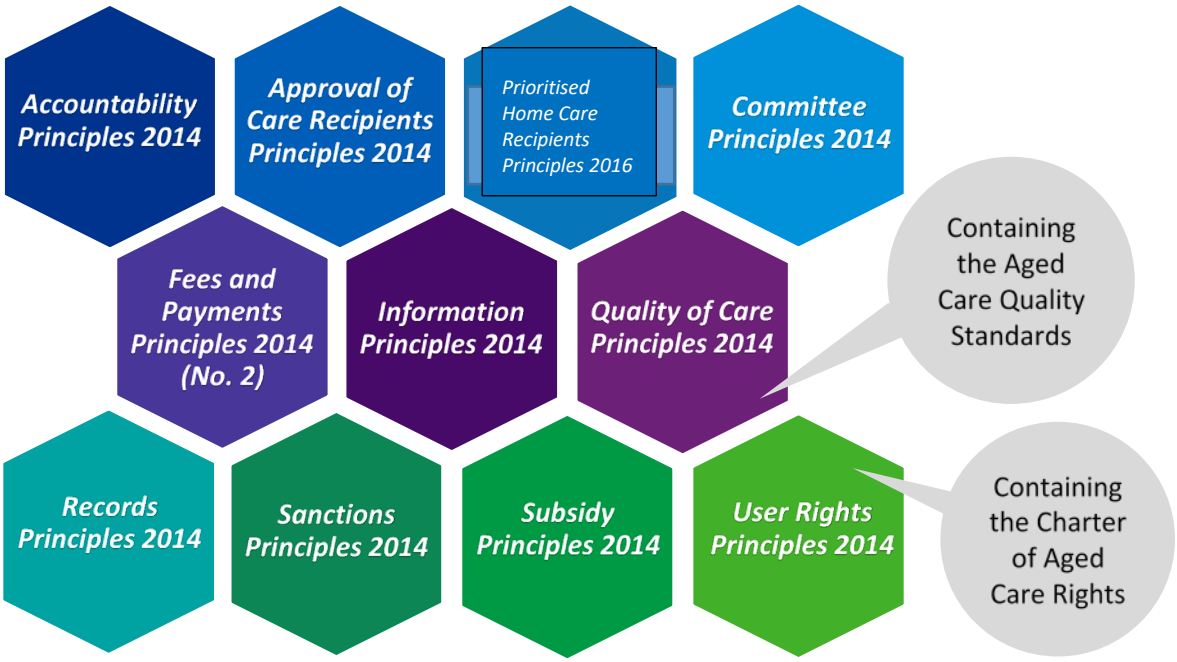
More information about wellness and reablement is at Section 7.3 of this manual.

2.5 What governs the Home Care Packages Program?

There are three tiers of laws that govern the HCP Program. These are:

- **Principal legislation.** This is the overarching law enacted by Parliament.
- **Legislative instruments.** These are subordinate legislation made with powers provided by the principal legislation. These instruments provide more details on how the HCP Program operates.
- **Determinations.** These are instruments that the legislation enables, if needed, to set out or clarify specific facts and details about the HCP Program.

For care recipients who entered the HCP Program after 1 July 2014, the *Aged Care Act 1997* governs the HCP Program. A number of legislative instruments, titled 'Principles', have been made to support that legislation. Eleven of these Principles are relevant to the HCP Program and have been cited throughout this manual. 'The Principles' (relevant to post-1 July 2014 care recipients in the HCP Program) are listed below for reference:



One determination is relevant for post-1 July 2014 care recipients: the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

In addition to the above law, transitional provisions have been established for people who entered the HCP Program before 1 July 2014 (pre-1 July 2014 care recipients). These are established by the following legislation, instrument and determination:

- *Aged Care (Transitional Provisions) Act 1997*
- *Aged Care (Transitional Provisions) Principles 2014*
- *Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014*.

Information regarding these pre-1 July 2014 provisions is at **Appendix A** of this manual.

Finally, provider compliance and the quality of aged care is governed by the following legislation and instrument:

- *Aged Care Quality and Safety Commission Act 2018*
- *Aged Care Quality and Safety Commission Rules 2018.*

The Federal Register of Legislation is frequently updated. As a result, this manual does not include links to the legislation. You will be able to find the most recent version by searching the title of the instrument you are looking for at www.legislation.gov.au[1].

The Department funds the Business Advisory Service to provide accounting and business advisory services to approved providers to maximise business performance and service viability. This involves reviewing and assessing the organisation then providing advice and business management and financial strategies. For more information go to this link.

- The HCP Program supports older Australians with complex ageing related care needs to live independently in their own homes, using a consumer-directed care approach to ensure the support suits a person's needs and goals.
- The HCP Program is designed to provide more co-ordinated care and services than the CHSP, but less intensive care than residential aged care.
- The HCP Program operates using a CDC model to provide more choice and flexibility to care recipients. Providers remain responsible for ensuring the delivery of quality and appropriate care.
- The HCP Program is governed by the *Aged Care Act 1997* and a number of other laws (including the Principles) all of which must guide providers in delivering packages.

[1] If you are not sure if you have the most recent version, you can check by looking at the top left corner of the web page. If you have the right version the words 'In force- latest version' will be marked in green above the heading 'View Series'. If it is not the current version, it will say 'In force – Superseded version' in red text.

3 Rights and responsibilities

This section outlines rights and responsibilities that should underpin delivery of the Home Care Packages Program.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 54-1, 56-2, and 56-4 of the *Aged Care Act 1997*
- *User Rights Principles 2014*
- *Quality of Care Principles 2014*
- *Accountability Principles 2014*
- *Record Principles 2014*
- *Aged Care Quality and Safety Commission Rules 2018*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

3.1 Charter of Aged Care Rights

The *User Rights Principles 2014*, made under the *Aged Care Act 1997*, contains the Charter of Aged Care Rights. The Charter came into effect from 1 July 2019 and applies to all Australian Government funded aged care recipients of the HCP Program. The Charter consists of 14 individual consumer rights and is extracted below:

Charter of Aged Care Rights
I have the right to: 1. safe and high quality care and services 2. be treated with dignity and respect 3. have my identity, culture and diversity valued and supported 4. live without abuse and neglect 5. be informed about my care and services in a way I understand 6. access all information about myself, including information about my rights, care and services 7. have control over and make choices about my care, and personal and social life, including where the choices involve personal risk 8. have control over, and make decisions about, the personal aspects of my daily life, financial affairs and possessions 9. my independence 10. be listened to and understood 11. have a person of my choice, including an aged care advocate, support me or speak on my behalf 12. complain free from reprisal, and to have my complaints dealt with fairly and promptly 13. personal privacy and to have my personal information protected 14. exercise my rights without it adversely affecting the way I am treated.

3.2 What responsibilities do I (as an approved provider) have in relation to the Charter of Aged Care Rights?

Approved providers must not act in a way that is inconsistent with the Charter of Aged Care Rights. Providers also have responsibilities, in relation to the Charter to:

- Give consumers a copy of the Charter signed by a staff member of the provider.
- Give the consumer information about their rights under the Charter.
- Assist the consumer to understand their rights under the Charter.
- Ensure the consumer, or their authorised person, is given a reasonable opportunity to sign a copy of the Charter.
- Keep a record of the Charter given to the consumer, which includes the:
  - signature of a staff member of the provider;
  - date on which the provider gave the consumer a copy of the Charter;
  - date on which the provider gave the consumer (or their authorised person) a reasonable opportunity to sign the Charter;
  - consumer (or authorised persons)'s signature (if they choose to sign); and
  - full name of the consumer (and authorised person, if applicable).

Providers must offer all consumers the choice to sign the Charter of Aged Care Rights. They are not required to sign and can receive care and services if they choose not to sign.

Asking the consumer to sign provides them with an opportunity to acknowledge that their provider has given them a copy of the Charter, has assisted them to understand it and that they understand their rights. Providers must meet all the consumer rights in the Charter of Aged Care Rights whether they sign their copy or not.

Resources to support the sector's understanding of the Charter, including a booklet, are available on the Commission's website at this link, or by searching "Charter of Aged Care Rights" at www.agedcarequality.gov.au.

3.3 What responsibilities do aged care consumers have in relation to the Charter of Aged Care Rights?

All people involved in aged care – care recipients, their families, carers, visitors and the aged care workforce – must respect and be considerate of each other. Quality aged care outcomes are more likely to be achieved in an environment of mutual respect. Aged care consumers are expected to:

- give providers the information they need to properly deliver care and services;
- comply with the conditions of their Home Care Agreement and pay fees outlined in the agreement on time; and
- respect the rights of aged care workers to work in a safe environment. Any kind of violence, harassment or abuse towards staff or others is not acceptable.
- Home Care Agreements have terms and conditions that set out the rights and responsibilities of the parties who have entered into the agreement. Home Care Agreements are discussed in detail at Section 6.

3.4 What responsibilities do I have as an approved provider?

Approved providers must understand and comply with a range of provider responsibilities specified in the *Aged Care Act 1997* (the Act) and associated legislation. These responsibilities relate to:

- the quality of care they provide
- user rights for the people to whom the care is provided
- accountability for the care that is provided, and the basic suitability of their key personnel
- pricing accountability for what they charge care recipients.

For information on responsibilities under the aged care legislation, see **Appendix E**.

3.4.1 Security of tenure

As part of responsibilities outlined in **Appendix E** providers are bound by security of tenure. Security of tenure means providers must deliver the agreed care and services for as long as the care recipient needs those services. Providers may only stop delivering home care where the requirements under the *User Rights Principles 2014* are met. Section 17 of the *User Rights Principles 2014* provides:

Exceptions to security of tenure

(1) For Section 56-2(f) of the Act, this section specifies the security of tenure that an approved provider of home care must provide to a care recipient to who the approved provider provides, or is to provide, home care.

(2) The approved provider may cease to provide home care to the care recipient only if:

(a) the care recipient cannot be cared for in the community with the resources available to the approved provider; or

(b) the care recipient notifies the approved provider, in writing, that they wish to move to a location where home care is not provided by the provider; or

(c) the care recipient notifies the approved provider, in writing, that they no longer wishes to receive the home care; or

(d) the care recipient's condition changes to the extent that:

(i) the care recipient no longer needs home care; or

(ii) the care recipient's needs, as assessed by an aged care assessment team, can be more appropriately met by other types of services or care; or

(e) the care recipient:

(i) has not paid to the approved provider, for a reason within the care recipient's control, any home care fee specified in the Home Care Agreement between the care recipient and the approved provider; and

(ii) has not negotiated an alternative arrangement with the approved provider for payment of the home care fee; or

(f) the care recipient has:

(i) intentionally caused serious injury to a staff member (as defined in section 63-1AA of the Act) of the approved provider; or

Exceptions to security of tenure
(ii) intentionally infringed the right of a staff member (as defined in section 63-1AA of the Act) of the approved provider to work in a safe environment.

Note: an approved provider of aged care is an organisation that has been approved to provide residential care, home and/or flexible care under the *Aged Care Act 1997.* For more information on becoming an approved provider see Section 4.

A provider should not use security of tenure provisions to cancel a home care agreement where a care recipient does not consent to a change. Cancelling an agreement on the basis of security of tenure should only ever be used as a last resort. If you use this provision, you will have to demonstrate sufficient grounds for terminating provision of care. Where service provision is no longer viable, you are expected to assist your care recipients to find a new provider, local to the region or support them to be referred to another system such as psychogeriatric care. For more information on negotiating changes to a home care agreement see section 6.7.1.

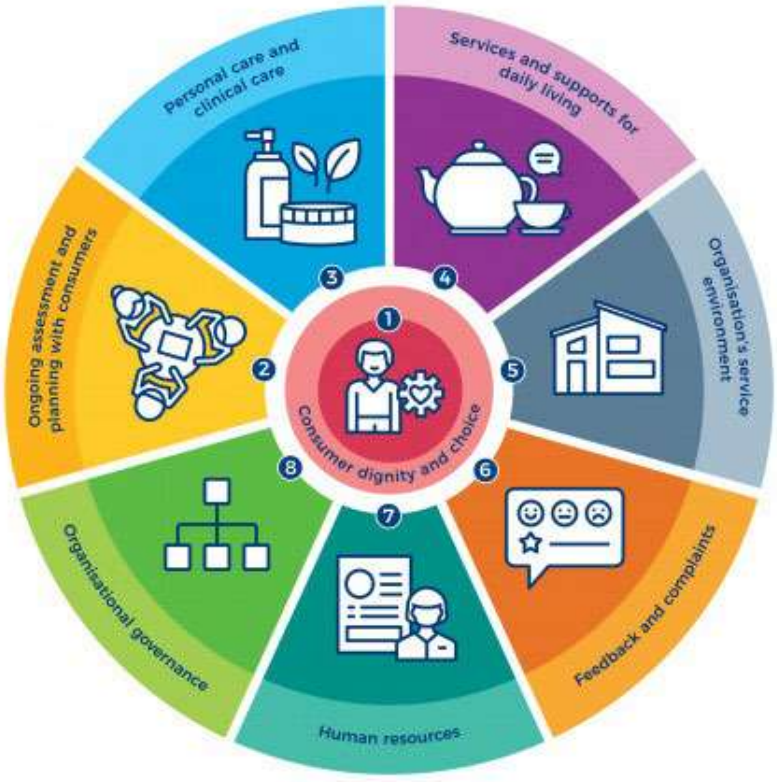
Where care recipients exhibit challenging behaviours that pose a risk to the worker, such as aggressive or disinhibited behaviours, a provider should consider any underlying health conditions that may be the cause of this behaviour and work with the care recipient and their nominee to put protocols in place to ensure the safety of the worker/s, including:

- scheduling two workers at a time (the provider may need to call My Aged Care to request a Support Plan Review by an ACAT if the package budget does not support such an arrangement);
- case conferencing with the care recipient's General Practitioner (GP) and other health professionals on a behaviour management plan (MBS items may be payable for GPs and other health professionals to participate if behaviours relate to a chronic disease; a provider would fund their involvement through care management charges); and
- contacting services such as Dementia Behaviour Management Advisory Service (DBMAS).

Providers continue to have legal obligations to worker safety that must be weighed up against the Charter of Aged Care Rights. If the above strategies do not foster a positive outcome, the provider may consider terminating the home care agreement.

3.4.2 Aged Care Quality Standards

Providers are also responsible for delivering quality care and services in a way that complies with the Aged Care Quality Standards ('the Standards'). All approved providers will be assessed against these standards and they must be able to provide evidence of their compliance with, and performance against, all the Standards.



The Standards focus on outcomes for consumers and reflect the level of care and services the community can expect from organisations that provide Australian Government funded aged care services. The Standards are made up of eight individual standards, outlined in the following diagram:

Source: Aged Care Quality and Safety Commission

The Standards are at this link, or can be found by searching "Download the Aged Care Quality Standards images" at www.agedcarequality.gov.au.

The Aged Care Quality and Safety Commission (the Commission) has developed the *Guidance and Resources for providers to support the Aged Care Quality Standards* (Guidance and Resources). It describes the Commission's expectations and provides supporting information, suggested practices, examples and evidence required to ensure compliance. It also indicates any matters that quality assessors will consider in evaluating compliance. It is available at this link or by searching "Quality Standards" at www.agedcarequality.gov.au and clicking on 'Quality Standards'.

3.5 How is compliance with the Aged Care Quality Standards assessed?

The Commission conducts quality reviews to assess whether approved providers deliver care and services in accordance with the Quality Standards. It also monitors quality through assessment contacts.

The Commission's quality assessors assess provider performance against the Quality Standards by collecting evidence and arriving at findings based on this evidence. Quality assessors collect evidence through:

- interviewing consumers or representatives;
- interviewing staff and management;
- sampling consumer records;

- reviewing documents such as policies, procedures, agreements and registers; and/or
- observing the environment, activities in progress and any interaction with consumers or representatives.

These assessment and monitoring processes are undertaken in accordance with the *Aged Care Quality and Safety Commission Rules 2018,* established under the *Aged Care Quality and Safety Commission Act 2018*. The rules can be located by searching "Aged Care Quality and Safety Commission Rules" at www.legislation.gov.au.

Through engagement and education work the Commission aims to build confidence and trust in aged care, empower consumers, support providers to comply with quality standards, and promote best practice service provision. Further information about the Commission's functions are available at this link, or by searching "Providers" at www.agedcarequality.gov.au/.

Further information regarding the Commission's assessment and monitoring process is available on the Commission's website at www.agedcarequality.gov.au/.

Provider governing bodies should familiarise themselves with Quality and Safety in Home Services – 5 Key Areas of Risk: Guidance for governing bodies of home service providers on the Commission's website.

✓ Key points to remember

- The Charter of Aged Care Rights provides the same rights to all consumers, regardless of the type of Australian Government funded aged care and services they receive, including the HCP Program. Quality aged care outcomes are best achieved in an environment of mutual respect.
- All supports provided as a part of a home care package need to be compliant with the Aged Care Quality Standards.
- All approved providers are responsible for understanding and complying with all relevant responsibilities under the law.

3.6 Serious and immediate health and safety risk management and reporting?

From 1 December 2022, the Serious Incident Response Scheme (SIRS) will also apply to home care and flexible care delivered in home and community settings.

The SIRS aims to reduce abuse and neglect in aged care.

Approved providers must comply with the incident management and reporting requirements under the *Aged Care Act 1997* (Part 4.1, Division 54) and the *Quality of Care Principles 2014* (Part 4B). The information below provides a high level summary of the SIRS requirements.

Approved providers should refer to the legislation for information on detailed requirements and check the Aged Care Quality and Safety Commission's (Commission) website at www.agedcarequality.gov.au/sirs for further SIRS information, including provider resources. Alternatively, the Commission can be contacted by emailing sirs@agedcarequality.gov.au or calling on 1800 081 549.

For more information refer to the SIRS guidance for providers on the Aged Care Quality and Safety Commission website.

4 Becoming an approved provider

To deliver care under the HCP Program, an organisation must become an approved provider. An approved provider of aged care is an organisation that has been approved to provide residential care, home and/or flexible care under the *Aged Care Quality and Safety Commission Act 2018* (the Act). Approved providers must comply with their responsibilities under the *Aged Care Act 1997.*

This section explains who can become an approved provider, how to complete the application process to become an approved provider, and what steps an organisation needs to take (if it gets approval as an approved provider) in order to provide services.

✓ **Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section**
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 54-1 and 63-1 of the *Aged Care Act 1997*
- *Aged Care Quality and Safety Commission Act 2018.*
- *Quality of Care Principles 2014*
- *Accountability Principles 2014*
- *User Rights Principles 2014*
- *Records Principles 2014*
- *Sanctions Principles 2014*.

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

4.1 What considerations do I need to satisfy to become an approved provider of Home Care Packages?

To be approved as a provider of aged care under the Act, providers must satisfy the matters established in Part 7A of the *Aged Care Quality and Safety Commission Act 2018*. A fee is payable to apply. Further information about becoming an approved provider is available at this link or by searching "Becoming an approved aged care provider" at www.agedcarequality.gov.au. To be approved, applicants must satisfy the following considerations:

Consideration 1.	Consideration 2.	Consideration 3.	Consideration 4.
The applicant must make the application in writing using the approved form and pay the application fee.	The applicant's organisation must be incorporated.	The applicant must be suitable to provide aged care.	The applicant must not have any disqualified individuals as key personnel.

4.1.1 Application process

To become an approved provider, an applicant needs to apply in writing. Corporations must apply using whichever of the forms is most applicable to their circumstances. You can access all

application forms at this link, or by searching "Becoming an approved aged care provider" at www.agedcarequality.gov.au.
The table below outlines the forms that can be used to apply, and the circumstances in which an applicant should use each form.

1. New applicant	2. Existing service provider	3. Government organisation
This form is for organisations that are not currently approved to provide any type of care under the Act. **Note**: if the applicant is an approved provider of CHSP only, and wants to provide home care, they must apply as a new applicant.	This form is for an existing approved provider that wants to provide another care type. Because existing approved providers have already had their suitability to provide aged care approved through a previous assessment process, the application form seeks specific detail to assess suitability to provide home care.	States, Territories, authorities of a State or Territory and local government authorities are taken to be approved in respect of all types of aged care. A simplified form has been developed for these Government organisations to enable the creation of a Departmental record and payment of subsidies to the organisation.

If you need further guidance, please see this link, or search "Aged care approved provider applicant guide" at www.agedcarequality.gov.au.

4.1.2 Incorporated organisations

Only organisations that are incorporated are eligible to become an approved provider of home care, residential care or flexible care. This means that if the applicant is a sole trader, partnership or other unincorporated entity, they cannot be approved as a provider of aged care under the Act and the application cannot be accepted. Definitions of each of these organisation structures can be found at www.business.gov.au.

States, Territories and local governments are automatically approved to provide aged care.

4.1.3 Suitability to provide aged care

Part 7A of the *Aged Care Quality and Safety Commission Act 2018* lists the areas each applicant must be assessed against. These are:

1. Experience in providing aged care or other relevant forms of care
2. Understanding of approved provider responsibilities
3. Systems it has, or will have, in place to meet these responsibilities
4. Record of financial management and the methods used, or proposed to ensure sound financial management
5. Conduct as a provider (including compliance with responsibilities as a provider) and obligations arising from the receipt of any payments from the Australian Government for providing aged care (if the applicant has been a provider of aged care).

It is up to the applicant to effectively demonstrate how and why their organisation meets these suitability considerations.

4.1.4 Key personnel

Identifying key personnel is a critical component of becoming an approved provider. Applicants must ensure they understand the meaning of key personnel and establish who within the organisation meet this definition. Key personnel are:

- People responsible for the executive decisions of the applicant (this includes directors and board members), whether or not the person is employed by the applicant;
- People having authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the applicant, whether or not the person is employed by the applicant;
- Any person responsible for nursing services provided, or to be provided, by the applicant, whether or not the person is employed by the applicant; and
- Any person who is, or is likely to be, responsible for the day-to-day operation of an aged care service conducted, or proposed to be conducted, by the applicant, whether or not the person is employed by the applicant.

There are specific requirements about who can/cannot be key personnel. Key personnel cannot be a disqualified individual. A disqualified individual is someone who has been convicted of an indictable offence, is insolvent or under administration, or is of unsound mind. Each State and Territory law identifies different types of offences as being indictable. These typically include serious offences such as murder, manslaughter, the intentional or unlawful administration of drugs or poisons, or committing fraudulent or dishonest activities. The applicant must also be certain that none of their key personnel are disqualified.

Under the *Sanctions Principles 2014*, all approved providers, including those providing home care, have ongoing responsibilities to continue to ensure key personnel meet the requirements about who can/cannot be key personnel as outlined in the Act. They also have reporting obligations if changes to key personnel materially affect their suitability to provider care, including if they become disqualified, or if changes to key personnel affects the organisation's contact details. This is discussed at Section 15 of this manual.

4.2 How do I know if I have been approved to provide packages?

Applicants must be notified if they have or have not been approved as a provider of aged care within 90 days of receiving a complete application. Applications cannot be assessed unless all the required documents have been provided. Applicants may be asked to provide additional information resulting in delays assessing their application.

Alternatively, applications may not be accepted and will be returned. In these cases, applicants will be informed of the reason the application was not accepted. If an applicant is required to provide further information, they will have 28 days to submit this. Once the information is received, a further 90 day timeframe for decision applies. Once an application is deemed complete, the applicant will receive written confirmation and advice that the application has progressed to assessment.

If the applicant is approved to provide aged care, they will receive a letter which includes the National Approved Provider System (NAPS) ID. You can find more information on NAPS at Section 5 of this manual.

4.2.1 Appeals pathways (if you are dissatisfied with the outcome of the assessment)

If the applicant would like reconsideration of the assessment of their application, they should submit a notice in writing within 14 days of receiving the decision letter. The request must detail the reasons for making the request and should take into account the reasons that the application was not approved. Reconsideration requests can be submitted by emailing approvedproviderapplications@agedcarequality.gov.au.

A different decision maker then reconsiders the decision, and decides whether to confirm, vary, or set the decision aside and substitute a new decision.

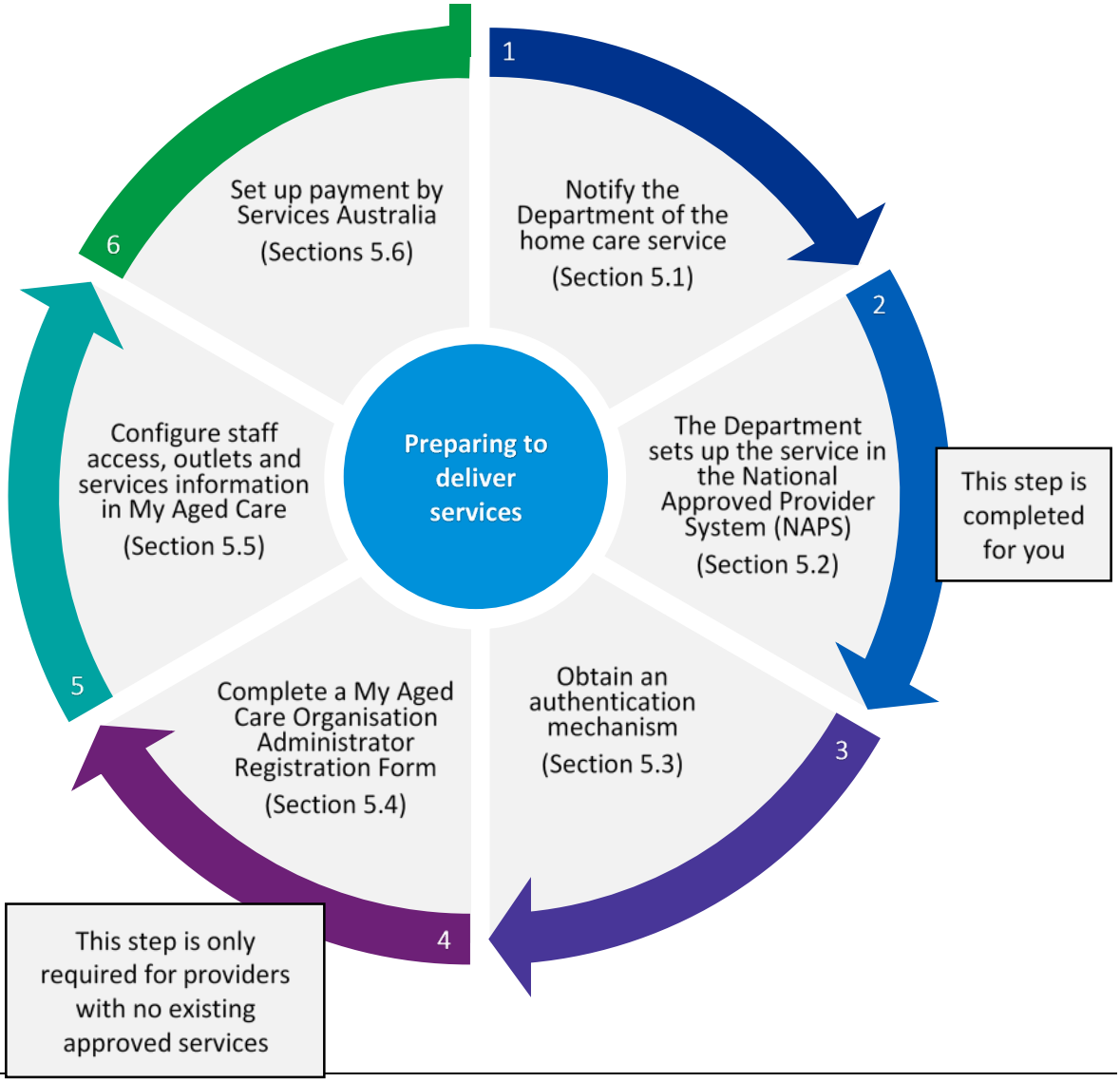
If the applicant wishes to appeal the outcome of the reconsideration they can make an application to the Administrative Appeals Tribunal (AAT).

You can find information on making an application to the AAT at www.aat.gov.au/.

- In order to provide Government-subsidised home care under the HCP Program, an organisation must be an approved provider.
- To become an approved provider, an organisation must be a corporation, and must show that they can meet the suitability matters and have the ability to provide quality aged care services.
- Organisations will need to apply to the Aged Care Quality and Safety Commission to become an approved provider.

5 Preparing to deliver services as an approved provider

This section provides information on each of the activities providers need to complete before they can deliver services as an approved provider. It includes processes, requirements and systems. These steps may be completed in a different order to suit provider needs. The diagram below outlines an order that may be helpful for providers.



Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section

Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 9-1A and 63-1 of the *Aged Care Act 1997.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

5.1 How do I notify the Department of my home care service?

Providers who have been approved will receive a confirmation approval letter from the Aged Care Quality and Safety Commission advising of their approved provider status and National Approved Provider System (NAPS) ID. This is also known as the Provider NAPS ID. Providers then need to notify the Department of the home care services that they will provide. This can be done by completing the **"Home Care Service Notification form"**. The form can be found at this link or by searching "Notification of changes for Home Care Packages" at www.health.gov.au.

A separate form must be submitted for each home care service from which providers intend to provide home care. This form must be lodged before starting to provide care through that service. Providers must do this to be able to claim and receive subsidies for home care services.

Once the **"Home Care Service Notification form"** has been submitted, the provider will receive an email with a tracking ID and a PDF of the completed form.

There are specific processes for moving home care services to another approved provider, merging home care services and combining home care services. Information on these is in Section 13.5.

5.2 How does NAPS registration work?

The Department will directly submit **"Home Care Service Notification form"** to the most relevant State or Territory office for processing.

The state-based team will enter the details into the NAPS system. The provider will be notified by email once the information has been processed (new services or changes to existing services) and will receive a Service ID for any new services. It is important to note that it can take up to 48 hours for a new service to appear in My Aged Care.

The provider can use this Service ID to submit claims to Services Australia.

5.3 How do I obtain authentication mechanism?

New providers will need an authentication mechanism to securely access and use the My Aged Care system.

From late March 2020, My Aged Care will support the following login methods:

- VANguard Federated Authentication Service (FAS); and
- myGovID and Relationship Authorisation Manager (RAM).

VANguard FAS

VANguard FAS integrates with an organisation's local network, allowing individuals to reuse their username and password to access external agencies without sharing the user's credentials. Staff authenticate once with their My Aged Care portal with subsequent authentications being transparent to the user.

VANguard FAS provides:

- Users with an improved login experience – allowing users to Single Sign On to My Aged Care using their own organisation credentials;
- Organisations with a single place to manage their authorisations – user access is controlled through an organisation's existing on-boarding and off-boarding procedures.

VANguard FAS is delivered by the Department of Industry, Innovation and Science (DIIS) and is suitable for any organisation with corporate network infrastructure that includes a Single Sign-On System (e.g. Active Directory Federation Server). There are no fees payable to DIIS for using FAS.

To find out more or get started with FAS, organisations can email the VANguard service desk at VANguard.Customer@industry.gov.au with their contact details and organisation name, phone number and email address.

myGovID and RAM

The Australian Taxation Office has introduced a flexible and secure way to access Government online services. These are:

- myGovID – an authentication service that allows you to prove who you are online. It is different to your myGov account.
- Relationship Authorisation Manager – an authorisation service that allows you to act on behalf of an organisation online when linked with your myGovID.

Together, myGovID and RAM offer a secure login experience:

- Users log in by authenticating with their myGovID app each time they access My Aged Care, protecting their digital identity.
- Organisations use RAM to control user access to Government online services from a single place.

myGovID and RAM form a whole-of-government solution that can be used to access many other Government online services.

5.4 How do I complete the My Aged Care Administrator Form?

Providers with no existing Provider Portal administrators will need to nominate an Organisation Administrator by completing and submitting the **"My Aged Care Organisation Administrator Registration Form"** located at this link or by searching "My Aged Care – Organisation Administrator Registration Form" at www.health.gov.au. The Department will email this form to providers at the appropriate time.

This allows the Department to set up the initial administrator for a provider organisation, to allow access to the Provider Portal. Once the Organisation Administrator registration form has been processed, the Department will contact the Organisation Administrator via email regarding next steps.

The nominated Organisation Administrator will be the first person from a provider organisation to log into the portal. They will be responsible for setting up staff access and managing the organisation's information and portal structure. The My Aged Care Assessor Portal – Organisation Administrator User Guide is available at this link or by searching "Organisation Administrator User Guide" at www.health.gov.au. Additionally, the My Aged Care – Provider Portal User Guide: Part 1 Administrator Functions is available at this link or by searching "My Aged Care – Service and support portal user guide – Part 1: Administrator functions" at www.health.gov.au.

Established users can then set up 'Outlets' and 'Services' in the portal and add the organisation's service information. Once the service item is 'Operational' and the outlet is 'Active', referrals can be received from My Aged Care. The My Aged Care – Provider Portal User Guide: Part 2 is available at this link or by searching "My Aged Care - Service and Support Portal User Guide Part 2: Team Leader and Staff Member" at www.health.gov.au.

Note: the Department recommends the initial administrator sets up other staff in a provider organisation as Organisation Administrators to allow for back up access.

Providers can find the My Aged Care Provider Portal at this link or by searching "For service providers" at www.myagedcare.gov.au.

5.5 How do I configure my information in the My Aged Care Provider Portal?

The My Aged Care Provider Portal is a web-based platform that allows providers to self-manage information about the services they provide. This information is displayed on the public 'find a provider' tool on the My Aged Care website, and is used by care recipients and their carers to search and compare potential home care providers that can best meet their assessed ageing related care needs in their preferred location. It is also used by My Aged Care contact centre staff and assessors to refer people to service(s). It allows providers to accept and reject referrals.

It is essential that providers ensure all of their information on this platform is current, correct and complete. It should be written for care recipients in plain English with enough detail to support their decision-making. A Quick Reference Guide on the procedures for creating and maintaining information about service delivery outlets is available at this link, or by searching "My Aged Care Process Overviews – Home Care Packages" on www.health.gov.au.

As an approved provider, details of services are automatically listed within the 'find a provider' tool. Providers, however, will need to ensure that these details are complete.

Providers can set up 'Outlets' and 'Services' in the portal and add the organisation's service information. Once the service item is 'Operational' and the outlet is 'Active', referrals can be received from My Aged Care.

This must include pricing information. New pricing requirements were introduced on 1 July 2019 to improve transparency for older Australians, to enable direct comparisons between providers, and to curb problematic charging practices by some providers. Information on providers' pricing obligations are at **Appendix B** and **Appendix C**.

From 1 January 2023, the amount a provider can charge for care and package management will be capped at 20 per cent and 15 per cent of the package level respectively. Additionally, providers will no longer be able to charge exit amounts or charge separately for costs associated with third party services. Updates to the My Aged Care Provider Portal will occur in February 2023 to support these changes. Providers affected by the changes will need to discuss pricing changes with their care recipients. Learn more about what the changes are and how you can prepare for them at this link or by searching "Home Care Packages Program update – November 2022" on www.health.gov.au.

Providers can also list other information on the 'find a provider' tool, which can help promote their services. This could include:

- cultural specialisations;
- religious specialisations;
- languages other than English that carers speak;
- specialised services; and/or

- ability to provide services to individuals with diverse needs.

Guidance on completing the 'specialisations' section of the provider portal is available from this link or by searching "My Aged Care – Service and support portal user guide – Part 1: Administrator functions " on www.health.gov.au.

Providers can configure this information, and their financial information, at an organisation and/or outlet level. This means that a larger provider can set up information for all the outlets they have, and then let the outlets provide further information, or amend the provided information, as required. A smaller provider can set all their information up at one time.

The Department expect providers' service information to meet their requirements for managing service information in the 'find a provider' tool on My Aged Care. The Department can choose to remove organisations who do not comply. The requirements include:

- the same service, with the same NAPS Service ID, must only be listed once per location i.e. the service must only appear once in the search results for that location;
- outlet and service item names must not include phone numbers or marketing slogans; and
- service delivery areas must reflect only those locations where the provider can deliver service.

Further information on these requirements is available at this link, or by searching "Home Care Services Notification Form" at www.health.gov.au.

5.6 How do I set up payment of subsidies with Services Australia?

Services Australia administers payments for aged care subsidies and supplements (where relevant) on behalf of the Department. Providers will need to set up their organisation with Services Australia to make claims for services and receive payments. They will need to complete and return the following forms to Services Australia:

- **"Register, amend or remove users for Aged Care Provider Portal form"** (AC004). AC004 is at this link, or can be found by searching "AC004" at www.servicesaustralia.gov.au.
- **"Application to add or change approved care service's bank details form"** (AC015). AC015 is at this link, or can be found by searching "AC015" at www.servicesaustralia.gov.au.

