



Australian Government

Department of Health and Ageing

HOME CARE PACKAGES PROGRAM GUIDELINES

AUGUST 2013

TABLE OF CONTENTS

FOREWORD	3
PART A – INTRODUCTION	5
1. <i>Living Longer Living Better</i> Aged Care Reforms.....	5
2. Home Care Packages Program.....	5
3. Consumer Directed Care (CDC).....	8
4. Use of innovative and digital technology	10
5. Evaluation	10
6. Legal framework	11
7. Pathway for the consumer	11
PART B – SUMMARY OF CHANGES AND TRANSITIONAL ARRANGEMENTS – 1 AUGUST 2013	13
1. Summary of Changes	13
2. Transitional arrangements.....	17
PART C – ACCESSING A HOME CARE PACKAGE	20
1. Finding information about Home Care Packages	20
2. Eligibility for a Home Care Package	20
3. Issues to be considered by ACATs in determining eligibility	22
4. ACAT approvals	23
5. Referral from an ACAT to a home care provider or other services and practitioners	23
6. Being offered a package by a home care provider	24
PART D – MAKING USE OF A HOME CARE PACKAGE	26
1. Being offered a package by a home care provider	26
2. Home Care Agreement	26
3. Packages delivered on a CDC basis	30
4. Packages not being delivered on a CDC basis.....	41
5. Topping-up services or additional services under a package (both CDC and non-CDC).....	42
6. Converting packages delivered on a non-CDC basis to a CDC basis	43
PART E – WHAT HOME CARE PACKAGES PROVIDE.....	44
1. Home care subsidy.....	44
2. Existing EACHD consumers	45
3. Care and services	45
4. Security of tenure	50
5. Leave provisions.....	51

PART F – RIGHTS AND RESPONSIBILITIES.....	55
1. Context.....	55
2. Consumers	55
3. Approved providers	58
4. Police check/certificate requirements.....	59
5. Quality Reporting Program	62
6. Qualifications of staff and workers.....	63
PART G – CONSUMER CARE FEES.....	64
1. Overview	64
2. Determining care fees.....	65
3. Payment of care fees in advance	66
4. Review of care fees	66
5. What constitutes income?	66
PART H – SUPPLEMENTS	67
1. Eligibility for Supplements	67
PART I – ADMINISTRATIVE ARRANGEMENTS FOR APPROVED PROVIDERS	72
1. Conditions of allocation to replace agreements	72
2. Variations, transfers and surrender or relinquishment of packages.....	74
3. Financial reporting to the Department.....	75
4. Claims process.....	76
PART J – INTERFACE WITH OTHER PROGRAMS	78
1. Interface with other programs	78
2. Commonwealth Home Support Program	78
3. Home and Community Care (HACC)	79
4. National Respite for Carers Program (NRCP).....	81
5. Residential respite	81
6. Day Therapy Centres program.....	82
7. Transition Care Program	83
8. Community Visitors Scheme	83
9. Disability programs	84
10. Continence Aids Payment Scheme (CAPS)	86
11. Palliative care	86
12. Hospital in the Home	87
13. Department of Veterans’ Affairs Programs	87
PART K – APPENDICES	95
Appendix A – Glossary of Terms	95

FOREWORD

These Guidelines provide policy guidance to support the delivery and management of the Home Care Packages Program, including the policy context for the *Living Longer Living Better* aged care reforms.

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

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

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

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

The development of the Guidelines was informed by advice from the National Aged Care Alliance, and feedback received from peak groups, organisations and individuals during consultations on the draft Guidelines in April and May 2013.

The Guidelines will be updated in the first half of 2014 to include information on the new income testing and care subsidy reduction arrangement that will apply in home care from July 2014.

Terminology

Consumer

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

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

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

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

Home care provider

In these Guidelines, the term “home care provider” is generally used to refer to the corporation that has been approved by the Department of Health and Ageing under Part 2.1 of the Act as suitable to provide home care.

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

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

Glossary of terms

There is a glossary of terms at the end of these Guidelines – Part K.

PART A – INTRODUCTION

Covered in this part

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

1. Living Longer Living Better Aged Care Reforms

On 20 April 2012, the Australian Government unveiled *Living Longer Living Better*, a comprehensive 10 year package to reshape aged care in Australia.

The *Living Longer Living Better* aged care reform package provides \$3.7 billion over five years. It encompasses a 10 year reform program to create a flexible and seamless system that provides older Australians with more choice, control and easier access to a full range of services, where they want it and when they need it.

As part of these reforms, the Australian Government is significantly expanding home care to assist people to remain living at home for as long as possible, and to introduce more choice and flexibility for people receiving care at home.

The Government is providing \$880 million over five years to increase the total number of Home Care Packages from around 60,000 packages (in 2012) to around 100,000 packages (by 2016-17). More than 40,000 additional packages are expected to be available over the following five year period, from 2017-18 to 2021-22.

2. Home Care Packages Program

2.1 Package levels

There are four levels of Home Care Packages, including two new levels:

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

- Home Care Level 3 – a new package to support people with intermediate care needs.
- Home Care Level 4 – a package to support people with high care needs, equivalent to the former Extended Aged Care at Home (EACH) package.

These packages form a new Home Care Packages Program which commences on 1 August 2013.

The Home Care Packages Program replaces the former Community Packaged Care Programs, which comprised Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) packages and Extended Aged Care at Home Dementia (EACHD) packages. Transitional arrangements are explained in Part B, Section 2.

It is no longer necessary to have a separate EACHD level, as a Dementia and Cognition Supplement will be available to all home care providers that provide care to consumers who meet the eligibility criteria for the supplement (across any of the four levels of Home Care Packages). There is also a Veterans' Supplement for veterans with an accepted mental health condition. Further information on the supplements is at Part H.

The first group of Home Care Packages (a total of 5,835 packages) is being allocated through the 2012-13 Aged Care Approvals Round (ACAR).

For successful applicants in the 2012-13 ACAR, there are conditions of allocation requiring all of the packages to be delivered on a Consumer Directed Care (CDC) basis. Successful applicants are also required to participate in an evaluation of the Home Care Packages Program, including the CDC arrangements.

2.2 Program objectives

The objectives of the Home Care Packages Program are:

- to assist people to remain living at home for as long as possible; and
- to enable consumers to have choice and flexibility in the way that care and support is provided at home.

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

2.3 Target population

There is not a minimum age requirement for eligibility purposes, but the Home Care Packages Program is targeted at frail older people. In 2011-12, the average age of admission into a CACP, EACH or EACHD package was 81 years. For Aboriginal and

Torres Strait Islander people, the average age of admission into a CACP, EACH or EACHD package was 66 years.

In some cases, younger people with disabilities, dementia or special care needs may be able to access a Home Care Package – if the person has been assessed and approved by an ACAT, and a home care provider is able to offer an appropriate package for the person.

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

2.4 Special needs groups

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

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

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

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

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

2.5 People with dementia

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

3. Consumer Directed Care (CDC)

3.1 What does CDC mean in the context of Home Care Packages?

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

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

CDC is a way of delivering services that allows consumers to have greater control over their own lives by allowing them to make choices about the types of care and services they access and the delivery of those services, including who will deliver the services and when. Under a CDC approach, consumers are encouraged to identify goals, which could include independence, wellness and re-ablement. These will form the basis of the Home Care Agreement and care plan.

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

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

CDC models were trialled in around 1,000 home-based packages, as part of a pilot program funded by the Australian Government from 2010 to 2012.

