Australian Government

Department of Health and Ageing

The Residential Care Manual

www.health.gov.au

Residential Care Manual

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EXECUTIVE SUMMARY

LEGISLATIVE REFERENCES

This Manual has been written in plain English and as a result, some aspects of the legislation and policy have been simplified. It is intended to be a general guide only and does not constitute legal advice. In cases of discrepancy between the Manual and the legislation, the legislation will be the source document for payment of Australian Government benefits and enforcement of approved provider responsibilities.

Welcome to the Residential Care Manual 2009, Edition 1.

This Manual has been updated and revised to help approved providers comply with their responsibilities under the *Aged Care Act 1997* (the Act); and to assist staff of aged care services understand the regulation of residential aged care. Additional information can also be accessed through the Aged Care Information Line 1800 500 853.

Australian Government-subsidised residential aged care is governed by the Act and the Aged Care Principles and is administered by the Department of Health and Ageing. The Act covers a number of types of aged care including residential care, community care (Community Aged Care Packages) and flexible care (Extended Aged Care at Home and Extended Aged Care at Home—Dementia packages, multi-purpose services, innovative care and transition care).

However, the purpose of this Manual is to provide a plain English guide to Government-subsidised residential aged care only.

Government-subsidised residential aged care provides a range of supported accommodation services for older people who are unable to continue living independently in their own homes; and is based on a set of objectives outlined in the Act. *See legislative reference.* These are to:

Division 2 (Objects), Aged Care Act 1997

- promote a high quality of care and accommodation
- protect the health and wellbeing of residents
- help residents enjoy the same rights as all other people in Australia
- ensure that care is accessible and affordable for all residents
- plan effectively for the delivery of aged care services
- ensure that aged care services and funding are targeted towards people and areas with the greatest needs
- encourage services that are diverse, flexible and responsive to individual needs
- provide funding that takes account of the quality, type and level of care
- provide respite for families and others who care for older people
- promote 'ageing in place'—that is, help older people stay where they want to live, by linking care and support services.

Approximately 70 per cent of the total funding for residential aged care is provided by the Australian Government, paid directly to providers of aged care services on behalf of the residents in those services.

EXECUTIVE SUMMARY

Australian Government subsidies can only be paid for a resident:

- when the resident has been approved by an Aged Care Assessment Team (ACAT)
- the resident's care is provided by a Government-approved aged care provider
- that care is provided in a Government-subsidised aged care place
- and the standard of care in that service meets the accreditation requirements.

While most of the funding comes via the Department of Health and Ageing, residential aged care for veterans is also funded by the Department of Veterans' Affairs.

Although the Government funds the majority of approved residential aged care services, residents are asked to make a contribution to the cost of their care and accommodation where they can, by paying fees direct to an approved provider. The legislation regulates the maximum fees an approved provider can ask a resident to pay.

All residents in Government-subsidised residential aged care can be asked to pay a basic daily fee as a contribution towards accommodation costs and living expenses, such as meals, cleaning, laundry, heating and cooling in the service.

Residents with sufficient assets may be asked to pay an accommodation payment. Accommodation payments include accommodation bonds for low-care residents or residents who receive high-care on an extra service basis; and accommodation charges for residents with high-care needs. Residents can only be asked for an accommodation payment if the aged care service is certified.

Residents who have the means will also make a contribution towards their costs of care, through an income tested fee.

The Government can assist older people experiencing genuine financial hardship through hardship provisions, whereby the Government steps in and makes up for any shortfall in fees these residents pay an approved provider. Hardship provisions also ensure that these residents have equal access to residential aged care and are not discriminated against in favour or residents who can afford to pay fees themselves.

In addition to regulating funding and income for residential aged care, the legislation sets out the planning and distribution of Government-subsidised aged care places, approval and classification of care recipients, approved providers' responsibilities and residents' rights.

In order to meet the objectives of the Act, approved aged care providers must meet building requirements for certification and for accreditation, as overseen by the Aged Care Standards and Accreditation Agency. They must also adhere to prudential regulation requirements. Under Government-subsidised residential aged care, protections are also afforded to residents by the Aged Care Commissioner and the Aged Care Complaints Investigation Scheme.

The structure of the Act is outlined in the Diagram A.

EXECUTIVE SUMMARY

Diagram A—Structure of the *Aged Care Act 1997*

CHAPTER 2—PRELIMINARY MATTERS RELATING TO SUBSIDIES

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EXECUTIVE SUMMARY

REVISED STRUCTURE

The Residential Care Manual 2009, Edition 1 is structured as per below.

- Table of contents

Section 1 Executive summary

- Executive summary

Section 2 Approved provider, allocations, accreditation and certification

- Becoming an approved provider
- Allocated places
- Extra service places
- Accreditation and quality of care
- Certification

Section 3 Approval and classification of residents

- Approval of residents
- Classification of residents

Section 4 Funding for residential aged care, residential respite and capital grants

- Funding for permanent residential aged care
- Residential respite care
- Capital grants for residential aged care

Section 5 Caring for residents and providers' responsibilities

- Residents' rights
- Protection and responsibilities relating to accommodation bonds
- Specified care and services
- Providers' responsibilities and non-compliance
- Compulsory reporting
- Record keeping

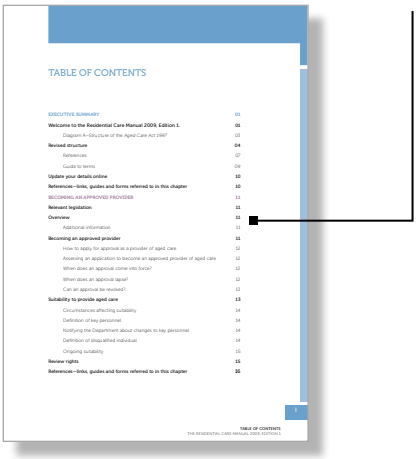
Index (will be provided on the Department's website shortly)

EXECUTIVE SUMMARY

For this update, chapters of the Manual have been re-organised, with similarly-themed chapters grouped together into five coloured main sections as outlined below.

To help approved providers find the information they need:

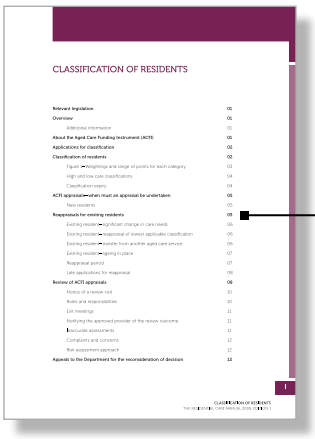
There is a table of contents at the beginning of the Manual



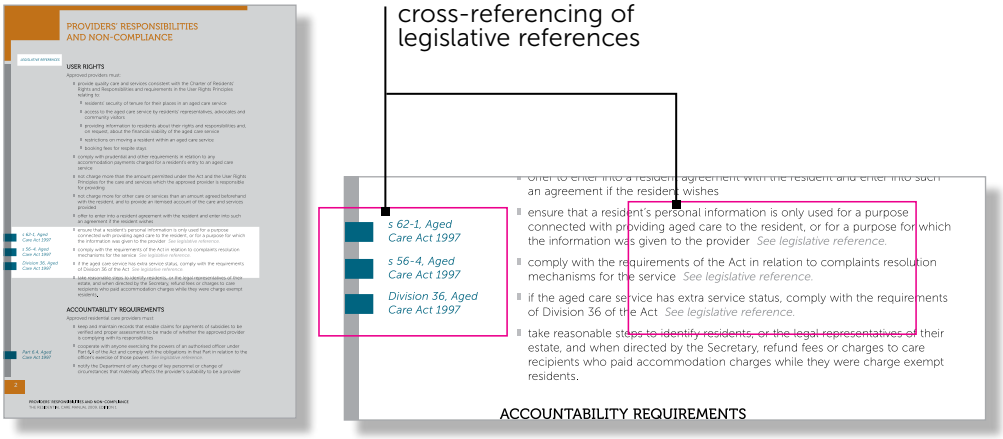
Each of the five colour-coded sections list the chapters in that section

EXECUTIVE SUMMARY

Each chapter also has a contents page



There is extensive cross-referencing in each chapter.



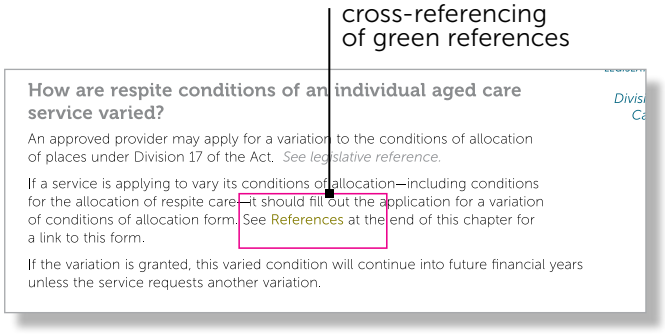
EXECUTIVE SUMMARY

References

A two-colour system has been used for references within this Manual. In the online version, all these references are hyperlinked.

GREEN REFERENCES

All references to links, guides, forms and information available on the Department's website or other sites are marked in green, like this:



EXAMPLE:

Notifying the Department about changes to key personnel

Approved providers must inform the Secretary of any change to key personnel within 28 days after the change occurs, by completing the notification of key personnel changes form. See References at the end of this chapter for a link to this form.

All these references can be found in the References section at the end of each chapter.

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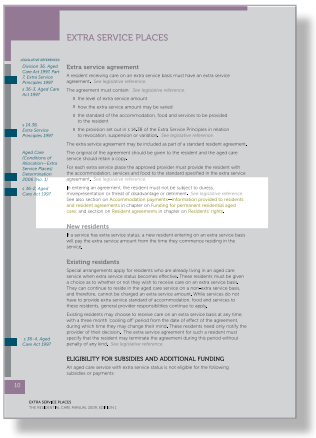
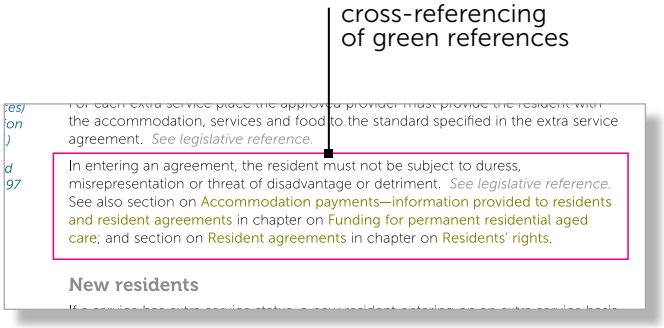
Green references are also used to refer to other sections within the same chapter; or to other sections in different chapters of the manual, like this:





EXAMPLE:

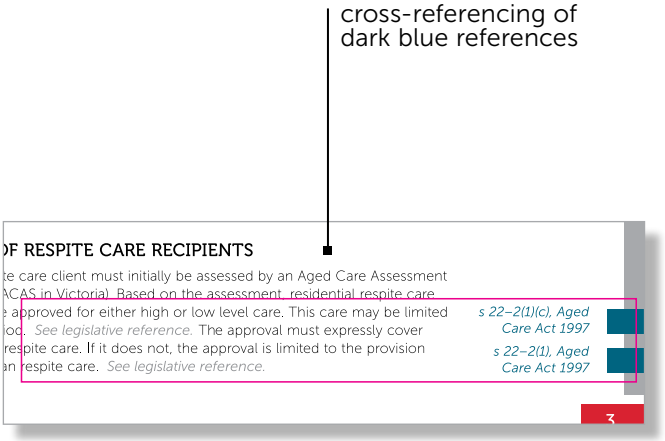
Extra service agreement

In entering an agreement, the resident must not be subject to duress, misrepresentation or threat of disadvantage or detriment. See also section on Accommodation payments—information provided to residents and resident agreements in chapter on Funding for permanent residential aged care; and section on Resident agreements in chapter on Residents' rights.

Sections in different chapters can be found using the table of contents at the beginning of each chapter; or the overall table of contents at the beginning of the Manual.

DARK BLUE REFERENCES

All references to the *Aged Care Act 1997* or the Aged Care Principles will be marked in dark blue. Legislative references will sit beside the sentence to which they relate, like this:



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EXAMPLE:

Accreditation—commencing services

An aged care service is considered a commencing service if an approved provider has been allocated places for that service, residential aged care has not previously been provided for those places and the service is not currently accredited by the Agency. *See legislative reference.*

Division 14, Aged Care Act 1997

Guide to terms

The following list includes some of the terms used throughout the Manual; and explains the way in which they are used. Where terms used in the Manual are not defined, they have their plain English meaning. A list of definitions is also included in the Dictionary at the end of the Act. *See legislative reference.*

Schedule 1—Dictionary, Aged Care Act, 1997

Aged care service
This is the term used to describe a residential aged care service operated by an approved provider. It replaces the older terms "nursing home" and "hostel".

Approved provider
An approved provider is a person or body who is approved by the Department to provide Government-subsidised residential aged care. This may be residential, community or flexible care or a combination of these care types. In this Manual, it is assumed that an approved provider has been approved to provide residential aged care. An approved provider is referred to either in full, as an approved provider; or in some instances as a provider.

Care recipient
A care recipient is a person who is receiving aged care provided by an approved provider. The terms care recipient, resident and person are used interchangeably throughout the Manual.

Department
All references to the Department mean the Department of Health and Ageing.

Health professional
The term health professional used in the Manual means a person who has qualifications acceptable to the relevant state or territory regulatory board or authority and who is currently registered with, or accredited by, that board or authority.

Minister
All references to the Minister mean the Minister for Ageing.

Resident
A resident is someone living in a residential aged care service. All references to resident also cover resident and/or their representative as appropriate. A resident's representative may be:

- a guardian appointed by a tribunal
- a person to whom the resident has formally delegated decision-making power ("power of attorney")
- a person nominated by the care recipient as his or her representative.

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In some circumstances, a person may nominate himself or herself as a resident's representative. If the approved provider is satisfied that the person has a connection with the resident, and is concerned for the safety, health and well-being of the resident, the person may be regarded as the resident's representative for some purposes. Such a person may be, for example, a family member or carer.

Secretary
All references to the Secretary mean the Secretary of the Department of Health and Ageing. References to the Secretary may include an officer of the Department holding, or performing powers of the Secretary as a delegate under the Act.

UPDATE YOUR DETAILS ONLINE

The Residential Care Manual will be updated in line with any changes in legislation, policy or regulatory arrangements. Let us know of any changes to your organisation's contact details, so we can send you updates and other important information.

To update your details go to

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-contacts-subscribe.htm

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN THIS CHAPTER

Aged Care Act 1997, Aged Care Principles

The Act and the Principles can be accessed via the Department's website *www.health.gov.au/internet/main/publishing.nsf/Content/ageing-legislat-aca1997-acaindex.htm*

Aged Care Information Line

Ph 1800 500 853

Dictionary—*Aged Care 1997*

A complete list of definitions is included in the Dictionary at the end of the Act, which can be accessed via ComLaw or via the Department's website.

Forms—all

All Departmental forms are available on the Department's website at *www.health.gov.au/internet/main/publishing.nsf/Content/health-forms.htm*

Legislation

Go to ComLaw to access all Commonwealth legislation, including the Act and the Principles and any other legislation mentioned in this Manual *www.comlaw.gov.au*

BECOMING AN APPROVED PROVIDER

BECOMING AN APPROVED PROVIDER

LEGISLATIVE REFERENCES

This Manual has been written in plain English and as a result, some aspects of the legislation and policy have been simplified. It is intended to be a general guide only and does not constitute legal advice. In cases of discrepancy between the Manual and the legislation, the legislation will be the source document for payment of Australian Government benefits and enforcement of approved provider responsibilities.

RELEVANT LEGISLATION

- Part 2.1, Divisions 6 to 10A, *Aged Care Act 1997* (the Act)
- *Approved Provider Principles 1997* (the Approved Provider Principles)

OVERVIEW

To receive Australian Government subsidies for providing aged care, an aged care service must be operated by an organisation that has been approved by the Australian Government—ie, an approved provider—and has an allocation of places in respect of care recipients occupying those places in a service. If providing residential care, the facilities must also be accredited by the Aged Care Standards and Accreditation Agency. For the approved provider to be eligible to receive subsidies, the care recipient must be assessed by an Aged Care Assessment Team as eligible to receive that type of care.

An applicant only needs to submit one application, even if they plan to operate in more than one state or territory. Approval can be for one or more types of care—ie, residential, community or flexible care. *See legislative reference.*

s 8-1(2)(a), Aged Care Act 1997

Additional information

This chapter has been updated and revised to help approved providers comply with their responsibilities under the Act; and to assist staff of aged care services understand the regulation of residential aged care. Additional information can also be accessed through the Aged Care Information Line on 1800 500 853; and questions about approval can be sent to: ApprovedProviderProgram@health.gov.au

BECOMING AN APPROVED PROVIDER

To gain approval as a provider of aged care an applicant and its associated key personnel such as directors, board members and service managers must be assessed by the Department as suitable to provide aged care.

In order to become an approved provider:

- the applicant must make an application by completing the approved form *See legislative reference.* — *s 8-1(1)(a), Aged Care Act 1997*
- the applicant must be a corporation as defined in the Act *See legislative reference.* — *s 8-1(1)(b), Aged Care Act 1997*
- the applicant must be suitable to provide aged care *See legislative reference.* — *s 8-1(1)(c), Aged Care Act 1997*
- none of the applicant's key personnel can be a disqualified individual as defined in s10A-1 of the Act. *See legislative reference.* — *s 8-1(1)(d), Aged Care Act 1997*

State, territory and local government authorities are taken to be approved providers unless the approval has lapsed or been revoked. *See legislative reference.* — *s 8.6, Aged Care Act 1997*

BECOMING AN APPROVED PROVIDER

LEGISLATIVE REFERENCES

How to apply for approval as a provider of aged care

Applications can be made at any time during the year. Prospective applicants should:

- read the Approved Provider Status Application: Guidelines
- read the relevant sections of the Act and Aged Care Principles
- make an application on the approved form, including the required documents
- obtain a National Criminal History Check from the Australian Federal Police or another agency accredited by Crimtrac, for the applicant organisation and each of their associated key personnel. Original documents must be included with the application. See also section on Police checks in chapter on Providers' responsibilities and non-compliance.

See References at the end of this chapter for these links.

Assessing an application to become an approved provider of aged care

The Secretary has 90 days to consider an application. If further information is required in order to properly assess the application, the Secretary may send a request for information, and the applicant then has 28 days to respond. If this additional information is not provided, the application is considered to be withdrawn. Once the information is received, the Secretary then has a further 90 days, to finalise the application.

In assessing an application, the Secretary will consider all relevant information available to the Department including:

- the application
- information from:
  - the Aged Care Standards and Accreditation Agency
  - the Australian Federal Police
  - the Aged Care Complaints Investigation Scheme
  - organisations which can independently investigate the financial probity and credit/debt of an applicant.

When does an approval come into force?

An approval comes into effect when a provider obtains an allocation of places. An approval is only in respect of each service for which an allocation of places is held. Places can be allocated by the Secretary, through the Aged Care Allocations Round; or by transfer from another approved provider with the approval of the Secretary.

When does an approval lapse?

s 8-1(4), Aged Care Act 1997

For a provider approved on or after 1 January 2009, an approval will cease if the provider does not receive an allocation of places within two years from the day the approval is made. *See legislative reference.*

LEGISLATIVE REFERENCES

For a provider approved before 1 January 2009, approval would have lapsed on 1 July 2009, if:

- no allocation of places is in effect
- no provisional allocation of a place is in force
- and a transfer of places has not occurred.

An approval which is in force will also lapse if the approved provider has no allocated places. *See legislative reference.*

s 10-2, Aged Care Act 1997

Can an approval be revoked?

Approval as a provider can be revoked under s10-3 of the Act if: *See legislative reference.*

s 10-3, Aged Care Act 1997

- the approved provider has ceased to be a corporation
- or the approved provider has ceased to be suitable to provide aged care (this includes suitability of the provider's key personnel)
- or the approved provider's application for approval contained false or misleading information.

Approval as a provider can also be revoked as a sanction under Part 4.4 of the Act where an approved provider has not met its responsibilities. *See legislative reference.*

Part 4.4, Aged Care Act 1997

SUITABILITY TO PROVIDE AGED CARE

The Secretary must consider a range of issues when assessing an applicant's suitability to provide aged care, including:

- the suitability and experience of the applicant's key personnel
- ability to provide, and any experience, in providing aged care
- ability to meet relevant standards for providing aged care
- commitment to the rights of residents
- record of financial management and methods for ensuring sound financial management
- if the applicant has been a provider of aged care, its conduct as a provider; and its compliance with its responsibilities and obligations arising from receiving any Commonwealth payments for providing aged care
- if key personnel are also relevant key personnel in common with a current or former approved provider, the record and suitability of that approved provider will be considered
- the conduct and experience of the applicant other than as a provider of aged care
- any other matters specified in the Approved Provider Principles.

LEGISLATIVE REFERENCES

Circumstances affecting suitability

s 63-1C, Aged Care Act 1997

If an applicant was granted approved provider status after 1 January 2009, the Secretary can specify any circumstance that would materially affect the applicant's suitability to provide aged care. The approved provider must get the Secretary's agreement before there is any change to the specified circumstance. *See legislative reference.* For example, if an approved provider has an ongoing arrangement to provide care through a management company and the Secretary specified that this is a circumstance that materially affects the provider's suitability, then the provider must get the Secretary's agreement before changing its management company or ceasing to engage a management company. An approved provider can be sanctioned if it does not comply with this responsibility.

Definition of key personnel

s 8-3A, Aged Care Act 1997

In the Act, the definition of provider's key personnel includes any person exercising one or more of the functions specified below:
See legislative reference.

- a member of a group of persons responsible for the executive decisions of the entity, including directors and board members
- a person who has authority or responsibility for, or significant influence over, planning, directing or controlling the activities of the entity
- any person who is, or is likely to be responsible for, the nursing services provided by the service
- any person who is, or is likely to be responsible for, the day-to-day operations of the service.

If a person performs one or more of these specified functions, they are one of the key personnel of the approved provider whatever their job title is and whether or not they are employed by the provider or applicant.

The definition of key personnel now includes an explicit statement that key personnel include any person having authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the applicant/approved provider.

Notifying the Department about changes to key personnel

s 9-1(1)(b), Aged Care Act 1997

Approved providers must inform the Secretary of any change to key personnel within 28 days after the change occurs, by completing the notification of key personnel changes form. *See legislative reference.* See References at the end of this chapter for a link to this form.

An approved provider who does not inform the Secretary about changes to key personnel within 28 days can be sanctioned under Part 4.4 of the Act, and is guilty of a strict liability offence of 30 penalty units (where 1 penalty unit is $110).

Definition of disqualified individual

A disqualified individual is anyone who:

- has been convicted of an indictable offence and the conviction is not a 'spent conviction'
- is an insolvent under administration—ie, an undischarged bankrupt
- or is of unsound mind.

BECOMING AN APPROVED PROVIDER

LEGISLATIVE REFERENCES

An approved provider must take all reasonable steps to ensure that none of its key personnel is a disqualified individual. Failure to do so may result in sanctions being imposed, and an offence of 300 penalty units may apply. *See legislative reference.*

Part 1A, Sanctions Principles 1997

Ongoing suitability

An approved provider must inform the Secretary of any change of circumstances that significantly affects their suitability to be a provider of aged care, including:

- suspending trading in shares
- appointing an administrator
- appointing a receiver or manager
- entering into voluntary liquidation
- an application for winding up. *See legislative reference.*

s 9-1(1)(a), Aged Care Act 1997

An approved provider who does not inform the Secretary about a change in circumstances that materially affects their suitability to be a provider of aged care within 28 days can be sanctioned under Part 4.4 of the Act, and is guilty of a strict liability offence of 30 penalty units (where 1 penalty unit is $110).

At any time, the Secretary can ask an approved provider for information relevant to the provider's suitability to be an approved provider of aged care. *See legislative reference.* An approved provider who does not comply with such a request within the time specified in the notice can be sanctioned under Part 4.4 of the Act, and is guilty of a strict liability offence of 30 penalty units (where 1 penalty unit is $110). *See legislative reference.*

s 9-2(1), Aged Care Act 1997

ss 9-2(2) and (3), Aged Care Act 1997

REVIEW RIGHTS

If an applicant's application for approval as an approved provider is rejected, they can write to the Secretary within 28 days of receiving the rejection, asking the Secretary to reconsider the decision. *See legislative reference.* The applicant should provide reasons for the request and any relevant supporting material. See References at the end of this chapter for mailing address.

s 85-5, Aged Care Act 1997

The Secretary must then reconsider the decision, and either confirm, vary or set the decision aside and substitute a new decision. If the Secretary does not give notice of a decision within 90 days after receiving the request, the Secretary is taken to have confirmed the decision—ie, the application is rejected. If an applicant wants to appeal against a decision after review by the Secretary, they can apply to the Administrative Appeal Tribunal for external review.

If an application is rejected, an applicant can reapply, at any time, on the approved form.

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN THIS CHAPTER

Aged Care Information Line

Ph 1800 500 853

Approved Provider Status Application—form, guidelines and postal address

Send applications to:

Approved Provider Section
Office of Aged Care Quality and Compliance
Department of Health and Ageing
MDP 12
GPO Box 9848
Canberra ACT 2601

Crimtrac accredited agencies—for more information go to

www.crimtrac.gov.au/criminal_history_checks/index.html

Forms—all

All Departmental forms are available on the Department's website at
www.health.gov.au/internet/main/publishing.nsf/Content/health-forms.htm

Form—notification of changes to key personnel

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-approvedp-index.htm

National Criminal History Check—consent, fees, form and guidelines

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-approvedp-index.htm

National Criminal History Checks—for more information on national police checks

www.afp.gov.au/business/national_police_checks

Questions and queries—about approval, email

ApprovedProviderProgram@health.gov.au

Reviews—requesting reconsideration of a decision not to grant approved provider status

Send requests in writing to:

Approved Provider Section
Office of Aged Care Quality and Compliance
Department of Health and Ageing
MDP 12
GPO Box 9848
Canberra ACT 2601

ALLOCATED PLACES

ALLOCATED PLACES

This Manual has been written in plain English and as a result, some aspects of the legislation and policy have been simplified. It is intended to be a general guide only and does not constitute legal advice. In cases of discrepancy between the Manual and the legislation, the legislation will be the source document for payment of Australian Government benefits and enforcement of approved provider responsibilities.

RELEVANT LEGISLATION

- Part 2.2, *Aged Care Act 1997* (the Act)
- *Allocation Principles 1997* (the Allocation Principles)

OVERVIEW

This chapter explains how the Government allocates new aged care places to approved providers, and includes information about:

- planning the provision of residential aged care places
- the allocation of residential aged care places
- conditions of allocation
- varying the conditions of allocated places
- transferring places between approved providers
- how the allocation of places may cease
- the exchange of care type mechanism.

Additional information

This chapter has been updated and revised to help approved providers comply with their responsibilities under the Act; and to assist staff of aged care services understand the regulation of residential aged care. Additional information can also be accessed through the Aged Care Information Line on 1800 500 853.

PLANNING THE PROVISION OF RESIDENTIAL AGED CARE SERVICES

In planning the allocation of residential care services across Australia, the Government seeks to:

- provide an open and clear planning process
- identify community needs, particularly in relation to people with special needs
- allocate places in a way that best meets the identified needs in the community.

To meet these objectives, the Government aims to:

- have a national provision of 113 residential and community aged care operational places per 1,000 people aged over 70 years, to be achieved by June 2011
  - these 113 places comprise a ratio of 88 places in a residential setting, (44 high care and 44 low care); and 25 in a community setting (4 high care and 21 low care)

- ensure an equitable balance in the provision of services between metropolitan, regional, rural and remote areas, as well as between people needing differing levels of care
- ensure that people with special needs have access to culturally appropriate, quality care
- provide an appropriate level of respite places
- increase the capacity for care recipients to age in place—ie, to stay where they are most comfortable, as they age.

Aged care services with places approved before October 1997 can offer low level and high level care. Places allocated after October 1997 may have conditions attached to them, including if the place can be used to provide high or low level care

ALLOCATING PLACES

Decisions about where and how many places are to be allocated in any planning year are made in three stages or levels.

Level 1 decision: Number of places made available nationally

The Minister decides the number of new residential and community and flexible aged care places to be made available to each state and territory for the financial year.

These numbers are calculated according to the national planning benchmark—currently 113 residential, community and flexible operational places per 1,000 people over 70 years (to be achieved by June 2011). The decision also takes into account state and territory population projections, current service provision levels, and the total number of places which have already been allocated, including operational and provisional allocations—ie, those which are yet to take effect.

Level 2 decision: Regional distribution of places

The Secretary decides how places should be distributed across the aged care planning regions in each state and territory. This distribution is based on the national planning benchmark and advice from individual state or territory Aged Care Planning Advisory Committees. The committees provide recommendations to the Secretary on the distribution of new aged care places across planning regions. The recommendations are based on data on current and future supply and demand and information provided by federal, state/territory and local governments, community groups, individuals and organisations.

The distribution of new places across aged care planning regions aims to achieve a balance in providing services between:

- metropolitan, regional, rural and remote areas
- people needing differing levels of care, including people with special needs.

Details of the distribution of places to regions are contained in the Regional Distribution of Aged Care Places which is incorporated in the Aged Care Approvals Round Essential Guide. See References at the end of this chapter for a link.

ALLOCATED PLACES

LEGISLATIVE REFERENCES

Level 3 decision: Allocation of places

After deciding on the regional distribution of aged care places, the Secretary asks for applications from organisations interested in providing aged care services, through the Aged Care Approvals Round process.

Advertisements about the places made available and the application process are published in major national, regional and selected ethnic newspapers in each state and territory.

Allocation Principles 1997, 4.36–4.40

All applications are competitively assessed by the Department against the criteria set out in the Act and the Allocation Principles. *See legislative reference.*

The allocation of places to successful applicants takes into account the number of places made available for the Aged Care Approvals Round, the identified needs of an aged care planning region and the merits of each proposal. Places can only be allocated to an applicant who has been approved, or will be approved, to provide the type of aged care the places are for, once the allocation takes effect or is in force.

NOTIFICATION PROCESS

Applicants are advised in writing whether or not they have been successful in being allocated places. As part of this notification process, successful applicants are advised of:

- the number and care type of the places to be allocated—for example, 10 residential high-care places
- the aged care planning region in which the service is located
- whether or not the places are allocated provisionally or take effect immediately
- conditions related to the allocation.

PROVISIONAL ALLOCATIONS

An allocation of places to a provider will be a provisional allocation if the provider is not ready to provide care immediately—if for example, the building subject to the allocation is not yet completed.

A provisional allocation remains in force until the end of the provisional allocation period, which is two years unless the Department approves a request made by the provider to extend the period. The provider is expected to commence the service within the provisional allocation period, in accordance with the conditions of allocation, otherwise the allocation will cease.

A provider cannot receive a subsidy for a provisional allocation.

ALLOCATED PLACES

LEGISLATIVE REFERENCES

HOW ALLOCATED PLACES TAKE EFFECT

s 15-1, Aged Care Act 1997, 4.49, Allocation Principles 1997

An allocation takes effect when the Secretary determines that the provider is ready to provide care. There are a number of matters that the Secretary will consider in deciding when a provider is ready to provide care: *See legislative reference.*

- in relation to all types of aged care, whether the provider has met all of the conditions that must be met before the determination is made
- in relation to community care, whether the provider has entered into any required agreement with the Department
- in relation to residential care, the results of any inspection by the Department and, in addition, whether:
  - certificates to occupy the facility have been received from relevant government authorities
  - accreditation has been applied for and associated fees paid
  - the provider has registered in accordance with aged care prudential requirements
  - administrative and operational arrangements have been put in place.

Once it has taken effect, the approved provider can begin to receive subsidies for care recipients in those places. Places for which an allocation has taken effect are usually referred to as operational aged care places.

CONDITIONS OF ALLOCATION

The Secretary places conditions on all allocations of places, including:

s 14-5, Aged Care Act 1997

- conditions relating to particular allocations *See legislative reference.*

s 14-6, Aged Care Act 1997

- conditions that apply to all allocations in general, or of a particular kind. *See legislative reference.*

Providers are not required to accept places which they are allocated, that have conditions attached. However if they do accept the places, they may face sanctions if they fail to comply with any of the conditions and this could lead to the allocated places being revoked.

Conditions applying to particular allocations

s 14-5, Aged Care Act 1997

See legislative reference.

It is a condition of every allocation that the place is allocated for a specified location and a particular aged care service. Any care provided for that place must be at that location and service. Some conditions may relate to the allocation while it is provisional, for example, planning or timeline factors in the construction of an aged care service, while others may relate to the ongoing operation of the service.

Examples of matters with which conditions may deal include:

- the proportion of care to be provided to:
  - people with special needs
  - supported, concessional and assisted residents
  - respite care recipients
  - residents needing a particular level of care

LEGISLATIVE REFERENCES

- the period within which
  - the service is to start providing care
  - the premises to be used to provide care must be built
- professional planning of the aged care service
- the treatment of any lump sums paid for entry to the service before the provider received an allocation of Government-subsidised places
- the terms of accommodation bond agreements entered into after a refund of such lump sums.

Conditions applying to allocations generally

s 14-5, Aged Care Act, 1997

A number of conditions apply to all allocations, including: *See legislative reference.*

- that an approved provider cannot discharge and re-admit a resident to attract concessional resident supplement or to charge the resident an accommodation bond
- that an aged care service which relocates will only be recognised as a new service if the relocation is
  - to a new purpose-built facility for providing aged care
  - or to a totally different catchment area.

In relation to provisionally allocated places, an approved provider must:

- provide quarterly reports on its progress towards satisfying the Secretary that the allocation of places should take effect
- ensure its reports are in a format approved by the Department and received by the Department by the due dates
- bring its allocated places on line in a timely manner

Applying to vary conditions for operational places

Division 17, Aged Care Act 1997, Part 8, Allocation Principles 1997

s 17-1 Aged Care Act 1997

An approved provider may apply to the Secretary to vary any of the specific conditions which apply to particular allocations of its operational places. *See legislative reference.* However, approved providers cannot apply to vary conditions which apply to allocations in general and which apply to all providers equally. *See legislative reference.*

In deciding whether a variation is justified, the Secretary will consider:

- whether the variation will meet community needs and is consistent with other objectives of the allocation planning process
- the financial viability of the service where the places are located
- whether care needs will continue to be met
- the suitability of any different premises proposed to be used
- the effect of any change in location on current and future care recipients, including access to respite care, diversity of care and continuity of care.

ALLOCATED PLACES

LEGISLATIVE REFERENCES

Applications to vary conditions must be made at least 60 days before the proposed day of variation, unless the Secretary agrees to a shorter period. Approvals cannot be backdated. Applications must be made on either:

- the standard application form for a variation of conditions of allocation, for all conditions except respite
- or the standard application form for a variation of conditions of allocation for residential respite

See References at the end of this chapter for a link to these forms.

The Department will take the date proposed in the application as the variation day; and the Department will not recognise the approved changes as having taken effect before the variation day. The Secretary must approve or reject the application at least 14 days before the proposed variation day.

However, it can be difficult for an approved provider to work out a precise date in advance, or circumstances may change which prevent the variation occurring on the nominated day.

If an application to vary conditions **has not yet been approved** by the Secretary and either a later or an earlier variation day is required—ie, a date earlier or later than the date nominated in the application to vary conditions:

s 17-2(8), Aged Care Act, 1997

- then the approved provider should write to the Secretary about the proposed change. *See legislative reference.*

If an application to vary conditions **has** been approved by the Secretary:

- and an earlier variation day is required—ie, a date earlier than the date nominated in the application to vary conditions
  - then a new application is required. The approved provider should write to the Secretary about the proposed new variation day, stating that this letter, together with the information in the original application, be treated as a new application *See legislative reference.*

s 17-2(5) Aged Care Act 1997 s

- and a later variation day is required—ie, a date later than the date nominated in the application to vary conditions
  - then the approved provider should apply to the Secretary for a new variation day. *See legislative reference.*

s 17-7(2), Aged Care Act, 1997

The Secretary cannot approve a variation of conditions which would mean that the care to which the place relates would be provided in a different state or territory. *See legislative reference.* s 17-1(1)(d) Aged Care Act 1997

s 17-1(1)(d) Aged Care Act 1997

If further information is needed to decide whether a variation of conditions should be approved, the Secretary may ask for further information to be provided within 28 days. *See legislative reference.* s 17-3, Aged Care Act 1997

s 17-3, Aged Care Act 1997

Special conditions apply to a change of location of places which affect extra service status. See also the section on Allocations, transfers and variations in chapter on Extra service places in this Manual.

ALLOCATED PLACES

LEGISLATIVE REFERENCES

Applying to vary conditions for provisionally allocated places

An approved provider may also apply to vary its provisionally allocated places. *See legislative reference.*

s 15-5, Aged Care Act 1997

The variation may be a reduction in the number of places to which the provisional allocation relates; or a variation of the conditions to which the provisional allocation is subject. *See legislative reference.*

s 15-5, Aged Care Act 1997

The application must be lodged before the end of the provisional allocation period—ie, two years after the day on which the allocation was made, unless an extension to the provisional allocation period is approved or an application for an extension is pending.

If the proposed variation means that provisional allocation period needs to be extended, the approved provider must lodge an application for an extension using the required form. *See legislative reference.*

s 15-7(4), Aged Care Act 1997

TRANSFERRING OPERATIONAL PLACES TO ANOTHER PROVIDER

Under the Act, a transfer occurs when operational places previously allocated to one approved provider become allocated to another approved provider. *See legislative reference.*

s16-1A, Aged Care Act 1997, Part 7, Allocation Principles 1997

As a result of a transfer of places:

- any entitlement to unpaid aged care subsidy passes to the transferee
- the transferee inherits any responsibilities for accommodation bond balances that the transferor had before the transfer day
- the transferee inherits any obligations that the transferor had before the transfer day under a resident agreement or community care agreement. *See legislative reference.*

s 16-1, Aged Care Act 1997

The transferor must give the following records or copies of records to the transferee for each resident whose place is being transferred:

- assessment and classification records
- individual care plans, medical care plans, progress notes and other clinical
- details of fees and charges, including accommodation payments
- any agreements between those residents and the transferor
- the accounts of those residents
- name and contact details for each representative of those residents.

In addition, where applicable the transferor must provide records of the prudential requirements for accommodation bonds relating to the tranferor's service.

Applying to transfer places

The Secretary must approve all transfers of places between approved providers.

Before applying for a transfer of places, it is a good idea for the transferor and/or transferee to contact their state or territory office of the Department to discuss their proposal. The Department may ask both the transferor and the transferee to discuss specific aspects of their application.

ALLOCATED PLACES

LEGISLATIVE REFERENCES

When applying for transfer, an approved provider should use the standard form, providing the following information:

- details of any conditions that the transferor wants to have varied as part of the transfer, such as the location or the service
- the names of the transferor and transferee
- the number of places to be transferred
- the proposed day of transfer
- the aged care service where the places currently are and its location
- if the places are being transferred to a different service, the name of that service and its location, whether the service or part of it has extra service status and proposals for ensuring that care needs of the residents whose places are being transferred will be appropriately met
- if the places are being transferred to more than one other service, the application will need to address these issues in relation to each service
- whether any of the places:
  - have extra service status
  - are adjusted subsidy places
  - in respect of which residential care grants have been paid
  - in respect of which grants under the *Aged or Disabled Persons Care Act 1954* have been paid.

See References at the end of this chapter for a link to this form. Providers should also note the further information listed in s 4.61 of the Allocation Principles that the transferor and transferee must provide with an application. *See legislative reference.*

s 4.61, Allocation Principles 1997

Both the approved provider holding the allocation of places (the transferor) and the provider seeking the places (the transferee) must complete this form.

The application must be made:

- at least 60 days before the proposed transfer day, if the transferee is already an approved provider
- at least 90 days before the proposed transfer day, if the transferee has not yet been approved as an approved provider.

The proposed transfer day is the day specified in the application for the transfer of places and is the date from which the Department will recognise the transferee as being responsible for the places. In special circumstances, at the request of both the transferor and the transferee, the Secretary can reduce the above notice periods. However approvals made by the Department to transfer places cannot be backdated.

Unless the transferor and the transferee agree to a later date, the Secretary will approve or reject the application at least 14 days before the proposed transfer day.

Circumstances may change which prevent the transfer occurring on the nominated day. In cases like this, the action the parties to the transfer are required to take is outlined as follows.

ALLOCATED PLACES

LEGISLATIVE REFERENCES

If an application to transfer places **has not yet** been approved by the Secretary:

- and either an earlier transfer day is required (that is, a date earlier than that nominated in the application to transfer places) or a later transfer day is required (that is, a date later than that nominated in the application to transfer places)
  - then the transferor and transferee must jointly advise the Secretary in writing of the proposed change. *See legislative reference.*

s 16-2(8), Aged Care Act 1997

If an application to transfer places **has** been approved by the Secretary:

- and an earlier transfer day is required (that is, a date earlier than that nominated in the application to transfer places)
  - then a new application is required. This can be done by advising the Secretary in writing of the proposed new transfer day and stating that this, together with the information in the original application, be treated as a new application
- a later transfer day is required (that is, a date later than that nominated in the application to transfer places)
  - then the approved provider should apply in writing to the Secretary. *See legislative reference.*

s 16-7(2), Aged Care Act 1997

In making a decision about an application for a transfer, the Secretary must consider a number of matters specified under the Act and the Principles, including but not limited to: *See legislative reference.*

s 16-4, Aged Care Act 1997, s 4.63, Allocation Principles 1997

- whether the proposed transfer meets the objectives of the allocation planning process. See also Planning the provision of residential aged care services on page 17
- the suitability of the proposed transferee to provide the required aged care
- the financial viability of the transferor's service if the transfer were to occur
- the financial viability of the transferee's service
- whether the care needs of residents will continue to be appropriately met
- the impact on continuity of care
- the aged care record of the transferee and its key personnel
- the suitability of the premises, and in particular whether it meets certification requirements
- the effect of the proposed transfer on current and future care recipients in the region from which the places would be transferred and the region to which the places would be transferred.

In making a decision the Secretary will also take into account all the information provided in the application. If further information is needed to assess the application the Secretary may ask the transferor and/or the transferee for more information—for example, financial information that is independently verified.

The Secretary may also use any other relevant information available to the Department, such as Aged Care Approvals Round applications, planning information, complaints and compliance information and prudential compliance statements.

The Secretary may also obtain information and documents from other persons or organisations, including the Aged Care Standards and Accreditation Agency and organisations able to undertake financial probity and credit/debt investigations.

LEGISLATIVE REFERENCES

The Secretary may take into account the transferee's record of compliance with care standards and whether it is meeting obligations arising from receipt of payments from the Government for providing aged care and any strategies the applicant has to improve compliance with Government requirements.

s 16-10, 16-11, Aged Care Act 1997

The responsibilities and obligations of the transferor in relation to accommodation bonds and resident agreements become responsibilities and obligations of the transferee from the day of transfer day. *See legislative reference.*

Approval for the transfer is only given if the transferee is an approved provider by the transfer date. In some cases, the transferee will not be an approved provider at the time the application is made, or will have its current approval limited to particular types of aged care or services. In this case, the transferee must complete a separate approved provider status' application form and attach it to the application for transfer. See References at the end of this section for a link to this form.

Proposals are unlikely to be approved if they will move places from under-supplied regions to over-supplied regions. The Secretary also needs to be sure that the transferee and/or transferor have appropriate arrangements in place to ensure ongoing care for residents in the service. The transferor must advise the department:

- how it has informed residents and their carers about the proposed transfer
- how it plans to deal with any residents' concerns
- what guarantees they are offering to ensure that residents will not be disadvantaged because of the transfer.

s 4.61, Allocation Principles 1997

The transferor and transferee must also include further information, listed in s 4.61 of the Allocation Principles, with the application. *See legislative reference.*

Existing residents have security of tenure in their current aged care service, while it stays operational and can meet the resident's assessed care needs. A transfer will only be approved if the transferee demonstrates care recipients' needs will continue to be met.

If the transferee intends to close its service after a transfer, it is legally obliged to inform residents of their rights about leaving, including their right of access to internal and external complaints processes and advocacy services. The transferee must not take action to make the resident leave, or imply that the resident must leave, before suitable alternative and affordable accommodation is available that meet the resident's assessed long-term needs.

The Secretary cannot approve a transfer of places where it would have the effect of the care being provided in a different state or territory. An approval of transfer notification from the Secretary will include statements setting out, among other things:

- the proportion of care to be provided to people with special needs, and supported, concessional and assisted residents
- the number of respite care places
- proposals for ensuring that care needs are appropriately met for care recipients whose places are being transferred
- the level of care for the residential places involved in the transfer.

LEGISLATIVE REFERENCES

The Department will contact the transferor and transferee to ensure that the transfer will settle or has settled on the proposed transfer date, and to ensure that both parties are aware that the transferee will assume responsibility for those places from that date.

Special conditions apply to the transfer of extra service places. See also section on Allocations, transfers and variations in chapter on Extra service places in this Manual.

TRANSFERRING PROVISIONALLY ALLOCATED PLACES TO ANOTHER PROVIDER

Subdivision 16-B, Aged Care Act 1997, Part 7A, Allocation Principles 1997

Provisionally allocated places can be transferred in certain circumstances. *See legislative reference.*

This change allows a transfer of provisionally allocated places in exceptional circumstances. A transfer of provisionally allocated places might be approved if for example a provider has progressed a residential aged care development to a point where significant delays in the provision of care would occur if the development was not completed in a short timeframe; and the transferor is able to demonstrate that another provider could ensure completion and commence providing care at the same location.

In deciding whether to approve a transfer of provisionally allocated places, the Department must consider a number of factors, including:

- whether the proposed transfer meets the objectives of the allocation planning process
- whether the transferor has made such significant progress towards being in a position to provide care, in respect of the places, that it would be contrary to the interests of the aged community in the region not to permit the transfer
- whether the transferee is likely to be in a position to provide care within a short timeframe after the transfer
- the suitability of both the transferee and the premises proposed to be used for the provision of the required type of aged care
- whether the transferee can properly provide care in relation to places allocated for people with special needs or for a particular type of aged care
- the record of the transferee and its key personnel in the provision of aged care, including compliance with Government obligations
- the financial viability of the transferee and the service to which the places are to be transferred
- provision for protection of the rights of care recipients
- other matters set out in the Allocation Principles. *See legislative reference.*

s 4.66I, Allocation Principles 1997

Where an approved provider seeks to transfer provisionally allocated places, they will need to apply to the Department and include all required information. *See legislative reference.*

s 16-14 Aged Care Act 1997, s 4.66G Allocation Principles 1997

Approved providers should discuss their particular circumstances with their relevant state or territory office before submitting an application.

ALLOCATED PLACES

LEGISLATIVE REFERENCES

RELINQUISHING OPERATIONAL PLACES

Division 18, Aged Care Act 1997

An approved provider can voluntarily relinquish operational places by writing to the Secretary. To ensure that the needs of residents are met when operational places are relinquished, the approved provider must: *See legislative reference.*

- notify the Secretary at least 60 days before the day on which the places will be relinquished
- provide details of the service and the number of places to be relinquished
- specify how the care needs of residents who are affected will be appropriately met

s 4.72, Allocation Principles 1997

- deal with a range of other matters set out in the Allocation Principles. *See legislative reference.*

The Secretary will decide whether the proposal is satisfactory; and may request the approved provider modify any proposal if it is not satisfactory. If the approved provider does not comply with the request, the Secretary may set out new proposals for ensuring that the care needs of residents are appropriately met. Penalties may apply if the approved provider does not comply with the Secretary's requirements.

REVOKING PLACES

The Secretary may revoke operational places if they have not been used for the purpose of their allocation for a continuous period of 12 months. In such a case, the Secretary will notify the approved provider of the reasons for considering the revocation; and ask the approved provider to explain in a submission why the places have not been used.

In deciding whether to revoke the allocation of a place, the Secretary will consider, amongst other matters:

- why the places have not been used
- whether they are likely to be used in the near future
- whether revoking the allocation would have detrimental effects on the local community.

The Secretary may also revoke provisionally allocated places if the conditions to which the allocation is subject have not been met. In this circumstance, the Secretary will invite the provider to explain in writing within 28 days why the provisional allocation should not be revoked.

EXCHANGE OF CARE TYPE

Division 14, Division 18, Aged Care Act 1997

Exchange of care type refers to the mechanism through which one of the three types of aged care may be exchanged for another type of care, with the approval of the Secretary. It is a two step process. An approved provider must relinquish existing operational places under Division 18 of the Act and apply for an allocation of places under Division 14. *See legislative reference.* Only places that have taken effect may be exchanged. The places that can be reallocated are limited to the number of places relinquished and the state or territory in which the places have been relinquished.

ALLOCATED PLACES

The types of care that can be exchanged are permanently allocated. They include:

- residential care places
- community care places
- and flexible care places, including Extended Aged Care at Home (EACH) places and places for multi-purpose services.

Other flexible aged care places such as EACH Dementia, transitional care or innovative pool places cannot be exchanged.

Applying for exchange of care type

Before applying for exchange of care type, approved providers should obtain the Exchange of Care Type—Guidelines for Approved Providers to ensure that they are fully aware of the requirements of this application and of any future action resulting from the application. When applying for an exchange of care type, approved providers should used the standard form. See References at the end of this chapter for a link to this form.

About special needs groups

The Government is committed to providing access to quality aged care services for special needs groups. People with special needs include those:

- from Aboriginal and Torres Strait Islander communities
- from non-English speaking backgrounds
- who live in rural or remote areas
- who are financially or socially disadvantaged
- who are veterans (including a partner, widow or widower of a veteran)
- people who are homeless or who are at risk of homelessness.

Approved providers must be able to provide appropriate care to special needs groups. Providers may also have obligations in relation to people with special needs in their allocation conditions.

ABOUT SUPPORTED, CONCESSIONAL AND ASSISTED RESIDENTS

The Department determines a proportion of supported, concessional and assisted residents for each region. All aged care services in a region are expected to accept an appropriate proportion of supported (including concessional or assisted) residents to meet these levels. The proportions are determined by comparing information on the number of people in these groups aged 70 years and over with the general population aged 70 years and over in each region. The Department publishes regional ratio concessional and assisted resident targets.

ALLOCATED PLACES

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN THIS CHAPTER

Aged care approvals round—residential aged care places and capital grant allocations
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acar2007-index.htm

Aged care approvals round—Essential Guide
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acar2008-essential-guide.htm

Aged Care Information Line
Ph 1800 500 853

Application to Exchange Care Type—guidelines and form
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-exchange-care.htm

Approved provider status guidelines and application form
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-approvedp-index.htm

Forms—all
All Departmental forms are available on the Department's website at
www.health.gov.au/internet/main/publishing.nsf/Content/health-forms.htm

Form—transfer of places—application to transfer places other than provisionally allocated places to another approved provider
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-transfer-agedcare.htm

Form—variation of conditions—application for a variation of conditions of allocation—residential, community and flexible care places
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-app-vca.htm

Form—variation of conditions, respite—application for a variation of conditions of allocation—residential respite form for respite only—application form
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-app-vca-respite.htm

Form—variation of provisional allocation of places—application for a variation of a provisional allocation of places
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-forms-appprov.htm

EXTRA SERVICE PLACES

EXTRA SERVICE PLACES

LEGISLATIVE REFERENCES

This Manual has been written in plain English and as a result, some aspects of the legislation and policy have been simplified. It is intended to be a general guide only and does not constitute legal advice. In cases of discrepancy between the Manual and the legislation, the legislation will be the source document for payment of Australian Government benefits and enforcement of approved provider responsibilities.

RELEVANT LEGISLATION

- Part 2.5, *Aged Care Act 1997* (the Act)
- Section 58-5, *Aged Care Act 1997*
- Part 2.5, *Aged Care (Consequential Provisions) Act 1997*
- *Extra Service Principles 1997* (the Extra Service Principles)

OVERVIEW

Extra service places provide a significantly higher standard of accommodation and services to residents, without impacting upon the level of care being provided. Residents are usually charged a higher daily fee for the extra service—ie, the extra service amount—and as a consequence, the provider receives a lower amount of residential care subsidy from the Government for an extra service place.

All aged care services funded under the Act, as well as distinct parts of a service, may be eligible for extra service status.

Extra service places are subject to the conditions which apply to other residential aged care places. For example, to receive subsidies, an aged care service with extra service status must meet its accreditation requirements and it needs to be certified. In addition, there are other conditions that relate specifically to extra service.

Additional information

This chapter has been updated and revised to help approved providers comply with their responsibilities under the Act; and to assist staff of aged care services understand the regulation of residential aged care. Additional information can also be accessed through the Aged Care Information Line on 1800 500 853.

WHAT IS AN EXTRA SERVICE PLACE?

s 31-3, Aged Care Act 1997

An extra service place is a place: *See legislative reference.*

- in an aged care service which has approved extra service status
- to which an approved extra service fee applies
- in which residential aged care is provided on an extra service basis.

s 30-3, Aged Care Act 1997, s 14.5, Extra Service Principles 1997

Extra service status may be granted to an aged care service or a distinct part of a service—for example, a separate wing. This allows more flexibility and choice, both for residents and providers. A distinct part is an area of the service that: *See legislative reference.*

- is physically identifiable as separate from the rest of the premises
- includes sufficient living space for the residents

LEGISLATIVE REFERENCES

- includes dining and lounge areas (located together or separately) that are for the exclusive use of the residents
- has at least five extra service places.

In this chapter, references to an aged care service with extra service status includes services with extra service status in a distinct part of the service.

HOW IS EXTRA SERVICE STATUS GRANTED?

The Secretary invites applications for extra service status twice a year. One of these application rounds coincides with the annual Aged Care Approvals Round in which new and existing providers can apply for new residential aged care places. Applications are sought from both providers with existing places and providers seeking new places in the Aged Care Approvals Round.

Both an allocation of places and a grant of extra service status are required for an aged care service, or a distinct part of a service, to operate on an extra service basis. An application for extra service status does not constitute an application for an allocation of places; and an approval of extra service status does not necessarily result in an allocation of new residential places.

Following the Secretary's invitation to apply for extra service status, applicants can contact the Department to obtain an application form and guidelines, or an application can be downloaded from the Department's website. See References at the end of this chapter for a link to the application form.

Applicants may be required to provide documents, photographs, samples, architectural drawings or other information to support statements made in their applications.

s 32-3, Aged Care Act 1997

In order to be able to properly assess the application against the selection criteria, the Secretary can ask an applicant for further information or to agree to an on-site visit. *See legislative reference.*

Criteria for approval

s 32-4, Aged Care Act 1997, Division 4, Extra Service Principles 1997

All applications will be assessed against standard criteria. In order to be approved, an application must meet all the assessment criteria. If any one of these criteria is not met, the Secretary will not approve the application. *See legislative reference.*

The criteria are:

s 32-3(1), Aged Care Act 1997

- the applicant must be an approved provider, or have applied for approved provider status, at the time of applying for extra service status *See legislative reference.*

s 44-7, Aged Care Act 1997

- access to residential aged care must not be unreasonably reduced for supported, concessional or assisted residents, or for people aged 70 years and over, in the same service, who may have difficulty affording an extra service amount. See s 44-7 of the Act for a definition of concessional resident *See legislative reference.*
- the proposed standard of accommodation, food and services, must be significantly higher than the average standard provided in non-extra service services or places
- if the applicant has already been providing aged care, the applicant must have a very good record of conduct as an aged care provider and compliance with its responsibilities as a provider

- if the applicant has relevant key personnel in common with a person who is or has been an approved provider, the person has a very good record of conduct as an aged care provider and compliance with its responsibilities as a provider
- the service must be certified
- the service must meet its accreditation requirements
- there will be significant benefit to current and future residents in the region if the application is granted
- there will be a significantly increased diversity of choice for current and future residents, and their carers and families, if the application is granted
- the extra services would provide current and future residents in the region with better access to continuity of care, if the application is granted.

More detail on some of these criteria follows.

Access to residential aged care

An application for extra service will not be approved if granting extra service status will unreasonably reduce access to residential aged care for people who:

- live in the state, territory or region concerned
- are concessional residents
- are aged at least 70, who would have difficulty affording an extra service amount.