For more general Services Australia information, see this link or search "Aged care providers" at www.servicesaustralia.gov.au.

✓ Key points to remember

- If an organisation is approved as an approved provider, there are six administrative tasks that need to be completed before they can provide services to care recipients. These are outlined in the diagram at the start of this section, but can be summarised as:

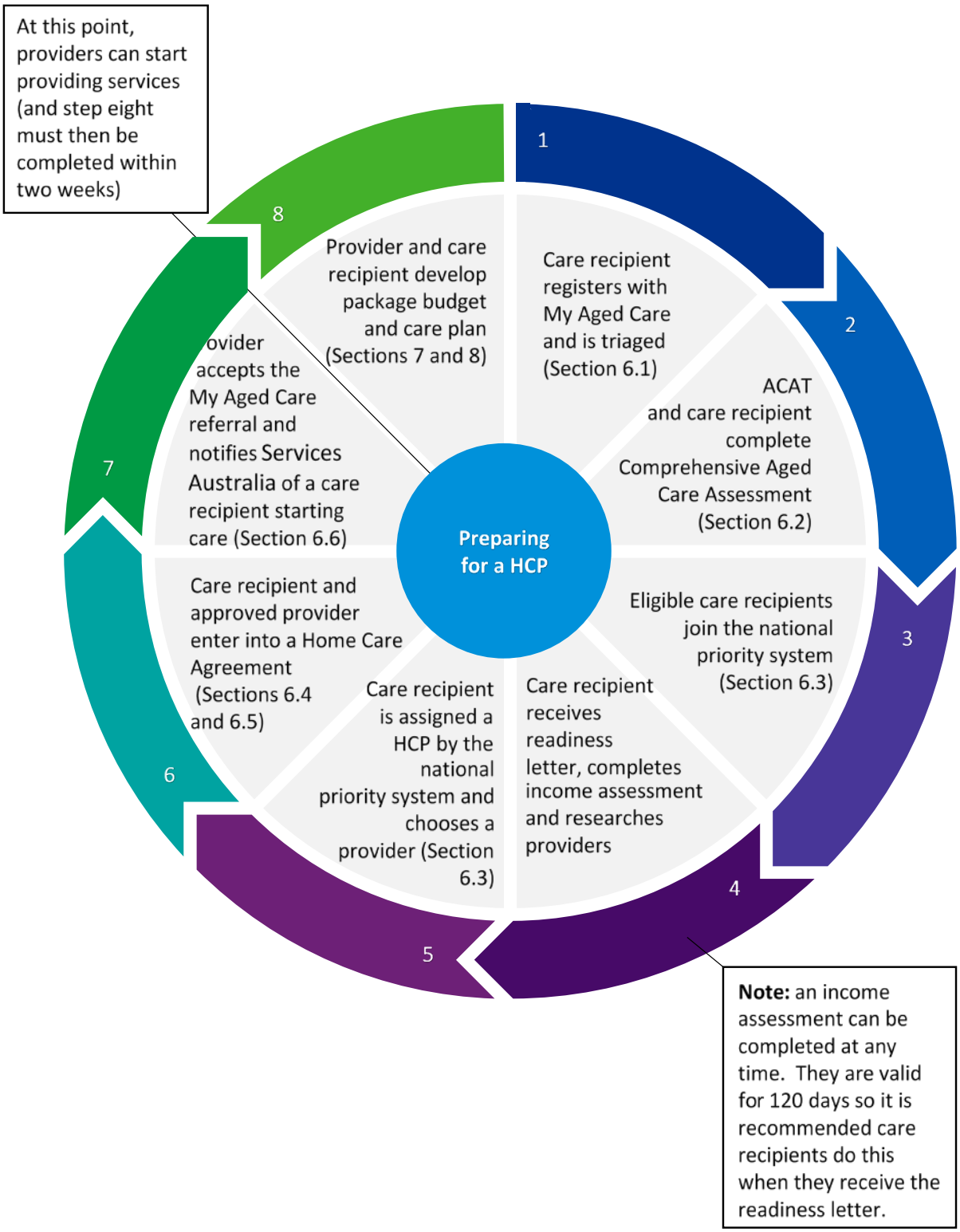
1. Notify the Department of the Home Care service
2. The Department sets up the service in the National Approved Provider System (NAPS)
3. Obtain an authentication mechanism
4. Complete a My Aged Care Organisation Administrator Form
5. Configure staff access, outlets and services information in My Aged Care
6. Set up payment by Services Australia.

Providers can complete these steps in a different order if they would like. If providers follow the above order, this process may run more smoothly.

6 Eligibility for care recipients to receive Australian Government funded packages

This section sets out the steps that care recipients need to take to receive services under a package. This information has been provided to support providers to help care recipients navigate this process, if needed. This section also sets out the steps that providers need to take after an individual has been assigned a package, but before they can start providing Government-subsidised home care services to that individual.

Note: care plans need to be reviewed regularly during the course of delivering a home care package. This review process is discussed at Section 10.3.



Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section

Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 56-2 and 63-1 of the *Aged Care Act 1997*
- *Accountability Principles 2014*

- *User Rights Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

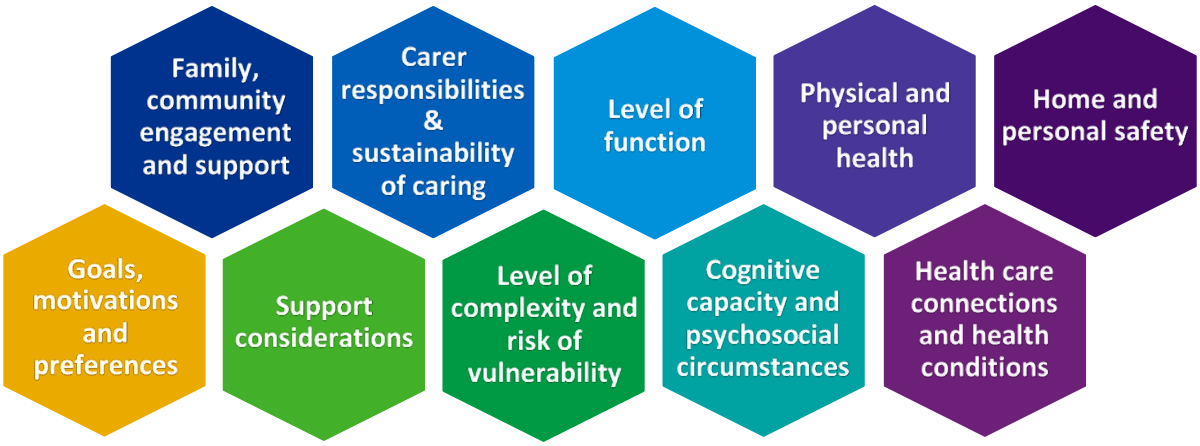
See **Appendix E** for further detail on specific provider responsibilities.

6.1 How do care recipients start the process to get a package?

Care recipients and/or their representative complete a screening with My Aged Care to determine their pathway to aged care services. They can do this by calling the My Aged Care contact centre on **1800 200 422** which will generate a reference for a face-to-face assessment based on the information given at the screening. If this information indicates a comprehensive assessment is required, the My Aged Care contact centre will refer them to an ACAT to conduct the assessment.

6.2 What is a comprehensive aged care assessment and how does it work?

Eligibility for the HCP Program is assessed by an ACAT. The comprehensive assessment will consider:



The assessment identifies an individual's strengths and areas of difficulties across these factors, which will be considered as the assessor works with them to develop a support plan. In some instances, it may be appropriate to use a supplementary assessment tool clarify their individual needs further.

The assessor will make recommendations based on the person's care needs at that time. After conducting a comprehensive assessment, an ACAT will send their assessment findings and recommendations to the ACAT delegate to determine eligibility for aged care services under the Act. Information on how to prepare for an assessment and what to expect has been provided in the HCP Program Consumer Manual.

Everyone assessed will receive the outcome of their assessment by mail. The letter will contain the assessment decision confirming eligibility for a package, the level of package approved (if eligible), the reasons and evidence supporting the decision and a copy of their support plan developed during their assessment.

6.3 What is the national priority system?

The national priority system is the system that assigns packages. Once an older Australian is assessed as eligible, they will be placed in the national priority system, where they will wait for the assignment of a package. They will not be able to access Australian Government subsidised home care services under the HCP Program until they have been assigned a package.

The national priority system ensures the equitable assignment of packages based on a person's assessed care needs and circumstances; not where they live. The system only takes into account:

- priority for home care services as determined by the ACAT during the comprehensive assessment; and
- the date of approval for home care at that level.

Older Australians who were actively seeking care at the time of their approval will be automatically placed in the national priority system and set as 'seeking services'. They will receive a package as soon as one is available based only on the above two factors.

Those who are not actively seeking care at the time of their approval should inform their assessor. They will then be set as 'not seeking services' and will not be assigned a package until they are advised otherwise. If Older Australians who was 'not seeking services' wishes to be assigned a package, they will need to indicate that they are actively seeking care. Following this, they will be assigned a package as soon as one is available.

An Older Australian can request to be set as 'seeking services' or 'not seeking services' at any point. This can be done by calling the My Aged Care contact centre on **1800 200 422**, or by using the My Aged Care Client Portal at this link, or by searching "View your My Aged Care client record" at www.myagedcare.gov.au.

The Department releases packages regularly, generally weekly, as indicated by the national priority system. The number of packages released at each level takes into account the number of new packages that are available, as well as the number of packages that other people have left or not accepted in previous weeks. Projected wait times for a package are available in time-bands in the client portal.

6.4 What does an eligible care recipient need to do to be assigned a package (after they have been assessed as eligible)?

Eligible home care recipients will receive a letter notifying them that they have been assigned a package.

After being assigned a package, care recipients have 56 calendar days from the date their package is assigned to find an approved provider and enter into a Home Care Agreement that best meets their needs. If a care recipient wants more time to find a suitable provider, they can contact the My Aged Care Contact Centre and request a 28 day extension, giving them a total of 84 calendar days to enter into a Home Care Agreement.

If the care recipient has not entered into a Home Care Agreement within 56 calendar days (or 84 calendar days with the extension), the package is withdrawn. This means the package is no longer assigned to them, and approved providers are not able to claim a subsidy.

If a person is assigned their approved level of package and it is withdrawn, they will be removed from the national priority system. If they later decide they want to receive services through a package, they need to re-join the national priority system by calling My Aged Care. People who

re-join the national priority system will have their date of entry recorded as the date they were originally approved for home care at that specific package level.

Providers may receive a referral in the provider portal through one of two ways:

- a system generated referral – created either by the My Aged Care contact centre or by a member of an ACAT; or
- a direct referral – direct receipt of a person's referral code e.g. an eligible person has presented their package assignment letter and requested that the provider deliver their services.

From the referral record providers can view the referral summary and a person's record. This will help them make an informed decision about whether they can deliver the services required by the person and when they need services to start.

Check the My Aged Care client record carefully for any active services and do not commit a package if a care recipient is currently in home care, residential aged care or Short-Term Restorative Care until cessation date with current provider has been confirmed.

Committing a package while another entry is in place, may result in a dispute, so keep records of all conversations with My Aged Care, care recipient and current provider. Failure to engage with current provider to confirm cessation date may result in an overpayment of subsidy and debt collection activities by Services Australia if two services claim for the one care recipient for the same period. Ensure you are aware of all program interfaces. Read more at How does the HCP Program interact with other programs and schemes?.

Detailed information on managing referral care recipients' records on My Aged Care is available at this link or by searching "My Aged Care for service providers" on www.health.gov.au.

6.5 What should I include in a Home Care Agreement?

When a care recipient chooses an organisation as their approved provider, the provider must enter into a Home Care Agreement with them before starting to deliver services and receive payment under the HCP Program. A provider is not eligible for subsidy on behalf of the care recipient if a Home Care Agreement is not in effect. Where a Home Care Agreement is not in effect, and a provider claims subsidy from the Commonwealth, the provider is liable for a debt owed to the Commonwealth for the period in which a Home Care Agreement was not in effect.

To ensure compliance, providers should follow guidance on Home Care Agreements available at this link or by searching "Home care agreements for Home Care Packages" on www.health.gov.au.

Providers should ensure their Home Care Agreements do not contain unfair contract terms. Although businesses may use standard form contracts for efficiency, it is important that businesses consider a consumer's (care recipient) rights when preparing their contracts. An Australia-wide law protects recipients from unfair terms in standard form consumer contracts. The law offers recipients increased protection in circumstances where they have little or no opportunity to negotiate with the provider.

Providers cannot charge people for entry or exit to the service. For more information on exit charges, see 13.4 When can I charge an exit amount?

The Home Care Agreement sets out the terms and conditions by which a provider will deliver care and services to a care recipient. It is the legal contract between a provider and a care recipient and captures each parties' responsibilities. It is critical that providers seek legal advice and assistance in drafting agreements.

The Act and Principles set out strict conditions by which the Home Care Agreement must comply. It is essential that providers understand the requirements under the Act.

A Home Care Agreement for people who started receiving services after 1 July 2014 must be written in plain English that is readily accessible. It must not contain any provision that would have the effect of the care recipient being treated less favourably in relation to any matter than they would otherwise be treated under any law of the Commonwealth in relation to the matter. Finally, it must include the following:

6.5.1 Relationship with the care recipient

#	Requirement	Legislation citation
1	A statement specifying that home care will be delivered on a CDC basis. CDC has been discussed at Section 2.1 of this manual.	Section 23(2)(b)(i) of the *User Rights Principles 2014*
2	A statement specifying the care recipient's rights in relation to decisions about the care and services that are to be provided. CDC has been discussed at Section 2.1 of this manual. **Note**: any changes to the Home Care Agreement must be agreed through informed, mutual consent of the provider and the care recipient. Variation of the Home Care Agreement is discussed at Section 6.5.5.	Section 23(2)(b)(iv) of the *User Rights Principles 2014*
3	A statement outlining: • that a care recipient is entitled to make a complaint about the provision of their care and services without fear of reprisal; and • the complaints mechanism the provider has in place. For more information on designing a complaints mechanism see Section 10.	Section 61-1(1)(f) of the *Aged Care Act 1997* Section 23(4) of the *User Rights Principles 2014*
4	A statement outlining any responsibilities of the care recipient as a recipient of home care from the service.	Section 61-1(1)(g) of the *Aged Care Act 1997*

6.5.2 Care and services

#	Requirement	Legislation citation
5	The date the provider will start to provide home care to the care recipient. If they are transferring from another provider, please see Section 13 of this manual.	Section 23(2)(a) of the *User Rights Principles 2014*
6	A statement specifying the level of home care to be provided. This will be the package level that the care recipient has been assigned. This process has been discussed at Section 6 of this manual.	Section 23(2)(b)(iii) of the *User Rights Principles 2014*
7	A statement specifying the care and services that the care recipient will receive. This will also need to be outlined in the care plan, as discussed in Section 7 of this manual.	Section 23(2)(b)(ii) of the *User Rights Principles 2014*
8	A statement specifying that the provider will give the care recipient copies of their care plan and package budget, including any updated copies if the provider and the care recipient make any changes to the care plan and package budget. Home Care Agreements entered into before 1 July 2015 do not need to be updated to include this provision. In practice, however, providers must provide their care recipients with these documents.	Section 23(2)(b)(v) of the *User Rights Principles 2014*
9	A statement that the care recipient may suspend, on a temporary basis, the provision of home care (known as taking leave) if the provider is notified. Leave has been discussed more generally at Section 11 of this manual.	Section 23(2)(f) of the *User Rights Principles 2014*
10	The amounts that the care recipient will be liable to pay to the approved provider for any period of suspension. Fees payable during suspension (leave) are discussion at Section 11 of this manual.	Section 61-1(1)(e) of the *Aged Care Act 1997*

6.5.3 Pricing and budget

#	Requirement	Legislation citation
11	A statement of home care fees (Income tested fees, Basic daily fee & additional fees) that the provider will charge to the care recipient. **Note**: the discussion at Item 13 of this table, below.	Section 23(2)(c)(i) of the *User Rights Principles 2014*

#	Requirement	Legislation citation
12	A statement of the policies and practices that the provider will follow in setting the price that the care recipient will be liable to pay to the approved provider for the provision of the care and services. Fees are discussed at Section 8 of this manual. Appendix C includes information on 1 January 2023 prices changes. Further information on how providers set, publish and charge for care and services can found on www.health.gov.au by searching "Pricing for Home Care Packages".	Section 61-1(1)(c) of the *Aged Care Act 1997*
13	A copy of the provider's Schedule as published on My Aged Care at the time the agreement is signed. This is discussed further in **Appendix B** of this manual. All agreements entered into after 1 July 2019 must comply with the new pricing requirements. All prior agreements must be updated to become compliant by 1 January 2023. The prices under the Agreement must be the same as those in the pricing schedule published on My Aged Care at the time the agreement is signed unless the provider and care recipient discuss and agree to a variation in pricing. If the provider and care recipient reach agreement on a variation, this must be documented within the Home Care Agreement. If the care recipient is to be charged an amount of the basic daily fee (discussed in Section 8 of this manual) that is different from the amount of the fee in the schedule, the provider and care recipient must also reach agreement on a variation, and this must be documented within the Home Care Agreement.	Sections 23(2)(ba)-(bc) of the *User Rights Principles 2014* Section 23(2)(c)(ii) of the *User Rights Principles 2014*
14	A statement specifying that the provider will give the care recipient a statement of the available funds and expenditure in respect of each month for the care and services provided to the care recipient during the month (a monthly statement). Monthly statements have been discussed further at Section 10.	Section 23(2)(cb) of the *User Rights Principles 2014*
15	A statement specifying that any care recipient portion or transfer portion of the care recipient's unspent home care amount will be paid in accordance with Part 3 Division 3A of the *User Rights Principles 2014*. For more information on how to action this please see Sections 13 and 14.	Section 23(2)(cc) of the *User Rights Principles 2014*

#	Requirement	Legislation citation
16	Provision for financial information to be given to the care recipient about the home care that the care recipient will receive, including a statement that the approved provider must, within seven days after a request by the care recipient, give the care recipient: • A clear and simple presentation of the financial position of the home care service, including the costs of home care that explains any ongoing fees payable by the care recipient. • A copy of the most recent statement of the audited accounts of the home care service or, if the home care service is operated as part of a broader organisation, the most recent statement of the audited accounts of the organisation's aged care component (that includes the home care service).	Section 23(2)(d) of the *User Rights Principles 2014*

6.5.4 Administration

#	Requirement	Legislation citation
17	A guarantee that the provider will take all reasonable steps to protect the confidentiality, as far as legally permissible, of information provided by the care recipient. Details of the use of information that is to be made by the provider and each person or entity to who the provider discloses the information.	Section 23(2)(e) of the *User Rights Principles 2014*
18	A statement specifying the home care service through which the approved provider will provide care to the care recipient.	Section 61-1(1)(a) of the *Aged Care Act 1997*
19	A statement specifying the levels of care and services that the provider has the capacity to provide to the care recipient while they are being provided with care through the home care outlet. **Note**: while an approved provider must be able to deliver all levels of packages, they are not required to be able to do so at all services.	Section 61-1(1)(b) of the *Aged Care Act 1997*
20	If the care recipient is not to be provided with the home care service on a permanent basis – the period for which the care and services will be provided.	Section 61-1(1)(d) of the *Aged Care Act 1997*

6.5.5 Variation or termination

#	Requirement	Legislation citation
21	A statement that the agreement may be varied by the approved provider if the variation is necessary to implement the *A New Tax System (Goods and Services Tax) Act 1999,* but that the agreement must not be varied pursuant to the above unless the provider has given reasonable notice of the variation, in writing, to the care recipient.	Sections 23(3)(a)(i) and 23(3)(b() of the *User Rights Principles 2014*

#	Requirement	Legislation citation
22	A statement that, in any case other than that discussed at Item 21 above, can only be varied by mutual consent, following adequate consultation of the care recipient with the provider. Mutual consent requires active acknowledgement by the care recipient. Mutual consent **is not** characterised by sending a letter to a care recipient to inform them of a change, offering an opt out and taking their silence as approval.	Section 23(3)(b) of the *User Rights Principles 2014*
23	A statement that the agreement must not be varied in a way that is inconsistent with *A New Tax System (Goods and Services Tax) Act 1999*, the *Aged Care Act 1997* or the *Extra Service Principles 2014*. **Note**: in their current form, the *Extra Services Principles 2014* contemplate residential care services only. They have not been considered further.	Section 23(3)(c) of the *User Rights Principles 2014*
24	The conditions under which either party may terminate the provision of home care, noting that providers may only terminate the provision of home care were security of tenure allows it. Security of tenure has been discussed at Section 3.4 of this manual.	Section 23(2)(g) of the *User Rights Principles 2014*

Home Care Agreements with care recipients who are in the pre-1 July 2014 arrangements must include different items. These are outlined in **Appendix A**.

6.6 What should I consider when entering into a Home Care Agreement with a care recipient?

In addition to obligations under the *Aged Care Act 1997*, outlined in **Appendix E**, providers have obligations under consumer and competition law. When negotiating with care recipients for the delivery of care and services and drafting the Home Care Agreement providers should also have regard to all these obligations.

The Australian Competition & Consumer Commission (ACCC) has developed guidelines for consumers and providers that outline consumer and business rights and obligations under the competition and consumer law (as they relate to the HCP Program).

The provider guide is at this link, or can be found by searching "Home care services – your business rights & obligations" at www.accc.gov.au. The consumer guide is at this link, or can be found by searching "Home care – a guide to your consumer rights" at www.accc.gov.au.

Approved providers should confirm with the care recipient or their family who has been authorised to enter into the Agreement. In some circumstances, other arrangements may be in place for an authorised representative to act on their behalf.

The Department cannot provide individual advice on business practices, nor is the Department in a position to offer legal advice. Providers may wish to seek independent legal advice about business arrangements and how they align with the legislation.

6.7 What do I do if a care recipient won't sign a Home Care Agreement?

Both the care recipient and the provider should sign the Home Care Agreement. The care recipient should be given a copy of the signed Home Care Agreement.

A care recipient, however, does not necessarily need to sign the Home Care Agreement for it to be in place. As long as there is mutual agreement between them (or their authorised representative) and the provider regarding the care and services to be delivered as part of the package, the agreement is considered 'in place'.

In the event that a care recipient does not sign the agreement, providers should keep detailed records of reasons why the agreement is not signed. This is because they must always be able to provide proof that an agreement is in place. Proof may include:

- a copy of the Home Care Agreement document the provider offered to the care recipient
- a file note of the discussion with the care recipient about the basis of the agreement (including the date the discussion took place); and/or
- proof that the provider is providing a package as described in the agreement.

6.7.1 When a care recipient does not agree to changes to an existing home care agreement

If a care recipient does not agree to the proposed changes, a provider needs to:

- negotiate to reach agreement with the care recipient – and provide a detailed rationale in a format that the care recipient will understand
- encourage a care recipient to seek independent advice from consumer advocates, family members, or legal advisers
- advise a care recipient they are able to change providers (My Aged Care provides a range of tools to support choice).

6.8 I don't speak the same language as my care recipient. How can I arrange interpreting services?

For home care recipients who speak a language other than English as their first language, the Department of Home Affairs provides free interpreting services through the Translating and Interpreting Service (TIS National). Providers must register online for a TIS National Code. You can find information on this at this link or by searching "Translating and Interpreting Service (TIS) National" at www.health.gov.au.

The intention of TIS National is primarily to assist care recipients to understand their package, including the Home Care Agreement, the package budget and monthly statements. When TIS National is used for this purpose including if required to discuss the monthly budget, there is no cost to the provider and there should not be any charges made to the care recipient's package budget.

TIS National is available 24 hours a day, seven days a week and provides both telephone and onsite services. Bookings can be made online via www.tisnational.gov.au. Alternatively, providers can call 131 450 for immediate telephone interpreting or 1300 655 082 for on-site bookings.

When accessing TIS National, providers will need to quote their service's unique code. If a provider is unsure of their care recipient's client code, they can contact TIS National on 1300 655 820.

Note: if providers are unable to provide aged care workers from TIS National, that can communicate in the required language, they may negotiate with the care recipient to engage a different organisation.

From 1 January 2023, a provider must not charge a separate amount for coordinating third-party services, even if:

- the provider made a business decision to engage a third-party or

- the care recipient chose a third-party to provide those services.

For more information on engaging a third party see section 7.5.

The agreed position and the responsibilities of the provider, care recipient and interpreter should be documented and included in the Home Care Agreement. Further information about the Translating and Interpreting Services charges for non-English speakers is available at www.tisnational.gov.au.

6.9 How and why do I notify Services Australia of a care recipient starting care with my service?

Providers need to declare care recipient entry information to Services Australia within 28 calendar days of when they commenced their home care services. Providers will first need to accept the referral in the My Aged Care Provider Portal, and then complete the paperwork to notify Services Australia. This paperwork can be completed through the Aged Care Provider Portal or through the submission of an Aged Care Entry Record (ACER).

The Aged Care Provider Portal can be found at this link, or by searching "Aged Care Provider Portal" at www.servicesaustralia.gov.au. An ACER can be completed using paper form AC021 at this link or by searching "AC021" at www.servicesaustralia.gov.au.

Entry information must be provided to Services Australia as early as possible and before the care recipient's package take up deadline to ensure their package is not withdrawn. If providers do not advise Services Australia of entry information, or if they do not have a Home Care Agreement in place, they will not be paid any applicable subsidy or supplements.

At this time, providers should also inform the Department if a care recipient has commenced a package and also receives a compensation entitlement. This is discussed at **Appendix C**.

✓ Key points to remember

- Before older Australians can receive services under the HCP Program, they need to register with My Aged Care, be assessed by an ACAT as eligible for the program, and be assigned a package through the national priority system.
- Once they have been assigned a package, they need to enter into a Home Care Agreement with a provider within 56 days (or 84 days with an extension).
- If providers are entering into a Home Care Agreement with a care recipient, they are bound by the obligations of consumer law. Providers can find out more in the ACCC provider guide at this link, or by searching "Home care services – your business rights & obligations" at www.accc.gov.au.
- If providers do not advise Services Australia of entry information they will not be paid any applicable subsidy or supplements.
- A free interpreting service is available to help providers negotiate the Home Care Agreement, develop the care plan with the care recipient and advise on the monthly budget. If the provider cannot provide aged care workers who speak the required language, they can negotiate with the care recipient to charge translation fees to their package budget.

7 Care planning

This section defines what a care plan is and outlines some strategies providers may use to complete care planning with care recipients.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 54-1 and 56-2 of the *Aged Care Act 1997*
- *User Rights Principles 2014*
- *Quality of Care Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers must familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

7.1 What is a care plan?

A care plan is a document that identifies a care recipient's assessed care and service needs, goals and preferences and details how the care and services are to be delivered as agreed with the care recipient to meet their care needs, goals and preferences. The package budget is discussed at Section 8.

Providers will need to undertake assessment and planning for care and services together with the care recipient within 14 calendar days of starting to provide care services. The assessment and planning has a focus on optimising health and well-being in accordance with the assessed ageing related care needs, goals and preferences. Providers must undertake initial and ongoing assessment and planning to meet Standard 2 of the Aged Care Quality Standards (see Section 3).

Assessment and planning is covered by the price deducted from care recipients' package for care management, consistent with a provider's advertised prices on My Aged Care. There should not be a separate charge for initial assessment over and above the agreed charge for care management costs. The legislation prohibits providers from charging a care recipient for entry to their service.

During the care planning process, providers will need to take into account any supports the care recipient already has in place, such as carers, family members, local community and other services. For each care recipient, providers need to be able to demonstrate assessment and planning that:

- includes consideration of risks to the care recipient's health and well-being to inform the delivery of safe and effective care and services;
- identifies and addresses the care recipient's current assessed ageing related care needs, goals and preferences, including advance care planning and end of life planning if the care recipient wishes;
- is based on working with the care recipient and others that the care recipient wishes to involve in assessment, planning and review of the care recipient's care and services; and
- includes other organisations, and individuals and providers of other care and services that are involved in the care of the care recipient.

The care planning document should provide a detailed outline of services to be delivered, including how, when and where. This information should be specific, for example 2-3pm Tuesdays, rather

than 'Tuesday'. Once the care plan and package budget (as discussed at Section 8) have been agreed, providers must give a copy to the care recipient for their records.

Information on approaches to care planning is set out at Section 7.3. Information on what services can (or cannot) be included in a care plan is set out at Section **9**.

7.2 How do I work with a care recipient to develop their care plan?

Because the HCP Program uses a CDC model and is governed by the Quality Standards (as discussed at Section 2.2), providers will need to work with a care recipient to develop their care plan with reference to the ACAT assessment. This is an opportunity to support the care recipient to understand the policy intent of the HCP Program and work out a care plan that assists them to manage their ageing related care needs and goals. To do this, providers will need to consider their obligations under the Quality Standards relating to care planning and understand what the potential inclusions and exclusions are for each individual home care package. Guidance on how to do this is set out at Appendix A.

The Department does not prescribe which validated tools, if any, should be used to inform care planning. However, if providers are looking for examples of what tools may be useful when conducting a care plan, it should be noted that currently ACATs may make use of the following tools when conducting the NSAF (listed below). Some of these tools may have licensing restrictions. If in doubt, providers are encouraged to contact the copyright holder of the tool, if they wish to use these tools for care planning/management purposes:

- Older Americans Resources and Services (OARD) Instrumental Activities of Daily Living
- Barthel Index of Activities of Daily Living
- Kimberley Indigenous Cognitive Assessment – Activities of Daily Living
- Revised Urinary Incontinence Scale (RUIS)
- Revised Faecal Incontinence Scale (RFIS)
- South Australian Oral Health Referral Pad
- Oral Health Assessment Tool (OHAT) for Non-Dental Professionals
- Mini-Nutritional Assessment (MNA)
- Brief Pain Inventory (Short Form)
- Resident's Verbal Brief Pain Inventory
- Abbey Pain Scale
- Alcohol Use Disorders Identification Test
- Standardised Mini-Mental State Examination
- Rowland Universal Dementia Scale
- Informant Questionnaire on Cognitive Decline in the Elderly
- Kessler 10
- Geriatric Depression Scale

One other validated tool used to determine eligibility for the dementia and cognition supplement is the *Psychogeriatric Assessment Scales*. The Commonwealth has enduring copyright over this tool, and this tool may be used freely by providers for all care planning/management purposes.

If the care recipient consents, there may be merit in case conferencing with their GP and other health professionals to support the development of their care plan. GPs and other health professionals may be able to access MBS items to fund their involvement in any case conferencing if

the care recipient has a chronic disease. A provider's involvement would be funded by HCP care management charges to the package.

Providers will also need to help care recipients understand what care, services, and/or purchases they can afford within their package budget. They should prepare for care plan conversations by developing an understanding of the likely components of each individualised package. The information found at Section 8 of this manual will help providers to do this.

Please note, if charges have been levied against a package for excluded items the provider will, at a minimum, be required to repay any amounts that have been unlawfully charged against the budget back into the package.

7.3 What approaches can I employ to work with a care recipient to develop their care plan?

When working with a care recipient to develop goals, providers may consider whether reablement or wellness approaches to providing care might help them meet their goals. Giving consideration to these two contemporary approaches supports providers to ensure that the care and services they deliver align with the core principles of the HCP Program. These concepts underpin a number of aged care services, and are outlined, at a high level, below.

No matter which approach to care planning providers choose to take, it is important to remember that care planning is a collaborative process, between the provider and the care recipient.

7.3.1 Wellness approach

Wellness is an approach that involves assessment, planning and delivery of supports that build on care recipients' strengths, capacity and goals, and encourages actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home. Wellness as a philosophy is based on the premise that, even with frailty, chronic illness or disability, care recipients generally have the desire and capacity to make gains in their physical, social and emotional wellbeing and to live autonomously and as independently as possible.

This approach supports care recipients to undertake a task or activity themselves, or with limited assistance, and to increase satisfaction with any achievements. It underpins all assessment and service provision, whether the need for assistance is episodic, fluctuates in intensity or type over time, or is of an ongoing nature.

The case study on the next page outlines how a wellness approach can make a difference.

Case study: Jing

Jing likes to keep busy and tries to do as many jobs around the house as possible. Lately, she has been unable to hang up some of her heavier clothing items on the line. The traditional approach would involve support workers coming into Jing's home once a week to hang out the clothes for her. The wellness approach would encourage the support worker to work with Jing to hang out her bigger, heavier items and encourage her to hang her smaller items by using a laundry trolley and an easy-to-reach drying rack. In this way, Jing can continue to do things for herself and can act independently to do all her washing except for those items she needs some support to lift. This preference is reflected in Jing's care plan.

Source: Silverchain

7.3.2 Reablement approach

Reablement involves time-limited interventions that are targeted toward a care recipient's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities. Like wellness, reablement aims to assist care recipients to reach their goals and maximise their independence and autonomy. Supports could include training in a new skill or re-learning a lost skill, minor modification to a person's home environment or having access to equipment or assistive technology.

In practice, reablement can mean different things for different people – it all depends on their individual situation. For example, it might mean working with the care recipient to:

- practice daily activities, such as cooking and bathing, to help them regain skills and get their confidence back;
- find new ways to do some things so that they feel safer and more confident;
- look at what else might help (for example, support to go out, personal alarms, home modifications or other equipment, such as bath rails); and/or
- involve their relatives and/or carers in helping them to live more independently – and discuss any support they might need.

The kind of supports reablement might draw on vary, but could include the following:

- equipment and technology to help a care recipient live more independently at home;
- skills for independent living provided through intensive, short-term support; and/or
- outreach - help with transport and getting out and about.

7.4 If two people live together, can they have one care plan that contains information for both of them?

Older Australians who live together must undergo individual assessments by an ACAT. These assessments will generate individual support plans. Each care recipient must be assigned a package and have their own care plan.

They may, however, elect to pool their resources to fund joint care or services across both of their package budgets. For example, if both have been assessed as requiring cleaning services once a week, they may pool resources to share the cost of the cleaner between the two packages. Providers are required to include information about their respective home care fees payable in the Home Care Agreement, and the calculated home care fee amount being recorded in their respective package budgets.

7.5 What do I do if a care recipient wants services my company doesn't deliver?

Providers can deliver home care directly, or can engage third party organisations or individuals to deliver care and services. This includes where a provider:

- sources and coordinates care and services through a third-party (including subcontractors, labour hire or brokered services)
- purchases goods, equipment, and assistive technology from a third party.

You may engage third parties on an ad hoc or ongoing basis to meet your care recipients' needs or their requests for specific workers or service providers.

Approved providers should, where possible, facilitate services being delivered by the person chosen by the care recipient. With CDC, if someone prefers a particular care worker to deliver their services, they can ask the provider to engage that care worker. Providers must discuss this cost with the care recipient before the care plan is agreed. It is good practice to document this conversation for records.

From 1 January 2023, providers must publish all-inclusive prices for third-party services and cannot set or charge a separate amount to cover administrative costs arising from using third-party services. This is regardless of whether:

- they made a business decision to engage a third-party
- the care recipient chose a third-party to provide those services.

This is to make costs more transparent and easier for care recipients to understand and compare.

The Department's website sets out how providers can incorporate costs into care and package management and direct charges when using a third-party. This information can be found at this link or on www.health.gov.au by searching "Third-party services for Home Care Packages".

It is expected most, if not all, additional costs to an approved provider associated with delivering third party services will be recouped through care and package management charges.

The Department cannot advise whether providers should add a percentage to their direct service charges from 1 January 2023. Prices must be value for money and consider the effort and resources it takes to coordinate the care and service delivered.

Regardless of how the services are delivered, providers remain responsible for ensuring services are delivered in a way that meets the requirements of the Act and the Aged Care Quality Standards, including care planning. Providers must also ensure services are delivered in line with the agreed care plan. The care plan will need to be revised periodically to ensure that the sub-contracted services continue to meet the care recipient's assessed ageing related care needs.

Approved providers also need to remember that they, not the sub-contracted service provider, remain responsible for meeting all regulatory responsibilities. These regulatory responsibilities include ensuring that all police checks, and key personnel suitability requirements are met, as well as all obligations under the legislation. **Note**: a list of provider responsibilities is extracted at **Appendix E**.

If the third-party arrangements materially affect approved provider suitability they will need to be disclosed to the Commission. When and how to do this is discussed at Section 15.

7.6 Are there any other models of care delivery which I should be aware of?

The Australian Government is supportive of innovative delivery of services under the HCP Program, to the extent that they are compliant with the intent and scope of the Program.

Home care support must still be offered on a CDC basis. This means the Home Care Agreement must be developed together with the care recipient and the supports delivered must meet the care recipient's assessed ageing related care needs, personal care goals and the care plan.