3.2 CDC principles

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

3.2.1 Consumer choice and control

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

3.2.2 Rights

CDC should acknowledge an older person’s right (based on their assessed needs and goals) to the individualised services and support that will assist them.¹

3.2.3 Respectful and balanced partnerships

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

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

3.2.4 Participation

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

3.2.5 Wellness and re-ablement

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

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

3.2.6 Transparency

Under a CDC package, older people have the right to use their budgets to purchase the services they choose.² To make informed decisions about their care, older people need to have access to budgeting information, including the cost of services, the contents of their individualised budgets and how their package funding is spent.

¹ Care and services must be within the scope of the Home Care Packages Program.

² Care and services must be within the scope of the Home Care Packages Program.

4. Use of innovative and digital technology

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

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

5. Evaluation

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

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

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

The evaluation will also consider:

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

The scope and timeframes for the evaluation will be finalised early in 2013-14. Details will be published on the Department of Health and Ageing website.

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

6. Legal framework

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

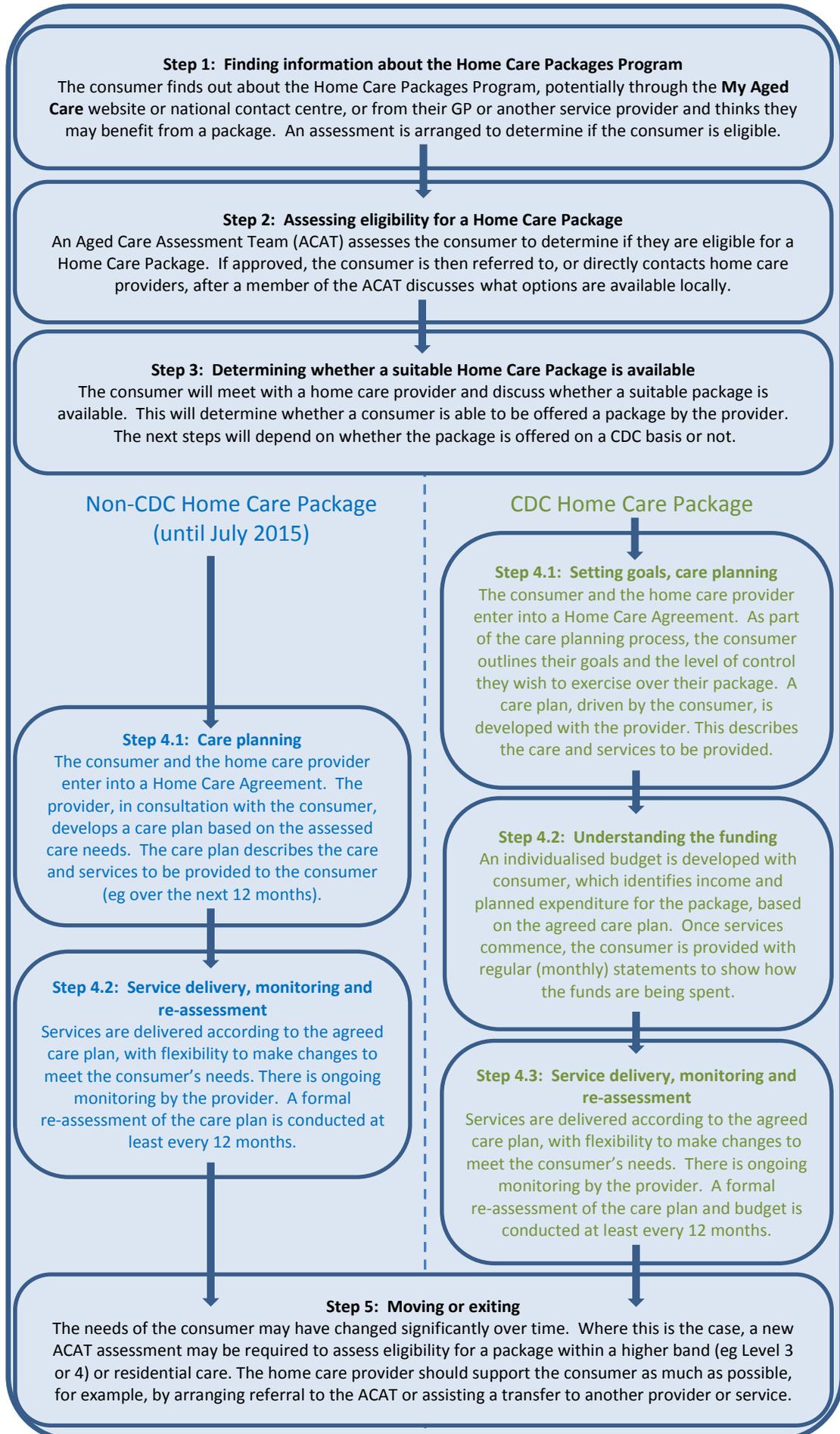
- the *Aged Care Act 1997*;
- Principles made under the Act;
- Determinations made under the Act (for example, setting relevant subsidy and supplement levels); and
- conditions of allocation made under the Act (for example, conditions applying to all packages and/or specific conditions applying to individual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

7. Pathway for the consumer

The pathway for the consumer involves a series of steps from finding information about the Home Care Packages Program, assessment by an Aged Care Assessment Team, contacting local home care providers, being offered a package by a provider, care planning and budget setting, service delivery, understanding how funds are being spent, monitoring and re-assessment, and exiting the program.

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

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



PART B – SUMMARY OF CHANGES AND TRANSITIONAL ARRANGEMENTS – 1 AUGUST 2013

Covered in this part

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

1. Summary of changes

Issue	Up until 1 August 2013	From 1 August 2013	Reference in Guidelines
Program name	Community Packaged Care Programs – comprising the CACP, EACH and EACHD Programs	Home Care Packages Program	Part A
Package levels	3 levels: <ul style="list-style-type: none"> – CACP – EACH – EACHD 	4 levels : <ul style="list-style-type: none"> – Home Care Level 1 – Home Care Level 2 – Home Care Level 3 – Home Care Level 4 	Part A
Supplements	<p>Viability Supplement applies to all package levels</p> <p>Oxygen Supplement and Enteral Feeding Supplement apply to EACH and EACHD packages, but not CACPs</p>	<p>Viability Supplement applies to all package levels</p> <p>Oxygen Supplement and Enteral Feeding Supplement applies to all package levels³</p> <p>Dementia and Cognition Supplement or Veterans' Supplement applies to all package levels⁴</p> <p>Aged Care Workforce Supplement applies to all package levels⁵</p> <p>Top-up Supplement applies to existing EACHD consumers (as at 31 July 2013)</p>	Part H

³ Payable to the home care provider where the consumer meets the relevant eligibility requirements for the supplements. Both supplements may be claimed if the consumer is eligible.