Factors which will be considered in determining whether access in the state, territory or region would be unreasonably reduced by approving the places sought in the application include:

- the number of existing and allocated residential aged places in the state, territory or region concerned
- the proportion of residential aged care that must be provided to concessional and assisted residents
- the estimated number of places providing care mainly or exclusively to special needs groups in the region, including whether the applicant has a particular focus on, or is required to provide places for residents from a special needs group—for example, residents from a culturally and linguistically diverse background. See also Conditions applying to particular allocations in chapter on Allocated places in this Manual.
- if the application is approved, the level of remaining non-extra service places for that state, territory or region
- the socio-economic status of the region, including concessional resident data
- relevant factors relating to the population or services in an adjoining region.

Accommodation, food and services

To be approved for extra service status, an aged care service must offer a significantly higher standard of accommodation, food and services than the average standard in an aged care service that does not have extra service status. This criterion is measured at the time of application.

The benchmarks for significantly higher standards of accommodation, food and services are met by providing a list of extra service choices that providers can offer. Providers do not have to offer each item listed but must score at least 60 out of

LEGISLATIVE REFERENCES

a possible 100 points in order for the significantly higher criterion to be satisfied, and must achieve minimum scores in the three categories of accommodation, food and services. Each category allows points to be earned for innovation and special features. There is also a mandatory requirement in regard to building standards. Points cannot be claimed for services that must be provided to all residents as specified care and services, or for services that are claimable under the Aged Care Funding Instrument (ACFI).

The application form provides some examples of significantly higher standards of food, accommodation and services. These examples are not intended to be prescriptive, but rather provide guidance for applicants. Applicants are encouraged to be innovative in their proposals in regard to additional facilities and services for residents.

Record of the applicant

s 14.19, Extra Service Principles 1997

If an applicant for extra service status has been a provider of aged care then the applicant must have a very good record of conduct as a provider over the previous three years or over their period of operation, if less than three years. *See legislative reference.*

The applicant's record in the following areas will be considered:

- compliance with responsibilities and obligations arising from the receipt of Government funding for aged care
- compliance with standards of care
- the number and nature of any complaints against the applicant
- the applicant's conduct in relation to other aged care services which are, or have been, operated by the applicant
- strategies the applicant has put in place to improve compliance with Government requirements.

Applications from new providers and from providers operating other services will also be considered. If the application is for a service that is not yet operating, the overall standards provided at any other services operated by the applicant are considered.

Certification and accreditation

An aged care service must be certified and meet its accreditation requirement to be granted extra service status. If a service ceases to be certified or no longer meets its accreditation requirement, its extra service status also ceases at the same time.

s 32-5, Aged Care Act 1997, Division 4, Extra Service Principles 1997

Competitive assessment

See legislative reference.

Applications may be assessed competitively if the Department receives more than one application for a state, territory or particular region, and if the Secretary is satisfied that approving the extra service status in each application would:

- unreasonably reduce access to residential aged care by concessional residents or by people aged 70 years and over who may find it difficult to afford an extra service amount
- or exceed the maximum number of extra services places which have been allowed by the Minister (currently 15 per cent of the total number of residential aged care places in each state and territory).

EXTRA SERVICE PLACES

LEGISLATIVE REFERENCES

Consideration will be given to:

- applications that best meet the assessment criteria
- the level of extra service fees proposed in the application.

Notification of extra service status

If extra service status is granted, the Secretary will notify an applicant within 90 days of receiving an application, unless the Secretary has requested further information from the applicant. In this case, the Secretary must notify the applicant of the outcome of the application within 90 days of receiving the additional requested information. *See legislative reference.*

s 32-9(1), Aged Care Act 1997

If extra service status is granted, the notice will include: *See legislative reference.*

s 32-9(2), Aged Care Act 1997

- any conditions to which the grant is subject
- when the extra service status commences
- when the extra service status ceases.

The notice can also specify that certain conditions must be met before extra service status commences. *See legislative reference.* If extra service status taking effect depends on certain conditions being met, the provider must write to the Department's relevant state or territory office and advise that the provider considers that the conditions can be met. The applicant must write 28 days before the proposed commencement, unless the proposed extra service status will become effective less than 60 days after the Department gives the notice granting extra service status. In this case, the applicant must write to the Department within seven days. *See legislative reference.*

s 14.25(1)(b), Extra Service Principles 1997

s 14.25(3), Extra Service Principles 1997

Conditions of extra service status

A grant of extra service status is subject to the conditions set out in the Act and the Extra Service Principles, and the specific conditions set out in a notice relating to the grant of extra service status. *See legislative reference.*

s 32-8(1), Aged Care Act 1997

A grant of extra service status is made for a particular service at a service's particular address. Conditions that may be included relate to the following:

- details of the accommodation, food and services to be provided
- arrangements regarding capital repayments
- agreements with residents setting out the terms on which they are to receive residential aged care on an extra service basis
- the level of the extra service charges.

Conditions can also include:

- criteria that must be met before the extra service status can take effect
- protection for residents—for example, residents must be offered the choice to occupy his or her place on an extra service basis, and elect not to receive care on an extra service basis if they were being provided with residential aged care through the aged care service or distinct part immediately before extra service status became effective.

EXTRA SERVICE PLACES

LEGISLATIVE REFERENCES

s 32-5, Aged Care Act 1997, Division 4, Extra Service Principles 1997

Conditions, other than those specified in the Act or the Extra Service Principles, may be varied by agreement between the provider and the Department. *See legislative reference.* The Department can take into consideration any relevant matter, and must consider the extent of any change in the level of the accommodation, food and services that may result from a proposed variation.

WHEN DOES EXTRA SERVICE STATUS CEASE?

Extra service status ceases when:

- the extra service status lapses
- the extra service status is revoked or suspended
- or the aged care service in which the place is located is no longer certified or does not meet its accreditation requirements. *See legislative reference.*

s 33-1, Aged Care Act 1997

Lapsing of extra service status

Extra service status lapses if:

- an allocation in respect all the places in the aged care service or distinct part, is relinquished or revoked
- a provisional allocation does not take effect before the end of the provisional allocation period
- or the approval of the person as a provider of aged care services ceases to have effect under Division 10 of the Act. *See legislative reference.*

Division 10, Aged Care Act 1997

Revoking or suspending extra service status as a sanction

s 66-1, Aged Care Act 1997

If a provider has not complied with its responsibilities under the Act, the Secretary can impose a sanction on the approved provider. *See legislative reference.* In some instances this may relate to the extra service status of the service, including:

- revoking or suspending the extra service status of a residential aged care service
- prohibiting the grant of extra service status in a residential aged care service.

Revoking or suspending extra service status on request

s 33-4, Aged Care Act 1997

See legislative reference.

If a provider requests it in writing, the Department must revoke or suspend extra service status at any time. A revocation or suspension has effect on the date requested by the provider, unless otherwise specified by the Department. However, the date of effect must not be earlier than 60 days after the request is received by the Department.

The Department will notify the provider in writing of the day from which extra service status is revoked or suspended.

EXTRA SERVICE PLACES

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FEES AND PAYMENTS

Extra service fee

As part of the application for extra service status, the provider must apply to the Secretary to set an extra service fee. *See legislative reference.* The extra service fee can vary for different places in an aged care service—for example, a provider can set a higher fee for a bigger room with a private bathroom.

s 35-1(1), Aged Care Act 1997

An application will be approved only if aged care services operated by the applicant have a very good record of compliance with standards of care and meeting obligations arising from Government payments. *See legislative reference.*

s 14.29, Extra Service Principles 1997

The Secretary cannot approve extra service fees where:

- the fee is a nil amount *See legislative reference.*

s 35-3(1), Aged Care Act 1997

- the average daily extra service fee across all extra service places in the service is less than $10. *See legislative reference.*

s 35-3(2), Aged Care Act 1997

EXAMPLE

How to calculate the average extra service fee

This is the average of the extra service fee for all places in the service or distinct part of the service with extra service status. The average must be at least $10 a place per day.

For example:

ROOM TYPES	PLACES		EXTRA SERVICE FEE	TOTAL
Single with ensuite	23	x	$12	= $276
Single without ensuite	23	x	$10	= $230
Double	4	x	$9	= $36
Total:	**50**			**$542**

$542 divided by 50 places = $10.84 average extra service fee

Extra service amount and extra service reduction

If eligible, approved providers may receive a residential care subsidy from the Government for each resident. *See legislative reference.* However, if the resident is occupying an extra service place then the residential care subsidy is reduced by 25 per cent of the approved extra service fee for that place. *See legislative reference*

s 42-1, Aged Care Act 1997

s 44-18, Aged Care Act 1997

The extra service amount is the maximum amount a provider can charge a resident for receiving extra service. A resident pays an extra service amount in addition to other fees, which may include the standard resident contribution (also known as the basic daily fee) and the daily income tested reduction (also known as the income tested fee).

EXTRA SERVICE PLACES

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s 58-5, Aged Care Act 1997

The extra service amount equals the extra service fee plus the extra service reduction. See the example below; and Extra service fee in chapter on Funding for Residential aged care in this Manual. *See legislative reference.*

EXAMPLE

If the extra service fee for a place is $20 per day, then the Government subsidy for a resident receiving extra service care in the place will be reduced by 25 per cent or $5 per day. The $5 per day is the extra service reduction.

The extra service amount is $25—ie, the extra service fee ($20 per day) plus the extra service reduction ($5 per day).

An aged care service cannot charge any fees above the extra service amount, for any of the accommodation, services or food specified in the conditions of grant of extra service status.

They can however charge GST for any item included in the extra service package that is not GST-exempt. This GST may be included in extra service payments agreed between the approved provider and the resident. Any accommodation, food or services listed in Schedule 1—Specified Care and Services of the Quality of Care Principles are GST-exempt. See also chapter on Specified care and services in this Manual. *See legislative reference.*

Schedule 1, Quality of Care Principles 1997

An aged care service can decide to charge less than the full extra service amount. If they do so, the extra service agreement with the resident should specify the circumstances under which they can increase the fee. In this instance, the extra service reduction is still calculated using the approved extra service fee. A resident receiving care on an extra service basis must have an extra service agreement with the provider. See Extra service agreement on page 40.

Extra service care recipients who are former prisoners of war would usually pay the extra service amount, while the Department of Veterans' Affairs may pay the resident contribution on their behalf.

Respite supplement

Part 7, Residential Care Subsidy Principles 1997

Aged care services with extra service status are eligible for the respite supplement. *See legislative reference.* Residents receiving respite care on an extra service basis may also be charged the extra service amount. The extra service reduction also applies to the extra service amount charged. See also chapter on Residential respite care in this Manual.

Changes in the levels of the extra service fee

An aged care service can apply to change the extra service fee for a place or places:

- as part of their overall application for extra service status
- while their extra service status is current. In this case, the application must be submitted to the Department's state or territory office at least 60 days before the proposed starting date of the new fee. This will allow time for the application to be considered and if approved, for residents to be notified.

EXTRA SERVICE PLACES

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The maximum amount by which an extra service fee may be increased is the total of:

- 20 per cent of the current fee
- plus the national consumer price index (CPI) percentage change, published for the most recent twelve month period, in which the additional extra service fee is currently being charged. *See legislative reference.*

s 14.34, Extra Service Principles 1997

EXAMPLE

An aged care service has been charging an extra service fee of $20 per day per place for three years; and their extra service amount is $25 per day. The service applies to the Department to increase the extra service fee by $2, up to $22. The application is received on 1 September 2009, with a request for the new fees to apply from 1 January 2010. The service sent the request more than 60 days before the proposed starting date of the new fee.

The current fee: $20

The permitted increase: 20 per cent plus 2.5 per cent (the national CPI rate change) which equals 22.5 per cent. 22.5 per cent of $20 equals $4.50. Therefore, the maximum increase is $4.50, up to $24.50

The requested $2 increase falls within this maximum. An application to vary the fees has not been approved in the previous 12 months. Therefore, subject to the other conditions for approval, the application is approved and the new fees can apply from 1 January, 2010.

Extra service fees cannot be adjusted until 12 months have elapsed from the date the most recent extra service fee variation or approval took effect. *See legislative reference.*

s 35-3(3), Aged Care Act 1997

Claiming arrangements

Providers need to notify the Department in writing when they start or stop providing a resident with care on an extra service basis.

The room type and start date should be entered on the monthly claim form for residential care subsidy when a resident first starts extra service care or moves to another room type. The start date should correspond with the date from which the extra service agreement takes effect, and the room type should correspond to the particular type of accommodation the resident has agreed to occupy—for example, a single room with private ensuite and balcony.

EXTRA SERVICE PLACES

LEGISLATIVE REFERENCES

Division 36, Aged Care Act 1997, Part 7, Extra Service Principles 1997

s 36-3, Aged Care Act 1997

s 14.38, Extra Service Principles 1997

Aged Care (Conditions of Allocation—Extra Service Places) Determination 2006 (No. 1)

s 36-2, Aged Care Act 1997

s 36-4, Aged Care Act 1997

Extra service agreement

A resident receiving care on an extra service basis must have an extra service agreement. *See legislative reference.*

The agreement must contain: *See legislative reference.*

- the level of extra service amount
- how the extra service amount may be varied
- the standard of the accommodation, food and services to be provided to the resident
- the provision set out in s 14.38 of the Extra Service Principles in relation to revocation, suspension or variation. *See legislative reference.*

The extra service agreement may be included as part of a standard resident agreement.

The original of the agreement should be given to the resident and the aged care service should retain a copy.

For each extra service place, the approved provider must provide the resident with the accommodation, services and food to the standard specified in the extra service agreement. *See legislative reference.*

In entering an agreement, the resident must not be subject to duress, misrepresentation or threat of disadvantage or detriment. *See legislative reference.* See also section on Accommodation payments—information provided to residents and resident agreements in chapter on Funding for permanent residential aged care; and section on Resident agreements in chapter on Residents' rights in this Manual.

New residents

If a service has extra service status, a new resident entering on an extra service basis will pay the extra service amount from the time they commence residing in the service.

Existing residents

Special arrangements apply for residents who are already living in an aged care service when extra service status becomes effective. These residents must be given a choice as to whether or not they wish to receive care on an extra service basis. They can continue to reside in the aged care service on a non-extra service basis, and therefore, cannot be charged an extra service amount. While services do not have to provide an extra service standard of accommodation, food and services to these residents, general provider responsibilities continue to apply.

Existing residents may choose to receive care on an extra service basis at any time, with a three month 'cooling off' period from the date of effect of the agreement, during which time they may change their mind. These residents need only notify the provider of their decision. The extra service agreement for such a resident must specify that the resident may terminate the agreement during this period without penalty of any kind. *See legislative reference.*

ELIGIBILITY FOR SUBSIDIES AND ADDITIONAL FUNDING

An aged care service with extra service status is not eligible for the following subsidies or payments:

LEGISLATIVE REFERENCES

- a viability supplement for any place in the service
- a hardship supplement, concessional resident supplement or supported resident supplement for a resident receiving care on an extra service basis
- capital grants. See Extra service status and capital repayment following. *See legislative reference.*

s 43-6, Aged Care Act 1997

EXTRA SERVICE STATUS AND CAPITAL REPAYMENT

Aged care services may receive funding under the Residential Care (Capital) Grants program, with funds provided in a capital payment. A service which has received a capital grant under the residential care capital grants programs will have to repay all or part of the grant if the service is approved for extra service status.

An aged care service will have capital repayment amounts deducted from the service's subsidy if:

- the service is granted extra service status
- the Department has previously made capital payments for the service, even if the payment were not made to that approved provider
- the payments have not been repaid to the Department.

See s 43-6 of the Act for a description of a capital payment. *See legislative reference.* See also section on Capital funding and extra service status in chapter on Capital grants for residential aged care in this Manual.

s 43-6, Aged Care Act 1997

Capital repayments can be deducted under an agreement signed between the provider and the Department and must be completed in three years. An aged care service will be required to repay only a proportion of the capital payment if:

- extra service status is granted for only a distinct part of a service. The proportion of capital to be repaid is equal to the proportion of places in the service which have extra service status
- or some or all of the capital payments were approved more than 5 years before the first of the deductions is to be made. The amount to be repaid is reduced by 10 per cent for each year beyond this 5 year period. See the example following.

EXAMPLE

An aged care service was approved for capital funding on 25 May 2000 for $100,000. The service, which has a total of 80 places, was granted extra service status for 20 places on 10 December 2008. These 20 places constitute a distinct part. *cont. p42*

EXAMPLE CONTINUED

The service would be liable for capital repayment deductions. The service and the Government would enter an agreement for those capital repayments to be repaid over three years. The proportion of capital repayment is calculated in the following way:

- a period of at least 6 months is counted as a complete year. In this example, the year 2000 is counted as a complete year.
- there are 9 complete years between date of approval and the due date for the first capital repayment deduction. For each complete year after 5 years, the proportion is reduced by 10 per cent. This means the amount to be repaid is reduced (by 4 x 10 per cent) to 60 per cent.
- $100,000 x 60 per cent = $60,000
- in addition, the service is being granted extra service status for a distinct part of 20 places from a total number of places of 80. The 20 places represent 25 per cent of the total places and therefore this means the amount to be repaid is further reduced to 25 per cent
- $60,000 x 25 per cent = $15,000
- the total amount to be repaid is $15,000.

EXTRA SERVICE STATUS AND SUPPORTED RESIDENT REQUIREMENTS

Aged care services which have extra service status for the whole facility generally do not have to meet supported resident requirements, unless specified under the conditions relating to the allocation of places or the grant of extra service status to that service.

However, if a service has a separate wing with extra service status, it will have to meet supported resident requirements for the remainder of the places in the service which do not have extra service status.

ALLOCATIONS, TRANSFERS AND VARIATIONS

Additional conditions apply if the allocation, transfer or variation of places involves relocating or allocating the places to an aged care service which has extra service status.

The Department can approve the allocation, transfer, or variation of places to an aged care service with extra service status if:

- the extra service places to be allocated, transferred or varied are able to form one or more distinct parts of the aged care service. In this case, the newly allocated or relocated places do not have extra service status (although this can later be applied for)
- or the existing extra service places do not form a distinct part but the Secretary is satisfied that the allocation, transfer, or variation meets the criteria for approving extra service status. In this case, the newly allocated or relocated places do have extra service status.

See also the chapter on Allocated places in this Manual.

EXTRA SERVICE PLACES

LEGISLATIVE REFERENCES

TRANSITIONAL ARRANGEMENTS—EXISTING APPROVALS

Aged care services that were approved for exempt status under the *National Health Act 1953* will continue to have this status under transitional arrangements made under the *Aged Care (Consequential Provisions) Act 1997*. These approvals are subject to conditions set out in the Act, the Extra Service Principles and any specific conditions that were attached to each approval. See References at the end of this chapter for a link to ComLaw for the *National Health Act 1953*.

Fees and subsidies

The approved levels of extra service fees made under the previous arrangements continue under the new arrangements.

The extra service amount is treated differently for different residents:

- for new residents who commence care on an extra service basis in the place on or after 1 October 1997, the extra service reduction is 25 per cent of the approved extra service fee. These residents will be income tested and may pay the extra service reduction
- or for people who were receiving care in an exempt bed prior to 1 October 1997, the extra service reduction is 50 per cent of the approved extra service fee. *See legislative reference.*

s 39AB(3)(1)(B), National Health Act 1953, s 64, Aged Care (Consequential Provisions) Act 1997

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN THIS CHAPTER

Aged Care Information Line

Ph 1800 500 853

Forms—all

All Departmental forms are available on the Department's website at *www.health.gov.au/internet/main/publishing.nsf/Content/health-forms.htm*

Form—application for extra service status

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-ess-essprov.htm#application

Legislation—other

Go to ComLaw to access other legislation mentioned in this chapter, including the National Health Act 1953
www.comlaw.gov.au

EXTRA SERVICE PLACES

ACCREDITATION AND QUALITY OF CARE

ACCREDITATION AND QUALITY OF CARE

LEGISLATIVE REFERENCES

This Manual has been written in plain English and as a result, some aspects of the legislation and policy have been simplified. It is intended to be a general guide only and does not constitute legal advice. In cases of discrepancy between the Manual and the legislation, the legislation will be the source document for payment of Australian Government benefits and enforcement of approved provider responsibilities.

RELEVANT LEGISLATION

- *Aged Care Act 1997,* Part 4.1 (the Act)
- *Quality of Care Principles 1997*
- *Accreditation Grant Principles 1999* (the Accreditation Grant Principles)
- *Accountability Principles 1998*

OVERVIEW

Ensuring that residents of aged care services have a good quality of life and receive good quality care is a priority for the Department and for the sector, and is central to the wellbeing of residents themselves. Accreditation plays an important role in achieving this outcome.

Accreditation is the arrangement established by the Government to verify that aged care services provide quality care and services for residents. It involves an independent team of quality assessors, appointed by the Aged Care Standards and Accreditation Agency Ltd (the Agency), evaluating the achievements of a service against a pre-determined set of Accreditation Standards. *See legislative reference.*

s 54-2, Aged Care Act 1997, Schedule 2, Quality of Care Principles 1997

All residential aged care services must be accredited in order to receive funding from the Australian Government through residential care subsidies. For exceptions to this, see Exceptional circumstances on page 50. Individual services, rather than an approved provider, are accredited. Once a service is accredited, it is monitored to check that it continues to comply with the Accreditation Standards.

Accreditation is formal recognition that the service is:

- operating in accordance with the Act and the Principles made under it
- providing high quality care including
  - working within a continuous improvement framework
  - making required improvements.

In addition to meeting the requirements of the Accreditation Standards, approved providers must also:

- comply with relevant local, state and Australian Government regulatory requirements
- comply with professional standards and guidelines
- adhere to requirements about charging fees, providing specified care and services and having appropriate staffing. See also chapter on Specified care and services in this Manual.

ACCREDITATION AND QUALITY OF CARE

Additional information

This chapter has been updated and revised to help approved providers comply with their responsibilities under the Act; and to assist staff of aged care services understand the regulation of residential aged care. Additional information can also be accessed through the Aged Care Information Line on 1800 500 853.

ABOUT THE AGED CARE STANDARDS AND ACCREDITATION AGENCY

The Agency was established to:

- manage the accreditation process using the Accreditation Standards
- promote high quality care including
  - identifying best practice in the industry, in order to help the industry improve
  - providing information, education and training to the industry
- assess services working towards accreditation
- monitor compliance with the Accreditation Standards and liaise with the Department about services that do not comply with the standards.

See References at the end of this chapter for the Agency's contact information.

ACCREDITATION

Who audits aged care services?

A team of quality assessors appointed by the Agency carries out accreditation audits of residential aged care services. All assessors have completed an approved training course and are registered as aged care quality assessors with the registrar of assessors. Quality assessors may either be employed by or contracted by the Agency. All assessors must update their registration annually.

In applying for re-accreditation, an approved provider can nominate up to three registered aged care quality assessors, one of whom is to be part of the assessment team which conducts the audit of their service. In selecting the members of an assessment team, the Agency considers any nominations made by the applicant, the availability of assessors for the full period of the audit, and potential conflicts of interest. Where an applicant has nominated one or more quality assessors who are eligible for inclusion in the team, the Agency must include one of the nominees on the team.

Accreditation fees

The Government subsidises the accreditation process. Aged care services with less than 20 places do not have to pay accreditation fees. Fees for larger services are subsidised. See References at the end of this chapter for a link to accreditation fees on the Agency's website.

LEGISLATIVE REFERENCES

Accreditation—commencing services

An aged care service is considered a commencing service if an approved provider has been allocated places for that service, residential aged care has not previously been provided for those places and the service is not currently accredited by the Agency. *See legislative reference.*

Division 14, Aged Care Act 1997

An accreditation application for a commencing service is assessed mainly on the basis of the information given by the applicant. No site audit is conducted, as persons are not yet receiving care at the service. However, once residents are admitted, the Agency monitors commencing services' provision of care and services.

The Agency must decide whether to accredit a commencing service within 14 days of receiving an application and application fee from the approved provider. The Agency must notify the applicant of its decision within 28 days of the decision. Commencing services are accredited for 12 months. *See legislative reference.*

Division 3, Subdivision 1, Accreditation Grant Principles 1999

Accreditation—existing services

For existing services, the accreditation process involves the steps below:

- an approved provider applies to the Agency for accreditation for an aged care service, using the Agency's standard form. See References at the end of this chapter for a link to the form.
- the application must include;
  - a self-assessment of the service's performance against each of the Accreditation Standards
  - the appropriate fee
  - a commitment that the service will undertake continuous improvement.
- within 49 days of receiving the application, a team of aged care quality assessors appointed by the Agency generally completes an assessment of the application and information provided by the Department about the service; and provides a report to the Agency which recommends whether or not the Agency continue with the application. This is called completing a desk audit
- within 7 days of receiving the completed desk audit, the Agency decides whether to continue processing or to reject the application for accreditation. The applicant must be informed in writing within 7 days of this decision
- if the Agency decides to proceed with the application for accreditation, a team of quality assessors conducts an on-site accreditation audit of the service—this is called a site audit. The site audit must be completed within 56 days after the Agency notifies the applicant of its decision to proceed with the application
- within 3 days of being told when the site audit will start, the approved provider must tell residents when the site audit will be carried out and that they will have an opportunity to talk to members of the assessment team
- during the site audit, the team assesses the service's performance against each of the 44 expected outcomes of the Accreditation Standards. The team looks at relevant documentation, observes practices and talks with staff, residents and others
- during a site audit, the assessors value the time and information given to them by residents. The assessors are required not to reveal the identity of residents or representatives of residents

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- at the end of the site audit the assessment team conducts an exit interview at which the aged care service is provided with a report which includes the major findings of the site audit
- within 14 days of the completion of the site audit, the assessment team is required to provide a written report to the Agency which, among other things, makes a recommendation about accreditation of the service and about the period of accreditation.

Division 3 Subdivision 4, Accreditation Grant Principles 1999

The accreditation decision

See legislative reference.

Within 28 days of receiving the site audit report from the assessment team, the Agency must decide whether or not to grant a further period of accreditation to the service. (This is unless a later date is agreed between the Agency and the applicant.)

s 2.27, Accreditation Grant Principles 1999

In deciding whether to accredit a service, the Agency considers: *See legislative reference.*

- the desk audit report (if any)
- the site audit report
- information received from the applicant in response to the report of the site audit
- information from the Department
- whether it is satisfied that the service will undertake continuous improvement measures against the Accreditation Standards.

s 2.31, Accreditation Grant Principles 1999

If the Agency decides **not** to accredit the service they must: *See legislative reference.*

- decide when the decision is to take effect from
- decide the form and frequency of support contacts
- advise the applicant and the Secretary of the decision within 28 days
- give the applicant written reasons for the decision, including a recommendation about the improvements that would be necessary to demonstrate compliance with the Accreditation Standards and
- give the applicant a copy of the information provided by the Department for the assessment, a copy of the site audit report, information about arrangements for support contacts, information about how and when to submit an improvement outline and information about how to apply for reconsideration by the Agency of the decision.

s 2.28, Accreditation Grant Principles 1999

If the Agency decides to accredit the service they must decide: *See legislative reference.*

- the period of accreditation
- the form and frequency of support contacts with the service
- any improvements that must be made to improve the service's compliance with the Accreditation Standards.

s 2.29, Accreditation Grant Principles 1999

The Agency must notify the applicant of the decision within 14 days and also provide the applicant with: *See legislative reference.*

- information on the period for which the service is to be accredited
- information on how to apply for reconsideration of the period of accreditation

- information on the arrangements for support contacts and how these may be varied
- information on whether there are any improvements that must be made to improve the service's compliance with the Accreditation Standards
- information on the circumstances in which a review audit may be conducted
- the arrangements for a further period of accreditation after the accreditation period ends and the date by which an application should be provided for that further period
- a copy of the site audit report
- a certificate of accreditation for the service, which sets out the period for which it is accredited.

A copy of the site audit report is also placed on the Agency's website.

If the Agency believes that a service presents a serious risk to the health, safety or wellbeing of residents, it will immediately notify the Department and make recommendations about whether or not sanctions under the Act should be imposed on the approved provider. In these circumstances, the aged care service may be granted a reduced period of accreditation or may not be accredited.

What happens once an aged care service is accredited?

The service is required to submit a plan for continuous improvement to the Agency. The Agency maintains regular contact with the service to monitor the service's progress and to ensure that the Accreditation Standards continue to be met. Services need to re-apply for another period of accreditation before the current one expires. The date by which an application must be provided for any further period of accreditation is advised at the time of accreditation.

Monitoring after accreditation

The Agency continues to monitor the performance of each service, through support contacts and other means, during its period of accreditation. Once a service has been accredited:

- the Agency carries out regular supervision to ensure
  - it is complying with the Accreditation Standards and its other responsibilities under the Act
  - and to help the service undertake continuous improvement.
- the Agency may also do a review audit if
  - it believes on reasonable grounds that a service is not complying with the Accreditation Standards or other responsibilities under the Act
  - there is a change in the service which the approved provider must tell the Department about—for example, a change in ownership or key personnel
  - it is requested to do so by the Department.

See Review audits on page 51.

LEGISLATIVE REFERENCES

EXCEPTIONAL CIRCUMSTANCES

ss 42-1 and 42-4, Aged Care Act 1997

An approved provider is eligible to receive residential care subsidies for any day, if the approved provider has a current allocation of places; is providing care to approved residents; and the service meets its accreditation requirement. *See legislative reference.*

s 42-5, Aged Care Act 1997

If an aged care service has applied for accreditation—but has not achieved accreditation or the Agency has revoked accreditation—the Secretary can decide that the service meets its accreditation requirements. *See legislative reference.* However, this can only happen if the Secretary is satisfied that exceptional circumstances apply to the service.

A determination of exceptional circumstances:

- cannot be made if there is an immediate or severe risk to the safety or wellbeing of residents at the aged care service and/or where the approved provider has not applied for accreditation
- is for a maximum of six months and cannot be extended. A second determination cannot be made in relation to a service unless the service has been accredited by the Agency after the first exceptional circumstances determination was made
- must be revoked, if the original reasons for granting exceptional circumstances no longer applies, or if an immediate or severe risk to the safety or well-being of residents arises at the service.

If an aged care service is not accredited but a determination is in place:

- the Agency will continue to monitor its performance, including any progress made in improving its performance, and the approved provider will continue to receive residential care subsidies for the residents in the service.

NON-COMPLIANCE WITH THE ACCREDITATION STANDARDS

The Agency can organise a review audit, if they assess a service and find:

- that it is not complying with the Accreditation Standards
- or has failed to implement required improvements.

Depending on the findings of a review audit:

- the Department may impose sanctions
- the Agency may decide to
  - vary the period of accreditation
  - revoke accreditation. See also section on What sanctions can be imposed? in chapter on Providers' responsibilities and non-compliance in this Manual
  - not revoke accreditation, in which case it may agree on a timetable for improvement. *See legislative reference.*

Part 4, Accreditation Grant Principles 1999

LEGISLATIVE REFERENCES

APPEALING, RECONSIDERATIONS AND REVIEWABLE DECISIONS

An approved provider can ask for reconsideration and/or review of a range of decisions resulting from the accreditation site audit, including: *See legislative reference.*

Part 7, Accreditation Grant Principles 1999

- refusal to include a nominated assessor on the assessment team
- inclusion of a specific qualified assessor on the assessment team
- refusal of application for accreditation following a desk audit
- the period of accreditation
- a decision not to accredit.

The timeframes and processes for seeking reconsideration or review are outlined in the Accreditation Grant Principles and vary depending on the particular decision.

When the Agency receives a request for reconsideration, the decision is made by a new decision-maker—that is, someone within the Agency other than the original decision-maker considers requests for decisions to be reconsidered. Following reconsideration of a decision by the Agency, in some circumstances, the approved provider can also apply to the Administrative Appeals Tribunal (AAT) for a review of that decision. Most decisions must be reconsidered by the Agency prior to review by the AAT, although a small number of decisions may go straight to the AAT for review. See References at the end of this chapter for a link to the Administrative Appeals Tribunal.

REVIEW AUDITS

A review audit assesses a service's quality of care against the Accreditation Standards. The Agency may arrange for an assessment team to conduct a review audit of an accredited aged care service if: *See legislative reference.*

s 3.21, Accreditation Grant Principles 1999

- it believes on reasonable grounds that the service is not complying with the Accreditation Standards or other responsibilities under the Act
- there has been a change to the service, such as change of ownership or key personnel
- there has been a change to the premises of the service
- there has been a transfer of allocated places
- the service has not complied with arrangements made for support contacts
- the Department directs the Agency to do so.

s 3.22, Accreditation Grant Principles 1999

A review audit: *See legislative reference.*

- is conducted by a team of at least two quality assessors
- may be announced or unannounced
- is carried out on the service's premises
- assesses the service's systems against all 44 expected outcomes of the Accreditation Standards
- considers information and comments received from the Secretary, residents and former residents and the approved provider of the service.

LEGISLATIVE REFERENCES

s 3.23, Accreditation Grant Principles 1999

At the end of a review audit the assessment team will meet with the approved provider to discuss the assessment and provide a written report of the major findings of the review audit. Within 7 days of that meeting, the approved provider or key personnel can give the Agency and the assessment team a written response to the report. *See legislative reference.*

The assessment team prepares a written report, which it gives to the Agency within 7 days of completing the review audit. The report makes a recommendation about whether or not the service's accreditation should be revoked and the reasons for that recommendation.

If the report recommends revoking accreditation, it will also include a recommendation about improvements which would be necessary for the service to be recommended for accreditation if it applied in the future.

If the report does not recommend revoking accreditation, then it will include recommendations about whether the period of accreditation should be varied; and details of further support contacts with the service.

s 3.24, Accreditation Grant Principles 1999

After it receives the review audit report from the assessment team, the Agency must decide whether or not to revoke the accreditation of the service or to vary the period of accreditation. The Agency must tell the aged care service in writing of its decision within 14 days of receiving the review audit report. *See legislative reference.*

s 3.25, Accreditation Grant Principles 1999

If the Agency decides **not** to revoke accreditation it must decide: *See legislative reference.*

- if there are matters which require improvements to be made to ensure the service complies with its responsibilities for continuous improvement
- the need to agree on a timetable to make improvements in these matters and
- the form and frequency of support contacts with the service.

The Agency must advise the approved provider about these decisions. Within 14 days of being told about the decision, the approved provider can write to the Agency and ask it to reconsider its decision. If the Agency receives a request for reconsideration, it must decide whether or not to confirm its decision, and advise the approved provider, in writing, within 14 days of receiving the request.

If the Agency decides **to vary** the period of accreditation, then it must give the approved provider written reasons for the variation.

If the Agency decides **to revoke accreditation** then it must:

- give the approved provider written reasons for the revocation, including recommendations about improvements that would be necessary to recommend continuation of the service's accreditation
- tell the approved provider when the decision takes effect
- advise the approved provider how to apply for reconsideration and review of the decision and about arrangements for the supervision of the service during the review period.

Within 14 days of being told about the decision, the approved provider may ask the Agency to reconsider a decision to revoke the accreditation of the service.

s 54.6 Accreditation Grant Principles 1999

If serious risk or non-compliance is identified during the review audit, the Secretary is notified. In cases of serious risk, a report on the serious risk is prepared; and the Secretary can consider imposing sanctions. *See legislative reference.*

LEGISLATIVE REFERENCES

REFERRAL TO THE DEPARTMENT

The Department will be notified immediately if an aged care service's accreditation is revoked. When accreditation is revoked Government funding to the service will stop.

The Agency must notify the Department of any serious risk or non-compliance identified during an audit or found at the end of a timetable for improvement. *See legislative reference.* A delegate to the Secretary makes the decision about whether or not to apply sanctions in such cases.

Part 4, Accreditation Grant Principles 1999.

NURSING AND RELATED STAFFING REQUIREMENTS

Skilled nursing and other staff play a major role in delivering quality care in residential aged care services. There are specific legislative and other requirements about the level and qualifications of staff employed in an approved aged care service, which providers need to consider when deciding on the staffing mix that best meets the needs of residents.

The Act and the Principles require providers to maintain an adequate number of appropriately skilled staff, including skilled nursing staff, to meet the care needs of residents. *See legislative reference.* Residents who need high level care must be provided with certain care and services, including nursing services provided by a registered nurse or other appropriate professional.

s 54-1(1)(b) Aged Care Act 1997

- Initial and ongoing assessment, planning and management of care for high care residents must also be carried out by a registered nurse.
- Where assessed care needs require nursing or other skilled staff, those staff must be engaged. For example, an expected outcome for residents with specialised nursing needs is that those needs are identified and met by appropriately qualified nursing staff. *See legislative reference.*
- The accreditation requirements take this further by explicitly requiring aged care services to have a skills mix in place which is appropriate to the needs of their residents.
- If the range of resident dependency in the service changes, the service needs to ensure staffing skills also change to match resident need.
- There must be at least one responsible person continuously on call to provide emergency assistance.

Schedule 1, Part 3, Schedule 2, Part 2, Quality of Care Principles 1997

THE ACCREDITATION STANDARDS

Services that apply for accreditation will be assessed against the four standards outlined below: *See legislative reference.*

Schedule 2, Quality of Care Principles 1997

- management systems, staffing and organisational development (Part 1)
- health and personal care (Part 2)
- resident lifestyle (Part 3)
- physical environment and safe systems (Part 4).

Each standard includes a number of expected outcomes. There are 44 expected outcomes in total.

LEGISLATIVE REFERENCES

Schedule 2, Part 1, Quality of Care Principles 1997

Standard 1: Management systems, staffing and organisational development

See legislative reference.

Within the philosophy and level of care offered in the residential care service, management systems are responsive to the needs of residents, their representatives, staff and stakeholders, and the changing environment in which the service operates.

- Continuous improvement—The organisation actively pursues continuous improvement.
- Regulatory compliance—The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines.
- Education and staff development—Management and staff have appropriate knowledge and skills to perform their roles effectively.
- Comments and complaints—Each resident (or his or her representative) and other interested parties have access to internal and external complaints mechanisms.
- Planning and leadership—The organisation has documented the residential care service's vision, values, philosophy, objectives and commitment to quality throughout the service.
- Human resource management—There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives.
- Inventory and equipment—Stocks of appropriate goods and equipment for quality service delivery are available.
- Information systems—Effective information management systems are in place.
- External services—All externally sourced services are provided in a way that meets the residential care service's needs and service quality goals.

Schedule 2, Part 2, Quality of Care Principles 1997

Standard 2: Health and personal care

See legislative reference.

Residents' physical and mental health will be promoted and achieved at the optimum level in partnership between each resident (or their representative) and the health care team.

- Continuous improvement—The organisation actively pursues continuous improvement.
- Regulatory compliance—The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines, about health and personal care.
- Education and staff development—Management and staff have appropriate knowledge and skills to perform their roles effectively.
- Clinical care—Residents receive appropriate clinical care.
- Specialised nursing care needs—Residents' specialised nursing care needs are identified and met by appropriately qualified nursing staff.
- Other health and related services—Residents are referred to appropriate health specialists in accordance with the resident's needs and preferences.

LEGISLATIVE REFERENCES

- Medication management—Residents' medication is managed safely and correctly.
- Pain management—All residents are as free as possible from pain.
- Palliative care—The comfort and dignity of terminally ill residents is maintained.
- Nutrition and hydration—Residents receive adequate nourishment and hydration.
- Skin care—Residents' skin integrity is consistent with their general health.
- Continence management—Residents' continence is managed effectively.
- Behavioural management—The needs of residents with challenging behaviours are managed effectively.
- Mobility, dexterity and rehabilitation—Optimum levels of mobility and dexterity are achieved for all residents.
- Oral and dental care—Residents' oral and dental health is maintained.
- Sensory loss—Residents' sensory losses are identified and managed effectively.
- Sleep—Residents are able to achieve natural sleep patterns.

Standard 3: Resident lifestyle

Schedule 2, Part 3, Quality of Care Principles 1997

See legislative reference.

Residents retain their personal, civic, legal and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community.

- Continuous improvement—The organisation actively pursues continuous improvement.
- Regulatory compliance—The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines, about resident lifestyle.
- Education and staff development—Management and staff have appropriate knowledge and skills to perform their roles effectively.
- Emotional support—Each resident receives support in adjusting to life in the new environment and on an ongoing basis.
- Independence—Residents are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential aged care service.
- Privacy and dignity—Each resident's right to privacy, dignity and confidentiality is recognised and respected.
- Leisure interests and activities—Residents are encouraged and supported to participate in a wide range of interests and activities of interest to them.
- Cultural and spiritual life—Individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered.
- Choice and decision-making—Each resident (or his or her representative) participates in decisions about the services the resident receives, and is enabled to exercise choice and control over his or her lifestyle while not infringing on the rights of other people.
- Resident security of tenure and responsibilities—Residents have secure tenure within the residential care service, and understand their rights and responsibilities.

LEGISLATIVE REFERENCES

Schedule 2, Part 4, Quality of Care Principles 1997

Standard 4: Physical environment and safe systems

See legislative reference.

Residents live in a safe and comfortable environment that ensures the quality of life and welfare of residents, staff and visitors.

- Continuous improvement—The organisation actively pursues continuous improvement.
- Regulatory compliance—The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines, about physical environment and safe systems.
- Education and staff development—Management and staff have appropriate knowledge and skills to perform their roles effectively.
- Living environment—Management of the residential care service is actively working to provide a safe and comfortable environment consistent with residents' care needs.
- Occupational health and safety—Management is actively working to provide a safe working environment that meets regulatory requirements.
- Fire, security and other emergencies—Management and staff are actively working to provide an environment and safe systems of work that minimise fire, security and emergency risks.
- Infection control—An effective infection control program.
- Catering, cleaning and laundry services—Hospitality services are provided in a way that enhances residents' quality of life and the staff's working environment.

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN THIS CHAPTER

Accreditation fees—administered by the Aged Care Standards And Accreditation Agency

www.accreditation.org.au/accreditation/accreditationfees

Administrative Appeals Tribunal

www.aat.gov.au

Aged Care Information Line

Ph 1800 500 853

Aged Care Standards And Accreditation Agency

www.accreditation.org.au

National Office
PO Box 773
Parramatta NSW 2124
Ph: (02) 9633 1711
Fax: (02) 9633 2422

Victoria and Tasmania office
PO Box 398
Box Hill VIC 3128
1800 288 025
Ph: (03) 9897 4322
Fax: (03) 9898 7577

Tasmania
GPO Box 313
Hobart TAS 7001
1800 288 025
Ph: (03) 6224 6482
Fax: (03) 6223 2410

South Australia and Northern Territory
GPO Box 620
Adelaide SA 5001
1800 288 025
Ph: (08) 8217 6000
Fax: (08) 8212 8544

Western Australia
PO Box 718
Osborne Park WA 6916
1800 288 025
Ph: (08) 9201 1344
Fax: (08) 9201 1355

New South Wales and Australian Capital Territory
PO Box 674
Parramatta NSW 2124
1800 288 025
Ph: (02) 9633 2099
Fax: (02) 9687 0415

Queensland
PO Box 1032
Spring Hill QLD 4004
1800 288 025
Ph: (07) 3852 3100
Fax: (07) 3852 3011

Form—accreditation application—from the Aged Care Standards And Accreditation Agency

www.accreditation.org.au/accreditation/applicationforaccreditation

Forms—all

All Departmental forms are available on the Department's website at *www.health.gov.au/internet/main/publishing.nsf/Content/health-forms.htm*

ACCREDITATION AND QUALITY OF CARE

CERTIFICATION

CERTIFICATION

LEGISLATIVE REFERENCES

This Manual has been written in plain English and as a result, some aspects of the legislation and policy have been simplified. It is intended to be a general guide only and does not constitute legal advice. In cases of discrepancy between the Manual and the legislation, the legislation will be the source document for payment of Australian Government benefits and enforcement of approved provider responsibilities.

RELEVANT LEGISLATION

- Part 2.6, Divisions 37-39; Part 4.2, Divisions 57, 57A, *Aged Care Act 1997* (the Act)
- *Certification Principles 1997* (the Certification Principles)
- *Residential Care Subsidy Principles 1997*
- *User Rights Principles 1997*

OVERVIEW

The certification process is designed to provide an incentive for approved providers to improve their buildings by investing in them; and providing an income stream to enable them to do so. Only certified services can:

- charge residents accommodation payments—ie, either an accommodation bond or an accommodation charge. See Accommodation bonds on page 65
- or receive the accommodation supplement or the concessional resident supplement.

When assessing whether a service can be certified under s38-1 of the Act, the Secretary must consider: *See legislative reference.*

s 38-1, Aged Care Act 1997

- the standard of the buildings and equipment that are being used to provide residential care
- the standard of residential care provided by the service
- the conduct of the approved provider and whether the provider has complied with its responsibilities and obligations under the Act
- any of the matters set out in s 8.10 of the Certification Principles. *See legislative reference.*

s 8.10, Certification Principles 1997

To achieve certification, a service must demonstrate, in an on-site building inspection, that it has achieved specified building quality measures. The service's buildings are assessed using the Aged Care Certification Assessment Instrument. See References at the end of this chapter for a link

The requirements of the certification program are also explained in Building Quality for Residential Care Services—Certification. See References at the end of this chapter for a link.

Certification is not time-limited—ie, a service's certification status generally does not expire. However, certification status can be reviewed. *See legislative reference.* A review may be undertaken if, for example, there are significant changes to the structure of the premises or an increase in the number of allocated places.

s 39-4, Aged Care Act 1997

CERTIFICATION

Additional information

This chapter has been updated and revised to help approved providers comply with their responsibilities under the Act; and to assist staff of aged care services understand the regulation of residential aged care. Additional information can also be accessed through the Aged Care Information Line on 1800 500 853.

THE CERTIFICATION ASSESSMENT INSTRUMENT

Services are inspected under the Aged Care Certification Assessment Instrument, November 2002 Revision. See References at the end of this chapter for a link.
To be eligible for certification, a service must:

- achieve an overall mark of at least 60 out of a possible 100 points
- score at least 19 out of 25 for Section 1: Safety.

THE CERTIFICATION ASSESSMENT INSTRUMENT INCLUDES THE SEVEN SECTIONS BELOW:

	ASPECT OF BUILDING QUALITY	MAXIMUM POSSIBLE POINTS
Section 1	safety	25 points
Section 2	hazards	12 points
Section 3	privacy	26 points
Section 4	access, mobility and occupational health and safety	13 points
Section 5	heating/cooling	6 points
Section 6	lighting/ventilation	6 points
Section 7	security	12 points

In addition to the seven criteria above, services are also required to meet a set of Australian Government standards relating specifically to fire, safety, privacy and space.

Homes are not eligible to receive the increased fees and subsidies introduced by the Government on 20 March 2008 until the targets for fire and safety and privacy and space are achieved.

Fire and safety

Aged care homes were expected to meet specific fire and safety standards by the end of 2005. Homes must score at least 19 out of 25 in section 1 of the Certification Assessment Instrument (Safety) to meet fire and safety standards

Privacy and space

Aged care homes had until December 2008 to meet specific standards relating to privacy and space. The specific standards for privacy and space in residential aged care homes are based on the date of construction of the buildings.

LEGISLATIVE REFERENCES

Privacy and space requirements for buildings constructed post-July 1999

- Number of residents per room
  - an average of no more than 1.5 residents per room
  - no one room can accommodate more than 2 residents
  - rooms to accommodate a higher number of residents may be approved in limited cases where the provider is able to demonstrate that a higher number of residents per room is culturally appropriate on an ongoing basis.
- Access to toilets and showers:
  - no more than 3 residents per toilet
  - no more than 4 residents per shower or bath
  - toilets, showers and baths distributed across the building to ensure that all residents have equitable and ready access. Showers and toilets used primarily by staff are not included when these averages are calculated.

Privacy and space requirements for buildings constructed pre-July 1999

- Number of residents per room
  - an average of no more than 4 residents per room. It is expected however, that providers will strive to meet the optimal target of a maximum of 2 residents per room
  - rooms to accommodate a higher number of residents may be approved in limited cases where the provider is able to demonstrate that a higher number of residents per room is culturally appropriate on an ongoing basis.
- Access to toilets and showers
  - no more than 6 residents per toilet
  - no more than 7 residents per shower
  - toilets, showers and baths distributed across the building to ensure that all residents have equitable and ready access. Showers and toilets used primarily by staff are not included when these averages are calculated. *See legislative reference.*

Schedule 1, Residential Care Subsidy Principles 1997

CERTIFICATION ASSESSMENTS

The entire service is certified

Certification is granted for an entire service, not for any one building or one part of a residential care service *See legislative reference.* If residential care is provided at more than one location through the same residential care service, only one application may be made for all those locations. *See legislative reference.*

s 39-2(4)(a), Aged Care Act 1997

s 38-2(3), Aged Care Act 1997

If a certified service moves to another site, certification lapses and the service must seek certification again for the new location.

Every residential aged care service must be certified separately, including separate services run by the one provider and separate residential care services conducted in the same premises. *See legislative reference.*

s 38-2(4)(b), Aged Care Act 1997

CERTIFICATION

LEGISLATIVE REFERENCES

Applying for certification

s 38-2, Aged Care Act 1997
s 8.6, Certification Principles 1997
s 8-7, Certification Principles 1997

An application for certification of an aged care service must be made on the approved form, by a provider who has an allocation of places at that service. *See legislative reference.* See References at the end of this chapter for a link to the form. The application must be signed by a person authorised in writing to act for the provider. *See legislative reference.*

The application must include: *See legislative reference.*

- the name of the aged care service
- the address where the service is being provided
- the postal address of the service
- the number of places allocated to the applicant for the service
- if a building in which the service is being provided is leased—the term of the lease and the lessor's name and address.

s 57-16, Aged Care Act 1997
s 57A-8, Aged Care Act 1997
s 44-5A(2)(c) Aged Care Act 1997

A provider can apply for certification at any time. However, a service must be certified to be eligible to:

- charge an accommodation bond *See legislative reference.*
- charge an accommodation charge *See legislative reference.*
- receive the accommodation supplement *See legislative reference.*
- or receive the concessional resident supplement.

s 44-6(2)(c), Aged Care Act 1997

It is recommended that a provider applies for certification at least 30 days prior to occupancy. *See legislative reference.*

If a service is a new service—ie, a commencing service—the provider can apply for a certification inspection before residential care services commence, provided that the appropriate building approval authority has issued a certificate of occupation or classification.

The following non-refundable application fees are charged:

s 8.17, Certification Principles 1997

- $150 for a service with less than 10 places allocated to it
- $700 for a service with more than 46 places allocated to it
- for any other service, $15 for each place allocated to the service. *See legislative reference.*

The fee is deducted from a service's first monthly subsidy payment after the certification decision has been made. Services applying for certification should authorise the deduction on the Authority to Deduct form included as part of the application. A certification assessment will not take place until the Authority to Deduct has been signed.

Preparing for an inspection

Part 2.6, Divisions 37-39, Aged Care Act 1997
Part 2, s 8.5-8.19, Certification Principles 1997

Prior to applying for certification, an approved provider should be familiar with:

- Part 2.6, Divisions 37 to 39 of the *Aged Care Act 1997* *See legislative reference.*
- Part 2, sections 8.5 to 8.19 of the Certification Principles *See legislative reference.*
- the Aged Care Certification Assessment Instrument

LEGISLATIVE REFERENCES

- the Aged Care Certification Guidelines
- the Aged Care Certification Assessment Scoring Matrix
- the Building Quality for Residential Care Services—Certification guide.

See References at the end of this chapter for these links.

After the Department receives an application for certification, it will contact an authorised assessor to conduct an inspection at that facility. *See legislative reference.* The Department has contracted a company with expertise in building survey and engineering to carry out assessments of residential care services. *See legislative reference.* An assessor will contact the approved provider to arrange a suitable time and date for the inspection.

s 38-4, Aged Care Act 1997

s 8-12, Certification Principles 1997

Before the inspection takes place, an approved provider should:

- tell residents and staff when and why the inspection is taking place
- arrange for an appropriate person such as the proprietor, the director of nursing or a senior manager to be on hand during the visit
- have building documentation ready—eg, floor plans, emergency exit plans, certificates, licences or other approval documentation for the premises, including any document that verifies the premises comply with state or local government fire, health and/or safety regulations.

The inspection process

On average, inspections take between 1 ½ and 3 hours. At larger services, they may take up to 4 hours. Inspections will focus on:

- whether the service provides a safe and secure environment
- exits from the service
- whether the service has adequate smoke-free compartments
- fire safety, including adequate fire protection and emergency evacuation systems
- hazards within or outside of buildings
- whether the service provides adequate personal privacy to residents
- facilities to allow access and mobility for residents to move freely within the building
- adequate heating and cooling
- adequate lighting and ventilation
- whether the service provides a home-like environment
- whether there is access to community services. *See legislative reference.*

s 8.13, Certification Principles 1997

If the service is new, the assessor will also determine whether the service meets the privacy and space requirements for new buildings. See The Certification Assessment Instrument on page 60.

LEGISLATIVE REFERENCES

Serious hazards

During the inspection, the assessor will look for serious hazards—ie hazards which are potentially life threatening. Serious hazards include:

- blocked fire escape doors
- exposed electrical wiring
- contaminants such as flaking lead paint
- structural instability
- the absence of a fire emergency warning system or fire suppression system as required under the Building Code of Australia.

If a facility has a serious hazard, certification assessment will not proceed until the hazard has been removed or rectified. See also Reviewing, revoking or suspending certification on page 65.

After the inspection

Immediately after the inspection, the assessor will discuss with the provider the general scoring methodology and aspects of building quality assessed. However, an assessor is not allowed to provide detailed and prescriptive advice on future upgrading priorities. Providers should seek independent professional advice for this.

s 8.15(1), Certification Principles 1997

Service providers will receive a copy of the assessment report and a copy of any other findings used by the Department in deciding whether to certify the service. *See legislative reference.*

SUITABILITY OF RESIDENTIAL CARE SERVICE FOR CERTIFICATION

s 38-3, Aged Care Act 1997, s 8.10, Certification Principles 1997

While the assessor inspects the buildings and physical aspects of a service applying for certification, it is the Secretary who decides to either certify a service or to reject an application for certification. In assessing an application for certification, the Secretary must consider a range of matters, including: *See legislative reference.*

- the standard of the buildings and equipment used by the service to provide residential care
- the standard of residential care provided by the service
- if the applicant has been a provider of aged care, its conduct as a provider, including compliance with responsibilities and obligations related to any Commonwealth payments made for providing aged care
- if key personnel are also relevant key personnel in common with a current or former approved provider, the conduct of that person as a provider of aged care will be considered

s 38-4(1), Aged Care Act 1997

- the assessment of the residential care service carried out under s 38-4(1) of the Act *See legislative reference.*
- whether the Department has imposed sanctions or taken any other action against the provider for non-compliance
- whether the service's buildings and equipment and the residential care it provides meet the requirements of any relevant state law or state or local government authorities

LEGISLATIVE REFERENCES

- whether any of the service's equipment or buildings are fire hazards or dangerous to the health or safety of residents or staff and therefore subject to an order by a state or local government authority for repair, renovation or restoration
- any findings by a Commonwealth, state or local government authority about the standard of the buildings or equipment or the standard of residential care being provided by the service.

Accommodation bonds

A resident can only be required to pay an accommodation bond after a service has been certified for six months *See legislative reference.* However, if a resident enters a service in the first six months after it has been certified, the service can charge the amount equivalent to the interest the provider could have derived from the resident's bond if it was charged from the date the service was certified. For more information see section on Accommodation bonds in chapter Funding for permanent residential aged care in this Manual.

s 57-16(2)(b), Aged Care Act 1997

REVIEWING, REVOKING OR SUSPENDING CERTIFICATION

Reviewing certification

The Secretary may review the certification of a service, and for the purpose of review authorise a person or body to assess the service. An assessment can relate to any aspect of the residential care service that the Secretary considers relevant to the ongoing suitability of the service for certification. Providers will receive at least 5 business days' notice before the start of a review. *See legislative reference.*

s 39-4, Aged Care Act 1997

Lapse of certification

Certification of a service will lapse if, after the service has been certified, there is a change in the location at which the residential care is provided through the service. *See legislative reference.*

s 39-2, Aged Care Act 1997

Revoking certification

The Secretary must revoke the certification of a residential care service:

- if the service is no longer suitable for certification *See legislative reference.*
- or if the provider's application for certification contained information that was false or misleading in a material way. *See legislative reference.*

s 39-3(1)(a), Aged Care Act 1997

s 39-3(1)(b), Aged Care Act 1997

The Secretary may also revoke the certification of a residential care service:

- if an approved provider has not complied with their responsibilities. See also chapter on Providers' responsibilities and non-compliance in this Manual
- or if an approved provider requests it. *See legislative reference.* Providers must make the request at least 60 days before the day on which the revocation is requested to take effect. The Secretary must notify the approved provider of the revocation by written notice at least 14 days before the day on which revocation is to take effect.

s 39-5, Aged Care Act 1997

LEGISLATIVE REFERENCES

s 39-3(2), Aged Care Act 1997

Before deciding to revoke the certification, the Secretary must: *See legislative reference.*

- notify the provider in writing that revocation is being considered
- explain the reasons for considering the revocation
- and invite the provider to make a written submission to the Secretary within 28 days after receiving the notice.