Charging for services that are not provided is likely to lead to sanctions. Providers must also continue to meet all their obligations under the Act and Principles.

7.7 Can I decline a care recipient's request to sub-contract services?

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

The following list provides a guide to home care providers as to when a request to use a particular service provider might be declined.

- The proposed service may cause harm or pose a threat to the health and/or safety of the care recipient or staff.
- The proposed service is outside the scope of the HCP Program.
- The home care provider would not be able to comply with its responsibilities under aged care legislation or other Australian Government or State/Territory laws.
- The requested third-party service provider will not enter into a contract with the home care provider.
- There have been previous difficulties or negative experiences with the requested service provider.
- The cost of the service/item is beyond the scope of the available funds for the package.

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

7.8 What do I need to provide to the care recipient at the end of their first care planning process?

Providers will need to give the care recipient a copy of their care plan within 14 calendar days of commencing service delivery and the package budget as soon as practicable. The package budget must identify what the budget is made up of (that is, the Government contributions and the home care fees) and how those budget funds have been allocated to care and services under the care plan.

Providers will need to consider pricing obligations when developing the budget. The budget is discussed at Section 8. Pricing obligations are discussed at **Appendix B**.

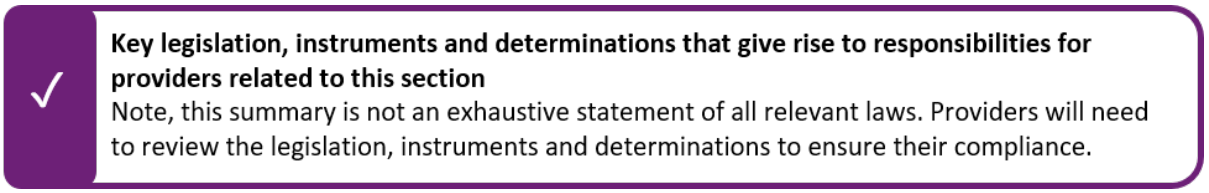
✓ Key points to remember

- Providers need to complete a care plan for all new care recipients within 14 calendar days of them starting services.
- Providers will need to collaborate with the care recipient to develop their care plan. When thinking about how to approach the care planning process, providers should consider taking a wellness or reablement approach.
- Providers' role in the care planning process is to help care recipients understand what care, services, or purchases they can choose to get from their package based on assessed need, and to enable them to make choices between those care and services.

8 A care recipient's package budget

As discussed at Section 7, providers need to work with each new care recipient to develop a care plan within 14 calendar days of the day the Home Care Agreement is completed. The individualised package budget needs to be done as soon as providers have all the information needed and the care plan is place. This section explains what makes up a package budget and how to calculate each component. All the financial aspects of the HCP Program are defined by the legislation. Providers should refer to the legislation for more information.

This section provides information relevant to people who entered the HCP Program after 1 July 2014, or who have opted into the post-1 July 2014 arrangements. For information on the pre-1 July 2014 arrangements, see **Appendix A**.



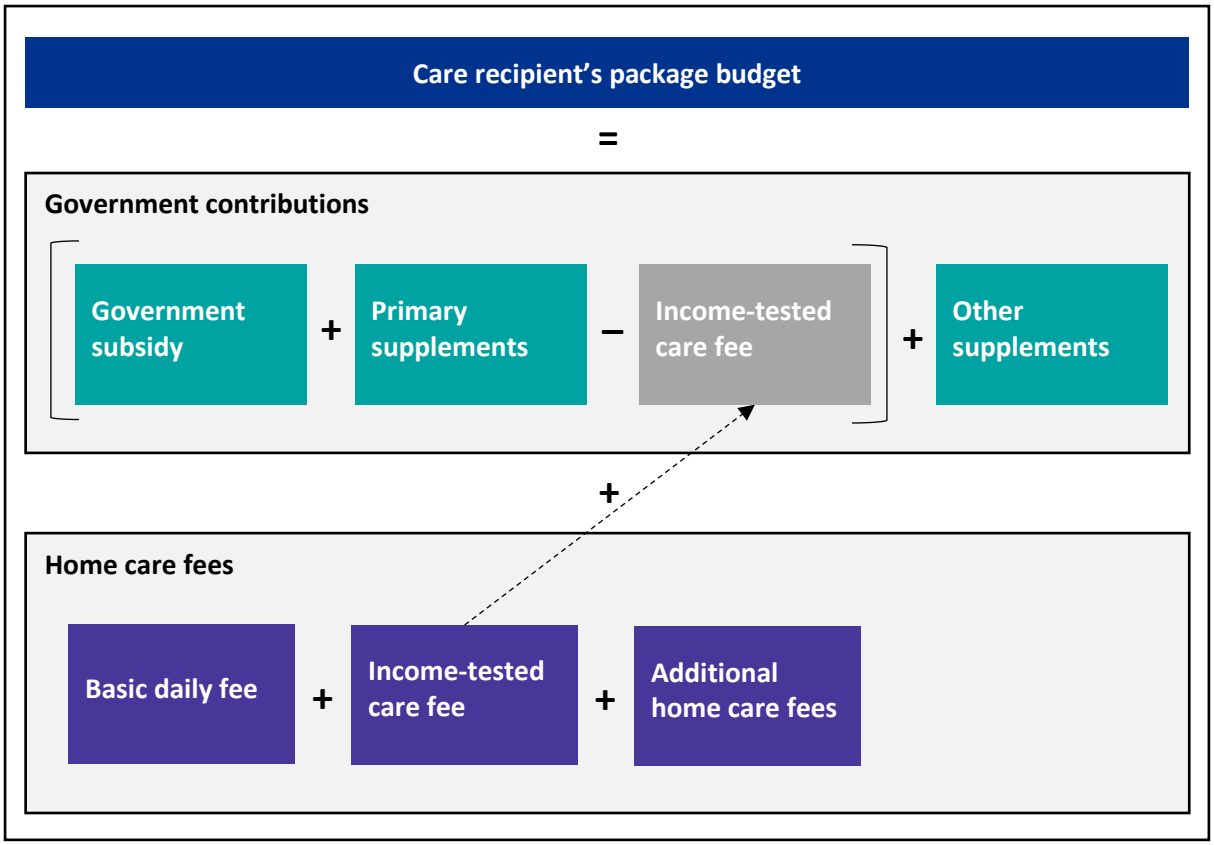
- Sections 47, 48, 52D-1, 56-2 and 96 of the *Aged Care Act 1997*
- *User Rights Principles 2014*
- *Fees and Payments Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

8.1 What makes up a care recipient's package budget?

Each care recipient's package budget is made up of contributions from the Australian Government and, where applicable, the home care fees payable by the care recipient. The components of a post-1 July 2014 package budget may include:



Note: It should be noted that a care recipient's package budget will be affected if they have received a compensable payment amount. These are discussed in **Appendix C**.

8.2 How do I determine the amount of Government contribution to a care recipient's budget?

The Government contribution is calculated as follows:

1. The basic subsidy amount
2. Plus any primary supplements (oxygen supplement, enteral feeding supplement, dementia and cognition supplement, veterans' supplement)
3. Less any reductions in subsidy and primary supplements (income-tested care fee)
4. Plus any other supplement (hardship supplement, viability supplement).

The Government subsidy and supplements are payable, and calculated daily, even on days a care recipient does not receive a service.

8.2.1 Basic subsidy

The subsidy is paid in accordance with the level of package the care recipient has been assigned. There are four package levels, outlined in the table below:

Package	Needs
Level one	Basic care
Level two	Low level care
Level three	Intermediate care
Level four	High level care

The current amount that can be paid by the Government can be accessed at this link or by searching "Home care packages subsidy" at www.health.gov.au.

8.2.2 Supplements

If care recipients are eligible, providers can also claim for supplements that will be added to the subsidy amount. An authorised signatory of the approved provider must sign the dementia, oxygen and enteral feeding claim forms. Once a form is completed, the form and supporting evidence can be emailed to Services Australia via aged.care.liaison@servicesaustralia.gov.au. Providers should keep copies of all supplement forms and supporting evidence in the associated care recipient's records.

Any supplements providers claim for a care recipient must be added to their total package budget. Although they will be eligible for supplements if they require particular types of supports, the supplement funds do not have to be used to provide that specific support. Supplements are an acknowledgement of additional needs, and the supplement funds can be used in the same ways as any other component of a package budget.

Providers can claim supplements for eligible care recipients on any package level; whether they are on a level one, two, three of four package.

The table below identifies and describes each of the supplements, and outlines the administration requirements.

Primary supplements

Supplement	Description	Application process and payment	What happens if the care recipient changes providers?
The Dementia and Cognition Supplement in Home Care	The dementia and cognition supplement provides additional funding in recognition of the extra costs of caring for people with cognitive impairment associated with dementia and other conditions. For further information go to this link, or search "Dementia and cognition supplement for home care" at www.health.gov.au.	Assessment using one of the prescribed tools by an approved assessor. The approved provider is responsible for lodging an application with Services Australia.	Supplement automatically transfers to new provider. The new provider must obtain a copy of the record of assessment undertaken by the care recipient.

Supplement	Description	Application process and payment	What happens if the care recipient changes providers?
The Veterans' Supplement in Home Care	The veterans' supplement in home care provides additional funding for veterans with a mental health condition accepted by the Department of Veterans' Affairs (DVA) as related to their service. For further information go to this link, or search "Veterans' supplement for aged care" www.health.gov.au.	DVA determines eligibility and advises Services Australia. No action required by provider.	Supplement automatically transfers to new provider.
Oxygen Supplement	The oxygen supplement is for care recipients with a specified medical need for the continual administration of oxygen. For further information go to this link, or search "Oxygen supplement for aged care" www.health.gov.au.	Paid to provider to help pay for specialised products and equipment. The approved provider is responsible for completing the application form available on the Services Australia website. Once the form is completed, the form and supporting evidence can be returned to Services Australia.	Supplement does not automatically transfer. The new provider needs to submit a new application to Services Australia, including medical evidence.
Enteral Feeding Supplement	The enteral feeding supplement is for care recipients with a specified medical need for enteral feeding. For further information go to this link, or search "Enteral feeding supplement for aged care" at www.health.gov.au.	Paid to provider to help pay for specialised products and equipment. The approved provider is responsible for completing the application form available on the Services Australia website. Once the form is completed, the form and supporting evidence can be returned to Services Australia.	Supplement does not automatically transfer. The new provider needs to submit a new form to Services Australia, including medical evidence.

Other supplements

Supplement	Description	Application process and payment	What happens if the care recipients changes providers?
Viability Supplement in Home Care	The viability supplement is paid to providers on behalf of recipients of home care in rural and remote areas in recognition of the higher costs of delivering care and services in these areas. For further information go to this link, or search "Viability supplement for home care" at www.health.gov.au.	Provide location details (suburb and postcode) to Services Australia through entry event and location event screen in the Aged Care Provider Portal.	Supplement automatically transfers to the new provider if a care recipient remains at the same location. The new provider must enter the same postcode and suburb on the Aged Care Provider Portal. A care recipient who relocates will automatically be reassessed for viability supplement based on their new location.
Hardship Supplement	The hardship supplement is available to recipients of home care in genuine financial hardship who do not have income to pay their costs of aged care due to circumstances beyond their control. Care recipients who have commenced receiving a package on or after 1 July 2014 need to apply to Services Australia for financial hardship assistance. For further information go to this link, or search "Financial hardship assistance" at www.health.gov.au.	Paid to provider as a hardship supplement in lieu of the basic daily fee and/or income-tested care fee. Care recipients (or their representative) applies and submits form to Services Australia.	Supplement automatically transfers to new provider if a valid approval exists. As this supplement is time-limited, the new provider should confirm if the care recipient is receiving a hardship supplement and the validity period.

The schedule of aged care subsidies and supplements contains the current daily rate for HCP Program subsidies and supplements. The schedule can be found at this link or by searching "Schedule of subsidies and supplements" at www.health.gov.au.

8.3 How do I determine the amount of a care recipient's home care fees?

There are three types of legislated fees a provider may ask a care recipient to pay:

- the basic daily fee;
- an income-tested care fee (mandatory); and
- any other amounts they have agreed to pay for additional care and services.

If a care recipient wishes to purchase additional services over and above those they could otherwise afford under the package, their provider can agree with them a further amount for additional care and services to increase the value of the package.

These fees are part of the individualised package budget and must be included in the Home Care Agreement as a statement of fees that may be payable. Providers must discuss any fees to be paid by the care recipient before they commence services.

If the care recipient is on leave there may be changes to the subsidy, supplements and home care fees payable. Please see Section 11 of this manual.

8.3.1 Basic daily fee

Providers can ask everyone to pay the basic daily fee. It is set by the Australian Government at:

- Level one - the maximum fee is 15.68 per cent of the single person rate of the basic age pension.
- Level two - the maximum fee is 16.58 per cent of the single person rate of the basic age pension.
- Level three - the maximum fee is 17.05 per cent of the single person rate of the basic age pension.
- Level four - the maximum fee is 17.50 per cent of the single person rate of the basic age pension.

Rates for the basic daily fee are reviewed in March and September each year in line with changes to the Age Pension. The current rates are available in the schedule of fees and charges for residential and home care. The schedule can be found at this link or by searching "Charging fees for aged care services" at www.health.gov.au.

As the maximum basic daily fee is linked to the package level, an increase in package level may result in an increase to the basic daily fee.

Home care fees are payable, and calculated daily, even on days a care recipient does not receive a service. The Government subsidy and supplements are payable, and calculated, in the same way.

8.3.2 Income tested care fee

The income-tested care fee is a contribution that care recipients may be asked to pay if they can afford to do so, and is in addition to the basic daily fee. The income tested care fee is determined through an income assessment, which is conducted by Services Australia or DVA as applicable.

If a care recipient has been assessed as needing to pay the income tested care fee, this will be deducted from the Government subsidy paid to the provider by Services Australia.

From 1 September 2021, if a care recipient's assessed income tested care fee is equal to or less than the price reported to Services Australia, no Government subsidy entitlement will be paid to the provider. Any unspent government subsidy will accrue in the care recipient's home care account for future care and services. See Appendix E for more information on Improved Payment Arrangements.

It is the responsibility of the provider to put in place the business processes to collect and manage income tested care fees from care recipients who have been assessed as needing to pay the fee.

Fees must be outlined in the Home Care Agreement and providers must discuss and agree these fees with the care recipient before they start services.

If prior to 1 September 2021, a provider was not collecting all or part of the income tested care fee because a care recipient was not using all of their package, this can continue as long as they:

- made a business decision prior to 1 September 2021 that they would not collect the income-tested care fee from care recipients where they are not using the full amount of their package; AND
- can demonstrate that they had not collected fees from that care recipient on an ongoing basis (not just ad-hoc) for some months prior to 1 September 2021; AND
- hold unspent funds and have not opted-in for this care recipient so have access to unspent funds.

Once the unspent funds that the provider holds for the care recipient have been used, or if the care recipient has no unspent funds, providers will only be able to waive the income tested care fee by using retained earnings (i.e. the provider pays the income tested care fee for the care recipient and reports it on the monthly statement, including any accumulation of the care recipient portion of funds if the package is underspent). If providers are not able to do this, the care recipient will need to start contributing their assessed income tested care fee.

The Services Australia home care account cannot be invoiced for amounts that would otherwise be payable by the income tested care fee. Doing so may result in regulatory action being brought against the provider.

This should not impact full pensioners as their means test is automatically matched by Services Australia through Government data and full pensioners do not pay the income tested care fee.

Providers cannot charge care recipients retrospectively for the income tested care fees that they have waived in the past.

If an income tested care fee is refunded to a provider due to a quarterly review, the fees must be returned to the care recipient. If the care recipient has already left care and their balance has been settled, then the income tested care fee must be refunded to the care recipient or their estate. If an income tested care fee is increased due to a quarterly review, the provider must ask the care recipient to pay the increased fee. If the care recipient has already left care and their balance has been settled, the income tested care fee should be claimed from the care recipient or their estate. If the provider does not collect the income tested care fee from care recipients, the provider could be out of pocket for package expenses and will be liable to pay these expenses out of retained earnings.

Once the Home Care Agreement has been entered into, providers may ask the care recipient to pay home care fees up to one month in advance. Providers cannot ask for payment of any home care fees before their package begins.

8.3.3 Income assessment

The easiest way for a care recipient to complete an income assessment is to use form SS313, at this link, or by searching **"Authorising a person or organisation to enquire or act on your behalf form (SS313)"** at www.servicesaustralia.gov.au. This is a dynamic form and will present different questions based on the answers provided.

If the care recipient prefers to complete a hardcopy form, they can download a copy of the **"Authorising a person or organisation to enquire or act on your behalf form (SS313)"** from the Services Australia website at this link or by searching "SS313" at www.servicesaustralia.gov.au. Or call Services Australia on **1800 227 475** to ask a copy to be sent to them. If the care recipient receives a means tested income support payment, they can call Services Australia on **1800 227 475**

or DVA on **1800 555 254** and request a pre commencement letter for home care. Services Australia (or DVA) will have sufficient information to calculate their maximum home care fees payable.

For an estimate of home care fees for the person, My Aged Care has a home care fee estimator at this link, or can be found by searching "Fee estimator" at www.myagedcare.gov.au.

Providers must continue to support care recipients to understand fees and their means assessment. This may also require providing information about how to request to Services Australia review of the assessment decision, or how to apply for financial hardship supports through Services Australia.

Delayed income assessment

A care recipient may begin to receive services prior to their means test being finalised. Services Australia assume no income tested care fee is payable and will pay the full monthly claim entitlement until the care recipient is assigned a 'means not disclosed status'.

If a care recipient is assigned a 'means not disclosed status' Services Australia assume the full income tested care fee is payable. This may result in a provider being paid less than the care recipient is entitled to.

Once a means test outcome is finalised, Services Australia will apply the correct income tested subsidy reduction backdated to the date the care recipient first entered the Home Care Packages Program. This means that:

- If a care recipient's means test outcome has resulted in an overpayment to the provider, Services Australia will deduct the overpayment from the next payment to the provider.
- If a care recipient paid income tested care fees in excess of what they were required to pay, the provider must repay these to the care recipient.

To manage risk for new care recipients, providers can apply the maximum income tested fee, the second daily cap in the Schedule of Fees and Charges, for any care recipients where they have not received their initial means testing advice. This should not impact pensioners as their means tests are automatically matched by Services Australia through Government data and full pensioners do not pay the income tested fee.

Providers should manage their cash-flow accordingly to cover any future liabilities arising from a late submitted means test.

Means testing adjustments

If a care recipient is paying an income tested care fee and receives a delayed income assessment which determines they should have been paying a lower contribution than the maximum income tested fee, or no fee, the provider must refund the difference to the care recipient once the care recipient fees are set.

If a care recipient receives a delayed income assessment which determines they should have been paying a higher income tested care fee, this is backdated to their date of entry. This means the income tested subsidy reduction is also backdated. An adjustment will be applied in the next claim, and the subsidy paid for that care recipient in the next claim would be reduced by the backdated adjustment amount.

If the adjustment amount was greater than the care recipient's payment determination for the current claim month, this would result in a negative payment amount for the care recipient for the month. This negative amount would be factored into the overall service payment. The provider may then claim the underpaid income tested care fee from the care recipient.

If an income tested care fee is refunded to a provider due to a quarterly review but the care recipient has already left care and their balances have been settled the following applies:

- If the care recipient has exited care to move to another provider, the refunded income tested care fee can be transferred from the previous provider to the new provider
- If the care recipient has exited care, due to entry into residential care or has passed away, then the income tested care fee can be refunded to the care recipient/or their estate.

If a care recipient does not agree with the outcome of their means test, they can request Services Australia to review this decision. If a care recipient is unable to pay their fees due to financial hardship, they can apply for financial hardship help from the Government.

8.3.4 Annual and lifetime caps

There are annual and lifetime caps that apply to the income-tested care fee. The current caps are at this link or can be found by searching "Schedule of Fees and Charges for Residential and Home Care" at www.health.gov.au. Once the annual cap is reached, the care recipient cannot be asked to pay any more income-tested or means-tested care fees until the next anniversary of when they first started receiving aged care. Providers can still ask for payment of the basic daily fee.

Services Australia will notify the provider and care recipient once the cap has been reached. The Government will pay the remaining income-tested care fees by way of increased subsidy to the provider after these caps have been reached.

8.3.5 Worked example

How do we calculate Adam's package budget?

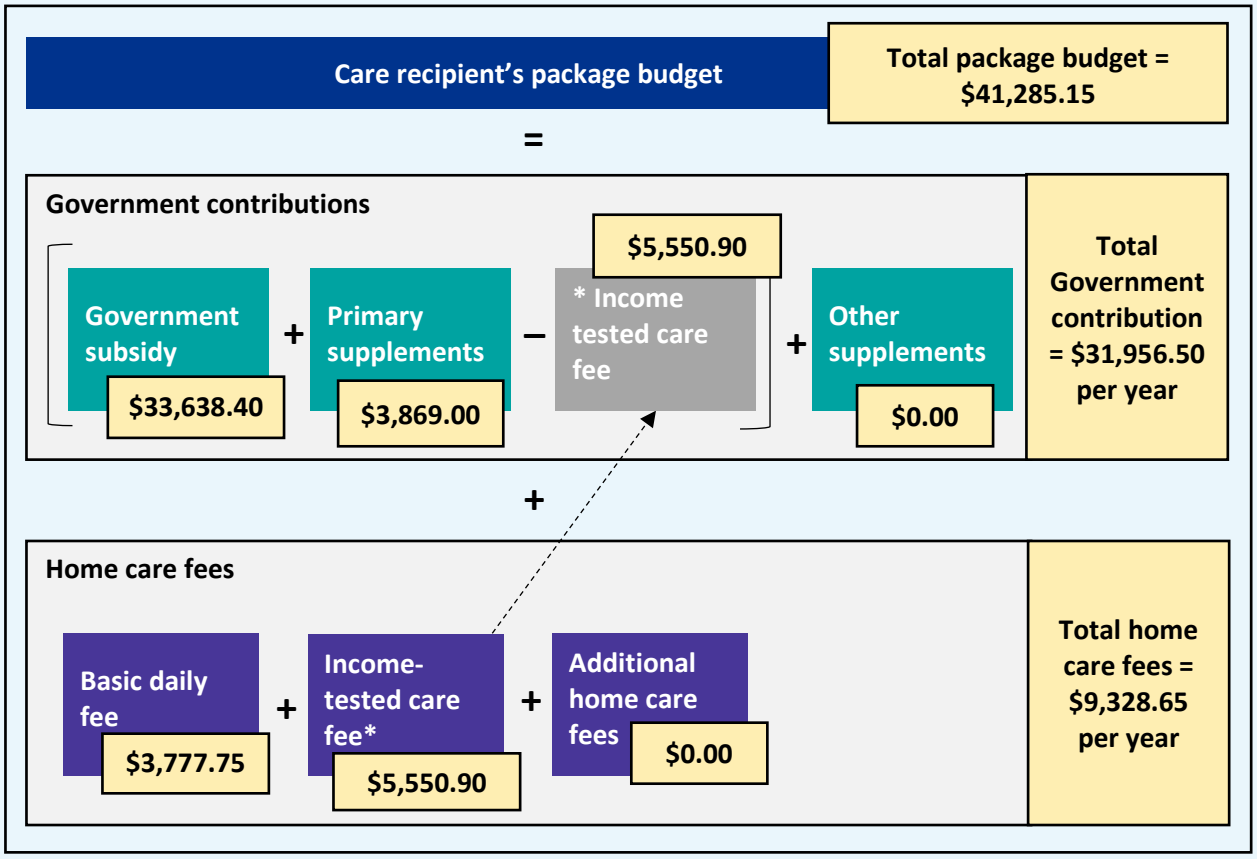
Fact scenario

- Adam lives at home with his partner David.
- Adam has been assigned a level three package. The value of his daily package subsidy is $92.16 per day (as at 20 September 2019). This equates to $33,638.40 per year.
- Adam is also eligible for the dementia and cognition supplement. The value of the supplement at his package level is $10.60 per day. This equates to $3,869.00 per year.
- Adam is not eligible for any other supplements.
- The basic daily fee for Adam's package level is $10.35 per day. This equates to $3,777.75 per year.
- Adam has completed his income assessment, and has been assessed by Services Australia as being able to pay an additional $15.24 per day or $5,550.90 per year in income-tested care fees.
- Adam did not agree to pay any additional fees in his Home Care Agreement.

How do we calculate Adam's package budget?

Calculation of package budget

The diagram below outlines how Adam's home care budget is calculated:



The Government subsidy and supplements of Adam's Home Care Package is valued at $37,507.40 ($33,638.40 + $3,869.00) per year.

The amount of basic daily fee charged adds to Adam's package budget. It has no impact on the amount of Government subsidy and supplements that are paid.

Adam, however, has been assessed by Services Australia as being able to contribute $5,550.90 per year towards his income tested care fee. The Government subsidy and primary supplement payable for Adam's care to his provider is reduced by Adam's income tested care fee. That is, $33,638.40 + 3,869.00 - $5,550.90 = $31,956.50.

If Adam fails to meet his responsibilities, including the payment of fees, as described in section 17 of the *User Rights Principles 2014*, his home care provider may cease to provide home care to him under the security of tenure provisions. Adam's Home Care Agreement must contain a statement setting out which home care fees are payable by him and the conditions under which either party may terminate the provision of home care.

8.4 What do I do if a care recipient is facing financial hardship?

If someone thinks they will face financial hardship when paying their aged care fees, they can apply to Services Australia for financial hardship assistance. Each case is considered on an individual basis. Depending on their situation, they may apply for financial assistance with the:

- basic daily fee; and/or
- income-tested care fee.

Care recipients experiencing financial hardship may be granted assistance with one, both or neither of these fees. If financial hardship assistance is granted, a hardship supplement will be paid to the provider in lieu of the basic daily fee and/or income tested care fee.

For more information on eligibility criteria and assessments for financial hardship go to this link, or by searching "Hardship supplement for aged care" at www.health.gov.au.

8.5 When should I review a care recipient's home care fees?

Rates for the basic daily fee are reviewed and changes announced in March and September each year in line with new rates for the Age Pension. Providers may need to discuss the impact of these fees changes with the care recipient and update their package budget accordingly.

Services Australia conducts a quarterly review of income-tested care fees in January, March, July and September. If a care recipient's financial circumstances change the care recipient can request a review with Services Australia or DVA.

For care recipients in the pre-1 July 2014 arrangements, see **Appendix A**.

✓ Key points to remember

- A package budget is made up of Government subsidies and supplements, and home care fees.
- A care recipient's home care fees will depend on their circumstances. All care recipients may be asked to pay a basic daily fee. Some may also be asked to pay an income tested care fee.
- Government subsidy and supplements are payable, and calculated daily, even on days a care recipient does not receive a service. Home care fees are also payable, and calculated daily.
- It is a business decision for the provider if they choose to collect the basic daily fee. Collecting this fee adds to the package budget and provides access to more care and services.
- It is the responsibility of the provider to put in place the business processes to collect and manage income tested care fees from care recipients who have been assessed as needing to pay the fee. Providers should work with their care recipients to ensure they are receiving the level of care and services they require.

9 Inclusions and exclusions

This section outlines the ageing related care and services that can and cannot be included in a Home Care Agreement, care plan and individualised budget. It gives providers information and tools to use when working with care recipients to develop a care plan that optimises health and wellbeing in accordance with their assessed ageing related care needs, care goals and preferences, and helps them to maintain their capabilities as they age.

Under a CDC service delivery model, care recipients have choice over the types of ageing related care and services they access and how these are delivered. Decisions on what is included or excluded in the care plan need to reflect that they have a 'dignity of risk' (under the Charter of Aged Care Rights) to accept the personal risks associated with making these choices. Providers need to balance this with their ongoing accountability for what each package budget is being spent on, and for delivering quality of care. This is necessary to ensure providers are compliant with the Aged Care Quality Standards and any relevant Australian Government or State and Territory laws.

To meet these obligations, providers may need to have challenging conversations with care recipients and their carers about whether a type of care, service or item can be included. A framework of considerations is included in Section 9.5 to support these discussions. It is also important that providers document and retain records of the reasons why a service or item is included or excluded.

✓ **Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section**
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Section 54-1 of the *Aged Care Act 1997*
- *Quality of Care Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual. Providers should familiarise themselves with the obligations required of them. See **Appendix E** for further detail on specific provider responsibilities.

Providers will need to act in compliance with all relevant State, Territory and Australian Government laws. A list of relevant Australian Government laws can be found at this link, or by searching "Legislation" at www.agedcarequality.gov.au/. The Aged Care Quality Standards can be found at this link or by searching "Quality Standards" at www.agedcarequality.gov.au/. Please consult your State or Territory register of legislation for information on relevant State or Territory laws.

9.1 How do I work out what services can be included in a care recipient's care plan?

The HCP Program is designed to provide a mix of services and supports that are customised to meet the individual care needs and goals of each eligible person. As discussed at Section 7, that mix is determined through care planning. Care planning involves:

- collaborating with the care recipient to discuss their assessed care needs and care goals;
- deciding which care and service types will best assist them to meet these needs and goals; and
- detailing these care and services types in the care plan.

When working with each person to clarify their assessed care needs and care goals, providers should encourage them to think about what supports will optimise their health and wellbeing. Their

priorities and preferences are a key part of the discussion to co-produce their care plan. Care and services included in the care plan that will be purchased using the package budget should be drawn, for the most part, from the legislated inclusions, and must not include any legislated exclusions (see Section 9.2).

Sometimes a care recipient will seek a care or service type that is not specified as an inclusion or exclusion in the legislation. This means that you will need to work with care recipients to determine if the service, support or purchase:

- is directly linked to their identified care needs and goals;
- supports for daily living that is important for the care recipient's health and wellbeing;
- is necessary for them to support functional safety in their home;
- can be delivered within their available package budget; and
- would be considered an acceptable use of Government funds.

You will also need to consider whether you have the capacity and capability to deliver, or source, the proposed support.

The framework supports providers to take a flexible and responsive approach to working with care recipients on whether to provide proposed care and services that are not identified in the legislated inclusions. It allows providers to take a person-centred approach to care planning that supports a balance between assessed care needs, care goals and individual preferences, and considers individual circumstances such as financial and social position, cultural diversity and location.

The following framework has been designed to support decision making when it comes to determining what can and cannot be included as part of a package:

Consider and understand the care recipient's care needs and care goals to support them in living independently in their own home (in the short and medium term).

The care recipient's care needs and care goals must be clearly understood by both the provider and the care recipient, noting that these care needs and care goals can change over time. Information provided in the ACAT assessment and discussions with the care recipient will provide the basis for understanding this.

For each care and service type the questions on the next page will need to be considered.

These questions have been developed to help providers determine with care recipients if a care or service type should be included as part of their package. The questions have been grouped by category. To draw a conclusion, it is important that all the questions are considered on balance of each other.

Document all discussions about the inclusion or exclusion.

All discussions surrounding inclusions and exclusions for each care recipient should be clearly documented. Care and services to be included in the package should be clearly documented in the care plan and package budget. Where a provider is unable to give effect to the care recipient's preferences or request for services, the reasons must be clearly explained to the care recipient and documented. Documenting these discussions provides justification for the decisions regarding inclusions and exclusions of a package. Providers may be required to produce this documentation as evidence for the Aged Care Quality and Safety Commission or the Department.

9.2 Specified Inclusions

As outlined in the above framework, the legislation provides guidance about specific items that can be included or must be excluded. It is worth remembering, however, that the care or service is only included when it meets assessed care needs and care goals.

This guidance is outlined in the *Quality of Care Principles 2014*.

The inclusions have been extracted below:

9.2.1 Care services

Service inclusions	Content
Personal services	Personal assistance, including individual attention, supervision and physical assistance, with: • Bathing, showering including providing shower chairs if necessary, personal hygiene and grooming, dressing and undressing, and using dressing aids • Toileting • Mobility • Transfer (including in and out of bed).

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

9.2.2 Support services

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

Service inclusions	Content
Care management	Includes ongoing assessment and planning undertaken on at least a monthly basis to ensure that the care recipient receives the care and services they need. This includes: • regularly assessing the care recipient's needs, goals and preferences • reviewing the care recipient's home care agreement and care plan • ensuring the care recipient's care and services are aligned with other supports • partnering with the care recipient and the care recipient's representatives about the care recipient's care and services • ensuring that the care recipient's care and services are culturally safe • identifying and addressing risks to the care recipient's safety, health and wellbeing.

9.2.3 Clinical services

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

The *Quality of Care Principles 2014* have also established a number of services that must not be included in the package. These are always excluded; even if they may advance the care recipient's assessed care needs and care goals, they are not aligned to the intent and scope of the HCP Program. Specified exclusions are listed in detail below:

9.3 Specified Exclusions

The *Quality of Care Principles 2014* lists those care and services that must not be included in the package. These are always excluded; even if they may advance the care recipient's assessed ageing related care needs and goals, as they are not aligned to the intent and scope of the HCP Program.

The following items **must not** be included in a package of care and services under the HCP Program.

Exclusions	Examples
Services, goods or supports that people are expected to cover out of their general income throughout their life regardless of age	• General home services that were never, or are generally not completed independently prior to age-related functional decline, including home repairs/maintenance/specialist cleaning performed by a tradesperson or other licensed professional • Food (**except** as part of enteral feeding requirements or items listed under food for special medical purposes as per the Australia New Zealand Food Standards Code – Standard 2.9.5). Further information on food is below under Meal services

Exclusions	Examples

	• Home insurance
	• Rates
	• Water, sewage, gas and electricity costs
	• Private transport related costs including vehicle registration, vehicle repairs, vehicle insurance and petrol
	• Local transit costs of public bus, ferry or train fares
	• Funeral plans / insurance costs
	• Pet care and associated costs such as pet food; registration; taxidermy, cremation
	• Internet and telephone costs, **exceptions include**:
	  ○ Care recipients who are homeless or at risk of homelessness (as identified in a care recipient's ACAT assessment) can use HCP funds for the ongoing monthly charges to ensure connection with service providers
	  ○ Care recipients who require the internet or landline to support delivery of medication management, remote monitoring service or delivery of an included service on the phone can use HCP funds to set-up telecommunications connections (e.g., to get internet connected)
	• Beauty therapy (e.g., manicures) and hairdressing
	• Cost of entertainment activities, such as club memberships and tickets to sporting events
	• Travel and accommodation for holidays
	• Supplies to participate in any activity, e.g. gardening or craft
	• Using HCP funds to pay for solicitors or accountants for maintaining care recipients' personal affairs
	• Funeral costs and funeral plans
	• Gym or pool memberships/access costs when not prescribed for aged-related functional decline and monitored by health professional operating within their scope of practice

Accommodation costs	• Assistance with home purchase • Mortgage payments • Rent • Permanent residential care (subsidised or private) and residential respite (subsidised) • Heating and cooling costs (installation and repairs) • Whitegoods and electrical appliances (except items designed specifically for frailty such as a tipping kettle) • Household furniture and furnishings: ○ lounge suites and recliners which do not support a care recipient's mobility, dexterity and functional care needs and goals

Exclusions	Examples
	○ Other general household furniture such as coffee tables, wardrobes, and bookshelves. ○ Massage chairs when not prescribed by treating medical practitioner and/or allied health professional ○ General mattress and frame for bed (exceptions for pressure relieving mattress or mattress/frame for an electrical adjustable bed or hospital bed) • Replacement/maintenance/servicing/cleaning of: ○ Water tanks ○ Solar panels ○ Fencing ○ Roofs ○ Heating and cooling or hot water systems ○ Swimming pools • Home modifications or capital items that are not related to the care recipient's ageing-related care needs, for example: ○ Windows, roofs, pergolas, sunrooms, decking ○ Home modifications that don't support ageing safely e.g., non-accessible bathroom and kitchen modifications; non-standard fittings in accessible bathroom modifications (e.g., mosaic tiles) ○ Home modifications requiring development applications ○ Aesthetic modifications of any kind ○ Repainting the home ○ Major plumbing ○ Emptying of septic tank; remedying sewage surcharge (matter for water company/insurer) ○ Major electrical work, e.g., rewiring house ○ Replacement of entire floor and floor coverings throughout the home unless safe passage for mobility equipment required or slip hazard reduction required, as recommended by a health professional for care recipients at risk of falls ○ Replacement of foundation e.g., concrete/cement slab ○ Significant changes to the floorplan of the home, such as adding a new bathroom or extension Extensive gardening services such as: • Planting and maintaining crops, natives and ornamental plants • The installation and/or maintenance of raised garden beds • Compost heaps • Watering systems

Exclusions	Examples
	• Water features and rock gardens • Landscaping • Tree removal • Removal of garden beds • Removal of shrubbery (unless preventing safe access and egress)
Payment of home care fees	• Defined at section 52D of the *Aged Care Act 1997* • Includes income tested care fees, basic daily fees and additional fees

Payment of fees or charges for care or services funded or jointly funded by the Australian Government	• Co-payments for state/territory government funded programs, such as subsidised taxi vouchers and/or aids and equipment schemes
	• Dentures, dentistry and dental surgery
	• Prescription glasses or contact lenses
	• Prostheses (e.g., artificial limb)
	• Spectacles
	• Hearing aids available under the Hearing Services Program. Contact the Hearing Service Program (HSP) for guidance on hearing aid replacement and delegate approval for non-standard hearing aids. **Exception** if care recipient is not a pension concession card holder as HCP may cover like for like of typical hearing aid covered by HSP in this case only.
	• Continence aids if a participant in the CAPS program
	• Diagnostic imaging
	• Natural therapies, including:
	  ○ Alexander technique
	  ○ Aromatherapy
	  ○ Bowen therapy
	  ○ Buteyko
	  ○ Feldenkrais
	  ○ Homeopathy
	  ○ Iridology
	  ○ Kinesiology
	  ○ Naturopathy
	  ○ Pilates (except sessions supervised by an exercise physiologist or physiotherapist)
	  ○ Reflexology
	  ○ Rolfing
	  ○ Shiatsu
	  ○ Tai chi (except sessions supervised by a Chinese Medicine Practitioner, exercise physiologist or physiotherapist)
	  ○ Western herbalism
	  ○ Yoga (except sessions supervised by an exercise physiologist or physiotherapist)
	• Payment for informal care – a Carer's Payments is available to fund the support of family and friends

Exclusions	Examples
	• Section 16.1 of the HCP Program Manual specifies more information about what ageing related programs can and cannot be accessed while receiving a HCP.
Payment for services and items covered by the Medicare Benefits Schedule (MBS) or the Pharmaceutical Benefits Scheme (PBS) (or items that should be considered for funding through these schemes)	• Co-payments or gap fees, including for services covered by private health insurance ○ Medications, vitamins and supplements (as well as items not covered by the PBS such as off-indication prescriptions, medicines not endorsed for listing by the Pharmaceutical Benefits Advisory Committee (PBAC) or medicines where the manufacturer has chosen not to list the product on the PBS ○ Consultation/tests/surgery with medical practitioner (GPs and specialists) ○ The only **exception** to this is a private appointment (i.e. not covered by MBS) with a GP to meet evidence requirements for the dementia and cognition supplement and oxygen and enteral feeding supplements • Hospital costs • Ambulance cover • Private health insurance premiums
Provision of cash debit cards or like payments to care recipients for any purpose	• Debit cards (unless the provider has rigorous systems in place to vet every payment and keep on file all receipts in accordance with the *Records Principles 2014*. Debit cards may pose issues for GST credits. Consult with the ATO for more information). • Cash payments or gift vouchers/cards, including online vouchers and coupons • Transfer of subsidy into care recipient or their family's personal/business bank account without rigorous acquittal by provider of funds against receipts matched to the Home Care Agreement, care plan and individualised budget in accordance with the *Records Principles 2014*.