Part B – Summary of changes and transitional arrangements

Issue	Up until 1 August 2013	From 1 August 2013	Reference in Guidelines
Consumer Directed Care (CDC)	Limited application ⁶	Applies to all new Home Care Packages from August 2013, and to all packages (including existing packages) from July 2015 Option to convert existing packages to CDC earlier than July 2015 if the provider wants to	Parts A & D
Care and services	<p>CACP:</p> <ul style="list-style-type: none"> – does not include nursing and allied health, or aids and equipment in the range of care and services <p>EACH/EACHD:</p> <ul style="list-style-type: none"> – include nursing and allied health, as well as some aids and equipment in specified care and services – contain exclusions such as motorised wheelchairs and custom-made aids 	<p>A single list of care and services applies to all package levels⁷ (the care and services listed do not provide an exhaustive list)</p> <p>All package levels, regardless of whether delivered on a CDC basis or not, will have:</p> <ul style="list-style-type: none"> – greater flexibility through other care and services required to support the consumer at home – access to nursing, allied health and other clinical services – access to a wider range of aids and equipment – limited number of specified exclusions 	Part E
Approved provider status	<p>Approved provider of Community Care required for CACP packages</p> <p>Approved provider of Flexible Care required for EACH/EACHD packages</p>	Approved provider of Home Care required for all package levels	Part B

⁴ Payable to the home care provider where the consumer meets the relevant eligibility requirements. Funding will be provided for either the Dementia and Cognition Supplement or the Veteran’s Supplement, but both supplements cannot be claimed for the same person.

⁵ Payable to the home care provider if they meet the relevant eligibility requirements for the supplement and choose to participate in the Aged Care Workforce Supplement.

⁶ Applies to 1,000 packages from the former CDC trial (converted to mainstream packages in July 2012).

⁷ Part 1 of Schedule 4 to the *Quality of Care Principles 1997*

Part B – Summary of changes and transitional arrangements

Issue	Up until 1 August 2013	From 1 August 2013	Reference in Guidelines
Age eligibility	Targeted at frail older people aged 70 years and over	No minimum age requirement for eligibility purposes, but the program is targeted at frail older people	Part C
ACAT approval	Separate approval required for each package level Approval for EACH/EACHD enables access to a CACP	Broadbanded approval – two assessment points (Level 1 / 2, Level 3 / 4) Approval to access a particular level enables access to any level of home care package that is lower than the approved level	Part C
Lapsing ACAT approvals	CACP approvals automatically lapse if care is not provided within 12 months after the approval No automatic lapsing of EACH and EACHD approvals	Existing approvals (including CACP approvals in force on 31 July 2013), and all new approvals from 1 August 2013, do not automatically lapse at any package level	Part C
Agreement between the home care provider and the consumer	Care Recipient Agreement	Now called a Home Care Agreement There are also some changes to the information that must be included in the Home Care Agreement	Part D
National Translating and Interpreting Service (TIS)	Service is available to residential care providers	Service is available to residential care and home care providers	Part D
Standards	Community Care Common Standards	Now re-named as the Home Care Common Standards (also known as the Home Care Standards)	Part F
Charter	Charter of Rights and Responsibilities for Community Care	Now re-named as the Charter of Rights and Responsibilities for Home Care	Part F

Part B – Summary of changes and transitional arrangements

Issue	Up until 1 August 2013	From 1 August 2013	Reference in Guidelines
Care fees (care recipient contribution fees)	Consumers can be asked to pay a care recipient contribution fee of: <ul style="list-style-type: none"> – Up to 17.5% of basic pension, plus up to 50% of income above the basic pension 	<p><u>From 1 August 2013</u> – no changes from previous arrangements</p> <p><u>From 1 July 2014</u> – new income testing arrangements, including hardship provisions, will apply</p>	Part G
Leave provisions (determining for how long and at what rate the home care subsidy will be paid when a consumer takes leave from a package)	A range of different leave provisions applied across CACPs and EACH/EACHD packages, with different rules depending on the type of leave taken by the consumer	New leave provisions apply to the Home Care Packages Program – with common rules applying across all package levels, and greater consistency between the different types of leave	Part E
Security of tenure	Security of tenure provisions are set out in Division 1, Part 3 of the <i>User Rights Principles 1997</i>	In addition to the existing provisions, a home care provider may also reallocate a package to another person if: <ul style="list-style-type: none"> – the consumer does not meet his/her responsibilities, as described in the Charter of Rights and Responsibilities for Home Care, for a reason within the consumer’s control⁸ 	Part E

⁸ Paragraph 23.21(e) of the *User Rights Principles 1997*

Issue	Up until 1 August 2013	From 1 August 2013	Reference in Guidelines
Agreements between the Commonwealth and home care providers	Requirement to enter into a Deed of Agreement for CACPs, and separate Payment Agreements for EACH and EACHD packages	No new agreements from 1 August 2013. Requirements are set out in the legislation (the Act, Principles and Determinations) and in conditions of allocation Existing agreements will cease from 1 August 2013, but existing conditions of allocation will continue to apply. All approved provider responsibilities will be set out in the legislation	Part I
Interface with other programs	Some information was included in the former Community Packaged Care Guidelines	The interface between the Home Care Packages Program and other programs is explained in these Guidelines	Part J

2. Transitional arrangements

2.1 Existing allocations of packages

From 1 August 2013, all existing allocations of:

- CACP packages will become Home Care Level 2.
- EACH packages will become Home Care Level 4.
- EACHD packages will become Home Care Level 4.

The change from the former CACP, EACH and EACHD packages to new Home Care Packages will take effect from 1 August 2013, when Schedule 1 to the *Aged Care (Living Longer Living Better) Act 2013* and the relevant subordinate legislation commences.

From 1 August 2013, there will no longer be a requirement for home care providers to enter into an agreement with Commonwealth in respect of allocations of new Home Care Packages.

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

2.2 Existing consumers

Existing consumers receiving CACP, EACH or EACHD packages will continue to receive home care from 1 August 2013. Existing consumers will not need to be re-assessed by an ACAT. The transitional provisions in the legislation mean that existing consumers receiving:

- a CACP will receive services under a Home Care Level 2 package.
 - an EACH package will receive services under a Home Care Level 4 package.
 - an EACHD package will receive services under a Home Care Level 4 package.
- The Dementia and Cognition Supplement and the Top-up Supplement will also be paid to the home care provider for existing EACHD consumers (ie people receiving services under an EACHD package on 31 July 2013).
 - Where the existing EACHD consumer is eligible for the Veterans' Supplement, the Veterans' Supplement (and the Top-up Supplement) may be paid to the home care provider rather than the Dementia and Cognition Supplement.⁹

Care Recipient Agreements (which, after 1 August 2013, will be known as Home Care Agreements) will continue to remain in force.

2.3 Existing ACAT approvals

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

From 1 August 2013, ACAT approvals will not automatically lapse across any of the four home care levels. Previously, a CACP approval automatically lapsed if care was not provided within 12 months after the approval.

Further details are in Part C, Section 4.

2.4. Changes to approved provider arrangements

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

Prior to 1 August 2013, providers of CACPs were required to be approved providers of **community care**. Providers of EACH and EACHD packages were required to be approved providers of **flexible care**. Providers delivering both types of packages (CACP and EACH/EACHD) were required have approval to provide both types of care.

⁹ The Dementia and Cognition Supplement, the Veterans' Supplement, and the Top-up Supplement are explained in Part H

From 1 August 2013, there will be a single approval to be a provider of **home care**. This will enable an approved provider to deliver services at any of the four levels of Home Care Packages (as long as they have an allocation of packages under the Act, eg usually this will occur through the Aged Care Approvals Round).

For existing approved providers (ie those who have approved provider status on 31 July 2013):

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

PART C – ACCESSING A HOME CARE PACKAGE

Covered in this part

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

1. Finding information about Home Care Packages

From 1 July 2013, older people, their families and carers will be able to access the [My Aged Care website](http://www.myagedcare.gov.au) at www.myagedcare.gov.au or the national contact centre on **1800 200 422** for information about the aged care system and services.