Suspension

The Secretary may suspend the certification of a residential care service if an approved provider has not complied with its responsibilities. See also What sanctions can be imposed? in chapter on Providers' responsibilities and non-compliance in this Manual.

Accommodation payments and the revocation or suspension of certification

If a residential care service ceases to be certified, the service must refund accommodation bond balances or cease charging accommodation charges. Until the date certification is revoked or ceases to have effect, the service can retain any retention amounts and income derived (ie, interest) on accommodation bonds.

APPEALS

A service can seek reconsideration of a decision to:

- reject an application for certification
- revoke the certification of a residential care service
- impose conditions on revocation of the certification, where the provider has requested that certification be revoked
- impose a sanction, including revoking or suspending certification.

s 85-5, Aged Care Act 1997

For reconsideration of a decision, the approved provider must write to the Secretary within 28 days of receiving notice of the decision *See legislative reference.* The approved provider should give reasons for the request and include any relevant supporting material.

The Secretary must then reconsider the decision, and either confirm, vary or set aside and substitute a new decision. If the Secretary does not give notice of a decision within 90 days after receiving the request, the Secretary is taken to have confirmed the decision. If an approved provider wants to appeal against the decision after review by the Secretary, then it can apply to the Administrative Appeals Tribunal for external review.

FIRE SAFETY DECLARATION

All residential care services must complete an annual fire safety declaration. Every January, the Department sends declaration forms to providers who have until 31 March of that same year to send declarations back to the Department, indicating whether or not they comply with all applicable state, territory and local government laws relating to fire safety. *See legislative reference.*

s 18.6B, Quality of Care Principles 1997

CERTIFICATION

As the Australian Government does not have responsibility for fire safety laws, any non-compliant declarations are referred to the relevant local council (in the ACT, they are forwarded to the ACT Fire Brigade). A copy of each of the non-compliant declarations is also provided to the Aged Care Standards and Accreditation Agency.

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN THIS CHAPTER

Aged Care Certification Assessment Instrument

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-certification-download-assessin-cnt.htm

Aged Care Information Line

Ph 1800 500 853

Building Quality for Residential Care Services—Certification Guidelines and Scoring Matrix

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-certification-buildqual.htm

Fire safety declaration form—enquiries

Phone the Department on (02) 6289 8977.

Forms—all

All Departmental forms are available on the Department's website at *www.health.gov.au/internet/main/publishing.nsf/Content/health-forms.htm*

Form—application for classification

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rcspage-form2568.htm

CERTIFICATION

APPROVAL OF RESIDENTS

APPROVAL OF RESIDENTS

This Manual has been written in plain English and as a result, some aspects of the legislation and policy have been simplified. It is intended to be a general guide only and does not constitute legal advice. In cases of discrepancy between the Manual and the legislation, the legislation will be the source document for payment of Australian Government benefits and enforcement of approved provider responsibilities.

RELEVANT LEGISLATION

- Part 2.3, Division 20, s 20-1–20-2, Division 21, s 21-1–21-4, Division 22, s 22-1–22-6, Division 23, s 23-1–23-4, *Aged Care Act 1997* (the Act)
- *Approval of Care Recipients Principles 1997* (Approval of Care Recipients Principles)
- *Aged Care Principles 1997*

OVERVIEW

To be eligible for Australian Government-subsidised aged care, a person must have a current Aged Care Assessment Team (ACAT)* approval, or have a decision made by the Secretary that exceptional circumstances exist such that an assessment by an ACAT is not needed. (*Known in Victoria as Aged Care Assessment Service (ACAS).)

While it is the Secretary who approves a person as eligible to receive Government-subsidised care, the Secretary has delegated this power to ACAT delegates and to Departmental delegates.

A person can be approved for one or more of the following types of care:

- residential care (including residential respite care)
- community care
- flexible care.

Flexible care in the form of Transition Care and Multi Purpose Services may be provided in residential care facilities.

ACATs help older people and their carers work out what kind of care will best meet their needs when they are no longer able to manage at home without assistance. ACATs provide information on suitable care options and can help arrange access or referral to appropriate residential or community care. ACATs cover all of Australia and are based in the local community or hospitals.

People do not need to have a current ACAT approval to place their name on a waiting list for an aged care service.

ACATs operate under the Act and associated principles and Commonwealth guidelines.

Additional information

This chapter has been updated and revised to help approved providers comply with their responsibilities under the Act; and to assist staff of aged care services understand the regulation of residential aged care. Additional information can also be accessed through the Aged Care Information Line on 1800 500 853.

APPROVAL OF RESIDENTS

APPROVAL FOR GOVERNMENT-SUBSIDISED RESIDENTIAL AGED CARE

It is policy that Government-subsidised aged care services are accessed by the people who need them most. The eligibility criteria for aged care services are applied in a nationally consistent way so that subsidised aged care services are accessed appropriately.

ACATs comprehensively assess and approve people as eligible to access Government-subsidised aged care services.

ACATs accept referrals from any source including self-referral. Following referral the ACAT will conduct a comprehensive, multidisciplinary assessment of the person's medical, physical, social and psychological needs to determine the person's care needs and the type of services that would be most appropriate to meet those needs.

The Aged Care Client Record (ACCR) is a record of the ACAT assessment. The ACCR contains:

- the application for approval form (completed by the client),
- the client's assessment information (completed by the ACAT),
- an approval section (completed by the ACAT delegate).

The ACCR is one of the nominated source documents for an Aged Care Funding Instrument (ACFI) appraisal and should be included by the approved provider in the ACFI Appraisal Pack wherever possible. It is a valuable component of the ACFI Appraisal Pack as it can also help to complete the overall picture of a person's care needs. However, if an ACCR is not available, it is not mandatory to obtain one to complete the ACFI appraisal.

If a person cannot complete the application for approval form themselves, it can be completed on their behalf. See Emergency Approvals on page 73.

The Secretary approves a person as eligible to receive Government-subsidised care. The Secretary has delegated this power to certain positions within ACATs, known as ACAT delegates; and to nominated positions within the Department, known as Departmental delegates.

A person can be approved for one or more of the following types of care:

- residential care (including residential respite care)
- community care
- flexible care. Flexible care in the form of Transition Care and Multi Purpose Services may be provided in residential care facilities. See References at the end of this chapter for a link to the Transition Care Program Guidelines.

The delegate can decide on any limitations to an approval—for example, a person may be approved for a low level of residential care—and will inform the person who applied for approval of these decisions in writing. These decisions are reviewable and can be appealed. ACAT delegates cannot revoke approvals. Only Departmental delegates can revoke approvals. See What limits can be placed on approval to receive care? on page 71 and Reviewable decisions on page 74.

WHO CAN BE APPROVED FOR RESIDENTIAL CARE?

A person is eligible for residential care if:

- they have physical, medical, social or psychological needs which require residential care
- and those needs cannot be met more appropriately through non-residential care services.

APPROVAL OF RESIDENTS

LEGISLATIVE REFERENCES

A person must meet the following criteria: *See legislative reference.*

s 5.5, Approval of Care Recipient Principles 1997

- being frail or disabled and requiring at least low level continuing personal care
- being incapable of living in the community without support
- meeting other eligibility criteria for a level of care for which they are assessed, as set out in the *Classification Principles 1997.*

Someone who is not an aged person may also be approved for residential care if there are no other care facilities or care services more appropriate to meet their needs.

In determining whether these criteria are met, the ACAT must consider the person's medical, physical, psychological and social circumstances.

WHAT LIMITS CAN BE PLACED ON APPROVAL TO RECEIVE CARE?

s 22, Aged Care Act 1997

An approval can be limited to *See legislative reference.*

- a particular kind of care
- care provided during a specific period starting on the day after the approval
- residential respite care for a specific period
- any other matters or circumstances specified in the Approval of Care Recipients Principles
- a low level of residential care.

Permanent residential care and residential respite care are different care types. An approval for permanent residential care does not automatically include respite care unless specified.

APPROVAL FOR HIGH LEVEL RESIDENTIAL CARE

s 22-4, Aged Care Act 1997

An ACAT approval will determine whether a person enters residential care at either a high or low level. *See legislative reference.*

Part 3, Quality of Care Principles 1997

The ACAT will approve a person to receive a high level of residential care when their needs are significant enough to require it. *See legislative reference.* A person approved for a high level of residential care will often require some nursing services.

s 5.9, Approval of Care Recipients Principles 1997

If a person is approved to receive high level residential care (permanent or respite), they are also eligible to receive residential care at a low level. *See legislative reference.*

Once a person enters permanent residential care, the aged care service must commence the ACFI appraisal within 28 days of their entry, to classify the resident for funding purposes. See also chapter on Classification of residents in this Manual.

PAYMENT OF SUBSIDY

A Government subsidy can only be paid:

- for people who have a current approval to receive care
- for the type and level of care approved
- for care provided in line with any limits set by the approval.

APPROVAL OF RESIDENTS

LEGISLATIVE REFERENCES

In claiming a subsidy, an approved provider must ensure that the prospective care recipient has current ACAT approval for the type and level of care to be provided. ACATs are unable to backdate an approval, except in emergency circumstances. See Emergency approvals on page 73.

For a person receiving residential respite care, subsidy will not be paid if:

s 21.18, Residential Care Subsidy Principles 1997

- the person has already used 63 days of respite care in each financial year covered by the approval and no additional 21-day extension periods have been approved prior to the end of the financial year. *See legislative reference.*

WHEN DOES AN APPROVAL CEASE TO HAVE EFFECT?

Approvals for high level residential care and residential respite care at the high and low levels **do not lapse**, but can expire if time limited.

An approval for residential care can cease to have effect in one of three ways—it can expire, lapse or be revoked:

s 23-2, Aged Care Act 1997

- an approval **expires** if it is limited to a specified period of care and that period ends *See legislative reference.*

s 23-4, Aged Care Act 1997

- an approval can be **revoked** if the Secretary is satisfied that the person has ceased to be eligible to receive the care for which they were approved. Only Departmental delegates of the Secretary can revoke an approval *See legislative reference.*

s 23-3, Aged Care Act 1997

- An approval for low level residential care (not provided as residential respite care) **lapses** 12 months from the day after the approval was given *See legislative reference.*.

s 23-3(3), Aged Care Act 1997, s 5.14(1), Approval of Care Recipients Principles 1997

- An approval for transition care **lapses** if the person does not enter care within four weeks from the day after the approval was given. Approval will also **lapse** if the person leaves transition care for at least one day after the lapsing period ends. *See legislative reference.*

A person should be reassessed at any time if their care needs change. See also chapter on Classification of residents in this Manual.

WHEN SHOULD AN AGED CARE SERVICE REQUEST AN ACAT REASSESSMENT?

Approvals for high level residential care and residential respite care at the high and low levels **do not lapse**. A reassessment for these approvals would only be required if the approval was time limited.

For other approvals, an aged care provider may request an ACAT reassessment when:

- there has been a significant change in the person's care needs and they require approval for a different type or level of care
- a person approved for transition care is not provided with the care to which their approval relates for a period of at least one day after the lapsing period and the person needs additional transition care
- a person's approval was time limited and has expired
- a person is transferring between facilities, they have aged in place and have a high ACFI classification and they want to pay an accommodation charge rather than rolling over the accommodation bond

LEGISLATIVE REFERENCES

- a person with a low level residential care approval leaves residential care for more than 28 days (excluding approved leave) after their approval has lapsed and they want to access Government subsidised care in an aged care service
- a service provider wishes to remove the Interim Low subsidy limitation. An ACAT approval for high care is one way the full ACFI high care subsidy may be paid for a resident
- a person's approval for residential respite care is limited to low and the person's care needs have changed and they would be eligible for high level respite approval
- an approved provider asks a care recipient to leave a residential care service. The long term care needs of the care recipient may be assessed by an ACAT or (in certain circumstances) at least 2 medical or other health professionals who meet the criteria. *See legislative reference.* See also section on Four steps—asking a resident to leave in chapter on Residents' rights in this Manual.

s 23.5, User Rights Principles 1997

For information on ageing in place, see section on Ageing in place in Classification of residents chapter in this Manual.

EMERGENCY APPROVALS

A person can receive care before approval by an ACAT if they urgently need care and it is not practicable to apply for approval beforehand.

Emergency admissions should occur rarely and will usually be precipitated by a crisis situation—for example, if there is no primary carer for the person and there are no other options available. *See legislative reference.*

s 22-5, Aged Care Act 1997

In order for subsidy to be payable for the care recipient from the day that the emergency care started, the ACAT delegate must firstly be satisfied that an emergency existed at the time the care started **and** service providers must satisfy the 5 business day rule.

Within 5 business days the provider should:

- inform the local ACAT of the emergency admission and ask for a copy of the statement of application (the front page of the ACCR) to be sent to them by fax. The ACAT should ensure that the care recipient's name is written on the form prior to faxing
- ensure that the Statement of Application is completed by the care recipient (or by someone else on their behalf)
- ensure that the Statement of Application identifies the date the care recipient entered the aged care service and the aged care service's address and telephone number, to enable the ACAT to arrange an assessment
- fax the signed and completed Statement of Application to the local ACAT within 5 business days (or any period as extended under the Act) after the day on which the care started
- provide the original statement of application to the ACAT at the time of assessment.

If an applicant is unable to sign the application, someone else can sign for them. If someone other than the applicant signs the application, additional information under the applicant's signature must be provided and the applicant must be informed that the application has been made.

If the applicant has a legal guardian, the guardian is the preferred person to sign the application on the person's behalf. If they do not sign on behalf of the person, they must be informed that the person has entered care.

APPROVAL OF RESIDENTS

LEGISLATIVE REFERENCES

An emergency situation is the only circumstance in which approval can take effect from the day on which the care started, rather than the day the approval was signed and dated.

If the person is approved by the ACAT as a care recipient for the level and type of care they are receiving, the subsidy will be paid from the date the care started. The delegate must be satisfied that there was an emergency when the person entered care.

Government subsidy will not be paid for a person who receives care prior to an ACAT assessment and approval, if the ACAT delegate determines that they did not urgently require that care.

APPROVAL FORM

The ACCR form is held by the ACAT and contains:

- statement of application—completed by the person seeking approval
- record of assessment—completed by the ACAT
- approval—completed by the ACAT delegate.

Approval for high level residential care and all residential respite care does not lapse, but an approval may expire if it is time limited. Approval for low level residential care lapses 12 months from the day after approval was given if the person has not entered care within that timeframe.

When a client enters residential care, they are responsible for providing the aged care service with a copy of the ACCR as evidence of their approval status. Aged care services with access to Medicare's Aged Care Online Claiming Gateway should always check if a potential client's approval is valid. See References at the end of this chapter for a link. It is the provider's responsibility to ensure that a client holds the requisite approval prior to entry if a subsidy is to be paid.

REVIEWABLE DECISIONS

Division 85, Aged Care Act 1997

A decision not to approve a person to receive care, and to set limitations to an approval can be reviewed. A revocation of approval to receive care can also be reviewed. *See legislative reference.*

The delegate must notify a person in writing about a reviewable decision. The letter must include the reason for the decision and information about the person's review rights.

Anyone whose interests are affected by such a decision, including aged care services, potential and current care recipients and their families or carers can ask the Secretary to reconsider the decision. However, discussing the issue with the ACAT involved in the first instance can often produce a speedy resolution of any differences or misunderstandings.

If someone wants to appeal a decision, they should:

- write to the Secretary within 28 days of receiving the decision (or within any extended period allowed by the Secretary) explaining their reasons for requesting a reconsideration of the decision
- send the letter to the state or territory office of the Department in the state or territory where the decision was made. See References at the end of this chapter for address.

APPROVAL OF RESIDENTS

LEGISLATIVE REFERENCES

s 85-5, Aged Care Act 1997

After receiving a request to review a decision, the Secretary will either:
See legislative reference.

- confirm the original decision
- vary the decision
- or make a new decision.

If the Secretary has not replied within 90 days of receiving the request, this means that the original decision stands. If the person is dissatisfied with the Secretary's reconsideration of the decision, they can apply to the Administrative Appeals Tribunal (AAT) to review the decision. See References at the end of this chapter for a link to the AAT.

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN THIS CHAPTER

ACAT finder

www.agedcareaustralia.gov.au/internet/AgedCare/Publishing.nsf/content/acat+finder

Administrative Appeals Tribunal

www.aat.gov.au

Aged Care Assessment Program Guidelines

www.health.gov.au/acats

Aged Care Information Line

Ph 1800 500 853

Appealing a decision

If someone wants to appeal a decision, they should write to the Secretary of the Department, within 28 days of receiving the decision:

The Secretary
Department of Health and Ageing
GPO Box 9848
Capital city, state/territory, postcode

Draft Community Packaged Care Guidelines

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-cacp-guidelines.htm1

Forms—all

All Departmental forms are available on the Department's website at
www.health.gov.au/internet/main/publishing.nsf/Content/health-forms.htm

Medicare's Aged Care Online Claiming Gateway

www.medicareaustralia.gov.au/provider/aged-care/gateway-logon.jsp

Transition Care Program Guidelines

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-transition-guidelines.htm

APPROVAL OF RESIDENTS

CLASSIFICATION OF RESIDENTS

CLASSIFICATION OF RESIDENTS

LEGISLATIVE REFERENCES

This Manual has been written in plain English and as a result, some aspects of the legislation and policy have been simplified. It is intended to be a general guide only and does not constitute legal advice. In cases of discrepancy between the Manual and the legislation, the legislation will be the source document for payment of Australian Government benefits and enforcement of approved provider responsibilities.

RELEVANT LEGISLATION

- Part 2.4, *Aged Care Act 1997* (the Act)
- Part 6.4, *Aged Care Act 1997*
- *Classification Principles 1997*

OVERVIEW

Residents of residential aged care services are given a classification according to the level of care they need. The classification of a resident is undertaken primarily to determine the level of care funding payable for that resident. The care funding model is divided into the following three domains:

- activities of daily living (ADL)
- behaviour (BEH)
- complex health care (CHC).

The level of funding provided depends on the assessed level of care need in each of the three domains. The level of care need is assessed using a funding tool called the Aged Care Funding Instrument (ACFI).

The current funding model and the funding instrument commenced on 20 March 2008, replacing the Resident Classification Scale (RCS).

Additional information

This chapter has been updated and revised to help approved providers comply with their responsibilities under the Act; and to assist staff of aged care services understand the regulation of residential aged care. Additional information can also be accessed through the Aged Care Information Line on 1800 500 853.

ABOUT THE AGED CARE FUNDING INSTRUMENT (ACFI)

The ACFI consists of 12 care need questions, and collects diagnostic information about mental and behavioural disorders and other medical conditions. This information is used to categorise residents as having nil, low, medium or high needs in each of the three care domains. No funding is provided for a domain if the resident has no or minimal assessed care needs in that domain.

The assessment of a resident's care needs utilising the ACFI is called an appraisal. The aged care provider undertakes the appraisal of the resident's care needs using an ACFI Answer Appraisal Pack. *See legislative reference.* An ACFI User Guide is available to assist providers to undertake appraisals. See References at the end of this chapter for a link to the ACFI User Guide; and email and phone contacts for ACFI queries.

s 9.17(2), Classification Principles 1997

CLASSIFICATION OF RESIDENTS

LEGISLATIVE REFERENCES

APPLICATIONS FOR CLASSIFICATION

The outcomes of the ACFI appraisal are included in the Application for Classification, a form which must be submitted to Medicare Australia in order for the resident to be allocated a classification.

Applications for classification can be submitted electronically or in hard copy. Electronic applications can be submitted via:

- Medicare Australia's ACFI web form (preferably broadband access)
- Medicare Australia's Online Claiming Business to Business (B2B) and file upload channel. This requires software developed by a registered software vendor.

Hard-copy ACFI assessments can be sent to Medicare Australia in the relevant capital city. See References at the end of this chapter for Medicare Australia contact information. Medicare Australia will return any incomplete applications or applications with errors to the aged care service to be corrected. The application receipt date will be the date the correctly completed application is received by Medicare Australia.

s 25-4, Aged Care Act 1997, Part 7.4, Criminal Code Act 1995

It is an offence to provide false or misleading information on the application for classification form. *See legislative reference.* The Act also provides a number of other possible consequences of giving false, misleading or inaccurate information in appraisals or reappraisals. See Inaccurate assessments on page 87.

The information provided in an application for classification may also be used by the Department and/or Medicare Australia to check that the funding provided in response to an application is used in accordance with:

- the requirements of the Act
- any other requirements determined by the Minister, the Secretary or the Chief Executive Officer of Medicare Australia.

CLASSIFICATION OF RESIDENTS

s 9.3B, Classification Principles 1997

The Department determines the classification of a resident based on the application for classification completed by the aged care provider and sent to Medicare Australia. This involves the following steps: *See legislative reference.*

- Step 1—For the activities of daily living (ADL) and behaviour (BEH) domains, the Department will identify a score for the A, B, C or D rating given for each question. The scores for each domain are then added to calculate a total score for each domain. The total score for each domain is then used to categorise the resident as having:
  - nil (N)
  - low (L)
  - medium (M)
  - or high (H) needs for that domain.

Parts 1, 2, Schedule 1, Parts 1 and 2, Schedule 2, Classification Principles 1997

See Figure 1 on page 79 for scores and thresholds. *See legislative reference.*

Part 3, Schedule 1, Part 3, Schedule 2, Classification Principles 1997

- Step 2—For the complex health care (CHC) domain, the Department will use the complex health care matrix. See Figure 1 on page 79. *See legislative reference.*
- Step 3—The resident's classification is summarised as a three part code. For example, the code for a resident assessed as being medium in the ADL domain,

low in the BEH domain and having no or minimal needs in the CHC domain, would be M-L-N. A provider is not required to submit an application for a resident who has no or minimal assessed care needs in all three domains—ie, an N-N-N classification.

Exceptions:

s 9.3B(2) Step 2 (b), Classification Principles 1997

- If a valid behavioural diagnosis code is not supplied, the maximum level for the behaviour (BEH) domain is medium (M). *See legislative reference.*
- A resident whose approval by the Aged care Assessment Team (ACAT) delegate for permanent residential care is limited to low care but whose initial appraisal indicates the resident requires a high level of residential care will be classified at an interim low classification. The rate of subsidy for this classification will not exceed the amount determined by the Minister. The resident will remain on the interim low classification until:
  - the resident ages in place including when a Departmental review officer confirms that the resident requires a high level of residential care during a review. See Existing resident—ageing in place on page 83.
  - or a new approval by an ACAT delegate for permanent residential care is provided, which is not limited to low care.

Figure 1—Weightings and range of points for each category

ACTIVITIES OF DAILY LIVING (ADL) AND BEHAVIOUR (BEH) CARE DOMAINS SCORES

ADL	QUESTION NUMBER				
Rating	**1**	**2**	**3**	**4**	**5**
A	0.00	0.00	0.00	0.00	0.00
B	6.69	6.88	7.89	6.11	5.79
C	13.39	13.76	15.75	12.21	11.53
D	20.09	20.65	23.63	18.31	17.31

BEH	Question number				
Rating	**6**	**7**	**8**	**9**	**10**
A	0.00	0.00	0.00	0.00	0.00
B	6.98	5.91	7.04	7.70	5.71
C	13.91	11.82	14.10	15.40	11.43
D	20.88	17.72	21.14	23.11	17.15

THRESHOLD SCORES FOR EACH LEVEL

Levels	Low	Medium	High
ADL	18	62	88
BEH	13	30	50

LEGISLATIVE REFERENCES

Figure 1 cont.

COMPLEX HEALTH CARE (CHC) DOMAIN MATRIX

	QUESTION 12—COMPLEX HEALTH CARE			
Question 11—medication	**A**	**B**	**C**	**D**
A	Nil	Nil	Medium	Medium
B	Nil	Low	Medium	High
C	Low	Low	Medium	High
D	Medium	Medium	High	High

High and low care classifications

In addition to determining the level of care funding, ACFI classifications are used to define a resident as requiring either a high level or a low level of care. In order to be considered high care, the resident must be classified at one or more of the following levels:

- medium or high in the activities of daily living (ADL) domain
- high in the behaviour domain (BEH)
- medium or high in the complex health care (CHC) domain.

However, providers should note that from 1 January 2010, the classification levels, in order for a resident to be considered high care, will be amended. An addendum to this chapter, detailing the amendments, will be provided in 2010.

Classification expiry

s 27-2, Aged Care Act 1997

Classifications allocated based on an ACFI appraisal generally do not expire. However, they will expire in the following circumstances: *See legislative reference.*

- the resident ceases being provided with residential or flexible care, without being on leave, and has not within 28 days entered a residential or flexible aged care service
- the resident has taken extended hospital leave (30 days or more)
- six months after a resident enters care directly from an in-patient hospital episode, if the person was not on leave from a residential aged care service during their hospital stay
- six months after a significant change in a resident's care needs
- if a resident returns to an aged care service from extended hospital leave, the classification which takes effect from the date of their return to care will expire six months after the resident returns from that extended hospital leave
- the Secretary has given the approved provider a notice requiring reappraisal of the level of care needed by a resident
- the resident is being provided with respite care.

CLASSIFICATION OF RESIDENTS

LEGISLATIVE REFERENCES

ACFI APPRAISALS—WHEN MUST AN APPRAISAL BE UNDERTAKEN

New residents

An ACAT delegate will initially approve a person for entry into residential care. The ACAT delegates will also determine whether the care level required for a person should be limited to low-level care. See also chapter on Approval of residents in this Manual.

If a person is approved for residential aged care, after he or she enters care, the person will need to be appraised using the ACFI. A new ACFI appraisal is also required for a resident entering an aged care service for high dependency care leave.

Appraisals:

- cannot be conducted in the first 7 days after a resident enters care *See legislative reference.* — *s 25-3(2)(a), Aged Care Act 1997*
  - except if a resident leaves care before 7 days have passed. In this instance, an appraisal can be conducted in less than 7 days *See legislative reference.* — *s 9.16, Classification Principles 1997*
- cannot be submitted to Medicare Australia, in an application for classification, until after the resident has been in care for 28 days, unless a resident has left care before 7 days have passed
- should be conducted within two months of the resident entering care. *See legislative reference.* Any application received by Medicare Australia more than two months after a resident has entered care is considered a late appraisal. If an application is received late, the subsidy paid for that resident will be reduced — *s 26-1, Aged Care Act 1997*
  - if the application is received within 3 months of the end of the appraisal period, the daily subsidy will be reduced by $25 for the period from entry, to the day before the late form is received by Medicare Australia
  - if the application is received more than 3 months after the end of the appraisal period, no subsidy will be paid from entry to the day before the late form is received by Medicare Australia—ie, a subsidy can only be paid from the day the late form is received by Medicare Australia
  - if an aged care service believes it sent the application to Medicare Australia in sufficient time to be received, the service can write requesting a review of the decision. The service should provide all information that is relevant to whether the application was sent in time. See References at the end of this chapter for address.

REAPPRAISALS FOR EXISTING RESIDENTS

Reappraisals **must** be completed in the following circumstances:

- when the classification expires. See section on Classification of residents on page 78.
- when the Department writes to the aged care service requesting a resident be reappraised. *See legislative reference.* — *s 27-3, Aged Care Act 1997*

CLASSIFICATION OF RESIDENTS

LEGISLATIVE REFERENCES

s 27-4, Aged Care Act 1997

A resident's care needs **can** be reappraised in the following circumstances: *See legislative reference.*

- at any time 12 months or more after the existing classification took effect
- when the resident has a significant change in care needs
- at any time when a resident is classified at the lowest applicable classification level.
- within 2 months of a resident transferring from another aged care service. See Existing resident—transfer from another aged care service on page 82.

Existing resident—significant change in care needs

During the life of a classification, another application for classification may be submitted if the resident's care needs have significantly changed. This change is defined as:

s 9.28(1)(a), Classification Principles 1997

- an increase of two or more classification levels—this increase can be within a single care domain—eg, an increase from low to high in the ADL domain; or across two separate domains—eg, increase from low to medium in both the BEH and CHC domains *See legislative reference.*

s 9.28(1)(b), Classification Principles 1997

- a single increase from medium to high in the CHC domain if the resident is already categorised as high in ADL. No change in the behaviour domain is required in these circumstances *See legislative reference.*

s 9.28(2), Classification Principles 1997

- for a resident who is classified at an interim low classification, the resident's care needs are taken to have changed significantly if this is the result of applying the above rules to the classification level that was determined for the resident by assessing their care needs using the ACFI. See Exceptions on page 79. *See legislative reference.*

s 9.29(2), Classification Principles 1997

- for a resident with a RCS classification, a significant change reappraisal can also be submitted for a resident if their calculated subsidy from the reappraisal would be $30 or more above the RCS saved rate. *See legislative reference.*

A new ACFI classification following a significant change remains in effect for 6 months starting from the date that the application was received by Medicare Australia, unless another circumstance takes effect during that 6 month period.

Existing resident—reappraisal of lowest applicable classification

A reappraisal can be done at any time for a resident classified at the lowest applicable classification level. For ACFI purposes, this is a resident assessed as having no or minimal care needs in each of the three care domains. Such a resident would be classified as N-N-N. The new classification will take effect from the date that the application is received by Medicare Australia.

Existing resident—transfer from another aged care service

ACFI classifications will generally not expire, including when a resident leaves one aged care service:

s 27-4(5), Aged Care Act 1997

- and enters the care of another service within 28 days
- or returns to the same service within 28 days. *See legislative reference.*

However, an aged care service can reappraise a resident within 2 months of the resident entering care, if the existing classification does not reflect the resident's current care needs. The provider of the original service can provide a copy of the resident's ACFI Answer Appraisal Pack to the new aged care service.

Because approval for permanent residential care will not lapse, a new ACAT approval is not required when a resident transfers from one aged care service to another. This includes situations where the initial ACAT approval was limited to low care and the resident has aged in place to high care in the original service.

Exceptions:

- An ACAT may be requested to approve the resident for a high level of care when the resident transfers from one aged care service to another, if the resident wants to pay an accommodation charge to the new service rather than rolling over an existing bond.
- An ACAT may be asked to assess the care needs of a resident where the existing aged care service can no longer provide the required level of care for the resident. This assessment can also be performed by two independent medical practitioners.

Existing resident—ageing in place

A resident, whose initial approval by the ACAT delegate for residential aged care is limited to low care, will continue to be able to age in place to a high care ACFI classification without the need for an ACAT reassessment.

Under ACFI, the high care subsidy may be paid for a resident with an ACAT approval limited to low care when the resident ages in place—that is, a high care ACFI reappraisal can be conducted if:

- an existing ACFI classification expires—eg, following a period of extended hospital leave, or six months after entering care directly from hospital
- there is a significant change in care needs
- there is a voluntary reappraisal 12 months or more after a previous appraisal
- there is a voluntary reappraisal within 28 days of a transfer. See Existing resident—transfer from another aged care service on page 82.
- the resident's ACAT assessment is not limited to low care
- a Departmental review officer confirms the resident requires a high level of care during a classification review.

Reappraisal period

A reappraisal can usually be conducted in a two month period, beginning one month before the existing classification expires and running until one month after it expires.

Exceptions:

- If a resident's classification expires while they are on extended hospital leave, the reappraisal period is for two months starting on the day the person returns to the service from leave.

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- The reappraisal period may also be extended in limited circumstances if an appraisal expires while the resident is on leave (other than extended hospital leave) or within one month after that leave ended.
- If the Secretary gives an approved provider a notice requiring a reappraisal, the reappraisal period is the period specified in the notice.

Late applications for reappraisal

If an application for classification is not received during the normal two month reappraisal period, the amount of subsidy paid for the resident will be reduced.

- If the application is received within 3 months of the end of the reappraisal period, the daily subsidy will be reduced by $25 from the day after the existing classification expires to the day before the late form is received by Medicare Australia.
- If the application is received more than 3 months after the end of the reappraisal period, no subsidy is payable from the day after the existing classification expires to the day before the late form is received by Medicare Australia.
- If an aged care service believes it sent the application to Medicare Australia in sufficient time to be received, the service can write to the Department requesting a review of the decision. The service should provide all information that is relevant to whether the application was sent in time. See References at the end of this chapter for address.

REVIEW OF ACFI APPRAISALS

A classification review program has been established to ensure that ACFI appraisals are conducted correctly. All reviews take into account the aged care service's appraisal using the ACFI User Guide that was in force at the time of the original appraisal.

Division 29, Aged Care Act 1997

The Secretary has the power to change an incorrect classification. *See legislative reference.* Before changing a classification, the Secretary must review the classification by examining any relevant material on which it was based. The Secretary will examine relevant material or information, including material or information that has become available since the classification was made. *See legislative reference.*

s 29-1(3)(c), Aged Care Act 1997

s 91-1(2)(c), Aged Care Act 1997

Classification reviews are undertaken by authorised officers from the Department. *See legislative reference.* If requested by the occupier of the aged care premises, the officer must produce their identity card, which includes their name and a photograph, on arrival at the aged care service. A classification review is not a reassessment. Review officers are seeking to confirm that the ACFI appraisal accurately reflected the level of care needed by the resident at the time it was completed by the aged care service.

s 91-1(3), Aged Care Act 1997

s 63-1(1)(b), Aged Care Act 1997

Division 92, Aged Care Act 1997

Normally, a review officer must not enter an aged care service without consent and must leave if consent is withdrawn. *See legislative reference.* However, an approved provider has responsibility to cooperate with a review officer. *See legislative reference.* The Department can seek a warrant to conduct reviews without consent if it believes that an aged care service may be using fraudulent or deceptive practices. *See legislative reference.* If a high proportion of incorrectly appraised residents are found during a review visit, the Department may review the classification of any other residents in the same service, at its discretion.

CLASSIFICATION OF RESIDENTS

Most review visits will be conducted along the following lines:

- A review officer will check the completeness and accuracy of ACFI Answer Appraisal Packs for a sample of residents in a service.
- For each reviewed resident, the review officer will then see if the checklists and supporting documentation enclosed in the ACFI Answer Appraisal Pack (eg, the Aged Care Client Record (ACCR), the medication chart, diagnoses) correspond; and may ask to meet the resident.
- If there is incongruence between the checklists and the supporting documentation, the review officer may seek further information by:
  - interviewing staff
  - interviewing the resident
  - observing the resident
  - assessing the resident's impairment using simple task assessments
  - or undertaking an ACFI assessment such as the Psychogeriatric Assessment Scales (PAS) to confirm that the classification is correct.
- Some review visits will focus on particular questions.
- Some ACFI questions/categories may be reviewed as a desk audit—for example, the service may be asked to provide the Department with copies of the depression diagnoses for residents where there is a C or D claim for ACFI 10 (Depression).

The ACFI record keeping requirements include the complete ACFI Answer Appraisal Pack including the specified enclosures (refer to the ACFI User Guide). In addition, post-appraisal treatment records for some specific complex health care procedures in ACFI question 12 can be requested as part of the validation process. This applies where there is a claim in relation to any of the following items in ACFI question 12:

ITEM	PROCEDURES
1	Daily pressure measurement
2	Daily glucose measurement
3	Pain management involving therapeutic massage or application of heat packs
4a	Complex pain management and practice undertaken by an allied health professional or registered nurse involving therapeutic massage and/or pain management involving technical equipment
4b	Complex pain management and practice undertaken by an allied health professional involving therapeutic massage and/or pain management involving technical equipment
7	Administration of suppositories or enemas
10	Management of chronic wounds
18	Continuous monitoring of vital signs

The service can be asked to produce the treatment record for the above procedures to demonstrate that the treatment was a usual and ongoing care need at the time of appraisal.

When the appraisal conducted by the aged care service is not accurate, the resident's classification will be corrected. A review classification applies for the same period as the classification that was being reviewed. However, a change of a classification will not be backdated more than 6 months from the date of the review decision letter. Adjustments will be made to the subsidy to reflect the changed funding category.

Notice of a review visit

The Department will usually phone and give at least 2 business days notice to the aged care service before the proposed date of the review visit. The advance notice is to ensure that the care manager/director of nursing and the staff member who completed or is familiar with the ACFI appraisal process are available during the review and if required can clarify any aspects of the appraisal documentation.

A review visit to an aged care service can only be postponed after the service consults with the review officer. If a service wants to postpone a visit, they must give the review officer at least 2 business days notice before the date of the original proposed visit.

Roles and responsibilities

A review officer and the aged care service staff both have responsibilities to ensure that the ACFI review process is conducted in a professional and amicable manner.

A review officer should:

- provide the care staff with a clear explanation on how the visit will be conducted, approximate duration of the visit and a list of the residents who are going to be reviewed on that day
- outline the rights of the approved provider under the Act in relation to the visit
- leave the contact details of the ACFI Program Manager in that state or territory and other contact details as agreed at the review.

The aged care service should:

- provide the necessary documentation—while the Act allow records to be kept in written or electronic form, approved providers must provide assistance so that electronic records can be read and reviewed or produce a paper copy of the record
- assist the review officer seeking further information about a resident's care needs—this may include having a senior staff member available to provide the review officer with information
- allow the review officer access to staff who have a knowledge of a resident's care needs
- further assist the review officer seeking additional information about a resident's care needs if there are any incongruities
- respect the privacy of the review officer to complete the review without disturbance.

There will be increasing use of electronic record keeping systems, including for the ACFI. In some cases, the completed ACFI Appraisal Answer Pack may be stored partly in hard copy—with third party documents such as medical practitioner notes and directives, comprehensive medical assessments and the Aged Care Client Record in hard copy—and partly electronically.

If the electronic record being substituted for a paper record requires signature, date and identification details, the electronic record must contain the same details. If an electronic signature or graphic is used then an approved provider must be able to show that there are systems in place to ensure that the electronic signature or graphic uniquely identifies a person. See also chapter on Record keeping in this Manual.

The aged care service should also provide the review officer with a work area which allows them to operate in a safe, clean and well-lit environment. If possible, this should include:

- a desk-height work area that has sufficient space to accommodate laptops and documentation for the number of officers conducting the review
- adjustable office chairs
- heating/cooling
- access to power points.

Exit meetings

After the review process, review officers may conduct an exit meeting with appropriate care staff. Where there are classification changes, the exit meeting can provide the opportunity for the service to understand why a classification has been changed.

At the exit meeting the review officer talks about general findings and any specific issues in relation to the use of the ACFI. This discussion can assist care staff to improve their understanding of the classification system.

During the exit meeting the care staff may realise that the review officer has not been provided with all the relevant material. If additional relevant material is made available at this stage it can be taken into account.

Notifying the approved provider of the review outcome

The Department will send a letter to an approved provider, informing them of the review outcome, usually within 14 business days of the review visit. This letter will include the following information:

- the date of the review visit
- the total number of reviews undertaken
- the name/s of the review officer/s
- a list of the names of residents whose classifications have changed, together with their original and revised categories
  - for these residents, copies of the review sheets that constitute the reasons for the decision will also be included
- the right to request a reconsideration of these decisions and the timeframe for doing so.

In certain circumstances there may be a delay of more than 14 days before the Department sends the letter to the approved provider—for example, where the review officer allows the service additional time to locate documentation to support ACFI claims. In such cases, the review officer will notify the service of the delay.

The letter is sent to the approved provider, which is not always located at the same address as the service. It is the approved provider's responsibility to forward this information to the relevant aged care service.

Inaccurate assessments

The Department can send a letter asking an approved provider to reappraise one or more residents in its care if the Department believes that the approved provider has

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continued to give false, misleading or inaccurate information in appraisals or reappraisals following a review. The Department can also vary or revoke such a request. *See legislative reference.*

s 27-3, Aged Care Act 1997

The Department may suspend an approved provider from making ACFI appraisals or reappraisals if the approved provider or the authorised person gives false, misleading or inaccurate information in a substantial number of appraisals that have been reviewed. *See legislative reference.* If an approved provider is suspended from appraising or reappraising, the Department can defer the suspension if the approved provider agrees to:

s 25-4, Aged Care Act 1997

- provide training for officers, employees and agents
- and/or appoint an advisor to assist the approved provider to conduct appraisals and reappraisals in a proper manner. *See legislative reference.*

s 25-4A(1), Aged Care Act 1997

The Department can also impose sanctions on an approved provider if the approved provider has not complied, or is not complying, with one or more of its responsibilities in terms of accountability. *See legislative reference.*

Part 4.4, Aged Care Act 1997

Complaints and concerns

The review should be conducted in a manner that allows the review visit to be completed without disruption. If a review officer considers that a review can't continue, they may stop the review process. If this happens, the management of the service will be advised of alternative arrangements for the review.

Management of the service may also request that a review be terminated if it is concerned about the manner in which the review is being conducted. However, prior to making such a request the review officer should be consulted and alternative options for conducting the review arranged.

If there is disagreement with the potential outcomes of the review or the way in which it is being conducted, then a service should discuss those concerns with the ACFI Program Manager in the Department's state or territory office. See References at the end of this chapter for a list of contact numbers.

Risk assessment approach

The classification review program uses a risk assessment approach to determine the priority of conducting review visits. This approach has both targeted and random elements. An aged care service could be visited as part of the risk assessed component or the random component. Review officers undertaking visits do not select the services or residents for review and usually do not know why a service has been selected.

APPEALS TO THE DEPARTMENT FOR THE RECONSIDERATION OF DECISION

An approved provider may request a reconsideration of these other types of decisions:

- to suspend an approved provider from making appraisals and reappraisals
- to refuse to lift such a suspension
- that an appraisal or reappraisal was not sent in sufficient time
- to refuse to renew a classification
- to change the classification of a care recipient. *See legislative reference.*

s 85-1, Aged Care Act 1997

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There is no right to seek internal reconsideration if the review officer has changed a score against the ACFI, but the change has not resulted in a change to the classification level of the resident.

If a provider has a concern regarding a review visit, which relates to issues other than classification changes or other types of decision that can be reconsidered, the provider should contact the ACFI Program Manager in the relevant state or territory office. See References at the end of this chapter for a list of contact numbers.

Before asking for a decision to be reconsidered, the approved provider should check that the appraisal or reappraisal was conducted in a proper manner. *See legislative reference.*

s 63-1(h), Aged Care Act 1997

To seek a reconsideration, an approved provider must write to the Department within 28 days of receiving the notification of the decision, stating that they are seeking a reconsideration of the decision. See References at the end of this chapter for address. The approved provider must indicate the classification change sought, including the questions and the ratings with which they disagree. Any information an authorised person provides in support of the request will be considered, along with other relevant material, before a reconsideration decision is made.

The Department will generally acknowledge receiving a request for reconsideration within five working days, including providing a contact name and telephone number for future enquiries regarding the reconsideration.

The reconsideration officer who conducts the internal reconsideration will not have been involved in the original decision.

A reconsideration decision will be made using the ACFI guidelines in force at the time of the original appraisal by the aged care service. The reconsideration process may require a visit to the aged care service. As reconsideration decisions must be made within a limited timeframe (90 days), a service may not be able to defer such a visit.

The reconsideration officer will:

- examine all relevant documents used by the aged care service, contained in the ACFI Answer Appraisal Pack, to assess the care needs of the resident against the ACFI, in determining whether the resident's classification is accurate
- if necessary, interview the resident whose classification is the subject of the review
- clarify with the appropriate care staff, if required, any inconsistent or unclear documentation.

Notification of the reconsideration decision

The Department must inform an approved provider of the outcome of the reconsideration within 90 days of receiving the request. The Department will:

- notify the approved provider in writing of the reconsideration decision
- inform the relevant Departmental state or territory office of the reconsideration decision
- advise Medicare Australia to make any necessary adjustments to the subsidy paid to the aged care service.

If the Department does not inform an approved provider of a decision within this timeframe, then the original decision is confirmed.

LEGISLATIVE REFERENCES

Date of effect

If no date is specified, the reconsideration decision takes effect on the date that the reconsideration decision was made. In exceptional circumstances, the reconsideration decision may specify the date the decision takes effect.

ADMINISTRATIVE APPEALS TRIBUNAL

If an approved provider disagrees with the reconsideration decision, within 28 days of receiving the letter, they can apply to the Administrative Appeals Tribunal (AAT). However, an approved provider cannot appeal directly to the AAT if there is a disagreement with the outcome of classification review. The approved provider must first request an internal reconsideration by the Department. See References at the end of this chapter for contact information.

SUBSIDY RATE

A care subsidy is paid for each level of each of the three care domains, except the nil level. Under the funding model, the total care subsidy paid for each resident is usually the sum of the rates for all three domains.

However, in the initial period of the operation of the current funding model, the maximum funding rate has been capped at:

- $10 more than the RCS S1 rate (as indexed) from 20 March 2008
- $20 more than the RCS S1 rate (as indexed) from 1 July 2009
- $30 more than the RCS S1 rate (as indexed) from 1 July 2010.

From 1 July 2011, the maximum funding rate will not be capped.

s 44-3(2), Aged Care Act 1997

The funding rates are determined by the Minister under section 44-3(2) of the Act. *See legislative reference.* These amounts are subject to indexation—ie, they are updated annually.

Grandparenting of Resident Classification Scale (RCS) subsidies

Residents initially classified using the Resident Classification Scale (RCS) have been progressively appraised using the ACFI from 20 March 2008. Grandparenting arrangements ensure that an aged care service continues to receive at least the same subsidy for these residents as was paid under the RCS.

Once the ACFI appraisal has been submitted for existing residents previously classified using the RCS, Medicare Australia will compare the calculated subsidy under the new funding model with the existing RCS subsidy. If the subsidy under the new model is $15 or more above the RCS amount, the new subsidy amount will be payable. If not, the existing RCS amount will continue to be paid.

If the calculated subsidy under the new funding model is $15 or more above the RCS subsidy, but the calculated subsidy is greater than the capped amount, the capped rate will be paid.

CLASSIFICATION OF RESIDENTS

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN THIS CHAPTER

ACFI Program Managers—contact details

ACT Office
(02) 6289 3377

NSW State Office
(02) 9263 3862

VIC State Office
(03) 9665 8290
(03) 9665 8118

TAS State Office
(03) 6221 1455
(03) 6221 1488

QLD State Office
(07) 3360 2560

SA State Office (also NT)
(08) 8237 8325

WA State Office
(08) 9346 5229

ACFI queries

Contact the Aged Care Information Line
Ph 1800 500 853
Or email acfi@health.gov.au, please include contact details.

Queries about ACFI review program
Email scale.accountability@health.gov.au
Please include contact details.

ACFI User Guide

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acfi-1007-userguide.htm

Administrative Appeals Tribunal

www.aat.gov.au

Aged Care Information Line

Ph 1800 500 853

Appeals—lodging an appeal for a change of a resident's classification to be reconsidered.

Send appeals to:

The Director
Accountability Section
Department of Health and Ageing
MDP 74
GPO Box 9848
Canberra ACT 2601

CLASSIFICATION OF RESIDENTS

Applications for classification—to Medicare Australia

Hard-copy applications for classification should be sent to Medicare Australia in the relevant state or territory capital city. In order to be processed, all questions on the application form must be answered clearly, the form must be signed and dated and a pen, not a pencil, must be used.

NSW and ACT
GPO Box 9923
Sydney NSW 2001
Ph 1800 195 206

VIC and TAS
GPO Box 9923
Melbourne VIC 3001
Ph 1800 195 206

SA and NT
GPO Box 9923
Adelaide SA 5001
Ph 1800 195 206

QLD
GPO Box 9923
Brisbane QLD 4001
Ph 1800 195 206

WA
GPO Box 9923
Perth WA 6001
Ph 1800 195 206

Forms—all

All Departmental forms are available on the Department's website at *www.health.gov.au/internet/main/publishing.nsf/Content/health-forms.htm*

Late applications for reappraisal—request for review of decision

The Assistant State Manager
Ageing and Aged Care
Department of Health and Ageing
GPO Box 9848
capital city of the relevant state or territory

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

LEGISLATIVE REFERENCES

This Manual has been written in plain English and as a result, some aspects of the legislation and policy have been simplified. It is intended to be a general guide only and does not constitute legal advice. In cases of discrepancy between the Manual and the legislation, the legislation will be the source document for payment of Australian Government benefits and enforcement of approved provider responsibilities.

OVERVIEW

Approximately 70 per cent of the total funding for residential aged care is provided by the Australian Government, paid directly to providers of aged care services on behalf of the residents in those services. Residents who can afford to do so also contribute to the cost of their care and accommodation.

These accommodation and care subsidies and payments can be grouped into two main categories:

- payments for accommodation and hotel-type services, which cover the cost of food, utilities and providing accommodation for residential aged care. These payments include the standard resident contribution (or basic daily fee), accommodation payments and related supplements. In general, residents pay for the majority of these charges. However, if a resident cannot afford one of these payments, the Government can assist them and the provider, paying the approved provider in lieu of the resident or paying the approved provider additional amounts—for example, viability supplement.
- care payments—for example, the basic subsidy amount and income tested fees. These payments fund care and related services. In general, the Government funds these payments, through the basic subsidy and supplements such as the oxygen and enteral feeding supplements. Residents who have sufficient income can be asked to help contribute to the cost of their care through an income tested fee. The amount of subsidy payable by the Government is reduced by the amount of the income tested fee.

The basic subsidy amount mentioned above is based on a resident's classification under the **Aged Care Funding Instrument (ACFI)**.

When a person enters residential aged care, an approved provider must offer the person a **resident agreement**, which both the provider and the resident sign, and which sets out the policies and practices the provider will follow in setting fees for the resident and the resident's date of permanent entry to the aged care service. *See legislative reference.*

s 59-1, Aged Care Act 1997

Providers may also be eligible to charge additional fees on top of the daily fees and any accommodation payment. A provider may charge an **extra service fee**, for providing a higher than standard level of accommodation services or food. Residents can also pay providers for **additional services**—such as hairdressing or hiring a television. Providers whose aged care service is located in a remote area may charge all of the residents of that service an additional daily amount. These additional fees must be outlined and agreed to in the **resident agreement**. For more information on extra service, see chapter on Extra service places; and for more information on resident agreements, see section on Resident agreements in chapter on Residents' rights in this Manual.

While the provider and the resident negotiate the level of a resident's fees and accommodation payment, the Government sets the maximum amount that can be charged.

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

In addition, funding for residential aged care includes **hardship arrangements**, which ensure that residents who cannot afford to make certain payments still have equal access to residential aged care. The Government helps these residents through hardship assistance. If a resident meets the criteria for hardship assistance, the Government will pay subsidies to the provider and the provider will deduct these subsidy amounts from the daily fees for that resident.

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

A. ACCOMMODATION AND HOTEL SERVICES

RELEVANT LEGISLATION—RESIDENT FEES (INCLUDING THE STANDARD RESIDENT CONTRIBUTION)

- Sections 42-2 and 42-3 of the *Aged Care Act 1997* (the Act)
- Division 58 of the *Aged Care Act 1997*
- Section 70 of the *Aged Care (Consequential Provisions) Act 1997*
- Part 5, *User Rights Principles 1997*

RELEVANT LEGISLATION—ACCOMMODATION PAYMENTS

- Division 44 of the *Aged Care Act 1997*
- Divisions 57 and 57A of the *Aged Care Act 1997*
- Part 6, *Residential Care Subsidy Principles 1997*
- Parts 4 and 4A, *User Rights Principles 1997*

OVERVIEW

Payments for accommodation and hotel-type services are designed to help providers meet the costs of providing accommodation and related services—such as meals, cleaning, laundry, heating and cooling in the service—for residents in their care.

These payments include:

- the standard resident contribution (also known as the basic daily fee)
- accommodation payments, including:
  - the daily accommodation charge (high care residents)
  - and accommodation bonds (low care or extra service residents)
- supplements, such as:
  - the resident contribution top-up supplement
  - the accommodation charge top-up supplement
  - and the accommodation supplement
- grandparenting arrangements and payments for residents who entered care before 20 March 2008 and 20 September 2009.

Rates and additional information

The maximum rates for fees and charges, including the standard resident contribution, change several times every year. For this reason, actual dollar amounts payable are not included in this Manual. Current rates are available on the Department's website, in the Aged Care Essentials newsletter (formerly known as Payment Essentials) and from the Aged Care Information Line on 1800 500 853. See References at the end of this chapter for links and contact information.

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

LEGISLATIVE REFERENCES

How to calculate fees payable by a resident

s 58-1(a), Aged Care Act 1997

To calculate the maximum daily fee that a resident may be asked to pay, approved providers should: *See legislative reference.*

(1) work out the applicable standard resident contribution—ie, the maximum basic daily fee

(2) add any compensation payment reduction that applies for the resident

(3) add any applicable maximum income tested fee for the resident

(4) subtract any hardship supplement that applies for the resident

(5) add any other amounts agreed between the provider and the resident, that is, agreed fees for additional services

(6) if the resident is in an extra service place and receiving care on an extra service basis, add the extra service amount

(7) for an aged care service located in a remote area, add the remote area allowance amount.

A resident may also be asked to pay an accommodation bond or an accommodation change.

STANDARD RESIDENT CONTRIBUTION (BASIC DAILY FEE)

s 58-3, Aged Care Act 1997

The standard resident contribution—also known as the basic daily fee—is paid by all residents as a contribution towards their accommodation and the costs of daily living in the aged care service—such as meals, cleaning, laundry, heating and cooling in the service. From 20 September 2009, the general rule is that the standard resident contribution is 84 per cent of the basic aged pension. *See legislative reference.* This includes residents receiving respite care.

While this is the general rule, there are exceptions which fall into three groups:

- protected
- phased
- and non-standard.

Residents in financial hardship can apply for help paying the standard resident contribution under financial hardship provisions. See Hardship, standard resident contribution and care payments (income tested fee) on page 143.

Protected resident contribution

Aged care residents who were in care on 19 September 2009, and who are self-funded retirees or part pensioners, whose pension, on 20 September 2009, did not increase by more than the corresponding increase in the standard resident contribution, are protected from paying higher fees. These residents will remain on their existing contribution rate subject to 6 monthly indexation commencing on 20 September 2009, until they leave care. This is the protected resident contribution.

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

Phased resident contribution

Residents who enter care from 20 September 2009 to 19 March 2013 inclusive, who are self-funded retirees or part pensioners, whose pension did not increase by more than the corresponding increase in the standard resident contribution, and who therefore did not benefit from the changed pension arrangements of 20 September 2009 are phased residents. Phased residents can be asked to pay a daily fee at the phased resident contribution rate.

The phased resident contribution for the period 20 September 2009 to 19 March 2010 is the same rate as the protected resident contribution. For the period 20 March 2010 to 19 March 2013, the contribution will increase every 6 months until it equals 84 per cent of the basic age pension. The rate of the phased resident contribution for each 6 month period as a percentage of the basic age pension is provided in Table 1 following.

TABLE 1—PHASED RESIDENT CONTRIBUTION RATE

IF THE PARTICULAR DAY IS IN THE PERIOD ...	THE RELEVANT PERCENTAGE IS
20 March 2010 to 19 September 2010 (inclusive)	78 per cent
20 September 2010 to 19 March 2011 (inclusive)	79 per cent
20 March 2011 to 19 September 2011 (inclusive)	80 per cent
20 September 2011 to 19 March 2012 (inclusive)	81 per cent
20 March 2012 to 19 September 2012 (inclusive)	82 per cent
20 September 2012 to 19 March 2013 (inclusive)	83 per cent

After 19 March 2013 there will no longer be any phasing arrangements. From 20 March 2013, residents who were previously phased residents will pay the standard resident contribution rate—ie, 84 per cent of the basic age pension.

Resident contribution top-up supplement

So that providers will be paid the same amount for all residents who enter care on or after 20 September 2009, a Government subsidy, the resident contribution top-up supplement can be paid to providers for phased residents for the period 20 September 2009 to 19 March 2013 inclusive. The amount of the supplement is the difference between the standard and phased rates of resident contribution.