9.4 Meal services

In relation to meal services and whether food can be included in a HCP:

- preparation and delivery of meals can be included
- the raw food component of those meals cannot be included, except in the case of enteral feeding.

The Department has not mandated a standard split/ratio for the raw food component. This is a business decision for the company providing the meal services to calculate how much the raw food component is. Home care providers should discuss with the care recipient the amount of the raw food contribution, as well as how and who it is paid to, as part of the negotiation with the meals provider and the care recipient.

Food referred to as 'takeaway' is also an excluded item. 'Takeaway' food is generally defined as food you would buy from a restaurant or food outlet.

9.5 How does a provider respectfully decline a request?

The following list provides a guide to providers on when it might be reasonable to decline a request from a care recipient:

- The proposed service may cause harm or pose a risk to the health and/or safety of the care recipient or staff.
- The proposed service is outside the scope of the *Quality of Care Principles 2014.*
- The provider would not be able to comply with its responsibilities under aged care legislation or other Australian Government or State/Territory laws.
- The care recipient's choice of service provider is outside the provider's preferred list of service providers and all reasonable effort has been made to establish an acceptable sub-contracting arrangement.
- The requested service provider will not enter into a contract with the provider.
- There have been previous difficulties or negative experiences with the suggested service provider.
- The cost of the service/item is beyond the scope of the available funds for the package.

The following is a case study of when an item might be clinically necessary, but is excluded:

Case study: Yashwant

Yashwant is in his 80s and on a level three package. He has accrued approximately $5,000 in unspent funds. Yashwant needs a new set of hearing aids. He can get these devices fully subsidised under the Australian Government Hearing Services Program. He has decided, however, that he would like to use his unspent funds to get different hearing aids that are partially subsidised or not available through the Hearing Services program.

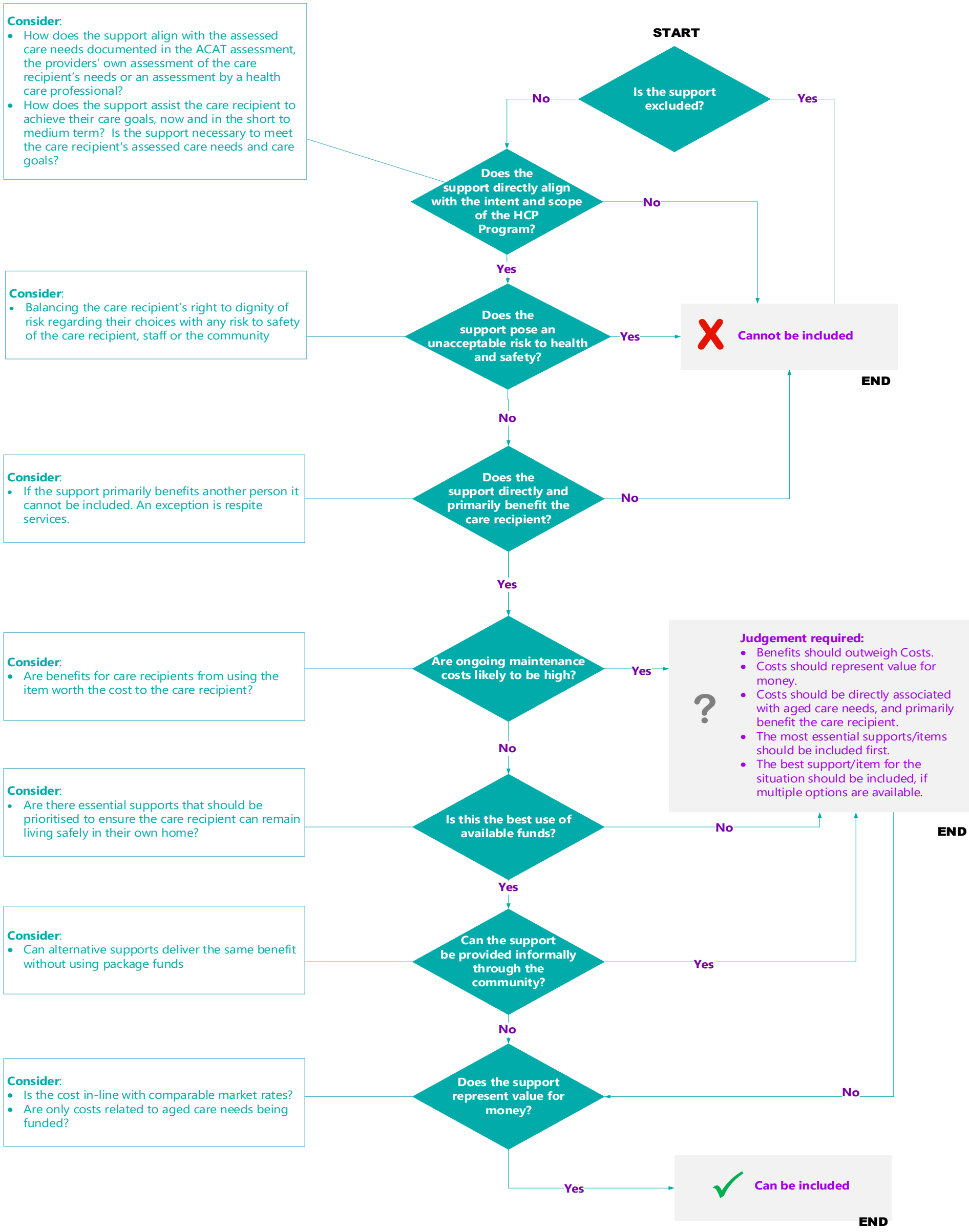
Yashwant's care manager meets with him to discuss his unspent funds. Yashwant notifies her that he would like to use $3,000 of his package towards a new pair of hearing aids.

Yashwant's case manager explains to him that unfortunately, his package cannot be used for care, services or purchases that are already available through other publicly funded programs such as the Hearing Services Program. His care manager asks permission to contact his audiologist to learn more. On contacting his audiologist, they reveal that they thought the Home Care Package Program could be used to purchase the more expensive hearing aids.

The care manager confirms it cannot. The audiologist thanks the care manager for the clarification.

Below is a decision tree and a template that providers can use to discuss the inclusions/exclusions framework when working with care recipients to develop their care plan and individualised budget.

9.6 Inclusions/Exclusions Framework – Decision Tool



9.7 Inclusion/Exclusion Framework – Template

Care recipient's Name:……..

Provider's Name:……

Care or Service:…….

Inclusion/exclusion framework (fill in with reference to Inclusions/Exclusions Framework Tool)

Questions	**Document discussions and considerations**
Is the support specifically excluded under the Aged Care Legislation?	
Does the support directly align with the intent and scope of the HCP Program?	
Does the support pose a risk to the health and safety of the care recipient?	
Does the support pose a risk to the health and safety of staff and the community?	
Is the support directly targeted at the care recipient, or does it significantly benefit others, instead of the care recipient?	
How does the support align with the assessed ageing related care needs as documented in the ACAT assessment, the providers' own assessment of the care recipient's needs or an assessment by a health care professional?	
How does the support assist the care recipient to achieve their ageing related care goals, now and in the short to medium term? Is the support necessary to meet the care recipient's ageing related assessed care needs and care goals?	
Has the evidence-base for the support which addresses a particular assessed ageing related care need been considered?	
Does the support require maintenance to ensure the safe use of the item that represents a significant portion of the budget? Is it difficult to provide the maintenance required?	
Is there an opportunity cost associated with the support? Will the care recipient miss out on a support identified in	

their assessment if package funding is used for a large purchase?	
Can the support be provided informally through the community?	
Does the support represent value for money to meet the care recipient's assessed ageing related care needs?	

Determination: The care or service type…….. is an Inclusion / Exclusion (circle one) to the care plan

9.8 Guidance on allied health

Introduction

This guidance is intended to assist home care providers and home care recipients to understand the allied health services which can and cannot be funded through a Home Care Package (HCP).

Information on allied health can be found on the Department of Health and Aged Care's website at: https://www.health.gov.au/health-topics/allied-health/

Allied Health
HCP funds can be used for allied health services but must only be used when the service is:

- required due to care recipient's age-related functional decline or to assess the need for aids and equipment
- delivered by an accredited provider, and
- not concurrently being funded by another government program.

Age-related functional decline
Age-related functional decline can be defined as a reduction in ability to perform activities of daily living (e.g., self-care activities) due to a decrease in physical and/or cognitive functioning associated with ageing.

Aids and equipment
Recommendations for aids and equipment, care and services may be funded under the HCP, provided they meet the other requirements of the inclusions and exclusions framework.
Goods, Equipment and Assistive Technology (GEAT) are available as part of a Home Care Package where there is an assessed need.

- Health professionals operating within their scope of practice may assess for GEAT. For further guidance on suitability of a health professional to assess for an item, consult Department of Veterans' Affairs Rehabilitation Appliances Program at this link or my searching "The RAP schedule" at www.dva.gov.au (for reference purposes only - noting not all equipment covered by DVA is available under HCP).

Accreditation and criminal history checks
Allied health providers must meet their respective accreditation and registration requirements and operate within the scope of practice of their regulated or self-regulated body. Depending on the respective accreditation and registration requirements, this may permit activities being undertaken by allied health assistants.

Example 1: Speech pathologists funded under the HCP Program must hold the Speech Pathology Australia Certified Practising Speech Pathologist credential.

Example 2: HCP funds can be used to pay for treatment from a registered podiatrist but not for a reflexologist which is not an accredited or registered profession.

Not all allied health professions are registered with Ahpra. Some are self-regulated by a national professional association. The Ahpra regulated professions must adhere to the Criminal History

Registration Standard, which requires the applicant to declare their criminal history on initial registration, and upon annual renewal disclose any changes to their criminal history. The self-regulated professions vary in whether they require professionals to declare criminal history on registration and/or renewal.

As there is not yet a consistent standard across the diverse allied health professions in regard to criminal history checks, a provider must seek this from prospective allied health employees to meet the requirements under the *Accountability Principles 2014*.

It is standard practice for allied health professionals to provide this on engagement with state and territory employers (such as in the form of a police check) and is then often maintained on a regular basis through credentialling requirements. Most allied health professionals are expected to maintain a working with vulnerable people check for any employment in a public setting, so this rule is not likely to be an impost to accessing allied health. Providers should consider seeking the following documentation from the allied health professional:

- Police check; **or**
- In some jurisdictions, a working with vulnerable people card may satisfy the requirements of the *Accountability Principles 2014*. However, providers should check with their relevant jurisdiction if this card is based on a police check no older than three years, and screens out persons who were convicted of murder, sexual assault; and conviction and imprisonment for any other form of assault; **or**
- NDIS worker screening clearance.

Other government programs

HCP funds cannot be used for allied health services when the service is:

- rebated by Medicare Benefits Schedule (MBS) or their private health insurance (even if only partially)
- treating a lifelong disability (except where trajectory is impacted by ageing e.g., post-polio syndrome)
- treating a short-term illness or chronic health condition where ageing is not a confounding factor to the severity of the condition

HCP funds cannot be used for allied health if the services are not related to age related functional decline, and/or the service is also being funded by another Government funding program such as the Medicare Chronic Disease Management program. Care recipients with a chronic (or terminal) medical condition, which is being managed by their GP, can access Chronic Disease Management through the MBS. Information on *Chronic Disease Management - Individual Allied Health Services* under Medicare can be found at this link or by searching "Managing chronic conditions" on health.gov.au, or at this link or this link or by searching for Ageing>Elder health and safety>Health care>managing chronic medical conditions on servicesaustralia.gov.au.

Care recipients should work with their provider to identify the best way to use their HCP funds alongside other funding streams.

> Example: A care recipient with Type II diabetes who is eligible for a Chronic Disease Management Plan through the MBS should make use of this plan first to access allied health and diabetes nursing services. When all access to allied health and nursing is exhausted under this plan and further support is required to address ageing related functional decline (if a confounding factor to the diabetes diagnosis), a care recipient may access these services through the HCP.

Psychology
Psychology services may be covered under Medicare's GP Mental Health Treatment Plans if the GP considers the care recipient has a diagnosable mental disorder and should be used in the first instance. Where these supports are exhausted and access to a psychologist is required for ageing related functional decline, this may be funded under the HCP. Psychiatry is a strict exclusion.

Acupuncture
Some GPs practice acupuncture and if available care recipients must go through their GP or other primary care provider to access this under the MBS.

Providers should only fund acupuncture where it can be demonstrated that the practitioner is an Ahpra registered Chinese Medicine Practitioner, and that the care recipient is not using private health insurance. Care recipients are still expected to seek advice from their GP before engaging in acupuncture as a suitable treatment.

Acupuncture may then be provided through a HCP where it meets the person's assessed care needs, it can be identified in their care plan and must fit within the available budget for their package level.

Gap Payments

Gap payments cannot be charged to the HCP budget, as many gap payments relate to services that are also funded or partly funded by the Australian Government, such as the MBS and the PBS.

While health insurers are not precluded from paying a benefit when the treatment is eligible for other benefits (e.g., HCP funds), many do not pay benefits for services funded by other programs. Private health insurers can pay benefits for various goods and services under general treatment. General treatment cover provides benefits for allied health service providers. There are various limits that may apply, for example a maximum amount or percentage limit per service, per year, or lifetime limits. Health insurers usually find it necessary to limit these benefits to keep the cost of policies affordable.

9.9 How can package funds be used to make large purchases (i.e., the cost exceeds monthly subsidy/fees payable), such as assistive aids, equipment and accessible home modifications, for care recipients?

Large purchases, defined as those items where the cost exceeds the monthly subsidy/fees payable such as assistive aids, equipment and accessible home modifications, must be:

- agreed within the care recipient's care plan;
- be within the available budget for the package level, with any charges or additional service fees mutually agreed with the care recipient through the Home Care Agreement before purchase:
- be related to the care recipient's ageing related care needs, which may require an assessment from a health professional operating within their scope of practice e.g., an occupational therapist, physiotherapist or registered nurse to ensure the aid/equipment/home modification is fit for purpose.
    - The cost of the assessment by the health professional may be covered by the existing charges for care management or direct service charge.
    - In considering suitability of what type of health professionals should make the assessment, providers are to make use of their clinical judgement or alternatively can

consult the following resources from other Australian Government programs for guidance on comparable health professional assessors for aids and equipment:

- Department of Veterans' Affairs Rehabilitation Appliances Program at www.dva.gov.au/get-support/providers/rehabilitation-appliances-program-rap/rap-schedule (for reference purposes only - noting not all equipment covered by DVA is available under HCP).
- Providers may also wish to review the product list for the geat2GO program for the Commonwealth Home Support Programme at www.indigosolutions.org.au/funding/commonwealth-home-support-programme/geat2go/assessors-and-prescribers which characterises products under General, Under Advice, Physiotherapist and Prescribed.

Providers can access unspent funds (including the home care account balance) to pay for large purchases.

Where a care recipient has transferred providers, their home care account (including any returned provider held Commonwealth unspent funds) will be under quarantine for a 70-day period – the new provider must wait until day 71 (release of unspent funds) to make the purchase.

Providers must not split the cost over multiple claim months unless the item is being leased.

Where a care recipient has paid upfront for an allowable item, the provider may only reimburse them within the relevant claim month. If a care recipient moves to a new provider and they obtained an item from their previous provider, a care recipient cannot seek reimbursement from their new provider.

Example 1. Mauve is with a provider that offers self-management, and she has an unspent funds balance of $10,000 and receives a monthly subsidy of $4,086.32. She buys a power wheelchair worth $3,000 in July. The purchase has been agreed in her care plan and she provides the provider her tax invoice and receipt. Her provider lodges the July claim for the service in the first week of August, including the price Mauve paid for the power wheelchair (which is GST free) + the price of her other care and services for the month of July – the total of the aggregated invoice is $7,000. The claim is approved and paid by Services Australia. The provider reimburses Mauve for the purchase.

Example 2. Petro has an unspent funds balance of $10 and receives a monthly subsidy of $704.20 and pays fees of $282.24 monthly. He has been assessed as requiring an accessible bathroom modification which will cost around $20,000. His provider advises him that this purchase cannot be made until he has accrued sufficient unspent funds and must be weighed up against the risk to his wellbeing of him not receiving other care and services such as wound management and transport to social activities. His provider discusses with him more affordable options, such as an over the toilet frame, to meet his aged care needs in the interim.

Where the cost exceeds available funds for the care recipient, like in Example 2, providers and their care recipients can:

- charge the care recipient additional service fees (agreement and consent required) to make up the difference – however, it is important to note that once additional services fees are charged, there is no capacity to use HCP funds to recompense the care recipient;
- postpone the purchase until there are sufficient funds to cover the costs;
- enter leasing arrangements (including to lease to buy) where appropriate; and
- if not on Level 4, arrange a Support Plan Review through an ACAT if the package is over-allocated through the provision of monthly care and services; and the need for the large purchase is crucial.

There are certain circumstances where a HCP care recipient can access CHSP services over and above the services provided through the HCP budget. See the Commonwealth Home Support Programme Manual for more information. This may be subject to the available capacity of CHSP providers and their available funding, given CHSP clients will be the priority. Care recipient contributions, additional to income tested care fee and basic daily fee, may apply.

9.10 Considerations for home modifications

Home modifications must only be provided to improve safety and accessibility and promote independence (e.g., widening doorways for wheelchair access, removing shower hobs).

Works must be recommended by a health professional operating within their scope of practice and tailored to the ageing-related needs of the care recipient. Any works completed must align with the recommendations of the health professional. All work must be conducted by a qualified tradesperson with appropriate licensing and insurances as per state/territory government laws. Building work must be in line with the Building Code of Australia.

Providers are responsible for the resolution of any disputes, including escalating the matter to the relevant consumer protection agency if necessary.

If a care recipient departs HCP unexpectedly, any remaining balance for the works, provided works were agreed to before date of departure, can be reconciled from the home care account within the 70-day period from date of cessation only.

9.11 What happens if the care recipient is not the homeowner or changes are required to common property covered by strata?

HCP funds can be used for modifications relating to the care recipient's ageing related needs when they are not the owner of the property, or modifications are needed to be made to common property in a strata where safe egress and access is required for the care recipient.

To avoid disputes, it is prudent for the provider to ascertain the ownership/management of any premises prior to agreeing to use HCP to fund any works to modify the property. The provider should also seek assurances that the care recipient's residence at the premises is secure and stable. However, this needs to be balanced against their current care needs and goals. For example, if a grab rail will prevent a fall, even if the care recipient has only been able to secure residence for a short period of time or is nearing the end of a lease agreement, and if the package budget allows it, this may still be a good investment of HCP funds. Conversely, it may not be prudent to modify a bathroom or a kitchen to make it more accessible if the care recipient does not have security of residence.

Providers should assist the care recipient, if the not the owner, or if the care recipient's residence is under strata, to obtain permissions from owners or body corporates before the commencement of any works.

However, any changes to common property in a strata complex to assist a care recipient's egress and access needs must be considered carefully. It is a poor outcome if the care recipient pays for the whole modification when others will benefit; and is risked being devoid of funds for personal care and/or other services. Negotiation should take place to understand what portion the strata will pay, and whether there is option for the strata to pay for the whole project if it benefits multiple residents also requiring safe egress and access from the building. It is also advisable to seek advice from the state/territory government body responsible for strata to understand the body corporate's

responsibilities under the *Disability Discrimination Act 1992*, noting the operation of this Act may vary across jurisdictions.

Providers and care recipients should also consider that the nature of how HCP funds are paid means that if a care recipient departs the Program there is no capacity to access HCP funds to return the property to its state before the modification. Thus, it must be made clear to any landlord/strata that all modifications will be considered permanent unless private arrangements with private means are made between the care recipient and owner/management.

10 Delivering care under a package

Once a provider has started providing services to a care recipient (in line with their care plan and package budget), they will need to manage their care. This section outlines the ordinary administrative things providers need to do to make sure care recipients are getting the best outcomes possible from their package.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 47, 48, 56-2, 56-4 and 96 of the *Aged Care Act 1997*
- *User Rights Principles 2014*.

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

10.1 Commencing services

Once a person is assigned a package and has entered into their Home Care Agreement, their care and services can begin. The date care is first delivered should be specified in their Agreement. Their package starts on the day the Home Care Agreement is entered into, not from the day that care is first delivered. Therefore, the commencement date on the ACER form may be the same or earlier than the date that care is first delivered. The commencement date on the ACER has to be within the package take up timeframe.

Check the care recipient's My Aged Care client record for active services before submitting the ACER. Do not lodge the ACER if they are currently receiving home care, residential aged care or Short-Term Restorative Care, until you have liaised with the current provider to confirm the care recipient's agreed cessation date from that provider. Document all conversations.

Do not lodge the ACER until a Home Care Agreement is in place.

Care and services should then be delivered according to the care plan that the provider and the care recipient have developed in partnership.

On 1 September 2021, as part of the Improved Payment Arrangements changes, Services Australia created a home care account for each care recipient who was in care, with a balance of $0. All new care recipients commencing after 1 September 2021 will also have a home care account created for them.

From 1 September 2021, when a provider lodges their monthly claim the Government subsidy less any income tested care fees payable will be used to cover the price. If the Government subsidy is:

- More than the price, the difference will accrue in the home care account for future use.
- Less than the price, Services Australia will draw down on the home care account balance to cover the difference.

Care recipients will retain their full Government subsidy under these changes. Appendix E provides further detail on Improved Payment Arrangements.

10.1.1 Client summary tab

A 'client summary tab' is available in the My Aged Care client record. This is also known as the 'Client journey dashboard'. This tab provides key information about the care recipient in one place, which may include:

- assessment information;
- approvals;
- service recommendations;
- service delivery information;
- goals and reablement; and
- any periods of linking support.

Information will only be displayed where it is applicable to that individual person.

More information is available at this link or by searching "My Aged Care - Client summary tab" at www.health.gov.au.

10.2 How do I claim the Government subsidy for services I provide?

Providers can only claim the home care subsidy for people who have been assigned a package from the national priority system and have a Home Care Agreement in place. This means that providers can only claim the Government subsidy from the date they entered into the Home Care Agreement, not the date they start negotiating with the care recipient or completing pre-service delivery care planning.

Services Australia will know the date a provider commences delivering services to a care recipient through the submission of the ACER. This must be completed within 28 days of when they entered home care.

The Services Australia payment system checks provider claims against the My Aged Care listing of care for people with an assigned package. Services Australia cannot process a claim for a care recipient if they do not have a package that is assigned and active.

The home care subsidy can only be paid once the Home Care Agreement has been entered into. The subsidy cannot be claimed for discussions and meetings with the care recipient (or carers and family members), or any services provided to them before the Home Care Agreement is entered into. Claiming for subsidy prior to entering into a Home Care Agreement with a care recipient will result in the provider owing a debt to the Commonwealth for such time that care was provided without a Home Care Agreement being in place.

10.2.1 Improved Payment Arrangements

The Australian Government changed the way providers were paid and unspent funds were managed over two phases:

Phase 1 (implemented on 1 February 2021)

- Providers funded in arrears rather than in advance.
- Payments for each month claimed in the next month, for the full subsidy, based on the number of care recipients in care.

Phase 2 (implemented on 1 September 2021)

- Providers paid in arrears, based on actual care and services delivered.

- The Government holds the Commonwealth portion of unspent funds, in each care recipient's home care account, until needed by the care recipient.

Legislation to support Phase 1 was passed by Parliament in December 2020, and for Phase 2 in February 2021. This measure reduces the financial and prudential risks of providers holding substantial amounts of unspent funds, as these will be held by the Government instead.

Where a care recipient has transferred providers, their home care account (including any returned provider held Commonwealth unspent funds) will be under quarantine for a 70-day period – the new provider must wait until day 71 (release of unpent funds) to access these funds. Monthly subsidy remains payable throughout this period.

More information about the Improved Payment Arrangements can be found in Appendix E.

10.2.2 Claiming payments through Services Australia

For claims for months post September 2021 onwards

Providers started submitting claims through Services Australia under the new model from the September 2021 claim period (from 1 October 2021). Providers claim through the Services Australia Aged Care Portal, Aged Care Web Services or through paper claims.

Providers only need to claim a total dollar amount for each care recipient in their monthly claim (this is referred to as the price or invoice amount). The price reported to Services Australia should incorporate the services delivered to care recipients minus any Basic Daily Fee or other care fees charged (not including the income tested care fee).

Package management and care management are considered services and can be included as part of the price. GST is not included in the claim.

Providers do not need to include an itemised list of fees, care and services delivered to the care recipient during the relevant month to Services Australia. However, this information must be provided to the care recipient as part of their detailed monthly statement. Services Australia may request this information if there is a dispute.

Providers should be accurate in their claiming and claim the costs associated with the services delivered in the month even if they have exceeded the subsidy. Providers cannot split the cost over multiple claim months. Instead, providers will be paid the lesser of: *The shortfall amount or the maximum contribution amount*. Any outstanding amounts for the claim period must be covered by the provider or by unspent funds held by the provider for the care recipient – or additional service fees payable by the care recipient.

Services Australia will automatically deduct the income tested care fee payable from the payment made to providers, for care recipients who are assessed as needing to pay it.

Supplements will automatically be applied by Services Australia if the home care recipient is eligible. It will be included as part of the calculation completed by Services Australia of the subsidy available to the care recipient.

If the Government subsidy is more than the price, the difference will accrue in the home care account for future use. A care recipient's home care account balance will be available to their current service provider through the Aged Care Provider Portal and the payment statement Services Australia issues to providers.

Further information on the new model is available at Appendix E, with Attachment A to explain the claims process.

10.3 How should I manage my care recipients' package services?

Care management is a service providers must provide to all care recipients.

A care recipient should be allocated a care manager by a provider. The care manager is responsible for enabling the steps discussed at Sections 6, 7 and 8 (initial assessment, care planning and establishing the Home Care Agreement), as well as:

- regularly assessing the person's needs, goals and preferences
- reviewing the Home Care Agreement and care plan;
- ensuring care and services are aligned with other supports;
- partnering with the care recipient and the care recipient's representatives about their care
- ensuring that care and services are culturally safe
- identifying and addressing risks to the care recipient's safety, health and wellbeing;
- referral to an ACAT (e.g. if their needs change);
- case conferencing with care recipient's treating health professionals and/or GP, if appropriate, and where care recipient has consented to the interaction; and
- supporting timely and appropriate referral to individuals, other organisations and/or providers of other care and services.

A provider's care management service must comply with the Aged Care Quality Standards, including:

- Standard 1 – Support care recipients to make informed choices.
- Standard 2 – Initial and ongoing assessment and planning with care recipients.
- Standard 3 – Deliver safe and effective personal and clinical care.
- Standard 4 – Provide safe and effective services and supports to support daily living and allow independence.
- Standard 8 – Engage and support care recipients in the development, delivery and evaluation of care and services.

For more information on care management visit this link or go to www.health.gov.au and search for "Care management and care plans for Home Care Packages".

10.4 What happens if a care recipient wants to self-manage their package?

Self-management means that a care recipient is involved in designing and directing their care, taking a lead role in making decisions to manage their package. This includes choosing preferred workers, and scheduling and co-ordinating their care and services. Care recipients can ask to do this because the HCP Program operates under a CDC model. Providers who offer this option should ensure that what is involved is fully understood.

It is important that both the provider and the care recipient understand that the approved provider is ultimately responsible for compliance with the legislation (see Section 2), Aged Care Quality Standards (see Section 3), and scope and intent of the HCP Program (see Section 2). Providers will still need to have oversight over what services self-managing care recipients receive services from and how they spend their package budget. Providers will also continue to undertake some required activities such as reviewing the care plan.

A provider must still provide care management to ensure delivery of safe and quality care and services based on their needs, goals and preferences. This may incur some costs and staff effort, so

providers can charge a care management price proportionate to the work incurred to oversee the care recipient's self-management.

10.5 Can a care recipient employ family and friends to deliver their care?

Payment to families and friends for care services are typically a program exclusion. Family and friends may instead access the Carer's Payment - https://www.servicesaustralia.gov.au/carer-payment

Using subsidy to pay for family carers raises serious probity issues under the *Public Governance, Performance and Accountability Act 2013* under which the aged care special appropriation sits – generally this is an exclusion unless it is a thin market (i.e. rural and remote Australia; Aboriginal and Torres Strait Islander and CALD populations) and the family member is especially qualified, doesn't live with the care recipient and the provider and family member (in their capacity as a personal care worker or health professional) have agreed a robust probity plan with the provider. It is a strict exclusion if the family member is already receiving a Carer's payment.

10.6 How often does the care plan need to be reviewed?

The care manager must review a care recipient's care plan:

- regularly and at least once every 12 months, to make sure the care and services received through the package still meet the care recipient's needs;
- at any time when requested by the care recipient's or their carer;
- if the care recipient has been receiving services through a lower level package than their approved level, and they get upgraded to a higher package level; and/or
- if there has been a change in the care recipient's package budget.

Reviews may also occur more frequently than every 12 months. Reasons for an additional or earlier review may include:

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

When thinking about how often to review the care plan, providers should be aware of compliance with Standards 2 and 3 of the Aged Care Quality Standards. For more information on the standards see Section 3 of this manual.

The review should have a reablement and wellness focus that does not assume a decline in the care recipient's health and functioning. It should involve:

- a review of current ageing related care needs, care goals and preferences;
- an evaluation of the quality and success of the services and supports that have been provided;
- a renegotiation and update of the care plan and individualised package budget; and
- support for the care recipient to continue to make informed choices about their care and services, and the life they choose to live, including whether they wish to change their level of involvement and decision-making in the management of the package.

Wellness and reablement are discussed further at Section 7.3.

The review should be done in person, wherever possible. Phone and video technology or other remote monitoring digital technology may also be used, where clinically appropriate.

Review of the care recipient's care needs may lead to significant changes in the nature of the support provided to them. The provider should support the care recipient (and anyone else they choose to involve, such as family or advocates), as much as possible, in any changes resulting from the review of the care plan.

As part of the review process, providers in consultation with care recipients, may need to undertake a further reassessment of care and service needs to determine if care and service needs have increased and require further supports or if needs have changed and require adjustments to the way care and services are delivered.

Another ACAT assessment may be required if the care recipient's care needs have increased significantly so that they potentially require more support in order to remain in their home, or entry to residential care or residential respite. Some care recipients may already have suitable approvals. To determine if an approval is already in place, providers can review their My Aged Care client record. If they do need a new ACAT assessment, the provider can assist to arrange this, with their permission. However, if unspent funds remain available in the package or if funds have been diminished without value for money consideration for purchases of aids and equipment and/or home modifications, ACAT reassessment is inadvisable.

As discussed at Section 7, providers need to undertake initial and ongoing assessment and planning for care and services in partnership with each person they enter into a Home Care Agreement with. Providers cannot change a care plan without mutual consent from the care recipient.

Review of the care plan is an included service, paid for out of the care management cost (if any), as agreed in the Home Care Agreement. Providers cannot charge additional costs to the care recipient's package budget for each time they request a review of their care plan or Home Care Agreement.

While the care plan should be reviewed regularly for effectiveness, if someone is asking for recurrent reviews of their care plan where their circumstances have not changed, providers should discuss why they are requesting reviews of the care plan, and what can be done to help. Providers should document records of these conversations taking place.

Note: where there is a change to the care recipient's care plan, the package budget will also need to be updated.

10.7 What is a monthly statement and what does it need to have in it?

Providers are required by the *User Rights Principles 2014* to issue care recipients with monthly statements that show the package budget funds available to them and what has been spent from their budget. Providers may also include any agreed additional charges. A monthly statement should clearly show services delivered so that the care recipient and/or their carers can easily understand how the service provider is charging for the package.

The following amounts must be itemised and included in the monthly statement:

- The amount of home care subsidy for the care recipient for the month
- The amount of home care fees (if any) paid or payable by the care recipient for the month, and any unpaid home care fees relating to previous months.
- An itemised list of:

    - The care and services provided to the care recipient during the month (including travel, subcontracting arrangements and package management) for which the care recipient was charged;
    - The price that the provider charged the care recipient for the month;
    - The total of those prices;
- The care recipient's unspent home care amount (provider-held unspent funds) in respect of: the previous month; and the current month;
- If, during the month, the provider received the care recipient portion of unspent funds from another provider – the amount that was received.

From the September 2022 payment period, you must split out the care recipient's unspent funds into the:

- Commonwealth portion of provider-held funds
- care recipient portion of provider-held funds
- home care account balance

The monthly statement should align with the provider claim for care and services delivered during the month (the payment period). That is, both the claim and the statement should include care and services even if the payment for these services has not been finalised, for example as it was delivered by a sub-contractor and the invoice has not been received. Any adjustments can be reflected in subsequent months (in both the claim and statement).

Any unspent funds amount must carry over from month to month, and from year to year, for as long as that person continues to receive a package.

Providers must continue providing detailed monthly statements for all care recipients. Providers must provide the total amount of all unspent funds they hold, including the funds being held in the home care account (if any).

Statements do not need to break down the unspent funds balance into the provider-held care recipient portion, Commonwealth portions, or the home care account balance until providers are ready to include this information. The Department will review this early in 2022, to determine the date at which this reporting requirement becomes mandatory. Advance notice will be provided to the sector.

A non-mandatory better practice monthly statement template and guide has been developed and providers should strive to align with this.

Services Australia will expand the payment statement issued to providers to report the balance of Government subsidy held within each care recipient's home care account and any provider-held amounts returned.