2. Eligibility for a Home Care Package

2.1 Age

There is not a minimum age requirement for eligibility purposes, but the Home Care Packages Program is targeted at frail older people. In 2011-12, the average age of admission into a CACP, EACH or EACHD package was 81 years. For Aboriginal and Torres Strait Islander people, the average age of admission into a CACP, EACH or EACHD package was 66 years.

In some cases, younger people with disabilities, dementia or special care needs may be able to access a Home Care Package – if the person has been assessed and approved by an ACAT, and a home care provider is able to offer an appropriate package for the person.

2.2 Residency or citizenship

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

2.3 Assessment by an Aged Care Assessment Team

In order to access a Home Care Package, a person needs to be assessed and approved as eligible for home care by an ACAT¹⁰, and then offered a Home Care Package by a home care provider.

2.4 Broadbanded assessments

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

For the first year (commencing 1 August 2013), the two assessment bands for eligibility will be:

- *Home Care Levels 1 and 2* – to be eligible to access either a Level 1 or 2 package, a person would be assessed by an ACAT (if they applied for approval to receive residential care) as eligible for low level residential care; and
- *Home Care Levels 3 and 4* – to be eligible to access either a Level 3 or 4 package, a person would be assessed by an ACAT (if they applied for approval to receive residential care) as eligible for high level residential care.

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

However, the definitions used to describe the eligibility bands (above) will be reviewed during the first year of the program, to take effect from 1 July 2014. The review will consider whether a person’s eligibility for home care should continue to be dependent on whether that person would have been assessed as eligible to receive residential care. The review will also consider how eligibility for home care within each assessment band should be defined once the distinction between low level and high level residential care is removed from the *Aged Care Act 1997* on 1 July 2014.

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

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

¹⁰ In Victoria, ACATs are known as Aged Care Assessment Services (ACAS).

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

3. Issues to be considered by ACATs in determining eligibility

3.1 Eligibility criteria

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

The requirements of the legislation¹¹ mean that, for a person to be eligible for a Home Care Package, the person must be assessed:

- as having needs that can only be met by a co-ordinated package of care services;
- as someone who would be eligible to receive at least low level residential care (for Home Care Levels 1 or 2) or high level residential care (for Home Care Levels 3 or 4) if they applied for residential care;
- have expressed a preference to live at home (including as a resident of a retirement village); and
- be able to remain living at home with the support of a Home Care Package.

3.2 Aged Care Client Record and information about the ACAT decision

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

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

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

¹¹ Sections 5.6 and 5.7 of the *Approval of Care Recipient Principles 1997*.

4. ACAT approvals

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

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

This means that:

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

4.2 Removal of automatic lapsing of approvals

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

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

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

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

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

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

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

6. Being offered a package by a home care provider

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

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

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

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

6.1 Moving between package levels or bands

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

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

6.2 Waiting lists

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

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

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

PART D – MAKING USE OF A HOME CARE PACKAGE

Covered in this part

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

1. Being offered a package by a home care provider

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

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

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

2. Home Care Agreement

2.1 Overview

For all Home Care Packages, whether delivered on a CDC basis or not, a Home Care Agreement (previously known as a Care Recipient Agreement) must be offered to the consumer before the package commences. This is a legal requirement.¹²

¹² Section 23.94 of the *User Rights Principles 1997*.

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

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

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

Once the Home Care Agreement is entered into, care and services can formally commence under the package and the home care provider is able to commence claiming the government subsidy for the package (see Part I, Section 4).

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

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

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

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

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

Home care providers are able to use TIS to provide interpreting services to assist Home care consumers to understand their Home Care Package, including the Home Care Agreement, the individualised budget and monthly statements. Arrangements for accessing this service will be the same as the TIS arrangements for residential aged care providers, ie providers will be given a unique code to access interpreting services from TIS. The arrangements for home care providers will commence in mid 2013.

In the future, home care providers will be offered opportunities to apply for funding through the Aged Care Service Improvement and Healthy Ageing Grants fund for the translation of template documents related to Home Care Packages.

2.2 Items to be included in the Home Care Agreement

Under the legislation¹³, the following information must be included in the Home Care Agreement:

Check	Item
<input type="checkbox"/>	Start date for the care
<input type="checkbox"/>	The level of the Home Care Package to be provided (ie Level 1, 2, 3 or 4)
<input type="checkbox"/>	Whether the Home Care Package will be provided on a CDC basis
<input type="checkbox"/>	Details outlining how the consumer can suspend care
<input type="checkbox"/>	An explanation of security of tenure
<input type="checkbox"/>	Conditions under which either party may terminate care
<input type="checkbox"/>	An explanation that any variation must be by mutual consent, following consultation between the consumer and the home care provider, and may only be made after the provider has given reasonable notice in writing to the consumer
<input type="checkbox"/>	A copy of the consumer's care plan, plus any subsequent changes to the care plan
<input type="checkbox"/>	Details of the consumer's rights about the service they are to receive. A copy of the <i>Charter of Rights and Responsibilities for Home Care</i> must also be provided to the consumer
<input type="checkbox"/>	A statement that the consumer is entitled to make, without fear of reprisal, any complaint about the Home Care Package, and an explanation of how to make a complaint. This refers to both internal complaint mechanisms and the Aged Care Complaints Scheme
<input type="checkbox"/>	A guarantee of the confidentiality, as far as legally permissible, of information provided by the consumer and the use to be made of the information
<input type="checkbox"/>	A clear itemised statement of the fees payable (if any) by the consumer and how they were calculated
<input type="checkbox"/>	Other financial information relevant to the care and services provided to the consumer
<input type="checkbox"/>	An explanation that a consumer is entitled to request a statement of the home care service's financial position, including a copy of the most recent version of the home care provider's audited accounts. This must be provided within seven days of the request

¹³ Section 23.95 of the *User Rights Principles 1997*.

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

For packages being delivered on a CDC basis, the individualised budget and regular statement of income and expenditure will also provide financial information to the consumer.

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

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

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

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

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

2.4 When can the home care subsidy be claimed?

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

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

3. Packages delivered on a CDC basis

3.1 Care planning

3.1.1 Overview

A key feature of a package being delivered on a CDC basis is that the consumer must have ownership of decision making. This requires an empowering decision making framework, which supports the consumer to set goals and determine the amount of control they want to exercise in relation to their package.

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

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

3.1.2 Goal setting

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

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

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

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

3.1.3 Level of consumer control over the management of the package

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

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

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

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

Where the consumer chooses to be more involved in the management of the package, the individualised budget should reflect this role – with lower care co-ordination and administration costs charged by the provider.

3.1.4 Determining who has authority to make decisions

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

3.1.5 Case management

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

- the initial assessment by the home care provider;
- identification of the consumer's goals;
- development of the Home Care Agreement, care plan and individualised budget;
- ongoing monitoring and informal reviews of the consumer;

- formal re-assessment of the consumer’s needs, and adjustment of the Home Care Agreement, care plan and individualised budget if required; and
- referral to an ACAT (eg if a reassessment is needed to move to a higher broad-banded level of package).

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

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

In some cases, a consumer may wish to have a specific person as a case manager. This can be negotiated between the consumer and the home care provider. If agreed, the home care provider will need to establish a contractual or employment relationship with the case manager suggested by the consumer. The case manager should have appropriate skills and qualifications to perform this role.