Non-standard resident contribution

Some residents who entered care prior to 20 March 2008 and who meet certain criteria pay the non-standard resident contribution rate until their circumstances change or they leave care.

To pay the non-standard resident contribution rate, a resident must have first entered residential aged care before 20 March 2008, and on 19 September 2009 and on each day since that day, the resident must:

- not have a dependent child
- not be receiving an income support payment
- or have paid an accommodation bond that is a big bond

- a big bond is more than 10 times the basic age pension amount at the time of entry into care, if the person entered the service before 20 September 2009
- or 9 times the basic age pension amount at the time of entry if the person entered the service on or after 20 September 2009

- or have not provided income and asset information to Centrelink (means not disclosed).

If a resident's circumstances change on or after 20 September 2009 and the criteria are no longer met, the person would no longer fall into this group and the standard resident contribution rate would apply.

ACCOMMODATION PAYMENTS

Accommodation payments, which include accommodation bonds and daily accommodation charges, are worked out according to a resident's assets—ie, the proportion of an accommodation payment which the Government will pay and the proportion which the resident will be asked to pay depends on the resident's assets.

Residents with assets above a minimum threshold can be asked to make a contribution toward the cost of their accommodation, through either an accommodation bond or a daily accommodation charge.

Accommodation supplements—including the accommodation supplement, the concessional supplement, the accommodation charge top-up supplement and transitional accommodation supplement—are paid to providers, for residents in their care who have very few assets.

While the provider and the resident negotiate accommodation payments, and the Government does not set the accommodation bond or accommodation charge, it does set various legal requirements for accommodation payments.

Only certified aged care services can receive accommodation payments. See also chapter on Certification in this Manual.

A provider cannot charge an accommodation bond unless the service is certified and complies with the various prudential requirements. See also chapter on Protection and responsibilities relating to accommodation bonds in this Manual.

A resident can apply to the Secretary that paying an accommodation bond or charge would cause financial hardship to themselves, to their partner or to their dependent child. See section on Hardship and accommodation payments on page 143.

Accommodation payments and assets testing

The amount of accommodation charge or bond a provider can ask a resident to pay—and any subsidies the Government may pay for that resident if they have supported, concessional or assisted resident status—depends on the resident's assets.

Most residents will have had an assets test done by either Centrelink or the Department of Veterans' Affairs (DVA) before they enter aged care. See References at the end of this chapter for links to the request for an asset assessment form.

LEGISLATIVE REFERENCES

The approved provider works out the amount of a new resident's accommodation payment on the basis of this asset information provided by the resident.

For example, a resident's asset letter from Centrelink or DVA will state if a resident is a supported, concessional or assisted resident, allowing the provider to work out what fees, subsidies and supplements may apply for that resident.

Some residents may choose not to give information about their assets or do not provide enough information for the value of their assets to be properly determined. In these cases, the resident can be asked to pay the amount agreed between the resident and the provider, up to the maximum as listed in the current rate sheet; and is not eligible for concessional, assisted or supported resident status and any corresponding supplements.

The value of a resident's assets

The value of a resident's assets is the net value of all the resident's property, including property outside Australia, at the time of entry to the aged care service.

However, a home owned by the resident is not included as an asset if, at the time of the resident's entry to care:

- the resident's partner or dependent child is living in it
- a carer of the resident has been living there for at least two years, and is eligible to receive an income support payment, from either Centrelink or the DVA
- a close relation has been living there for at least five years, and is eligible to receive an income support payment. *See legislative reference.*

s 44-10(2), Aged Care Act 1997

If the resident is a member of a couple, the value of the resident's assets is half the value of the couple's combined assets. A person will be a member of a couple:

- if they are legally married or in a relationship registered under a state or territory law, providing they are not living separately or apart from the other person on a permanent basis
- or if they are living in a de facto relationship.

The other person in the relationship may be the same or a different sex.

Where an asset is held jointly, or in common, with a person other than the resident's partner, the value of the asset is taken to be the value of the resident's interest in the asset.

s 21.15, Residential Care Subsidy Principles 1997

Assets can include the following: *See legislative reference.*

- accounts including interest free accounts, with banks, building societies and credit unions
- interest-bearing deposits
- fixed deposits
- bonds
- debentures
- shares
- investments in property trusts, friendly societies, equity trusts, mortgage trusts and bond trusts

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- real estate (the family home may be exempt in some circumstances)
- businesses
- farms
- loans, including interest-free loans
- motor vehicles, boats and caravans
- surrender value of life insurance policies
- investment collections, including investment collections of coins or stamps
- superannuation assets, from which lump sums can be withdrawn
- household contents and personal effects. The value of household contents and personal effects is taken to be $5000 if there is no evidence of another value.

ACCOMMODATION CHARGE

Eligible residents who enter an aged care service at a high level of care may be asked to pay an accommodation charge. It is in addition to the basic daily fee and any income tested fee that may apply for that resident.

Providers must use income from accommodation charges:

- to meet capital works costs relating to residential care
- to retire debt relating to residential care
- to improve the quality and range of aged care services, if no capital expenditure is necessary. *See legislative reference.*

s 57A-2(1)(l), Aged Care Act 1997

For residents to pay an accommodation charge, they must have assets above the minimum asset level and must have entered into an accommodation charge agreement with the approved provider, which specifies the amount of the accommodation charge. The provider must also advise the resident

- of the interest rate to be charged on amounts owed under the accommodation charge or resident agreements
- and when the accommodation charge is not required or, if paid, is refundable.

See Accommodation payments—information provided to residents and resident agreements on page 116.

The accommodation charge is payable for the entire period of the resident's admission (however, some exceptions apply) and is paid directly to the provider. The accommodation charge cannot be charged more than one month in advance.

Residents can be asked to pay an accommodation charge if they have assets above the minimum asset level at date of entry and require high level residential aged care that is not on an extra service basis and cannot be charged an accommodation bond. *See legislative reference.*

s 57A-2(1)(a), Aged Care Act 1997

The following residents **cannot** be asked to pay an accommodation charge:

- residents with assets below the minimum asset level at date of entry
- residents receiving low level residential aged care
- respite residents

- fully supported residents
- concessional residents
- a resident who has applied for a determination of financial hardship from the Secretary; or for whom a current financial hardship determination applies. These residents can only be asked to pay an accommodation charge
  - if their application is rejected—ie, if the Secretary declines to make a determination of financial hardship for that resident. If the resident has agreed to pay an accommodation charge, the accommodation charge is payable from their day of entry as a permanent resident
  - if a determination of financial hardship ceases to be in force. If the resident has agreed to pay an accommodation charge, the charge is payable from the day after the determination ceases to be in force
- residents entering an extra service place—however, they may be asked to pay an accommodation bond
- residents who first entered permanent care before 1 July 2004 and have already paid daily accommodation charges for a total of five years
- charge exempt residents
- residents who were in care before 1 October 1997, as long as they remain in the same service.

A person other than the resident cannot be required to pay an accommodation charge as a condition of a resident's entry to an aged care service.

How much is the accommodation charge?

The upper limit for any accommodation charge is set by legislation. The maximum amount of any accommodation charge, up to this limit, depends on the level of the resident's assets when they enter the service as a permanent resident.

Whilst the Department advises on the maximum rate of accommodation charge for most residents, the actual amount payable can be negotiated between the resident and provider.

See also Accommodation payments and assets testing on page 98.

Charge exempt residents—residents who entered care prior to 1 October 1997

A person who was receiving high level care in an approved bed in an approved nursing home on 30 September 1997, and who then enters an aged care service as a permanent resident, where they are otherwise eligible to pay an accommodation charge (including residents who would be assessed as assisted or partially supported), will be a charge exempt resident. *See legislative reference.*

s 44-8B, Aged Care Act 1997

The Department will advise of a resident's charge exempt status in a fee advice letter. A charge exempt resident cannot be asked to pay an accommodation charge. *See legislative reference.*

s 57A-2(1)(b), Aged Care Act 1997

Charge exempt resident supplement will be paid by the Government where a charge exempt resident is being provided with residential care in a certified residential care service (except if that care is provided on an extra service basis). *See legislative reference.*

s 44-8A(2), Aged Care Act 1997

LEGISLATIVE REFERENCES

The following residents, however, cannot be charge exempt:

- residents of uncertified aged care services cannot start paying an accommodation charge and therefore, cannot become charge exempt residents until the service becomes certified.
- residents receiving low level care and those receiving care on an extra service basis cannot be asked to pay the accommodation charge and therefore, cannot be charge exempt residents
- concessional and fully supported residents cannot be charge exempt residents, as they cannot be asked to pay an accommodation charge
- residents who were receiving a low level of care on 30 September 1997.

Residents who entered care 1 October 1997–30 June 2004

Depending on their assets, residents who entered care between 1 October 1997 and 19 March 2008 (inclusive):

- may be a concessional resident
- may be an assisted resident
- may have insufficient assets to pay an accommodation charge but are not concessional
- may pay an accommodation charge.

Concessional residents

Concessional residents cannot be asked to pay an accommodation charge. The Government will pay the concessional resident supplement to the provider.

A person who entered care between 1 October 1997 and 30 June 2004 (inclusive), even if they have had a break in care of 28 days or more, will be a **concessional resident** if, at the time they entered care:

- they had assets less than the minimum permissible asset level
- they were receiving an income support payment
- they had not been a homeowner for 2 years or more or if they owned a home during that period, the home was occupied by:
  - their partner
  - their dependent child
  - a carer who had occupied the home for at least 2 years and was eligible to receive an income support payment
  - a close relation who had occupied the home for at least 5 years and was eligible to receive an income support payment. *See legislative reference.*

s 44-7, Aged Care Act 1997

A person who entered care between 1 October 1997 and 30 June 2004 (inclusive) will also be a **concessional resident** if there is a determination that paying an accommodation charge will cause the person financial hardship. *See legislative reference.*

s 44-7(3), Aged Care Act 1997

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Assisted residents

A person who entered care between 1 October 1997 and 30 June 2004 (inclusive), even if they have had a break in care of 28 days or more, will be an **assisted resident** if, at the time they entered care:

- they had assets more than the minimum permissible asset level
  - and for admissions prior to 20 September 2009, less than 4 times the basic age pension amount
  - for admissions on, or after, 20 September 2009, 3.61 times the basic age pension amount
- they were receiving an income support payment
- they had not been a homeowner for 2 years or more or if they owned a home during that period, the home was occupied by:
  - their partner
  - their dependent child
  - a carer who had occupied the home for at least 2 years and was eligible to receive an income support payment
  - a close relation who had occupied the home for at least 5 years and was eligible to receive an income support payment. *See legislative reference.*

s 44-8, Aged Care Act 1997

The maximum accommodation charge payable by assisted residents is the margin of assets above the minimum that the resident must be left with divided by 2,080 up to the maximum pre-1 July 2004 assisted accommodation charge rate.

For residents who meet the assisted resident criteria, the Government will also pay the concessional supplement at the assisted resident rate to the provider.

Insufficient assets to pay an accommodation charge but not concessional

Residents with assets below the minimum asset amount may not meet the criteria to be a concessional resident—for example, because they were not in receipt of an income support pension. While the concessional resident supplement is not payable for these residents, they cannot be asked to pay an accommodation charge.

Charge-paying residents

All other residents who entered care between 1 October 1997 and 30 June 2004 (inclusive), even if they have had a break in care of 28 days or more, may be asked to pay an accommodation charge. The rate of accommodation charge is set at the date of entry.

However, if the person has paid the daily accommodation charge for a total of five years, they cannot be asked to pay further accommodation charges.

Note that the five-year period for these residents paying an accommodation charge is cumulative. For instance, if a resident moves from one service to another after paying an accommodation charge to the first service, then the accommodation charge is payable to the second service only for the remainder of this five-year period.

Residents who entered care 1 July 2004–19 March 2008 (inclusive)

The amount of the accommodation charge for residents who entered care between 1 July 2004 and 19 March 2008 (inclusive) can be asked to pay will be based on their asset assessment letter from Centrelink or DVA. The approved provider determines the accommodation charge based on this letter.

Depending on their assets, residents who entered care between 1 October 1997 and 19 March 2008 (inclusive):

- may be a concessional resident
- may be an assisted resident
- may have insufficient assets to pay an accommodation charge but are not concessional
- may pay an accommodation charge.

If a resident first entered care between 1 July 2004 and 19 March 2008 (inclusive) but had a break in care of 28 days or more and re-entered care on or after 20 March 2008, they will be treated in the same way as a resident who first entered care on or after 20 March 2008.

Concessional residents

Residents with assets below the minimum asset amount who also meet the other concessional resident criteria cannot be asked to pay an accommodation charge. The Government will pay the concessional resident supplement to the provider.

Assisted residents

Residents with assets more than the minimum permissible asset level; and for admissions prior to 20 September 2009, less than 4 times the basic age pension amount; and for admissions on or after 20 September 2009, 3.61 times the basic age pension amount can be asked to pay a small accommodation charge.

The maximum accommodation charge payable by assisted residents is the margin of assets above the minimum that the resident must be left with, divided by 1,825 up to the maximum pre-20 March 2008 assisted accommodation charge rate.

For residents who meet the assisted resident criteria, the Department may also pay the concessional supplement at the assisted resident rate to the provider.

Charge-paying residents

If the resident is non-concessional, the maximum accommodation charge payable is the margin of assets above the minimum that the resident must be left with, divided by 1,825, up to the maximum pre-20 March 2008 accommodation charge rate.

Insufficient assets to pay an accommodation charge but not concessional

Residents with assets below the minimum asset amount may not meet the criteria to be a concessional resident—for example, because they were not in receipt of an income support payment. While the concessional resident supplement is not payable for these residents, they cannot be asked to pay an accommodation charge.

Residents who entered from 20 March 2008; or entered 1 July 2004–20 March 2008 with break in care and re-entered on/after 20 March 2008

Depending on their assets, post-2008 reform residents—ie, residents who either entered care after 20 March 2008; or who entered care between 1 July 2004 and 19 March 2008 (inclusive) but who had a break in care of 28 days or more and re-entered care on or after 20 March 2008, may be:

- fully supported residents
- partially supported residents and also may be asked to pay an accommodation charge
- asked to pay an accommodation charge.

Residents with assets below the minimum permissible asset threshold are known as fully supported and cannot be asked to pay an accommodation charge. The Department will pay the maximum amount of accommodation supplement (appropriate to the service) to the provider.

If the resident is a pensioner resident, paying the maximum pensioner accommodation charge, then an accommodation charge top-up supplement will be payable to the provider for that resident. See also Accommodation charge top up supplement on page 107.

If the resident's assets are below the maximum asset amount, the maximum accommodation charge is the margin of assets above the minimum that the resident must be left with, divided by 2,080. These residents are known as partially supported and the Department will pay an accommodation supplement to the provider. The amount of accommodation supplement, when added to the amount of accommodation charge, will equal the maximum accommodation charge.

If the resident is not a fully or partially supported resident, the provider may charge the maximum applicable rate of accommodation charge.

ACCOMMODATION SUPPLEMENT

Starting on 20 September 2010, the cap on the accommodation charge will be gradually increased until 20 September 2011, when it will be $32.38 per day (indexed). From 20 March 2012, the maximum rate of the supplement will be increased on 20 March and 20 September each year, in line with movements in the Consumer Price Index (CPI). However, different caps will continue to apply to new pensioner and self funded retiree residents who enter before 20 March 2010.

The accommodation supplement will ensure that providers receive the equivalent of the maximum accommodation charge for all residents, either from the resident or the Government or from a combination of both.

The maximum rate of the accommodation supplement payable for residents in an aged care service depends on:

- the proportion of residents who are supported residents
- and whether or not the service complies with the 1999 fire safety and 2008 space and privacy building certification requirements.

From 20 March 2008, the single asset-tested accommodation supplement also replaces the concessional resident supplement and the pensioner supplement. Under these new arrangements, the maximum level of the new accommodation

supplement was increased and eligibility for it was extended. Self-funded retiree residents with few assets are also eligible for accommodation assistance.

The accommodation supplement is only payable for eligible permanent residents who entered an aged care service from 20 March 2008.

Calculating a resident's supplement

The level of a new resident's accommodation supplement depends on:

- the level of their assessable assets
- whether the aged care service meets the 1999 fire safety and 2008 privacy and space requirements
- whether the aged care service provides more than 40 per cent of its eligible care days to supported residents
    - supported residents are residents receiving one of the following: the concessional resident supplement; the hardship (accommodation bond) supplement; the hardship (accommodation charge) supplement; or the new accommodation supplement.

The maximum supplement will be paid to all new residents, including self funded retirees, with assets below the minimum permissible asset amount.

For residents with assets above this threshold, the amount of the supplement will be reduced by the amount of the accommodation charge payable.

Accommodation supplement—assets test

Centrelink or the Department of Veterans' Affairs (DVA) will assess a resident's assets on behalf of the Department. A person will not be eligible for an accommodation supplement if they choose not to have the level of their assets assessed by Centrelink or DVA and can be asked to pay the maximum accommodation charge. See Accommodation payments and assets testing on page 98.

Encouraging quality

A lower maximum supplement rate will apply to residents in aged care services that do not meet the 1999 fire safety and 2008 privacy and space requirements. This lower maximum supplement rate will equal the sum of the indexed maximum rates of the current concessional resident supplement and the pensioner supplement.

Supported resident ratios

All aged care services, whether or not they are certified, are required to meet the supported resident ratio—formerly known as the concessional resident ratio—which applies to their region. Sanctions may be applied to those services that do not meet the required ratio.

For example, a 25 per cent discount will be applied to the supplement paid to residents in services that do not provide more than 40 per cent of their eligible care days to supported residents. Services where more than 40 per cent of their new residents receive the new accommodation supplement or a hardship (accommodation bond or charge) supplement will be paid the undiscounted rate for those new residents.

Supported, concessional and assisted residents count towards the supported resident ratio.

Because the definition of a supported resident is more generous than the definition of concessional/assisted residents, many more aged care services will be able to achieve the 40 per cent concessional threshold. About 50 per cent of post-March 2008 residents are expected to qualify for some level of accommodation supplement (and so be supported residents); while pre-March 2008, only about 30 per cent of new residents would have qualified as either concessional or assisted residents.

Providers who are unsure about which region they are in should contact the state or territory office of the Department. See References at the end of this chapter for contact information.

These ratios do not apply to services with extra service status or with extra service status in a distinct part of a service. However, the ratio does apply to the non-extra service places in a service with an extra service distinct part.

ACCOMMODATION CHARGE TOP-UP SUPPLEMENT

To compensate aged care providers for the phasing in of the new cap on the accommodation charge for pensioners, approved providers will receive an additional accommodation supplement for all pensioner residents who enter an aged care service for high-level care from 20 March 2008 to 19 March 2010.

Aged Care (Residential care subsidy—amount of accommodation charge top-up supplement) Determination 2008 (No.2)

The accommodation charge top up supplement (ACTUS) is an additional primary supplement paid for residents for whom the combined accommodation supplement and the accommodation charge (as a result of a cap), is less than the maximum accommodation supplement on the day they enter care. *See legislative reference.*

Providers may receive ACTUS payments for eligible post-2008 reform pensioner residents if:

- the resident is in receipt of an income support payment
- and is eligible to pay an accommodation charge on entry to the residential aged care service that is less than the accommodation charge the resident would have been eligible to pay if they had not been receiving income support payment.

Depending on the resident's assets, the accommodation supplement will go some way towards making up this gap. However, in some cases the accommodation supplement will not equal the gap. The ACTUS supplement, therefore, seeks to remove any potential disadvantage to approved providers by covering the gap and compensating the provider for the lower accommodation charge which pensioners may be asked to pay to the service.

The ACTUS is not payable during pre-entry leave (because the resident does not pay the accommodation charge for pre-entry leave days). See Leave on page 145.

For a given eligible resident, the rate of the additional accommodation charge top-up supplement will equal:

- the maximum rate of the accommodation supplement payable for residents in that aged care service
- less the maximum rate of the accommodation charge payable by that resident
- less the amount of the accommodation supplement paid in respect of the resident.

LEGISLATIVE REFERENCES

Residents who move to another aged care service

Special arrangements apply to residents if they move aged care services within 28 days of leaving the previous service.

If the resident transfers within 28 days, the maximum rate of accommodation charge payable can be no more than the rate payable at the previous aged care service. There is also no requirement for another asset assessment to be done unless the resident believes that there has been a decrease in their assets since the time of the previous asset assessment.

Pre-20 March 2008 residents who were assessed as concessional or assisted in their previous admission can roll over their concessional or assisted status provided that this was determined through an asset assessment done by either Centrelink or DVA. Pre-1 July 2004 concessional or assisted residents will need to have an asset assessment done to determine their status if this had previously been determined by the aged care provider.

If the resident originally entered care after 1 July 2004 and there has been a break in care of 28 days or more, the maximum rate of accommodation charge payable will be reassessed at the date of re-entry into care as though the resident had not had any previous admissions into care.

Interest on delayed payments

If the accommodation charge is not paid when it is due, the provider can charge interest on the outstanding amount, provided this was specified in the resident agreement or accommodation charge agreement. Information on interest charges that can apply should by clearly outlined in the accommodation charge agreement.

Division 2 (Objects), Aged Care Act 1997

Interest can be charged starting from one month after the due date. The maximum permissible rate of interest which may be charged is twice the below threshold rate as outlined in the *Social Security Act 1991*. See References at the end of this chapter for a link to Comlaw for this Act. *See legislative reference.*

Accommodation charge and hardship arrangements

See Hardship and accommodation payments on page 143 for information about residents who cannot afford to pay an accommodation charge.

ACCOMMODATION BONDS

An accommodation bond may be payable by a resident who enters permanent care in a residential aged care service at a low level of care. Residents who enter permanent high level care in an extra service facility can also be asked to pay an accommodation bond. Residents who have previously paid an accommodation bond and who are moving to high care may elect to roll over their accommodation bond.

s 57-2(l)(aa)(iv), Aged Care Act 1997, 23.28B, User Rights Principles 1997

Some residents entering a multi-purpose service for the equivalent of low level care in a residential setting may also be asked to pay an accommodation bond. *See legislative reference.*

s 57-2(1)(a), Aged Care Act 1997

An accommodation bond only becomes payable if the residential care service is certified. *See legislative reference.*

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Residents can choose to pay an accommodation bond as a lump sum, a regular periodic payment or a combination of both. See Types of accommodation bond payments on page 111.

The provider can keep an amount out of the accommodation bond—a retention amount—with the balance of the bond to be refunded to the resident, or their estate, when they leave the service. Providers can also keep any interest from accommodation bonds.

The bond amount is negotiated between an approved provider and a resident. The Department does not receive any of the accommodation bond and does not determine the amount, although the maximum bond that can be paid must leave the resident with a certain level of assets. Providers are not required by law to ask residents for an accommodation bond. However, if they do there are various legal requirements regulating accommodation bonds. See Amount of accommodation bond on page 110; and Types of accommodation bond payments on page 111. See also chapter on Protection and responsibilities relating to accommodation bonds in this Manual.

Providers must use the income from accommodation bonds and retention amounts to:

- meet capital works costs relating to residential care
- retire debt relating to residential care
- improve the quality and range of aged care services, where no capital expenditure is necessary. *See legislative reference.*

s 57-2(1)(n), Aged Care Act 1997

The accommodation bond must not be used for a purpose that is not related to providing aged care to care recipients or does not comply with prudential requirements. *See legislative reference.*

s 57-2(1)(k), Aged Care Act 1997

Which residents can be charged an accommodation bond?

In order for a provider to ask a resident to pay an accommodation bond, a resident must meet the following criteria. They must:

- not be eligible to pay an accommodation charge
- be a low care level resident or be in a service or a distinct part of a service with extra service status, or have agreed to roll over an accommodation bond
- have assets which exceed the minimum permissible asset level
- have entered into an accommodation bond agreement which specifies the amount of the accommodation bond
- have been provided with information about accommodation bonds by the approved provider before they enter care. *See legislative reference.*

s 57-2(1)(d), Aged Care Act 1997, s 23.28, User Rights Principles 1997

The following residents **cannot** be asked to pay an accommodation bond:

- residents receiving high level residential aged care (except if they are in a service, or a distinct part of a service, with extra service status, or have agreed to roll over their accommodation bond)
- residents with assets below the minimum asset level
- fully supported residents
- concessional residents
- respite residents
- charge exempt residents

- residents for whom a hardship determination is in place
  - if such a determination is subsequently revoked or ceases to be in force, the resident can then be charged an accommodation bond, provided that they agreed to the accommodation bond at the time of entry
- residents who were in a nursing home or hostel before 1 October 1997, as long as they remain in the same service—these residents can only be charged an accommodation bond if they move to another service
  - bonds can be charged to existing residents only where the service moves to a totally new catchment area or to a new purpose-built service, either on the same site or in another location, and is classified by the Department as a new service.

A person other than the resident cannot be required to pay an accommodation bond as a condition of a resident's entry to the aged care service.

Varying amount of accommodation bond with existing resident

The amount of an accommodation bond can be varied by mutual agreement between a provider and a resident, provided that any revised amount is not more than the maximum that applied at the time of the person's entry to care.

Any agreed increase in a bond amount should be associated with an improvement in accommodation for the resident—for example, the resident moving from a shared to a single room.

This does not alter the requirement of the Act that a person transferring between providers cannot be charged as a bond an amount that is greater than the bond balance refundable by the provider they are transferring from, either at the time of transfer or thereafter.

Amount of accommodation bond

The maximum amount of any accommodation bond that a person can be asked to pay depends on the level of the resident's assets when they enter the service as a permanent resident. See also Accommodation payments and assets testing on page 98.

Provided that the resident is left with the minimum permissible asset amount, there is no ceiling on the amount of an accommodation bond that can be charged. As of 20 September 2009, the minimum asset amount which a resident must be left with is 2.25 times the annual single rate age pension, rounded to the nearest $500, as at the day they enter care. This rate applies for people whose date of entry to care is after 20 September 2009.

Some residents may choose not to give an approved provider sufficient information to determine their assets. In these cases, the resident can be asked to pay the amount specified in the accommodation bond agreement, as long as the provider is assured that if the resident pays this amount, the resident will still have at least the minimum permissible asset level.

Residents who choose to pay an accommodation bond wholly or partly by periodic payments must still be left with at least the minimum permissible asset value when they enter the aged care service.

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

Types of accommodation bond payments

Residents can pay an accommodation bond as a lump sum, a regular periodic payment or a combination of both.

A resident must not be required to pay a lump sum accommodation bond, including retention and interest amounts, until six months after they have entered care. They can, however, choose to pay before this date. Retention amounts and interest may accrue from the resident's date of entry to the service. If the service is not certified when the resident enters, the resident must not be required to pay an accommodation bond until the service has been certified for six months.

Periodic payments are payable from the date the resident enters the service, or the date the service is certified if this is later. The resident and the service provider must agree on the frequency of periodic payments, which cannot be more often than weekly.

If the resident has applied for a determination of financial hardship, the resident must not be required to pay an accommodation bond unless the Secretary declines to make such a determination, or the determination of financial hardship ceases to be in force. See Hardship and accommodation payments on page 143.

If the resident has agreed to pay an accommodation bond, and the Secretary does not make a determination of financial hardship, or a determination ceases to be in force, the resident must not be required to pay an accommodation bond until six months after receiving notice from the Secretary.

If the resident has agreed to pay an accommodation bond by periodic payment, these are usually payable from the resident's date of entry.

Retention amounts

A retention amount may be deducted from an accommodation bond balance for each month, or part of a month, for a maximum of five years. The maximum monthly retention amount that a provider may keep from a resident's accommodation bond is the lower amount of:

- the capped maximum amount applicable at the time the resident enters the aged care service. The capped maximum amount is indexed annually in July in line with the consumer price index (CPI)
- the amount the provider and resident agree on in the accommodation bond agreement entered into when the resident entered the service.

The retention amount is not set down in the legislation, but the legislation does specify the maximum amounts that may be deducted. The amount needs to be agreed on by the provider and the resident and included in the accommodation bond agreement. Bond agreements may not specify an amount that exceeds the capped maximum.

Where a bond is paid partly by lump sum and partly by periodic payments, the maximum retention amount applies to the total (lump sum equivalent) accommodation bond.

The monthly retention amount that providers can keep cannot change while the resident lives at that aged care service.

Once the five year limit is reached no further retention amounts can be deducted from the bond. The five-year period is cumulative and is reduced by each month for which retention amounts were deducted from an accommodation bond (or entry contribution) the resident paid to another aged care service.

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If a resident is provided with care for two months or less, retention amounts can be retained for a total of three months—ie, the whole of the month in which the resident entered the aged care service plus the following two months.

Months commence on the date the resident entered the service and end on the day before the corresponding date in the next month. If there is no such corresponding day, the month ends on the last day of that next month.

The five-year period generally commences on the day the recipient enters as a permanent resident. However:

- if the aged care service is not certified on that day, it commences on the day the service becomes certified
- or if a determination of financial hardship is in force for that resident, the day after the day it ceased to be in force
- or if the resident is transferred from respite care to permanent accommodation, the day of the transfer.

If a resident transfers to another aged care service, the maximum retention amount that applies in the new service may be different to the maximum retention amount that applied in the old service:

s 23.71(1)(a), (c), (3), (4), User Rights Principles 1997

- in some cases it will increase—for example, where it is linked to CPI and a CPI increase has taken effect *See legislative reference.*

s 23.71(1)(b), User Rights Principles 1997

- in other cases it will decrease—for example, where it is linked to the amount of the bond and the new bond is less than the old bond due to the deduction of retention amounts *See legislative reference.*
- in some cases, it will stay the same—for example, where it is linked to the amount of the bond, but no retention amounts have been deducted; or where it is linked to CPI, and the CPI increase matches the effect of the deduction of retention amounts.

EXAMPLE

Peggy is a bond-paying resident, who entered an aged care service on 30 January 2008 and left on 26 February 2009. The provider could keep 13 months worth of retentions from Peggy's bond—ie, 12 full months from 30 January 2008 to 29 January 2009, plus the part month from 30 January to 26 February 2009.

EXAMPLE

Frank is a bond-paying resident who entered an aged care service on 31 January 2008 and left on 1 March 2009. The provider could keep 14 months worth of retentions from Frank's bond—ie, 13 full months from 31 January 2008 to 28 February 2009 plus the part month of one day in March.

Interest charges

Provided that the accommodation bond agreement allows interest to be charged, providers can charge interest on overdue accommodation bonds. While the legislation sets a maximum rate of interest that can be charged, agreements may specify a rate that is less than the maximum permissible interest rate.

The legislation determines the maximum permissible interest rate which residents may be asked to pay:

- on lump sum accommodation bonds which are paid after the date due, including bonds which are unpaid at the time of departure from the aged care service
- on periodic payments of accommodation bonds
- on amounts owed which may be deducted from the bond balance
- in certain situations where the resident leaves the aged care service within two months of entering care.

The rate that applies when the resident arrives is the maximum that can be charged for the period that the resident stays in the service—ie, the rate does not change. The maximum permissible interest rate for each quarter is available on the Department's website, in the Aged Care Essentials newsletter (formerly known as Payment Essentials) and from the Aged and Community Care Information Line. See References at the end of this chapter for links and contact information.

Interest can be charged:

- when the resident pays a lump sum bond after the due date—for the days starting on the due date and ending on the day the lump sum was paid. The due date will usually be the date of the resident's entry to the aged care service; or may be the date of certification, if the service is uncertified when the resident enters
- when the resident receives care for two months or less and their bond is refunded within three months of their entry to the aged care service—for the number of days between the day of the refund and the three months after they entered
- when the resident pays a lump sum bond after the due date and it is refunded within three months of entry, the total of the two points above
- when the resident was provided with care for two months or less, and agreed to pay an accommodation bond but did not pay it before they left the aged care service—for the days starting on the due date and ending three months after they entered
- when the resident was provided with care for more than two months, and agreed to pay an accommodation bond, wholly or partly as a lump sum, but did not pay before they left the aged care service—for the days starting on the first day of the month in which the resident entered and ending on the last day of the month in which they left the service.

Interest cannot be charged when a service is uncertified. The number of days detailed above must be reduced to exclude any period during which the service was not certified.

Periodic payments

Periodic payments are:

- regular payments from a resident to a provider
- of an amount equivalent to the amount of interest the provider could have derived from the accommodation bond if it had been paid as a lump sum
- plus a retention amount.

Periodic payments are not refundable, unless they are paid for a period for which the resident was not liable for a periodic payment.

The provider may charge the full amount of the periodic payment for the month that the resident leaves the service.

If a resident is in care for less than three calendar months, the service can still charge an amount equal to the periodic payments payable for three months.

A periodic payment includes a component for the retention amount the provider could have received on the lump sum equivalent, and a component for the income that the provider could have derived from the lump sum equivalent. See Interest charges on page 112.

Retention component of a periodic payment

Periodic payments can only include a retention component for a maximum of five years. For the remainder of the person's period in care, the periodic payment would be based only on the income the provider could have derived from the lump sum equivalent.

If an accommodation bond is paid partly as a lump sum, and partly through periodic payments, the retention amounts can be included wholly in the periodic payment formula or deducted wholly from the lump sum, or partly through each in an agreed proportion.

Calculating periodic payments

The formula for calculating the periodic payment for the first five years in care is (rounded to the nearest cent):

$$\frac{\text{(lump sum equivalent x interest rate per cent*)} + \text{(12 x monthly retention amount),}}{\text{divided by number of periodic payments in the year.}}$$

*A provider can charge interest up to the maximum permissible interest rate. The current maximum permissible interest rate is available on the Department's website. See References at the end of this chapter for a link.

Examples

The total accommodation bond is $90,000 and is not paid at date of entry. The interest rate is 10 per cent (example rate only*), and payments are made monthly. The monthly periodic payment, including retention and interest, is:

$$\frac{\text{(\$90,000 x 10 per cent)} + \text{(12 x \$299.00) = \$1049.00}}{12}$$

*A provider can charge interest up to the maximum permissible interest rate. The current maximum permissible interest rate is available on the Department's website. See References at the end of this chapter for a link.

After the first five years in care, the payment would be calculated only on the interest* payable on the lump sum. In the above example, the monthly periodic payment would be reduced to:

$$\frac{\$90{,}000 \times 10 \text{ per cent} = \$750}{12}$$

*A provider can charge interest up to the maximum permissible interest rate. The current maximum permissible interest rate is available on the Department's website. See References at the end of this chapter for a link.

The total accommodation bond is $90,000. The resident pays $60,000 of it as a lump sum with a remaining lump sum equivalent of $30,000. If the monthly retentions of $299.00 were taken equally from the periodic payment and the lump sum, then the monthly periodic payment for the first five years in care would be:

$$\frac{(\$30{,}000 \times 10 \text{ per cent}^*) + (12 \times \$299.00 \div 2) = \$399.50}{12}$$

*A provider can charge interest up to the maximum permissible interest rate. The current maximum permissible interest rate is available on the Department's website. See References at the end of this chapter for a link.

The total accommodation bond is $90,000, with $60,000 of it agreed to be paid as a lump sum and the remaining lump sum equivalent of $30,000. If the monthly retentions were taken wholly from the lump sum, with none of them included in the periodic payments, then the periodic payment for the whole of the period in care would be:

$$\frac{(\$30{,}000 \times 10 \text{ per cent}^*) + \$0 = \$250}{12}$$

*A provider can charge interest up to the maximum permissible interest rate. The current maximum permissible interest rate is available on the Department's website. See References at the end of this chapter for a link.

Refunding the accommodation bond balance

See section on Refunding accommodation bond balances in chapter on Protection and responsibilities relating to accommodation bonds in this Manual.

Residents who move to another aged care service

Special arrangements apply to residents if they move aged care services within 28 days of leaving the previous service.

If the resident transfers to another service, to receive low level care, the maximum amount of accommodation bond that can be charged by the second service is the balance of the previous accommodation bond.

If the resident transfers to another service to receive high level care, they can choose (with the agreement of the service provider) to either have the balance of their accommodation bond rolled over to the second service or to begin to pay an accommodation charge.

Pre-20 March 2008 residents who were assessed as concessional or assisted in their previous admission can roll over their concessional or assisted status provided that this was determined through an asset assessment done by either Centrelink or DVA. Pre-1 July 2004 concessional or assisted residents will need to have an asset assessment done to determine their status if this had previously been determined by the aged care provider.

What if the resident's care needs increase after entry?

If a bond-paying resident's care needs increase from low to high care after entering a service, the original bond agreement cannot be changed into an accommodation charge agreement.

However, if a resident moves from one service to another because the first service is unable to provide the higher level care the resident needs, then a new accommodation payment agreement may be entered into for the second entry.

Transitional accommodation supplement

Approved providers will be eligible for a transitional accommodation supplement for some new residents who enter low level care.

The transitional accommodation supplement will be paid for new permanent residents who entered low-level care after 20 March 2008 and before 19 September 2011, for whom the level of the accommodation supplement would be less than the level of the pensioner supplement it replaces. Initially, this transitional accommodation supplement will fully offset the loss of pensioner supplement and largely offset the loss of the additional basic fee for these residents. This will allow providers time to adjust to the new arrangements. The rate of the supplement will depend on the resident's entry date.

Accommodation bonds and hardship

Financial hardship assistance is available to aged care residents who do not have sufficient assets to pay their accommodation payment. See Hardship and accommodation payments on page 143.

ACCOMMODATION PAYMENTS—INFORMATION PROVIDED TO RESIDENTS AND RESIDENT AGREEMENTS

Essential information in accommodation charge agreements

Providers must include the following in an accommodation charge agreement:

- the amount of the daily accommodation charge
- the resident's date of permanent entry to the aged care service

LEGISLATIVE REFERENCES

- how the daily accommodation charge is to be paid and when it is payable
- the interest rate payable if interest is to be charged because there is a delay in paying the daily accommodation charge
- if the agreement charge entitles the resident to specific accommodation or additional services (additional services are those which the provider is not required to provide under the Act)
- if the resident has obtained or has applied to the Department for a determination that paying an accommodation charge would cause financial hardship, the amount of daily accommodation charge which will be payable if the determination stops being in force, or if the Department declines to make such a determination
- information about the accommodation charge which the resident agrees that the provider can give to the approved provider of a different residential aged care service, if a resident wants to move to that service. This includes whether the care recipient has agreed to pay an accommodation charge and the period remaining for which accommodation charges may be levied. *See legislative reference*.

ss 57A-3(1) and 57A-12(1)(c), Aged Care Act 1997, ss 23.81M and 23.81N, User Rights Principles 1997

If an agreement does not include the above detail, it is not an accommodation charge agreement under the Act. No provision in an accommodation charge agreement can override the provisions of the Act or the Aged Care Principles. *See legislative reference.*

Division 57A, s 57A-5, Aged Care Act 1997

Essential information in accommodation bond agreements

If a provider asks a resident to pay an accommodation bond, the provider must give the resident the following information before they enter the service:

- the range of bonds charged
- payment options available to the resident—eg lump sum, periodic or a combination of both
- the retention amount and the periods for which retention amounts can be retained by the provider
- the interest rate on the bond if there is a delay in payment, or if the bond is paid wholly or partly by periodic payments, and the periods when interest is payable by the resident
- that amounts owed by the resident under the accommodation bond agreement, any resident agreement and any extra service agreement, plus any accrued interest on these amounts owed, can be deducted from the accommodation bond balance before it is refunded to the resident
- when a bond is not required, or is refundable
- refund arrangements
- information about the service's prudential arrangements—this includes providing a copy of the service's most recent annual prudential statement
- if the resident has given the provider sufficient information to establish the value of their assets, the requirement that the resident must be left with assets of at least the minimum permissible asset value after paying the bond.

Accommodation bond agreements

An accommodation bond agreement must specify:

- the bond amount
- the resident's date of permanent entry to the aged care service
- how and when the bond is to be paid
- if the bond is to be paid wholly or partly by periodic payments
  - the amount of the lump sum equivalent
  - the amount and frequency of periodic payments
  - the components representing retention and income
  - whether interest charges are payable if periodic payments are overdue
  - the right of the resident to convert to a lump sum at any time
- the interest rate payable if there is a delay in payment of the bond or if the bond is paid wholly or partly by periodic payments
- that before the accommodation bond balance is refunded to the resident, amounts owed by the resident under the accommodation bond agreement, resident agreement or extra service agreement, plus any accrued interest on these amounts can be deducted from the balance
- conditions which will apply if a person agrees to pay a bond but does not enter the aged care service
- if agreement to pay a bond, or a bond of a certain size, entitles the resident to specific accommodation or additional services (additional services are those which the provider is not required by legislation to provide)
- if the accommodation bond is more than 9 times (10 times if prior to 20 September 2009) the annual single age pension, any additional resident fees payable by the resident as a result of the aged care service not being entitled to pensioner supplement for that resident
- if the resident has obtained, or has applied to the Department for a determination that payment of an accommodation bond would cause financial hardship, the amount of accommodation bond that would be payable if the determination stopped being in force, or if the Department declined to make such a determination
- the amount the provider can charge if the resident stays 2 months or less
- the dollar amount of each retention amount and when it will be deducted
  - such an amount must not exceed the maximum retention amount which applies at the time of entry to the aged care service
  - if transferring to another aged care service, the retention amount should be the amount calculated on the bond payable at the second service
- the circumstances in which the bond must be refunded and the way the refund will be worked out
- prudential arrangements for the bond
- information about the accommodation bond which the resident agrees that the service provider may provide to the new aged care service when the resident wishes to move to that new service, including:

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- the amount of any accommodation bond agreed, including the lump sum equivalent if the amount is to be paid wholly or partly by periodic payments
- the retention amounts and the period remaining in which retention amounts can be deducted
- any amounts owed under an accommodation bond agreement, resident agreement or extra service agreement which can be deducted from the accommodation bond balance, if the bond was paid wholly or partly as a lump sum. *See legislative reference.*

s 57-9, Division 5, Part 4, User Rights Principles 1997

If an agreement does not set out the above matters, it is not an accommodation bond agreement under the Act. No provision in an accommodation bond agreement can override the provisions of the *Aged Care Act 1997* or the Aged Care Principles. *See legislative reference.*

Division 57, s 57-11, Aged Care Act 1997

An accommodation bond agreement can be incorporated into another agreement, for instance a resident agreement or extra service agreement.

EXTRA SERVICE FEE

The extra service amount is the maximum additional amount a provider can charge a resident for receiving extra service in a residential care service with extra service status. Extra service status is granted for services, or distinct parts of services, where residents are provided with significantly higher standards of accommodation and food.

A resident pays an extra service amount in addition to other fees, which includes the resident contribution (also known as the basic daily fee) and may include an income tested fee.

The amount of the extra service fee must be approved by the Secretary. A provider cannot charge any fees above the approved extra service fee amount, for any of the accommodation, services or food specified in the conditions of grant of extra service status.

If a resident is occupying an extra service status place, the residential care subsidy for that resident is reduced by 25 per cent of the approved extra service fee for that place.

EXAMPLE

If the extra service fee for a place is $20 per day, then the Government subsidy for a resident receiving extra service care in the place will be reduced by 25 per cent or $5 per day. The $5 per day is the extra service reduction.

The extra service amount is $25—ie the extra service fee ($20 per day) plus the extra service reduction ($5 per day).

See section on Fees and payments in chapter on Extra service places in this Manual.

FEES FOR ADDITIONAL SERVICES

An approved provider may charge a resident additional fees for additional services—for example hairdressing—which the resident has asked the provider to provide and which have been set out in the resident agreement. The amount of any charge for additional services must be agreed beforehand with the resident and an itemised account given to the resident once the service has been provided. *See legislative reference.*

s 56-1(d), Aged Care Act 1997

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

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Residents cannot be asked to pay extra for the care and services that the provider is required to provide. See also chapter on Specified care and services in this Manual.

GRANDPARENTING ARRANGEMENTS

Concessional resident supplement

A concessional resident is a person who cannot afford to pay an accommodation bond or accommodation charge and who initially entered permanent care prior to 20 March 2008. The Government pays the concessional resident supplement for them and providers are required to set aside a certain number of places for concessional and supported residents.

ss 57-14 and 57A-9, Aged Care Act 1997

A person can also be a concessional resident if the Secretary has made a determination that paying an accommodation bond or charge would cause the person financial hardship. *See legislative reference.* The concessional resident supplement stops if this determination ceases to be in force because, for example, previously unrealisable assets have actually been realised.

Concessional resident supplement can only be paid

- for concessional and assisted residents who initially entered an aged care service between 1 October 1997 and 19 March 2008
  - and who are in a certified service.

Concessional resident supplement cannot be paid for:

- residents receiving care on an extra service basis
- respite residents
- the lowest classification level. The supplement can be paid if the resident's classification level rises. The supplement may still be paid when a resident, classified at a higher level, is attracting basic subsidy at the lowest level only because the resident is on extended hospital leave.

Providers must meet regionally-based ratios for concessional, assisted and supported residents. Assisted residents are also counted towards concessional resident ratios.

Concessional resident—eligibility

Concessional resident status is determined based on a resident's circumstances on the day he or she entered the aged care service. To be a concessional resident, a resident:

- must be a pre-March 2008 reform resident—ie, have initially entered an aged care service before 20 March 2008
- must not have had an absence from care for a continuous period of more than 28 days after 20 March 2008
- must be receiving an income support payment
- must not have owned a home for the past 2 years or more
- and have assets of less than the applicable minimum asset level.

For concessional resident purposes, a person is taken not to have owned a home if at the time they entered the aged care service their home is occupied by:

- their partner or dependent child

- a dependent child includes a child under 16 years or a full-time student under 25 years. A child is dependent even if the resident does not have custody of that child, if the resident is paying child support for that child under the Child Support Scheme or another legally binding arrangement

- a carer who has lived in the home continuously for the past 2 years and that carer is eligible for an income support payment at the time the person enters the aged care home
- or a close relation who has lived in the home continuously for the past 5 years and that close relation is eligible for an income support payment at the time the person enters the aged care home.

The resident is not classed as a home-owner in determining concessional resident status if the value of their interest in the home does not exceed an amount that is 2.25 times the basic age pension amount at the time they enter the aged care service. The value of their home is still included in calculating their assets.

A person is not considered to be a home-owner in determining assisted resident status if the value of their interest in the home does not exceed an amount that is 3.61 times the annual single basic rate age pension. The value of their home is still included in calculating their assets.

Structure of the concessional resident supplement

The concessional resident supplement is paid at a high and a low rate depending on the proportion of place days occupied by the combined number of concessional and assisted residents.

- the lower rate is paid for all concessional residents in services where up to 40 per cent of post-30 September 1997 residents are concessional or assisted residents
- the higher rate is paid for all concessional residents in services where more than 40 per cent of their post-30 September 1997 residents are concessional or assisted residents—ie, a service where 60 per cent of their post-30 September residents were concessional or assisted residents would receive the higher rate for each concessional resident.

Aged care services will be paid the full rate of the accommodation supplement for new residents, if more than 40 per cent of their permanent residents are supported residents. See Accommodation supplement on page 105.

Assisted residents

Aged care services receive an assisted resident supplement. The criteria for determining assisted resident status are the same as for concessional resident status except that:

- an assisted resident has assets of between 2.25 and 3.61 times the annual single basic age pension amount, rounded to the nearest $500.

An assisted resident, unlike a concessional resident, may be asked to pay an accommodation bond or charge as long as the resident is left with assets of at least 2.25 times the annual single basic pension amount.

Charge exempt resident supplement

The rate of charge exempt resident supplement is equal to the concessional supplement and is also indexed in March and September each year. The charge exempt resident supplement rate is reduced by the amount of the assisted or

supported resident supplement for charge exempt residents who are also assisted or supported residents. See References at the end of this chapter for a link to current supplement rates.

Charge exempt residents and supported resident ratios

Service providers should encourage any potential charge exempt residents to complete a request for an assets assessment form if they have not already done so, even though the resident will not be asked to pay an accommodation charge.

Residents assessed as concessional, assisted or supported will be counted towards an aged care service's supported ratios, whereas charge exempt residents are not.

Pensioner supplement

Pensioner supplement is payable for pre-March 2008 reform residents who either have a dependent child or receive an income support payment and have not agreed to pay a big bond. A big bond is more than 10 times the basic age pension amount at the time of entry into care, if the person entered the service before 20 September 2009; or 9 times the basic age pension amount at the time of entry if the person entered the service on or after 20 September 2009.

Transitional supplement

Residents who were already in aged care services prior to 1 October 1997 cannot be asked to pay an accommodation charge or an accommodation bond or be considered for a supported or concessional resident status while they remain a resident in the same service.

Providers also have a responsibility to provide security of tenure for all residents, and it is a condition of approval that residents are not discharged and readmitted in order to receive extra funding.

Providers therefore receive a transitional supplement for these residents.

Grandparenting of hostel variable fees

Residents who entered a hostel before 1 October 1997 and who had sufficient income may have agreed to pay a higher variable fee at that time. The grandparenting arrangements allow providers to continue to charge the 30 September 1997 variable fee for these residents, less any residential care allowance (rent assistance) the residents may have received at that time.

The grandparenting arrangements only apply to residents who:

- occupied a hostel place on 30 September 1997
- on that day, paid a fee which, after deducting any residential care allowance they may have received, was greater than the fee would otherwise be under the Act.

Grandparented fees cease permanently if:

- the resident leaves the hostel
- the resident's fee under the grandparenting arrangements falls below the applicable resident contribution.

Providers must review the resident's grandparented fee annually or more often if the resident requests it. The grandparented fee must be reduced if the review indicates that the resident's income has fallen from the 30 September 1997 level, or from the most recently reviewed level of income. The amount of the reduction to the grandparented fee is the amount of reduction in the resident's net income. The grandparented fee cannot be increased as a result of a review.

Income for the purpose of reviews of grandparented fees is to be calculated in accordance with the General Conditions formulated under section 10F of the *Aged or Disabled Persons Care Act 1954*. Actual income, rather than the deemed amount is to be used and the income amount should be net of any income tax and Medicare levy. Where residents get non-weekly income, such as periodic interest payments through the year, the payments are averaged to a weekly rate and added to any other weekly income to produce an average weekly income. See References at the end of this chapter for a link to ComLaw for this Act.

Transitional arrangements for entry contributions

Special transitional arrangements apply for residents who agreed, prior to the 1 October 1997 introduction of the current arrangements, to pay an entry contribution under the *Aged or Disabled Persons Care Act 1954*.

The requirements of the general conditions under section 10F of the *Aged or Disabled Persons Care Act 1954* continue to apply for those entry contributions, including:

- refunds of the appropriate entry contribution amount must be made within 6 calendar months of the resident's departure from the service, unless the resident moves to another aged care service within 28 days of departing, in which case the rules of the Aged Care Act apply
- in calculating the amount of the entry contribution refund, retention amounts may be deducted for each 6-month period the resident has lived in the hostel. If the resident's period of residence is not exactly divisible by 6-month periods, the final period is deemed to be a 6-month period
- if a resident delays payment of the entry contribution, in addition to the usual retention amounts, the service can retain an amount equivalent to the retention amount for each 6 month period, or part thereof, that the payment is delayed, up to a maximum of five years.
- if a resident moves to another aged care service within 28 days of leaving the first aged care service where an entry contribution was paid, or agreed to be paid, the maximum accommodation bond which may be charged by the second service is the amount of the entry contribution refund from the first service
    - the entry contribution refund from the first service must be made within 7 days.

The five-year period for which retention amounts can be deducted from accommodation bonds are affected by any periods for which the resident's entry contribution has had retention amounts deducted. Each 6-month period for which retention amounts have been deducted from the entry contribution count as 6 months toward the five-year period.

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN PART A OF THIS CHAPTER

See References at the end of this chapter.

LEGISLATIVE REFERENCES

B. FUNDING AND INCOME FOR CARE SERVICES

RELEVANT LEGISLATION

- Part 3.1, *Aged Care Act 1997* (the Act)
- Division 42, *Aged Care Act 1997*
- *Residential Care Subsidy Principles 1997* (the Residential Care Subsidy Principles)
- Part 2, *Aged Care Act 1997*
- s 96-4, *Aged Care Act 1997*
- Division 43, *Aged Care Act 1997*
- Division 44, *Aged Care Act 1997*

OVERVIEW

Care payments contribute to the cost of providing care for residents of aged care services.

The care payment includes a basic subsidy or residential care subsidy amount, which is based on a resident's classification under the Aged Care Funding Instrument (ACFI) and additional supplements.

The amount of basic subsidy which the Government pays to a provider for providing residential care to a resident may be reduced if the resident is able to contribute to the cost of their own care and pay an income tested fee. If they can contribute, then an amount known as the income tested subsidy reduction will apply to the basic subsidy.

The Government sets the maximum income tested fee that the provider may charge, depending on the resident's income.

From 1 January 2010, the income tested fee will apply from the day of entry. Before 1 January 2010, an income tested fee will not apply until the 29th day after a resident's date of admission.

Rates and additional information

The rates for fees, subsidies and supplements, including the basic subsidy and the income tested fee, change several times every year. For this reason, actual dollar amounts payable are not included in this Manual. Current rates are available on the Department's website, in the Aged Care Essentials newsletter (formerly known as Payment Essentials) and from the Aged Care Information Line. See References at the end of this chapter for links and contact information.

How to calculate fees payable by a resident

s 58-1(a), Aged Care Act 1997

To calculate the maximum daily fee that a resident may be asked to pay, approved providers should: *See legislative reference.*

(1) work out the applicable standard resident contribution—ie, the maximum basic daily fee

(2) add any compensation payment reduction that applies for the resident

(3) add any applicable maximum income tested fee for the resident

(4) subtract any hardship supplement that applies for the resident

(5) add any other amounts agreed between the provider and the resident, that is, agreed fees for additional services

(6) if the resident is in an extra service place and receiving care on an extra service basis, add the extra service amount

(7) for an aged care service located in a remote area, add the remote area allowance amount.

A resident may also be asked to pay an accommodation bond or an accommodation change.

RESIDENTIAL CARE SUBSIDY

The Government pays approved providers an amount of residential care subsidy, where they are eligible to receive subsidy, for the residential care they provide to residents approved for that form of care.

Residential care subsidy is paid monthly and is calculated by adding the amounts due for each resident for each day of the month. Providers submit a claim for each month, including the details of each resident for whom they are claiming subsidy in that month. They receive an advance payment in the first few days of each month. This advance payment is then reconciled with the claim for that month and the following month's payment is adjusted accordingly, either by making an additional payment or by reducing the total amount paid in lieu of the previous month.

A provider can be paid residential care subsidies in the following circumstances:

- only accredited services are eligible for subsidies
- on any day, subsidy can only be paid for the number of places allocated to the provider
  - if subsidy is claimed for more residents than the allocated number of places, residents are excluded from subsidy in reverse order—ie, the last resident who entered is the first one excluded from the claim
- if another person is operating the aged care service, for example under a contract or a lease arrangement, the approved provider remains the person eligible for the subsidy. This means that it is the approved provider who is responsible for meeting all the responsibilities of providing approved residential care
- providers are paid for a resident's first day of care
  - a resident's day of entry and day of departure are counted as one day.

How residential care subsidy is paid

Residential care subsidy is payable to approved providers for each eligible approved resident cared for during the claim period. If a provider has approved places in more than one service, separate claims must be made for each service.

The claim period for residential care subsidy is one calendar month:

- if a service opens during a month, the first claim period is from the opening day to the end of the month, and thereafter monthly
- if a service closes during a month, the claim period is from the first day of the month to the day of closure.

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

Medicare Australia makes an advance payment at the start of each month, generally by the third working day of each month. The calculation of the monthly advance payment is based on a service's actual entitlements for the monthly claim period two months ago.

For example, the calculation of the advance payment for September is based on the actual entitlements for July.

Therefore, a service's claim form must have been received and processed by Medicare Australia before the advance can be made. In the case of new services, the first two advances will be manually estimated by Medicare Australia.

At the end of each month, a service must submit a formal claim for payment to Medicare Australia. To assist services, Medicare Australia provides each service with a pre-populated claim form listing their residents' details. Each service is then required to confirm or amend the details on the claim before the form is submitted to Medicare Australia for processing.

Upon receipt of the claim form, Medicare Australia calculates the actual entitlement of the service. If the entitlement exceeds the advance, an additional payment will be made to Medicare Australia; whereas if the advance exceeded the entitlement, a negative amount will be carried forward to a future claim. At this stage Medicare Australia will also send the service a payment statement and include a pre-populated claim form for the next month.