10.8 What are unspent funds and how can they be used for care and services?

Unspent funds are the total amount of home care subsidy, supplements (if applicable) and home care fees that have not been spent or committed on a person's care. Since 31 December 2021 – under the Improved Payment Arrangements Phase 2 changes (see Appendix F and Appendix G) – providers must report the Commonwealth portion of unspent funds they hold for each care recipient to Services Australia. Unspent funds may be made up of the following:

- provider-held Commonwealth portion of unspent funds
- provider-held care recipient portion of unspent funds
- Services Australia held home care account balance

10.9 How can I work with my care recipients to manage unspent amounts?

Providers should work with care recipients to ensure they are able to benefit from the full use of their package and budget. However, there are several reasons why unspent funds may accumulate in a package budget – key examples are listed below:

Reason	Information
Care recipient choice	The package budget for a care recipient's assessed level of care should be used to meet their current care needs. However, they may actively choose to set aside a small proportion of their package budget for future events, such as leave of a carer.
Temporary leave	Care recipients can temporarily suspend their package if they take leave. Depending on the reason, the full rate of home care subsidy is payable for up to 28 cumulative or consecutive days (depending on the leave type) in a financial year and they may continue to be asked to pay their home care fees. After this, the subsidy is payable at a rate of 25 per cent. Further information on leave arrangements for subsidy, supplements and home care fees is at Section 11.

If a care recipient transfers to a new service provider, the previous provider will need to transfer the care recipient portion of unspent funds to the new service.

If a care recipient exits the HCP Program, the provider must transfer the care recipient portion of unspent funds back to the care recipient or the care recipient's estate.

If a care recipient exits the HCP Program the Commonwealth Government portion of unspent funds must be returned to the Government.

Providers have a legal obligation to transfer any unspent funds if someone changes provider, or return unspent funds if they leave home care.

This is discussed further at Sections 13 and 14. The Department uses information about the returned Commonwealth Government portion of unspent funds as an input to determine the number of packages to be released to people on the national priority system.

Further information on the treatment of unspent funds under Improved Payment Arrangements is available at Appendix F and Appendix G.

The table below outlines two strategies providers may use to help manage any unspent funds they may hold for care recipients:

Strategy	Information
Revise the care plan and package budget	Providers should work together with their care recipients to develop a plan that meets their assessed care needs. This includes talking about the funds available and how to spend those funds, through the package budget. This may include an agreement, based on the care recipient's choice, to set aside a small part of their package budget for future care needs. It is important to be able to save for future events, such as a carer going on holiday or needing respite. Providers should also ensure record keeping regarding care recipients' days in care are accurate and up to date (see section 11 for further information on leave).

Strategy	Information
Actively manage packages	Providers also play an important role in managing their care recipient's package. Providers will receive a notification if their care recipient's package is upgraded. The provider should talk to their care recipient about their assessed care needs and make updates to the care plan, Home Care Agreement and package budget as soon as possible, so that more essential services can be arranged. Doing this quickly will prevent unspent funds accumulating from the date of the automatic package upgrade.

10.10 What happens when a care recipient's care needs have increased?

A care recipient's care needs may increase significantly so that they potentially require home care at a higher level or entry to residential care. In these circumstances, they may need another assessment by an ACAT. With the care recipient's prior consent providers can assist in arranging the ACAT assessment. Providers can do this by submitting a Support Plan Review (SPR) request via the My Aged Care provider portal. More information is available at this link or by searching "request a Support Plan Review" at www.health.gov.au.

Care recipients can request a SPR themselves by calling My Aged Care.

If it is determined that another assessment is necessary, the provider should attach supporting documentation about the care recipient's care arrangements. For example, a package budget or care plan. These attachments are required to be attached to the SPR requests for people who are receiving a package. The My Aged Care contact centre will also request this information when submitting SPR requests on behalf of service providers.

If someone is already in receipt of a Level Four package, they may need to consider other options including:

- reviewing their care plan to identify alternatives and priorities (for example, reducing higher cost services, such as support on weekends, and replacing with informal supports);
- purchasing additional care and services from their own funds if an option; or
- the benefits of residential care, either as short-term respite to complement their package or as a long-term option.

10.10.1 Respite

The primary purpose of respite is to support and maintain the care relationship between carers and care recipients by providing good quality respite care for the care recipient so their carer may take a break from their usual care arrangements. Respite can be provided in the home, in a day centre, in a Cottage-style accommodation (overnight community respite), or residential setting.

Respite in the home may take the form of additional services where the carer would otherwise provide those services. This could include providing a break during the day for the carer or overnight respite to allow the carer to rest.

Residential respite provides temporary care in an aged care home. Residential respite may be used on a planned or emergency basis. An ACAT approval is required to access this care.

A package can be suspended when a home care package recipient is receiving residential respite. For information on taking 'leave', see **Section 11**. In this case, the services delivered under the

package would be put on hold. Providers are unable to collect the basic daily fee from the care recipient, however, the income-tested care fee may remain payable. If this occurs, it is important for the home care provider to engage with the residential respite provider to ensure continuity of care and allow the care recipient to be supported in their continuing care goals. This may be facilitated by sharing their home care plan with the residential respite provider. This will allow the respite provider to consider any wellness or reablement approaches that remain relevant within the residential setting.

It is also important that the residential respite provider enters their payment claim correctly in the Services Australia payments system. If they enter a claim for permanent residential care this will result in the withdrawal of an active package.

Alternatively, a care recipient may choose to receive residential respite and their home care package services at the same time. This may be an appropriate option where some of their assessed care needs can continue to be met by the home care provider outside the aged care home. For example, maintaining a safe environment for their return.

In this situation, it is vital that the home care provider engages with the residential respite provider to share the care plan and ensure there is no duplication of services. Again, it is important to consider wellness, reablement and continuing care goals. A care recipient must also be made aware of the impact this will have on their fee arrangements (see **Section 11**).

Private Respite

If a HCP care recipient does not have a current ACAT approval for residential respite care, or decides not to use government funded residential respite care, HCP funds can be used to pay for a non-government funded bed in a private respite care facility. Providers would also need to consider 'cost effectiveness' and 'value for money' in purchasing private respite, turning to the most cost-effective and economical respite that meets the care recipient's needs.

Care recipients may wish to consider private respite care as an alternative way to gain access to respite care. If the HCP is used to contribute towards the cost of private respite care, it would be appropriate for a care recipient to discuss this with their approved provider as using the HCP funds for respite in a private facility will impact on the package budget and the capacity to deliver other care and services.

The duration must be monitored. Payment for long-term residential care is an exclusion.

Cottage Respite

Cottage respite provides overnight care delivered in a cottage-style facility or community setting other than in the home of the carer or care recipient. Service providers are required to structure services in such a way that allows them to be as responsive as possible to requests from carers for short-term or non-ongoing respite.

If a carer would like to arrange for respite services, whether in the home or residential facilities, they may wish to contact the Carer Gateway on 1800 422 737. The Carer Gateway can book short-term and emergency respite in residential facilities and help carers access a range of other respite options, including in-home and centre-based respite.

The Carer Gateway provides practical information and support, accessed via www.carergateway.gov.au.

10.11 What if I can't meet the care recipient's needs?

Once providers enter into a Home Care Agreement, they are required to continue to deliver the agreed care and services for as long as the care recipient needs those services. As discussed at Section 3.4, this is called security of tenure.

There are exceptions to security of tenure, such as when the care recipient can no longer be cared for safely in their home. These exceptions are extracted in full at Section 3.4.

If providers do not think they can meet the care recipient's needs, but none of the exceptions to security of tenure apply, they should consider sub-contracted arrangements to help fulfil obligations under security of tenure. Sub-contracting is discussed at Section 7.

If the reason the provider cannot meet the care recipient's needs is due to the provider being unable to make contact with the care recipient and/or their authorised representative for a period of multiple months, the provider must place the care recipient on social leave until such time that contact is made. Should communication continue to be unanswered the provider may send notice to terminate the Home Care Agreement to the care recipient advising they have a reasonable period of time to respond to the request (e.g., four weeks) before date of cessation; and that upon termination of the Home Care Agreement the care recipient has 56 days to enter into a new Home Care Package or will otherwise lose their unspent funds. However, the provider should also consider the vulnerability of the care recipient. For example, if the care recipient is homeless, it may be a better outcome to leave them on perpetual social leave until such time that the care recipient is able to re-engage with the aged care system.

10.12 What do I do if I think someone is being subjected to elder abuse?

The World Health Organization defines elder abuse as 'a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person'. It can take various forms, such as physical, psychological or emotional, sexual and financial abuse. It can also be the result of intentional or unintentional neglect.

If providers would like to talk to someone about potential or actual elder abuse they can call the national **1800 ELDERHelp** (**1800 353 374**) line. This service provides information on how to get help, support and referrals to assist with potential or actual elder abuse.

Providers may have obligations in relation to elder abuse under State or Territory laws in the jurisdictions in which they operate. Each State and Territory provides information about abuse and abuse prevention, as well as useful contacts and options for getting help:

State/Territory	Organisation or resource	Contact
Australian Capital Territory	Older Persons Abuse Prevention Referral and Information Line (APRIL)	**02 6205 3535**
New South Wales	NSW Elder Abuse Helpline	**1800 628 221**
Northern Territory	Elder Abuse Information Line	**1800 037 072**
Queensland	Elder Abuse Prevention Unit	**1300 651 192**

State/Territory	Organisation or resource	Contact
South Australia	Aged Rights Advocacy Service Elder Abuse Phoneline	**08 8232 5377** **1800 700 600**
Tasmania	Tasmanian Elder Abuse Helpline	**1800 441 169**
Victoria	Seniors Rights Victoria	**1300 368 821**
Western Australia	Elder Abuse Helpline	**1300 724 679**

Providers can find a case study that provides an example of financial elder abuse at this link or by searching "case studies" at www.agedcarequality.gov.au.

10.13 What do I need to do to manage complaints?

The Aged Care Quality Standards require providers to have a complaints management function in place. The purpose of this function should be:

- **For the care recipient to:** feel safe, encouraged and supported to give feedback and make complaints; feel engaged in processes to address feedback and complaints; and feel comfortable that appropriate action has been taken.
- **For the provider to:** regularly seek input and feedback from care recipients, carers, the workforce and others; and use the input and feedback to inform continuous improvements for individual and the whole organisation.

The complaints function must be outlined in every Home Care Agreement. If it is appropriate, providers may want to refer a care recipient to the Commission material on making a complaint at this link or by searching "making a complaint" at www.agedcarequality.gov.au/.

If a complaint arises, the provider must:

a. use their complaints resolution mechanism to address the complaint; and

b. advise the complainant of any other mechanisms that are available to address complaints, such as the Commission.

It is important that providers view complaints as an opportunity to further develop their customer service by gaining insights into the needs and wants of care recipients. If staff are open to complaints and educated on how to manage them, complaints can be an opportunity to address minor issues before they become significant, and to build positive relationships with care recipients, their families, friends and representatives.

The Commission 'Better Practice Guide to Complaint Handling in Aged Care Services' provides information on how to design a complaints function. It is at this link, or by searching "Better Practice Guide to Complaint Handling in Aged Care Services" at www.agedcarequality.gov.au/.

The Commission also has case studies that outline some strategies providers might use to resolve complaints. These can be found at this link or by searching "Case studies" at www.agedcarequality.gov.au/.

10.14 Contingency funds

Providers are required to discuss future planning, including any large purchases, with their care recipients and take these into account when planning package budgets. This must then be

documented in a care recipient's Home Care Agreement and their care plan. Providers must ensure care recipients understand and agree to their care plan before services are put in place.

Unspent funds can be used to pay for a care recipient's future care and services, such as in the event of a change in care needs. In some cases, care recipients and providers may agree to not fully utilise the package budget on care and services in order to 'save' unspent funds for future use.

Charging and claiming for "contingency" is not consistent with the policy intent of the HCP Program.

Contingency fees cannot be charged and accrued for future needs. Under Improved Payment Arrangements, from 1 September 2021, any additional fees should only be used for current identified and delivered care and service needs, noting:

- Payment by Services Australia is only paid in arrears for services already delivered and providers should no longer be accruing unspent funds.
- The Department does not support unnecessary fees which may have adverse impacts on the financial wellbeing of care recipients and do not serve to benefit the care recipient. In line with *Aged Care (Transition Provisions) Act 1997*, Part 4.2 which sets out the responsibilities relating to home care fees.
- Any additional fees a care recipient contributes are drawn down first by deduction from the price reported to Services Australia as part of a monthly claim.
- Where the claim is less than the subsidy, any unspent funds accruing would be the Commonwealth portion in the home care account and these funds would therefore not be available for reimbursement to the care recipient upon departure.
- In line with the *Aged Care Act 1997*, Part 3A.1, 52D-1(d): if the care recipient dies or provision of home care ceases—any fees paid in advance in respect of a period occurring after the care recipient's death, or the cessation of home care, must be refunded in accordance with the Fees and Payments Principles.

✓ Key points to remember

- Providers are required to review each care recipient's care plan regularly, at least once per year, and if their care needs change or they request it.
- Changes to a care recipient's care plan will result in changes to their package budget.
- Providers are required to give care recipient's monthly statements. This is a financial document and shows them what makes up their package budget and how it is being spent.
- Approved providers and all of their employees need to be aware of elder abuse, including obligations in regards to reporting and response to elder abuse, which vary by State or Territory.
- Providers need to have a complaints management function in place, and they must use it to manage complaints they receive.
- From 1 September 2021, providers receive funding based on the actual services delivered to care recipients in the previous month. This aligns home care with other Government-funded programs like the National Disability Insurance Scheme, as well as modern business practices. These changes will not affect care recipients' subsidy entitlements.

11 Leave

This section outlines what providers need to do if someone wants to take leave from receiving services under their package (also known as suspension) and how that affects their budget.

This section provides information relevant to care recipients who entered the HCP Program after 1 July 2014, or who have opted into the post-1 July 2014 arrangements. For information on the pre-1 July 2014 arrangements, see **Appendix A**.

✓ **Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section**
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

The *Fees and Payments Principles 2014 (No.2)* and the *Subsidies Principles 2014* outline how leave operates within the HCP Program. As providers of services under the program, providers are expected to comply with those laws.

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

11.1 When can a care recipient take leave?

Care recipients are allowed to temporarily suspend their package for any reason. Leave may be taken:

- for a hospital stay;
- for transition care following a hospital stay;
- to receive residential respite care; and/or
- other reasons (such as social leave).

A care recipient's security of tenure is not affected by the choice to take leave. They must, however, notify their provider that they are choosing to take leave from their package and specify the date that leave commences, or they will be liable for services delivered. This notification is not required to be in writing, but providers need to record the leave dates, and how and who informed them of the leave.

Providers must include information in each Home Care Agreement, explaining how the care recipient can notify them if they are planning to take leave. If they choose to take leave, the provider should work with them to update their care plan accordingly. See What if I can't meet the care recipient's needs? for circumstance (non-contactable for multiple months) where a provider may place a care recipient on social leave without their consent.

11.2 What is the impact of leave on the home care subsidy and supplements?

The amount of home care subsidy paid to the provider is dependent on the type of leave the care recipient takes from their package, as set out in the table on the next page:

Type of leave	Impact on payment of subsidy or eligible supplements to provider
• **Hospital** • **Transition Care**	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 consecutive days in a financial year, for each episode of hospitalisation or transition care at each particular package level. • After 28 consecutive days, the subsidy is payable at 25% of the basic subsidy rate. • After 28 consecutive days, primary supplements* are not payable.
• **Residential respite care** • **Social leave****	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 cumulative days in a financial year at each particular package level. • After 28 cumulative days, the subsidy is payable at 25% of the basic subsidy rate. • After 28 cumulative days, primary supplements* are not payable.

* Primary supplements are oxygen, enteral feeding, dementia and cognition, and veterans. Other eligible supplements (such as the viability and hardship supplements) continue to be paid during periods of leave. Supplements are discussed at **Section 8.2.2**.

** Package suspension for any other reason.

11.3 What is the impact of leave on home care fees?

A care recipient may be required to pay ongoing home care fees to the provider while they are on leave from their package. The amount and type of fee that can be charged while a care recipient is on leave from their package is set out below:

Leave type	Basic daily fee	Income-tested care fee
Hospital	Yes	Yes - payable at the full rate for 28 **consecutive** days, after which the care recipient can be asked to pay the lesser of their income-tested care fee or 25% of the basic subsidy rate for their package level.
Transition care	No	Yes - payable (at the full rate for 28 **consecutive** days, after which the care recipient can be asked to pay the lesser of their income-tested care fee or 25% of the basic subsidy rate for their package level.
Residential respite	No	Yes - payable at the full rate for 28 **cumulative** days, after which the care recipient can be asked to pay the lesser of their income-tested care fee or 25% of the basic subsidy rate for their package level.
Social leave	Yes	Yes - payable at the full rate for 28 **cumulative** days, after which the care recipient can be asked to pay the lesser of their income-tested care fee or 25% of the basic subsidy rate for their package level.

11.4 What is the impact of leave on monthly statements?

Any subsidy, relevant supplements or home care fees paid or payable to the provider while the care recipient is on leave must be included in their monthly statement.

11.5 How do leave balances work?

A care recipient's leave balance resets on 1 July each year or if their package level changes at any time. Leave balances are specific to each person receiving a home care package and will transfer with them, for example, if they change providers.

Worked examples:

A care recipient has been in hospital for more than 28 consecutive days, and because they advised their provider to suspend their package, the basic subsidy has stepped down to 25% after the 28th day. The care recipient then moves into transition care for a period. How is the rate of subsidy calculated and how should the home care fees be calculated?

Hospital leave and transition care leave are two different types of leave. Each time a care recipient accesses either hospital leave or transition care leave, their provider receives the full subsidy amount for up to 28 consecutive days, after which the subsidy reduces to 25% of the basic subsidy rate. The leave will also impact on their basic daily fee and income-tested care fee (if applicable).

Hospital leave: the care recipient's provider would receive the full home care subsidy for up to 28 consecutive days for each episode of hospital leave. During this period, the provider can continue to charge them the basic daily fee and the income-tested care fee.

After 28 consecutive days, the subsidy will be reduced to 25% of the basic subsidy rate. The basic daily fee remains payable, however, the income-tested care fee may change (if the new subsidy rate is less than the income-tested care fee). Services Australia will notify the provider and care recipient of any adjustments through the quarterly review process.

If the care recipient is admitted to transition care immediately after being discharged from hospital, the provider will recommence receiving the full subsidy for up to 28 consecutive days of transition care leave. During this period, the provider cannot charge the basic daily fee but may continue to charge the income-tested care fee. After 28 consecutive days, the subsidy reduces to 25% of the basic subsidy rate. The income-tested care fee remains payable but may change if the new subsidy rate is lower than the income-tested care fee. Services Australia will notify the provider and care recipient of any adjustments through the quarterly review process.

Note 1, the income-tested care fee will be reduced to the lesser of the income-tested care fee or the reduced subsidy. This means that for some care recipients the Government will stop paying the subsidy and primary supplements.

Note 2, this worked example assumes that the care recipient chooses to take leave while they are in hospital. If they do not take leave from their package and want to continue receiving some services (for part or all of the leave period), they may be asked to pay the basic daily fee and the income-tested fee.

A care recipient is on leave in hospital but needs minor modifications to the home before they can be released from the hospital to go home. Do I need to do these minor modifications for the care recipient while they are on leave?

In situations such as a hospital stay, it is usually expected that the care recipient is provided with a full range of care and services in the hospital setting. They can, however, choose not to suspend their package and discuss with the provider what services should continue during the period of the hospital stay and have that reflected in their care plan. This might include minor home modifications if there are sufficient funds available in the package to fund the required work.

Therefore, if the care recipient wants minor home modifications to be done within their package, they will need to return from leave in order for these to be done. If they will not agree to return from leave to have the modifications done then the provider does not have to provide for any care, services, or purchases under their package until they return from leave.

A care recipient is going on a three month holiday. Their home needs household maintenance services (such as mowing) in order to make the home safe while they are away ready for their return home. Can I charge to the package budget while they are on leave?

If the care recipient requires care, services, or purchases to be actioned during a period of planned leave then they cannot take leave from their package.

Providers can amend their care plan so that the care and services they will not use are not scheduled during the period they are away. The funds typically used to pay for these will accrue as unspent funds in their package budget. These funds should be used for care and services that will advance their care goals when the care recipient returns from leave.

✓ Key points to remember

- People can take a break from receiving services under their package. This is known as taking leave, and does not affect their entitlement to receive home care services when they want to come back from leave.
- The Government may still pay the Home Care subsidy to that care recipient's home care account while they are on leave. This will depend on the reason the care recipient is taking leave, and how much leave they have already taken in the financial year.
- Depending on the type of leave and how much leave, the care recipient may be asked to pay their basic daily fee and income tested care fee.

12 Responding to special needs and changing cognition in home care package delivery

As discussed at Section 2.1, the HCP Program is underpinned by a CDC model. This means that aged care services should be designed in partnership with the care recipient and adapted to their individual needs and care goals. An individual's needs may include special needs or changes to their cognitive function.

Approved providers need to be ready and able to respectfully and safely provide aged care services to people with special needs and changing cognition. They have a right to have their special needs and/or changing cognition respected. Any services must treat each care recipient with dignity and respect, enable them to maintain their identity, and account for and cater to any special needs and/or changing cognition if they would like them to, or if it is necessary for them to remain living safely in their home.

This section defines the terms 'special needs' and 'changing cognition', and outlines strategies providers may employ to support care recipients with special needs and/or changing cognition.

✓ **Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section**
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

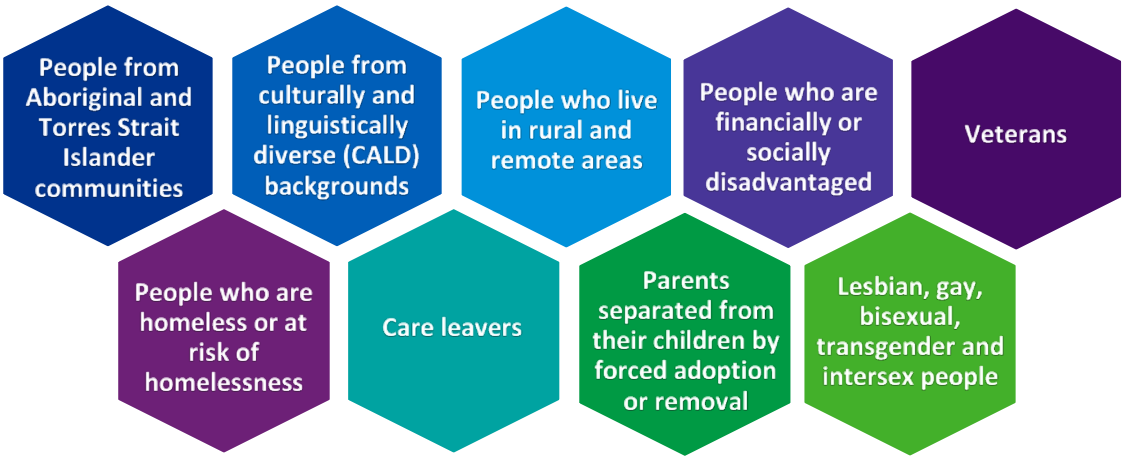
- Section 56-2 of the *Aged Care Act 1997*
- *User Rights Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

12.1 What are special needs?

The *Aged Care Act 1997* defines nine types of special needs, as outlined in the figure below:



When thinking about whether a person has any of the above special needs, providers should not focus on what they look like or whether they show certain physical characteristics. Instead, they should think about how the care recipient sees themselves, and their circumstances.

This manual does not provide specific guidance on what providers should do when providing services to people with each type of special need. This is because the HCP Program is based on a CDC model, which focusses on the needs of the individual. Each person will view their special needs differently and their needs will have different impacts on their lives. Approved providers should be open and respectful, and work together with them to design a program of care and services that is adapted to their particular circumstances.

When working with people with special needs, it is worth remembering that they may have had negative experiences of discrimination, or other adverse actions, in the past. The best way to approach this is to work in partnership with them and have open and respectful conversations about their care needs and goals.

The Commission provides several examples on meeting the care needs of aged care recipients with special needs at this link. Or you can search "case studies" at www.agedcarequality.gov.au/.

The Aged Care Diversity Framework and action plans also helps providers consider how their services may be appropriately tailored to care recipients with diverse characteristics and life experiences. These can be found at this link, or by searching "Aged Care Diversity Framework action plans" at www.health.gov.au.

12.2 What is changing cognition?

Changing cognition is not defined by legislation; it is a broad term used to describe dementia or other changes in care recipient capacity and memory.

12.2.1 Early warning signs of dementia

Early symptoms of dementia often vary a great deal, which can make it hard to identify. Providers' clinicians or other service providers may have regular contact with care recipients. This means they are well placed to help identify when someone may be in the early stages of dementia.

Dementia Australia provides guidance on early warning signs of dementia, which may be helpful to the provider and their team members in identifying whether one of their care recipients may be living with dementia. It can be found at Warning signs of dementia | Dementia Australia or by searching "Warning signs of dementia" at www.dementia.org.au.

12.2.2 Determining capacity

If a provider's staff member, or a care recipient's family and/or friends are concerned about signs of dementia or other changes in cognition, providers will need to determine whether the person still has 'capacity' to make a choice for themselves. 'Capacity' is a legal term, and as a starting point, must always be assumed (even if the care recipient has been diagnosed with dementia or another type of cognitive impairment). It is also decision-specific. Just because someone has not had capacity in the past that does not mean that they will not have capacity to make future or less complex choices.

The individual's right to make their own choices, decisions, mistakes and take risks must be respected. Providers are obliged to support and encourage care recipient autonomy and self-direction, whilst also being mindful of indicators of incapacity and potential abuse of their care recipients.

Capacity means being able to:

It is also important that the care recipient can apply their personal values to the decision, and that there is some stability and consistency to the decision-making over time. Another way of checking capacity is to ask them to explain the decision in their own words, including why the decision is made. Capacity is not an all or nothing concept. It is decision-specific and can also fluctuate over time. A person may lack capacity in one area (such as making complex financial decisions) but may be able to make decisions about other areas of life (such as the type of supports they need and who they would like to provide them).

The case study below provides guidance on what a provider could do to manage care planning with a care recipient who has dementia but still retains capacity to make choices about their care. It is important to remember that anyone who retains capacity has a right to their own dignity of risk.

Case study: Olga

Olga has been receiving home care services for several years. She has dementia and her needs have gradually increased, but she is capable of living semi-independently for now. Her two children live nearby and at least one of them visits daily. Olga gets on well with the care staff and makes it clear to them that she wants to keep doing as much of her own housework and personal care as she can.

Her children, however, express concern to the provider that she is no longer capable of making decisions that best meet her needs. They ask the provider to add laundry, ironing and bed-making to their duties, tasks that Olga has been doing herself until now without mishap. The care staff who look after her directly tell the service co-ordinator they think this change is unnecessary and risks making Olga unhappy and affecting her confidence. The provider has to balance the wishes of Olga's family with Olga's own preferences.

The main priorities are Olga's safety, her well-being, and respecting her wish to keep doing her daily tasks. There are certainly safety and hygiene issues to consider. So far, these have not arisen but may as Olga's dementia progresses. A care co-ordinator with experience in dementia meets with Olga to talk about these issues. Olga understands the concerns being raised by her children and decides that the risks discussed with her are outweighed by the importance of the benefits she get from doing her own laundry and ironing. She agrees to a small increase in staff supervision for these activities, and that the bed-making service can start. In explaining the plan to Olga's children, the co-ordinator emphasises how important it is for their mother to maintain a sense of independence, self-worth and purpose. The co-ordinator also makes it clear that the provider has carefully discussed the health and safety risks with their mother and will continue to monitor them from day to day.

12.2.3 Dementia Training Program

The Dementia Training Program is a program for providers that offers a national approach to accredited education, up-skilling, and professional development in dementia care. Services include:

- accredited dementia care vocational level training courses - free to eligible care workers in residential, respite, community care or the wider health services;
- an online training portal allowing staff to undertake web-based training; and
- tailored onsite training to aged care providers who request assistance, including a dementia skills and environment audit, followed by a tailored training package.

The Dementia Training Program website is at www.dementiatrainingaustralia.com.au.

12.2.4 Dementia Behaviour Management Advisory Services

The Dementia Behaviour Management Advisory Services (DBMAS) provides advice to providers and individuals caring for people living with dementia where behavioural and psychological symptoms of dementia (BPSD) are impacting on their care and quality of life. Access is through the 24 hour helpline, on **1800 699 799**, or the DBMAS website at www.dementia.com.au.

12.3 How do I manage issues related to changing cognition?

CDC encourages people receiving a package to continue to make choices and direct the support that they need. Some individuals, however, may have more difficulty engaging with CDC and making choices about their care goals and services. If they would like or need it, there are different ways in which they can be supported in their decision-making and in expressing their views about their service arrangements:

Strategy	Description
Representative	A person may appoint a representative to assist with their decision making or be authorised to make decisions on their behalf. This may take various forms, such as an informal arrangement with a friend, family member or ally, someone with a formal power of attorney or a legal guardian.
Supported decision-making	Supported decision-making is a model that has mainly been used for supporting people with disabilities, often cognitive disabilities, to make significant decisions and exercise their legal capacity. Specific decisions are addressed, weighed and concluded by the person with the disability, while drawing on the support of a network of people or an individual. Potential supporters may be friends, family, volunteers, community members or any other trusted person. These unpaid supporters may help the person with disability to gather, understand and consider relevant information about the decision in question, assist them to weigh pros and cons, predict likely outcomes and consequences or evaluate the available options. With this support, the person then makes the decision themselves. This process can be formally facilitated, for instance by creating written supported decision-making agreements. It often occurs informally, however, within the community, both to support people with impaired decision-making capacity and to support anyone in making a challenging decision. This model of support aims to build and extend the decision-making skills of those using it, developing the ability of people to make and communicate decisions with more independence and confidence. Source: Disability Advocacy Network Australia

Strategy	Description
Power of Attorney	Powers of attorney are legal documents that let a person choose someone they trust to make decisions for them. An enduring financial or medical power of attorney, or enduring guardianship, are a way a competent person can appoint others to make decisions and manage their affairs in the event they are unable to make decisions for themselves. Arrangements may differ in each State or Territory. Contact your Office of the Public Advocate in your State or Territory for further information.
Guardianship	Guardianship is the appointment of a person (a 'guardian') to make decisions for an adult with a disability (the 'represented care recipient) when they are unable to do so. All adults over the age of 18 years, regardless of disability, are entitled to make their own decisions when they are able to do so. Australian guardianship law is the key regulatory mechanism for protecting the health of young persons, adults with disabilities and the elderly. Australia has eight different guardianship regimes, which vary widely in their forms of regulation. See www.austguardianshiplaw.org for more information.
Care planning	All care recipient care plans should include a contingency plan, which is reviewed each year and provides clear guidance around what to do in the event that their capacity to make decisions regarding their care declines.
Advance care planning	Advance care planning provides an opportunity for people to think, discuss and plan for the medical treatment they would prefer if they became too ill in the future to express their wishes. An Advance Care Directive is a written document that records the medical treatment wishes of a person, which can then be used if they are unable to speak for themselves due to illness or injury. The document may also appoint a substitute decision maker and include non-medical wishes for end of life, such as spiritual care. You can find information about advance care planning at this link or on www.health.gov.au by searching "advance care planning". Information, guidance, and resources are available from the End of Life Directions for Aged Care website at this link or at www.eldac.com.au. Advance Care Planning Australia has information about contacts in each State and Territory. For more information see www.advancecareplanning.org.au.

The case study on the next page outlines how advance care planning can help provide the care recipient, their families and the approved provider with comfort through end of life planning.

Case study: Ricardo and Alicia

Ricardo and Alicia had been living in their own unit for three years when Ricardo, aged 70, was diagnosed with a form of dementia that is progressing rapidly. They contacted their provider to discuss extra services they expected to need as the illness progressed. Recognising how important it was for Ricardo's final months to be comfortable and dignified and to reflect his wishes, even when he could no longer express them, the provider encouraged them to make a formal advance care plan.

A staff member trained in developing advance care plans helped Ricardo identify his values and treatment preferences. What mattered to Ricardo most was staying in his home with his wife and dog, taking daily walks and looking after the unit's small garden. He did not want treatment that

Case study: Ricardo and Alicia

might extend his life while its quality deteriorated. Following the provider's protocol for end of life planning, the staff member worked with Ricardo and Alicia to document a detailed advance care plan. Ricardo was pleased everyone knew his clinical, cultural and spiritual preferences.

For more information on supported decision making in aged care please go to this link or search "Supported decision-making" at cdpc.sydney.edu.au/.

12.4 What do I do if care recipients need additional support in exercising their choice?

Advocacy has an important role in supporting care recipients in exercising choice and directing their services. An advocate can help them understand their rights and choices within their package, and supports them through decision-making processes. Advocacy can be particularly useful for people who are experiencing changing cognition.

The care recipient (either the care recipient or their representative) can request that another person assist them in dealings with their approved provider. An advocate is not the same as a representative, in that they may be present to support decision-making or negotiations with the provider, but are not necessarily authorised to make decisions for the individual.

Providers must allow the advocate of the care recipient's (or their representative's) choice access to the home care service.

An advocate may be made available through the National Aged Care Advocacy Program (NACAP). The NACAP is delivered on the behalf of the Australian Government by the Older Persons Advocacy Network (OPAN). It provides free, confidential and independent advocacy support to older Australians receiving or looking to access Government-funded aged care services.

An advocate's support can help with the following:

For more information on advocacy services go to opan.com.au.

✓ Key points to remember

- Providers need to be ready and able to provide care and services to people with special needs and/or changing cognition. Care and services must be considerate of and appropriate to special needs and/or changing cognition.

- The Aged Care Diversity Framework and action plans can help providers consider how services may be appropriately tailored to people with diverse characteristics and life experiences. These can be found at this link, or by searching "Aged Care Diversity Framework action plans" at www.health.gov.au.
- Capacity can be difficult to navigate with an older Australian and their family. This section outlines legal and advocacy strategies that providers can use to help with this.
- OPAN provides free, independent advocacy services. If care recipients need support making decisions, but can still make decisions for themselves, providers can connect them to this service.

13 Changing home care providers

This section outlines the obligations of a provider if one of their care recipients chooses to change home care providers. This includes details on how to calculate and transfer their unspent funds.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Section 56-2 of the *Aged Care Act 1997*
- *User Rights Principles 2014*
- *Accountability Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

13.1 When can a care recipient change home care providers?

Once receiving a package, a care recipient can change providers if they are looking for a better fit, or for any other reason. If they decide to make a change, their unspent Home Care funds (less any exit amount as agreed in the Home Care Agreement if departing before 1 January 2023) will move with them to their new provider.

When someone transfers to a new provider, they must notify their existing provider that they no longer wish to receive care and agree on the date that services from the existing provider will cease. They should also advise their existing provider of who their new provider will be.

13.1.1 Agreeing on a cessation day

A care recipient may tell their existing provider they wish to change providers directly, or they may reactivate their referral code in My Aged Care, triggering a notification to the existing provider through the Provider Portal. The existing provider should discuss the care recipient's needs and the timing of their move once they become aware of their intent to change providers.

This includes agreeing on a cessation day for the existing home care services that takes into consideration the care recipient's situation, the terms of the Home Care Agreement, and legislative requirements of home care. As per the *Records Principles 2014*, the existing provider will need to document the agreed cessation day.

The existing provider must continue providing care up until the agreed cessation day.

13.2 How does this affect the claims for that care recipient's home care subsidy?

Reaching an agreed cessation day with the care recipient is important to know the period for which the existing provider can claim home care subsidy. It also allows the existing provider to accurately reconcile the balance of package funds and calculate any unspent funds.

The start date for the new provider must be on or after the cessation day of the existing provider. When someone changes providers and there is no gap in care, the start day for the new provider should be the same date as the cessation day for the existing provider. This ensures there is no gap in payment of home care subsidy.

When a care recipient changes home care provider, the existing provider is not paid a home care subsidy for the cessation day, while the new provider is paid home care subsidy for the start day. An example of how subsidies are paid to the existing provider and new provider when there is no gap in services to the care recipient is outlined in the table below:

Recipient	26 June	27 June	28 June	29 June	30 June
Existing provider	Subsidy paid	Last day of services, Subsidy paid	Cessation day		
New provider			Start date, Subsidy paid	Subsidy paid	Subsidy paid

Before providing home care services, the new approved provider should confirm the cessation day with both the care recipient and the existing provider to ensure there are no overlapping claims for home care subsidy. Where two or more approved providers claim subsidy for the same person on the same day, payment will be made to the provider that first entered into a Home Care Agreement with them. When the start day and the cessation day are the same date, this does not represent an overlapping claim as home care subsidy is not paid for the cessation day.