3.1.6 Choosing care and services

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

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

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

3.1.7 Care plan

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

- the consumer’s goals – what it is the consumer would like to achieve through their package;

- the care and services to be provided to support the identified goals;
- who will provide the care and services;
- when care and services will be provided, including the frequency of services and days/times when regular services are expected to be provided;
- the level of involvement and control the consumer will exercise over the management of the package;
- case management arrangements, including how ongoing monitoring and informal reviews will be managed; and
- the frequency of formal reassessments (which must be undertaken at least every 12 months).

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

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

3.1.8 Giving effect to the consumer's choices and preferences

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

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

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

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

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

- The proposed service may cause harm or pose a threat to the health and/or safety of the consumer or staff.
- The proposed service is outside the scope of the Home Care Packages Program (see Part E, Section 3.6).
- The home care provider would not be able to comply with its responsibilities under aged care legislation or other Commonwealth or state/territory laws.
- The consumer's choice of service provider is outside the home care provider's preferred list of service providers and all reasonable effort has been made to broker an acceptable sub-contracting arrangement.

- The requested service provider will not enter into a contract with the home care provider.
- There have been previous difficulties or negative experiences with the consumer’s suggested service provider.
- Situations in which a consumer may want to go without necessary clinical services (resulting in a possible compromise of their health and/or wellbeing) in order to “save” for a more expensive non-clinical service.
- The cost of the service/item is beyond the scope of the available funds for the package.

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

3.1.9 Sub-contracted or brokered services

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

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

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

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

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

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

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

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

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

3.1.11 Contracting to informal carers, family members or friends

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

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

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

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

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

3.2 Individualised budget

3.2.1 Overview

For packages delivered on a CDC basis, the government subsidy for the package is still paid to the home care provider, not directly to the consumer.

The home care provider is the fund holder and will administer the budget on behalf of the consumer in a transparent manner, meeting quality and accountability requirements.

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

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

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

3.2.2 What is an individualised budget?

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

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

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

Income

The budget should clearly identify the total funds available under the package, comprising:

- the full amount of the government subsidy for the package level (including relevant supplements¹⁴, eg Dementia and Cognition, Veterans', Oxygen, Enteral Feeding and Top-up Supplements (where applicable); and
- any consumer contribution/care fee.

¹⁴ Funding paid to the approved provider through the Aged Care Workforce and Viability Supplements (if applicable) does not have to be included in the individualised budget.

Planned expenditure

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

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

These categories are explained below.

- *Administration costs* – reflect establishment costs for the organisation and would also include the costs of meeting government quality and accountability requirements. Administrative costs include:
 - insurance and government reporting
 - corporate overheads
 - capital costs
 - ongoing research and service improvement
 - CDC administrative overheads including staff and IT
 - developing statements and other consumer communication
 - establishing contracts with sub-contracted providers
 - setting up and cancelling appointments.
- *Core advisory and case management services* – this category will include the costs associated with:
 - care planning
 - set up costs for new consumers
 - periodic reviews or re-assessments
 - case co-ordination or case management
 - provision of support to consumers who elect to manage their package themselves.

The budget should describe and quantify what tangible services will be provided to the consumer, eg costs are based on personal and phone contact of X hours per week at \$Y per hour (or appropriate service unit). The budget should also specify when reviews or re-assessments are to be conducted.

- *Service and support provision and/or purchasing* – this category will include the costs of direct service provision. This part of the budget should confirm the decisions made in the care plan about what services have been chosen to be delivered or purchased (eg nursing, domestic assistance) and the individual cost of those services.

3.2.3 Contingency

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

As a guide, if a contingency is set aside, it should be no more than 10% of the total annual budget for the package. The contingency amount must be clearly identified in the individualised budget and in the monthly statement of income and expenditure provided to the consumer. The ongoing balance of funds available to the consumer (if separate from the contingency amount) must also be clearly identified in the monthly statement.

Contingency amounts cannot be pooled across consumers.

3.2.4 Regular income and expenditure statement to the consumer

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

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

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

3.2.5 Unspent funds when a consumer leaves a package

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

- If the consumer continues to receive a package from the home care provider (at a different package level), any unspent funds from the previous package must continue to be available under the consumer’s new package.
- If the consumer moves to a different home care provider (eg to take up a package with another home care provider or to enter residential care), any unspent funds can be retained by the previous home care provider to support service delivery for other consumers, or for infrastructure purposes.

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

3.3 Monitoring, review and re-assessment

3.3.1 Ongoing monitoring and review by the home care provider

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

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

3.3.2 Re-assessment by the home care provider

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

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

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

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

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

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

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

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

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

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

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

If the consumer's care needs have increased significantly so that the person potentially requires home care in a higher band (eg Level 3 or 4, rather than Level 1 or 2), or entry to residential care, the consumer will need another assessment by an ACAT. The home care provider can assist in arranging the ACAT assessment, with the permission of the consumer.

4. Packages not being delivered on a CDC basis

4.1 Overview

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

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

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

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

4.2 Level of consumer control over the management of the package

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

4.3 Giving effect to the consumer’s choices and preferences

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

4.4 Individualised budget

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

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

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

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

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

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

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

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

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

All Home Care Packages, including packages allocated before the 2012-13 ACAR¹⁵, must be delivered on a CDC basis from 1 July 2015. The period leading up to this date is a transitional period for home care providers to introduce any changes in administration, systems and training that may be needed to deliver Home Care Packages on a CDC basis.

Home care providers do not have to wait until 1 July 2015, but can elect to convert existing packages to a CDC basis once they are ready to make the transition. Providers must advise the Department when they intend to start offering pre-existing packages on a CDC basis, so that this can be incorporated in new conditions of allocation for the relevant packages.

The Department will provide further advice about how home care providers can convert existing packages to a CDC basis.

¹⁵ Packages allocated to providers before the 2012-13 ACAR were allocated as CACP, EACH or EACHD packages. These will become Home Care Level 2 or 4 packages from 1 August 2013.

PART E – WHAT HOME CARE PACKAGES PROVIDE

Covered in this part

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

1. Home care subsidy

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

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

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

The basic subsidy amounts for 2013-14 (effective 1 August 2013) are set out below.¹⁶ Other supplement amounts may also apply – see Part H of these Guidelines.

Details of subsidy and supplement amounts are also published on the [Department of Health and Ageing Australian Government subsidies and supplements website](#). The information on the website is updated when subsidy and supplement amounts change.

¹⁶ Changes to subsidy amounts usually take effect from 1 July each year. Providers are advised about changes in subsidy amounts by the Department of Health and Ageing, usually through a mailstream or faxstream notice.

Level of Home Care Package	Basic home care subsidy in 2013-14 (per day)	Basic home care subsidy in 2013-14 (per annum ¹⁷)
Level 1	\$20.55	\$7,501
Level 2	\$37.38	\$13,644
Level 3	\$82.20	\$30,003
Level 4	\$124.95	\$45,607

2. Existing EACHD consumers

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

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

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

Home care	Total funding available in 2013-14 (per day)	Total funding available in 2013-14 (per annum)
Existing EACHD consumers only	\$139.92 (see note below)	\$51,071

Total funding for existing EACHD consumers comprises the Home Care Level 4 basic subsidy (\$124.95 per day), plus 10% for the Dementia and Cognition Supplement or Veteran's Supplement (\$12.50 per day), plus the Top-up Supplement (\$2.47 per day).

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

3. Care and services

3.1 Overview

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

¹⁷ Annual subsidy amounts have been rounded to the nearest dollar.