Example

This is how the funding cycle would operate for September and October:

- the September advance is based on the final entitlement for July
- this July entitlement is pro-rated for the number of days in September—ie, if the final calculated entitlement for July was $100,000, the September advance would be $100,000 divided by 31 days (the number of days in July) times 30 days (number of days in September)
- the July entitlement is calculated in late August and paid in early September
    - the provider acquits the September advance in October, advising changes to resident details that occurred during September
    - the September claim is processed within seven working days of it being received and any adjustments are made to the advance
- if the advance was too small, a further payment is made
- if the advance was too large, a negative amount is carried forward to a future claim
- late in September, the October advance is calculated, based on the final entitlement for August, and paid by the third working day in October.

Claims for residential care subsidy

Every month the Department sends providers an explanatory advice about their payments and provides forms to be completed for claiming subsidy for residents within the aged care service.

For each month, the claim for payment:

- must be forwarded on the approved form
- along with any supporting documentation, such as a medical practitioner's certification for a claim for enteral feeding

LEGISLATIVE REFERENCES

- providers should ensure that any changes to bank account details are notified promptly on the banking details for the direct deposit of payments form. See References at the end of this chapter for a link.

Working out the amount of residential care subsidy

s 44-2(1), Aged Care Act 1997

A provider's residential subsidy amount for the claim period is: *See legislative reference.*

- the sum of the subsidy for each resident of the aged care service
- for each day during which residential care was provided to the resident
- and for each day on which the resident was eligible for subsidy.

The amount of residential care subsidy for a month can be calculated from:

(1) the basic subsidy amount, given the service's number and mix of residents and their classification under the Aged Care Funding Instrument (ACFI)

(2) plus any primary supplements

(3) less any reductions in subsidy

(4) less any reduction resulting from income testing of residents

(5) plus any other supplements.

In certain circumstances, some other amounts may also be deducted from the payments to a provider in relation to repayment of capital grants, payment of additional recurrent funding and recovery of overpayments.

Basic subsidy amount

s 44-3, Aged Care Act 1997, s 21.11, Residential Care Subsidy Principles 1997

The basic subsidy for a resident, for the payment period, is obtained by adding the amounts applicable for each day in the period for which the resident received residential care through the aged care service. Different rates apply depending on a range of factors. These include: *See legislative reference.*

- each resident's ACFI classification
- whether the care provided is respite. Respite care recipients can be admitted at either high care or low care level
- each resident's Aged Care Assessment Team (ACAT) assessment
- periods of leave.

Subsidies will not be paid:

- for the day a resident leaves an aged care service
- to one provider if another provider is being paid for providing care to the resident for that same day—this ensures that if a resident is on leave, the original service is still eligible for subsidy for that resident, even if the resident enters another service during the leave period. See High-dependency care leave on page 146 for the only exception to this rule.

Transitional measures

Because nursing service proprietors were paid for the last day of care rather than the first prior to 1 October 1997, nursing service proprietors are paid for the day on which existing residents at 1 October 1997 leave the aged care service.

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

LEGISLATIVE REFERENCES

Conditional adjustment payment

The conditional adjustment payment (CAP) provides financial assistance to residential care providers to assist them to become more efficient and to improve their corporate governance and financial management practices.

Receipt of CAP funding by individual approved providers is voluntary, and is conditional on compliance with requirements set out in the Residential Care Subsidy Principles.

The CAP payment is calculated as a percentage of the basic subsidy payable in respect of each resident. The CAP is also applied to the basic subsidy amounts in calculating the rates of payment for the Multi-purpose Services program and the flexible services funded under the Aboriginal and Torres Strait Islander Aged Care Strategy.

Division 4, Part 10, Residential Care Subsidy Principles 1997

For providers to remain eligible to receive CAP, they must satisfy the following three eligibility conditions: *See legislative reference.*

- encourage staff training
- prepare a general purpose financial report for each financial year; have that report audited and be able to provide a copy of that report to residents or a person or agency authorised by the Secretary to the Department
- participate in any aged care workforce census conducted by the Department.

Eligible oxygen treatment and enteral feeding supplement

Oxygen and enteral feeding supplements are primary supplements paid to aged care services for residents with a specified medical need for the continual administration of oxygen and /or enteral feeding. This includes residents receiving respite care and is irrespective of the classification level of the resident.

A medical practitioner must certify in writing that the care recipient has a continual need for the administration of oxygen or a medical need for enteral feeding and Medicare Australia must sight this documentation.

Standard supplements are available for residents who require oxygen and/or enteral feeding. A higher supplement may be approved where higher costs are incurred.

To apply for the oxygen and/or enteral feeding supplement, the aged care service must complete an application for the oxygen and/or enteral feeding supplement. This form is available on the Medicare Australia website. See References at the end of this chapter for a link.

Oxygen supplement

To be eligible for the oxygen supplement, a resident must have an ongoing medical need for the administration of oxygen—ie, the resident must need oxygen on a continual basis rather than for episodic or short-term illnesses, such as bronchitis. This need will normally be met by a concentrator.

The standard supplement allows for some cylinder oxygen, such as for social outings and required use within the aged care service.

A higher supplement may be approved for a resident whose medical requirements cannot be met by concentrator oxygen. A higher level supplement may only be approved if the costs incurred are 25 per cent or more above the standard supplement.

s 21.21(4), Residential Care Subsidy Principles 1997

Oxygen must be administered in the most economical way available, taking into account the medical needs of the resident. *See legislative reference.*

LEGISLATIVE REFERENCES

To verify the care recipient's medical needs, a medical practitioner must certify in writing:

- the care recipient's particular oxygen requirements
- that the care recipient has a continual need for the administration of oxygen.

Enteral feeding supplement

To be eligible for an enteral feeding supplement a resident must be receiving a nutritionally complete formula by means of a nasogastric, gastrostomy or jejunostomy feeding method.

s 21.23(5), Residential Care Subsidy Principles 1997

The enteral feeding supplement is not payable for intermittent or supplementary enteral feeding that is given in addition to oral feeding. *See legislative reference.*

There are two levels of the supplement, one for bolus and another for non-bolus feeding.

A higher level supplement may only be approved if the costs incurred are 25 per cent or more above the standard supplement.

The enteral feeding must be administered in the most economical way available, taking into account the medical needs of the care recipient.

s 21.23(1), Residential Care Subsidy Principles 1997

To verify the care recipient's medical needs, the following is required:

- written certification by a medical practitioner that the care recipient has a medical need for enteral feeding *See legislative reference.*
- written certification by a medical practitioner or dietician that the dietary formula prescribed is nutritionally complete *See legislative reference*

s 21.23(3), Residential Care Subsidy Principles 1997

- the care recipient's particular enteral feeding requirements. These can be detailed in the medical certificate, the resident's care plan, hospital discharge papers or in the dietician's enteral feeding instructions.

Payroll tax supplement

Payroll tax is a state/territory based tax levied upon employers whose total payroll costs exceed the relevant threshold amount in their particular state or territory. The payroll tax supplement is paid to aged care services in recognition of the unique costs associated with the provision of aged care.

The supplement is meant to represent a proxy for wages of care related staff only, rather than for staff employed by all business enterprises, such as administrative assistants.

The supplement is payable to approved residential aged care facilities only, including Multi-Purpose Services (MPS). It is not payable to independent living units, Community Aged Care Packages (CACPs), Extended Aged Care in the Home (EACH) packages, day therapy centres and any other non-residential aged care initiatives.

Approved providers are eligible for the payroll tax supplement in relation to all permanent and respite residents, except for those classified as N-N-N under the Aged Care Funding Instrument (ACFI), and for any remaining residents classified at Resident Classification Scare (RCS) 1 to 7, if:

- they are an approved provider under the Act
- they provide that resident with residential care under the Act
- they have either a direct payroll tax liability or an indirect payroll tax liability. Facilities can claim only a direct or indirect liability.

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

LEGISLATIVE REFERENCES

Direct payroll tax liability is the payroll tax owed by an employer to the relevant state or territory revenue office for wages paid by that employer to its employees. The employer is registered with the relevant state or territory revenue office as being either individually, or as part of a group, responsible for the payment of payroll tax.

A payroll tax group occurs where two or more businesses are registered with their respective relevant state or territory revenue office where, in total, they are responsible for the payment of the group's direct payroll tax liability. Groups may consist of businesses across more than one state or territory, and/or more than one approved provider.

Employers who are charitable and not-for-profit organisations typically incur an indirect payroll tax liability. Indirect payroll tax liability occurs where a provider is not registered with a state or territory revenue office for the purposes of paying payroll tax, but pays invoices to another business, including a cost breakdown showing the payroll tax component of any services rendered.

Who can claim the payroll tax supplement?

To be eligible to claim the payroll tax supplement, an aged care service must meet the following criteria:

Part 2.1, Aged Care Act 1997

- the service must be operated by an approved provider *See legislative reference.*

s 21.25(4), Residential Care Subsidy Principles 1997

- the approved provider must either be a registered or non-registered entity
  - a registered entity is an approved provider that is registered with their relevant state or territory revenue office for payroll tax *See legislative reference.*

s 21.25(5), Residential Care Subsidy Principles 1997

  - a non-registered entity is an approved provider that is **not** registered with their relevant state or territory revenue office for payroll tax. These providers have incurred a liability to pay payroll tax to a registered entity in relation to residential care services *See legislative reference.*
- the approved provider must be able to substantiate to the Medicare Australia any claims for payment of the supplement—ie, invoices or evidence of registration for payroll tax liability.

How the supplement is calculated

The way in which the amount of supplement is calculated will vary according to whether the approved provider has a direct or indirect payroll tax liability in relation to residential care provided to care recipients.

However, to calculate all payroll tax supplements, subsidy and supplement payments, as well as bed day totals paid in the previous financial year are used to determine the payroll tax supplement in the current financial year. New facilities that have no prior funding history to draw from are paid a default rate that is equal to the state or territory payroll tax supplement rate for the state in which the service is located.

Approved providers should consult their financial or tax adviser for information on the relevant state or territory payroll tax supplement rates which may apply to their services and how to calculate payroll tax supplements.

INCOME-TESTED FEE

The aged care income test determines whether a person is eligible to pay an income tested fee and, if so, the amount of fee that is payable.

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

LEGISLATIVE REFERENCES

s 44-22(1), Aged Care Act 1997, s 21.30, Residential Care Subsidy Principles 1997

Which residents cannot pay an income tested fee?

The following residents cannot be asked to pay income tested fees: *See legislative reference.*

- full pensioners
- respite care resident
- former prisoners of war (POWs)
- residents who have one or more dependent children
- residents who the Secretary determines should have their income tested fees reduced to zero—ie, because they applied for and were granted a determination of hardship
- residents who die before their maximum income tested fee has been notified to the provider by the Department. There will be a lapse between the death of a resident and the Department updating its records to reflect the death, so the Department may advise of the maximum income tested fee for that resident after they have died. Providers must not recover income tested fees from the resident's estate in these cases
- residents who depart from the aged care service before their income tested fee amount has been notified to the provider and who do not move to another service
- residents for whom the service is not receiving income tested subsidies (care subsidy and/or primary supplements) and therefore whose cost of care is zero. A resident's cost of care is the amount worked out using steps (1), (2) and (3) of the residential care subsidy calculator
- residents who could otherwise have been asked to pay a maximum income tested fee of less than $1.00 per day
- residents who don't receive sufficient income to be asked to pay an income tested fee
- people who were permanent residents in an aged care service between 1 October 1997 and 28 February 1998 inclusive, even if they move to another service or take a break before entering another service.

Maximum income tested fee

The maximum income tested fee that a resident can be asked to pay, is the lesser of:

- the assessed income tested fee based on their income
- or the maximum income tested fee
- or the cost of care.

The maximum income tested fee is capped and from 20 September 2009 is equivalent to 135 per cent of the basic age pension worked out on a daily basis.

Working out the amount of income tested fee

Residents may be asked to pay an income tested fee if their total assessable income is above the applicable threshold rate. The income tested fee is then calculated as 5/12th of income above the applicable threshold rate.

The only exception to the above calculation is for pre-March 2008 reform residents who will have their income tested fee set at the lesser of the amounts calculated as follows;

- 5/12th of all income above the threshold rate
- or 25 per cent of private income above the pension income free area.

INCOME TESTING PROCESS

The major steps and processes in the income testing process are as follows.

Resident entry record (RER)

The provider completes and sends in a RER for each new resident to their Aged Care, Medicare Australia State Office. Providers are required to complete an RER for each new resident within 28 days of them entering permanent care. However, providers are advised to return the RER as soon as possible after the resident enters care, so that the matching process can commence. See References at the end of this chapter for a link to the RER.

Data matching and income assessment

Information from the RER is passed electronically to Centrelink and DVA for data matching. For people receiving an income support payment such as age or service pensions, the resident's income amount is identified by either Centrelink or DVA from information already on record for that person. For other residents, and for people receiving non-means tested pensions such as aged blind pension, DVA war widow pension, or DVA disability pension, their income amount can be worked out on the form 'Helping you with your residential aged care fee' (SA316).

To protect residents' privacy, only agreed information is transferred between departments in the income testing process. Serious penalties apply if any of the protection of resident privacy is breached.

Data matching occurs automatically in most cases and a person's income amount is passed electronically to the Department.

Applicable fees and fee advice letters

The Department uses the income amount to calculate the maximum basic daily fee and income tested fee. The Department writes to both the resident and to the provider to inform them of their assessed maximum basic daily fee and/or income tested fee.

Residents cannot appeal to the Department against the advised maximum income tested fee, since this is based on a formula applied to the assessed income. However, they can appeal through either Centrelink or the DVA if they disagree with the assessed income amount on which the maximum income tested fee is based.

A resident can apply to the Department under the aged care hardship provisions, if the resident can show that paying their advised daily fee would cause genuine financial hardship. If a determination of financial hardship is granted, the resident's fee will be reduced by the amount of the hardship supplement notified in the determination. See Hardship on page 140.

For most residents, the income testing process is completed within a week of the Department being advised of their entry to permanent care.

However, if no letter has been received within a month of the RER being sent:

- the provider should check that the information on the RER is exactly the same as it appears on the resident's pension concession card
- check whether non-pensioner residents have completed and returned the form 'Helping you with your residential aged care fee' (SA316) to the local Centrelink office
- pensioners may also need to contact Centrelink on DVA if they have not been matched
- the provider can contact the Department for further investigation.

Revised fees

Centrelink and DVA electronically pass revised income amounts to the Department as they occur. Changes may occur automatically—for example, financial assets reviews—or as a result of information provided by the resident. The Department uses the revised income amount to calculate the revised maximum basic daily fee and/or income tested fee, if applicable. The Department advises the service and the resident about changes to the fees at quarterly review times.

Centrelink form 'Helping you with the assessment of your residential aged care fee' (SA316)

For residents who cannot be automatically matched for income assessment, Centrelink uses information obtained from this form to assess income. Residents such as self-funded retirees and those who do not receive a means-tested payment, should complete and return this form as soon as possible, so that this information can be used for their income assessment.

Residents who choose not to provide income information should be informed that they may be asked to pay the maximum fee, or their cost of care, whichever is less. Residents should be encouraged to seek financial advice before choosing this option. This form is available from Centrelink. See References at the end of this chapter for a link to Centrelink.

Residents who do not provide income information (means not disclosed) residents

Residents who cannot be identified as DVA or Centrelink means-tested pensioners and who do not complete the form 'Helping you with your residential aged care fee' (SA316) will be identified to the Department by Centrelink as means not disclosed (MND). For these residents, the Department will apply the maximum income tested fee.

MND residents can choose, at any time, to provide their income and asset information to Centrelink. Once Centrelink has conducted the income assessment, the income tested fee will be reassessed and adjusted accordingly.

Reviews of income tested fees

The Department will conduct reviews of residents income tested fees. These reviews can occur automatically when a resident's circumstances change, at set times or manually. Some reviews will also calculate any refund of overcharged income tested fees that the resident may be entitled to. The different types of reviews are:

- Significant change—this review will occur when there is a significant change in the resident's income status—for example, when a resident's status changes from MND to having provided information to Centrelink.

- ACFI—an ACFI review occurs if the initial ACFI assessment is placed on the aged care payment system after the resident has had an initial income tested fee set. This ensures that residents are not asked to pay an income tested fee that is more than their cost of care.
- Ad-hoc—the Department can perform ad-hoc reviews if requested to by a resident. If the resident believes that there has been a reduction to their income, and they have had a reassessment done by either Centrelink or DVA, they can contact the Aged Care Information Line on 1800 500 853 to request a review of their income tested fee.
- Quarterly (which can calculate a refund amount)—the Department reviews all residents income tested fees four times a year, in March, June, September and November. The effective date of the changes to the income tested fees will be 20 March, 1 July, 20 September and 1 January. The set income tested fee will only change if it has been reduced or there has been an increase of more than 10 cents per day. These reviews will also calculate any refund amount that the resident may be entitled to for periods prior to the quarterly review effective date. See Refunds of overcharged income tested fees following for more information.
- Discharge (which can calculate a refund amount)—when the Department receives advice that a resident has been discharged from an aged care service, a discharge review will be conducted to calculate any refund amount that the resident may be entitled to for overcharged income tested fees for periods up to the date of discharge.

Residents will only receive review advice letters if there has been a change in their income tested fee or they are entitled to a refund.

Refunds of overcharged income tested fees

When the Department conducts quarterly and discharge reviews, a calculation of the previously charged amounts will occur to determine whether the resident has been overcharged for any past periods.

Generally the refund calculation will only look at periods that have not previously been included at quarterly review times, up to the date of the last certified claim period. For example, if a resident was admitted on 1 January and the first quarterly review was conducted on 20 March, the refund calculation would look at the period from 1 January to 28 February (provided that this was the last certified claim month for the aged care service). The following quarterly review, if conducted on 10 June, would look at the period from 1 March to 31 May (provided that this was the last certified claim month).

However, refund calculations will also look at any periods in which the resident has had a change to their assessed income amounts. For example, if in the above situation the Department had received advice, on 20 May, that the resident had a change to their income backdated to date of admission, the quarterly review conducted on 10 June would then look at the period from date of admission up to 31 May.

Providers are required, under the Act, to charge residents no more than the amount permitted under the Act. They therefore must pay any advised refund amounts to the resident or their estate. Full details of the refund, including the period and the corrected amount of income tested fee, are provided on the next payment statement generated after the review is conducted.

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

REMOTE AREA ALLOWANCE

LEGISLATIVE REFERENCES

ss 23.82 and 23.83, User Rights Principles 1997

Centrelink pays a remote area allowance to pensioners who live in certain remote areas. Providers whose aged care service is located in one of these areas may charge residents of that service an additional daily amount. *See legislative reference.* Providers who wish to check whether their aged care service is located in a qualifying remote area should contact Centrelink.

See References at the end of this chapter for Centrelink contact information; and for a link to the maximum amount from the remote area allowance an approved provider can currently charge a resident.

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN PART B OF THIS CHAPTER

See References at the end of this chapter.

LEGISLATIVE REFERENCES

C. GOVERNMENT-FUNDED SUPPLEMENTS AND SUBSIDY REDUCTIONS

RELEVANT LEGISLATION

- s 58-1(a), *Aged Care Act 1997* (the Act)
- ss 23.82 and 23.83, *User Rights Principles 1997*

OVERVIEW

Additional supplements referred to in the following pages are funded wholly by the Government. They are paid to approved providers in recognition of the high costs associated with providing certain types of residential aged care, such as respite care; or with providing residential aged care in certain locations, such as remote and rural areas.

Information on reductions in subsidy which apply to residents who have a compensation entitlement and to residents receiving care in extra service places, is also outlined in Reductions in subsidy on page 138.

Rates and additional information

The rates for supplements change over the course of a year. For this reason, actual dollar amounts payable are not included in this Manual. Current rates are available on the Department's website, in the Aged Care Essentials newsletter (formerly known as Payment Essentials newsletter) and from the Aged Care Information Line. See References at the end of this chapter for links and contact information.

How to calculate fees payable by a resident

s 58-1(a), Aged Care Act 1997

To calculate the maximum daily fee that a resident may be asked to pay, approved providers should: *See legislative reference.*

(1) work out the applicable standard resident contribution—ie, the maximum basic daily fee

(2) add any compensation payment reduction that applies for the resident

(3) add any applicable maximum income tested fee for the resident

(4) subtract any hardship supplement that applies for the resident

(5) add any other amounts agreed between the provider and the resident, that is, agreed fees for additional services

(6) if the resident is in an extra service place and receiving care on an extra service basis, add the extra service amount

(7) for an aged care service located in a remote area, add the remote area allowance amount.

A resident may also be asked to pay an accommodation bond or an accommodation change.

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

VIABILITY SUPPLEMENT

Some aged care services in rural and remote areas receive an additional viability supplement in recognition of the higher costs of providing care in those regions. The viability supplement aims to improve the capacity of small, rural aged care services to offer quality care to residents. Providers do not need to apply for the viability supplement. The supplement is paid automatically, every month, to eligible providers.

Services with extra service status are not eligible for the viability supplement.

In addition to the current viability supplement scheme, which is known as the 2005 scheme, there are two previous schemes—the 2001 scheme and the 1997 scheme. Services will continue to be paid under previous schemes, unless they would receive an increase in the supplement under the 2005 scheme. See Viability supplement—previous schemes following.

Viability supplement—current 2005 scheme

Funding for the current 2005 scheme is based on points scored in relation to the three criteria below. To be eligible for the 2005 scheme, a service must score at least 50 points out of a possible 100. The criteria are:

- the remoteness of a service's location—the Accessibility/Remoteness Index of Australia (ARIA) is used to assess the remoteness of a service. Up to 65 eligibility points are awarded for this criterion
- the number of places in the service, which is taken as an indicator of its size. Up to 30 eligibility points are awarded for this criterion. If a service has 19 or fewer places, it receives 30 eligibility points
- the proportion of residents in the service who have special needs (excluding people who are financially or socially disadvantaged and people living in rural and remote areas). If more than 50 per cent of the residents are Aboriginal or Torres Strait Islander people, people from a non-English speaking background, veterans or war widows, the service receives 5 eligibility points.

See References at the end of this chapter for a link to ARIA scores for all locations; and for current rates for the viability supplement.

Viability supplement—previous schemes

All services that received viability funding under the 1997 or 2001 viability funding arrangements will continue to receive at least their level of viability funding received under the previous arrangements until they close, relocate or cease to be eligible under the previous arrangements.

Where a service's score under the 2005 scheme's criteria is such that the rate of funding under the 2005 arrangements is greater than the rate of funding under the previous arrangements, the service will receive its entitlement under the 2005 arrangements.

If adjacent services combine and at least one of these facilities was receiving viability supplement under a previous scheme, the combined service will be reassessed for the viability supplement under the 2005 viability arrangements.

RESPITE SUPPLEMENT

An approved provider is eligible for residential care subsidy, including the respite supplement, for each day they provide residential respite care to an approved respite care recipient who has not used up his or her annual allocation of respite days. For more information on the respite supplement, see Residential care subsidies in chapter on Residential respite care in this Manual.

REDUCTIONS IN SUBSIDY

Compensable residents

If a resident with a compensation entitlement (such as an entitlement to compensation arising from a workplace or motor vehicle accident or from a common law claim) is admitted to an aged care service, the service must inform the Department.

The Department may then apply a compensation payment reduction amount from the day that the resident is admitted; and will advise the aged care service and the compensable resident of the amount of the compensation payment reduction. The service will be able to invoice the compensable resident for the total amount of the compensation payment reduction in addition to the other relevant resident fees and charges.

A provider should inform the Department about a compensable resident by completing the relevant section on the Resident Entry Record form.

If a service does not tell the Department that a resident is entitled to compensation and the Department only becomes aware of this later, the Department will recover the residential care subsidy paid on behalf of the compensable resident for the period where a compensation payment reduction should have applied.
A compensation payment reduction will be applied thereafter.

Approved providers can contact the Department with queries about compensable residents. See References at the end of this chapter for contact information.

Claim not settled yet

If a compensable resident's claim has not been settled, the Department will continue to pay subsidy for that resident until settlement. After settlement, conditions for compensable residents will apply, as outlined in Compensable residents on page 138.

Extra service reduction

If a resident receives care on an extra service basis, the residential care subsidy will be reduced for the care of this resident. The amount of this reduction is called the extra service reduction. See also Extra service amount and extra service reduction in chapter on Extra service places in this Manual.

Adjusted subsidy reduction

The adjusted subsidy reduction is applicable for residents in an aged care service, or part of a service, that is determined by the Minister to be an adjusted subsidy aged care service. Since 1 July 2007, only services that are operated by state or territory governments are subject to this subsidy reduction.

The adjusted subsidy reduction is indexed annually and is approximately 9 per cent of the daily high care subsidy. Any places affected by the adjusted subsidy reduction that are transferred to the non-Government sector have the reduction removed effective from the date of transfer.

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN PART C OF THIS CHAPTER

See References at the end of this chapter.

LEGISLATIVE REFERENCES

D. HARDSHIP

RELEVANT LEGISLATION

- Sections 44-30, 44-31, 57-14, 57-15, 57A-9, 57A-10 and 85-1, *Aged Care Act 1997* (the Act)
- Part 15, *Residential Care Subsidy Principles 1997*

OVERVIEW

Residents who have difficulty paying the standard resident contribution, an accommodation payment or a care fee (ie, income tested fee) can apply for assistance under the hardship provisions.

If a resident meets the hardship criteria, the Department will pay the provider a hardship supplement for this resident. The provider then reduces the resident's fee by the amount of any hardship supplement paid for that person.

In general, residents need to apply for a hardship supplement. However, there are five classes of people for whom an amount of hardship supplement is automatically paid. See Class hardship determinations following.

A hardship supplement will not be payable for a resident:

- who is an ex-hostel resident paying a variable fee agreed to under the *Aged or Disabled Persons Care Act 1954*
- who is receiving care on an extra service basis.

Rates and additional information

The rates for fees, subsidies and supplements change over the course of a year. For this reason, actual dollar amounts payable are not included in this Manual. Current rates are available on the Department's website, in the Aged Care Essentials newsletter (formerly known as Payment Essentials) and from the Aged Care Information Line. See References at the end of this chapter for links and contact information.

s 21.37, Residential Care Subsidy Principles 1997

CLASS HARDSHIP DETERMINATIONS

There are five classes of people for whom an amount of hardship supplement is automatically paid. These are: *See legislative reference.*

- Class A—paid to residents under 21 years of age who receive an income support payment and whose total income is below the amount of the single age pension. The resident's basic daily fee is reduced by the amount of supplement. The Department will contact these residents about the reduction in fees and to ascertain whether additional financial hardship assistance is required. If these residents do not have an income support payment, they may apply for financial hardship assistance.
- Class B—paid to residents under 16 years of age who are dependent children and whose total income is below the single rate of the social security pension amount. As with Class A, the resident's basic daily fee is reduced and the Department will contact the resident's representative regarding the reduction in basic daily fees and any additional financial hardship assistance that may be available.

- Class C—paid to pre March 2008 self-funded retirees who receive an income that is just above the pension income test cut-off and therefore may be asked to pay up to the non-pensioner rate of basic daily fees. It is recognised that these residents may be disadvantaged by paying the difference between the pensioner and non-pensioner rate of the basic daily fee. The Class C Hardship supplement ceases if a resident's income is not within a specific range.
- Class D—paid to residents who were in receipt of an income support payment that was lost as a result of the aged care arrangements that commenced on 1 October 1997.
- Class E—paid to residents who were living in a hostel on 30 September 1997, who have not since moved to a nursing home which was approved prior to 1 October 1997.

INDIVIDUAL HARDSHIP DETERMINATIONS

A resident can apply to the Secretary for a determination that paying the standard resident contribution, an accommodation payment or a care fee (income tested fee) would cause financial hardship. *See legislative reference.* Each case of hardship assistance is assessed on an individual basis.

s 44-31, Aged Care Act 1997

The Department may ask the applicant for further information in order to make the determination. In these cases, the extra information will generally need to be provided to the Department within 28 days, or the hardship application will be taken as withdrawn. Where a legal guardian signs on behalf of the resident, a copy of their authority to act on the resident's behalf must be attached to the application.

The resident and the provider will be notified in writing of the decision on whether to make a determination under the hardship provisions. This will usually happen within 28 days of the Department receiving the application, or within 28 days of receiving any other information that has been requested.

A hardship determination may include a specified period during which it will remain in force or a particular event which will cause the determination to cease to be in force. The inclusion of any such period or event is a reviewable decision.

A hardship determination can take effect retrospectively—for example, the determination may apply from the resident's date of entry to the aged care service, or from the date a resident's assets are not realisable.

An applicant may also seek a review of a decision not to make a hardship determination. The Department will provide details of how to apply for a review with the notification of determination.

Applications must be made on the approved application for financial hardship assistance form. See References at the end of this chapter for a link to the form.

How are hardship assessments conducted?

An assessment of a resident's income and assets is undertaken by Centrelink or DVA. Currently, hardship assistance may be approved in situations where a resident retains less than the equivalent of 15 per cent of the maximum rate single age pension, following the payment of their essential expenses. This amount is subject to change.

The resident's realisable assets are also taken into account by the decision maker where a reduction in the basic daily fee and/or income tested fee has been requested.

LEGISLATIVE REFERENCES

Generally speaking, only essential care-related expenses that total more than $20.00 per fortnight can be taken into account in the assessment of hardship applications for permanent care. Examples of such expenses include:

- pharmaceutical and continence aid expenses
- optical, dental or podiatry expenses
- other non-discretionary expenses.

For respite care, a wider range of expenses are taken into account due to the need for a resident to maintain their service in the community. Additional expenses able to be considered are:

- utilities and rates expenses
- home and contents insurance
- rental or mortgage payments.

How do hardship determinations end?

If a hardship determination will end following a specified period or event, the Department will advise both the resident and the provider of this. For example, the notice of hardship determination may state that the determination will end on a particular date, or earlier if the resident's circumstances change. If the determination ends earlier than expected due to a change in circumstances, the aged care provider and resident will be advised.

Revoking financial hardship

A determination of financial hardship may be revoked. The Department will write to the resident and the provider if revocation is being considered, giving 28 days in which to respond to the Department with a written submission. If no submissions are made within that time, revocation of the hardship determination will take effect on the day after this 28-day period has lapsed. Once the date for submissions has passed, the Department has a further 28 days in which to make a decision about whether to proceed with revocation and to advise the resident and the provider. *See legislative reference.*

s 57-15, Aged Care Act 1997

A revocation takes effect the day after both the resident and the provider have received notice of the decision. If they received notice on separate days, this means the day after the later day.

Reviewable decisions

s 85-1, Aged Care Act 1997

The following decisions relating to a determination of hardship are reviewable: *See legislative reference.*

- refusing to make a determination that a resident is eligible for a hardship supplement
- specifying that at the end of a certain period or due to the occurrence of a certain event, a determination under s 44-31 will cease to be in force
- to refuse to make a determination that payment of an accommodation payment would cause financial hardship

- to refuse to make a determination that paying an accommodation payment of more than a specified maximum amount would cause financial hardship or to specify a particular maximum amount under such a determination
- revocation of a determination that paying an accommodation payment would cause financial hardship.

HARDSHIP, STANDARD RESIDENT CONTRIBUTION AND CARE PAYMENTS (INCOME TESTED FEE)

The maximum reduction of the standard resident contribution (basic daily fee) that is available under the financial hardship provisions is a reduction to zero. In most instances, a favourable assessment results in a partial reduction of the basic daily fee. Applications can be considered for both permanent and respite care.

An income tested fee may only be set to zero. Income-tested fees cannot be partially reduced and for this reason it is more common to see a reduction in the basic daily fee which takes into consideration the impact of the payment of the income tested fee.

How is a hardship supplement paid where financial assistance is given for the basic daily fee?

Where a determination has been made regarding a basic daily fee, an individual hardship supplement is paid to the approved provider, and the resident's basic daily fee is reduced accordingly. The total amount of the hardship supplement the approved provider receives for a resident must be subtracted from the total basic daily fee that the resident would otherwise have been charged. Approval is almost always time-limited. At the end of the specified period, a resident must reapply if they require ongoing assistance.

How is subsidy paid where financial assistance is given for income tested fees?

Where an income tested fee is set to zero, the provider receives increased subsidy to compensate for not receiving the income tested fee. This is also the case for residents who do not have sufficient income to be asked to pay an income tested fee.

HARDSHIP AND ACCOMMODATION PAYMENTS

Financial hardship assistance is available to aged care residents who do not have sufficient assets to pay their accommodation payment. Each case is assessed on an individual basis, taking into consideration a range of issues which may be unique to the resident.

From 1 January 2009, the financial hardship provisions have been amended to allow for circumstances where a person has the ability to pay an amount towards their full accommodation bond or accommodation charge. Where it has been determined that a person's assets are below the maximum threshold for the payment of either a concessional resident supplement, assisted resident supplement or accommodation supplement, the appropriate amount of supplement will be paid to the provider where a hardship determination is in place.

LEGISLATIVE REFERENCES

In cases where a resident's realisable assets are determined to be above the maximum threshold, the Act allows for a resident to pay a lesser amount of accommodation bond for a period of time, while a hardship determination is in place. As the resident's assets remain above the maximum threshold, the care provider would not be entitled to receive a supplement.

While a determination of financial hardship is in force, the resident must not be asked to pay an accommodation bond or the daily accommodation charge greater than the maximum amount determined under the financial hardship provisions.

If a resident has logged a financial hardship application, and if that resident would otherwise be eligible to pay an accommodation payment, then an accommodation payment agreement must still be entered into within 21 days of the resident's entry to the service. The accommodation payment agreement must specify the accommodation payment which will be payable if the hardship application is declined or if a hardship determination ceases to be in force.

Applications for financial hardship must be made on the approved form. See References at the end of this chapter for a link.

Financial hardship—circumstances

The circumstances in which a determination can be made include, but are not limited to, cases in which payment of an accommodation payment would cause hardship to the resident, or to their partner or dependent child.

s 11(12)-(13), Social Security Act 1991.

A number of factors are taken into consideration, including unrealisable assets. *See legislative reference.* Unrealisable assets are assets which the resident either cannot or cannot reasonably be expected to sell or realise or use as security for borrowing. Examples include a farm that was supporting other family members, a property that has been on the market for a realistic price for six months, or frozen financial resources.

For information on assessment of hardship applications, see Individual hardship determinations on page 141. See References at the end of this chapter for a link to ComLaw for the Social Security Act.

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN PART D OF THIS CHAPTER

See References at the end of this chapter.

LEGISLATIVE REFERENCES

E. LEAVE

FEES DURING PERIODS OF LEAVE

The Act provides the number of days a resident may be on leave from the residential aged care service. For each day that a resident is on leave, the aged care service receives resident fees and a Government subsidy as though the resident was actually receiving care. This means that a provider's responsibilities, including security of tenure for the resident's place, still apply when a resident is on leave.

When a provider is counting days of leave, they should:

- include the day when the resident left the aged care service
- and not include the day of return. *See legislative reference.*

s 42-3(1), Aged Care Act 1997

A resident and an approved provider can agree that the resident can be absent for periods in excess of leave entitlements. In this case, the maximum fee that the resident can be charged is the applicable resident fee plus an amount equal to the subsidies which would normally be paid to the provider for that day. *See legislative reference.*

s 58-6, Aged Care Act 1997

HOSPITAL LEAVE

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

EXTENDED HOSPITAL LEAVE

Extended hospital leave is where a resident has hospital leave for a continuous period of 30 days or more, in order to receive treatment in hospital.

For residents who are on extended hospital leave, the basic subsidy amount paid to the aged care service is reduced by:

- 50 per cent, for residents classified under the ACFI
- or 2 category levels, if the resident is still on an Residential Classification Scale (RCS).

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

SOCIAL LEAVE

Residents are entitled to up to 52 overnight absences—ie, 52 days of social leave—per financial year. This enables residents to spend weekends with their families, without losing their place at the aged care service.

Subsidies to the service will continue during social leave. However, once a resident has used up their 52 days of social leave, government subsidies for that resident will stop. The approved provider can then charge residents the subsidy amount in addition to their daily fee. *See legislative reference.*

s 58-6, Aged Care Act 1997

PRE-ENTRY LEAVE

Pre-entry leave is a maximum of 7 days of leave, which gives a prospective resident time to make arrangements to enter an aged care service or to transfer from one service to another. It enables the service to receive a subsidy and keep the place vacant for the resident for up to 7 days after he or she agrees to enter care.

LEGISLATIVE REFERENCES

s 42-3(3), Aged Care Act 1997

See legislative reference. It is the only type of leave which can be taken before a resident enters a service.

Pre-entry leave:

- can only be taken from the date the resident agrees to enter the service
  - or the day 7 days before the day of entry, whichever is later
- can be claimed for days on which the intending resident is in hospital
- can only be taken for up to 7 days before the resident enters care
- can only be claimed where the resident actually enters the service
- ceases to be paid once the resident enters the service permanently
- cannot be claimed where the person is on leave from another aged care service
- the resident can be charged applicable aged care fees for the period of pre-entry leave.

Up to 7 days of social leave can be used as pre-entry leave, immediately before a resident enters an aged care service.

HIGH-DEPENDENCY CARE LEAVE

High-dependency care leave is when a low care resident temporarily needs a high level of care and is transferred to an aged care service providing high-level care. Subsidy is payable for both service providers and the resident may be required to pay fees to both providers.

s 42-1(4), Aged Care Act 1997

The requirements for high dependency care leave are: *See legislative reference.*

- the permanent service is unable to provide a high level of care
- the resident temporarily requires a high level of care
- the resident's Aged Care Assessment Team (ACAT) approval cannot be limited to low level care
- the resident must have available social leave days.

Providers should advise the Department about high-dependency care leave as follows:

- on the monthly claim form, the permanent service advises of the resident's use of social leave days while the resident is at the temporary service
- the temporary service:
  - completes a Resident Entry Record for this new resident, identifying them as a high dependency care leave resident
  - undertakes the usual resident ACFI appraisal process to determine the level of funding for the resident's period of stay.

The permanent and temporary aged care services will receive subsidy according to the relevant ACFI categories—ie, the permanent service will continue to receive low care subsidy, so long as there is a current appraisal in force, and the temporary service will receive high care subsidy in accordance with the ACFI.

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN PART E OF THIS CHAPTER

See References at the end of this chapter.

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN THIS CHAPTER

Accessibility/Remoteness Index of Australia (ARIA)

ARIA scores for all locations
www9.health.gov.au/aria/ariainpt.cfm

Current rates for the viability supplement are listed with other subsidy and supplement rates
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-whatnew.htm

Aged Care Information Line

Ph 1800 500 853

Compensable residents—queries

Providers with queries about compensable residents can call the

Aged Care Information Line
Ph 1800 500 853

Or write to

Director
Accountability Section
Department of Health and Ageing
MDP 74
GPO Box 9848
Canberra, ACT, 2601

Financial information service—free—for residents

Centrelink provides a free financial information service, for residents of aged care services and other citizens.
Ph 13 2300
www.centrelink.gov.au

5 Steps to Entry into Residential Aged Care information pack

5 Steps is available online
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-resentry_a.htm-copy3
or by calling the Aged Care Information Line
Ph 1800 500 853

Forms—all

All Departmental forms are available on the Department's website at
www.health.gov.au/internet/main/publishing.nsf/Content/health-forms.htm

Form—banking details for the direct deposit of payments

Medicare Australia—Aged Care forms
www.medicareaustralia.gov.au/provider/aged-care/forms.jsp#N10185

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

Form—financial hardship assistance—application for

The form can be downloaded from the Department's website
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-fha-form.htm
or obtained by phoning the Aged Care Information Line
Ph 1800 500 853

Form—helping you with the assessment of your residential aged care fee (SA316)

This form is sent to self funded retirees by Centrelink.
Ph 132 300
www.centrelink.gov.au

Forms—oxygen treatment/enteral feeding supplement

Available from Medicare Australia Aged Care forms
www.medicareaustralia.gov.au/provider/aged-care/forms.jsp

Form—nominee—appointment of

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-nomform.htm
or *www.medicareaustralia.gov.au/provider/aged-care/forms.jsp*

Form—resident entry record (RER)

www.medicareaustralia.gov.au/provider/aged-care/forms.jsp

Interest rates—base interest rate and maximum permissible interest rate—current

The Department updates the base interest rate and the maximum permissible interest rate each quarter. For current rates check

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-finance-refundrates.htm

Legislation—other

Go to ComLaw to access other legislation mentioned in this chapter, including the *Social Security Act 1991* and *Aged or Disabled Persons Care Act 1954*.

www.comlaw.gov.au

Medicare Australia Aged Care forms

www.medicareaustralia.gov.au/provider/aged-care/forms.jsp

Remote area allowance

The maximum amount of the remote area allowance that an approved provider can charge a resident is listed with other current rates information
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-finance-resfees.htm-copy2

Request for an asset assessment form

These forms are included with the 5 Steps to Entry into Residential Aged Care information pack, which is available online

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-resentry_a.htm-copy3

or by calling the Aged Care Information Line
Ph 1800 500 853

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

Resident entry record (RER)

www.medicareaustralia.gov.au/provider/aged-care/forms.jsp

Residential care fees, subsidies and supplements—current

For current rates for residential care fees and charges go to *www.health.gov.au/internet/main/publishing.nsf/Content/ageing-finance-resfees.htm-copy2*

For current Australian government subsidies and supplements go to *www.health.gov.au/internet/main/publishing.nsf/Content/ageing-subs-supplement.htm*

State/territory offices of the Department—information on supported resident ratios for each region.

See Supported resident ratios reference.

Subsidy rates—current

Current ACFI and other subsidy and supplement rates

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acfi-subsidy-rate-0708.htm

Supported resident ratios—by region

Contact the relevant state or territory office of the Department for information on ratios which apply in each region.

New South Wales
GPO Box 9848
Sydney NSW 2001
Ph 02 9263 3555
Ph 1800 048 998
Fax 02 9263 3509

Queensland
GPO BOX 9848
Brisbane QLD 4001
Ph 07 3360 2555
Ph 1800 177 099
Fax 07 3360 2999

South Australia
GPO Box 9848
Adelaide SA 5001
Ph 08 8237 8111
Ph 1800 188 098
Fax 08 8237 8000

Tasmania
GPO Box 9848
Hobart TAS 7001
Ph 03 6221 1411
Ph 1800 005 119
Fax 03 6221 1412

Victoria State Office
GPO Box 9848
Melbourne VIC 3001
Ph 03 9665 8888
Ph 1800 020 103
Fax 03 9665 8181

Western Australia
GPO Box 9848
Perth WA 6001
Ph 08 9346 5111
Ph 1800 198 008
Fax 08 9346 5222

Northern Territory
GPO Box 9848
Darwin NT 0801
Ph 08 8919 3444
Fax: 08 8919 3400

Australian Capital Territory
PO Box 9848
Canberra ACT 2601
Ph 02 6289 1555
Ph 1800 020 102
Fax: 02 6289 3388

Viability supplement

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-whatnew.htm

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

RESIDENTIAL RESPITE CARE

RESIDENTIAL RESPITE CARE

This Manual has been written in plain English and as a result, some aspects of the legislation and policy have been simplified. It is intended to be a general guide only and does not constitute legal advice. In cases of discrepancy between the Manual and the legislation, the legislation will be the source document for payment of Australian Government benefits and enforcement of approved provider responsibilities.

RELEVANT LEGISLATION

- Part 2.2, Division 12, s 12-5; Division 13, s 13-2, 13-3; Division 14, s 14-5; Division 16, s 16-6, 16-8, *Aged Care Act 1997* (the Act)
- Part 2.3, Division 22, s 22-2; Division 23, s 23-3, *Aged Care Act 1997*
- Part 2.4, Division 25, s 25-2, 25-3; Division 26, s 26-3; Division 27, s 27-2, *Aged Care Act 1997*
- Part 3.1, Division 42, s 42-2; Division 43, s 43-8; Division 44, s44-4, 44-5, 44-6, 44-12, 44-22, 44-28, *Aged Care Act 1997*
- Part 4.2 Division 56, 56-1; Division 58, s 58-3; Division 59, s 59-1, *Aged Care Act 1997*
- Part 6.5, Division 96, s 96-2; Schedule 1 Dictionary—definition of "respite care", *Aged Care Act 1997*
- *Approval of Care Recipients Principles 1997*
- *Allocation Principles 1997*
- *Residential Care Subsidy Principles 1997*
- s 23.16(3A), s 23.16(3B), s 23.16(3), s 26.14(3A), s 26.14(3B), s 23.16(4), s 23.16(3B), 23.16(5), *User Rights Principles 1997* (User Rights Principles)

OVERVIEW

Residential respite care provides a break for people living in the community and their carers.

Respite care is defined in the Act as "residential or flexible care (as the case requires) provided as an alternative care arrangement with the primary purpose of giving a carer or a care recipient a short-term break from their usual care arrangement. A person can have up to 63 days of respite care in a financial year with the possibility of 21 day extensions if approved by an Aged care Assessment Team (ACAT or ACAS in Victoria). Residential respite care is provided as either low or high level care. However, it does not include residential care provided through a residential care service while the care recipient in question is on leave under section 42-2 from another residential care service". *See legislative reference.*

Schedule 1—Dictionary, Aged Care Act 1997

This chapter of the Manual is intended as a guide to the administrative procedures relating to the provision of residential respite care.

In summary:

- as part of the planning process for residential care, the Government aims to ensure there is adequate provision of respite care, providing for an equitable distribution across regions
- in making an allocation of places to an approved provider subject to conditions, the Secretary can set a minimum proportion of care that must be provided as respite *See legislative reference.*

s 14-5, 14-6, Aged Care Act 1997

LEGISLATIVE REFERENCES

- respite care recipients are not assessed against the ACFI. Classifications for respite care are based on an ACAT approval for either high or low level care
- permanent residents of a residential aged care service cannot be approved for residential respite care in another aged care service
- in order to provide residential respite care, service providers need to be approved to provide residential aged care. See also chapters on Becoming an approved provider and Allocated places in this Manual.

Additional information

This chapter has been updated and revised to help approved providers comply with their responsibilities under the Act; and to assist staff of aged care services understand the regulation of residential aged care. Additional information can also be accessed through the Aged Care Information Line on 1800 500 853.

CONDITIONS OF ALLOCATION RELATING TO THE PROVISION OF RESPITE CARE

In applying for an allocation of places through the Aged Care Allocations Round (ACAR), an approved provider may undertake to make a certain proportion of care available for respite care—also known as a number of respite place days. The competitive advantage given to applications undertaking to deliver a high level of respite care will depend on factors such as the existing regional level of supply and demand for residential respite care.

What proportion of residential aged care should be provided as respite care?

s 14-5, 14-6, Aged Care Act 1997

In making an allocation of places to an approved provider subject to conditions, the Secretary can set a minimum proportion of care that must be provided as respite. *See legislative reference.* Before determining such conditions, the Secretary must consider:

- the demand in the region concerned for respite care
- the demand in the region for permanent care
- the needs of carers and care recipients
- equity in the respite care provided in different regions.

s 4.47, Allocation Principles 1997

However, the Secretary may also consider any other matters relevant to the effective provision of respite care. *See legislative reference.*

s 43-8, Aged Care Act 1997

If an approved provider fails to meet a condition of allocation, non-compliance deductions may apply. *See legislative reference.* See also section on Conditions applying to particular allocations in chapter on Allocated places in this Manual; see References at the end of this chapter for a link to the ACAR Essential Guide.

What proportion of a service's care can be provided as respite?

The proportion of care to be provided as respite may be a condition of a service's allocation of places. The proportion can be varied through a variation of the conditions of allocation of the places.

RESIDENTIAL RESPITE CARE

LEGISLATIVE REFERENCES

How are respite conditions of an individual aged care service varied?

An approved provider may apply for a variation to the conditions of allocation of places under Division 17 of the Act. *See legislative reference.*

Division 17, Aged Care Act 1997

If a service is applying to vary its conditions of allocation—including conditions for the allocation of respite care—it should fill out the application for a variation of conditions of allocation form. See References at the end of this chapter for a link to this form.

If the variation is granted, this varied condition will continue into future financial years unless the service requests another variation.

How are places which can be used for respite allocated to new and existing services?

The Minister determines how many residential aged care places are available for allocation. The Secretary then distributes these places among the regions, also deciding what proportion of care is to be provided as respite care. In order to determine this proportion, the Secretary must take into account the demand for respite care and permanent care in the region, the needs of carers and care recipients and equity of respite provision between regions. *See legislative reference.*

Division 12, Aged Care Act 1997

When it applies for an allocation of residential care places, an approved provider must specify the proportion of care, if any, to be given as respite care. In considering the application, the Secretary will then take into account the applicant's readiness to comply with respite planning objectives and their stated commitment to make the respite place days available for respite care.

If an aged care service applies for an allocation of residential care, the Secretary may allocate the places with a condition specifying the proportion of respite care to be provided by that service. This is stated as a condition of approval of the service. The applicant will be notified of this condition if their application is successful.

CONDITIONS OF ALLOCATION OF RESPITE PLACES—TRANSFERRING PLACES

When allocations of residential care places are transferred, any condition of allocation will generally transfer with the places, unless the transferor and transferee apply to have the conditions varied. *See legislative reference.* As the obligation to provide respite is a condition of allocation of these places, the proportion of care that must be provided as respite will continue to apply, and this obligation to provide respite transfers to the provider who is transferred these places. *See legislative reference.*

s 16-2(2)(d), Aged Care Act 1997

s 16-6(e)(iii), Aged Care Act 1997

APPROVAL OF RESPITE CARE RECIPIENTS

A potential respite care client must initially be assessed by an ACAT. Based on the assessment, residential respite care recipients will be approved for either high or low level care. This care may be limited to a specific period. *See legislative reference.* The approval must expressly cover the provision of respite care. If it does not, the approval is limited to the provision of care other than respite care. *See legislative reference.*

s 22-2(1)(c), Aged Care Act 1997

s 22-2(1), Aged Care Act 1997

RESIDENTIAL RESPITE CARE

LEGISLATIVE REFERENCES

s 44-12, Aged Care Act 1997

s 5.9(2), Approval of Care Recipients Principles 1997

Both residential care subsidy and respite supplement can only be paid where a person is approved as a respite care recipient. *See legislative reference.* High level subsidy and supplement will be paid for care recipients approved by an ACAT as needing high level residential respite care. The lower subsidy and supplement level is paid for all care recipients approved by the ACAT as needing low level residential respite care. A person approved to receive high level respite care can, however, receive low level respite care. *See legislative reference.* This would normally occur if both the aged care service and the resident agree that this is more appropriate; and in such a case, the low level respite subsidy and supplement would be payable. See also chapter on Approval of residents in this Manual.

How does a person become approved as a respite care recipient?

Approval for residential respite care is obtained in the same manner as approval for permanent residential care and other forms of Government-subsidised care. The approval must be on the Aged Care Client Record, and indicate that the person is eligible and approved for residential respite care at either a high or low level.

Who is eligible for approval as a respite care recipient?

People who meet the eligibility criteria for approval for residential care, and who need respite care, are eligible for approval for residential respite care. It is possible for a person to be approved for both residential respite and permanent care at the same time.

However, a permanent resident of a residential aged care service cannot receive residential respite care in another aged care service.

What are the limits on approval to receive respite care?

s 22-2, Aged Care Act 1997

The ACAT can limit a person's approval for residential respite to a specific level of care or to a specified period of time. *See legislative reference.* ACAT approvals specify the level of residential respite care a person needs as either high or low. This is used to determine the level of respite subsidy and supplement payable for the person.

Respite care subsidies and supplements are only paid where the care recipient is approved by an ACAT to receive residential respite care.

When does an approval cease to have effect?

An approval for residential respite care will not lapse but can expire if it is either time limited or revoked.

An approval allows for up to 63 days of subsidised residential respite care in a financial year. If respite care is needed for longer than this, a person can apply for a 21-day extension. See Approving an extra 21 days of respite on page 156.

Where a care recipient's approval is limited to a low level of residential respite care and their care needs have changed, they must be reassessed by an ACAT before they can be approved for high level residential respite care.

RESIDENTIAL RESPITE CARE

EXAMPLE

Tessa was approved for residential respite care, limited to a low level, almost two years ago. Since being approved by the ACAT, Tessa has twice been admitted to hospital and her care needs have increased significantly and she requires some nursing care. Tessa's daughter, who is her primary carer, has booked to go on a six week holiday and contacts the local nursing home to book Tessa in for respite care. In discussing Tessa's care needs and recent hospitalisations, it is clear to the care team manager that Tessa will require high level care. The care team manager advises Tessa's daughter that even though Tessa's approval for low level respite care is current, as it does not lapse, her care needs have changed, so a new ACAT assessment and approval for high level care is required prior to Tessa commencing respite care, so that Tessa can occupy a high level bed and the aged care provider can be paid the correct rate of subsidy. Tessa's daughter contacts the ACAT and arranges a reassessment prior to Tessa's admission.

EXAMPLE

Bill is approved for high level residential respite care. He applies to enter an aged care service for respite, not having used residential respite care since the ACAT signed the approval over twelve months ago. Bill does not need to be reassessed by the ACAT unless his care needs have changed.

CLASSIFICATION APPRAISAL

There are only two levels of classification and therefore subsidy available to respite care residents:

- high level care
- or low level care.

The classification level applies from the day that the person enters care, as determined based on their ACAT approval level only.

Respite care recipients are not appraised and the ACFI does not need to be completed for respite care recipients.

When do classifications cease to take effect?

A respite care recipient's classification ceases if the care recipient has used more than 63 days of respite care in the financial year; plus any extra periods of 21 days approved by an ACAT. In this case the classification ceases on the day after the number of days is used. *See legislative reference.*

Item 7, s 27-2(1), Aged Care Act 1997

Respite care residents, if not already approved for permanent care, need to be reassessed and approved for permanent care by an ACAT before transferring to permanent care. They will also be assessed against the ACFI. See Transfers from respite to permanent care on page 159; see also chapter on Approval of residents in this Manual.

RESIDENTIAL RESPITE CARE

LEGISLATIVE REFERENCES

Approved period of respite care

s 44-12(2)(c), Aged Care Act, 1997, s 21.18(1), Residential Care Subsidy Principles 1997

Respite days used by the respite care recipient are cumulative across services. The approved number of respite days is the maximum number a resident may use during the approval period, regardless of the number of services that provide the care to them. *See legislative reference.*

The approved provider **must** satisfy themselves that the care recipient has sufficient respite days remaining to cover the proposed period of respite and a valid ACAT approval. If in doubt the provider should contact Medicare Australia to check. See References at the end of this chapter for Medicare Australia contact information.

s 21.18(1), s 21.18(2) Residential Care Subsidy Principles 1997

A care recipient can receive up to 63 days of subsidised respite in any financial year. This total covers respite admissions to all Government-subsidised residential aged care services. However, if a person needs more than 63 days of respite care in the financial year, the ACAT can approve extension periods of 21 days at a time. See Approving an extra 21 days of respite following. *See legislative reference.*

The service is also unable to claim subsidies for the person as a permanent care recipient unless an ACAT:

- has either approved the care recipient for both respite and permanent care (and the approval is still valid) or has reassessed and approved the person as eligible for permanent residential care.

Respite care residents cannot transfer to permanent residential care unless they have a valid ACAT approval for permanent care.

Approving an extra 21 days of respite

If a care recipient has entered residential respite care, and their 63 day allocation is due to expire, an application for a 21-day extension should be made to the Secretary through the ACAT. More than one 21-day extension may be approved in a financial year.

In deciding whether or not to extend residential respite care, the delegate will consider circumstances such as carer stress, a temporary or unexpected increase in the severity of a care recipient's condition, absence of the carer and any other relevant matter.

The care recipient's needs, abilities and wishes, access to and use of appropriate community and social supports will also be considered. In extending residential respite care, delegates must consider the appropriateness of continued respite care arrangements or whether permanent residential care may be a more suitable option.

Any extension must be at the same level of care as approved on the Aged Care Client Record. If an approval is limited to a low level of residential respite care and the person now requires high level residential respite care, reassessment and approval by the ACAT is required.