13.2.1 Notifying the cessation day and start date

The new provider must accept the care recipient's referral in My Aged Care and submit the ACER within 28 calendar days of the cessation day. They have 56 calendar days from their agreed cessation day to enter into a new Home Care Agreement with their new provider before their package is withdrawn.

The existing provider must notify the Australian Government that they have ceased providing services to a care recipient within 31 calendar days of their cessation day. This must be done by submitting the care recipient's name and their cessation day through the Aged Care Provider Portal. The Aged Care Provider Portal is at this link, or can be found by searching "Aged Care Provider Portal" at www.servicesaustralia.gov.au.

Note: For continuing care recipients if they wish to retain their pre-1 July 2014 fee arrangements they must enter care with the new provider within 28 days. For more information see **Appendix A**.

13.3 What are the obligations on providers?

13.3.1 Obligations for the existing approved provider

The diagram below outlines the obligations for the existing approved provider:

1. Provide cessation information to Services Australia	2. Notify care recipient of unspent amount/arrange payment	3. Retain records
Once a cessation day is agreed with the care recipient, the existing provider must notify Services Australia within 31 calendar days of care ceasing. It is important to remember that a home care subsidy is not paid for the cessation day.	Three steps must be taken: a. Calculate the unspent home care amount b. Provide written notice of the unspent home care amount c. Make payment of the unspent home care amount.	The existing provider must retain: • Written notice of the care recipient's unspent home care amount • Records relating to the payment of the unspent home care amount to the new provider.

Further information on the steps necessary to notify the care recipient of the unspent amount and arrange payment is outlined below:

a. Calculate the unspent home care amount

The steps and requirements for calculating a care recipient's unspent home care amount are detailed in the *User Rights Principles 2014*. Before completing the final reconciliation, the provider must make sure claims for the care recipient are up-to-date; that home care fees have been received; and all expenses have been identified, including any outstanding invoices from sub-contracted or brokered services.

Note: The calculation of unspent home care amount should not include:

- any home care fees paid in advance, as these must be separately refunded to the care recipient by the provider; or
- home care subsidy for the cessation day, as home care subsidy is not paid for the care recipient on that day.

b. Provide written notice of the unspent home care amount

Within 56 calendar days after the cessation day, the existing service provider must give the care recipient (or their representative) a written notice about their unspent home care amount. The written notice must include the:

- Cessation day for care and services.
- Exit amount that has been deducted (if applicable/prior to 1 January 2023).
- Unspent home care amount, which is the balance of any unspent funds (less any exit amount if departure occurred prior to 1 January 2023) in the package budget, broken down into the following portions:
  - the care recipient portion, which is the unspent amount of home care fees paid to the provider by the care recipient, less any unpaid home care fees owed by the care recipient;
  - the Australian Government portion held by the provider (if any), which is the unspent amount of home care subsidy and supplements for a care recipient;
- Any unpaid home care fees which have been deducted (if applicable).

Under Improved Payment Arrangements, from 1 September 2021, the existing service provider will need to:

- transfer the care recipient portion of unspent funds to the new service provider if the care recipient is moving services, or
- refund the care recipient portion of unspent funds to the care recipient or their estate if the care recipient exits home care.

If a provider still holds the Commonwealth portion of unspent funds for the care recipient, the existing service provider will need to:

- transfer the Commonwealth portion to Services Australia where it will be held in the care recipient's home care account, available for use with their new provider, or
- return the Commonwealth portion to Services Australia, where the funding will be reinvested by the Government into the Home Care Packages Program if the care recipient exits home care.

For providers who have opted-in to draw down on the Commonwealth portion of unspent funds and have used these funds entirely, they will only need to transfer or refund the care recipient portion. The Commonwealth portion of unspent funds will be in care recipient's home care account, managed by Services Australia.

Where a care recipient has unpaid home care fees, this is a matter for the approved provider to manage with them directly under the terms of the Home Care Agreement. The written notice must explain how the unspent home care amount will be paid, so they (or their estate) understands the process and the timeframes involved.

Providers cannot charge care recipients fees that they have waived in the past or fees that are not detailed in the Home Care agreement.

Refer to Section 13.4 for more information on exit amounts.

c. Make payment of unspent home care amount

The care recipient must notify their existing provider within 56 calendar days after the cessation day of the new provider who they have entered into a Home Care Agreement with. This is to allow their existing provider to arrange payment of the care recipient portion of the unspent home care amount to the new provider. If the existing provider is not notified within this period, the existing provider must treat any unspent home care amount as if the care recipient has left home care. This is discussed at Section 14**.**

The existing provider is required to make payment to the new provider as soon as possible, but within 70 calendar days, after the cessation day. The existing provider must also provide a copy of the written notice of the unspent home care amount to the new provider at the time the payment is made. This allows the new provider to identify the transferred amount for the care recipient.

13.3.2 Obligations for the new approved provider

The diagram below outlines the obligations for the new approved provider:

1. Accept the care recipient referral in My Aged Care	2. Develop a Home Care Agreement with the care recipient.	3. Provide care recipient entry information to Services Australia.
Providers must accept the care recipient's referral in the Provider Portal before submitting entry information to Services Australia.	The new provider should work in partnership with their new care recipient to develop a Home Care Agreement, care plan and package budget based on their assessed care needs.	The new provider must notify Services Australia within 28 calendar days of the care recipient starting care by submitting an ACER.

Once the new provider receives the unspent funds amount they must separately identify the transfer portion of the unspent home care amount in the care recipient's monthly statement. Under Improved Payment Arrangements (from 1 September 2021 onwards) the transfer portion will only consist of the care recipient portion of unspent funds. The Commonwealth portion will be held in the care recipient's home care account.

Care recipients who join the HCP Program after 1 September 2021, will never have an Commonwealth portion held by the provider. Any unspent funds held by the provider will be entirely made up of the care recipient portion.

13.4 When can I charge an exit amount?

From 1 January 2023, providers cannot charge a care recipient an exit amount in any circumstance.

If a person leaves a provider's care before 1 January 2023, the provider can charge an exit amount if:

- the provider has published the exit amount on the My Aged Care website
- the care recipient has agreed to an exit amount in their Home Care Agreement
- the care recipient still has unspent funds held by the provider when they exit care.

This can occur even if accounts are finalised after 1 January 2023.

Activities related to care recipient's exiting or moving to a new provider, such as transferring documents, may be covered under package management or care management, where reasonable and appropriate.

13.5 My organisation has undergone a merger or acquisition. How do I transfer my care recipients?

When a provider has undergone a merger or acquisition, their care recipients will need to be exited from their service and transferred to the new provider.

Services are required to contact the Department to advise of transfers, mergers or closures, including effective dates. The Department will advise Services Australia of this information.

It is also the services' responsibility to transfer all care recipient from the closing service to the continuing service.

Further guidance on obligations if a provider is subject to a merger or acquisition can be found at this link, or by searching "Transferring Home Care Packages services at www.health.gov.au.

Note that if a provider is looking to move care recipients from one of their home care services to another within their control, they can do this via a self-service process in the My Aged Care Provider Portal. Providers can find support with technology and guidance on how to use the My Aged Care Provider Portal at this link. They can also search "My Aged Care for service providers" at www.health.gov.au.

More information on administrative responsibilities is at Section 15 of this manual.

✓ Key points to remember

- Care recipients can change home care providers at any time.
- If someone receiving home care services chooses to change providers, it is important that they and their existing provider agree a cessation date. This affects the way the providers claim the care recipient's package subsidy and when the existing provider will need to transfer the care recipient's unspent funds.
- The existing provider must transfer the care recipient's unspent funds to their new provider as soon as possible, but within 70 calendar days, of the cessation date.
- If a provider has a transferring care recipient who entered care before 1 July 2014 and they want to opt into the post-1 July 2014 fee arrangements, they must complete the **"Continuing Care Recipient opting into the New Aged Care Arrangements from 1 July 2014 (AC022)"** form. The care recipient must submit this form to their new provider. The new provider must give them a copy of the *New Arrangements for Aged Care from 1 July 2014 – Home Care* publication before they transfer to the new service.

14 Leaving the HCP Program

This section tells providers the steps they need to take if a care recipient leaves the HCP Program.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 52D-1 and 56-2 of the *Aged Care Act 1997*
- *Fees and Payments Principles 2014 (No.2)*
- *User Rights Principles 2014*
- *Accountability Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

14.1 What administrative tasks do I need to complete?

14.1.1 Notify Services Australia of a care recipient ceasing care

Within 31 calendar days of a care recipient ceasing services, the provider must notify Services Australia through the Aged Care Provider Portal of their name, cessation date, and the reason for their departure (for example, moving to residential aged care or passing away). The Aged Care Provider Portal is at this link, or can be found by searching "Aged Care Provider Portal" at www.servicesaustralia.gov.au.

If a care recipient moves into permanent residential aged care, their start date with their residential aged care provider will be the date their home care provider ceases receiving payment of subsidies. It is important that the home care provider agrees with the individual and their residential aged care provider the cessation date for their package and the start date for residential care, to ensure the home care provider is eligible to receive all subsidies they are expecting to receive.

If a person passes away, in addition to making the necessary changes on the Provider Portal, providers should call My Aged Care on **1800 200 422** so they can update their record. This is important, as it will ensure future communications with family members are mindful of this fact, and do not cause further distress. Alternatively, providers can advise the care recipient's representative to call My Aged Care.

14.1.2 Complete hand over (if relevant)

It is important that aged care recipients have continuity of care. As a part of care management, providers should do a hand over with relevant parties when needed, to ensure each person's care needs are understood. Providers should seek the care recipient's permission to share their information and documentation about their care. This will ensure any new providers of aged care will have as much information as possible to inform the care they provide.

This should occur before the care recipient's cessation date. If it occurs after the cessation date, the provider will not be able to charge the care management to them.

This will not be required if the care recipient has passed away.

14.1.3 Make payment of unspent home care amount

If a care recipient leaves home care or passes away, their provider must undertake the following with respect to unspent funds:

- Transfer the care recipient portion to the person or their estate. If they are leaving the HCP Program, this must be completed within 70 days after the cessation date. If they have passed away, this must be completed within 14 days of being shown the probate of the Will or letters of administration.
- If the provider has not opted-in under Improved Payment Arrangements to draw down on the Commonwealth portion of unspent funds (or if they have opted-in but not yet drawn down these funds to $0) the provider will need to notify the Australian Government of the Commonwealth portion (including nil amounts) within 70 calendar days through the claims process managed by Services Australia.

Care recipients who join the HCP Program after 1 September 2021, will never have an Commonwealth portion held by the provider. Any unspent funds held by the provider will be entirely made up of the care recipient portion.

- Providers should support care recipients through their transition to other aged care programs.
- Providers must notify Services Australia when a care recipient leaves the HCP Program.

15 Providers' reporting and administrative responsibilities

Once providers are set up to provide services under the HCP Program they need to continue to comply with their disclosure and reporting obligations.

✓ **Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section**
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Sections 9-1A, 9-2, 9-3, 9-3B, and 63-1 of the *Aged Care Act 1997*
- *Accountability Principles 2014*
- *Records Principles 2014*
- *Sanctions Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations required of them.

See **Appendix E** for further detail on specific provider responsibilities.

15.1 My organisation's circumstances have changed. What do I need to do?

There are two types of changes that providers need to notify either the Department or the Commission about:

15.1.1 Changes to the home care service

Changes to the home care service includes things like changes of name, address or contact details. In short, if the change affects who or how the Department can contact the approved provider they must notify the Department.

This can be done by completing the form at this link. You can also find the form by searching "Notification of changes for Home Care Packages" at www.health.gov.au.

15.1.2 Material changes to suitability

Approved providers have an ongoing responsibility to ensure they are ready and able to provide legislatively compliant, high quality and safe home care services at all times. For more information on this, see Sections 2, 3 and 4 of this manual.

Provider suitability is assessed against the following five considerations:

1. Experience in providing aged care or other relevant forms of care
2. Understanding of approved provider responsibilities
3. Systems it has, or will have, in place to meet these responsibilities
4. Record of financial management and the methods used, or proposed to ensure sound financial management
5. Conduct as a provider (including compliance with responsibilities as a provider) and obligations arising from the receipt of any payments from the Australian Government for providing that aged care or any other relevant form of care.

If anything changes that materially affects these criteria, providers are required to disclose this information to the Commission. This information must be disclosed using the **"Notification of Material Change"** form. The form is at this link or can also be found by searching "Notification form - s9-1, s9-2A notifications" at www.agedcarequality.gov.au.

All notifications must be made within 28 days of the change occurring. Penalties may be applied if a provider does not notify the Commission within this timeframe.

The **"Notification of Material Change Form"** (discussed above) can also be used by an approved provider to update information about its organisation which may include key personnel responsible for the overall governance of the organisation or the authorised contacts or address information.

15.2 My key personnel have changed. What do I need to do?

Providers are responsible for knowing who in their organisation meets the definition of key personnel as outlined in Section 8B of the *Aged Care Quality and Safety Commission Act 2018* and ensuring their key personnel are not a disqualified individual. Providers will be liable for any sanctions if it is determined that key personnel are disqualified individuals.

As discussed at Section 4, a disqualified individual is someone who has been convicted of an indictable offence, is insolvent or under administration, or is certified by a medical practitioner that they have a mental incapacity to perform their duties as key personnel. Each State and Territory law identifies different types of offences as being indictable. These typically include serious offences such as murder, manslaughter, the intentional or unlawful administration of drugs or poisons, or committing fraudulent or dishonest activities.

Providers must take reasonable steps to ensure none of their key personnel are a disqualified individual. The following steps are taken by the legislation to constitute 'reasonable steps'.

For each of a provider's existing key personnel:

- Ensure that the person understands the obligations of key personnel and of approved providers under the Act in relation to disqualified individuals
- If the provider reasonably believes that the person may be mentally incapable of performing his or her duties as one of their key personnel, make arrangements for the person to be examined by a registered medical practitioner
- If the provider reasonably believes that the person may be a disqualified individual, take the steps outlined below
- If the provider has ascertained that the person is a disqualified individual, ensure that the person ceases to be one of their key personnel.

For any person who proposes to become, or becomes, one of a provider's key personnel:

- Obtain a police certification for the person (this requires their written consent);
- Conduct a search of bankruptcy records; and
- Conduct previous employment and referee checks.

If a provider fails to take reasonable steps to ensure their key personnel are not disqualified individuals, they may be liable to pay a fine, face revocation of their approved provider status or, in certain circumstances, face a prison sentence.

Providers need to keep documentation, such as police checks, confirming the suitability of their key personnel. These obligations arise under the *Records Principles 2014* and have been outlined at **Appendix E** of this manual.

15.3 What are my financial disclosure obligations?

Approved providers must complete an Aged Care Financial Report (ACFR) annually, four months after the end of their financial year. All financial reporting requirements for residential aged care, HCP Program and short-term restorative care are reflected in the ACFR template so providers can report on all the aged care services they provide in one report to the Department.

15.3.1 Home Care financial reporting

To support all aged care providers to meet their legal obligation to complete the ACFR annually, the Department sends each provider an ACFR User Guide. This guide is sent out during August, and a customised cover letter explains which sections of the ACFR are relevant to the recipient's organisation.

Home care providers will be prompted to complete the Home Care Financial Report (HCFR) section of the ACFR. The HCFR is to be completed at a Planning Region level, with a home care service defined as an approved provider's home care operation within an aged care planning region. While some providers will have their Home Care Service IDs at the planning region level, others will have their Service IDs at the package level (i.e. Level two packages). Where Service IDs are at the package level, providers may be required to aggregate their financial information in order to complete the Financial Report.

Commencing with the 2021-22 ACFR, non-government home care providers are also required to complete the Approved Provider Income & Expenditure Statement, Approved Provider Balance Sheet and Approved Provider Cash Flow Statement which all collect financial data on the total operations of the approved provider, not just home care. There have also been recent changes to who can sign the Declaration which is required to be submitted with the ACFR.

> If the approved provider is not a State, a Territory, an authority of a State or Territory or a local government authority, the aged care financial report must be signed by:
>
> (a) if the provider is a body corporate that is incorporated, or taken to be incorporated, under the Corporations Act 2001—a director of the body corporate for the purposes of that Act; and
>
> (b) otherwise—a member of the provider's governing body.
>
> If the approved provider is a State, a Territory, an authority of a State or Territory or a local government authority, the aged care financial report must be signed by one of the approved provider's key personnel who is authorised by the provider to sign the report.

15.3.2 Lodgement

Providers must lodge all required sections of the ACFR with the Department, via the online ACFR portal. The portal can be found at health.formsadministration.com.au. The ACFR portal can only be accessed through VANguard or myGovID login. Providers must complete and lodge their ACFR by 31 October for the previous financial year ending 30 June.

There are no provisions within the legislation to grant extensions. Providers must lodge their ACFRs early to provide adequate time to address any issues and finalise all components of the ACFR as it relates to their organisation. The Department may take compliance action if providers fail to comply with these requirements. A range of sanctions can be imposed on an approved provider including revoking or suspending approval as a provider of aged care services and restricting approval to provide aged care services. The type of sanctions imposed on an approved provider will depend on the nature of the non-compliance.

ACFRs cannot be lodged until all the required sections are completed and correct, and all necessary documents have been uploaded at the ACFR portal. The customised cover letter sent directly to all providers with each financial year's ACFR user guide will outline all sections relevant to providers delivering the HCP Program.

15.3.3 Pricing review

Providers must also review their full price list and do one of the following:

- Report to the Department that they have done so. This can be done by entering 'Confirm review of pricing information' in the My Aged Care Provider Portal.
- Update their price list. This will cause the 'last updated date' to update in the Department's systems, and will be sufficient evidence that the provider has reviewed their price list.

More information on obligations related to pricing is at **Appendix B**.

15.4 What happens if I am not compliant with my obligations or responsibilities?

The consequences of identified non-compliance by aged care providers depends on the risks posed by the non-compliance and the provider's response to the Commission's concerns. The Commission's primary concern is the risks to the health, welfare or interests of current and/or future recipients of aged care services.

Reflecting this, compliance can include things like education, repayments, issuing a non-compliance notice or sanctions. If there is a recurring non-compliance, continued unwillingness or inability by the provider to address the non-compliance, the Commission may revoke their approval to provide aged care. In some instances non-compliance could also result in a criminal charges for the most serious breaches.

Please note, other penalties or sanctions may also arise under other legislation, such as the consumer law.

✓ Key points to remember

- Providers must notify the Department of changes to their circumstances.
- Providers have annual obligations to report financial information to the Department. They can complete reporting for all aged care services they provide in one form.
- Providers must notify the Commission of material changes to suitability.
- Providers are responsible for ensuring that key personnel are not disqualified individuals.
- Providers also have an annual obligation to review their price list annually.
- If providers have a financial year that ends on 30 June, they must report their financial information by 31 October.
- On 1 January 2020 the Commission took on compliance functions, previously the responsibility of the Department of Health and Aged Care. The regulatory management of this matter now rests entirely with the Commission.

15.5 Reporting issues

Aged care providers must spend package funds appropriately.

15.5.1 Reporting suspected non-compliance with provider requirements

The Commission has processes for people to raise a concern or make a complaint about the quality of care or services provided to people receiving Australian Government funded aged care. More information is available at this link or by searching for 'complaint' at https://www.agedcarequality.gov.au/.

The consequences of identified non-compliance by aged care providers depends on the risks posed.

When resolving complaints in relation to the care and services, if the Commission finds a provider used package funds inappropriately then it can initiate compliance action, including at a minimum, repayment of any amounts that have been incorrectly charged.

15.5.2 Reporting suspected fraud

The Department does not tolerate fraudulent use of HCP funding. If funding is used for purposes stipulated in the 'Specified Exclusions' table at 9.2.3 or for other items deemed not part of services or care to be funded by a HCP, the Department may initiate a fraud investigation and take action accordingly.

The Department has the power to investigate allegations of fraud against health funding and programs and is actively engaged in intelligence gathering with external agencies.

IF YOU SEE SOMETHING, SAY SOMETHING BECAUSE FRAUD IS A CRIMINAL OFFENCE.

The Department can investigate allegations of fraud against health funding and programs. If you suspect someone is engaging in fraud, please contact the Department with the details of your concerns via email at agedcarefraud@health.gov.au. Alternatively, you can call the Health Fraud Hotline on **1800 829 403**, open 9am to 5pm Australian Eastern Standard Time, Monday to Friday. You can report suspected fraud anonymously.

If an approved provider wants to self-report a concern, they should contact the Department.

16 Interface with other Programs and Schemes

This section provides information on what programs can be accessed at the same time as the HCP Program. It focusses on the CHSP, because it is related to the HCP Program within the Australian Government continuum of care for older Australians, but also discusses a broad range of other programs.

Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

No specific obligations arise. The *Aged Care Act 1997*, however, governs how the HCP Program interacts with other programs. As providers of services under the program, providers are expected to comply with those laws.

16.1 How does the HCP Program interface with other programs?

As outlined at Section 2, the HCP Program is a part of the Australian Government's continuum of care for older Australians. The table below outlines what other services can or cannot be received at the same time as the HCP Program:

Services that may be received while receiving HCP Program services	Services that cannot be received while receiving HCP Program services
Commonwealth Home Support Programme^	Permanent residential aged care
Community Visitors Scheme	Short Term Restorative Care
Continence Aids Payment Scheme	Transition Care Programme
DVA Programs	Multi-Purpose Services Program
Residential Respite Care*	National Aboriginal and Torres Strait Islander Flexible Aged Care Program
Dementia Behaviour Management Advisory Services (DBMAS)	Disability Support for Older Australians
Palliative Care	
National Dementia Support Program	
National Disability Insurance Scheme (NDIS)^	

^Under limited circumstances

* Unless the care recipient has taken leave from their package.

16.2 What is the Commonwealth Home Support Programme?

The CHSP represents the entry tier of the Australian Government aged care system. Investment in entry-level support that focuses on keeping people independent and safe in their own homes can

delay the need to move to more intensive forms of care. This benefits frail older Australians through increasing their independence and quality of life as well as reducing Australian Government outlays for other forms of care, such as residential aged care.

Assessment for eligibility to access the CHSP is completed by the Regional Assessment Service (RAS). An ACAT may also approve eligibility.

The CHSP provides funding for a broad range of entry-level support services to assist frail older Australians aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) and who have functional limitations (including cognitive), to remain living independently at home and in their community[2].

CHSP subsidised services are delivered on a short-term, episodic or ongoing basis, with a strong focus on activities that support independence and social connectedness and taking into account each person's individual goals, preferences and choices. As with the HCP Program, people receiving services through the CHSP may need to contribute funds towards their services[3].

As an 'entry-level' program, the CHSP is designed to provide relatively low intensity (small amounts) of a single service or a few services to a large number of frail older Australians. These services are designed for older Australians who need only a small amount of assistance or support to enable them to maintain their independence, continue living safely in their homes and participate in their communities.

The CHSP is not designed for older Australians with more intensive, multiple or complex aged care needs, and does not replace or fund support services already provided for other programs or schemes, including the health care system. People with higher needs are supported through other aged care programs.

16.3 How does the HCP Program interact with Commonwealth Home Support Programme?

The HCP Program is designed to support older Australians living in the community whose care needs exceed the level of support that can be provided through the CHSP.

CHSP service providers should only supply additional CHSP services to a person receiving a home care package where they have the capacity to do so without disadvantaging the CHSP target population. People who need CHSP subsidised services, but do not have access to other relevant support services, should be prioritised over people who are already receiving a home care package.

There are defined circumstances in which care recipients are able to receive specific CHSP subsidised services on a time-limited basis when they are in a package (that is, the additional CHSP services will not be charged to their package budget). These circumstances are limited, to ensure the CHSP continues to, in the main, deliver entry-level services.

[2] **Note**: the eligible ages for the Assistance with Care and Housing (ACH) Sub-Program differ from those for the core Commonwealth Home Support Programme. Further detail on the sub-program can be found in the Commonwealth Home Support Programme Manual. The manual is at this link, or can be found by searching "Commonwealth Home Support Programme (CHSP) Manual" at www.health.gov.au/.

[3] This occurs through the 'Client Contribution Framework'. Further detail can be found at Chapter 5 of the Commonwealth Home Support Programme Manual (at the link above).

They include:

- For care recipients on a Level one or two package: where the care recipient's package budget is already fully allocated, they can access additional, short-term or episodic Allied Health and Therapy services or Nursing services from the CHSP, where these specific services may assist the care recipient to regain functionality after a setback (such as a fall).
- For care recipients on a Level one to four package: where the care recipient's package budget is already fully allocated and a carer requires it, they can access additional planned respite services under the CHSP (on a short-term basis).
- For care recipients on a Level one to four package: in an emergency (such as when a carer is not able to maintain their caring role), where the care recipient's package budget is already fully allocated, additional services under the broader CHSP can be obtained on an emergency or short-term basis. These instances must be time limited, monitored and reviewed.
- For care recipients on an interim Level one or two package who are waiting for a Level three or four package; where the care recipient's package budget is already fully allocated, they can access additional minor home modifications from the CHSP.
- For care recipients on a Level one to four package: care recipients who have transitioned from the CHSP may continue to access their existing CHSP social support group on an ongoing basis to allow the continuity of social relationships. This only applies to care recipients attending a pre-existing CHSP social support group service.

For care recipients on Level one to four package or awaiting their package: where there is urgent need, and the care recipient has insufficient funds in their package budget for goods, equipment and assistive technology (GEAT), they may access GEAT in the short term. These instances should be time limited, monitored and reviewed. During these times, the package is not suspended; both the HCP Program and the CHSP will be received concurrently.

More information is available in the Commonwealth Home Support Programme Manual. The manual is at this link, or can be found by searching "Commonwealth Home Support Programme (CHSP) Manual" at www.health.gov.au.

16.4 How does the HCP Program interact with other programs and schemes?

It may be possible for a person to receive care and services through a range of other programs and schemes that they cannot receive as part of a home care package. Key programs and schemes are outlined below. Providers should work with their care recipients to identify additional services that they may need, and to explore the best available combination of health and aged care services.

More detailed information about the individual programs is available on the My Aged Care website, at www.myagedcare.gov.au. You can also call the My Aged Care contact centre on **1800 200 422**. For information on how other programs or schemes interact with the HCP Program, please refer to information on the program or scheme of interest.

16.4.1 National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFAC)

The National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFAC) is a separate aged care program specifically for Aboriginal and Torres Strait Islander peoples. Aboriginal and Torres Strait Islander peoples can access either HCP or the (NATSIFAC) but they cannot access both services. Where Aboriginal and Torres Strait Islander people access HCP, culturally appropriate aged care services similar to the NATSIFAC home-care like program is appropriate.

16.4.2 Residential Aged Care

Under the *Aged Care Act 1997*, an entry into permanent residential care will result in the immediate withdrawal of an active home care package. If a care recipient is receiving HCP Program services and needs to permanently move to a residential aged care facility, their home care provider is responsible for discussing this move with them and mutually agreeing a cessation date where entry is foreseen.

Sometimes entry to permanent residential care is unforeseen. HCP providers should thus plan with care recipients when negotiating the Home Care Agreement on how they will be alerted to an entry into permanent residential care so that they can cease service provision with immediacy. Home care providers are also encouraged to create linkages with hospitals and residential care services in their region to support continuity of care for the care recipient.

16.4.3 Check all prospective home care recipients' My Aged Care client records for any active permanent residential care services before committing a package

COVID-19 emergency leave in residential care has created situations where care recipients are on long-term leave from residential care, sometimes for six months or longer – these care recipients may enter the National Priority System and be assigned a HCP. This is allowed by the system to ensure the care recipient is given choice and control to exit residential care.

However, HCP providers should thus check prospective care recipient's My Aged Care client record carefully before committing a package on their behalf and reject any care recipients who are still entered into permanent residential care until such time that they have:

- formally exited permanent residential care, or
- the home care provider has contacted the residential aged care service and confirmed cessation date; and a start date for home care is agreed to by both the care recipient and residential aged care service.

Do not lodge the ACER until cessation date from permanent residential aged care is known. Once known, and if a Home Care Agreement is in place, make the entry date for home care for the day after departure from residential aged care.

If there is a lag in agreeing a cessation date from residential aged care, and the package assignment letter from My Aged Care is withdrawn in the interim, either

1) the care recipient can call My Aged Care and ask to be placed back on the National Priority System – a new package will be assigned within a short period of time – entry can then be lodged from date of package assignment; or

2) where the care recipient requires the package assignment referral code to be urgently reassigned for continuity of care, call My Aged Care and ask them to make an escalation to the Department for delegate approval of package reassignment.

16.4.4 Care recipient believed they were in residential respite but were entered for permanent residential care

Where a care recipient believes they are in residential respite, and a residential aged care service submits an entry into the aged care portal or to Services Australia for permanent residential care or backdates a permanent care entry to override the period the care recipient was in residential respite, home care providers should contact the residential aged care service (if known) and ask them to change the entry.

Where the matter is still unresolved, providers should encourage the care recipient to make a complaint to the Aged Care Quality and Safety Commission for exposing the care recipient to loss of

unspent funds and or making the care recipient liable to pay the home care provider private fees if care and services continued (i.e. the package was not suspended due to the need to support the care recipient to return to the community e.g. home modifications, light gardening; podiatry; speech pathology) for the period while the care recipient was thought to be in residential respite.

16.4.5 Care recipient knowingly enters permanent residential care while receiving a HCP

Where a care recipient knowingly entered permanent residential aged care, but did not alert their home care provider, depending on the terms of the Home Care Agreement, they may be liable to pay privately for any HCP care and services provided while they were in permanent residential aged care.

Providers must warn care recipients that entry to permanent residential care will result in the immediate termination of their package. In addition, entry to permanent residential care will potentially result in the loss of their Commonwealth unspent funds and, where relevant, a refund of their care recipient portion of unspent funds, **if** they do not return to the package within 56 days. Where a care recipient has been in residential care for more than 56 days, and the care recipient intends to return to the community. Care recipients must notify My Aged Care several weeks in advance of their return to facilitate re-assignment of their package.

Any HCP care and services provided to a care recipient who has withdrawn from the Program cannot be funded through the HCP.

16.4.6 Resolution options for overlapping home care and residential care service claims

For retrospective overlapping claims, Services Australia will contact both the residential aged care service and HCP providers and may ask for copies of Home Care Agreements and resident agreements to consider which claim to pay. Services Australia may offer you alternative options to seek recompense. It is suggested you follow this advice.

If a HCP provider is unhappy with the outcome, contact your state/territory office to discuss other options for resolution. When contacting the state office, providers will need to provide copies of Home Care Agreements, care plans, individualised budgets, monthly statements, record of communication with care recipient and/or nominee, and record of communication with residential aged care service (if any) when making their case.

In extenuating circumstances where a care recipient has been in permanent residential care for less than 70 days and they exit residential care and return to the community, and where the residential care service is unable to retrospectively change the entry and an open complaint exists with the Aged Care Quality and Safety Commission, the delegate to the Secretary of the Department of Health and Aged Care may agree to prospectively reinstate the HCP and the home care account balance of the affected care recipient should there be evidence, substantiated by the Aged Care Quality and Safety Commission, that

a) choice and control was not provided to them by the residential aged care service because the residential aged care service did not have the respite allocation to admit them for residential respite; or

b) where an acute health event led to an emergency admission and the care recipient and their family were not in a position to exercise choice and control.

16.4.7 Transition Care

Transition care provides time-limited, goal-oriented and therapy-focused packages of services to older Australians after a hospital stay. Transition care aims to optimise the functioning and independence of older Australians after their hospital episode, and where possible, delay a person's entry into residential aged care.

People receiving HCP Program services are able to access transition care after a hospital stay if they are assessed and approved as eligible by an ACAT and take appropriate leave from their package. Information on leave can be found at Section 11. It is the responsibility of the care recipient to notify their HCP provider of their intention to take leave and enter transition care. It is expected, however, that the care recipient's home care provider discuss the provision of care with the relevant transition care provider to coordinate care provision and ensure that the care recipient's care needs are met.

People receiving Transition Care cannot commence receiving HCP Program services until after they have completed their Transition Care episode. Therefore, it is strongly recommended that HCP providers check for active transition care episodes and discuss this criterion with potential home care recipients to ensure that they are aware that their transition care episode will cease if they enter into a HCP agreement. It is expected that any transition from transition care to HCP will be discussed with the TCP provider before commencement of the home care package, and coordinated between the providers to ensure the care recipients' continuing care needs are met.

This program is jointly funded by the Commonwealth and State or Territory governments. Further information, including in relation to the interface between transition care and the HCP Program, is available in the Transition Care Programme Guidelines.

16.4 Short-Term Restorative Care

Short Term Restorative Care (STRC) provides a time-limited, goal-oriented, multi-disciplinary and co-ordinated package of services. STRC aims to reverse and/or slow 'functional decline' in older Australians and improve their wellbeing.

A care recipient cannot receive STRC if they are also receiving a package. Therefore, it is strongly recommended that providers check for active STRC episodes and discuss this criterion with potential HCP care recipients to ensure they are aware their STRC episode will immediately cease if they enter into a HCP agreement. It is expected that any transition from STRC to HCP will be discussed with the STRC provider before commencement of the home care package, and coordinated between the providers to ensure the care recipients' continuing care needs are met.

Care recipients may choose to end their STRC even if they have not yet met their physical and cognitive goals in order to enter the HCP Program. In this circumstance, the home care provider should ensure the care plan incorporates strategies to assist the care recipient to achieve these physical and cognitive goals.

16.4.8 Aged Care Volunteer Visitors Scheme

The Aged Care Volunteer Visitors Scheme (ACVVS) supports volunteers to make regular visits to older Australians who are socially isolated or are at risk of social isolation or loneliness. ACVVS provides friendship and companionship by matching individuals with volunteer visitors.

The ACVVS is available to recipients of Australian Government subsidised residential aged care services or home care.

Further information about the ACVVS, including frequently asked questions, can be found at this link, or by searching "Aged Care Volunteer Visitors Scheme" at www.health.gov.au.

Any eligible care recipient whose quality of life could be improved by the companionship of a regular community visitor can be referred to the ACVVS.

As part of the Lesbian Gay Bisexual Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy, the ACVVS was expanded to include services that specifically cater for the needs of LGBTI people.

Home care recipients who are socially isolated and whose quality of life would be improved by friendship and companionship may access the ACVVS program without any impact on services received through their package.

16.4.9 Continence Aids Payment Scheme

HCP Program care recipients can receive funding support under the CAPS so long as the HCP does not include continence aids as part of their care plan. This is consistent with the eligibility requirements noted in the CAPS application form and guidelines.

The Continence Aids Payment Scheme (CAPS) is an Australian Government scheme that provides a payment to eligible people to assist with some of the costs of their continence products. Continence Aids Payment Scheme (CAPS) | Continence Foundation of Australia

Under a Home Care Package, the amount of care will vary from person to person, depending on factors such as the type of care and services being offered to the person, how and when those services are delivered, and whether some of the available budget is being used for specific items such as aids and equipment.

The care and services provided must be identified in the care plan, and must fit within the available budget for the package level. Continence is listed as an included item as per the Home Care Packages Provider Manual (refer to link below).

www.health.gov.au/resources/publications/home-care-packages-program-operational-manual-a-guide-for-home-care-providers

Alternatively, HCP Program care recipients are eligible to access the Continence Aids Payment Scheme, through Services Australia, as long as their care plan does not already include continence support.

A major resource of help for carers is the National Continence Helpline. The National Continence Helpline is staffed by professional continence nurse advisors who provide prompt and confidential advice and referral for people with incontinence, their families and carers, as well as health professionals and organisations with an interest in continence management. The Helpline can arrange for resources and publications and provide advice regarding continence products and suppliers.

The National Continence Helpline operates from 8am to 8pm, Monday to Friday on 1800 33 00 66.

If people feel that their circumstances have changed or they need more support, call My Aged Care to discuss if a review of their needs is appropriate to determine if more care and services are required. Please note that it is up to the independent ACAT to firstly accept the referral for a review, and if accepted, determine whether a change of priority or level or both (as applicable) is required.

16.4.10 DVA Programs

Older veterans or a war widow/widower may be able to get aged care services from the DVA and the Department at the same time, as long as the same services are not accessed for both.

For example, a care recipient may access low-level domestic assistance and personal care through the Veterans' Home Care Program, and receive social assistance and respite through the home care package.