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

The list of care and services and the excluded items are set out in the following tables (Sections 3.5 and 3.6). These tables are based on the information contained in Schedule 4 to the *Quality of Care Principles 1997*.¹⁸

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

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

The consumer and the home care provider can also negotiate other care and services required to support the consumer to live at home where this will assist the consumer to achieve his/her goals, consistent with the consumer's care needs.¹⁹ The home care provider must also be able to provide the care and services within the limits of the resources available for the package, and the care and services must not be an excluded item (ie outside the scope of the Home Care Packages Program).

This increased flexibility applies to all Home Care Packages, including packages that were previously allocated as CACP, EACH or EACHD packages.

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

3.2 Nursing, allied health and other clinical services

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

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

¹⁸ As amended by the *Quality of Care Amendment (Home Care) Principle 2013*.

¹⁹ The consumer's goals and care needs should be identified in the consumer's care plan.

The home care provider is responsible for ensuring that all home care consumers receive quality care and services that are safe and appropriate to their assessed needs.²⁰ This includes putting in place appropriate systems to support consumers in an emergency situation, including access to a person or service who can give emergency assistance when needed. Where a consumer has been assessed as requiring nursing services, the home care provider should consider whether there is a need to include in the Home Care Package 24-hour on-call access to care provided by, or under the supervision of, a registered nurse.

3.3 Telehealth and digital technology

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

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

3.4 Aids and equipment

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

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

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

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

²⁰ *Charter of Rights and Responsibilities for Home Care.*

3.5 List of care and services

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

A. Care services

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

B. Support services

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

C. Clinical services

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

3.6 Excluded items

The following services or items are outside the scope of the Home Care Packages Program and must not be included in a package (at any of the four levels of home care).²¹

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

4.1 Responsibilities for the provider

Under the legislation, home care providers are responsible for ensuring a consumer’s security of tenure.²²

The Home Care Agreement must specify how either party may terminate the Home Care Agreement²³ and must not contradict the security of tenure provisions set out in the *User Rights Principles 1997*.²⁴

²¹ These items are excluded under Part 2 of Schedule 4 to the *Quality of Care Principles 1997*.

²² Section 56-2 of the *Aged Care Act 1997* and Division 1, Part 3 of the *User Rights Principles 1997*.

²³ Section 23.95 of the *User Rights Principles 1997*.

²⁴ Division 1, Part 3 of the *User Rights Principles 1997*.

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

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

- the consumer cannot be cared for in the community with the resources available to the home care provider;
- the consumer tells the home care provider, in writing, that they wish to move to a location where home care is not available through the home care provider;
- the consumer tells the home care provider, in writing, that they no longer wish to receive the care; or
- the consumer's condition changes so that:
 - they no longer need home care; or
 - the consumer's needs, as assessed by the ACAT, can be more appropriately met by other types of services or care.
- the consumer does not meet his/her responsibilities, as described in the Charter of Rights and Responsibilities for Home Care, for a reason within the consumer's control.

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

4.2 Consumers moving locality

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

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

5. Leave provisions

5.1 Overview

A consumer may choose or need to take temporary leave from their Home Care Package for various reasons – for social purposes such as a holiday, a hospital stay which may sometimes be followed by transition care, or to receive respite care.

There were previously different leave provisions between CACP and EACH/EACHD packages.

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

5.2 Leave arrangements

The following arrangements will apply to all Home Care Package levels (1 to 4).

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

A consumer's tenure will not be affected while on leave as long as they advise the home care provider in writing they are taking leave. The consumer must also advise the home care provider in writing of any extension to a planned episode of leave.

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

Leave entitlements are usually calculated on a financial year basis from 1 July. However, in 2013-14, leave entitlements will be calculated from the commencement of the Home Care Packages Program on 1 August 2013. This means that any leave taken by a consumer in during the period 1 - 31 July 2013 under the former CACP, EACH or EACHD packages will be re-set from 1 August 2013, once these packages convert to Home Care Level 2 or 4 packages.

If a consumer transfers to a different Home Care Package level, such as from Level 3 to Level 4, within the same financial year, their full leave entitlements are available under the new level.

5.3 Impact of leave on consumer fees (care fees)

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

Care fees must not be charged by the home care provider where the consumer takes leave for transition care or residential respite care.

5.4 Impact of leave on supplements

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

The Viability Supplement and the Aged Care Workforce Supplement will also continue to be paid during a period of leave, including where the home care subsidy is paid at the reduced (25%) rate. The amount payable for the Aged Care Workforce Supplement will be based on the basic subsidy amount applicable at that time, ie the 25% rate. The amount of the Viability Supplement remains unchanged while the consumer is on leave.

No other supplement will be paid when the home care subsidy is paid at the reduced (25%) rate (as explained in the above table at Section 5.2).

5.5 Subsidy and care fees during leave periods (in packages delivered on a CDC basis)

For Home Care Packages being delivered on a CDC basis, any subsidy, relevant supplements²⁵ or care fees paid to the home care provider while the consumer is on leave must be included in the regular statement of income and expenditure provided to the consumer.

²⁵ Dementia and Cognition, Veterans, Oxygen, Enteral Feeding and Top-Up Supplements (where applicable).

PART F – RIGHTS AND RESPONSIBILITIES

Covered in this part

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

1. Context

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

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

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

2. Consumers

2.1 Rights and responsibilities

The rights and responsibilities of the consumer in relation to Home Care Packages are set out in the *Charter of Rights and Responsibilities for Home Care* (the Charter).²⁶

The Charter is contained in Schedule 2 to the *User Rights Principles 1997*. The full Charter will be available on the Department’s website.

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

²⁶ The Charter was previously called the *Charter of Rights and Responsibilities for Community Care*.

2.2 Advocacy

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

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

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

The approved provider must allow an advocate acting for an authorised body access to the home care service if the consumer or their representative has requested the assistance of such a person.²⁷

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

Approved providers should give consumers information about the role of advocates.

The National Aged Care Advocacy Program (NACAP) is a program funded by the Australian Government under the *Aged Care Act 1997*. The program promotes the rights of people who are seeking or are receiving Australian Government funded aged care services.

The National Aged Care Advocacy line is **1800 700 600** (free call).

2.3 Complaints

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

Approved providers must have appropriate processes in place to receive, record and resolve complaints.²⁸ These processes are to include consideration of people with special needs such as people with vision or hearing impairments and people from culturally and linguistically diverse backgrounds. Approved providers are required to inform consumers about these mechanisms and they must be identified in the Home Care Agreement.

²⁷ Section 23.23 of the *User Rights Principles 1997*.

²⁸ Section 56-4 of the *Aged Care Act 1997*.

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

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

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

2.4 Aged Care Complaints Scheme

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

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

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

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

The processes of the Complaints Scheme, including options for resolution, are governed by the *Complaints Principles 2011* under the Act.

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

- the Charter of Rights and Responsibilities for Home Care; and
- the Home Care Standards.

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

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

3. Approved providers

3.1 Responsibilities

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

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

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

3.1.1 Quality of care

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

This includes providing care and services in accordance with the *Quality of Care Principles 1997* and complying with the Home Care Standards.

Through the Quality Reporting Program, the Department undertakes reviews of approved providers against the Home Care Standards. The Quality Reporting Program is explained below (see Section 5 in this Part).

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

3.1.2 User rights

Division 56 of the Act outlines the general responsibilities of approved providers in relation to consumers (users and proposed users) of Home Care Packages. These responsibilities are described in further detail in Part 4.2 of the Act and in the *User Rights Principles 1997*.