If an extension is granted the ACAT will complete a Residential Respite Extension Form and submit the form to Medicare Australia. The care recipient automatically becomes eligible for another 63 days of residential respite at the commencement of the new financial year. The extension form must be completed each time an extension is required.

RESIDENTIAL RESPITE CARE

An ACAT reassessment and approval is required if:

- the original ACAT approval was time limited and has expired
- the care needed is permanent and the original approval did not include approval for permanent residential care
- the original ACAT approval was limited to a low level of residential care and the care needed is high level care.

If a person uses his or her approved number of days and an ACAT does not approve an extension, the service will not receive further subsidy for that person.

RESPITE CARE FOR VETERANS AND WAR WIDOWS AND WIDOWERS

Veterans and war widows and widowers share the same entitlement of up to 63 days of respite in a financial year. Extensions are also available.

Subject to prior approval, Department of Veterans' Affairs (DVA) beneficiaries who have full entitlement to treatment services can have the resident's daily fee for up to 28 days respite care per financial year paid at DVA's expense. This can be taken as residential respite, in-home respite, or a combination of both, and is not cumulative from one financial year to the next. This means that any in-home respite access will reduce the number of days for which DVA meets the cost of residential respite.

For former prisoners of war (POWs) who receive the higher level of respite care, DVA will meet the daily fee for the full length of stay in a residential aged care service.

EXTRA SERVICE PLACES

Services with extra service status are eligible for the respite supplement. Respite care recipients receiving care on an extra service basis may also be charged the extra service amount. The extra service reduction also applies to these residents. See also chapter on Extra service places in this Manual.

RESIDENTIAL CARE SUBSIDIES

An approved provider is eligible for residential care subsidy, including the respite supplement, for each day they provide residential respite care to an approved respite care recipient who has not used up his or her annual allocation of respite days.

A provider is not eligible for subsidy if:

- the service does not meet its accreditation requirements after the accreditation day
- the provider is not providing respite care in accordance with its conditions of allocation
- if the provider does not provide respite care in an allocated place.

Respite care recipients attract either high or low level residential care subsidy, as determined by the ACAT assessment, including the respite supplement. Other supplements can be paid where applicable. See the following section on Rules about payment of subsidies and supplements.

Rules about the payment of subsidies and supplements

The respite supplement can only be paid for days on which:

- the care provided was respite care
- the care recipient had been approved for respite care by an ACAT
- the care recipient had not used more than 63 days of respite care in that financial year, or an extended period of respite care approved by an ACAT
- the service has provided the care in an allocated place and has met any conditions of allocation.

The accommodation and concessional supplements are not paid for respite recipients, as an equivalent amount is already built into the respite supplement. The days used by respite care recipients cannot be counted towards concessional resident levels.

Services which are certified are eligible for a higher respite supplement.

Other supplements—for example, oxygen and enteral feeding—can be paid as applicable.

A service will not be paid for any form of leave for a respite care recipient.

Additional amount for high care respite

An additional amount for high care respite is available for eligible providers. Providers are eligible for the additional rate if they use an average of 70 per cent or more of their available respite places up to the end of the current claim period, based on an averaging period of 12 months. If the 70 per cent target is met, a payment is made at the end of the month for each of the high care respite days provided during that month.

While low care respite residents count towards the 70 per cent target, they do not attract the higher amount—ie, low and high respite care days are counted to reach the 70 per cent but only high care respite days attract the higher payment.

The averaging period will generally be the current claim month and the preceding 11 claim months. A provider is eligible for the additional rate of the high care respite amount if, on any given day, the average number of respite bed days provided over the previous 11 months and current claim month is equal to or greater than 70 per cent of the average number of respite bed days required to be provided over that period of time under the provider's conditions of allocation.

The averaging period takes into consideration the date respite care places are first allocated. Any increase or decrease in the level of allocation will be reflected in the averaging methodology from the date the increase or decrease takes effect. While the total number of places may fluctuate across the averaging period, the impact of any increase or decrease is gradual as it is spread out across the relevant period.

Respite bed days are not counted in the averaging period if they are provided:

- in excess of the level specified in the conditions of allocation relating to respite
- to non-eligible care recipients
- in excess of the maximum number of days per care recipient.

If a provider is eligible for any additional respite amount it will automatically be included in the normal advance monthly payments for residential subsidy, based on the provider's claim form for residential respite. See References at the end of this chapter for a link to current subsidy rates.

LEGISLATIVE REFERENCES

The sale of an aged care home will not affect the averaging period. That is, the averaging period will continue to be calculated regardless of changes in association, with the new provider taking on the old provider's usage averages.

A provider receiving the additional payment can apply for a variation to their allocation of respite. See Applying to vary conditions for operational places in chapter on Allocated places in this Manual.

Transfers from respite to permanent care

Care recipients can only transfer from respite to permanent care if:

- they have an ACAT approval for both respite and permanent care
- or they are reassessed by the ACAT and approved for permanent care.

The Minister can determine a different rate of respite supplement for respite care recipients where the person subsequently transfers to permanent care in the same service. This is to provide a disincentive for transfers from respite to permanent care. Respite usage is monitored to see if such a rate should be set.

Date of entry into permanent care

Subsidies and supplements are payable for the day of admission, but not for the day of discharge. If a person transfers from respite care to permanent care, respite subsidy will be paid from the first day of admission to the day before the day of transfer. Permanent care subsidy will then be paid from (and including) the day of transfer.

Notification of entry into respite care

Respite care recipients in receipt of pensions and allowances through Centrelink should be advised to notify Centrelink that they are entering an aged care service to receive respite care. This is to ensure that Centrelink can continue sending them correspondence relating to their pensions and allowances. A person's entry into respite care can also affect the payment of carer's payment or carer's allowance.

Monthly claim forms

There is a separate monthly claim form for respite care recipients. On the form, the area relating to leave is shaded to ensure it is not used, as leave provisions do not relate to respite care recipients.

CARE FEES

The fee for respite recipients is the same as the standard pensioner contribution regardless of their income or eligibility for income support payments. *See legislative reference.* There is no income-testing for respite recipients. They can be charged a booking fee. See the following section on Respite booking fees.

s 58-3(2)(b), Aged Care Act 1997

What fees can be charged for respite care?

There is no income-testing for respite care recipients and they pay the standard pensioner contribution. Respite care recipients can be charged an extra service fee if the place they occupy is an extra service place.

RESIDENTIAL RESPITE CARE

LEGISLATIVE REFERENCES

Respite booking fees

s 23.26(1), User Rights Principles 1997

Booking fees are paid to a service in advance to secure a period of respite care. Booking fees must not exceed the equivalent of the fee for one week's respite care, or 25 per cent of the fee for the proposed period of respite care, whichever is less. *See legislative reference.*

s 56-1(c), Aged Care Act 1997
s 59-1(1)(d), Aged Care Act 1997

It is one of an approved provider's responsibilities to charge no more than the amount permitted under the User Rights Principles by way of a booking fee for respite care. *See legislative reference.* Any resident agreement must specify the period that the care and services will be provided and any respite care booking fee. *See legislative reference.*

Once the resident enters the service, the booking fee must be deducted from the care recipient's daily fees.

EXAMPLE

If George books two weeks of respite care he can be charged a booking fee equivalent to 25 per cent of the period or 3 1/2 days worth of the booking fee—ie, 25 per cent of 14 days is 3 1/2 days. He will then only need to pay fees for the additional week and a half once he has entered the aged care service.

EXAMPLE

If Georgia books 6 weeks of respite care, she can only be charged one week's fee—ie, 25 per cent of 42 days is 10 1/2 days, and therefore greater than one week. Georgia will then be charged for the remaining five weeks after she enters for her period of respite care.

Reasons for not taking up a respite admission

s 23.16(3A), User Rights Principles 1997
s 23.16(3B), User Rights Principles 1997

If the care recipient cancels their booking **more** than 7 days before the proposed day for entry into respite care, the booking fee must be refunded within 14 days after the approved provider was notified that the care recipient cancelled the booking. *See legislative reference.* However, if the care recipient cancels their booking **less** than 7 days before the proposed day for entry, in any circumstances other than where the care recipient has died or is entering hospital, the approved provider can retain all or part of the booking fee. *See legislative reference.*

s 23.16(3), User Rights Principles 1997
s 26.14(3A), 26.14(3B), User Rights Principles 1997

If a person enters hospital or dies within seven days before the proposed day for entry into respite care, the booking fee must be returned to the person or their estate. *See legislative reference.* In these circumstances, the booking fee must be refunded within 14 days after the approved provider was notified that the care recipient cancelled their booking, regardless of whether the approved provider was notified more than 7 days before the cancellation. *See legislative reference.*

s 23.16(4), User Rights Principles 1997

The booking fee must also be refunded if the approved provider requires the respite recipient to leave before the end of the booked period. *See legislative reference.*

s 23.16(3B), 23.16(5), User Rights Principles 1997

In any other circumstance, all or part of the booking may be retained. *See legislative reference.*

LEGISLATIVE REFERENCES

EXAMPLE

If Terence booked for four weeks of respite care and paid one week's booking fee, then died two days prior to the proposed day of entry into respite care, the service must refund the booking fee to Terence's estate.

Leaving a service before the end of a booked period

If the respite care recipient decides to leave the service before the end of the booked respite period, all or part of the fee for the unused part of the booked period may be retained from the booking fee. *See legislative reference.*

s 23.16(5), User Rights Principles 1997

EXAMPLE

Denise booked for four weeks of respite care, paid one week's booking fee and then decided to leave after two days of care. The service may decide to keep the remainder of Denise's booking fee, which is equivalent to a fee for five days respite.

Resident's agreement

Conditions relating to the booking fee must be included in the respite resident agreement. *See legislative reference.* This agreement must also state the dates on which respite care is to be provided.

s 59-1(1)(d), Aged Care Act 1997

While a booking fee may be charged to respite care recipients, it must be deducted from the fee charged for the respite care.

ACCOMMODATION PAYMENTS

Care recipients receiving respite care cannot be charged an accommodation bond (for low level care) or accommodation charge (for high level care).

Care recipients receiving respite care who later become permanent residents can be charged an accommodation bond, if they require a low level of residential care, or an accommodation charge, if they require a high level of residential care. Once they become permanent residents, the entry date is taken to be the day of transfer to permanent care. Retention amounts, amounts representing income derived, and periodic payments cannot be charged for the period of respite care. See also chapter on Funding for residential aged care in this Manual.

RESIDENTS' RIGHTS

All new respite residents must be offered a resident agreement with the approved provider before they enter the service. *See legislative reference.* A resident agreement may also be entered into at any time during the recipient's stay. Respite recipients have the right to choose whether or not they wish to enter into a written agreement with the approved provider. See also section on Resident agreements in chapter on Residents' rights in this Manual.

s 56-1(g), Aged Care Act 1997

RESIDENTIAL RESPITE CARE

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN THIS CHAPTER

ACAR Essential Guide

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acar2008-essential-guide.htm

Aged Care Information Line

Ph 1800 500 853

Forms—all

All Departmental forms are available on the Department's website at *www.health.gov.au/internet/main/publishing.nsf/Content/health-forms.htm*

Form—approval for respite care

www.health.gov.au/internet/main/publishing.nsf/Content/514F5C8B6E979F9DCA256F1900106124/$File/5stepapp.pdf

Form—varying respite allocation conditions

Go to *www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-app-vca-respite.htm*

Or contact the Aged Care Information Line
Ph 1800 500 853

Forms should be submitted to the relevant state or territory office of the Department

New South Wales
GPO Box 9848
Sydney NSW 2001
Ph 1800 048 998
Fax 02 9263 3509

Queensland
GPO BOX 9848
Brisbane QLD 4001
Ph 1800 177 099
Fax 07 3360 2999

South Australia
GPO Box 9848
Adelaide SA 5001
Ph 1800 188 098
Fax 08 8237 8000

Tasmania
GPO Box 9848
Hobart TAS 7001
Ph 1800 005 119
Fax 03 6221 1412

Victoria State Office
GPO Box 9848
Melbourne VIC 3001
Ph 1800 020 103
Fax 03 9665 8181

Western Australia
GPO Box 9848 Perth 6001
Ph 1800 198 008
Fax 08 9346 5222

Northern Territory
GPO Box 9848
Darwin NT 0801
Ph 08 8919 3444
Fax: 08 8919 3400

Australian Capital Territory
PO Box 9848
Canberra ACT 2601
Ph 1800 020 102
Fax: 02 6289 3388

RESIDENTIAL RESPITE CARE

Medicare Australia

Ph 1800 195 206

Residential care fees, subsidies and supplements—current

For current rates for residential care fees and charges go to *www.health.gov.au/internet/main/publishing.nsf/Content/ageing-finance-resfees.htm-copy2*

For current Australian Government subsidies and supplements go to *www.health.gov.au/internet/main/publishing.nsf/Content/ageing-subs-supplement.htm*

Veterans, war widows and widowers—respite care for—Department of Veterans' Affairs

For more information on respite care paid for by the Department of Veterans' Affairs

Ph 133 254 (general enquiries—from anywhere in Australia)

Ph 1800 555 254 (general enquiries—country areas only)

RESIDENTIAL RESPITE CARE

CAPITAL GRANTS FOR RESIDENTIAL AGED CARE

CAPITAL GRANTS FOR RESIDENTIAL AGED CARE

This Manual has been written in plain English and as a result, some aspects of the legislation and policy have been simplified. It is intended to be a general guide only and does not constitute legal advice. In cases of discrepancy between the Manual and the legislation, the legislation will be the source document for payment of Australian Government benefits and enforcement of approved provider responsibilities.

RELEVANT LEGISLATION

- Part 5.1, Divisions 70–75, s 85, s 43-6 *Aged Care Act 1997* (the Act)
- *Residential Care Grant Principles 1997*

OVERVIEW

Limited capital funding is made available through the Residential Care (Capital) Grants program and the Rural and Regional Building Fund to assist service providers who are unable to meet the cost of necessary capital works.

Residential Care (Capital) Grants and Rural and Regional Building Fund Grants are allocated on a competitive basis through the annual Aged Care Approvals Round. Applicants for capital funding are responsible for providing information based on thorough research and analysis of all aspects of the proposal, including any associated building costs and the current and future financial capacity of the applicant organisation. Grants may also be made outside this process to address urgent and immediate needs. See also chapter on Allocated places in this Manual. See References at the end of this chapter for a link to the Aged Care Approvals Round Essential Guide

Additional information

This chapter has been updated and revised to help approved providers comply with their responsibilities under the Act; and to assist staff of aged care services understand the regulation of residential aged care. Additional information can also be accessed through the Aged Care Information Line on 1800 500 853.

ELIGIBLE CAPITAL WORKS

Financial assistance is available for:

- buying buildings or land on which to construct buildings, for providing residential aged care
- acquiring, erecting, altering or extending buildings to provide residential aged care
- acquiring furniture, fittings or equipment for buildings to provide residential aged care
- altering or installing furniture, fittings or equipment in buildings to provide residential aged care.

CAPITAL GRANTS FOR RESIDENTIAL AGED CARE

LEGISLATIVE REFERENCES

Capital funding is not available for:

- routine administration of the service, whether or not the costs are related to the proposed works
- acquiring and operating vehicles
- rent, insurance and state and local Government statutory charges—eg, rates
- any taxation payable by the service, including any tax which is payable as a result of receiving a grant.

Grants will not be made for capital works which have been contracted, commenced or completed prior to the execution of a grant agreement—ie, the signing of the agreement by both a grantee and an Australian government representative.

ELIGIBILITY

Residential Care (Capital) Grant

The eligibility criteria for a Residential Care (Capital) Grant are:

Part 5.1, Divisions 70–75, Aged Care Act 1997, Residential Care Grant Principles 1997, Allocation Principles 1997

- a majority of care recipients in the service to which the grant relates are supported, concessional or assisted residents
- a majority of care recipients who will receive care in that service are people with special needs—ie, those from rural or remote communities, those from Aboriginal and Torres Strait Island communities, those from Non-English speaking background, those who are financially or socially disadvantaged and veterans or war widows or people who are homeless or at risk of becoming homeless. *See legislative reference.*

Rural and Regional Building Fund grants

Rural and Regional Building Fund eligibility is limited to residential aged care services in all areas of Australia other than major cities, as defined by the Australian Standard Geographical Classification (ASGC) 2006 Remoteness Structure.

Services not eligible for a grant

Capital grants are not available to:

- residential care services that have been granted extra service status for a residential care service or a distinct part of a residential care service
- services run by an approved provider which is a state/territory government or a state/territory government body.

CAPITAL GRANTS FOR RESIDENTIAL AGED CARE

ASSESSMENT OF CAPITAL FUNDING PROPOSALS

All applications are assessed on a competitive basis. In ranking applications, the following will be considered:

- how urgently work needs to be carried out:
  - to meet Federal, state or local government fire, safety, health or occupational health and safety standards, including certification requirements for aged care services
  - because of fire, flood, earthquake or any other unforeseen circumstances
- the proportion of care recipients who are supported, concessional or assisted residents, and people with special needs—this applies only to Residential Care (Capital) Grants
- if implemented, the extent to which the proposal would maintain or extend the range of residential care services in the region and the consequent diversity of choice for current and future care recipients
- the provider's ability to provide continuity of care for residents in the facility and/or the region, both in the long term and during the capital works projects
- the extent of other benefits to current or future care recipients and their families from the implementation of the proposal, including value for money to the Government
- the extent to which the applicant has a demonstrated lack of capacity to fund the proposed works, taking into consideration all possible sources of finance
- the approved provider's record in meeting its responsibilities and obligations under the Act and other legislation relating to the provision of Australian Government-subsidised aged care.
- any other relevant information available to the Department.

See also chapter on Allocated places in this Manual. See References at the end of this chapter for a link to the Aged Care Approvals Round Essential Guide

Applications from services conducted in leasehold premises are unlikely to be given high priority in the competitive allocation of capital funds. Funding will be provided to applicants in leased premises only if:

- the lessor agrees to the proposal
- and agrees to operate the premises as a residential aged care facility for a period of interest, dependent on the size of the grant, after the capital works are finished.

These conditions would form part of the Grant Agreement.

THE GRANT AMOUNT

In deciding the amount of the grant, the Secretary will consider:

- the cost of the project
- the extent to which the applicant has a demonstrated lack of capacity to fund the proposed works, taking into consideration all possible sources of finance

The Secretary may allocate less than the amount applied for.

CAPITAL GRANTS FOR RESIDENTIAL AGED CARE

LEGISLATIVE REFERENCES

There is no provision for increasing an approved grant. The maximum amount payable is the amount approved at the time of application. Any increases in costs are to be met by the grantee. Where a grantee requires additional funding, and the capital works have not been contracted, commenced or completed, it may apply for an additional capital grant. The application for an additional grant will be considered on its merits in the competitive Aged Care Approvals Round.

DEED OF AGREEMENT

s 73-2, Aged Care Act 1997

Organisations will be expected to enter into a formal, legal Deed of Agreement with the Department, which may include the following: *See legislative reference.*

- the kinds of people who will receive care when the project is completed
- the number of concessional or assisted residents who will receive care
- the period in which conditions must be complied with
- the period in which the residential care service for which the grant is being paid will be operational
- the period in which the project must be completed
- the amount of money the approved provider will make available for the project
- the information the approved provider will give the Department
- the approved provider's compliance with:
  - any responsibilities regarding quality of care, the rights of care recipients and accountability for care provided
  - any conditions imposed in regard to the payment of previous residential care grants

PAYMENT ARRANGEMENTS AND REPORTING REQUIREMENTS

Payments will be made:

- in line with the payment schedule set out in the Deed of Agreement
- once the provider has given the Department the documentary evidence which meets the requirements described in the Deed of Agreement.

Under the Deed of Agreement, the grantee also has to make periodic reports to the Department on the progress of the capital works project for which the grant was allocated.

Similar matters are covered in a Deed of Agreement for a grant from the Rural and Regional Building Fund.

CEASING TO PROVIDE RESIDENTIAL AGED CARE

A condition of any grant is that the grantee continues to provide residential aged care, funded under the Act, in the building constructed with the assistance of a grant.

If the grantee stops providing residential aged care in the building, or sells, transfers or demolishes the building, the Government can ask for all or part of the grant to be

repaid. In considering whether to ask for all or part of the grant to be repaid, the Department will consider:

- the amount of the grant
- the time which has elapsed since the capital works were completed/occupied
- the circumstances in which the grantee stopped providing residential aged care
- the proposed future use of the buildings constructed with the grant
- the impact that any requirement to repay all or part of the grant might have on achieving the Government's aged care policy objectives
- whether the building is likely to be sold, or ownership of the building otherwise transferred to a third party
    - and the financial arrangements associated with any transfer
- the overall financial situation of the grantee and the impact repaying all or part of the grant may have on the organisation's future financial viability
- any other matters the grantee or the Department considers relevant.

Grantees should advise the Department as early as possible if they intend to stop providing care in a building, to transfer ownership or effective control, or to sell, demolish or otherwise dispose of the building.

Grantees will be given an opportunity to make a submission, before a decision on the amount of any repayment is made. The grantee's submission should include detailed, relevant information and any associated documentary evidence.

Further information on decisions to seek repayment of all or part of a grant is set out in the Recovery of Aged Care Capital Funding guidelines. See References at the end of this chapter for a link.

REVOKING OR DECREASING AN ALLOCATION

The Secretary can revoke or decrease a residential care grant if a condition of the grant has not been met.

Before deciding to revoke or decrease the allocation, the Secretary will advise the approved provider in writing, and invite a written submission within a specified timeframe (usually 28 days).

In deciding to revoke or decrease an allocation, the Secretary will consider any submissions made within the specified time.

If no submission is received, the grant will be revoked or decreased on the day after the last day for making submissions. The approved provide will be notified of the decision in writing.

VARYING CONDITIONS OF AN ALLOCATION

Grantees are required to meet the conditions of allocation set out in the Deed of Agreement. If a grantee is unable or unwilling to meet these conditions, it must apply to vary the conditions prior to doing anything which would cause it to breach the conditions of the grant set out in the Deed of Agreement.

CAPITAL GRANTS FOR RESIDENTIAL AGED CARE

LEGISLATIVE REFERENCES

A grantee can apply to the Secretary at any time to vary a condition of allocation of a residential care grant. A variation can be either to reduce the amount of the grant or to vary any of the conditions of the grant.

CAPITAL FUNDING AND EXTRA SERVICE STATUS

s 43-6, Aged Care Act 1997

If extra service status is granted after a capital grant has been allocated, the applicant will be required to repay the grant. *See legislative reference.* A similar condition is included in grant agreements for capital grants from the Rural and Regional Building Fund. See also section on Extra service status and capital payment deductions in chapter on Extra service places in this Manual.

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN THIS CHAPTER

Aged Care Approvals Round Essential Guide

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acar2008-essential-guide.htm

Aged Care Information Line

Ph 1800 500 853

Forms—all

All Departmental forms are available on the Department's website at

www.health.gov.au/internet/main/publishing.nsf/Content/health-forms.htm

Recovery of Aged Care Capital Funding guidelines

www.health.gov.au/internet/main/publishing.nsf/content/ageing-finance-capfund.htm

RESIDENTS' RIGHTS

RESIDENTS' RIGHTS

LEGISLATIVE REFERENCES

This Manual has been written in plain English and as a result, some aspects of the legislation and policy have been simplified. It is intended to be a general guide only and does not constitute legal advice. In cases of discrepancy between the Manual and the legislation, the legislation will be the source document for payment of Australian Government benefits and enforcement of approved provider responsibilities.

RELEVANT LEGISLATION

- Part 4.2, *Aged Care Act 1997* (the Act)
- *User Rights Principles 1997* (User Rights Principles)
- *Investigation Principles 2007*
- *Accountability Principles 1998*

OVERVIEW

Approved providers must ensure that the civil, human and legal rights of older people living in subsidised aged care services are protected. In order to do so, they must have in place systems, services and staff that respect the rights of residents.

Additional information

This chapter has been updated and revised to help approved providers comply with their responsibilities under the Act; and to assist staff of aged care services understand the regulation of residential aged care. Additional information can also be accessed through the Aged Care Information Line on 1800 500 853.

CHARTER OF RESIDENTS' RIGHTS AND RESPONSIBILITIES

The Charter of Residents' Rights and Responsibilities is designed to ensure that a person's rights are not diminished when they move into an aged care service. The Charter, reproduced below, also sets out that residents in aged care services should exercise their individual rights in ways that do not adversely affect other residents' rights. *See legislative reference.*

s 56-1 Aged Care Act 1997, s 23.12, s 23.14, User Rights Principles 1997

RESIDENTS' RIGHTS

LEGISLATIVE REFERENCES

Schedule 1, User Rights Principles 1997

Charter of Residents' Rights and Responsibilities
See legislative reference.

A. Each resident of a residential care service has the right:

- to full and effective use of his or her personal, civil, legal and consumer rights;
- to quality care which is appropriate to his or her needs;
- to full information about his or her own state of health and about available treatments;
- to be treated with dignity and respect, and to live without exploitation, abuse or neglect;
- to live without discrimination or victimisation, and without being obliged to feel grateful to those providing his or her care and accommodation;
- to personal privacy;
- to live in a safe, secure and service-like environment, and to move freely both within and outside the residential care service without undue restriction;
- to be treated and accepted as an individual, and to have his or her individual preferences taken into account and treated with respect;
- to continue his or her cultural and religious practices and to retain the language of his or her choice, without discrimination
- to select and maintain social and personal relationships with any other person without fear, criticism or restriction
- to freedom of speech
- to maintain his or her personal independence, which includes a recognition of personal responsibility for his or her own actions and choices, even though some actions may involve an element of risk which the resident has the right to accept, and that should then not be used to prevent or restrict those actions;
- to maintain control over, and to continue making decisions about, the personal aspects of his or her daily life, financial affairs and possessions;
- to be involved in the activities, associations and friendships of his or her choice, both within and outside the residential care service;
- to have access to services and activities which are available generally in the community;
- to be consulted on, and to choose to have input into, decisions about the living arrangements of the residential care service;
- to have access to information about his or her rights, care, accommodation, and any other information which relates to him or her personally;
- to complain and to take action to resolve disputes;
- to have access to advocates and other avenues of redress; and
- to be free from reprisal, or a well-founded fear of reprisal, in any form for taking action to enforce his or her rights.

LEGISLATIVE REFERENCES

B. Each resident of an aged care service has the responsibility:

- to respect the rights and needs of other people within the residential care service, and to respect the needs of the residential care service community as a whole;
- to respect the rights of staff and the proprietor to work in an environment which is free from harassment;
- to care for his or her own health and wellbeing, as far as he or she is capable; and
- to inform his or her medical practitioner, as far as he or she is able, about his or her relevant medical history and his or her current state of health.

INFORMATION FOR RESIDENTS

Residents of aged care services must be given enough information to help them make informed choices. When a new resident enters a service, the provider must give the resident information about residents' rights and obligations as specified in the Charter, and the requirements of the User Rights Principles as set out in this chapter. *See legislative reference.*

s 23.14, User Rights Principles 1997

This information can be included in the formal agreement between the resident and the service. Residents can also choose not to enter into a written agreement with the approved provider. If a resident does not want to sign a formal agreement, the approved provider must still give them comprehensive information, including details about the levels of care and service the service can provide for the resident. See Information for residents who do not sign agreements on page 175.

RESIDENT AGREEMENTS

An approved provider must offer each resident a formal resident agreement *See legislative reference.* A formal agreement is usually an agreement in writing, signed by both the approved provider and the resident when the resident enters the service. However, the agreement may be signed by the resident at any future time during their stay. The agreement must specify the care and services the service will provide and the resident's rights and responsibilities while staying in the service. It must also provide information on fees and charges and any other matters negotiated between the approved provider and the resident. A formal agreement may be entered into at any time during the resident's stay.

56-1 (g), Aged Care Act 1997

The agreement between the resident and the approved provider must

- treat the resident and provider as equal parties to the agreement and clearly set out the rights and obligations of each party
- be written in plain language
- be easy to understand.

It should specify the following:

- the name of the aged care service
- the levels of care and service that the provider has the capacity to provide to the resident and any limitations to these levels of care.
- the policies and practices that the provider will follow in setting fees for the resident
- the period of the agreement if the resident is not entering the service on a permanent basis

LEGISLATIVE REFERENCES

- circumstances in which the resident can be asked to leave the aged care service
- assistance the provider will give the resident to obtain suitable alternate and affordable accommodation if the resident is asked to leave
- the internal complaints resolution mechanism that the aged care service provides to deal with complaints made by or on behalf of a resident
- the resident's responsibilities as a resident in the aged care service
- any other matters relevant to the agreement, and/or matters negotiated between the approved provider and the resident.

An agreement should also:

- allow for the terms of the agreement to be varied, by mutual consent following adequate consultation
- allow for the agreement to be terminated upon seven days written notice from the resident or their representative
- allow for the agreement to be voided if the resident or their representative tells the provider in writing that they wish to withdraw from the agreement, within 14 days after signing the agreement. In these circumstances, the resident is still liable for any fees and charges accrued under the agreement during their time in the aged care service. Providers must refund any other amount paid by the resident under the agreement.
- explain and help the resident or their representatives understand all the terms of the agreement. *See legislative reference.*

s 23.85, User Rights Principles 1997

The rights the agreement gives the resident are in addition to any other rights the resident has in law. The agreement must not contain any provision that would allow the resident to be treated less favourably than they would otherwise be treated under any law of the Commonwealth. *See legislative reference.*

s 59-1(3), Aged Care Act 1997

If a resident does not want to have a formal agreement with the aged care service, the service must still comply with aged care legislative requirements, including those set out in the User Rights Principles in order to continue to receive Government funding.

Signing agreements

If the resident chooses to enter into a resident agreement, the agreement must be signed by both the provider and the resident. If a resident is physically unable to sign the agreement, the resident can ask another person to sign on his or her behalf and the agreement should be annotated to this effect. If a resident is cognitively impaired and cannot understand and sign the agreement, a legally authorised representative should sign for them.

If a resident is unable to sign an agreement and does not have a legally authorised alternative decision maker, an approved provider can contact the relevant state or territory guardianship authority or public advocate or public trustee. See References at the end of this chapter for contact details for guardianship authorities, public advocates and trustees offices.

Resident agreement for respite residents

A formal agreement between the resident and the approved provider must be offered to all new residents, including respite residents, before they enter the service. See Resident agreements on page 173 for details. Conditions about any booking fee

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must be included in respite agreements. These agreements must also state the dates between which respite care is to be provided. Respite residents do not pay an accommodation bond or charge. They can occupy an extra service place and if they do, an approved provider may ask the resident to pay additional fees for that extra service place. See also chapters on Extra service places and Residential respite care in this Manual.

Transitional arrangements for agreements

To ensure that existing resident agreements will continue to be honoured, agreements between nursing service or hostel proprietors and residents which were in place before the Act came into effect are considered resident agreements under the Act.

Information for residents who do not sign agreements

If the resident does not enter into a resident agreement, the provider must still give them all the information in writing that would otherwise be provided in a resident agreement, including:

- the levels of care and service that the provider can provide to the resident
- the policies and practices that the provider will follow in setting fees for providing care and services to the resident
- if the resident is not entering the service on a permanent basis, the period of respite care to be provided to the resident and, if applicable, any respite care booking fees
- conditions under which the resident can be asked to leave
- assistance the provider will give the resident to obtain suitable, alternative and affordable accommodation if the resident is asked to leave
- the internal complaints resolution mechanism that the aged care service provides to deal with complaints made by or on behalf of a resident
- the resident's responsibilities as a resident in the aged care service.

Disclosure of financial information to residents

Approved providers are required to provide the following information to residents:

- a copy of any accommodation bond agreement and guarantee
- routine provision of information at the end of the financial year
- provision of information on request, at any other time.

See also section on Disclosure to residents in chapter on Protection and responsibilities relating to accommodation bonds in this Manual.

Protecting residents' information

Providers must protect the personal information of a resident. *See legislative reference.* Personal information can only be used:

Division 62, Aged Care Act 1997

- for a purpose related to providing aged care services to the resident, by the provider
- for a purpose for which the resident or his or her representative provided the information.

LEGISLATIVE REFERENCES

Without the written consent of the resident, personal information must not be disclosed to any other person other than for:

- a purpose related to the provision of aged care services to the resident by the provider
- a purpose related to the provision of aged care to the resident, by another approved provider but only relating to the person's accommodation bond balance
- a purpose agreed to by the resident or his or her representative.

s 62-1(c), Aged Care Act 1997

Personal information must be protected by safeguards which protect against the loss or misuse of information. *See legislative reference.*

s 62-2, Aged Care Act 1997

However, approved providers are not precluded from providing a resident's personal information to a court, tribunal or authority. *See legislative reference.*

SECURITY OF TENURE

s 23.5, User Rights Principles 1997

Under the legislative provisions for security of tenure, a provider may ask a resident to leave if: *See legislative reference.*

- the aged care service is closing
- the aged care service can no longer provide accommodation and care suitable for the resident, having regard to the resident's long-term assessed needs, and the provider has not agreed to provide the care that the resident presently needs in cases where the resident's care needs have changed.
- the resident no longer needs the care provided through the aged care service, as assessed by an Aged Care Assessment Team (ACAT)
- the resident has not paid any agreed fee to the provider within 42 days after the due date, for a reason within the resident's control
- the resident has intentionally caused serious damage to the aged care service, or serious injury to the provider, an employee of the aged care service, or to another resident
- the resident is away from the aged care service for a continuous period of at least seven days for a reason other than permitted by the Act or an emergency.

s 23.6, User Rights Principles 1997

The provider must give written notice if the resident is required to leave the service and must give the notice to the resident or his or her representative at least 14 days before the resident is to leave. *See legislative reference.*

Four steps—asking a resident to leave

There are four steps that the provider must follow in asking a resident to leave.

Step 1—providing written notice

The written notice from the approved provider must include:

- the decision
- reasons for the decision
- when the resident is to leave (which must be at least 14 days after the notice is given);
- the resident's rights about leaving, including his/her access to complaints resolution mechanisms; independent complaints processes; and 1 or more representatives of an advocacy service.

Step 2—considering suitable alternate accommodation

The approved provider should discuss with the resident whether they wish to find their own alternate accommodation. However, ultimately it is the approved provider's responsibility to ensure that accommodation is available for the resident, before the resident can be required to leave.

The suitability of the alternate accommodation is linked to the assessment of the resident's long-term care needs—for example, a service that provided only low level care would not be suitable alternate accommodation for a resident who was assessed as requiring a high level of care. See also Step 3 following.

The alternate accommodation does not necessarily have to be the preferred accommodation of the resident who is being asked to leave. However, the alternate accommodation does have to be available and able to provide care which is suitable to meet the needs of the resident. Some alternate accommodation may not be considered suitable, such as a service where there are sanctions in place or a service that is a great distance from the existing service.

The resident must be able to afford the suitable alternate accommodation—for example, an extra service facility may not be appropriate for a concessional resident. Hospital is not considered to be suitable alternate accommodation.

Step 3—assessing the resident's long-term needs

Where the resident is asked to leave because the aged care service can no longer provide accommodation and care suitable for the resident's long-term assessed needs, and the provider has not agreed to provide the care that the resident presently needs, the long-term needs of the resident must be assessed by:

- an ACAT
- or at least two medical or other health practitioners who meet the following criteria
  - one must be independent of the provider and the aged care service and chosen by the resident
  - and both must be competent to assess the aged care needs of the resident.

After such an assessment, if those conducting the assessment consider that the present accommodation and care cannot continue to meet the care needs of the resident, then the process associated with requiring the resident to leave must be undertaken.

Step 4—when the resident is no longer required to leave

If the decision requiring the resident to leave was based on their behaviour, and since giving the original notice to leave, the approved provider has agreed with the resident that the resident should stay because their behaviour has changed, then the approved provider should give the resident a notice stating that they are no longer required to leave.

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Security of place within the residential service—moving residents

s 23.15, User Rights Principles 1997

It is important that residents feel secure in their room or bed within an aged care service. Accordingly, a resident can only be moved to another bed or room in the following circumstances: *See legislative reference.*

- if the resident asks to be moved
- if the resident agrees to move, after being fully consulted and without any pressure
- if the move is necessary on genuine medical grounds as assessed by an ACAT or at least two medical or other health practitioners
  - one of whom is independent of the provider and the aged care service and chosen by the resident
  - both of whom are competent to assess the aged care needs of the resident
- if the place occupied by the resident becomes an extra service place and the resident elects not to pay the extra service fee
- if the move is necessary because repairs or improvements to the aged care service need to be carried out and the resident has the right to return to the bed or room, if it continues to exist as a bedroom for residents, once the repairs or improvements are completed.

s 23.16, User Rights Principles 1997

RESPITE BOOKING FEES

See legislative reference.

Respite booking fees are prepaid daily fees, paid to ensure a period of respite care. Conditions relating to the booking fee must be included in a resident's agreements. These agreements must also state the dates on which respite care is to be provided. See also section on Respite booking fees in chapter on Residential respite care in this Manual.

RESOLVING COMPLAINTS

There are two systems available to people wanting to make a complaint about an aged care service:

- internal—ie, within in each service
- and external, through the Aged Care Complaints Investigation Scheme.

Internal complaint resolution

s 56-4, Aged Care Act 1997

Approved providers are required to establish and operate an effective process for addressing complaints, as well as making sure that people are aware that they can complain to the Aged Care Complaints Investigation Scheme. The internal process established and operated by service providers must meet the requirements set out under the Accreditation Standards. *See legislative reference.*

Aged Care Complaints Investigation Scheme

The Aged Care Complaints Investigation Scheme (the Scheme) is managed by the Department's Office of Aged Care Quality and Compliance. The Scheme investigates complaints and concerns about Government-subsidised aged care services, including residential and community aged care services which are funded under the Act.

RESIDENTS' RIGHTS

The Scheme provides a free and confidential service. Anyone can contact the Scheme with a concern, including care recipients, family members, care providers, staff members or health professionals. Concerns or complaints can be about anything that affects the quality of care or services for aged care recipients, such as care, catering, hygiene, security, activities, choice, comfort, safety, neglect or financial matters.

Often the best way to resolve a complaint is directly with the aged care service. However any person who is uncomfortable doing this or who is unhappy with the response they have received from the service is encouraged to contact the Scheme.

The Scheme can be contacted in writing, by phone or by submitting an online form via the Department's website. See References at the end of this chapter for contact information.

All parties to a complaint have the right to be kept informed about what is happening and have a right to have their case reviewed if they are not happy with the way in which their complaint has been handled.

If a person is not satisfied with how their complaint has been handled he or she may take their concerns to the Departmental manager responsible for the Scheme in their state or territory.

The Office of the Aged Care Commissioner

The Office of the Aged Care Commissioner has been established to independently review the way in which the Scheme handles complaints. The Commissioner can look at decisions made by the Scheme in relation to the investigation of complaints and also has the power to examine, as a result of a complaint, or on his or her own initiative, the Scheme's administrative processes for investigating complaints. See References at the end of this chapter for contact information.

ADVOCACY SERVICES

Under the National Aged Care Advocacy Program, the Department funds an advocacy service in each state and territory to provide free and confidential services to assist people receiving Government-subsidised aged care services as well as other representatives who may be acting on behalf of residents. Aged care advocacy services can:

- assist people receiving aged care services to resolve problems or complaints in relation to aged care services
- support people receiving aged care services to be involved in decisions that affect their life
- provide people receiving aged care services with information and advice about their rights and responsibilities
- promote the rights of people receiving aged care services to aged care service providers.

Aged care advocacy services achieve this through the delivery of advocacy, information and education. The provision of information and education, to both recipients and providers of aged care, can contribute to the protection of consumers' rights and foster improvements to the quality of life for consumers of aged care services. See References at the end of this chapter for contact information.

RESIDENTS' RIGHTS

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s 56-1(k), Aged Care Act 1997

Aged care services must allow advocacy services access to the premises during normal business hours, or at any other time if a resident or their representative has asked the advocacy service to call. *See legislative reference.*

COMMUNITY VISITORS' SCHEME

The Community Visitors' Scheme (CVS) helps to establish links between people living in an aged care service and their local community. The CVS aims to improve the quality of life of residents of aged care services who have limited family and social contact, and may be at risk of isolation from the general community for social or cultural reasons, or through disability.

An aged care service can identify a resident who would benefit from being matched with a community visitor. A community visitor then befriends that resident.

Aged care services are expected to support community visitors by welcoming them to the service, and liaising with CVS coordinators. Where possible, aged care services should advise the coordinator if a resident cannot receive visits, for example, if the resident has become very ill or has passed away.

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN THIS CHAPTER

Advocacy Services

New South Wales
The Aged Care Rights Service
Level 4, 418a Elizabeth Street
Surry Hills NSW 2010
Ph (02) 9281 3600
Ph 1800 424 079
Fax (02) 9281 3672

Victoria
Elder Rights Advocacy
Level 4
140 Queen Street
Melbourne VIC 3000
Ph (03) 9602 3066
Ph 1800 133 312
Fax (03) 9602 3102

Queensland
Queensland Aged and Disability Advocacy (QADA) Inc.
121 Copperfield Street
Geebung QLD 4034
Brisbane Office
Ph (07) 3637 6000
Ph 1800 818 338
Fax (07) 3637 6001

South Australia
Aged Rights Advocacy Service Inc.
45 Flinders Street
Adelaide SA 5000
Ph (08) 8232 5377
Ph 1800 700 600
Fax (08) 8232 5388

Western Australia
Advocare
Unit 1/190 Abernethy Road
Belmont WA 6104
Ph (08) 9479 7566
Ph 1800 655 566
Fax (08) 9479 7599

Australian Capital Territory
ACT Disability, Aged and Carer Advocacy Service (ADACAS)
Suite 207, Block C
Canberra Technology Park
Phillip Avenue
Watson ACT 2602
Ph (02) 6242 5060
Fax (02) 6242 5063

Tasmania
Advocacy Tasmania Inc
Suite 6, Mayfair Plaza
236–244 Sandy Bay Road
Sandy Bay TAS 7005
Ph (03) 6224 2240
Ph 1800 005 131
Fax (03) 6224 2411

Darwin
Darwin Community Legal Service
Aged/Disability Rights
8 Manton Street
Darwin NT 0801
Ph (08) 8982 1111
Ph 1800 812 953
Fax (08) 8982 1112

Alice Springs
Catholic Care NT
6 Hartley Street
Alice Springs NT 0871
Ph (08) 8958 2400
Ph 1800 354 550
Fax (08) 8958 2499

Aged Care Commissioner—Office of

Ph 1800 500 294
www.agedcarecommissioner.net.au.

Aged Care Complaints Investigation Scheme

Ph 1800 550 552

The line is open Monday–Friday, 8:30am–5pm; Saturday, Sunday and public holidays, 10am–5pm. Outside these hours, people can leave a message.

People can also write to the Scheme at:

Department of Health and Ageing
GPO Box 9848
In your Capital City

Go to *www.health.gov.au/internet/main/publishing.nsf/content/ageing-complaints-index.htm* for an online complaints form

If a person is not satisfied with how their complaint has been handled, they can take their concerns to the Departmental manager responsible for the Scheme in their state or territory, by calling the Scheme freecall number above.

Aged Care Information Line

Ph 1800 500 853

Community Visitors' Scheme

For more information contact the Aged Care Information Line
Ph 1800 500 853

Guardianship authorities, public advocates and trustees offices

New South Wales

Office of the Public Guardian
www.lawlink.nsw.gov.au/opg
Parramatta Office
160 Marsden St
Parramatta NSW 2150
Ph (02) 8688 2650
Ph 1800 451 510 (outside Sydney)
Fax (02) 8688 9797

Sydney Office
Level 2, Suites 204–206
83 York St
Sydney NSW 2000
Ph (02) 8083 9100
Fax (02) 8083 9111

Gosford Office
Level 3, 4 Watt St
Gosford NSW 2350
Ph (02) 4320 4888
Fax (02) 4320 4818

Guardianship Tribunal
2a Rowntree Street
Balmain NSW 2041
Ph (02) 9556 7600
Ph 1800 463 928
Fax (02) 9555 9049
www.gt.nsw.gov.au

Office of the Protective Commissioner
160 Marsden St
Parramatta NSW 2124
Ph (02) 8688 2600
TTY 1800 882 889
Fax (02) 8688 9783

Victoria

State Trustees Ltd
168 Exhibition Street
Melbourne VIC 3000
Ph (03) 9667 6444
Fax (03) 9663 4260

Guardianship List
55 Kings Street
Melbourne VIC 3000
Ph (03) 9628 9911
Ph 1800 133 055
Fax (03) 9628 9932

Office of the Public Advocate
5th Floor
436 Lonsdale Street
Melbourne VIC 3000
Ph 1300 309 337
Fax (03) 9603 9501

Western Australia

Office of the Public Advocate
Level 1, Hyatt Centre
30 Terrace Road
East Perth WA 6004
Ph 1300 858 455
Ph 1800 807 437 (WA only)
Fax (08) 9278 7333

Public Trustee
PT Building
565 Hay Street
Perth WA 6000
Ph 1300 746 212
Ph 1800 642 777
Fax (08) 9222 6607

State Administrative Tribune
Western Australia
Level 4
12 St George Terrace Road
Perth WA 60040
Ph (08) 9219 3111
Ph 1300 306 017
Fax (08) 9325 5099

Queensland

Office of the Adult Guardian
PO Box 13554
George Street
Brisbane 4003
Ph (07) 3234 0870
Ph 1300 653 187
Fax (07) 3239 6367

Public Trustee
444 Queen Street
Brisbane QLD 4000
Ph (07) 3213 9288
Fax (07) 3213 9489

Guardianship and Administration Tribunal
Level 9
259 Queen St
Brisbane QLD 4000
GPO Box 1639
Brisbane QLD 4001
Ph (07) 3234 0666
Ph 1300 780 666
Fax (07) 3221 9156

South Australia

Public Trustee Office of South Australia
25 Franklin Street
Adelaide SA 5000
GPO Box 1338
Adelaide 5001
Ph (08) 8226 9200
Ph 1800 673 119
Fax (08) 8231 9518

Office of the Public Advocate
Level 7, ABC Building
85 Northeast Road
Collinswood SA 5081
PO Box 213
Prospect SOUTH AUSTRALIA 5082
Ph (08) 8269 7575
Ph 1800 066 969
Fax (08) 8269 7490

Guardianship Board of SA
ABC Building
Level 8
85 Northeast Road
Collinswood SA 5081
Ph (08) 8368 5600
Ph 1800 800 501 (SA only)
Fax (08) 8368 5699

Tasmania

Public Trustee
116 Murray Street
Hobart TAS 7001
Ph (03) 6233 7598
Ph 1800 068 784
Fax (03) 6231 0621

Guardianship and Administration Board
54 Victoria Street
Hobart TAS 7000
PO Box 1307
Hobart 7001
Ph (03) 6233 3085
Fax (03) 6233 4509

Office of the Public Guardian
Level 3
15 Murray Street
Hobart TAS 7000
PO Box 825
Hobart 7001
Ph (03) 6233 7608
Fax (03) 6233 4882

Australian Capital Territory

Public Advocate of the ACT
Level 3
12 Moore Street
Canberra City
ACT 2601
PO Box 1001
CIVC SQAURE 2600
Ph (02) 6207 0707
Fax (02) 6207 0688

Public Trustee
PO Box 221
Civic Square ACT 2608
Ph (02) 6207 9800
Fax (02) 6207 9811

ACT Civil and Administrative Tribunal
ACT Magistrates Court
Knowles Place
Canberra ACT 2600
Ph (02) 6207 1740
Fax (02) 6205 1740

Northern Territory

Office of the Public Guardian
Darwin Office
Shops 1 & 2
Ground Floor
Casuarina Plaza
Trower Road
Casuarina NT 0811
Ph (08) 8922 7116
Fax (08) 8922 7051

Public Trustee
Nichols Place
Corner Cavenagh & Bennett Streets
Darwin NT 0800
Ph (08) 8999 7271
Fax (08) 8999 7882

Alice Springs
AAHS Building
Flynn Drive
Alice Springs NT 0870
Ph (08) 8951 6741
Fax (08) 8951 6789

RESIDENTS' RIGHTS

PROTECTION AND RESPONSIBILITIES RELATING TO ACCOMMODATION BONDS

PROTECTION AND RESPONSIBILITIES RELATING TO ACCOMMODATION BONDS

This Manual has been written in plain English and as a result, some aspects of the legislation and policy have been simplified. It is intended to be a general guide only and does not constitute legal advice. In cases of discrepancy between the Manual and the legislation, the legislation will be the source document for payment of Australian Government benefits and enforcement of approved provider responsibilities.

RELEVANT LEGISLATION

- Division 57, *Aged Care Act 1997* (the Act)
- Part 4, *User Rights Principles 1997*
- *Aged Care (Bond Security) Act 2006*
- *Aged Care (Bond Security) Levy Act 2006*

OVERVIEW

This chapter is designed to help approved providers, who hold accommodation bonds and entry contributions, comply with:

- the timeframes for repayment of accommodation bonds
- requirements to pay interest to residents for the period between the resident leaving a service and the refund of the accommodation bond balance or entry contribution balance
- prudential requirements including the Liquidity Standard, Records Standard and Disclosure Standard.

This chapter also provides information about the use of accommodation bond funds and the Accommodation Bond Guarantee Scheme (Guarantee Scheme).

Additional information

This chapter has been updated and revised to help approved providers comply with their responsibilities under the Act; and to assist staff of aged care services understand the regulation of residential aged care. Additional information can be accessed through the Aged Care Information Line on 1800 500 853; and people can email prudential@health.gov.au with enquiries about prudential regulation.

USE OF ACCOMMODATION BOND FUNDS

Approved providers must not use accommodation bonds for a purpose that is not related to providing aged care to care recipients or that does not comply with prudential requirements.

PROTECTION AND RESPONSIBILITIES RELATING TO ACCOMMODATION BONDS

LEGISLATIVE REFERENCES

Income derived from accommodation bond balances

Approved providers are entitled to retain income derived from investing accommodation bond balances. Such income, including allowed retention amounts or investment earnings, must be used in the following ways:

- to meet capital works costs relating to residential care
- to retire debt relating to residential care
- to improve the quality and range of care services.

Deductions from accommodation bond balances

Approved providers may make the following deductions from an accommodation bond only if a valid accommodation bond agreement has been entered into:

- retention amounts. See also Accommodation payments section in chapter on Funding for residential aged care in this Manual
- amounts owed to the approved provider by the care recipient under an accommodation bond agreement, a resident agreement or an extra service agreement
- interest on the amounts owed to the approved provider by the care resident under an accommodation bond agreement, a resident agreement or an extra service agreement.

Approved providers must not deduct any other amounts from the accommodation bond balance.

REFUNDING ACCOMMODATION BOND BALANCES

Refunding accommodation bonds is arranged under the following four headings:

- to whom accommodation bonds are refunded—ie, they must be refunded in the name of the resident
- when a refund is due
- the amount of the refund
- interest payable on late refunds.

Recipient of the refund

s 57-21(2), Aged Care Act 1997

The accommodation bond must be refunded in the name of the care recipient. *See legislative reference.* This protects the resident who paid the accommodation bond, by ensuring that the refund is dealt with according to their wishes, including (where the refund occurs following the resident's death) as set out in their will. It also protects the approved provider by ensuring that they are able to clearly identify the person who may deal with the refund. These protections for the resident and the approved provider are increasingly important as the value of accommodation bonds continues to rise over time.

ss 57-13 and 57-23, Aged Care Act 1997

If a resident moves from one service to which they had paid an accommodation bond to another service, they may agree to pay an accommodation bond for entry to the new service, including for moving from a low-care service to high-care service. *See legislative reference.* This bond cannot be greater than the bond balance refunded or payable to the resident by the first service.

PROTECTION AND RESPONSIBILITIES RELATING TO ACCOMMODATION BONDS

When a resident leaves a service to move to another service, the first service must refund the resident's accommodation bond. The legislation requires that the refund be made to the resident. However, the Department accepts that as a matter of practical administration, the refund of the original accommodation bond and payment of the new one can be done in one of two ways with the explicit agreement of the resident:

- if the resident transfers to a new service operated by the same approved provider, the bond balance continues to be held so that it is not refunded to the resident and then paid again by them
- if the resident transfers to a service operated by a different approved provider, the original approved provider, with whom the resident agreed to pay a bond, pays the bond balance to the second approved provider.

These practices are only acceptable when performed with the prior agreement of the resident or representative.

Refunding accommodation bond balances—resident transfers from one service to another

An approved provider is required to refund the accommodation bond balance if the care recipient is to enter another service to receive residential care. The timing of the refund will vary, depending on whether the care recipient has notified the approved provider that they will be leaving, as set out below:

- if the care recipient has notified the approved provider more than 14 days before they leave then the accommodation bond balance must be refunded on the day the care recipient leaves
- if the care recipient notified the approved provider only 14 or fewer days before they leave, then the accommodation bond balance must be refunded within 14 days of the day that the notification was given
- if the care recipient did not notify the approved provider they were leaving, then the accommodation bond balance must be refunded within 14 days of the day the care recipient leaves.

The provisions do **not** require a resident to notify the approved provider of the date when the resident was to enter another service to receive residential care. As a matter of practice, approved providers may wish to request that residents provide notice in writing and if they do not, approved providers might wish to record the communication. This will avoid any unnecessary dispute regarding the date of notification.

Refunding accommodation bond balances—resident leaves a service to move back to their home or carer's home

If a resident leaves a service to return to their own home or the home of a carer, the approved provider must refund the accommodation bond balance within 14 days of the resident leaving the service.

Refunding accommodation bond balances—resident dies

If a resident dies, an approved provider must refund their accommodation bond balance within 14 days after the day on which the approved provider is shown the probate of the will or letters of administration. In practice, this means the approved provider may:

- make a refund at any time (which must be in the name of the former resident) without evidence of probate or letters of administration if they are sufficiently confident that the person receiving the payment may deal with it
- or wait for the probate or letters of administration before refunding the accommodation bond balance.

When an approved provider is shown grant of probate or letters of administration, they should take a copy and date stamp it. This will assist in record keeping and reduce the risk of any dispute regarding when the approved provider was shown the probate or letters of administration.

Refunding entry contribution balances

Entry contributions must be refunded in accordance with the formal agreement.

Delaying refunds to secure re-entry

A resident who leaves a service, other than on leave, may agree with the approved provider to delay refunding the accommodation bond balance, on the following conditions:

- if the resident wants to re-enter the service, the approved provider must allow the resident to enter the service if there are any places vacant, and the resident is an approved resident
- the resident must not be charged an increased amount of accommodation bond or a second accommodation bond for re-entry.

If the accommodation bond balance is carried over in this way, retention amounts must not be deducted for the period from the day after the recipient leaves to the day they re-enter the service (inclusive). This period does not count towards the five years for which retention amounts can be deducted.

Record keeping requirements in relation to accommodation bond balance refunds

All approved providers holding accommodation bonds or entry contributions are required to maintain a bond register which includes details of all accommodation bonds and entry contributions.

When an accommodation bond balance or an entry contribution is refunded by an approved provider, certain information about the refund must be entered on the bond register, including:

- relevant dates—ie, when the resident left the service or died, the date the care recipient notified the approved provider they were leaving, when the accommodation bond balance or entry contribution was due to be refunded and when the accommodation bond balance or entry contribution was actually refunded, and any periods where the service failed to be certified

LEGISLATIVE REFERENCES

- information about the amount of the accommodation bond balance or entry contribution that was refunded and the amount of any interest paid. See The Records Standard—bond register on page 200.

Former approved providers must refund accommodation bonds

From 1 January 2009, where an approved provider ceases to be an approved provider in respect of a service and continues to run that service, they must refund any accommodation bonds paid for entry to that service. It is an offence for a former approved provider which is a corporation not to repay the accommodation bond balance within the set period. A court may impose a penalty of up to 30 penalty units (where each penalty unit is $110). *See legislative reference.*

57-21AA(3), Aged Care Act 1997

The timing for the former approved provider to refund the accommodation bond balance will be different depending on the circumstances of the care recipient.

If the care recipient dies within 90 days of the former approved provider ceasing to be an approved provider, then the accommodation bond balance must be refunded within 14 days after the former approved provider is shown the probate of the will or letters of administration. In practice, this means the approved provider may:

- make a refund at any time (which must be in the name of the former resident) without evidence of probate or letters of administration if they are sufficiently confident that the person receiving the payment may deal with it
- wait for probate or letters of administration before refunding the accommodation bond balance.