16.4.11 Residential Respite Care

People receiving HCP Program services are able to access residential respite if they are assessed and approved as eligible by an ACAT. Respite is standard practice to give carers a break, and needs to be

accounted for in care planning with care recipients. This is discussed further at Section 10 of this manual.

Care recipients can receive respite at the same time as a package, provided that they are not receiving the same services from both. For example, they may have a period of residential respite care but choose not to take leave from their package if they need gardening or other services about the home to keep it safe and secure. Leave is discussed at Section 11.

16.4.12 Palliative Care

Palliative care and HCP Program

Across the aged care and palliative care sectors, there is an expectation for home care workers to use a palliative approach to care.

The Palliative Approach

The palliative approach to care reflects a positive and open attitude towards dying and death, although it is important to note that 'palliative care' is not confined to the end stages of illness.

The use of a palliative approach to care by home care providers is reinforced in Standards 2 and 4 of the Aged Care Standards. Standard 2 details the need for service providers to undertake assessment and planning to address current needs. The use of the palliative approach by aged care workers enables assessment and planning of the palliative care needs of care recipients with life limiting illness (e.g. dementia, heart disease, cancer) as well as end-of-life planning. The assessment and planning done by the home care provider will identify and address the care recipient's current needs, goals and preferences, including advance care planning and end of life planning.

Standard 4 Services and supports for daily living connects very well to the services and supports included in the Home Care Package Program listed in Section 9.2 Home Care Manual.

It should be noted that many care recipients will be well managed by aged care workers and primary care providers such as General Practitioner and allied health providers and will not require specialist palliative care services (SPC). When a care recipient has complex or complicated symptoms which cannot be managed by aged care workers using a palliative approach, a referral to a specialist palliative care service is appropriate.

The skill mix and scope of practice of specialist palliative care team members is highly specialised and outside of the skill mix of the palliative approach provided by Home Care Providers. Overall, specialist palliative care services offer a consultancy service where the SPC Team member will review/assess the care recipient, liaise with primary care providers and HC provider and develop a palliative care plan for the care recipient. The responsibility for everyday care such as personal care, ongoing generalist nursing, support services, care management and clinical care remains with the HCP Provider. There is no duplication of services across Nursing with the involvement of SPC services as the services they provide are outside of the expectations of the palliative approach to care of home care providers.

Specialist palliative care services

While the Australian Government provides a national leadership, education and policy role in palliative care, it provides funding to state and territory governments for the delivery of specialist care services in their jurisdictions. This arrangement enables each state and territory government to make decisions about the provision and delivery of specialist palliative care services in their health systems, to meet the needs of their community. This forms part of their responsibilities through hospital and community service provision. Information on specialist palliative care service providers can be found here: Find a palliative care service provider | Australian Government Department of Health and Aged Care

Resources for aged care workers

The Australian Government provides funding for education, experiential learning and resources in the Palliative Approach to Care. The ***Program of Experience in the Palliative Approach – PEPA***, pepaeducation.com is available to all aged care workers. The experiential and learning resources cover all levels of aged care workers (personal care workers, enrolled nurses, endorsed enrolled nurses and registered nurses). Aged care workers are expected to utilise a palliative approach to care when caring for older Australians across the three tiers of support for aged care. In 2020, PEPA released Learning guides for Care Workers as a learning resource on adopting a palliative approach to care. Learning & Placement Guides - PEPA (pepaeducation.com). An aged care worker who has a working knowledge of the palliative approach to care will be able to assess and plan for the palliative care and end-of-life needs of care recipients.

The ***End of Life Directions for Aged Care (ELDAC) Project***, End of Life Directions for Aged Care - ELDAC aims to improve the palliative care skills and advance care planning expertise of aged care providers and GPs providing health care for recipients of aged care services. ELDAC provides a range of resources to support aged care workers to deliver quality palliative care including toolkits, services to improve connections between aged, primary and specialist palliative care services and palliative care navigation services.

Also available to the aged care sector is **palliAGED**, a resource that provides palliative care evidence and practice information for those providing care and also for older Australians, their families and friends. PalliAGED is managed through the Flinders University CareSearch project. More information about palliAGED can be found here: palliAGED Home.

A comprehensive list of the palliative care funded programs and initiatives can be found here:

Palliative care initiatives and programs | Australian Government Department of Health and Aged Care

Guidelines for spiritual care in aged care can be found here:

National-Guidelines-for-Spiritual-Care-in-Aged-Care-DIGITAL.pdf (meaningfulageing.org.au)

16.4.13 National Dementia Support Program

The National Dementia Support Program (NDSP) provides education, resources, and counselling and support to people living with dementia and their families and carers to improve awareness and understanding about the disease.

The NDSP offers a website and national helpline, where professional counselling or group and individual support sessions can be scheduled. These resources can help care recipients, including people living with dementia and their families and carers, with support strategies to cope with dementia, and provide advice on what to expect once a diagnosis of dementia is received. The NDSP also offers education and training to family members and carers of people living with dementia to help them remain in their own homes for longer, where appropriate, and help ensure they are aware of the requirements of people living with dementia.

People living with dementia, their families and carers and health professionals can contact the National Dementia Helpline on **1800 100 500** (free call). People can also go to www.dementia.org.au to discuss any concerns or access information about memory loss or dementia.

16.4.14 National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) funds reasonable and necessary supports that are not provided from other formal and informal sources. Care recipients cannot receive the same care and services through NDIS support and the HCP Program at the same time. Providers can find more information on the NDIS at this link, or by searching "Provider toolkit" at www.nds.org.au.

The webpage at this link provides information that may be useful for providers who deliver home care to younger people who may also be eligible for the NDIS. You can also find the webpage by searching "providing aged care services to younger people" at www.health.gov.au.

16.4.15 Disability Support for Older Australians

DSOA provides support to older people with disability who are receiving state-administered specialist disability services at the time of implementation of the CoS Programme but are ineligible for the NDIS.

People receiving DSOA funding are eligible for aged care services, however, if they chose to accept a HCP or enter residential aged care they are required to exit the DSOA Program.

Section 6.3 of the DSOA program manual covers Aged care assessments:

- A DSOA client can initiate an ACAT to access supports not available under the DSOA Program (CHSP services such as social support, transport, home maintenance etc); or
- A DSOA client feels their needs can be met through either a HCP or residential aged care and accept that accessing these services will mean exiting the DSOA Program.

The DSOA service provider needs to make clear to aged care assessors if:
a) the client is being referred to access supports not available under the DSOA Program; or

b) the referral is because the client is expressing an interest in accessing aged care supports instead of the DSOA Program.

✓ Key points to remember

- Generally, care recipients cannot receive CHSP and HCP Program services at the same time. In limited circumstances they may be able to receive small amounts of top up CHSP at the same time as they receive HCP Program services.
- Care recipients can receive support from some other programs where needed. Some of these programs are listed at **Section 16.4**.
- The HCP Program cannot be received at the same time as STRC, transition care, or permanent residential aged care.

Appendix A: Pre-1 July 2014 arrangements

On 1 July 2014, the way home care fees are calculated changed. For people that received a package before 1 July 2014, these changes do not apply and they may continue to be asked to pay their current home care fees.

This manual has outlined the way the HCP Program currently operates, under the post-1 July 2014 arrangements. Care recipients who were in the program before 1 July 2014, however, are entitled to continue to receive home care on the basis of the pre-1 July 2014 arrangements.

If a person was receiving a package on or before 30 June 2014 and they move to a new home care service (and do not spend more than 28 days outside of care, other than on approved leave), they can opt into the fee arrangements that started on 1 July 2014.

To make this choice, they will need to complete and sign the **"Continuing Care Recipient opting into the New Aged Care Arrangements from 1 July 2014 (AC022)"** form and submit this form to the new provider before they transfer to the new service. Form AC022 is at this link or by searching "AC022" at www.servicesaustralia.gov.au. The new provider must submit this form with the ACER to Services Australia through the Services Australia Provider Portal. The new provider also needs to give the care recipient the *New Arrangements for Aged Care from 1 July 2014 – Home Care* publication available at this link or by searching for the form at www.health.gov.au.

If the care recipient does not complete this form and have it submitted to Services Australia before they transfer providers, they will automatically be classed as a 'continuing care recipient' and will remain on their pre-1 July 2014 fee arrangements. This is not a reviewable decision and must be done correctly in order to opt into the post-1 July 2014 fee arrangements.

This section outlines how the package budget and leave work for pre-1 July 2014 care recipients, and provides a checklist of components that must be included in a Home Care Agreement with a pre-1 July 2014 care recipient. Unless indicated in this appendix, the HCP Program operates in the same manner for people receiving a home care package, regardless of when they entered the HCP Program.

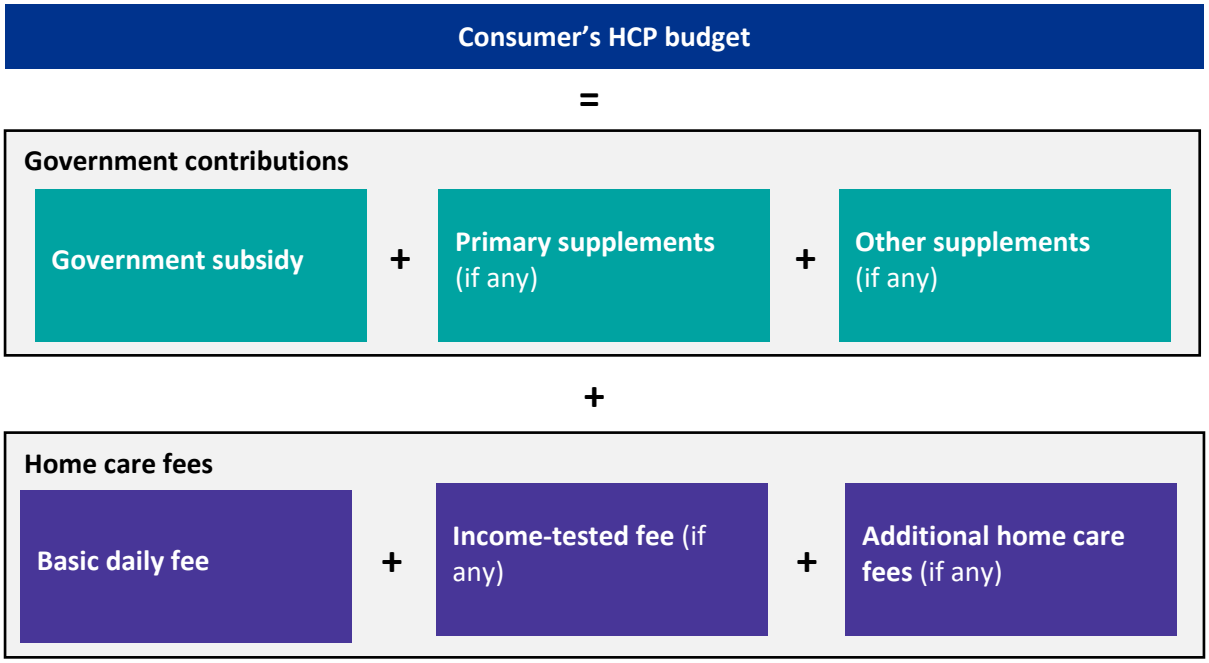
Key legislation, instruments and determinations that give rise to responsibilities for providers related to this section
Note, this summary is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Section 56-2 of the *Aged Care Act 1997*
- Sections 60-1 and 60-2 of the *Aged Care (Transitional Provisions) Act 1997*
- *Aged Care (Transitional Provisions) Principles 2014*
- *User Rights Principles 2014.*

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with the obligations pursuant to them.

See **Appendix E** for further detail on specific provider responsibilities.

What makes up the package budget for care recipients in the pre-1 July 2014 arrangements?



How do I work out the Government contribution for pre-1 July 2014 care recipients?

The Government contribution can be determined by adding together the Government subsidy, plus any primary and other supplements for which the care recipient is eligible. This is outlined in the diagram at Section 0 of this Appendix.

In home care, prior to 1 July 2014, there was no reduction in subsidy and primary supplements paid by Government if the provider did not charge the income tested fee. If collected, any fee would be additional to the value of the package. In setting these fees, providers need to consider if they would cause the care recipient financial hardship and reduce the level of fees as necessary.

The same subsidy and supplement rates will apply for people receiving a home care package, regardless of when they entered the HCP Program.

Pre-1 August 2013 care recipients who were receiving an Extended Aged Care at Home – Dementia (EACH-D) package are eligible for the dementia and cognition supplement plus the top up supplement. This supplement is automatically applied by Services Australia, and will automatically transfer to the new provider if the individual changes providers.

How do I work out the home care fees for pre-1 July 2014 care recipients?

Providers are responsible for working out the home care fees that they will charge to care recipients in the pre-1 July 2014 arrangements. The Services Australia income assessment that people who entered the HCP Program after 1 July 2014 complete does not consider the pre-1 July 2014 fee structure.

Basic daily fee

- Level 1 - the maximum fee 15.68 per cent of the basic rate of the single age pension.
- Level 2 - the maximum fee 16.58 per cent of the basic rate of the single age pension.
- Level 3 - the maximum fee 17.05 per cent of the basic rate of the single age pension.
- Level 4 - the maximum fee 17.50 per cent of the basic rate of the single age pension.

Income tested fee

For care recipients with income above the basic rate of pension, providers can charge an additional amount of up to 50 per cent of income above the single Age Pension.

Calculating income

Income is defined as income after income tax and the Medicare levy. When calculating income for the purpose of determining ongoing fees, the following are excluded:

- any Pharmaceutical Allowance, Rent Assistance or Telephone Allowance;
- the Pension Supplement;
- the Clean Energy Supplement; and
- in the case of a Disability Pension payable under the *Veterans' Entitlements Act 1986* an amount equal to four per cent of the amount of the pension.

Please see Division 60 of the *Aged Care (Transitional Provisions) Act 1997* or section 130 of the *Aged Care (Transitional Provisions) Principles 2014* for more information.

Financial hardship

Home care recipients who began a home care package before 1 July 2014 are not eligible for the hardship supplement. Rather, these home care recipients are able to negotiate lower fees with their provider. The Aged Care (Transitional Provisions) Act 1997 allow providers to consider care recipients' other expenses such as high pharmaceutical bills, utilities and other living expenses when setting fees.

Review of fees

A review of fees should be conducted periodically (or whenever the care recipient requests a review). The care recipient should be encouraged to seek a review if their financial circumstances change.

The maximum fees may need to be varied when new rates for the Age Pension are announced each March and September. Providers may need to discuss the impact of these changes on fees with the care recipient and update their budget accordingly.

How does leave work for a care recipient in the pre-1 July 2014 arrangements?

Care recipients in the pre-1 July 2014 arrangements are entitled to take leave in the same circumstances as care recipients in the post-1 July 2014 arrangements, although the home care fees that will be payable differ. The table below outlines when home care fees will be payable:

Leave type	Home care fees
Hospital	Yes
Transition care	No
Residential respite care	No
Other leave	Yes

What do I need to include in a Home Care Agreement for a care recipient in the pre-1 July 2014 arrangements?

In addition to the components of a Home Care Agreement outlined at **Section 6.5** of this manual, a pre-1 July 2014 care recipient's Home Care Agreement will need to include the following:

- ☐ A statement that the provider may charge the care recipient home care fees in accordance with Division 6 of the *Aged Care (Transitional Provisions) Act 1997*

- A statement setting out which fee (if any), as determined in accordance with section 130 of the *Aged Care (Transitional Provisions) Principles 2014*, the provider will charge
- If the provider is charging the care recipient a daily amount of home care fees in accordance with Division 60 of the *Aged Care (Transitional Provisions) Act 1997* that is different from the daily amount of home care fees mentioned in their Schedule, the different amount and the reason for the different amount.

✓ Key points to remember

- Care recipients who entered the HCP Program before 1 July 2014, and who have not moved to the post-1 July 2014 arrangements, have different home care fee arrangements.
- Providers are responsible for calculating home care fees for pre-1 July 2014 care recipients.
- Providers will also need to ensure any Home Care Agreement entered into with a pre-1 July 2014 care recipient reflects the provisions that apply to them.

Appendix B: 1 July 2019 changes to pricing

Pricing requirements were introduced on 1 July 2019 to improve transparency for older Australians. These requirements enable direct comparisons between home care providers, and are intended to curb problematic charging practices by some providers.

Key legislation, instruments and determinations underpinning this section
Note, this section is not an exhaustive statement of all relevant laws. Providers will need to review the legislation, instruments and determinations to ensure their compliance.

- Section 56-2 of the *Aged Care Act 1997*
- *User Rights Principles 2014*.

The Aged Care Quality Standards are relevant throughout this manual as a whole. Providers should familiarise themselves with their obligations pursuant to them.

See **Appendix E** for further detail on specific provider responsibilities.

What is the pricing Schedule and what do providers need to do with it?

All home care providers are required to publish their pricing information in a new standardised pricing comparability Schedule (the Schedule) on the My Aged Care Service Finder. The Schedule has been designed to:

- encourage older Australians to consider other factors in addition to the price of the service when choosing an approved provider
- provide clear and unambiguous pricing information on the common home care package services
- achieve price comparability across common home care package services
- limit any impact on the ability of providers to innovate by catering for different business models
- ensure equity in the requirements across providers and allowing dedicated areas to promote their value statement and point of difference.

The Schedule includes five common home care services:

- personal care
- nursing
- cleaning and household tasks
- light gardening
- in-home respite.

Providers will also be able to indicate if they charge a per kilometre cost for a care worker to travel to the care recipient's location.

Providers will need to explain their approach to any separate cost, for example, if it is charged separately or included in the service price.

Providers should explain their approach to charging for third-party services.

Within the Schedule, providers will need to nominate a single price (the most common) for each common home care service within the Schedule. Where providers offer genuine care recipient choice of different prices for a service, they will also be able to enter the minimum and maximum price points.

Providers will be able to complete a different pricing Schedule where required, for example to account for regional variability in pricing.

Providers must review, and if required, update their pricing Schedule on My Aged Care annually. This will ensure accurate pricing information is published. Current pricing information must also be included within each individual Home Care Agreement. As discussed at Section 15 providers are required to complete one of the following, to show that they have reviewed their Schedule:

- Report to the Department that they have done so. Providers can do this by entering 'Confirm review of pricing information' in the My Aged Care Provider Portal.
- Update their price list. This will cause the 'last updated date' to update in the Department's systems, and will be sufficient evidence that the provider has reviewed their price list.

Relationship between published and contracted price

The price published in the Schedule will be the default price charged.

A copy of the Schedule must be included within a care recipient's Home Care Agreement. This ensures the published price is a meaningful and accurate indication of the costs charged under a home care package.

There are situations where the contracted price will need to differ from the published price. For example, where the care recipient has a particular request. In these instances, the home care provider will need to negotiate and agree a price with their care recipient. This difference in price and accompanying reason will need to be clearly outlined within the Home Care Agreement and package budget. It is expected this would be an exception. In most instances, the price published will be the price charged.

Obligations through transition

For care recipients already in the program at 1 July 2019, providers have until 1 July 2020 to:

- review their Home Care Agreement and include a copy of the pricing schedule
- charge them the prices in that schedule, unless otherwise agreed — any different prices and the reason must be included in their Home Care Agreement
- roll any separate business-related administration costs they are retaining into service prices
- make sure any administration costs are reasonable.

Compliance

These pricing changes apply to all home care providers. This is to ensure consistency across the sector and allow all older Australians to benefit.

Providers' compliance with these requirements is actively monitored. Compliance action may be taken, consistent with the compliance policy and procedures, as discussed throughout this manual.

How do the pricing changes affect care management?

Care management, often called case management or care coordination, is a mandatory component of every home care package. The introduction of the Schedule provides an opportunity to better define care management, and educate older Australians.

Providers need to indicate the cost for care management services and outline their approach to care management in the Schedule.

Care management should ensure there is no overlap, over-servicing or mismanagement of services. These services may be provided in different ways including face-to-face or via phone or email.

How do the pricing changes affect the way administration costs can be charged?

There are different components to administration costs; package management costs, and other administration costs. Providers are able to include their fortnightly package management costs across each home care package level in the Schedule.

Package management is the ongoing organisational activities associated with ensuring the smooth delivery and management of a home care package. It may include the costs for preparing monthly statements; managing package funds; and compliance and quality assurance activities required for home care.

It does not include costs that are unrelated to supporting a care recipient's care or costs associated with running any business, such as marketing, office rent, insurance, or activities completed before a person enters into a Home Care Agreement.

Any other administrative costs that need to be recouped from a home care package, apart from package management, will need to be included in the unit price for specific care services. This will ensure people can see the all-inclusive cost of delivering the service. Providers cannot charge more than a reasonable amount for any administration-related costs.

For more information on the 1 July 2019 changes to pricing please see this link or search "Pricing for Home Care Packages" at www.health.gov.au.

Appendix C: 1 January 2023 changes to pricing

The Australian Government is reducing excessive administration and management charges in the HCP Program. This ensures that more funds are available to meet the needs of care recipients. A number of changes came into effect on 1 January 2023.

Charging for care and package management

Providers must not charge more than the amount specified in the User Rights Principles 2014 for care and package management per day. The table below shows maximum daily prices for care management and package management. These will increase in line with basic subsidy increases.

Item	HCP Level 1:	Care management	Package management
1	Level 1	$5.03	$3.77
2	Level 2	$8.85	$6.64
3	Level 3	$19.25	$14.44
4	Level 4	$29.19	$21.89

The caps set the maximum amount a provider can charge. They are not the target price for these services or an indicator of what is considered a 'reasonable' price.

Providers can continue to charge for care and package management at a fortnightly or monthly rate and do not have to pro rata the price if the care recipient ceases their home care part way through a period.

Providers cannot charge for package management in a calendar month where no services (other than care management) are delivered, except for the first month of care.

Additionally, to support providers in setting their prices, the Government is clarifying that care management is a mandatory support service.

Charging for third-party services and exit amounts

Providers cannot charge separately for third-party services (prices must be all-inclusive).

Providers cannot charge exit amounts.

Pricing for all services

Prices for all care and services must be reasonable and justifiable. This means they must be value for money and consider the effort and resources it takes to coordinate them.

The Government will closely monitor provider behaviour following implementation of this measure, including identifying any providers:

- appearing to be systematically raising prices to meet the caps
- unreasonably shifting costs to other billing areas.

For further information on how providers set, publish and charge for care and services see: Pricing for Home Care Packages or go to www.health.gov.au and search "Pricing for Home Care Packages".

Appendix D: Compensation payments

If a person receives a compensation entitlement under a judgment, a settlement, or a reimbursement arrangement, their home care package budget is amended slightly to account for this. A compensation entitlement includes things like a permanent impairment or incapacity payment to a veteran, a workplace insurance claim settlement, a motor vehicle accident claim settlement, or some types of common law settlements (such as, potentially, an award for personal injury caused by negligence).

The provider is responsible for asking the care recipient if they have a compensation entitlement and, if so, notifying the Department of that entitlement. Providers can notify the Department when they complete the form to notify a new care recipient starting in their care, discussed at Section 6, or at any other time by completing an ACER. An ACER can be completed using paper **"Aged care entry record form AC021"** at this link or by searching "AC021" at www.servicesaustralia.gov.au.

If a claim has not been settled, subsidies will continue to be paid on the care recipient's behalf up until the date liability has been accepted. Once the compensation insurer has agreed to pay or to contribute to the care costs, payment of subsidies will cease with the date of effect from the date of liability or settlement. Providers should notify the Department as soon as they become aware of a care recipient's compensations claims.

If a provider does not advise the Department that a care recipient is entitled to compensation and the Department later becomes aware of this, the Department will need to recover funds in arrears.

Package budget with compensation entitlement

If a provider has entered into a Home Care Agreement with a care recipient who has a compensation entitlement, and they have notified the Department, the Department will advise both parties of the amount of the compensation reduction amount. The provider will then be able to invoice the care recipient for the total amount of the compensation payment reduction and home care fees (if applicable). The amount is deducted from the Government's contribution and added to the care recipient's contribution.

Below is an example of a budget, including a compensation entitlement:

How do we calculate Sonali's package budget?

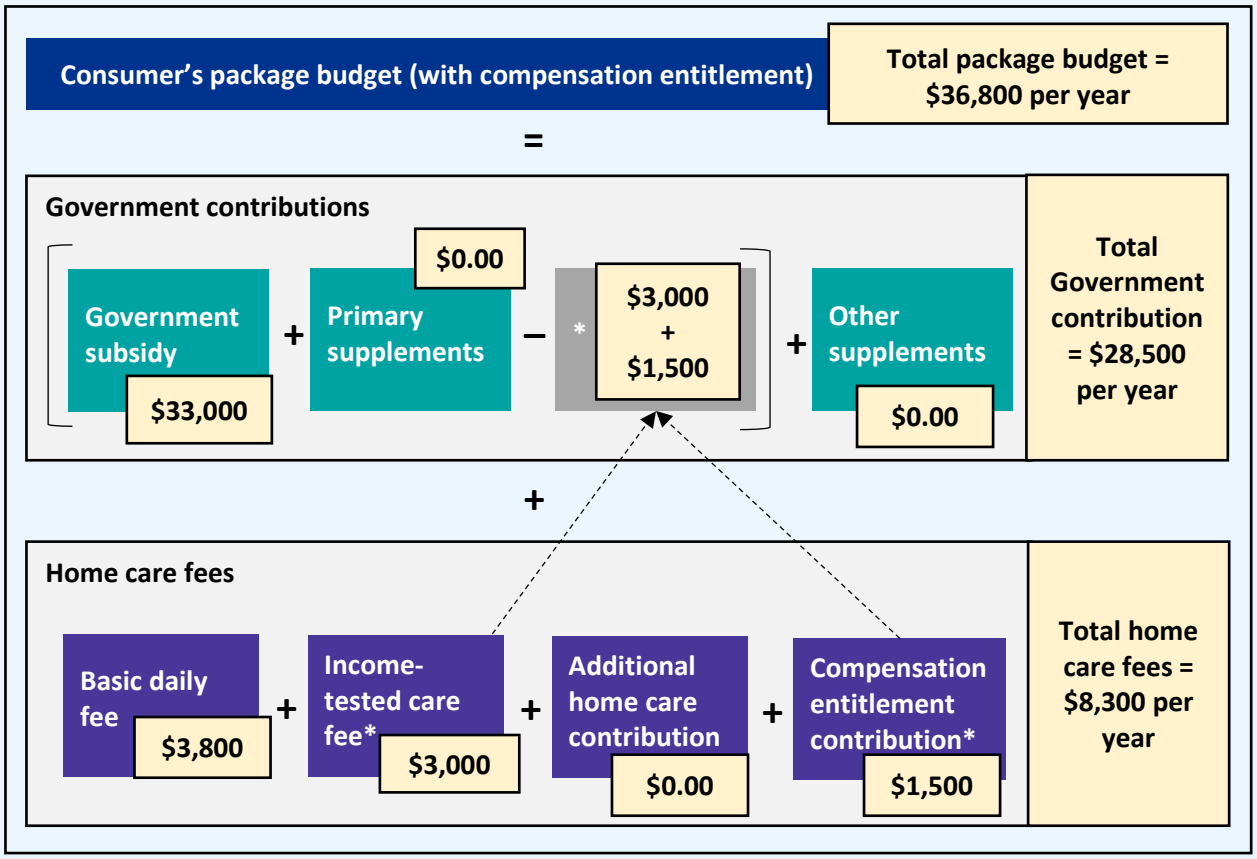
Fact scenario

- Sonali has been assigned a Level 3 package. The value of her package is approximately $33,000 per year.
- Sonali is not eligible for any primary or other supplements.
- The basic daily fee for Sonali's package level is $3,800 per year.
- Sonali has completed her income assessment, and has been assessed by Services Australia as being able to pay an additional $3,000 per year in income tested care fees.
- Sonali received a workplace injury settlement. Her provider notified Services Australia of the value of the settlement, and Sonali was told she would need to contribute an additional $1,500 per year in compensable entitlement contributions.
- Sonali did not agree to pay any additional fees in her Home Care Agreement.

How do we calculate Sonali's package budget?

Calculation of package budget

The diagram below outlines how Sonali's home care budget is calculated:



Appendix E: Responsibilities of approved providers

Approved providers must deliver aged care that aligns with the responsibilities and standards that are specified in the *Aged Care Act 1997* (the Act) and associated legislation. This information is designed to assist approved providers to meet their obligations as providers of aged care.

Quality of care – Part 4.1 in the *Aged Care Act 1997*

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Quality of care	Approved providers must comply with the Aged Care Quality Standards.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 3
Quality of care	Providers must maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 4
Care and services	An approved provider of a home care service must provide a package of care and services that includes: (a) care management; and (b) at least one other service that is specified in Part 1 of Schedule 3 of the Quality of Care Principles (or is agreed per subsection 13(2) of the Quality of Principles 2014). Extracted at section 9.2 of this manual.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 9
Care and services	Part 2 of Schedule 3 of the Quality of Care Principles specify excluded items that must not be included in the package of care and services provided under section 13 of the Quality of Care Principles. Extracted at section 9.3 of this manual.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 9
Care and services	Care and services provided to the care recipient must be consistent with the care recipient's care plan.	Section 54-1 of the *Aged Care Act 1997*	*Quality of Care Principles 2014*	Section 7

Rights of care recipients – Part 4.2 in the *Aged Care Act 1997*

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Budgets, fees and pricing	An approved provider of home care must not charge for the care recipient's entry to the service through which the care is, or is to be, provided.	Section 56-2(a) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 6
Budgets, fees and pricing	If the care recipient is a post-1 July 2014 care recipient, providers must not charge more than the maximum daily amount. The maximum daily amount depends on the care recipient and will need to be worked out using the home care fee calculator. The home care fee calculator is at section 52D-2 of the *Aged Care Act 1997.*	Sections 52D-1, 52D-2 and 56-2(b) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Budgets, fees and pricing	If a care recipient who is a post-1 July 2014 care recipient leaves the HCP Program, any fees paid in advance in respect of a period occurring after the care recipient's death, or the cessation of home care, must be refunded to the care recipient.	Sections 52D-1 and 56-2(b) of the *Aged Care Act 1997*	*Fees and Payments Principles 2014 (No.2)* *User Rights Principles 2014*	Section 14
Budgets, fees and pricing	If the care recipient is a pre-1 July 2014 care recipient, providers must charge no more for provision of the care and services then the amount permitted by the *Aged Care (Transitional Provisions) Principles.* This is outlined in Appendix A Section 3 of this manual.	Section 56-2(c) of the *Aged Care Act 1997* Sections 60-1(a) and 60-2 of the *Aged Care (Transitional Provisions) Act 1997*	*Aged Care (Transitional Provisions) Principles 2014* *User Rights Principles 2014*	Appendix A
Budgets, fees and pricing	Care recipients must not be required to pay home care fees more than one month in advance.	Section 52D-1 of the *Aged Care Act 1997* Section 60-1(b) of the *Aged Care (Transitional*	*User Rights Principles 2014*	Appendix A

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
		Provisions) Act 1997		
Budgets, fees and pricing	Providers must not charge home care fees for any period prior to the time the care recipient was being provided with home care.	Sections 56-2(b), 56-2(c) and 52D-1 of the *Aged Care Act 1997* Section 60-1(c) of the *Aged Care (Transitional Provisions) Act 1997*	*User Rights Principles 2014*	Appendix A
Fees and payments	If a care recipient who is a pre-1 July 2014 care recipient leaves the HCP Program, any fees paid in advance in respect of a period occurring after the care recipient's death, or the cessation of home care, must be refunded as soon as practicable to the care recipient or a person authorised to receive the refund for the care recipient's estate.	Section 60-1(d) of the *Aged Care (Transitional Provisions) Act 1997*	*Aged Care (Transitional Provisions) Principles 2014*	Appendix A
Agreements with care recipients	Providers must provide such other care and services as agreed in the Home Care Agreement between the approved provider and the care recipient.	Section 56-2(e) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Fees and payments	Providers must charge no more for any other care or services than an amount agreed beforehand with the care recipient.	Section 56-2(d) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Budgets, fees and pricing	Providers must give the care recipient an itemised account of any other care or services.	Section 56-2(d) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Stability of approved provider	Providers must provide security of tenure to care recipients. The approved provider may cease to provide home care to the care recipient only if:	Section 56-2(f) and 63-1AA of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	• the care recipient cannot be cared for in the community with the resources available to the approved provider; or • the care recipient notifies the approved provider, in writing, that they wish to move to a location where home care is not provided by the provider; or • the care recipient notifies the approved provider, in writing, that they no longer wishes to receive the home care; or • the care recipient's condition changes to the extent that the care recipient no longer needs home care, or the care recipient's needs, as assessed by an aged care assessment team, can be more appropriately met by other types of services or care; or • the care recipient: has not paid to the approved provider, for a reason within the care recipient's control, any home care fee specified in the home care agreement between the care recipient and the approved provider; and has not negotiated an alternative arrangement with the approved provider for payment of the home care fee; or • the care recipient has: intentionally caused serious injury to or infringed the right of a staff member (to work in a safe environment) of the approved provider.			
Agreements with care recipients	Providers must offer to enter into a Home Care Agreement with the care recipient, and, if the care recipient wishes, to enter into such an agreement.	Section 56-2(g) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 6
Agreements with care recipients	The Home Care Agreement must include specified provisions. These are extracted at Section 6 of this manual.	Section 61-1 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 6

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Monitoring, compliance and other access	Providers must allow people acting for bodies that have been paid advocacy grants under Part 5.5 to have access to each home care service through which they provide home care.	Section 56-2(j) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 12
Rights of care recipients	Providers must not act in a way which is inconsistent with the legal and consumer rights of a care recipient.	Sections 54-1(1)(d) and 56-2(k) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 3 and 6
Rights of care recipients	Providers must give a prospective care recipient a copy of the Charter of Aged Care Rights ('the Charter'). The copy of the Charter that is provided must: • be signed by a staff member of the provider; • include the signature of the care recipient or their authorised person if they have signed it; • include the date on which the care recipient or their authorised person was given reasonable opportunity to sign the Charter, if they have not signed it, • set out the full name of the care recipient, • set out the full name of an authorised person who was present at the time the copy of the Charter was given to the care recipient, if relevant, and • set out the date on which the copy of the Charter was given to the care recipient. This must be done before the care recipient enters into a home care agreement with the provider the provider's home care service, or by 1 December 2019 for care recipients who were already receiving home care services from the provider on 1 July 2019.	Sections 56-2(k) and 56-2(l) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Rights of care recipients	Providers must give a prospective care recipient information about their rights and responsibilities (including in relation to the payment of home care fees), and the rights and responsibilities of their provider. This must be done before the care recipient enters into a home care agreement with the provider.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3
Rights of care recipients	Providers must assist prospective care recipients to understand information provided to them, including the Charter of Aged Care Rights.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3
Rights of care recipients	Providers must ensure that the care recipient, or an authorised person of the care recipient, has been given reasonable opportunity to sign a copy of the Charter of Aged Care Rights (after it has been provided to them).	Section 56-2of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 3
Rights of care recipients	Providers must take reasonable steps to prevent the provider, or a person employed or otherwise engaged by the provider, from causing damage to a care recipient's home and other property in the course of providing the home care.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	-
Rights of care recipients	Providers must provide such information as is reasonably necessary to assist a care recipient to choose the care and services that best meet his or her goals and assessed needs and preferences, within the limits of the resources available.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 8
Care and services	Providers must give care recipients a written plan of the care and services that they will receive before the care recipient receives home care or within 14 days of the date on which they commence receiving home care.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 8
Budgets, fees and pricing	Providers must give care recipients invoices that are clear and in a format that is understandable.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Budgets, fees and pricing	Providers must periodically review the home care fees that each care recipient is liable to pay, including if requested to do so by a care recipient on the grounds that the care recipient's financial circumstances have changed.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Budgets, fees and pricing	Providers must provide notice of their pricing Schedule to the Secretary before offering to enter into a Home Care Agreement with a care recipient.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B
Budgets, fees and pricing	Providers must review their pricing Schedule and price list at least every 12 months, and: • if there is to be a change, provide the Secretary with an updated notice, or • if there is not to be a change, provide the Secretary with a written notice that they have reviewed the information.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B
Care recipients changing providers/ leaving	If a pre-1 July 2014 care recipient intends to move to another home care service, the provider that is to provide the new service must give the care recipient written notice of the following: • If the care recipient moves to the new service within 28 days of leaving the old service, they may make a written choice to be covered by the post-1 July 2014 arrangements in relation to the new service. That choice cannot be made after they have already moved to the new service. If they do not make a choice before entering the new service they will be covered by the pre-1 July 2014 arrangements. • If the care recipient moves to the new service 28 days or more after leaving the old service, they will automatically be covered by	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix A