In summary, the responsibilities of approved providers include:

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

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

3.1.3 Accountability

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

- record keeping;
- complying with powers being exercised by authorised officers;
- complying with conditions of allocation;
- complying with responsibilities specified in the *Accountability Principles 1998* (includes police check/certificate requirements); and
- obligations in relation to key personnel.

4. Police check/certificate requirements

4.1 Key personnel

Section 22.3B of the *Sanctions Principles 1998* outline the reasonable steps to be taken by an approved provider to ensure none of its key personnel is a disqualified individual. Approved providers are required to obtain a signed statutory declaration from its key personnel stating whether he or she has been convicted of an indictable offence or is an insolvent under administration.

The approved provider must:

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

Sections 1.19 to 1.22 of the *Accountability Principles 1998* and section 19.5A of the *Records Principles 1997* outline the responsibilities of approved providers in relation to police checks or police certificates (the names are used interchangeably) for staff members, contractors and volunteers.

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

- all staff members who are reasonably likely to have access to care recipients, whether supervised or unsupervised; and
- volunteers who have unsupervised access to care recipients, except in the case of volunteers sourced by an approved provider through the Community Visitors Scheme (CVS). Organisations funded under the CVS to recruit, train and place volunteers are required to undertake the police checks for such volunteers.

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

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

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

4.2 Staff member

A staff member is defined in section 1.18 of the *Accountability Principles 1998* as a person who:

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

4.3 Volunteer

Under section 1.18 of the *Accountability Principles 1998*, a volunteer is defined as a person who:

- is not a staff member; and
- offers his or her services to the approved provider; and
- provides care or other services on the invitation of the approved provider and not solely on the express or implied invitation of a care recipient; and
- has, or is reasonably likely to have, unsupervised access to care recipients; and
- has turned 16 years of age or, if the person is a full-time student, has turned 18 years of age.

4.4 Contractors

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

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

4.5 Independent contractors

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

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

Visiting medical practitioners, pharmacists and other health professionals who have been requested by, or on behalf of, a consumer but are not under contract to the approved provider also do not require police checks. The policy intention is to allow for reasonable judgments to be made.

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

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

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

The difference between a contractor and an independent contractor is generally decided on the basis of the degree of control that is exercised over the person's

work. A precise determination of whether a contractor is under the control of an approved provider can be difficult, and whether someone is a staff member or an independent contractor is a matter that might ultimately be determined by the courts.

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

Further information about police checks is available:

- by phone: **1800 200 422**
- in writing to:
 - the Department’s inbox “[Police Checks@health.gov.au](mailto:PoliceChecks@health.gov.au)”
 - Police Checks MDP 452
Department of Health and Ageing
GPO Box 9848
Canberra ACT 2601
- online: at the [Police Certificate Guidelines for Aged Care Providers website](#).

5. Quality Reporting Program

The Home Care Standards apply to the delivery of Home Care Packages. The Standards are contained in Schedule 5 to the *Quality of Care Principles 1997*.

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

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

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

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

The quality review process is currently managed by the Department of Health and Ageing. From 1 July 2014, this will be one of the responsibilities of the Australian Aged Care Quality Agency.

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

6. Qualifications of staff and workers

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

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

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

PART G – CONSUMER CARE FEES

Covered in this part

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

1. Overview

1.1 Arrangements from 1 August 2013

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

These arrangements will continue to apply from 1 August 2013 under the Home Care Packages Program – as set out in this Part, Sections 2 to 5 below.

1.2 Arrangements from 1 July 2014

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

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

Further information about these changes will be available from the **My Aged Care** website and national contact centre prior to the introduction of the new subsidy and fee arrangements in July 2014. The Home Care Packages Guidelines will also be updated in the first half of 2014 to explain the new income testing and care subsidy reduction arrangements.

2. Determining care fees

The maximum fee that a consumer can be asked to pay in a care recipient contribution (referred to in these Guidelines as a care fee) is determined by the legislation.²⁹

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

Example: Where a consumer receives the maximum single pension, for example \$733.70 per fortnight, the maximum fee they would pay is \$128.40 per fortnight. This is a notional calculation. For the most up to date basic pension amount refer to the [Centrelink website](#).

For a consumer receiving the maximum single pension, the maximum amount payable is updated twice a year and published on the [Department of Health and Ageing care recipient contributions and subsidies for Home Care Packages website](#).

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

The maximum amount that can be levied depends on the consumer's income but the provider must also have regard to unavoidable expenses such as high pharmaceutical bills, rent, utilities and other living expenses.

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

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

The legislation also requires that information about fees, including how fees are calculated and the fees payable, is included in the Home Care Agreement between the consumer and the home care provider.³⁰

²⁹ Paragraph 56-2(b) and Division 60 of the *Aged Care Act 1997* and Part 7 of the *User Rights Principles 1997*.

³⁰ Paragraph 23.95(a) of the *User Rights Principles 1997*.

3. Payment of care fees in advance

Home care providers may ask for fees to be paid up to one month in advance. If a consumer leaves the care program, any payment in advance beyond the date of leaving must be refunded to the consumer or their representative as soon as possible.

4. Review of care fees

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

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

5. What constitutes income?

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

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

PART H – SUPPLEMENTS

Covered in this part

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

1. Eligibility for Supplements

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

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

1.1 Dementia and Cognition Supplement and Veterans’ Supplement

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

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

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

Guidelines for these supplements are available on the [Living Longer Living Better website](#).

Supplements amounts for 2013-14 are outlined in the following table.

Home Care Package	Level 1	Level 2	Level 3	Level 4
Home Care Package basic subsidy	\$20.55	\$37.38	\$82.20	\$124.95
Dementia and Cognition Supplement (10%)	\$2.06	\$3.74	\$8.22	\$12.50
Veterans' Supplement (10%)	\$2.06	\$3.74	\$8.22	\$12.50

1.2 Oxygen Supplement

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

The Oxygen Supplement is paid to the home care provider for a consumer who has an ongoing medical need for oxygen. There is no supplement available for episodic or short-term illnesses such as bronchitis.

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

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

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

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

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

The rates for the Oxygen Supplement are the same as the Residential Aged Care Supplements (Care Related) rates. The rates are available on the [Department of Health and Ageing Australian Government subsidies and supplements website](#).

1.3 Enteral Feeding Supplement

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

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

A higher supplement may be approved when, for example:

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

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

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

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

The rates for the Enteral Feeding Supplements are the same as the Residential Aged Care Supplements (Care Related) rates. The rates are available on the [Department of Health and Ageing Australian Government subsidies and supplements website](#).

1.4 Viability Supplement

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

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

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

Information about the Viability Supplement including the subsidy rates is available on the [Department of Health and Ageing Australian Government subsidies and supplements website](#).

1.5 Aged Care Workforce Supplement

The *Living Longer Living Better* aged care reform package includes funding to better support the people who work in aged care. All home care providers that meet the requirements of the Aged Care Workforce Supplement will be eligible to apply for the Workforce Supplement.

From 1 August 2013, the Australian Government will provide additional funding through the Aged Care Workforce Supplement to participating home care providers that meet the eligibility requirements. This additional funding will assist participating providers to pay higher wages to aged care workers.

The amount of the Aged Care Workforce Supplement payable to home care providers is 1% of the basic subsidy amount.

Further information about the supplement and details on how to apply can be found in the Aged Care Workforce Supplement Guidelines on the [Living Longer Living Better website](#).