If the care recipient is entering another service to receive residential care, the timing of the refund will vary, depending on whether the care recipient has notified the former approved provider within 90 days of it ceasing to be an approved provider that they will be leaving:

- if the care recipient has notified the former approved provider more than 14 days before they leave then the accommodation bond balance must be refunded on the day the care recipient leaves
- if the care recipient notified the former approved provider only 14 or fewer days before they leave, then the accommodation bond balance must be refunded within 14 days of the day that the notification was given
- if the care recipient did not notify the former approved provider they were leaving, then the accommodation bond balance must be refunded within 14 days of the day the care recipient leaves.

In any other case, including if the care recipient decides to stay in the same service, the refund must be made within 90 days of the day on which the former approved provider ceased to be an approved provider.

PAYING INTEREST

Approved providers pay interest to residents at two different rates. Interest must be paid to the resident on the same day that the accommodation bond balance or entry contribution is refunded. *See legislative reference.*

Division 14, 15, Part 4, User Rights Principles 1997

Providers pay interest:

- at the base interest rate (BIR) for the period between the day after the resident dies or leaves the approved provider's service and the date the accommodation bond balance is refunded OR the end of the legislated timeframe for refund of the accommodation bond balance, whichever comes first
- at the maximum permissible interest rate (MPIR) between the end of the legislated timeframe for refund of the accommodation bond balance and the date the accommodation bond balance is actually repaid
- at the MPIR for entry contributions refunded from the day after the refund date (in accordance with the formal agreement) or 1 July 2006, whichever occurs later, and ending on the day the entry contribution is refunded.

Base interest

Interest is not payable for the day a resident leaves a service, but for each day after the resident has departed the service until the accommodation bond balance is actually refunded or the legislated timeframe expires, whichever is earlier. The base interest rate (BIR) used in calculating interest is the BIR applicable on the day after the resident's departure.

The base interest payable is calculated by:

- dividing the number of days for which interest is payable by 365 days and multiplying the result by the accommodation bond balance and the applicable BIR.

Maximum permissible interest rate

The rate of maximum applicable interest rate (MPIR) used in calculating interest is the MPIR applicable on the day after the end of the legislated timeframe for the refund of the accommodation bond. The interest rate remains fixed at this rate until the accommodation bond is refunded.

The MPIR payable is calculated by:

- dividing the number of days for which interest is payable by 365 days and multiplying the result by the accommodation bond balance and the applicable MPIR.

Period during which interest accrues and how to calculate interest

The accommodation bond balance has been refunded:

- when the approved provider deposits the money in the resident's account
- on the day the approved provider sends a cheque payable to the resident (or their representative), regardless of when the resident actually cashes the cheque
- when the approved provider otherwise makes the funds available to the resident (or their representative).

In the three examples provided below

- If the resident dies after leaving the service and before expiry of the legislated timeframe for the refund of the accommodation bond then the approved provider will accrue interest at the BIR if it chooses to await presentation of evidence of probate or letters of administration before refunding the bond (though it may choose to refund the bond without such evidence).
- If the resident dies after expiry of the legislated timeframe for the refund of the accommodation bond and the approved provider has not refunded the accommodation bond within that timeframe then the approved provider is required to pay interest at the rate of MPIR for the period from the day after expiry of the legislated timeframe until the refund is made.

Accrual of interest—resident gives approved provider more than 14 days notice of moving to another service (applicable since 1 July 2006)

If the resident gives more than 14 days notice, then the accommodation bond balance is due to be refunded on the day that the resident leaves the service. If the approved provider refunds the accommodation bond balance on the day the resident leaves the service then they will not have to pay any interest. If the approved provider does not refund the accommodation bond balance by the time the resident leaves the service, then the approved provider must pay the interest calculated at the MPIR for the period starting the day after the resident leaves the service and ending on the day the accommodation bond balance is actually refunded.

EXAMPLE

On 1 July 2006 John told Scott's Hostel that he would move to Andy's Hostel on 16 July 2006. He moves on July 16. If Scott's Hostel gave the accommodation bond balance to John on:

- 16 July 2006, then no interest would be payable.
- 25 July 2006, then MPIR is payable for the period 17–25 July 2006—ie, from the day after John left the service and the accommodation bond balance should have been refunded until the accommodation bond balance is refunded.

Accrual of interest—resident gives less than 14 days notice of moving to another service (applicable since 1 July 2006)

If the resident provides notice within 14 days before leaving the service, then the accommodation bond balance must be refunded within 14 days **after** the day on which notice was given. If the accommodation bond balance is refunded within 14 days, then BIR is payable from the day after the resident leaves the service until the end of 14 days after the resident provided notice; or until the accommodation bond balance is paid.

If the approved provider does not refund the accommodation bond balance within 14 days of when the notice was given, then the approved provider must pay the MPIR for the period commencing on the day after 14 days' notice was given and ending on the day the accommodation bond balance is actually refunded.

EXAMPLE

On 10 July 2006, Fred told Georgie's Hostel that he was moving to Sunset Hostel on 15 July 2006. He moves on 15 July 2006. If Georgie's Hostel gave the accommodation bond balance to Fred on:

- 15 July 2006, then no interest is payable
- 18 July 2006, then BIR is payable for 3 days
- 28 July 2006, then BIR is payable for the period 16–24 July 2006. MPIR is payable for the period 25–28 July 2006.

Accrual of interest—resident leaves service to move to another service without giving any notice (applicable since 1 July 2006)

The accommodation bond balance must be refunded within 14 days of the day after the resident leaves the service. If the accommodation bond balance is refunded within the 14 days, then the approved provider pays BIR for the period commencing the day after the resident left the service and finishing on the day the approved provider actually refunded the accommodation bond balance. If the approved provider does not refund the accommodation bond balance within the 14 day period, then the approved provider pays BIR for the period from the day after the resident left the service to the expiration of 14 days; and MPIR for the period commencing on the day after the accommodation bond balance should have been refunded and finishing on the day the accommodation bond balance is actually refunded.

EXAMPLE

Bob left Rosie's Hostel on 10 July 2006 to move to another service and did not provide any notice. If the accommodation bond balance was refunded on:

- 15 July 2006 then BIR is payable from 11 July 2006 until the accommodation bond balance was actually refunded on 15 July 2006
- 28 July 2006 then BIR is payable for the period 11–24 July 2006; and MPIR is payable for the period 25–28 July 2006.

Accrual of interest—resident dies (applicable since 1 July 2006)

BIR begins to accrue from the day after the day on which the resident dies. If the approved provider refunds the accommodation bond balance before the end of 14 days after the approved provider has been shown probate or letters of administration, then the approved provider pays BIR for the period commencing on the day after the resident died and finishing on the day the accommodation bond balance is actually refunded. No MPIR is payable because the approved provider has refunded the accommodation bond balance within the legislated timeframe.

LEGISLATIVE REFERENCES

If the approved provider does not refund the accommodation bond balance within 14 days after being shown probate or letters of administration, then the approved provider must pay:

- BIR for the period from the day after the resident died to the end of 14 days after being shown probate or letters of administration
- MPIR for the period commencing on the day after the accommodation bond balance should have been refunded and finishing on the day the accommodation bond balance is actually refunded.

An approved provider can also decide to refund an accommodation bond balance before being shown probate or letters of administration.

EXAMPLE

Paula died on 5 July 2006 and probate was shown to the approved provider on 20 August 2006. The accommodation bond balance was due to be refunded by 3 September, 2006, 14 days after probate was shown.

- If the approved provider refunds the accommodation bond balance on 2 September 2006 then BIR is payable for the period 6 July–2 September 2006.
- If the approved provider refunds the accommodation bond balance on 10 September 2006, BIR is payable for the period 6 July–3 September 2006; and MPIR is payable 4–10 September 2006.

Resident paid entry contribution for entry into hostel before 1 October 1997 under formal agreement

Under this arrangement, entry contributions must be refunded by the timeframe detailed in the formal agreement. If the entry contribution is not refunded by this time, then the approved provider pays MPIR from the day after the entry contribution was required to be refunded under the formal agreement, until the day the entry contribution is actually refunded. *See legislative reference.*

23.80C, 23.80D, User Rights Principles 1997

If the formal agreement required the entry contribution to be refunded prior to 1 July 2006 and it was not, the approved provider must pay MPIR for the time between 1 July 2006 and the date the entry contribution is actually refunded. *See legislative reference.*

23.80C, 23.80D, User Rights Principles 1997

Exception! If the approved provider is awaiting probate or letters of administration prior to refunding the entry contribution, interest is not payable for the period during which the approved provider is awaiting probate or letters of administration.

Record keeping requirements in relation to interest

Certain information about interest payments must be entered on the bond register. This includes information about BIR and MPIR paid to the resident. See The Records Standard—bond register on page 200.

Pre-allocation lump sums of new approved providers

From 1 January 2009, where a person who does not already have allocated residential care places for a particular aged care service receives an allocation of residential care places, either by transfer or allocation of new places for that facility,

LEGISLATIVE REFERENCES

they may be required under the conditions of allocation of those places to refund any pre-allocation lump sums taken from existing residents.

A pre-allocation lump sum:

- does not accrue daily
- is for the care recipient's entry to a residential care service or flexible care service run by the pre-allocation lump sum holder
- is not an accommodation bond, as was not paid to an approved provider
- is not an entry contribution, as it is was not paid prior to 1 October 1997 for entry to a hostel
- is not an unregulated lump sum as it was not paid to an approved provider before 1 January 2009 or fails to meet the other criteria in subsection 6(3) of the *Aged Care (Bond Security) Act 2006* for unregulated lump sums. *See legislative reference.*

s 6(3), Aged Care (Bond Security) Act 2006

Once the pre-allocation lump sum has been refunded, the approved provider may then ask the care recipient to pay an accommodation bond or accommodation charge as if the resident had entered care on the day that the approved provider's allocation took effect and on terms that cannot be less advantageous to the resident than the previous agreement. *See legislative reference.* This will ensure that the existing care recipients receive the same protections for their payments as new care recipients under the Act and the Guarantee Scheme. See Accommodation Bond Guarantee Scheme on page 208.

s14-5 (5), Aged Care Act 1997

Pre-allocation lump sum paid to organisation not yet approved as a provider

Where an allocation or transfer of places results in an aged care service becoming eligible to receive Government funding then the Secretary may determine conditions of allocation for these places, which can include:

- the treatment of pre-allocation lump sums by an approved provider, including its refund or forgiveness within certain timeframes, with the consent of the care recipient
- the conditions and entry into force of any accommodation bond agreement entered into once the pre-allocation lump sum has been refunded

Protection of unregulated lump sums held by existing approved providers

Some approved providers hold lump sums which are not accommodation bonds because the payment was made before the approved provider became an approved provider.

s 6(3), Aged Care (Bond Security) Act 2006

See legislative reference. If the person to whom the payments were made was an approved provider immediately before 1 January 2009, these unregulated lump sums are protected by the Guarantee Scheme. The aim of this was to ensure that residents in similar circumstances receive similar protections.

From 1 January 2009, requirements for the refund of pre-allocation lump sums prevent the flow of new unregulated lump sums into the Government-subsidised aged care sector.

PROTECTION AND RESPONSIBILITIES RELATING TO ACCOMMODATION BONDS

LEGISLATIVE REFERENCES

THE THREE PRUDENTIAL STANDARDS

All providers holding accommodation bonds or pre-1997 entry contributions are required to comply with three prudential standards:

- the Liquidity Standard
- the Records Standard
- the Disclosure Standard. *See legislative reference.*

ss 57-3 and 57-4, Aged Care Act 1997, Division 3, User Rights Principles 1997

Approved providers must report to the Secretary annually on their compliance with the prudential standards within 4 months of the end of their financial year—ie, approved providers operating on a standard financial year of 1 July to 30 June must report on compliance by the end of October each year.

Under these arrangements, approved providers are responsible for the financial management of their business and meeting their regulatory responsibilities. The aim of the prudential arrangements is to reduce the risk of default on the refund of accommodation bond balances.

THE LIQUIDITY STANDARD

Division 3, 3.2 User Rights Principles 1997

See legislative reference. The aim of the Liquidity Standard is to ensure that approved providers have access to sufficient, readily available funds so that they can refund accommodation bond balances as they fall due over the coming 12 months.

The Liquidity Standard requires approved providers to develop, implement and adhere to a Liquidity Management Strategy (LMS). The purpose of the LMS is to apply a systematic approach and a level of rigour to determining the level of funding that will be required to meet expected accommodation bond balance refunds as they fall due. A LMS should include a nominated minimum level of liquidity.

In assessing their funding needs to ensure that they can refund accommodation bond balances as they fall due, approved providers must:

- have sources of funding that can be accessed quickly—ie, access to liquid funding. While cash has a high level of liquidity, bank and term deposits and lines of credit are also considered liquid
- be mindful of expected accommodation bond payments received from new residents. The minimum level of funding which approved providers may need ready access to, may be the difference between expected accommodation bond refunds and expected accommodation bond payments.

Approved providers are required as part of their annual prudential compliance statement to confirm that the approved provider has, during the financial year, complied with the Liquidity Standard. The approved provider's independent auditor is required to provide an opinion on whether the approved provider has complied with all prudential requirements including the Liquidity Standard in the relevant financial year.

Requirements of the Liquidity Standard

Any approved provider who holds at least one accommodation bond balance (including entry contributions) during the financial year must comply with the Liquidity Standard, which requires approved providers to:

- maintain sufficient liquidity to ensure that they can refund accommodation bond balances (including entry contributions) as they fall due in the following 12 months

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- implement and maintain a written LMS, which identifies
  - the minimum level of liquidity—the amount required to ensure that the approved provider has enough liquidity to refund accommodation bond balances (including entry contributions) as they fall due
  - the factors an approved provider considered in determining the minimum level of liquidity
  - form/s in which the approved provider will maintain the minimum level of liquidity.

The approved provider must then:

- maintain the minimum level of liquidity in the form specified in the LMS to ensure that the LMS is up-to-date
- and ensure that it complies with the requirements of the Liquidity Standard. An approved provider must modify or replace its LMS if it no longer meets the requirements of the Liquidity Standard.

s 23.37(2), User Rights Principles 1997

At any point in time, an approved provider must meet the requirements of the Liquidity Standard *See legislative reference.* The provider must maintain the minimum level of liquidity identified in the LMS necessary to meet refunds over the following 12 months. *See legislative reference.*

s 23.36, User Rights Principles 1997

Determining the minimum level of liquidity

Each approved provider should identify and assess the factors used in determining its minimum level of liquidity, based on their individual circumstances and experiences. While some factors might be common to many approved providers, their relative importance can differ for individual approved providers. Factors that approved providers could consider in determining their minimum level of liquidity include:

- cash requirements for operating and capital expenditure
- their historical pattern of accommodation bond balance refunds
- characteristics of the residents in their care, such as Aged Care Funding Instrument (ACFI) categories, ages, genders and length of time spent in care, which can affect the timing of accommodation bond balance refunds
- the average value of accommodation bond balances held
- the average time taken to replace departing residents
- the expected number and amount of accommodation bonds that will be paid by new residents
- the time taken for new residents to make accommodation bond payments.

An approved provider should consider a range of different approaches in assessing their liquidity requirements, to determine the most appropriate approach for their circumstances. Possible approaches that approved providers could consider include the following:

- in some cases, the minimum level of funding which is readily accessible may be the difference between the expected accommodation bond balance refunds and the expected accommodation bond payments over the next 12 months
- the need to refund several of its largest accommodation bond in the next 12 months

- for its minimum level of liquidity, an approved provider could use the likely value of accommodation bond balance refunds that will be required over the coming 12 months, by identifying residents who are likely to leave the service in the coming 12 months; and the size of their accommodation bonds. For example, an approved provider could decide to maintain as its minimum level of liquidity the total value of accommodation bonds held on behalf of residents with a greater than 50 per cent likelihood of leaving, less expected accommodation bond payments from new residents. This may be appropriate for approved providers that have a significant proportion of residents with characteristics, such as age or Aged Care Funding Instrument (ACFI) category, which may mean they are more likely to leave the service over the coming 12 months.

An approved provider can also maintain a prudent margin to provide a buffer against unexpected developments. A prudent margin could be incorporated into the minimum level of liquidity in various ways. For example, approved providers may choose to adopt conservative estimates for key parameters or include an explicit additional buffer to their level of liquidity. Factors that could be considered include conservative assumptions for:

- the average size of accommodation bonds expected to be received from new residents in the region given market conditions
- the rate of replacement of exiting residents.

Identifying forms in which the minimum level of liquidity is maintained

To ensure that an approved provider can refund accommodation bond balances as they fall due, it is important that the minimum level of liquidity for an approved provider is maintained in readily accessible forms.

It is the responsibility of the approved provider to determine the appropriate form/s in which their minimum level of liquidity will be maintained. Many financial instruments have a high level of liquidity, including:

- cash
- bank bills
- stand-by lines of credit
- guarantees.

In considering the form/s in which they hold their minimum level of liquidity, approved providers may also wish to consider cost issues. The cost to approved providers could be considered in terms of both the actual cost of accessing the funds (that is the actual cost of the transaction) and the economic cost (the difference between the purchase price and the price realised on disposal). For example, liquid instruments such as cash and financial products like term deposits have relatively low costs as the fee for accessing them is not significant and they can be redeemed at their face value.

Review of Liquidity Management Strategy

The Liquidity Management Standard (LMS) requires approved providers to:

- ensure that the LMS remains up-to-date and complies with the requirements of the Liquidity Standard
- modify or replace the LMS if it no longer complies with the requirements of the Liquidity Standard.

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Approved providers should review the LMS at least annually. This review should include an assessment of whether the factors used to determine the minimum level of liquidity are still appropriate. Approved providers should consider:

- whether changes in services they operate or the profile of their residents require variations to the factors included in the LMS
- whether parameters or assumptions such as the size of accommodation bonds received from new residents should be adjusted
- whether to include events in the LMS that would trigger a review outside of an annual review cycle. These events may increase the risk that they would not have the liquidity to meet accommodation bond balance refunds over the coming 12 months. They include:
  - the acquisition or divestment of residential services
  - a significant change in the allocated places within a residential service
  - a significant change in the profile of residents
  - a significant change in the size of accommodation bonds received
  - changes in legislative requirements
  - changes in the corporate structure of the approved provider.

Other issues

The approach to documenting the LMS is a matter for individual approved providers. In determining their approach, approved providers should consider:

- that they must be able to demonstrate their compliance with the Liquidity Standard to their auditor
- and that the Department might ask to see the LMS for monitoring and compliance purposes.

See Monitoring compliance of the prudential requirements on page 206.

Division 3, subdivision 3.3, User Rights Principles 1997

THE RECORDS STANDARD—BOND REGISTER

See legislative reference. The Records Standard is designed to ensure that accurate, comprehensive and up-to-date information on accommodation bond holdings (including entry contributions) is collected and maintained.

An accurate record of accommodation bonds will help approved providers to refund accommodation bond balances quickly once a resident leaves a service. It will also enable the Department to accurately assess the amount owed to residents, if an approved provider becomes bankrupt or insolvent and fails to refund outstanding bonds to the residents. (This would trigger the Guarantee Scheme, under which the Australian Government refunds accommodation bond balances to residents.)

Under the Records Standard, all approved providers holding accommodation bonds must establish and maintain a bond register.

- The bond register may be maintained at a service level or at approved provider level. However, for the annual prudential compliance statement, approved providers must report at approved provider level, referring to the name and number of services covered by the statement.
  - If a resident has paid partly by lump sum and partly by periodic payments, an entry on the bond register, including all of the information detailed

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below, must be made for the lump sum component of the accommodation bond. An approved provider might also voluntarily include additional information in the bond register about the periodic payments.

- The bond register may be kept in hard copy or electronic form. The bond register will contain personal information that should be protected by the approved provider. *See legislative reference.*

Division 86, Aged Care Act 1997, Privacy Act 1988

- Historical bond register entries should be kept for a minimum of 3 years, after the 30 June of the year in which the record was made, as should other records detailed in Division 88 of the Act and in the Records Principles 1997.

Information included in the bond register

Resident details including resident ID number and resident name must be recorded and kept for each resident. An approved provider can include additional information in this part of the bond register. For example, they might want to include a resident's RCS/ACFI category. They should also include the information below:

- accommodation bond details
- the date the resident entered the service
- if a resident is transferring from another service, the date the resident entered the original aged care service. This information is useful so that the current approved provider knows the period over which retention amounts may continue to be drawn. If a resident has moved a number of times, approved providers may wish to record any other relevant details that will enable them to determine when retention amounts should cease being drawn
- the date the accommodation bond was paid by the resident. If a resident pays an accommodation bond in more than one instalment, each date must be entered
- the amount of accommodation bond paid by the resident. If an accommodation bond has been paid in more than one instalment this figure must reflect the amount of each instalment and the total paid.

Deductions

The bond register should include the following information about deductions:

- the amount of accommodation bond balance as at 1 July 2006 (for accommodation bond balances held prior to 1 July 2006)
- the date, amount and reason for each deduction taken from an accommodation bond balance (from 1 July 2006). The type of deduction may be interest on an unpaid accommodation bond, extra services drawn from accommodation bond, fees that the resident has agreed should be paid from the accommodation bond, retention amounts, or any other deduction authorised under the Act.
- the accommodation bond balance at the end of each calendar month. An approved provider should update the bond register on a monthly basis. During any month there may be one or more deductions and these deductions may have been made on one or more dates. One of the purposes of the bond register is to ensure that all approved providers retain a record of the details of all deductions made (date, amount and type of deduction) from 1 July 2006.

Refund of accommodation bond

The bond register should include the following information about the refund of an accommodation bond:

- date of refund event and other relevant dates including
  - the date the resident died and the date probate or letters of administration were shown to the approved provider
  - or the date the resident left the service, and if notice was provided, the date the notice was provided
  - or the date the service ceased to be certified.
- date the accommodation bond is due to be refunded in accordance with the requirements under Subdivision 57-G of the Act
- date the accommodation bond was actually refunded
- amount of accommodation bond refunded
- have interest paid and the date paid
- maximum permissible interest paid and the date paid.

The refund event is the initial trigger for determining when the accommodation bond refund is due. The refund event may be the death of the resident or the departure of the resident from the service. The date that the resident left the service should be the date on which the resident was formally discharged from the service. Residents may enter hospital on hospital leave and then transfer to another service without returning to the original service, but the date to be recorded will be the date that the resident was discharged, not the date they went on leave.

Entry contributions

The bond register should include the following information about entry contributions:

- resident details including the resident's name and resident ID number
- the date the entry contribution was paid
- the amount of the original entry contribution
- the date the resident left the facility
- the date the entry contribution is due to be repaid in accordance with the formal agreement
- the date the entry contribution was refunded
- the amount of entry contribution balance refunded
- maximum permissible interest paid and the date paid.

Additional information

An approved provider can also keep other information in the bond register to assist with record-keeping. For example, approved providers can include information on periodic payments of accommodation bonds and accommodation charges or information that is needed for completing the Department's annual survey of aged care services.

PROTECTION AND RESPONSIBILITIES RELATING TO ACCOMMODATION BONDS

LEGISLATIVE REFERENCES

Division 3, Subdivision 3.4 User Rights Principles 1997

THE DISCLOSURE STANDARD

See legislative reference. The Disclosure Standard requires approved providers holding accommodation bonds (including entry contributions) to give the Secretary, residents, prospective residents and their representatives information on their compliance with the Liquidity and Records Standards; and information on their financial standing.

Disclosure to residents

There are three requirements for information that must be provided to residents (or their representatives) by approved providers.

Copy of accommodation bond agreement and guarantee

Within 7 days of an accommodation bond agreement being entered into, approved providers must provide the resident or their representative with a copy of the accommodation bond agreement and a copy of the written guarantee of the refund of the accommodation bond balance.

Routine provision of information at the end of the financial year

Within 4 months after the end of the approved provider's financial year, approved providers are required to provide residents who have paid an accommodation bond or an entry contribution with the following information:

- the number of accommodation bond balances that were not refunded within the statutory timeframe in the previous financial year; or for entry contributions, in accordance with a formal agreement
- a statement about whether the provider complied with the prudential standards in the financial year
- a copy of the audit opinion on whether the provider has complied with the prudential standards in the financial year
- a copy of the resident's entry in the bond register, as at the end of the financial year (assuming that the resident had paid an accommodation bond prior to the end of the financial year).

Provision of information on request at any other time

If a resident who has paid an accommodation bond or entry contribution requests the following information, an approved provider must provide it within 7 days:

- the resident's entry in the bond register, as at the time of the request
- and either the most recent statement of the aged care service's audited financial statements
- or the most recent statement of the audited financial statements of the organisation's aged care component, if the service is operated by a parent organisation
- if the approved provider is in receipt of the Conditional Adjustment Payment, the statement of accounts provided to the resident could be the audited general purpose financial statements for the previous financial year.

LEGISLATIVE REFERENCES

Keeping records of disclosures to residents

Approved providers must demonstrate their compliance with the Disclosure Standard on an annual basis, as part of their Annual Prudential Compliance Statement (APCS). To do this, and to provide evidence of compliance to auditors or the Secretary, approved providers need to keep records of the following types of information:

- number of requests made
- whether the information was provided within 7 days.

An approved provider may want to specify that information requests be made in writing. If a request is made in writing, an approved provider should keep a copy of it. If the request is not in writing, an approved provider may wish to make a note of the date the request was made, the type of information requested and the date the information was provided.

Disclosure to prospective residents

A prospective resident is a person approved as a recipient of residential care and who is considering receiving residential care through that service. In the case of residential aged care services, a prospective resident is someone who is approved by an Aged Care Assessment Team (ACAT or ACAS in Victoria). An approved provider might want to confirm that somebody is a prospective resident if that person requests information. *See legislative reference.*

s 23.43 User Rights Principles 1997

Prospective residents (or their representatives) can request the following:

- a statement detailing the number of accommodation bond balances not refunded within the statutory timeframe and the number of entry contribution balances that were not refunded in accordance with the relevant formal agreement in the previous financial year
- a statement detailing whether the approved provider complied with the prudential standards in the previous financial year
- a copy of the audit opinion on whether the approved provider complied with the prudential standards in the preceding financial year
- the most recent statement of the approved provider's audited accounts or the accounts of the organisation's aged care component, if the service is operated by a parent organisation.

If a prospective resident or their representative requests any of the above information then the approved provider must give the information to the prospective resident within 7 days of the request. This does not limit the information that an approved provider may voluntarily choose to give a prospective resident.

As detailed in the previous section, approved providers will be required to attest to their compliance with the Disclosure Standard on an annual basis, as part of their APCS. Approved providers will therefore need to keep records in order to be able to demonstrate their compliance with the requirement to provide information to prospective residents.

Disclosure to the Secretary of the Department

The APCS will require certain disclosures to be made regarding the approved provider's prudential compliance.

Annual disclosure requirements

The Department will issue an annual prudential compliance statement (APCS) to approved providers at the end of the approved provider's financial year requiring them to provide the following information.

Information about accommodation bonds held:

- total number of accommodation bond balances (including entry contributions) held by the approved provider as at the end of the approved provider's financial year
- total value of accommodation bond balances (including entry contributions) held by the approved provider as at the end of the approved provider's financial year
- whether there was any period during the year when the approved provider was not entitled to charge accommodation bonds.

Information about compliance with accommodation bond agreement and written guarantee requirements:

- whether an accommodation bond agreement was entered into with all residents who paid an accommodation bond during the year and whether the agreements were in accordance with the legislation
- whether each resident who paid a accommodation bond during the year was provided with a written guarantee of the refund of the accommodation bond balance and a copy of the accommodation bond agreement.

Information about the repayment of accommodation bond balances:

- whether any accommodation bond balances or entry contributions were required to be refunded
- whether all accommodation bond balances (including entry contributions) that were required to be repaid were repaid within the legislated timeframes (or in the case of entry contributions, refunded within the time required by the formal agreement). If not, approved providers will be required to provide details of accommodation bonds not paid within required timeframe and the reason for delay.

Information about compliance with the prudential standards:

- whether the approved provider has complied with each of the prudential standards during the financial year and if not how many times and the reasons for this.

Approved provider declaration:

- including all the statements and information required by the form, approved provider details and the signature of one of the approved provider's key personnel who is authorised by the approved provider to sign the statement.

Audit opinion

The APCS must be supported by an independent audit opinion from an independent auditor. The audit must be undertaken by a registered company auditor within the meaning of the *Corporations Act 2001* or a person approved by the Secretary. *See legislative reference.* See References at the end of this chapter for a link to ComLaw for the Corporations Act.

s 21.26F(6), Residential Care Subsidy Principles 1997

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The Secretary will only approve an alternative auditor if the Secretary is satisfied that the person has appropriate qualifications and experience.

The independent audit must include an audit opinion on whether the provider has complied with the prudential standards and other prudential requirements in the financial year.

MONITORING COMPLIANCE OF THE PRUDENTIAL REQUIREMENTS

The Department is responsible for monitoring compliance with the prudential requirements; and the Department's principal focus in this area is on working with approved providers to assist them to comply with the prudential requirements. However, in some instances, the Department may need to take compliance action—including imposing sanctions.

Responsibilities of approved providers

All approved providers who hold accommodation bonds must ensure that they comply with the prudential requirements. Approved providers must implement and maintain appropriate systems and processes to meet the legislative requirements and also to demonstrate compliance.

If an approved provider is having difficulties complying, or has any queries regarding the requirements, they can seek further advice from their professional advisors, from their peak body or from their auditor. The Department can help approved providers understand their regulatory obligations, but it is the provider's responsibility to determine the most appropriate way to meet the requirements. See References at the end of this chapter for the Department's prudential email address.

Mechanisms used to monitor compliance

Possible compliance issues may be identified via information:

- obtained through the APCS
- obtained from an approved provider—this may be through a formal request for information, for example under section 9-2, 9-3 or 9-3A of the Act *See legislative reference.*
- from the Aged Care Standards and Accreditation Agency
- from the Aged Care Complaints Investigation Scheme
- obtained from other reporting by approved providers or the public.

ss 9-2, 9-3 and 9-3A, Aged Care Act 1997

Annual Prudential Compliance Statements (APCS)

A key element of monitoring the compliance of approved providers is through the requirement for approved providers to lodge an audited APCS. This requirement ensures that an approved provider's compliance is scrutinised by an independent party (an auditor). Failing to lodge the APCS, or to obtain the opinion of a registered company auditor (or a person approved by the Secretary), will provide the Department with an initial indication of potential compliance concerns.

Information obtained from an approved provider

The Secretary can ask the approved provider for information on issues relating to its financial management. For example, the Secretary can ask for further information on an approved provider's bond register or liquidity management strategy. Such a request can be part of routine monitoring by the Department or may be in response to more specific events such as complaints from residents or information from the Aged Care Standards and Accreditation Agency.

Aged Care Standards and Accreditation Agency

The Aged Care Standards and Accreditation Agency has general responsibility for checking that approved providers have systems in place to ensure their compliance with prudential obligations under the Act. The Agency can check if providers have these systems in place, and for documents such as a liquidity management strategy, but the Agency is not responsible for assessing their appropriateness. The Agency may become aware of possible prudential compliance issues through its auditing arrangements. See References at the end of this chapter for Agency contact information.

Aged Care Complaints Investigation Scheme

The Aged Care Complaints Investigation Scheme (the Scheme) investigates complaints and concerns about Australian Government-subsidised aged care including residential and community care. Concerns about compliance with the requirements for accommodation bonds may be reported to the Scheme and will then be investigated by the Department in accordance with the rules governing the Scheme. See References at the end of this chapter for Scheme contact information.

Other reporting by approved providers or the public

The Department may receive information about potential compliance issues from approved sources such as other approved providers and concerned members of the public.

This information would be compared to information received through other mechanisms and may also be followed up or verified with the approved provider concerned.

Actions the Department can take in the event of non-compliance

In the area of prudential regulation, the primary objective of Department is to work with the aged care industry to promote compliance with the prudential requirements. In line with this objective, the Secretary will consider taking compliance action if the Secretary, or delegate, is concerned about the security of accommodation bonds or the actions of an approved provider.

Any compliance action considered by the Secretary will be influenced by:

- the level of risk posed by the non-compliance in terms of the security of residents' accommodation bonds and entry contributions
- whether the non-compliance involved failure to refund an accommodation bond balance within the required timeframe

LEGISLATIVE REFERENCES

- the extent and frequency of non-compliant behaviour by the approved provider in relation to prudential requirements
- and whether the approved provider failed to remedy the non-compliance after it was brought to the approved provider's attention.

The Department may respond in one of the following ways:

No action

If alleged non-compliance is unsubstantiated, no further action will be taken although the Department/Agency may continue to monitor the provider.

Education

If an approved provider's non-compliance was unintentional and based on a mis-understanding of the requirements, the Department may work with the approved provider to help put in place systems to enable it to comply.

Issue a non-compliance notice

s 67-2, Aged Care Act 1997

Following assessment and possible investigation by the Department, a notice of non-compliance may be issued. *See legislative reference.* The notice of non-compliance will ask the approved provider to submit details about what it has done or intends to do to remedy the non-compliance.

Impose sanctions

If the approved provider's response to a notice of non-compliance is not satisfactory, this may result in further compliance action including the imposition of sanctions. The Secretary could impose any of the following sanctions:

- prohibiting the charging of accommodation bonds
- restricting funding to existing residents
- revoking or suspending the existing allocation of places
- revoking or suspending the provider's approval as a provider of aged care services
- varying the conditions of approval for allocated places
- prohibiting any further allocation of places.

ACCOMMODATION BOND GUARANTEE SCHEME

Aged Care (Bond Security) Act 2006 (the Bond Security Act)

In addition to prudential requirements placed on approved providers and the regulation of these requirements by the Secretary, further protection of accommodation bonds is provided by the Bond Security Act.

The Bond Security Act establishes a scheme to guarantee the repayment of aged care residents' accommodation bond balances if an approved provider is bankrupt or insolvent and cannot refund accommodation bonds.

The Bond Security Act enables the Australian Government to pay to a person an amount equal to the accommodation bond balance owed to them by an approved provider. In exchange for the payment, the Bond Security Act provides that any rights that a person had to recover the amount from an approved provider are transferred to the Commonwealth.

PROTECTION AND RESPONSIBILITIES RELATING TO ACCOMMODATION BONDS

The Bond Security Act does not create any day-to-day obligations with which approved providers must comply. Approved providers should be aware that if they become bankrupt or insolvent they must immediately notify the Department. Penalties may be imposed for non-compliance. See References at the end of this chapter for a link to ComLaw for the Bond Security Act.

Aged Care (Bond Security) Levy Act 2006 (the Bond Levy Act)

This Bond Levy Act operates in conjunction with the Bond Security Act and enables levies to be imposed on approved providers to recover any costs to the Australian Government from repaying accommodation bond balances to residents.

Approved providers would only be liable to pay a levy if there is a default on refunding accommodation bonds by an approved provider and the Minister imposes a levy to recover costs—for example, if costs cannot be recovered from the defaulting provider. If this happens, the Department will notify all approved providers.

Like the Bond Security Act, the Levy Act imposes no daily obligations on approved providers. See References at the end of this chapter for a link to ComLaw for the Bond Levy Act.

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN THIS CHAPTER

Aged Care Complaints Investigation Scheme

Ph 1800 550 552

The line is open Monday–Friday, 8:30am–5pm; Saturday, Sunday and public holidays, 10am–5pm. Outside these hours, people can leave a message.

People can also write to the Scheme at:

Department of Health and Ageing
GPO Box 9848
In your Capital City

An online complaints investigation form is available at:
www.health.gov.au/internet/main/publishing.nsf/content/ageing-complaints-index.htm

If a person is not satisfied with how their complaint has been handled, they can take their concerns to the Departmental manager responsible for the Scheme in their state or territory, by calling the Scheme freecall number above.

Aged Care Information Line

Ph 1800 500 853

Aged Care Standards and Accreditation Agency

www.accreditation.org.au

Forms—all

All Departmental forms are available on the Department's website at
www.health.gov.au/internet/main/publishing.nsf/Content/health-forms.htm

PROTECTION AND RESPONSIBILITIES RELATING TO ACCOMMODATION BONDS

Interest rates—current

BIR and MPIR—current and previous; rates are updated quarterly
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-finance-refundrates.htm

Legislation—other

Go to ComLaw to access other legislation mentioned in this chapter, including the *Corporations Act 2001*, the *Privacy Act 1988*, the *Aged Care (Bond Security) Act 2006* and the *Aged Care (Bond Security) Levy Act 2006*.
www.comlaw.gov.au

Prudential regulation—enquiries

Email: prudential@health.gov.au

SPECIFIED CARE AND SERVICES

SPECIFIED CARE AND SERVICES

This Manual has been written in plain English and as a result, some aspects of the legislation and policy have been simplified. It is intended to be a general guide only and does not constitute legal advice. In cases of discrepancy between the Manual and the legislation, the legislation will be the source document for payment of Australian Government benefits and enforcement of approved provider responsibilities.

RELEVANT LEGISLATION

- Part 4.1, s 54-1(1)(a), *Aged Care Act 1997* (the Act)
- Part 4.2, paragraph 56-1(b); Division 58, paragraph 54-1(1)(a), *Aged Care Act 1997*
- Part 4.4, s65-1, Division 66, Part 4.1, 4.2 or 4.3, s65-2, Division 67, *Aged Care Act 1997*
- *Quality of Care Principles 1997* (the Quality of Care Principles)

OVERVIEW

Approved providers of residential aged care are required to provide a range of care and services to residents, as specified in the Quality of Care Principles, Schedule 1, at no additional cost to residents. The care and services must be provided in a way which meets the needs of the individual resident and also meets the outcomes under the Accreditation Standards.

The resident agreement should clearly state all the care and service that a provider is obliged to provide under the legislation, as well as any additional care or services provided either at no additional cost to the resident or which the resident may have to pay for. Any other matters negotiated with the resident should also be included in the resident agreement. See also section on Resident agreements in chapter on Residents' rights in this Manual.

Providers are not only subsidised by the Government, but residents may also make a significant contribution to the cost of their care and are therefore entitled to receive the care and services they require.

While some of the items listed in Schedule 1 to the Quality of Care Principles are non-specific, the intent of the legislation must be remembered—**that is, to ensure that residents receive the care and services they require, taking into account their individual needs.**

For example, a mattress must be provided for all residents irrespective of whether the resident is high care or low care. In providing a mattress the provider must ensure that the mattress meets the assessed care needs of the resident, whether that is compromised skin integrity, falls prevention or another matter.

If a provider makes this commitment to residents in the quality of care and services provided, then the requirements under the Accreditation Standards, set out in Schedule 2 to the Quality of Care Principles, may also be addressed. See also chapter on Accreditation and quality of care in this Manual.

If an approved provider does not meet the responsibilities specified in Schedule 1, then compliance action may be taken.

SPECIFIED CARE AND SERVICES

LEGISLATIVE REFERENCES

Approved providers have a responsibility under the Act and the Principles to:

s 54-1 (1) (a), Aged Care Act 1997

- provide the care and services specified in the Quality of Care Principles for the type of aged care required *See legislative reference.*

s 56-1(b), Aged Care Act 1997

- only charge the amount permitted under Division 58 for provision of the care and services the approved provider is responsible for providing *See legislative reference.*

s 56-1(d), Aged Care Act 1997

- to charge no more for any other care or service than an amount agreed beforehand with the resident and to give the resident an itemised account of the other care or services *See legislative reference.*

s 54-1(d), Aged Care Act 1997

- to comply with the Accreditation Standards set out in Schedule 2 to the Quality of Care Principles. *See legislative reference.*

Additional information

This chapter has been updated and revised to help approved providers comply with their responsibilities under the Act; and to assist staff of aged care services understand the regulation of residential aged care. Additional information can also be accessed through the Aged Care Information Line on 1800 500 853.

SCHEDULE 1 SPECIFIED CARE AND SERVICES FOR RESIDENTIAL CARE SERVICES

The three Parts to the Schedule are reproduced in the following tables. The information set out in the third column is intended to assist providers to interpret each Item, and has been developed in response to a wide range of enquiries from providers, residents and their representatives about specified care and services.

However, the list of examples is not exhaustive, as it would be difficult to cover all the care and services that could be provided under each Item. In providing specified care and services, approved providers should bear in mind **that they must meet the individual needs of each resident;** and provide a level of care and services which is in step with current care regimes and practice.

The resident agreement must clearly state all the care and services that will be provided at no additional cost as well as those care and services which the resident has agreed to pay for.

Schedule 1, Part 1, Hotel Services—to be provided for all residents who need them Quality of Care Principles 1997

Part 1, Hotel Services—to be provided for all residents who need them

See legislative reference.

Part 1 refers to the hotel services to be provided for all residents who need them. Aged care services are required to supply these items, unless a resident specifically wishes to bring their own items with them, and this has been agreed on by the provider.

ITEM AND SERVICE	CONTENT	EXAMPLES
Item 1.1 Administration	General operation of the residential care service, including resident documentation.	An approved provider cannot charge a resident for: ▪ registering a resident for a place on a waiting list ▪ preparing a resident agreement ▪ preparing invoices and statements for a resident's care ▪ residents' handbook ▪ informing residents of meetings ▪ administration/booking fees for all residents, except for recipients of residential respite care. See also section on Respite booking fees in chapter on Residential respite care in this Manual. If specified in the resident agreement and **agreed** by the resident/legal representation a resident may be charged for: ▪ storage fees, provided this is stated in resident agreement ▪ television rental ▪ management of resident trust accounts provided ▪ the arrangement is voluntary—ie, residents can handle their finances without placing their money in a trust account with the provider ▪ the provider charges no more than an amount agreed beforehand with the resident ▪ the provider gives the resident an account showing the amount charged.
Item 1.2 Maintenance of all buildings and grounds	Adequately maintaining buildings and grounds.	An approved provider cannot charge a resident for: ▪ gardening ▪ maintenance inside and outside the service ▪ any repairs/replacements necessary because of normal wear and tear. If specified in the resident agreement and **agreed** by the resident/legal representation a resident may be charged for: ▪ repairs and replacements necessary because of deliberate damage.

ITEM AND SERVICE	CONTENT	EXAMPLES
Item 1.3 Accommodation	Utilities such as electricity and water.	An approved provider cannot charge a resident for: ▮ inspection of the provider 's electrical equipment for occupational health and safety purposes ▮ telephone sockets ▮ access to pay telephone ▮ the cost of heating/cooling the service to provide a comfortable environment for residents ▮ moving from one room to another within the service. If specified in the resident agreement and **agreed** by the resident/legal representation a resident may be charged for: ▮ inspection of a resident's electrical equipment for occupational health and safety purposes. However, a resident can choose who performs the inspection—this could be a qualified electrician on behalf of the service, or a qualified electrician of the resident's choice ▮ if a resident has a heating/cooling unit for their own use (in addition to an effective cooling/heating system provided by the service) then the resident may be asked to pay the cost of running the unit. The approved provider must inform the resident beforehand about the policies regarding personal heating/cooling systems. This should be included in the resident agreement or in a variation to the resident agreement ▮ telephone line rental and handset for the resident's personal use and cost of calls made by the resident.
Item 1.4 Furnishings	Bedside lockers, chairs with arms, containers for personal laundry, dining, lounge and recreational furnishings, draw screens (for shared rooms), resident wardrobe space and towel rails. Excludes furnishing a resident chooses to provide.	An approved provider cannot charge a resident for: ▮ a comfortable lounge chair for each resident to meet their care, comfort and safety needs ▮ if a high care resident has been assessed by an appropriate allied health professional or doctor as needing a chair with particular features in order to provide for the safety, care and comfort of the resident, then the approved provider cannot charge the resident for a chair with these features.

ITEM AND SERVICE	CONTENT	EXAMPLES
Item 1.5 Bedding	Beds and mattresses, bed linen, blankets and absorbent or waterproof sheeting.	An approved provider cannot charge a resident for: ▮ beds, pillows and mattresses that meet the assessed care, comfort and safety needs of residents ▮ non-standard beds if required to meet the needs of exceptionally tall or heavy residents.
Item 1.6 Cleaning services, goods and facilities	Cleanliness and tidiness of the entire residential care service. Excludes a resident's personal area if the resident chooses and is able to maintain it himself or herself.	An approved provider cannot charge a resident for: ▮ cleaning each resident's room and ensuite ▮ cleaning of floor covering including carpet ▮ cleaning materials including materials for the use of residents who choose to maintain their own personal area.
Item 1.7 Waste disposal	Safe disposal of organic and inorganic waste material.	This includes: ▮ the safe disposal of sharps and contaminated waste.
Item 1.8 General laundry	Heavy laundry facilities and services, and personal laundry services, including laundering of clothing that can be machine washed. Excludes cleaning of clothing requiring dry cleaning or another special cleaning process, and personal laundry if a resident chooses and is able to do this himself or herself.	An approved provider cannot charge a resident for: ▮ general laundry, including both washing and ironing of clothing that can be machine washed. Aged care services are not obliged to hand-wash residents' clothing. ▮ the service must have in place a system for identification of residents' clothing and laundry items. However, a resident may choose and pay for their own identification system as long as it is at least of an equivalent standard to the service's system—eg, woven name tapes rather than laundry marking pen.
Item 1.9 Toiletry goods	Bath towels, face washers, soap and toilet paper.	An approved provider cannot charge a resident for: ▮ suitable soap, or soap substitute for residents who cannot use soap because of clinical need. If specified in the resident agreement and **agreed** by the resident/legal representation a resident may be charged for: ▮ a resident's personal choice to use alternative items to those provided by the service such as specific brands of soap.

ITEM AND SERVICE	CONTENT	EXAMPLES
Item 1.10 Meals and refreshments	(a) Meals of adequate variety, quality and quantity for each resident, served each day at times generally acceptable to both residents and management, and generally consisting of 3 meals per day plus morning tea, afternoon tea and supper; (b) Special dietary requirements, having regard to either medical need or religious or cultural observance; (c) Food, including fruit of adequate variety, quality and quantity, and non-alcoholic beverages, including fruit juice.	An approved provider cannot charge a resident for: ▮ quality food in accordance with residents' individual nutritional needs. Residents should be consulted about menu planning to ensure that menu choices take into account their preferences ▮ food appropriate to meet medical, cultural and religious needs as well as special dietary requirements, eg vegetarian, kosher, halal, gluten free, low fat and thickened drinks if required by an individual resident ▮ nutritional supplements—for residents who are assessed by an appropriate health professional as needing a special dietary supplement to ensure they receive adequate nourishment and hydration.
Item 1.11 Resident social activities	Programs to encourage residents to take part in social activities that promote and protect their dignity, and to take part in community life outside the residential care service.	Aged care services are expected to consult with residents and/or their representatives in the care, planning and development of activity programs and base the activities offered on the needs, wishes and abilities of residents. While residents may choose not to be involved in social activities, services should discuss the reasons for non-participation with a resident and/or their representative. If specified in the resident agreement and **agreed** by the resident/legal representation a resident may be charged for: ▮ special packaging of medication for residents going on social leave ▮ outing costs—for example, transport costs, entry fees and food. However, many services may choose to pay for these costs. Residents must be advised in advance of any costs.
Item 1.12 Emergency assistance	At least one responsible person is continuously on call and in reasonable proximity to render emergency assistance.	The number of residents and their dependency levels should be considered in deciding the number and qualifications of emergency assistance personnel available.

SPECIFIED CARE AND SERVICES

Part 2, Care and services—to be provided for all residents who need them

See legislative reference.

LEGISLATIVE REFERENCES

Schedule 1, Part 2, Care and services—to be provided for all residents who need them,Quality of Care Principles 1997

ITEM AND SERVICE	CONTENT	EXAMPLES
Item 2.1 Daily living activities assistance	Personal assistance, including individual attention, individual supervision, and physical assistance, with: ▮ (a) bathing, showering, personal hygiene and grooming ▮ (b) maintaining continence or managing incontinence, and using aids and appliances designed to assist continence management ▮ (c) eating and eating aids, and using eating utensils and eating aids (including actual feeding if necessary) ▮ (d) dressing, undressing, and using dressing aids ▮ (e) moving, walking, wheelchair use, and using devices and appliances designed to aid mobility, including the fitting of artificial limbs and other personal mobility aids ▮ (f) communication, including to address difficulties arising from impaired hearing, sight or speech, or lack of common language (including the fitting of sensory communication aids), and checking hearing aid batteries and cleaning spectacles. Excludes hairdressing.	An approved provider cannot charge a resident to ensure that all care needs are assessed and appropriately met. Assistive devises should be available for use by residents who need this equipment so that activities of daily living can be appropriately maintained. Low care residents may be able to access continence aids through the Continence Aids Assistance Scheme. See References at the end of this chapter for a link.

ITEM AND SERVICE	CONTENT	EXAMPLES
Item 2.2 Meals and refreshments	Special diet not normally provided.	Approved providers must provide individual residents with medically prescribed special diets or components of special diets. See also Item 1.10 on page 216. Additional funding is only available for an enteral feeding formula provided enterally. Approved providers can apply to the Department for an enteral feeding supplement, if this is supported by medical certification of the resident's ongoing need. See also section on Enteral feeding supplement in chapter on Funding for permanent residential aged care in this Manual.
Item 2.3 Emotional support	Emotional support to, and supervision of, residents.	An approved provider cannot charge a resident for: ▮ individual support in adjusting to life in the new environment and on an ongoing basis, where needed ▮ support in exercising rights under the Charter of Residents' Rights and Responsibilities ▮ ensuring that residents have access to support through counsellors, appropriate health professionals, chaplains, community visitors and advocacy. If a resident needs professional counselling services, they may be asked to pay the counsellor's fee provided that the amount is agreed beforehand with the resident.

ITEM AND SERVICE	CONTENT	EXAMPLES
Item 2.4 Treatments and procedures	Treatments and procedures that are carried out according to the instructions of a health professional or a person responsible for assessing a resident's personal care needs, including supervision and physical assistance with taking medications, and ordering and reordering medications, subject to requirements of state or territory law.	An appropriately qualified health professional must identify what treatments and procedures a resident requires. The treatments and procedures must be carried out by an appropriately qualified health professional, or undertaken under the supervision of an appropriately qualified health professional as required under state or territory law. An approved provider cannot charge a resident for: ▮ nurses to come in to the service to provide treatment. If the service chooses to employ home and community care (HACC), community or agency nurses then the approved provider pays for this. This includes nurses employed to administer regular injections—for example, insulin injections—or to provide complex wound care. ▮ services must have a system in place for ordering, reordering, safely storing and administering medications. If a packaging system is the chosen medication administration system, then the service must pay for this system and must not charge the resident or arrange for the pharmacist to charge the resident. A resident may be charged for: ▮ the cost of medications and other pharmaceutical items unless these are for a high care resident and are covered by Item 3.7 on page 224 ▮ a different medication administration system to the one used in the service, if a resident chooses to have a different system ▮ for a low care resident, the cost of any dressings or equipment, required for the treatment or procedure. For high level care residents, see Item 3.7 on page 224. The Department provides assistance to aged care services for those residents who have an ongoing need for oxygen treatment irrespective of whether the resident is classified as receiving high or low level care. For more information about assistance for residents with an ongoing need for oxygen treatment, see also section on Oxygen supplement in chapter on Funding for permanent residential aged care in this Manual.

ITEM AND SERVICE	CONTENT	EXAMPLES
Item 2.5 Recreational therapy	Recreational activities suited to residents, participation in the activities, and communal recreational equipment.	This item is considered essential for the general health and wellbeing of residents. Services are expected to consult with residents and/or their representatives as part of the care planning activities so they can provide activities that residents enjoy and include activities that cater to minority interests. While residents may choose not to be involved in social activities, services should discuss the reasons for non-participation with the resident and/or their representative. See also Item 1.11 on page 216. If specified in the resident agreement and **agreed** by the resident/legal representation a resident may be charged for: ▮ outing costs—for example, transport costs, entry fees and food. However, many services choose to pay the costs. Residents must be advised in advance of any costs.
Item 2.6 Rehabilitation support	Individual therapy programs designed by health professionals that are aimed at maintaining or restoring a resident's ability to perform daily tasks for himself or herself, or assisting residents to obtain access to such programs.	An approved provider cannot charge a resident for: ▮ an assessment by an appropriate health professional—for example, a physiotherapist, occupational therapist or nurse practitioner—of the resident's rehabilitation support needs. This may involve a health professional visiting the service to design an appropriate program, or the service making arrangements for the resident to visit the health professional. This should include discussion with residents and/or their representative regarding achievable goals.
Item 2.7 Assistance in obtaining health practitioner services	Arrangements for aural, community health, dental, medical, psychiatric and other health practitioners to visit residents, whether the arrangements are made by residents, relatives or other persons representing the interests of residents, or are made direct with a health practitioner.	Approved providers are required to make arrangements for the listed health practitioners to visit the resident at the service, as appropriate to a resident's needs. Alternatively, they should make arrangements for the resident to visit a health practitioner if the practitioner is not able to visit the service. The provider should assist with arranging transport to and from appointments when necessary.

LEGISLATIVE REFERENCES

ITEM AND SERVICE	CONTENT	EXAMPLES
Item 2.8 Assistance in obtaining access to specialised therapy services	Making arrangements for speech therapy, podiatry, occupational or physiotherapy practitioners to visit residents, whether the arrangements are made by residents, relatives or other persons representing the interests of residents.	Approved providers are required to: ▮ make arrangements for the listed health practitioners to visit the resident at the service, as appropriate to the needs of the resident ▮ assist with the arrangements of transport ▮ arrange for a relative, representative or volunteer to accompany the resident to appointments.
Item 2.9 Support for residents with cognitive impairment	Individual attention and support to residents with cognitive impairment (e.g. dementia, and other behavioural disorders), including individual therapy activities and specific programs designed and carried out to prevent or manage a particular condition or behaviour and to enhance the quality of life and care for such residents and ongoing support (including specific encouragement) to motivate or enable such residents to take part in general activities of the residential care service.	

Schedule 1, Part 3, Care and Services—to be provided for residents receiving a high level of residential care, Quality of Care Principles 1997

Part 3, Care and Services—to be provided for residents receiving a high level of residential care

See legislative reference.

ITEM AND SERVICE	CONTENT	EXAMPLES
Item 3.1 Furnishings	Over-bed tables.	

ITEM AND SERVICE	CONTENT	EXAMPLES
Item 3.2 Bedding materials	Bed rails, incontinence sheets, restrainers, ripple mattresses, sheepskins, tri-pillows, and water and air mattresses appropriate to each resident's condition.	Bedding materials must meet the resident's individual needs as assessed by an appropriate health professional. The service must provide pressure-relieving items of suitable type and quality. An approved provider cannot charge a resident for: ▮ water, air and gel cushions and comfort chairs used for pressure relieving purposes ▮ if a high level care resident is unable to walk or move about independently, and cannot use a conventional arm chair, then the provider should provide the resident with a chair, such as an air, water or gel chair, which meets the residents comfort, safety and care needs.
Item 3.3 Toiletry goods	Sanitary pads, tissues, toothpaste, denture cleaning preparations, shampoo and conditioner, and talcum powder.	
Item 3.4 Goods to assist residents to move themselves	Crutches, quadruped walkers, walking frames, walking sticks, and wheelchairs. Excludes motorised wheelchairs and custom made aids.	An approved provider must provide: ▮ sufficient numbers of the listed equipment, including non-motorised wheelchairs, so that they are available for a resident as required within the aged care service ▮ sufficient wheelchairs appropriate to the needs of high care residents, which take into account pressure care and allow for optimum levels of mobility and participation. The fact that one resident needs full time use of a wheelchair should not deny other residents access or mean that the resident using the chair full-time has to purchase a wheelchair in order to have use of one. If specified in the resident agreement and **agreed** by the resident/legal representation a resident may be charged for: ▮ custom made aids specifically made for a resident and only for the use of that resident—for example, tailor made arm, hand and/or leg splints.