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	the post-1 July 2014 arrangements. • If the care recipient is covered by the post-1 July 2014 arrangements that may result in a change to their fees payable. • If the care recipient moves from the pre-1 July 2014 arrangements to the post-1 July 2014 arrangements, they cannot make a choice to return to the pre-1 July 2014 arrangements.			
Care recipients changing providers/ leaving	If a pre-1 July 2014 care recipient intends to move to another home care service, the provider that is to provide the new service must give the care recipient a copy of the document titled 'New Arrangements for Aged Care – for 1 July 2014', published by the Department, as it exists on 1 July 2014.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix A
Budgets, fees and pricing	Providers must give every care recipient to whom they provide, or are to provide, home care, a written individualised budget which sets out a budget for the care and services detailed in the care recipient's care plan. The budget must be provided as soon as practicable after the provider has all the necessary information to complete it. The budget must state the amount of home care subsidy payable to the provider for the care recipient in respect of the period agreed between the care recipient and provider, and the maximum amount of home care fees payable by the care recipient in respect of that period.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7
Budgets, fees and pricing	Providers must prepare a care recipient's individualised budget: • in partnership with the care recipient, and • considering the care recipient's goals, assessed needs, preferences, resources available,	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 7

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	and the services selected by the care recipient.			
Budgets, fees and pricing	Providers must review and, if necessary, revise the individualised budget of the care recipient if: • a change to the care and services to be provided through the home care service is proposed, or • the costs or providing the care and services change, or • the care recipient requests the provider to do so. If the care recipient requests the review, the review must be completed within 14 days of the request.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10
Budgets, fees and pricing	If the provider reviews the individualised budget they must give the care recipient a copy of the revised individualised budget and help them to understand it.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10
Budgets, fees and pricing	Providers must give all care recipients a written monthly statement of the available funds and the expenditure in respect of the home care provided to the care recipient during the month. The statement must be provided as soon as practicable after the provider has all the necessary information to complete it. The monthly statement must specify: • the amount of home care subsidy paid or payable to the provider for the care recipient in respect of the month; • the total amount of home care fees paid or payable by the care recipient in respect of the month; • the total amount paid or payable by the provider in respect of the home care provided to the care recipient during the month; • an itemised list of the care and services provided to the care recipient during the month and the total amount paid or payable	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	in relation to each kind of care or service; • the total amount (if any) of the funds received or to be received in respect of any previous month for the provision of home care to the care recipient that have not been spent; • if, during the month, the transfer portion of the care recipient's unspent home care amount was received by the approved provider—the amount that was received.			
Budgets, fees and pricing	Providers must help care recipients to understand their monthly statements.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 10
Care recipients changing providers/ leaving	Provider must give notice to care recipients or, if the care recipient has passed away, their legal personal representative, of care recipients ceasing to receive care from their service within 56 days of the cessation day. The notice must specify: • the cessation day, • the care recipient's total unspent home care amount and amounts broken into the Commonwealth portion, the care recipient portion and the transfer portion, • the exit amount deducted (if relevant/prior to January 2023), • the unpaid home care fee amount deducted (if relevant). The notice must also explain how unspent funds will be transferred.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 14
Care recipients changing providers/ leaving	Providers must pay the care recipient and transfer portion of unspent funds as specified in the User Rights Principles. The relevant tables have been extracted at Sections 13 and 14 of this manual.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 13 and 14

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Care recipients changing providers/ leaving	Providers who are making payment of a transfer amount to a care recipient's new provider must give the new provider the notice issued to the care recipient on their cessation at the time they pay the transfer portion to the new provider.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Section 13
Care recipients changing providers/ leaving	Providers must give written notice to the Secretary, in an approved form, within 70 days after a care recipient's cessation day that specifies if there is a Commonwealth portion of the care recipient's unspent home care amount, or if the Commonwealth portion of the care recipient's unspent home care amount is nil.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 13 and 14
Care recipients changing providers/ leaving	Providers must not deduct an exit amount for a care recipient leaving their care from a care recipient's unspent funds after 1 January 2023, unless the care recipient leaves before 1 January 2023 and the exit amount was agreed in the Home Care Agreement, and the provider's standard exit amount was notified to the Secretary in the pricing Schedule before that Home Care Agreement was executed.	Section 56-2(aa) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Sections 13 and 14
Budgets, fees and pricing	Providers must not charge care recipients separately for costs (however described) that are business costs or costs of providing care or services through a subcontracting arrangement.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B and Appendix C
Budgets, fees and pricing	Providers must not charge care recipients more than a reasonable amount for care or services; and travel, sub-contracting arrangements and package management.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B
Budgets, fees and pricing	Providers must not charge care recipients more than a reasonable amount for business costs and costs of providing care or services through a subcontracting arrangement.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B and Appendix C

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Budgets, fees and pricing	Providers must charge care recipients the fees and/or prices listed in their pricing Schedule (as it applies on the relevant day the service was provided) unless the Home Care Agreement specifies a different fee and/or price and the reason for the different amount.	Section 56-2 of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix B
Budgets, fees and pricing	An approved provider of home care must not charge more for a home care service than is specified in the User Rights Principles 2014.	Section 56-2(ab) of the *Aged Care Act 1997*	*User Rights Principles 2014*	Appendix C
Rights of care recipients	Provider must establish a complaints resolution mechanism for their aged care service.	Section 56-4(1) of the *Aged Care Act 1997*	-	Section 10
Rights of care recipients	Providers must use their complaints resolution mechanism to address any complaints made by or on behalf of a care recipient to whom care is provided through the service. The complaints resolution mechanism must be the complaints resolution mechanism provided for in the Home Care Agreement entered into between the provider and the care recipient.	Section 56-4(1) of the *Aged Care Act 1997*	-	Section 10
Rights of care recipients	Providers must advise a complainant of any other mechanisms that are available to address complaints, and provide such assistance as the care recipient requires to use those mechanisms.	Section 56-4(1) of the *Aged Care Act 1997*	-	Section 10
Rights of care recipients	Providers must comply with any requirement made of the provider in relation to a direction made by the Aged Care Quality and Safety Commissioner.	Section 56-4(1) of the *Aged Care Act 1997* Section 21(2) of the *Aged Care Quality and Safety Commission Act*	*Aged Care Quality and Safety Commission Rules 2018*	Section 3

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Information and record keeping	Personal information must not be used other than: • for a purpose connected with the provision of aged care to the person by the approved provider; or • for a purpose for which the personal information was given by or on behalf of the person to the approved provider.	Sections 56-2(h) and 62-1 of the *Aged Care Act 1997*	-	-
Information and record keeping	Except with the written consent of the person, personal information must not be disclosed to any other person other than: • for a purpose connected with the provision of aged care to the care recipient by the approved provider; or • for a purpose connected with the provision of aged care to the care recipient by another approved provider; or • for a purpose for which the personal information was given by or on behalf of the care recipient; or • for the purpose of complying with an obligation under the *Aged Care Act 1997*, the *Aged Care (Transitional Provisions) Act 1997* or any of the principles.	Section 56-2(h) and 62-1(b) of the *Aged Care Act 1997*	-	-
Information and record keeping	Personal information must be protected with security safeguards that it is reasonable in the circumstances to take against the loss or misuse of the information.	Section 61-1(c) of the *Aged Care Act 1997*	-	-

Accountability – Part 4.3 in the *Aged Care Act 1997*

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Record keeping	Providers must keep the following kinds of records about care recipients:	Sections 63-1(1)(a) and 87-2 of	*Records Principles 2014*	-

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	• assessments of care recipients; • individual care plans; • medical records, progress notes and other clinical records; • schedules of fees and charges; • Home Care Agreements; • accounts of care recipients; • records relating to care recipients' entry, discharge and leave arrangements, including death certificates where appropriate; • records relating to a determination that a care recipient is a care recipient with financial hardship; • in relation to a continuing home care recipient of care to whom the approved provider starts to provide home care through a home care service on or after 1 July 2014—a record of whether the care recipient made a written choice regarding whether they would be covered by the pre or post-1 July 2014 arrangements; • up-to-date records of: the name and contact details of at least one representative of each care recipient; and the name and contact details of any other representative of a care recipient; • copies of unspent funds notices; • records relating to the payment of the care recipient portion or transfer portion of care recipients' unspent home care amounts; • copies of notices of published exit amounts; • records required by the National Aged Care Mandatory Quality Indicator Program Manual to be kept.	the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	*User Rights Principles 2014*	

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Record keeping	Providers must keep all required records for care recipients for three years after the 30 June of the year in which they ceased to provide care to the care recipient.	Section 63-1(2) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	*Records Principles 2014*	-
Record keeping	Providers must keep records relating to each copy of the Charter of Aged Care Rights given a care recipient. **Note:** this requirement does not apply if the care recipient does not enter the provider's home care service.	Sections 63-1(1)(a) and 87-2 of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	*Records Principles 2014*	-
Record keeping	Providers must keep records that enable them to demonstrate that: • they have police certificates for all staff members or volunteers that are not more than three years old; • for any period where a staff member or volunteer was without a police certification, an application for a police certificate had been made, and • any statutory declaration required to be made by a staff member or volunteer has been made. Police certificates must be kept in compliance with the *Privacy Act 1988*.	Sections 63-1(1)(a) and 87-2 of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	*Records Principles 2014*	-
Record keeping	Providers must keep records (in written or electronic form) that enable claims for payments of subsidy to be properly verified. These records must be kept for	Section 63-1 of the *Aged Care Act 1997* and Part 7B of	-	-

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	three years after 30 June of the year in which the record was made.	the *Aged Care Quality and Safety Commission Act 2018*		
Record keeping	Providers must keep records (in written or electronic form) that enable proper assessments to be made of whether the approved provider had complied, or is complying, with its responsibilities. These records must be kept for three years after the 30 June of the year in which the record was made.	Section 63-1(1) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	-	-
Monitoring, compliance and other access	Providers must co-operate with any person who is exercising powers under Part 6.4 in relation to the service and comply with Part 6.4 in relation to the person's exercise of those powers. Part 6.4 of the *Aged Care Act 1997* makes provisions for authorised officers to exercise monitoring and questioning powers. The following obligations arise in relation to exercise of those powers: • a person at any premises entered into under a warrant must provide reasonable assistance to an authorised officer; • a person whom the Secretary has requested to give evidence pursuant to section 93-1 must attend at a time and place specified in the notice, take any oath or affirmation requirement, and answer any questions put by an officer or produce any documents (or copies or documents) as are referred to in the notice. (They may refuse any requests that lead to self-incrimination, or do	Sections 63-1(1)(b) and 90-1 to 94-2 of the *Aged Care Act 1997*	-	-

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	not relate to: a) the affairs of a corporation that is/has been an approved provider or b) the payment of a subsidy).			
Monitoring, compliance and other access	Providers must co-operate with any person who is exercising powers under Part 8 of the *Aged Care Quality and Safety Commission Act 2018* in relation to the services. Part 8 of the *Aged Care Quality and Safety Commission Act 2018* currently enables authorised officers and regulatory officials to enter and search premises.	Section 63-1(1)(ba) of the *Aged Care Act 1997* Part 8 of the *Aged Care Quality and Safety Commission Act 2018*	-	-
Reporting and disclosure	Providers must notify the Secretary of the name and address of the service in relation to each home care service, in the form approved by the Secretary, before providing home care through the service.	Sections 9-1A and 63-1(1)(c) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	-	Sections 5 and 15
Reporting and disclosure	Providers must notify the Secretary of any changes to the name and address of the service within 28 days of the change.	Sections 9-1A and 63-1(1)(c) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	-	Section 15
Reporting and disclosure	Providers must notify the Aged Care Quality and Safety Commissioner (the Commissioner) of any change of circumstances that materially affects the approved provider's suitability to be a provider of aged care within	Sections 9-1 and 63-1(1)(c) of the *Aged Care Act 1997* and Part 7B of	-	Section 15

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	28 days of the change. Commonwealth for providing that aged care. If that change in circumstances relates, wholly or partly, to key personnel becoming a disqualified individual, the approved provider must notify the Secretary of the reason why they are, or are about to become, a disqualified individual.	the *Aged Care Quality and Safety Commission Act 2018*		
Reporting and disclosure	Providers must respond to a written request from the Commissioner for information relating to: • the provider's suitability to be a provider of aged care, • payments made under the *Aged Care Act 1997* or *Aged Care (Transitional Provisions) Act 1997*, • the provider's financial situation, within 28 days after the request was made, or within any shorter period as is specified in the notice, or (if a periodic request is made with respect to financial information) before the time or times worked out in accordance with the request.	Sections 9-2, 9-3, 9-3B and 63-1(1)(c) of the *Aged Care Act 1997* and Part 7B of the *Aged Care Quality and Safety Commission Act 2018*	-	Section 15
Monitoring, compliance and other access	Providers must allow RAS assessors, ACAT assessors, or other people authorised by the Secretary to assess the care needs of any care recipient, access to the service.	Section 63-1(1)(g) of the *Aged Care Act 1997*	-	-
Monitoring, compliance and other access	Providers to comply with any agreement they make in lieu of revocation of approved provider status, and with any undertaking they give to respond to notice to remedy non-compliance.	Sections 66-2(1)(b), 63-1(1)(k) and 67-4 of the *Aged Care Act 1997*	-	-

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
Reporting and disclosure	Providers must notify the Secretary, in writing and in an approved form, of each care recipient who starts to be provided with home care through the service. Notice must be provided within 28 days of the date the care recipient starts to be provided with home care through the service.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles*	Section 6
Reporting and disclosure	Providers must notify the Secretary, in writing and in an approved form, of each care recipient who ceases to be provided with home care through the service. Notice must be provided within 31 days of the date the care recipient ceases to be provided with home care through the service.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Sections 13 and 14
Reporting and disclosure	Providers must give the Secretary an aged care financial report each financial year, within four month of the end of the financial year. The report must be signed by one of the providers' key personnel (who is authorised by the provider to sign the report).	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Section 15
Reporting and disclosure	If a provider of an aged care service receives an aged care workforce census form sent by or on behalf of the Department, the approved provider must complete the form and return it to the Department by the date specified in the form.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	-
Staff and volunteers	A provider must not allow a person to become a staff member or volunteer of the provider, unless satisfied that: • the person has a police certificate that is not more than three years old; or the person has applied for a police certificate, will be supervised when with care recipients, and has completed a statutory	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Section 4

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	declaration stated that they have not been convicted murder or sexual assault, or convicted or imprisoned for any other form of assault; and • the police certificate does not record that the person has been convicted of murder or sexual assault, or convicted or imprisoned for any other form of assault; and • if the person has been, at any time after turning 16, a citizen or permanent resident of a country other than Australia—the person has made a statutory declaration stating that the person has never been convicted of murder or sexual assault, or convicted or imprisoned for any other form of assault.			
Staff and volunteers	Providers must continue to satisfy the above requirements related to police certificates and suitability of staff members or volunteers. Providers must ensure that each person who is a staff member or volunteer is not allowed to continue to be a staff member or volunteer unless the above is satisfied.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Section 15
Staff and volunteers	Providers must take reasonable measures to require each person who is a staff member or volunteer to notify them if they are convicted of murder or sexual assault, or convicted or imprisoned for any other form of assault.	Section 63-1(1)(m) of the *Aged Care Act 1997*	*Accountability Principles 2014*	Sections 4 and 15
Monitoring, compliance and other access	Providers must do the following in relation to each of their key personnel: • ensure that the person understands the obligations of key personnel and of approved providers under the Act in	Section 63-1A of the *Aged Care Act 1997*	*Sanctions Principles 2014*	Sections 4 and 15

Topic	Responsibility	Principal legislation reference	Relevant Principles	Section in this manual
	relation to disqualified individuals; and • if the provider reasonably believes that the person may be mentally incapable of performing his or her duties as one of the approved provider's key personnel—make arrangements for the person to be examined by a registered medical practitioner; and • if the provider has ascertained that the person is a disqualified individual—ensure that the person ceases to be one of the approved provider's key personnel.			
Monitoring, compliance and other access	Providers must do the following in relation to each person who proposes to become, or becomes, one of their key personnel: • obtain (with the person's written consent) a police certificate for the person; and • conduct a search of bankruptcy records; and • conduct previous employment and referee checks.	Section 63-1A of the *Aged Care Act 1997*	*Sanctions Principles 2014*	Sections 4 and 15
Monitoring, compliance and other access	If the Secretary requests it, providers must provide information related to the steps the provider has taken to ensure that a person who is a key personnel is not a disqualified individual.	Section 63-1A of the *Aged Care Act 1997*	*Sanctions Principles 2014*	-
Monitoring, compliance and other access	An approved provider of home care must do all things reasonably practicable to ensure that there is no change to circumstances materially affecting their suitability to provide aged care.	Section 63-1C of the *Aged Care Act 1997*	-	-

Appendix F: Improved Payment Arrangements

The Australian Government changed the way Home Care Program providers are paid.

Phase 1 (implemented on 1 February 2021)

- Providers are funded in arrears rather than in advance.
- Payments for each month are claimed in the next month, for the full subsidy, based on the number of care recipients in care.

Phase 2 (implemented on 1 September 2021)

- Providers are paid in arrears, based on actual care and services delivered.
- The Government holds the Commonwealth portion of unspent funds, in each care recipient's home care account, until needed by the care recipient.

Legislation to support Phase 1 was passed by Parliament in December 2020, and for Phase 2 in February 2021. This measure reduces the financial and prudential risks of providers holding substantial amounts of unspent funds, as these will be held by the Government instead.

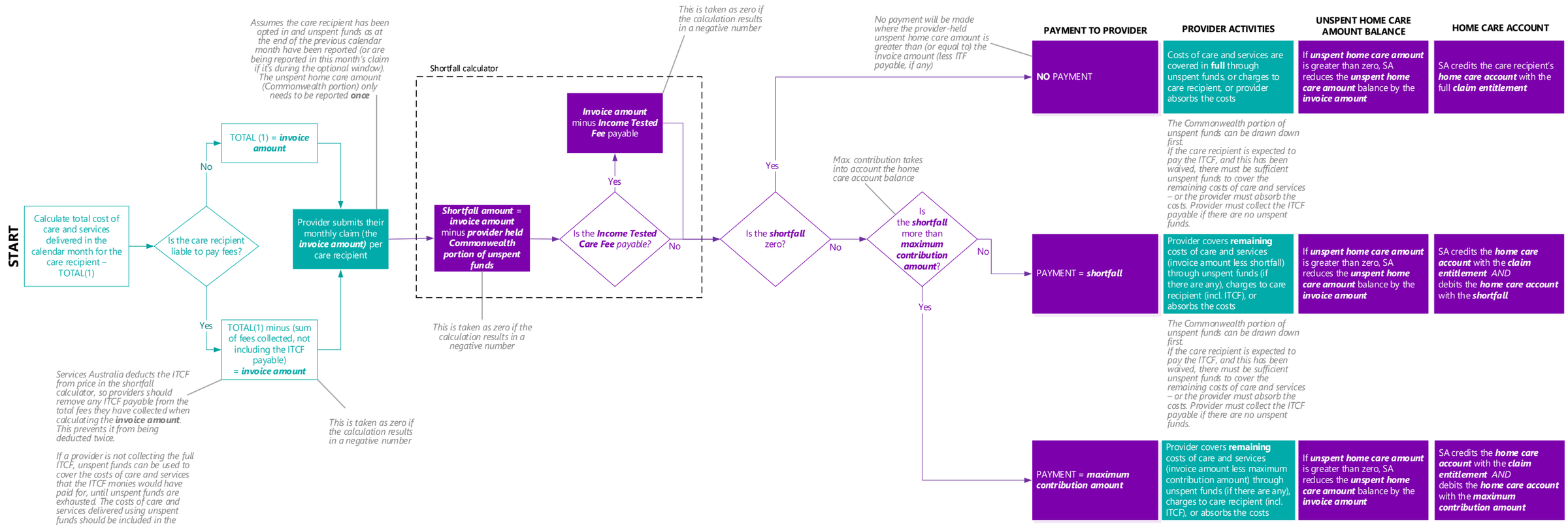
As mentioned in 2.5 of this manual, the Government offers free accounting and business advisory services to all home care providers to help them review their operations and provide advice on business management and financial strategies. For more information go to this link.

You can find further information about Improved Payment Arrangements, such as the Questions & Answers, provider and care recipient fact sheets and calculators are available on this link or by searching "Improved payment arrangements for home care" at www.health.gov.au.

Attachment A shows the claim processes for providers under Improved Payment Arrangements [updated 19 August 2021].

Attachment A – Claims Process

Claim Process if a Provider Chooses to 'Opt-in'



Invoice amount / price

Definition: the amount a provider can submit in their monthly claim for the care recipient.

Calculation:
1. Tally the total cost of care and services delivered for the care recipient in the calendar month being claimed and any administrative, care management costs
2. Tally the total fees collected/payable – including BDF, ITCF, and any other fees agreed with the care recipient
3. Deduct ITCF payable from the total at step 2. This is the available home care fees.
4. Deduct the total at step 3 from the total at step 1.

Legislative reference: Subsidy Principles 2014, 99B Price for home care

Claim entitlement / Commonwealth contribution amount

Definition: the amount of government subsidy a care recipient is entitled to for the month.

Calculation:
1. Tally the basic monthly Government subsidy amount + primary supplements (if any) – Income Tested Care Fee (if any) + other supplements (if any)

Legislative reference: Aged Care Act 1997, s 48-1A Commonwealth contribution amount

Maximum contribution amount

Definition: the total amount of Government subsidies available to cover the price for the care recipient, including this months' claim entitlement and the balance of the home care account.

Calculation:
1. Sum of the care recipient's claim entitlement and the balance of their home care account at the end of the previous month.

Legislative reference: Subsidy Principles 2014, Division 5 – Shortfall amount

Shortfall amount

Definition: in this case, where the provider has opted in the care recipient to return their provider-held unspent Commonwealth funds, the shortfall is the invoice amount, less any funds the provider is returning (unspent home care amount), less the Income Tested Care Fee the care recipient is liable to pay (if any)

Calculation:
1. Invoice amount minus unspent home care amount, up to the amount to cover the invoice amount or 100% of the unspent home care amount
3. The result of step 1 less the Income Tested Care Fee (if any)
3. If the result of step 2 is negative, this is taken as zero

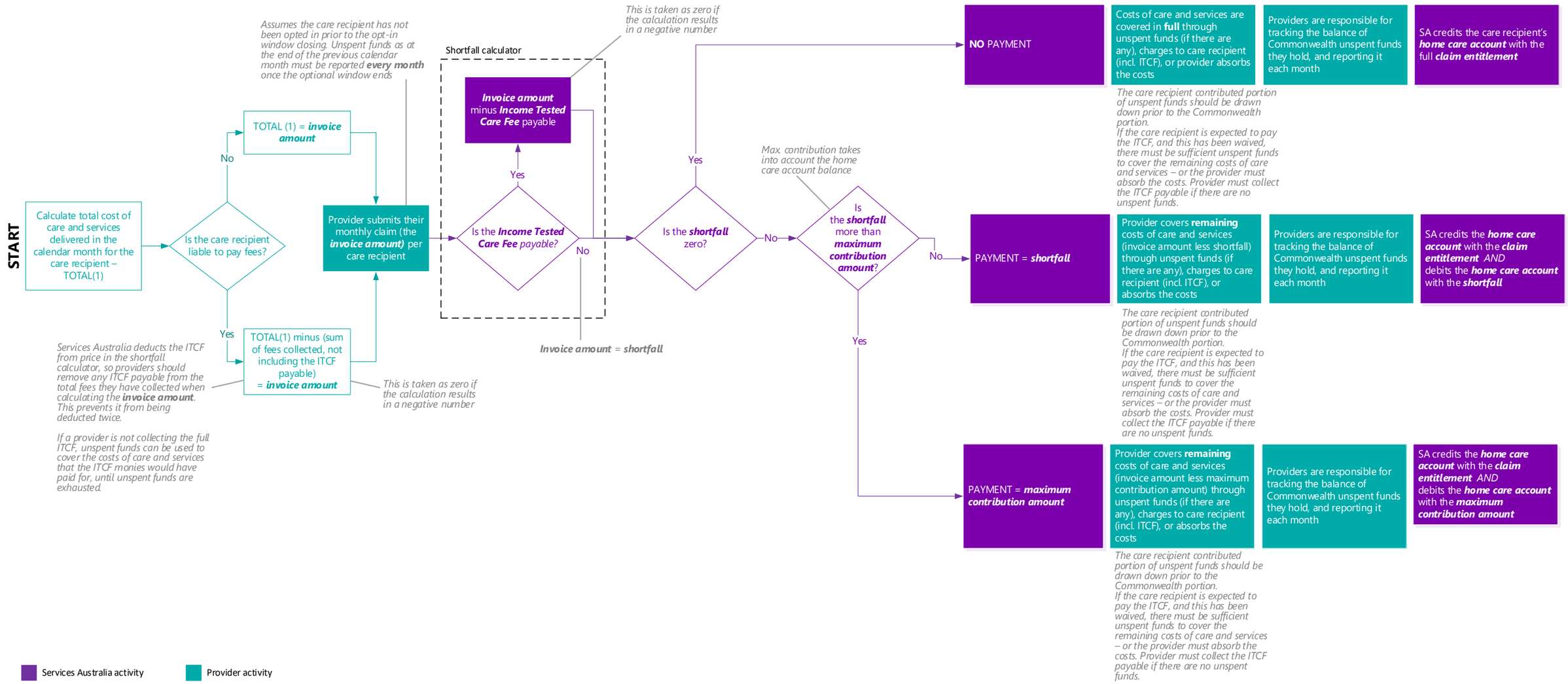
Legislative reference: Aged Care Act 1997, s 48-13 Shortfall amount; *Subsidy Principles 2014,* Division 5 – Shortfall amount

Unspent home care amount

Definition: the Commonwealth portion of the provider-held unspent funds, as at the end of the previous calendar month.

This only needs to be reported ONCE by the provider, after which the balance of the Commonwealth portion of the provider-held unspent funds is updated by Services Australia (if required) with each monthly claim submitted, until the balance reaches zero.

Claim process if a provider chooses NOT to 'opt-in'



Services Australia activity Provider activity

Invoice amount / price

Definition: the amount a provider can submit in their monthly claim for the care recipient.

Calculation:
1. Tally the total cost of care and services delivered for the care recipient in the calendar month being claimed and any administrative, care management costs
2. Tally the total fees collected/payable – including BDF, ITCF, and any other fees agreed with the care recipient
3. Deduct ITCF payable from the total at step 2. This is the available home care fees.
4. Deduct the total at step 3 from the total at step 1.

Legislative reference: Subsidy Principles 2014, 99B Price for home care

Claim entitlement / Commonwealth contribution amount

Definition: the amount of government subsidy a care recipient is entitled to for the month.

Calculation:
1. Tally the basic monthly Government subsidy amount + primary supplements (if any) – Income Tested Care Fee (if any) + other supplements (if any)

Legislative reference: Aged Care Act 1997, s 48-1A Commonwealth contribution amount

Maximum contribution amount

Definition: the total amount of Government subsidies available to cover the price for the care recipient, including this months' claim entitlement and the balance of the home care account.

Calculation:
1. Sum of the care recipient's claim entitlement and the balance of their home care account at the end of the previous month.

Legislative reference: Subsidy Principles 2014, Division 5 – Shortfall amount

Shortfall amount

Definition: in this case, where the provider has not opted in the care recipient to return their provider-held unspent Commonwealth funds (or the care recipient doesn't have unspent funds) the shortfall is the invoice amount less the Income Tested Care Fee the care recipient is liable to pay (if any)

Calculation:
1. Invoice amount minus the Income Care Tested Fee
2. If the result of step 1 is negative, this is taken as zero

Legislative reference: Aged Care Act 1997, s 48-13 Shortfall amount; *Subsidy Principles 2014,* Division 5 – Shortfall amount

Unspent home care amount

Definition: the Commonwealth portion of the provider-held unspent funds, as at the end of the previous calendar month.

This needs to be reported EVERY MONTH by the provider until the balance reaches zero.

Appendix G: Unspent funds under Improved Payment Arrangements – calculating and reporting

The unspent funds calculation on the next page is an example of how to work out unspent funds leading up to 31 August 2021 (the last day before Improved Payment Arrangements Phase 2 began on 1 September 2021). The example is based on the percentage of the unspent funds held by the provider that have come from Government subsidies and supplements as opposed to the care recipient fees. The purpose of calculating these unspent funds this is to set a baseline for the Government and care recipient portions of unspent funds and enable consistent reporting under Improved Payment Arrangements.

Providers will need to reconcile the Government portion of unspent funds they are currently holding for each care recipient to support meeting the 31 December 2021 deadline for reporting. The amount that should be reported is the Government portion of unspent funds held for each care recipient at the end of the previous claim month.

Under Improved Payments Arrangements, there is no need to recalculate the percentage breakdown of Government and care recipient portions when a care recipient exits care.

From 1 September 2021, the provider must be tracking the care recipient portion and (if they have not opted-in) tracking the Government portion separately. If the provider has opted-in, Services Australia will track the Government portion on their behalf.

From 1 September 2021 onwards, if there are changes to the subsidies and fees paid to the provider, this change should be applied to the Government portion of unspent funds. If there are changes to the fees paid by the care recipient, this should be applied to the care recipient portion of unspent funds. When a care recipient leaves care, these fees should be included in the care recipient portion of unspent funds once all claims have been finalised.

After 1 January 2022 providers who have chosen not to opt-in will need to continue to report on the Government portion of unspent funds held for a care recipient each month.

If a provider has agreed to waive the income tested care fee with the care recipient, and the care recipient has not paid any other fees, the Government portion would comprise 100 percent of the unspent funds.

Unspent funds – worked example for pre-1 September 2021 (Improved Payment Arrangements Phase 2)

- May has received care from a home care provider for 2 years.

Commonwealth contributions (Government subsidy and supplements):	$15,000
Care recipient contributions (Home care fees):	$5,000
Total accumulated funds:	$20,000

- During this time, she has received $18,000 worth of services.

Total accumulated: - Total debits:	$20,000 $18,000
Total unspent funds amount:	$2,000

- Calculate what proportion of May's total home care package budget came from the Commonwealth and from care recipient fees, as below:

Total accumulated funds: $20,000	
Commonwealth portion: $15,000/$20,000 = 75%	Care recipient portion: $5,000/$20,000 = 25%

- Then apply these proportions to the unspent funds amount:

Unspent funds amount: $20,000	
Commonwealth portion: 75% of $2,000 = $1,500	Care recipient portion: 25% of $2,000 = $500

Appendix H: Glossary

Term	Meaning
ACAT	Aged Care Assessment Team. ACATs are known as Aged Care Assessment Services (ACAS) in Victoria.
ACER	Aged Care Entry Record. ACERs are used to notify Services Australia of new care recipients entering care, or changes to existing care recipients' circumstances.
Australian Government	The Federal Government of Australia.
The Commission	The Aged Care Quality and Safety Commission. The Commission is a statutory body, responsible for overseeing the Aged Care Quality Standards across the aged care sector.
The Department	The Australian Government Department of Health and Aged Care
Quality Standards	The Aged Care Quality Standards. The Quality Standards are established under the *Aged Care Act 1997*, and all approved providers of aged care are expected to be compliant.
Approved provider (or provider)	An approved provider of aged care is an organisation that has been approved to provide residential care, home and/or flexible care under the *Aged Care Act 1997*.
Basic daily fee	Refers to a home care fee that a care recipient may be asked to pay by a home care provider based on their package level (separate to the Government subsidy).
Care plan	A care plan is a document that defines the care, services and/or purchases that a care recipient is going to use their package budget to fund.
Care recipient	A person who is receiving care and services under a package funded by the Australian Government, under the *Aged Care Act 1997*
CDC	Consumer directed care.
Consumer	Consumer means a person to whom an approved provider provides, or is to provide, care through an aged care service. Includes other people who are authorised to act on behalf of the care recipient.
Commonwealth Home Support Programme	This program provides home and community care services for frail older Australians aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.
Dignity of risk	An individual's right to make choices to take reasonable risks.
DVA	Department of Veterans' Affairs
Exclusions	Care, services or purchases that cannot be funded from a package budget.
FAS	VANguard Federated Authentication Service

Term	Meaning
Home care	A type of aged care for which a home care subsidy is payable under Part 3.2 of the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997*.
Home care recipient (or care recipient)	A person who is receiving care and services under a package funded by the Australian Government. In the *Aged Care Act 1997*, this person is referred to as a "care recipient".
Home care provider (or approved provider)	An organisation approved by the Department of Health and Aged Care under Part 2.1 of the Act as suitable to provide home care. In the *Aged Care Act 1997*, this person or body is referred to as an "approved provider".
Home Care Agreement	An agreement entered into by a care recipient and a home care provider outlining rights and responsibilities and what services will be provided to the care recipient under the package.
Home Care Packages Program	The Australian Government program that provides funding for packages aimed at supporting people to remain living at home.
HCP	Home care package
Home care account	On 1 September 2021, Services Australia will create a home care account for each care recipient. See Appendix E for further information.
Home care subsidy	The subsidy payable to a home care provider by the Australian Government under Part 3.2 of the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997*.
Inclusions	Care, services or purchases that can be funded from a package budget.
Income-tested care fee	Refers to a home care fee a care recipient may be asked to pay based on an income assessment.
Instrument	Primary legislation, delegated legislation, or a determination under legislation.
Improved Payment Arrangements	Changes to how the Australian Government pays home providers. See Appendix E for further information.
Key personnel	Key personnel are: • People responsible for the executive decisions of the applicant (this includes directors and board members), whether or not the person is employed by the applicant • People having authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the applicant, whether or not the person is employed by the applicant • Any person responsible for nursing services provided, or to be provided, by the applicant, whether or not the person is employed by the applicant • Any person who is, or is likely to be, responsible for the day-to-day operation of an aged care service conducted, or proposed to be conducted, by the applicant, whether or not the person is employed by the applicant.

Term	Meaning
Leave	A care recipient suspending care, services and purchases under their package for a specified period of time.
Maximum contribution amount	The full Government subsidy and anything available in the care recipient's home care account
Monthly statement	A document provided to care recipients every month that shows the package budget funds available to that care recipient and what has been spent from the budget.
My Aged Care	My Aged Care is the starting point to access Australian Government-funded aged care services. The phone line and website can help older Australians, their families and carers to get the help and support they need.
NAPS	National Approved Provider System
National priority system	The national priority system is a standardised process for prioritising assignment of packages.
Package budget	The funds available to be spent under a care recipient's package. A care recipient's package budget is made up of contributions from the Australian Government and, where applicable, home care fees paid by the care recipient themselves.
Pre-1 July 2014 care recipients	Care recipients who entered the HCP Program before 1 July 2014. Packages for pre-1 July 2014 care recipients have different home care fee arrangements.
Price	The amount that providers report to Services Australia in their claim. Providers report the price per care recipient, each month. Services Australia refers to the price as the invoice amount.
Principles	Delegated legislation made under the *Aged Care Act 1997*.
Reablement	Reablement is an approach to aged care, involving time-limited interventions that are targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities.
Residential aged care	This program provides high-levels of care to people in a residential aged care home.
Security of tenure	Security of tenure means providers are required to continue to deliver the agreed care and services for as long as the care recipient needs those services.
Services Australia	Formerly known as Department of Human Services
Shortfall amount	The price (minus the Commonwealth portion of any unspent funds which are being returned, for providers that opt-in), minus any income-tested care fee the care recipient is assessed to pay.
Subsidy	An Australian Government contribution to all care recipient's package budgets, determined on the basis of the level of the package the care recipient has been allocated.

Term	Meaning
Supplement	An Australian Government contribution to a care recipient's package budget, where the care recipient satisfies the specific eligibility criteria for that contribution.
The Act	*Aged Care Act 1997.*
The Principles	• *Accountability Principles 2014* • *Approval of Care Recipients Principles 2014* • *Committee Principles 2014* • *Fees and Payments Principles 2014 (No.2)* • *Information Principles 2014* • *Quality of Care Principles 2014* • *Records Principles 2014* • *Prioritised Home Care Recipients Principles 2016* • *Sanctions Principles 2014* • *Subsidy Principles 2014* • *User Rights Principles 2014*
Unspent funds	Any component of a care recipient's package budget that has not been spent, including the balance of the provider-held care recipient contributed unspent funds, the provider-held Commonwealth portion of unspent funds, and the Services Australia home care account balance (Government held unspent funds)
Wellness	Wellness is an approach to aged care involving assessment, planning and delivery of supports that build on the strengths, capacity and goals of individuals, and encourage actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home.