ITEM AND SERVICE	CONTENT	EXAMPLES
Item 3.5 Goods to assist staff to move residents	Mechanical devices for lifting residents, stretchers, and trolleys.	Approved providers must have sufficient lifting devices on hand to provide access for all residents who need this type of support and to ensure occupational health and safety obligations are met. Equipment must be fit for the purpose intended and staff trained in its use. An approved provider cannot charge a resident for: ▮ slings for lifting machines.
Item 3.6 Goods to assist with toileting and incontinence management	Absorbent aids, commode chairs, disposable bed pans and urinal covers, disposable pads, over-toilet chairs, shower chairs and urodome, catheter and urinary drainage appliances, and disposable enemas.	An approved provider cannot charge a resident for: ▮ assessment by an appropriately qualified health professional to ensure that the individual continence needs of a resident are determined and met. If a resident is assessed as requiring continence pads or other equipment to manage their continence and the resident is receiving high level care, then the provider must provide the pads/equipment at no additional cost to the resident. ▮ absorbent sheets ▮ items to meet the needs of all high level care residents in regard to toileting and incontinence. See References at the end of this chapter for a link to the Continence Aids Assistance Scheme. Stoma related products are available free of charge through the Stoma Scheme to residents who are ostomates. See References at the end of this chapter for more information on the Stoma Scheme.

ITEM AND SERVICE	CONTENT	EXAMPLES
Item 3.7 Basic medical and pharmaceutical supplies and equipment	Analgesia, anti-nausea agents, bandages, creams, dressings, laxatives and aperients, mouthwashes, ointments, saline, skin emollients, swabs, and urinary alkalising agents. Excludes any goods prescribed by a health practitioner for a particular resident and used only by the resident.	It is expected that basic medical and pharmaceutical supplies and equipment provided are in accord with current care regimes and practices, and comply with relevant state and territory legislation. Obtaining a doctor's prescription for an over-the-counter item that would normally be provided by the aged care service at no additional cost does not necessarily mean a resident can be charged for this item. If large quantities of a generally available item are prescribed by a doctor for ongoing treatment to meet an identified care need as documented in the resident's care plan, and the item is to be used only by that resident, then the resident can be asked to pay for this item.

ITEM AND SERVICE	CONTENT	EXAMPLES
Item 3.8 Nursing services	Initial and ongoing assessment, planning and management of care for residents, carried out by a registered nurse. Nursing services carried out by a registered nurse or other professional appropriate to the service (eg, medical practitioner, stoma therapist, speech pathologist, physiotherapist or qualified practitioner from a palliative care team). Services may include, but are not limited to, the following: (a) establishment and supervision of a complex pain management or palliative care program, including monitoring and managing any side effects; (b) insertion, care and maintenance of tubes including intravenous and nasogastric tubes; (c) establishing and reviewing a catheter care program, including the insertion, removal and replacement of catheters; (d) establishing and reviewing a stoma care program; (e) complex wound management; (f) insertion of suppositories; (g) risk management procedures relating to acute or chronic infectious conditions; (h) special feeding for care recipients with dysphagia (difficulty with swallowing); (i) suctioning of airways; (j) tracheostomy care; (k) enema administration; (l) oxygen therapy requiring ongoing supervision because of a care recipient's variable need; and (m) dialysis treatment.	A service must not charge a high care resident for nursing services or nursing consultancy services, if an aged care service employs a nurse consultant for advice concerning specialist nursing care. The list of services in this item is not exhaustive; they are only examples of what may be included. Stoma related products and supplies are available through the Stoma Scheme free of charge to residents who are ostomates. See References at the end of this chapter for more information on the Stoma Scheme.

ITEM AND SERVICE	CONTENT	EXAMPLES
Item 3.10 Medications	Medications subject to requirements of State or Territory law.	An approved provider cannot charge a resident for: ▮ the provision of systems for dispensing medication—for example, blister packs. The provider pays the costs of these types of systems. See also Item 2.4 on page 219.
Item 3.11 Therapy services, such as recreational, speech therapy, podiatry, occupational and physiotherapy services	(a) Maintenance therapy delivered by health professionals, or care staff as directed by health professionals, designed to maintain residents' level of independence in activities of daily living. (b) More intensive therapy delivered by health professionals, or care staff as directed by health professionals, on a temporary basis that is designed to allow residents to reach a level of independence at which maintenance therapy will meet their needs. Excludes intensive, long-term rehabilitation services required following, for example, serious illness or injury, surgery or trauma.	This includes assessment by a relevant health professional. Following the assessment the health professional can deliver the care or direct the care, which may be provided by care staff in accordance with the relevant state and territory legislation.
Item 3.12 Oxygen and oxygen equipment	Oxygen and oxygen equipment needed on a short-term, episodic or emergency basis.	This item indicates that oxygen must be available for emergency use. It includes the provision of tubing and masks for the administration of oxygen. The Department provides assistance to aged care services for those residents who have an ongoing need for oxygen treatment irrespective of whether the resident is classified as receiving high or low level care. See also section on Oxygen supplement in chapter on Funding for permanent residential aged care in this Manual.

SPECIFIED CARE AND SERVICES

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN THIS CHAPTER

Aged Care Information Line

Ph 1800 500 853

Continence Aids Payment Scheme and Continence Aids Assistance Scheme

From 1 July 2010, the Continence Aids Payment Scheme will replace the current Continence Aids Assistance Scheme. For information on both go to:
www.bladderbowel.gov.au

Forms—all

All Departmental forms are available on the Department's website at
www.health.gov.au/internet/main/publishing.nsf/Content/health-forms.htm

Stoma scheme

www.health.gov.au/internet/main/publishing.nsf/Content/Stoma+Appliance+Scheme-1

SPECIFIED CARE AND SERVICES

PROVIDERS' RESPONSIBILITIES AND NON-COMPLIANCE

PROVIDERS' RESPONSIBILITIES AND NON-COMPLIANCE

LEGISLATIVE REFERENCES

This Manual has been written in plain English and as a result, some aspects of the legislation and policy have been simplified. It is intended to be a general guide only and does not constitute legal advice. In cases of discrepancy between the Manual and the legislation, the legislation will be the source document for payment of Australian Government benefits and enforcement of approved provider responsibilities.

RELEVANT LEGISLATION

- Chapter 4, *Aged Care Act 1997* (the Act)
- Division 85, *Aged Care Act* 1997
- *Quality of Care Principles 1997* (the Quality of Care Principles)
- *Sanctions Principles 1997* (the Sanctions Principles)
- *User Rights Principles 1997* (the User Rights Principles)
- *Accountability Principles 1998* (the Accountability Principles)
- *Accreditation Grant Principles 1999* (the Accreditation Grant Principles)
- Sections 19.5A and 19.5B, *Records Principles 1997*

OVERVIEW

This chapter explains the actions that can be taken when providers do not comply with their responsibilities under the Act for:

- quality of care *See legislative reference.*
- user rights—ie, the rights of residents *See legislative reference.*
- accountability for the care that is provided. *See legislative reference.*

Part 4.1, 4.2, 4.3 Aged Care Act 1997

Additional information

This chapter has been updated and revised to help approved providers comply with their responsibilities under the Act; and to assist staff of aged care services understand the regulation of residential aged care.

More information about police check requirements is available in the Police Certificate Guidelines for Aged Care Providers. See References at the end of this chapter for a link. Additional information can also be accessed through the Aged Care Information Line on 1800 500 853.

QUALITY OF CARE

Approved residential care providers must:

- provide such care and services specified in the Quality of Care Principles in respect of the type of aged care that is provided by the service
- maintain an adequate number of appropriately skilled staff to ensure that the care needs of residents are met
- provide care and services of a quality that is consistent with any rights and responsibilities of residents specified in the User Rights Principles
- comply with the Accreditation Standards. *See legislative reference.*

Schedule 2, Quality of Care Principles 1997

PROVIDERS' RESPONSIBILITIES AND NON-COMPLIANCE

LEGISLATIVE REFERENCES

USER RIGHTS

Approved providers must:

- provide quality care and services consistent with the Charter of Residents' Rights and Responsibilities and requirements in the User Rights Principles relating to:
  - residents' security of tenure for their places in an aged care service
  - access to the aged care service by residents' representatives, advocates and community visitors
  - providing information to residents about their rights and responsibilities and, on request, about the financial viability of the aged care service
  - restrictions on moving a resident within an aged care service
  - booking fees for respite stays
- comply with prudential and other requirements in relation to any accommodation payments charged for a resident's entry to an aged care service
- not charge more than the amount permitted under the Act and the User Rights Principles for the care and services which the approved provider is responsible for providing
- not charge more for other care or services than an amount agreed beforehand with the resident, and to provide an itemised account of the care and services provided
- offer to enter into a resident agreement with the resident and enter into such an agreement if the resident wishes
- ensure that a resident's personal information is only used for a purpose connected with providing aged care to the resident, or for a purpose for which the information was given to the provider *See legislative reference.*

s 62-1, Aged Care Act 1997

- comply with the requirements of the Act in relation to complaints resolution mechanisms for the service *See legislative reference.*

s 56-4, Aged Care Act 1997

- if the aged care service has extra service status, comply with the requirements of Division 36 of the Act *See legislative reference.*

Division 36, Aged Care Act 1997

- take reasonable steps to identify residents, or the legal representatives of their estate, and when directed by the Secretary, refund fees or charges to care recipients who paid accommodation charges while they were charge exempt residents.

ACCOUNTABILITY REQUIREMENTS

Approved residential care providers must:

- keep and maintain records that enable claims for payments of subsidies to be verified and proper assessments to be made of whether the approved provider is complying with its responsibilities
- cooperate with anyone exercising the powers of an authorised officer under Part 6.4 of the Act and comply with the obligations in that Part in relation to the officer's exercise of those powers *See legislative reference.*

Part 6.4, Aged Care Act 1997

- notify the Department of any change of key personnel or change of circumstances that materially affects the provider's suitability to be a provider

of aged care within 28 days after the change occurs; and respond within 28 days to any request by the Secretary for information about the provider's suitability, payments made to the provider or information relating to accommodation payments

- comply with any conditions on the allocation of any places in the aged care service, for example:
  - people with special needs
  - supported, concessional and assisted residents
  - people needing a particular level of care
  - people receiving respite care
  - other people specified in the notice of allocation of places to the provider
- provide records or copies of records to another approved provider in accordance with s 16-10 of the Act, for any places transferred to that provider *See legislative reference.*

s 16-10, Aged Care Act 1997

- if the provider has relinquished any places:
  - notify the Department at least 60 days before the proposed date of relinquishment
  - comply with any proposal accepted, modified or set out by the Secretary to ensure that the care needs of residents in those places are appropriately met
- allow people authorised by the Secretary access to the aged care service to assess the care needs of any person provided with care at the service
- conduct appraisals or reappraisals of the care required by residents in a proper way
- comply with the conditions under which extra service status was granted or renewed
- allow people authorised by the Secretary access to the aged care service to review the service's certification
- comply with any agreement the approved provider undertakes in lieu of revocation of approved provider status imposed as a sanction, or any undertaking they give to the Secretary, to remedy non-compliance with the provider's responsibilities
- allow representatives from the Aged Care Standards and Accreditation Agency (the Agency) access to the aged care service to assess compliance with the Accreditation Standards through accreditation site visits, review audits, support contacts and spot checks.

POLICE CHECKS

From 1 January 2009, approved providers must ensure that **all** staff and unsupervised volunteers who are likely to have access to residents have a current police certificate. Approved providers are therefore required to ensure that all staff and unsupervised volunteers undergo a police check every three years to determine their suitability to work in aged care. (Previous police check requirements related only to staff and volunteers who were reasonably likely to have unsupervised access to residents.)

PROVIDERS' RESPONSIBILITIES AND NON-COMPLIANCE

LEGISLATIVE REFERENCES

What is a national criminal history record check?

State or territory police, or the Australian Federal Police, can conduct a national criminal history record check to determine if a person has been charged with and/or convicted of a criminal offence which has not been removed from their record under a spent conviction scheme.

Who is required to have a police check?

s 1.18, Accountability Principles 1998

All people who are employed, hired, retained or contracted by an approved provider, whether directly or through an employment or recruitment agency, to provide care or services within an aged care service, who are reasonably likely to have access to residents, are required to have a police check. *See legislative reference.*

This covers people over the age of 16 who work or provide services at the aged care service, including:

- key personnel of the approved provider
- employees and contractors of the approved provider who provide care
- allied health professionals contracted by the approved provider to provide care
- kitchen, laundry, garden and office personnel employed by the approved provider
- consultants, trainers and advisors for accreditation support or systems improvement who are under the control of the approved provider
- staff who are not directly engaged by the approved provider but who are under the control of the approved provider, for example, agency staff
    - where an approved provider has a contract with an agency that provides staff, the contract should be amended to include the requirement for police checks. The contract should state that any staff provided must have had a police check, and that the check does not preclude them from working in aged care
- volunteers who are organised by the provider and who have, or are reasonably likely to have, unsupervised access to a resident
- volunteers visiting residents under the Community Visitors Scheme.

This excludes:

- volunteers who are under the age of 16 or under the age of 18 if they are a full-time school student
- visiting people who attend the service at the invitation of a resident
- visiting medical practitioners, pharmacists and other allied health care personnel who are requested by, or on behalf of, the resident but not contracted by the approved provider
- tradespeople and independent contractors—for example, plumbers, electricians, delivery people—who provide services on an ad hoc basis
- volunteers who only have supervised access to residents

For further information about who is required to have a police check, contact the Aged Care Information Line on 1800 500 853.

LEGISLATIVE REFERENCES

What are the consequences for staff and volunteers whose police checks reveal a criminal offence?

Approved providers must be satisfied that the police certificate does not record that the person has been:

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

s 1.19 and s 1.21(2), Accountability Principles 1998

If the approved provider cannot be satisfied of this, the person is **not** permitted to work within an aged care service. *See legislative reference.*

For convictions for other offences it is up to the approved provider to determine whether the individual is suitable to be engaged in the service. Providers should consider the seriousness and relevance of the conviction, the level of access the person has to care recipients and the length of time since the conviction. There are a range of factors to weigh up, and providers should consult the Police Certificate Guidelines for Aged Care Providers when making their decision. However, the overriding responsibility that providers should bear in mind is the health, safety and well-being of care recipients. See References at the end of this chapter for a link to the Guidelines.

When should a statutory declaration be made?

There are two circumstances in which a staff member or unsupervised volunteer will be required to make a statutory declaration:

- where, prior to receiving a police certificate, a new staff member commences working within the service they will be required to make a statutory declaration stating that they have never been convicted of murder or sexual assault, or convicted of, and sentenced to imprisonment for, any other form of assault. The application for a police certificate must have been made and until the certificate is received, the person must be subject to appropriate supervision. *See legislative reference.*

s 1.22, Accountability Principles 1998

- if a staff member, since turning 16 years of age, was a citizen or permanent resident of any country other than Australia, they are required to make a statutory declaration stating that they have never been convicted of murder or sexual assault, or convicted of, and sentenced to imprisonment for, any other form of assault in Australia or another country. *See legislative reference.*

s 1.24, Accountability Principles 1998

Maintaining and renewing police checks

Approved providers have a responsibility to take reasonable measures to require each of their staff members and volunteers to notify the approved provider if they are convicted of a precluding offence in the three year period between obtaining and renewing their police check.

Where an approved provider is satisfied on reasonable grounds that a staff member or volunteer has been convicted of a precluding offence they must ensure that person does not continue as a staff member or volunteer. *See legislative reference.*

ss 1.21(3) and (4), Accountability Principles 1998

Approved providers have a continuing responsibility to ensure that for each person who is a staff member or unsupervised volunteer there is a police certificate that is not more than 3 years old. *See legislative reference.*

s 1.21(1), Accountability Principles 1998

LEGISLATIVE REFERENCES

Keeping staff and volunteers' police checks on file

s 19.5A, Records Principles 1997

s 19.5B, Records Principles 1997

Approved providers are required to retain records demonstrating that police checks not more than 3 years old have been undertaken for all staff and relevant volunteers. *See legislative reference.* Storage of personal information about staff and volunteers must be in accordance with the *Privacy Act 1988*. See References at the end of this chapter for a link to ComLaw for the *Privacy Act 1988*. *See legislative reference.*

To help approved providers complete and assess records for staff and volunteers, there are two templates at Appendix 3 of the Police Certificate Guidelines for Aged Care Providers.

For a link to the Guidelines; and for a link to the office of the Privacy Commissioner, see References at the end of this chapter.

MISSING RESIDENTS

Approved providers are required to notify the Department if:

- there is an unexplained absence of a care recipient from a residential aged care service
- and the police have been notified.

s 62-1, Aged Care Act 1997, s 1.14A, Accountability Principles 1998

After the provider has notified the missing resident's family and the police, the approved provider must then notify the Department. The notification should be made to the Aged Care Complaints Investigation Scheme as soon as practicable and in any case within 24 hours of reporting to the police. *See legislative reference.* See References at the end of this chapter for contact information.

These requirements do not override an approved provider's responsibility to comply with the Charters of Residents' Rights and Responsibilities, which includes the resident's rights to move freely both inside and outside the service without undue restriction.

This notification will enable the Department to determine whether appropriate action has been taken by the approved provider in respect of the missing residents and whether there are adequate systems and processes in place to ensure other residents' safety. This reporting requirement is part of an approved provider's responsibility under the Act to provide a safe and secure environment.

The Department's response to the notification will be to review the matter to establish whether there is an ongoing risk to residents. For example, it is unlikely further action will be taken where a missing resident turns up, having spent a day with family or friends. Whereas, if a resident is reported as missing without reasonable explanation and it is considered that the approved provider did not have adequate systems and processes in place to prevent the absence, then the Department can investigate and compliance action could be taken.

MONITORING COMPLIANCE

Both the Department and the Agency are responsible for monitoring aged care services' compliance with their responsibilities under the Act.

PROVIDERS' RESPONSIBILITIES AND NON-COMPLIANCE

LEGISLATIVE REFERENCES

Role of the Department of Health and Ageing

The Department is required to take appropriate action when an approved provider is not complying with their responsibilities in relation to quality of care, user rights and accountability under the Act. *See legislative reference.* This includes taking into account a provider's compliance with the Accreditation Standards.

Part 4.1, 4.2, 4.3, Aged Care Act 1997

The Department monitors approved providers' responsibilities under the Act. While the Agency's regulatory role focuses on a provider's compliance with the Accreditation Standards, officers authorised by the Department can also monitor compliance with the Accreditation Standards, particularly if compliance notices or sanctions are being considered.

In order to monitor compliance by approved providers, the Secretary can appoint authorised officers who can conduct spot checks—or unannounced visits—on aged care services. *See legislative reference.* Authorised officers can also conduct site visits. For a site visit, an authorised officer will notify an approved provider of the intended visit and agree on a time for the visit. At all times, an authorised officer must be able to produce an identity card verifying their authority to conduct a compliance monitoring visit.

Part 6.4, Aged Care Act 1997

The authorised officer must obtain the consent of the occupier of the premises before entering the service. An approved provider can also withdraw their consent at any time. *See legislative reference.* However, if an approved provider fails to cooperate with an authorised officer, for example, by denying access or refusing to provide reasonable assistance, the Department may take compliance action.

s 91-1, Aged Care Act 1997

If a service breaches their responsibilities under the Act, the Department can start compliance action. This can include issuing a notice of non-compliance to the approved provider or imposing sanctions. Different sanctions can be imposed depending on the type of non-compliance.

Role of the Aged Care Standards and Accreditation Agency

The Agency manages the process of accreditation of residential aged care services in accordance with the Accreditation Grant Principles. It assesses and monitors Government-subsidised aged care services against the Accreditation Standards.

If the Agency finds that a service is not complying with the Accreditation Standards and its other responsibilities under the Act, but the non-compliance has not placed the safety, health or wellbeing of the residents at serious risk, it will write to the service informing them of: *See legislative reference.*

s 4.6(4), Accreditation Grant Principles 1999

- areas where improvements must be made to ensure compliance with the Accreditation Standards
- the timetable set to make the necessary improvements
- the program of support contacts by an Agency representative to assess progress in making the necessary improvements

If the level of care provided at the end of the timetable does not comply with the Accreditation Standards, the Agency must give the approved provider and the Department information and evidence about the way in which the level of care is not satisfactory. The Agency must also recommend to the Department that sanctions be imposed. *See legislative reference.*

s 4.7, Accreditation Grant Principles 1999

PROVIDERS' RESPONSIBILITIES AND NON-COMPLIANCE

LEGISLATIVE REFERENCES

s 4.4(1)(a), Accreditation Grant Principles 1999

If the Agency finds that an aged care service is not complying with the Accreditation Standards or other responsibilities under the Act and is putting the safety, health or wellbeing of residents at serious risk, then the Agency must inform the Department of this in writing. *See legislative reference.* The Agency may also make recommendations on whether sanctions should be imposed by the Department; and may decide to vary or revoke a service's period of accreditation. The Department can take compliance action, consistent with the Act and appropriate to the nature and level of non-compliance. See Compliance action following.

For more information on the Agency, see chapter on Accreditation and quality of care in this Manual.

COMPLIANCE ACTION

Part 4.4, Aged Care Act 1997

The Act sets out a series of formal steps leading to sanctions which the Department can take if an approved provider is not complying with its responsibilities. *See legislative reference.*

When can sanctions be imposed?

s 65-1, Aged Care Act 1997

Sanctions can be imposed on a provider if: *See legislative reference.*

- the approved provider is not complying with one or more of its responsibilities in relation to quality of care, user rights and/or accountability
- the Secretary is satisfied that it is appropriate to impose sanctions.

s 65-2, Aged Care Act 1997

In deciding whether or not to impose sanctions, the Secretary will consider: *See legislative reference.*

- whether the non-compliance is minor or serious
- whether the non-compliance has occurred before, and if so, how often
- whether the non-compliance threatens the health, welfare or interests of the residents or of future residents
- whether the approved provider has failed to comply with any undertaking to remedy the non-compliance
- the desirability of deterring any future non-compliance
- any other matters specified in the Sanctions Principles.

s 67-1, Aged Care Act 1997

Sanctions can be imposed in two ways: *See legislative reference.*

- immediately, if the Secretary believes there is an immediate and severe risk to the safety, health or wellbeing of residents as a result the provider's non-compliance
- if there is no immediate or severe risk to the safety, health or wellbeing of residents, the Secretary must first issue a series of notices, starting with a notice of non-compliance, before imposing sanctions.

What sanctions can be imposed?

s 66-1, Aged Care Act 1997

The Secretary can impose one or more of the following sanctions, by notice in writing *See legislative reference.*

LEGISLATIVE REFERENCES

- revoking or suspending approval as a provider of aged care services See Agreeing to certain matters in lieu of revoking approved provider status following.
- restricting approval to existing services or places
- restricting funding to existing residents
- revoking or suspending the existing allocation of places
- varying the conditions of approval for allocated places
- prohibiting the further allocation of places
- revoking or suspending extra service status
- prohibiting granting of approval for extra service status
- revoking or suspending certification
- prohibiting the charging of accommodation charges or accommodation bonds
- requiring repayment of grants
- other sanctions as specified in the Sanctions Principles.

Agreeing to certain matters in lieu of revoking approved provider status

See legislative reference.

s 66-2, Aged Care Act 1997

If a provider's approval is revoked, the provider can agree to certain matters to ensure that the revocation does not take effect. If the sanction notice specifies that this is an option, the provider can agree to:

- provide, at its expense, training for officers, employees and agents
- provide security for a debt owed to the Commonwealth
- appoint an adviser or an administrator, approved by the Commonwealth
- and/or transfer some or all of its allocated places to another approved provider.

The Department has established adviser and administrator panels and the Sanctions Principles sets out the timetable for nominating and appointing people from those panels for sanctions purposes.

Duration of sanctions

Some sanctions are for an indefinite period of time—for example, revocation of approved provider status. Other sanctions can be applied progressively, for example, a provider may no longer have approval for high care residents; or may be imposed for a specific period of time

Sanctions no longer apply when the sanction period set out in the notice expires.

A provider can also apply to have sanctions lifted before the specified expiry date. An application must provide the following details: *See legislative reference.*

s 22.20, Sanctions Principles 1997

- what the provider has done to remedy the non-compliance
- where relevant, any assessments of the aged care service made against the Accreditation Standards while the sanction was in effect
- any consultations with staff, residents, residents' relatives or representatives about the non-compliance
- the provider's proposals for sustaining its compliance with its responsibilities.

LEGISLATIVE REFERENCES

s 68-6(1), Aged Care Act 1997

The Secretary must notify the provider of the decision within 28 days of receiving the application; or if the Secretary requests the provider to submit further information, within 28 days of that information being provided. *See legislative reference.*

Division 85, Aged Care Act, 1997

The following sanctions cannot be lifted, but may be reconsidered if the provider applies for a review of the decision to impose sanctions: *See legislative reference.*

- the revocation of approved provider status
- the revocation of the allocation of places
- the revocation of extra service status
- the revocation of certification
- requiring the provider to repay grants, where the provider has not complied with responsibilities related to those grants.

s 67-2, Aged Care Act 1997

Notice of non-compliance

See legislative reference.

If the provider is not complying with its responsibilities under the Act in relation to quality of care, user rights or accountability, and the risks to residents are not immediate or severe, the Secretary can issue a notice of non-compliance, including:

- details of the non-compliance
- broadly what action the Secretary requires the provider to take to remedy the non-compliance
- the timeframe in which the provider must make a written submission to the Department
- what sanctions can be imposed.

The provider will be invited to make a written submission within 14 days of receiving the notice, including what action will be taken to address the non-compliance.

After considering any submissions made by the provider, the Secretary can decide to:

- issue a notice of intention to impose sanctions
- issue a notice to remedy the non-compliance
- or issue a combination of these

See also Publishing sanctions and notices of non-compliance on page 240.

s 67-4, Aged Care Act 1997

Notice to remedy non-compliance

See legislative reference.

If the Secretary thinks the provider's submission in response to a notice of non-compliance:

- proposes appropriate action to remedy the non-compliance
- provides sufficient reason for the non-compliance
- or is otherwise satisfactory

the Secretary can give the provider a notice to remedy the non-compliance. The notice will require the provider to give a written undertaking within 14 days of receiving

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the notice to remedy the non-compliance. The notice will also inform the provider that failure to either give, or fulfil, the undertaking can lead to sanctions being imposed.

s 67-4(3), Aged Care Act 1997

The undertaking that the provider must sign will set out: *See legislative reference.*

- a description and acknowledgement of the provider's non-compliance with its responsibilities
- the action which the provider proposes to take to remedy the non-compliance
- the timetable for carrying out the action
- an acknowledgment that failure to fulfil the undertaking may lead to sanctions being imposed.

Notice of intention to impose sanctions

s 67-4(3), Aged Care Act 1997

See legislative reference.

If the provider does not make a submission in response to a notice of non-compliance or if the Secretary thinks the submission:

- does not propose appropriate action to remedy the non-compliance
- fails to establish that the non-compliance did not occur or is not occurring (ie, does not challenge the charge of non-compliance)
- fails to provide a sufficient reason for the non-compliance
- is otherwise unsatisfactory

the Secretary can give the provider a notice of intention to impose sanctions.

The notice will set out in writing:

- a description of the provider's non-compliance with its responsibilities
- the reasons for proposing to impose sanctions
- the consequences of imposing the proposed sanctions.

The provider will be invited to make a submission in writing in relation to the matter within 14 days of receiving the notice.

Notice of decision on whether to impose sanctions

s 67-5, Aged Care Act 1997

See legislative reference.

After considering any submissions from a provider in response to a notice of intention to impose sanctions, the Secretary will decide whether or not to impose sanctions and inform the provider.

If the decision is to impose sanctions, the Secretary will give the provider a notice of decision to impose sanctions. See When can sanctions be imposed? on page 236.

If the Secretary decides not to impose sanctions, the Secretary will give the provider a notice of the decision not to impose sanctions, including reasons for this decision.

s 67-5(2), Aged Care Act 1997

A notice to impose sanctions will set out: *See legislative reference.*

- a description of the provider's non-compliance
- the sanction to be imposed
- the consequences of imposing the sanction

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- when the sanction commences
- where applicable, the sanction period
- the reasons for imposing the sanction.

Review rights

s 85-1, Aged Care Act 1997

A decision to impose a sanction can be reviewed. If the Secretary refuses to lift a sanction, this is also a reviewable decision. *See legislative reference.*

Broadly, if an approved provider considers that the Secretary has made an invalid decision in terms of imposing or refusing to lift a sanction, they can apply to the Department for these decisions to be reconsidered. After reconsideration, the decision will either be confirmed, varied or set aside. If the provider still believes that the decision is invalid, they can seek a review of the decision at the Administrative Appeals Tribunal. See References at the end of this chapter for a link to the Administrative Appeals Tribunal.

However, giving a provider a notice of non-compliance, a notice to remedy or a notice of intention to impose sanctions are not reviewable decisions.

PUBLISHING SANCTIONS AND NOTICES OF NON-COMPLIANCE

Information about current and archived sanctions imposed on approved providers is available on the Department's website. The Department publishes online:

- the names and addresses of aged care services where sanctions are in place
- the names of the approved providers of the aged care services
- sanctions action taken under the Act and the reasons for that action
- the status of the sanction action.

The site is updated with information about new sanctions, as they are applied. Information on sanctions which have expired or have been lifted is archived on the Department's website. See References at the end of this chapter for a link

Case management and consumer information

A key element in managing sanctions action is an early meeting between the Department and the approved provider to establish the provider's plans for the future. The Department also requests that the provider arrange a meeting for residents and their nominated representatives to outline the current situation and the approved provider's plans for improvement in order to achieve and maintain compliance.

When sanctions are imposed, the Department writes to all residents and their representatives to ensure that they are kept well informed. Information about the sanctions may also be sent to other relevant stakeholders including Aged Care Assessment Teams, advocacy services, peak industry organisations, and the Agency.

PROVIDERS' RESPONSIBILITIES AND NON-COMPLIANCE

Notices of non-compliance

Information from notices of non-compliance (NNCs) issued in the last 2 years is available on the Aged Care Australia website. See References at the end of this chapter for a link.

The information about current NNCs includes the name and address of the service; the name of the approved provider; the date the NNC was issued; and general information on the non-compliance. This information is only made available online after the delegate has considered any submission made by the due date specified in the NNC.

Information about the NNC is moved from the current NNCs page to an archived NNCs page following confirmation by the Department or the Agency that the non-compliance has been addressed. Additional information on the archived page will indicate whether the provider had addressed the non-compliance, or was issued with a sanctions notice.

The NNC site is updated weekly to reflect the current status of NNCs. Any change of provider status is also amended in cases where this may apply to archived information.

If a sanction notice is issued, it will appear on the sanctions page of the Department's website. See References following, for a link.

Providers are encouraged to inform residents, or their legal representatives, about the issuing of a NNC and the action taken to address the non-compliance. Providers may also wish to include specific information on their own websites regarding any non-compliance and action taken to address the matter.

Concerns about information in regard to a previous or current NNC issued should be raised with the manager in the relevant state or territory office of the Department or emailed to the Department's compliance email address. See References following, for the address.

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN THIS CHAPTER

Accreditation—for information about accreditation or accreditation reports

www.accreditation.org.au

Administrative Appeals Tribunal

www.aat.gov.au

Aged Care Complaints Investigation Scheme

Ph 1800 550 552

The line is open Monday–Friday, 8:30am–5pm; Saturday, Sunday and public holidays, 10am–5pm. Outside these hours, people can leave a message.

People can also write to the Scheme at:

Department of Health and Ageing
GPO Box 9848
In your Capital City

PROVIDERS' RESPONSIBILITIES AND NON-COMPLIANCE

An online complaints investigation form is available at:
www.health.gov.au/internet/main/publishing.nsf/content/ageing-complaints-index.htm
for an online complaints form

If a person is not satisfied with how their complaint has been handled, they can take their concerns to the Departmental manager responsible for the Scheme in their state or territory, by calling the Scheme freecall number above.

Aged Care Information Line

Ph 1800 500 853

Crimtrac—National Criminal History Check

www.crimtrac.gov.au/criminal_history_checks/index.html

Forms—all

All Departmental forms are available on the Department's website at
www.health.gov.au/internet/main/publishing.nsf/Content/health-forms.htm

Legislation—other

Go to ComLaw to access other legislation mentioned in this chapter, including the *Privacy Act 1988*.
www.comlaw.gov.au

National Criminal History Checks—Australian Federal Police

www.afp.gov.au/business/national_police_checks

National Criminal History Check—consent, fees, form and guidelines

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-approvedp-index.htm

Notice of non-compliance—concerns about

Concerns about information in regard to a previous or current notice of non-compliance (NNC) issued should be raised with the manager in the relevant state or territory office of the Department or emailed to Aged.Care.Compliance@health.gov.au

Notice of non-compliance—current and archived

www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/quality+of+care

Notice of non-compliance—information about

Information from notices of non-compliance (NNCs) is available on the Aged Care Australia website
www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/quality+of+care

Police Certificate Guidelines for Aged Care Providers

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-quality-police.htm
or contact the Aged Care Information Line, Ph 1800 500 853

PROVIDERS' RESPONSIBILITIES AND NON-COMPLIANCE

Privacy—Office of the Privacy Commissioner

www.privacy.gov.au

Sanctions—current and archived sanctions

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-sanction.htm

PROVIDERS' RESPONSIBILITIES AND NON-COMPLIANCE

COMPULSORY REPORTING

COMPULSORY REPORTING

This Manual has been written in plain English and as a result, some aspects of the legislation and policy have been simplified. It is intended to be a general guide only and does not constitute legal advice. In cases of discrepancy between the Manual and the legislation, the legislation will be the source document for payment of Australian Government benefits and enforcement of approved provider responsibilities.

RELEVANT LEGISLATION

- Part 4.3 and s 96-8, *Aged Care Act 1997* (the Act)
- *Investigation Principles 2007*
- *Accountability Principles 1998*
- *Records Principles 1997* (Records Principles)

OVERVIEW

This chapter explains the compulsory reporting requirements which commenced on 1 July 2007 following amendments to the Act. These requirements aim to ensure that any allegation or suspicion of a reportable assault—ie, unlawful sexual contact or unreasonable use of force—on a resident of an aged care service is reported and managed appropriately.

This chapter includes information about:

- the definition of reportable assaults
- approved providers' responsibilities regarding compulsory reporting of a reportable assault on a resident
- making a report to the Department
- responding to allegations of assault on a resident
- protecting the identity of informants
- record keeping and privacy.

Compulsory reporting requirements are part of an approved provider's responsibilities under the Act to provide a safe and secure environment for care recipients.

Additional information

This chapter has been updated and revised to help approved providers comply with their responsibilities under the Act; and to assist staff of aged care services understand the regulation of residential aged care. Additional information can also be accessed through the Aged Care Information Line on 1800 500 853; and further information about compulsory reporting can be found on the Department's website. See References at the end of this chapter for a link.

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THE 5 KEY ELEMENTS TO COMPULSORY REPORTING REQUIREMENTS

Except in very specific circumstances, approved providers of residential aged care must report all allegations or suspicions of a reportable assault.

Exception

The exception to reporting a reportable assault applies to circumstances involving residents affected by an assessed cognitive or mental impairment, or where there are repeated allegations of the same assault. See Specified circumstances in which the responsibility to report does not apply on page 249.

An approved provider should not wait until an allegation is substantiated. The fact that a person has alleged, or the approved provider suspects, that someone has assaulted a resident is sufficient to trigger the reporting requirements.

s 63-1AA(5), Aged Care Act 1997

So that approved providers can comply with their responsibilities under the Act, approved providers must take reasonable measures to require staff to report alleged or suspected reportable assaults. *See legislative reference.* This requirement recognises that in many cases, it may be staff who first suspect or become aware of assaults. Approved providers are therefore required to:

- give staff information about how to report assaults
- actively require staff to make reports if they see, or suspect, an assault on a resident.

s 63-1AA(2), Aged Care Act 1997

Reports must be made to both the police and the Department, via the Aged Care Complaints Investigation Scheme, within 24 hours of the allegation being made, or the approved provider starting to suspect on reasonable grounds that a reportable assault may have occurred. *See legislative reference.* This timeframe ensures that alleged assaults are acted upon immediately.

s 63-1AA(7), Aged Care Act 1997

If a staff member makes a report, the approved provider must take reasonable measures to ensure the identity of that staff member is not disclosed, except to: *See legislative reference.*

- a police officer
- the Secretary
- a person, authority or court to which the approved provider is required to disclose the identity of the person
- one of the approved provider's key personnel.

An approved provider is responsible for ensuring that the staff member who discloses the information is not victimised. This is important in encouraging ongoing reporting by staff members.

If an approved provider fails to meet compulsory reporting requirements, the Department can take compliance action. Compliance with the compulsory reporting requirements is monitored by the Department and the Aged Care Standards and Accreditation Agency.

REPORTABLE ASSAULTS

s 63-1AA(9), Aged Care Act 1997

A reportable assault means: *See legislative reference.*

- unlawful sexual contact with a resident of an aged care service
- or unreasonable use of force on a resident of an aged care service.

The definition of reportable assault used in the Act provides a simple and readily understood definition. It avoids the difficulties of applying legalistic definitions that vary widely throughout Australia.

Unlawful sexual contact

The term unlawful sexual contact is intended to cover any sexual contact with a resident, without consent, that is unlawful under any Commonwealth, state or territory law. If the contact involves a resident with an assessed cognitive or mental impairment, the resident may not be able to provide informed consent.

The term unlawful sexual contact has been used:

- to avoid the use of specific terms, such as sexual intercourse, rape and sexual assault, which are terms defined differently under Commonwealth, state and territory legislation
- and to ensure that all unlawful sexual contact, no matter how described, is covered.

It is not intended to cover situations where there is no physical contact.

Unreasonable use of force

Unreasonable use of force is intended to cover assaults ranging from deliberate and violent physical attacks on residents to the use of unreasonable physical force on a resident. The definition includes hitting, punching or kicking a resident regardless of whether this in fact causes visible harm, such as bruising.

There may be circumstances where a staff member could be genuinely trying to assist a resident, and despite their best intentions, the resident is injured because they bruise easily or have fragile skin. Injury alone therefore may not provide conclusive evidence of the use of unreasonable force or the seriousness of an assault.

The following guides can assist providers to identify signs of abuse:

- the Benevolent Society's Policy and Procedures for Residential Aged Care —Preventing and Responding to Abuse
- Aged and Community Care Victoria (AACV), in collaboration with Victoria Police, have developed a Compulsory Reporting Resource Guide.

See References at the end of this chapter for links.

MAKING A REPORT TO THE DEPARTMENT

Approved providers have a responsibility to make compulsory reports to the Department via the Aged Care Complaints Investigation Scheme. See References at the end of this chapter for Scheme contact information.

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APPROVED PROVIDER RESPONSIBILITIES REGARDING COMPULSORY REPORTING OF ASSAULT ON A RESIDENT

Reporting reportable assaults

s 63-1AA, Aged Care Act 1997

An approved provider is responsible for reporting an alleged or suspected reportable assault as soon as possible and in any case must report within 24 hours, to: *See legislative reference.*

- the local police service
- and the Department via the Aged Care Complaints Investigation Scheme.

An approved provider is required to report as soon as they start to suspect on reasonable grounds that a reportable assault has occurred. This is to ensure that both allegations and suspicions of reportable assaults are reported.

An allegation usually requires a claim or accusation to have been made to the approved provider; and can be linked to physical evidence of an assault or witnessing an assault.

Reporting suspicion allows reports to be made where there is no allegation or where the suspected assault may not have been witnessed but a staff member observes signs that an assault may have occurred. Approved providers should have internal policies and processes in place aimed at creating a culture of reporting and responding to alleged or suspected assaults on residents and documenting critical incidents.

The Benevolent Society and Aged and Community Services Australia have developed guides that approved providers could adapt for their own use. See References at the end of this chapter for links.

Requiring staff members to report reportable assaults

s 63-1AA(5), Aged Care Act 1997

An approved provider is responsible for taking reasonable measures to require each staff member who works in the aged care service and who suspects on reasonable grounds that a reportable assault has occurred, to report the suspicion as soon as reasonably practicable. *See legislative reference.*

A staff member can report to **one or more** of the following:

- the approved provider
- one of the approved provider's key personnel or another person authorised by the approved provider to receive reports of suspected reportable assaults
  - approved providers must ensure that staff know who these authorised people are
- a police officer with responsibility relating to the area, including the place where the assault is suspected to have occurred
- the Department.

The Act allows staff members to report directly to the police or the Department. This may occur if a staff member does not feel comfortable reporting alleged incidents involving the service's personnel or the approved provider.

Approved providers have a responsibility to ensure that staff are trained in, and familiar with, issues such as recognising if an assault may have occurred and how to respond. This includes awareness of the following:

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- the requirement and procedures for reporting any alleged or suspected incidents of assault on a resident as soon as possible; and who they should report to
- the option to report to the Department if they are concerned about anonymity, or where the manager or approved provider may be the subject of the allegation
- the protections in place and the circumstances in which they would qualify for protection
- that providing false or misleading information is a prosecutable offence.

Specified circumstances in which the responsibility to report does not apply

s 63-1AA(3), Aged Care Act 1997, s 1.31, Accountability Principles 1998

There are two specified circumstances under which the requirement to report a reportable assault does **not** apply: *See legislative reference.*

- alleged assaults that are perpetrated by residents with an assessed cognitive or mental impairment
  - Cognitive impairment refers to declining ability in judgment, memory, learning, comprehension, reasoning and/or problem solving. Cognitive impairment can result from a number of conditions, including dementia, delirium and/or depression.
  - Mental impairment includes senility, intellectual disability, mental illness, brain damage, and severe personality disorder. *See legislative reference.*

s 7.3(8), Criminal Code Act 1995

- subsequent reports of the same or similar incident.

The requirements an approved provider must comply with in these circumstances focus on an approved provider's responsibility to provide a safe environment for all residents. This includes managing the behaviour of a resident who has an assessed cognitive or mental impairment and may have committed an assault.

These circumstances do not prevent an approved provider from reporting an assault to the police or the Department if this is the appropriate response. Depending on the severity of an assault, and in cases where a resident is seriously harmed, the Department strongly encourages providers to report.

Assaults perpetrated by a resident with cognitive or mental impairment

s 1.31(1), Accountability Principles 1998

An approved provider has a discretion not to report an allegation or suspicion of a reportable assault if: *See legislative reference.*

- within 24 hours of starting to suspect or receiving an allegation, the approved provider believes that the assault was committed by a resident
- prior to the receipt of the allegation or start of the suspicion, the resident has been assessed by an appropriate health professional as suffering from a cognitive or mental impairment
  - and the approved provider has a copy of the assessment (or other documents) regarding the resident's cognitive or mental impairment
- within 24 hours of receiving the allegation, or starting to suspect that an assault has occurred, the approved provider makes arrangements to manage the resident's behaviour
  - and the approved provider has a record of these behaviour management arrangements.

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A behaviour management plan for such a resident must be developed, documented and regularly reviewed by a suitably qualified health professional. It must include information regarding:

- environmental factors which could contribute to or cause the behaviour
- possible health or medical factors which could contribute to or cause the behaviour
- possible communication needs of the person which may be contributing to the behaviour
- and interventions being trialled or used to manage the behaviour, including alternatives to restraint.

Health professionals who can assess cognitive and mental impairment

One or more of the following people are appropriate to assess a resident's cognitive or mental impairment, in either a community or hospital setting:

- an Aged Care Assessment Team (ACAT) or an Aged Care Assessment Service (ACAS)
- a resident's GP
- a registered nurse (RN)
- another health professional with the appropriate clinical expertise, such as a geriatrician, psycho-geriatrician, geriatric nurse or clinical psychologist.

Similar or previously reported incidents

The requirement to report reportable assaults does not apply to later allegations which could include the following:

- related to the same or substantially the same factual situation or event as an earlier allegation
- has previously been reported to the police and the Department under 63-1AA of the Act *See legislative reference.*
- where different people report the same event
- the same person makes allegations repeatedly and these allegations have been followed up.

s 63-1AA, Aged Care Act 1997

s 19.5AA, Records Principles 1997

Approved providers must keep records in relation to the above circumstances and in accordance with the Records Principles *See legislative reference.*

RESPONDING TO ALLEGATIONS OF ASSAULT ON A RESIDENT

Role of the Department

When incidents of alleged or suspected assault are reported, the police are responsible for investigating the incident. The police will determine whether the allegation involves a criminal offence and what further action is required. Only the police can investigate criminal activity.

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The Department's role is to make sure that an approved provider has met its responsibilities so that:

- the victim of the alleged or suspected assault has received appropriate care and support
- residents are safe
- compulsory reporting requirements are complied with
- the provider has appropriate internal systems and protocols in place for compulsory reporting.

When an alleged or suspected assault is reported, the Department will take the following steps:

- establish the details of the alleged or suspected assault, including when it took place (and if it has been reported within 24 hours)
- establish if the alleged or suspected assault has been reported to the police. If it has not, the Department will refer the incident to the relevant state or territory police service
- advise any staff member or approved provider who makes a report, of the informant identity protections and whether and how they qualify for protection
- establish that residents are not at further risk from the alleged perpetrator
- undertake an investigation to ensure that the approved provider has met its responsibilities under the Act. This includes ensuring appropriate medical care and support for the victim and notifying legal representatives or family members if required.

The Department can take compliance action where an approved provider does not meet the compulsory reporting requirements.

Role of the Agency

The Aged Care Standards and Accreditation Agency (the Agency) monitors approved provider compliance with the compulsory reporting requirements. The Agency does this through its usual audit and accreditation processes. These include:

- monitoring that processes are in place to require staff to report suspicions of incidents of assault on a resident
- monitoring that an approved provider is keeping records of all incidents of assault
- reviewing circumstances in which the discretion not to report an incident of assault was exercised
- informing the Department where a breach of the legislation is identified.

PROTECTING AN INFORMANT'S IDENTITY

There are a range of protections for staff and approved providers who report alleged or suspected assaults. *See legislative reference.*

s 96-8, Aged Care Act 1997

A disclosure of information regarding a suspected reportable assault by a person qualifies for protection if: *See legislative reference.*

s 96-8(1), Aged Care Act 1997

- the person is an approved provider of an aged care service or a staff member of an approved provider
- the disclosure is made to:

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- a police officer
- the Department
- the approved provider
- one of the approved provider's key personnel
- another person authorised by the approved provider to receive such reports

- the discloser informs the person to whom the disclosure is made of their name before making the disclosure
- the discloser has reasonable grounds to suspect that the information indicates that a reportable assault has occurred.
- the discloser makes the disclosure in good faith.

The approved provider or staff member who makes a protected disclosure is protected in a number of different ways, as outlined below.

s 96-8(2)(a), Aged Care Act 1997

- The discloser is protected from any civil or criminal liability for making the disclosure. *See legislative reference.*

s 96-8(2)(b), Aged Care Act 1997

- The discloser is protected from someone enforcing a contractual or other remedy against that person based on the disclosure. *See legislative reference.* For example, if a staff member had a contract of employment that specified that they must not discuss issues that arise in an aged care service with anyone outside the service, a disclosure by the staff member that qualifies for protection under this section would not give the employer the right to terminate the contract. However, if a staff member disclosed information to a person who is not specified in the list above, their contract could be terminated or other disciplinary action could be taken by their employer.

s 96-8(3)(a), Aged Care Act 1997

- The discloser has qualified privilege in proceedings for defamation relating to the disclosure and is not liable to an action for defamation relating to the disclosure. *See legislative reference.*

s 96-8(4), Aged Care Act 1997

- This provision does not affect any other right, privilege or immunity the discloser has as a defendant in proceedings, or an action, for defamation. *See legislative reference.* For example, if a person assaulted a resident and then informed the Department of this fact, they would not be protected from prosecution for the assault. The person is only protected from liability in disclosing the information.

s 96-8(2)(b), Aged Care Act 1997

- The discloser is protected from a contract to which they are a party being terminated, on the basis that the disclosure constitutes a breach of the contract. *See legislative reference.* For example, if a staff member has a contract of employment that specifies that they must not discuss issues that arise in an aged care service with anyone outside the service, a disclosure by the staff member under these provisions would not give the employer the right to terminate the contract. If a court is satisfied that an employee made a protected disclosure and the employer—either an approved provider or a recruitment agency who employs the person on behalf of the approved provider—terminates the employer's contract because of the disclosure, the court can order that the employee be reinstated or that compensation be paid to them. *See legislative reference.*

s 96-8(5), Aged Care Act 1997

s 96-8(6) Aged Care Act 1997

- The discloser is protected from victimisation. A person must not cause detriment or threaten the discloser on the grounds that a disclosure was made or may be made. *See legislative reference.* The provider has a responsibility to ensure that all staff comply with this requirement. Compliance action may be taken if the provider does not comply with this responsibility.

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Residents of aged care services, their families and advocates, visiting medical practitioners, other allied health professionals, volunteers and visitors are not compelled to report assaults and are not afforded statutory protection under the legislation. However, these people are strongly encouraged to report incidents of abuse or neglect of an aged care resident to the Department's Aged Care Complaints Investigation Scheme. The person providing information may do so openly, anonymously or ask the Scheme to keep their identity confidential. See References at the end of this chapter for contact information.

These people also have access to common law protections from defamation action. As these people can often identify if an assault of a resident is reasonably likely to have occurred, an approved provider should consider establishing visitor policies and protocols encouraging reporting where it is in the best interests of the residents.

RECORD KEEPING AND PRIVACY

Approved providers must keep consolidated records of all incidents involving allegations or suspicions of reportable assaults. *See legislative reference.* These records will be monitored by the Department and the Agency and they must:

s 19.5AA(1), Records Principles 1997

- be distinguishable from other incident records
- be retained in one central place
- be accessible to the Department and Agency when required.

s 19.5AA(2), Records Principles 1997

The record for each incident must include: *See legislative reference.*

- the date the approved provider received the allegation, or started to suspect on reasonable grounds, that a reportable assault had occurred
- a brief description of the allegation or the circumstances that gave rise to the suspicion
- information about whether a report of the allegation or suspicion has been made to a police officer and the Department in accordance with subsection 63-1AA(2) of the Act; or whether the allegation or suspicion has not been reported to a police officer or the Department because of the discretion under subsection 63-1AA (3) not to report, as outlined above. *See legislative reference.*

s 63-1AA(2), 63-1AA (3), Aged Care Act 1997

Approved providers must also have in place systems and procedures which will allow them to:

- comply with requirements relating to protection of personal information *See legislative reference.*

s 62-1, Aged Care Act 1997

- comply with all relevant legislation and regulatory requirements in relation to privacy issues, including state, territory or Commonwealth legislation such as the *Privacy Act 1988*. See References at the end of this chapter for a link to ComLaw for this Act.

COMPULSORY REPORTING

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN THIS CHAPTER

Aged Care Complaints Investigation Scheme

See Compulsory reporting—reporting to the Department, via the Aged Care Complaints Investigation Scheme below.

Aged Care Information Line

Ph 1800 500 853

Compulsory reporting—by people not given statutory protection under the Act

Residents of aged care services, families and advocates, visiting medical practitioners, other allied health professionals, volunteers and visitors are not compelled under the Act to report assaults. These people may still report incidents of abuse or neglect to the Department's Aged Care Complaints Investigation Scheme.

Ph 1800 550 552

Compulsory reporting—further information

Further information about compulsory reporting can be found on the Department's website
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-quality-guidelines-cr-ap.htm

Compulsory reporting—reporting to the Department, via the Aged Care Complaints Investigation Scheme

People can report to Department via the Aged Care Complaints Investigation Scheme, Ph 1800 550 552

The line is open Monday–Friday, 8:30am–5pm; Saturday, Sunday and public holidays, 10am–5pm. Outside these hours, people can leave a message.

People can also write to the Scheme at:
Department of Health and Ageing
GPO Box 9848
In your Capital City

An online complaints investigation form is available at:
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-complaints-index.htm

If a person is not satisfied with how their complaint has been handled, they can take their concerns to the Departmental manager responsible for the Scheme in their state or territory, by calling the Scheme number above.

Guides—reporting abuse, preventing and responding to abuse

Compulsory Reporting Resource Guide—available to Aged and Community Care Victoria (AACV) members. Providers in other states should contact their peak body to access this report.
www.accv.com.au

Policy and Procedures for Residential Aged Care—Preventing and Responding to Abuse, published by the Benevolent Society. Find the report via the resources page on this site.
www.bensoc.org.au

COMPULSORY REPORTING

Forms—all

All Departmental forms are available on the Department's website at
www.health.gov.au/internet/main/publishing.nsf/Content/health-forms.htm

Legislation—other

Go to ComLaw to access other legislation mentioned in this chapter, including *Criminal Code Act 1995 and Privacy Act 1988*.
www.comlaw.gov.au

COMPULSORY REPORTING

RECORD KEEPING

RECORD KEEPING

LEGISLATIVE REFERENCES

This Manual has been written in plain English and as a result, some aspects of the legislation and policy have been simplified. It is intended to be a general guide only and does not constitute legal advice. In cases of discrepancy between the Manual and the legislation, the legislation will be the source document for payment of Australian Government benefits and enforcement of approved provider responsibilities.

RELEVANT LEGISLATION

- Part 6.3, Divisions 87–89, *Aged Care Act 1997* (the Act)
- *Records Principles 1997*

OVERVIEW

An approved provider must keep records so that:

- claims for payment of Government subsidies can be verified
- and approved providers can be assessed to see if they are meeting their responsibilities under Chapter 4 of the Act
  - to provide quality care
  - in relation to user rights
  - to be accountable for the care they provide. *See legislative reference.*

s 88-1(1)(a), Aged Care Act 1997

Providers must keep these records for three years after the end of the financial year:

- in which the record was made *See legislative reference.*
- in which the provision of care ceased permanently. *See legislative reference.*

s 88-1(1)(b), Aged Care Act 1997

s 88-1(2), Aged Care Act 1997

Providers will have to decide if they need to keep records for longer than a three-year period in order to comply with taxation regulations, state government legislation or possible medical or legal matters.

A record may be kept or retained in written or electronic form. *See legislative reference.*

s 88-1(3), Aged Care Act 1997

Additional information

This chapter has been updated and revised to help approved providers comply with their responsibilities under the Act; and to assist staff of aged care services understand the regulation of residential aged care. Additional information can also be accessed through the Aged Care Information Line on 1800 500 853.

KINDS OF RECORDS

An approved provider must keep the following records relating to residents: *See legislative reference.*

s 19.5, Records Principles 1997

- resident assessments
- appraisal and reappraisal records in the form of Answer Appraisal Packs
- copies of applications for classification for residents that are not provided to the Department in electronic form
- individual care plans for residents

LEGISLATIVE REFERENCES

- medical records, progress notes and other clinical records of residents
- schedules of fees and charges (including retention amounts relating to accommodation bonds and/or accommodation charges) for previous and current residents
- agreements between residents and the approved provider
- residents' accounts
- records relating to the approved provider's compliance with prudential requirements for accommodation bonds
- records about the payment and repayment of accommodation bonds (including periodic payments)
- records about the payment of accommodation charges
- records about a resident's entry, departure and leave arrangements, including death certificates where appropriate
- records about a financial hardship determination for a resident
- records about the amount of accommodation charge refunded to residents who were charge exempt residents
- up-to-date records of the name and contact details of at least one representative of each resident and the name and contact details of any other representative of a resident, both according to information given to the approved provider by the resident, or by the representative.

s 89-1, Aged Care Act 1997
s 19.6, Records Principles 1997

An approved provider who permanently ceases to provide care must retain these records in relation to residents for a period of three years commencing on the day that the person ceased to be an approved provider. *See legislative reference.*

An approved provider must also keep:

- consolidated records of all incidents involving allegations of or suspicions about reportable assaults. See also sections on Record keeping and privacy in chapters on Providers responsibilities and non-compliance and Compulsory reporting in this Manual.
- records showing compliance regarding police certificate requirements for staff members and volunteers. See also section on Police checks in chapter on Providers' responsibilities and non compliance in this Manual.

The requirements referred to in this chapter relate to Australian Government requirements only. Providers may also be required to keep records to meet state or territory requirements.

False or misleading records

s 88-3(2), Aged Care Act 1997
s 88-3(1), Aged Care Act 1997

A person who makes a false or misleading record may be guilty of an offence punishable by a fine. *See legislative reference.* Sanctions can also be imposed on an approved provider who makes a record that is false or misleading. *See legislative reference.*

RECORD KEEPING

REFERENCES—LINKS, GUIDES AND FORMS REFERRED TO IN THIS CHAPTER

Aged Care Information Line

Ph 1800 500 853

Legislation—other

See ComLaw for a link to the *Privacy Act 1988*.
www.comlaw.gov.au

RECORD KEEPING