1.6 Top-up Supplement (for existing EACHD consumers)

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

PART I – ADMINISTRATIVE ARRANGEMENTS FOR APPROVED PROVIDERS

Covered in this part

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

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

1. Conditions of allocation to replace agreements

Prior to 1 August 2013, approved providers were required to enter into contractual agreements with the Commonwealth in relation to allocations of community care places (CACP) or flexible care places (EACH or EACHD packages).

CACPs were governed by a Community Care Deed of Agreement, and EACH and EACHD packages were governed by separate Payment Agreements.

From 1 August 2013, there will no longer be a requirement for approved providers to enter into an agreement with the Commonwealth in respect of allocations of new Home Care Packages. This change will take effect when Schedule 1 to the *Aged Care (Living Longer Living Better) Act 2013* and the transitional provisions in the *Allocation Principles 1997* commence.

Instead, the types of matters contained in the previous agreements will be included in the various Principles made under the *Aged Care Act 1997* or will be part of the conditions of allocation for the package. For all new packages, including those allocated to providers in the 2012-13 ACAR, the conditions of allocation will include a requirement that the packages must be delivered on a CDC basis.

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

1.1 Conditions of allocation

The conditions of allocation for Home Care Packages form part of the Notice of Allocation issued to the approved provider under section 14-8 of the Act.

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

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

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

1.2 Commencement of packages

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

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

If the package has been allocated on a provisional basis, the approved provider must advise the Department in writing when they are able to commence providing services. An approved provider must apply in writing to the Secretary using the form

titled, *Application for a Determination that an Approved Provider is in a Position to Provide Care – Home Care*. This application form will be available on the Department's website.

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

2. Variations, transfers and surrender or relinquishment of packages

2.1 Variations of packages

An approved provider can apply to the Secretary of the Department to vary an allocation of places (Home Care Packages) in certain circumstances, for example, to change conditions of allocation relating to geographic locations or special needs groups.

There are separate application forms for the variation of packages that have taken effect (operational places) and packages that are yet to take effect (provisionally allocated places). These forms will be available on the Department's website from mid 2013.

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

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

- Where an approved provider is seeking to change the name of a service, the approved provider should advise the Department in writing. However, this does not have to be done via an application form.
- There is no capacity under the legislation to approve a variation in the level of the Home Care Package that has been allocated to an approved provider, for example, from a Level 1 or 2 package to a Level 3 or 4 package. Providers seeking to obtain packages at a different level should apply through the Aged Care Approvals Round.
- There will be a separate process for approved providers seeking to "convert" existing packages from a non-CDC basis to a CDC basis. Further information about this process will be available on the Department's website after the commencement of the Home Care Packages Program. Information will also be communicated to existing providers through a mailstream/faxstream.

2.2 Transfer of packages

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

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

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

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

2.3 Surrender or relinquishment of packages

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

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

3. Financial reporting to the Department

Approved providers are required to provide an audited Financial Accountability Report (FAR) and Statement of Compliance to the Department of Health and Ageing each financial year.

These requirements were previously specified in the relevant agreements for the CACP, EACH and EACHD packages. While these agreements will no longer have effect from 1 August 2013, providers must continue to provide financial reporting information to the Department (in the same format used in previous financial years).

The current Financial Accountability Report and Statement of Compliance process will continue to apply for the 2012-13 financial year (and possibly for 2013-14). Providers who have previously been involved in the Trial of Alternate Audit Approaches can continue to report to the Department through the use of Segment Notes or Extraction Reports.

The Financial Accountability Report (or Segment Notes and Extraction Reports) and Statement of Compliance for the reporting period, 1 July 2012 to 30 June 2013, must be provided to the Department no later than **31 October 2013**.

The Aged Care Financing Authority (ACFA) has been asked to provide advice to the Minister for Mental Health and Ageing by 31 July 2013 on cost effective options for improving the collection of appropriate financial data from aged care providers.

ACFA's advice will be considered by the Minister in the second half of 2013 and will help to inform future financial reporting requirements. Any new requirements are likely to apply from 1 July 2014 when the new financing arrangements for the aged care system commence.

4. Claims process

4.1 Home care subsidy payments

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

There is information on the subsidy amounts for the Home Care Packages at Part E, Section 1 and on the [Department of Health and Ageing Australian Government subsidies and supplements website](#).

Subsidy payments are made by the Department of Human Services on behalf of the Department of Health and Ageing. An approved provider's initial payment claim form covers the payment period from the date when the Home Care Packages become operational.

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

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

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

The current provider statement is valid for the period 1 July 2011 to 30 June 2014. The next statement is due 30 June 2014 and will be sent to providers with services not registered for Aged Care Online Claiming from the Department of Human Services in April 2014.

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

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

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

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

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

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

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

4.2 Home care subsidy is GST free

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

4.3 Other taxation matters

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

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

PART J – INTERFACE WITH OTHER PROGRAMS

Covered in this part

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

1. Interface with other programs

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

This Part provides a short overview of these programs, including the nature of the interface between each program and the Home Care Packages Program.

From 1 July 2013, more detailed information about the individual programs will be available on the [My Aged Care website](http://www.myagedcare.gov.au) at www.myagedcare.gov.au or the national contact centre on **1800 200 422**.

2. Commonwealth Home Support Program

2.1 Overview of program

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

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

2.2 Interface with the Home Care Packages Program

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

3. Home and Community Care (HACC)

3.1 Overview of program

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

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

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

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

3.2 Interface with the Home Care Packages Program

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

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

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

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

3.2.2 Accessing HACC services in addition to a Home Care Package

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

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

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

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

4. National Respite for Carers Program (NRCP)

4.1 Overview of program

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

4.2 Interface with the Home Care Packages Program

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

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

5. Residential respite

5.1 Overview of program

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

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

5.2 Interface with the Home Care Packages Program

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

The home care subsidy cannot be used to pay the consumer contribution for residential respite care. If the consumer is unable to afford the respite care contribution, this should be negotiated with the respite facility.

Under the legislation, a home care fee must not be charged by the home care provider where the consumer takes leave for residential respite care.³¹

6. Day Therapy Centres program

6.1 Overview of program

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

6.1.1 Therapy and services

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

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

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

6.2 Interface with the Home Care Packages Program

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

³¹ Section 23.89(4A) of the *User Rights Principles 1997*.

7. Transition Care Program

7.1 Overview of program

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

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

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

7.2 Interface with the Home Care Packages Program

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

Under the legislation, a home care fee must not be charged by the home care provider where the consumer takes leave for transition care.³²

8. Community Visitors Scheme

8.1 Overview of program

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

The CVS funds community-based organisations, which arrange community volunteers to visit identified aged care consumers on a regular basis.

These organisations (known as Community Visitors Scheme auspices) carry out the tasks of:

- recruiting, training and supporting volunteer community visitors;
- matching volunteers to residents of aged care homes; and
- supporting visitor-resident relationships.

³² Section 23.89(4A) of the *User Rights Principles 1997*.

The CVS is funded by the Australian Government and operates in every state and territory.

8.2 Interface with the Home Care Packages Program

From 1 August 2013, the CVS will be expanded to home care. The expansion will also provide opportunities to use innovative technology in home care environments to encourage social networking and help reduce social isolation.

The CVS is available to any home care consumer who is identified by their service provider as at risk of isolation or loneliness, whether for social or cultural reasons or because of disability. A focus of the CVS home care visitor places is people who are in one of the special needs groups identified in the Act.

Consumers receiving a Home Care Package can access the CVS, but they must not be charged fees for visits provided through the CVS.

9. Disability programs

9.1 Overview of program

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

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

These arrangements came into place on 1 July 2012.

9.2 DisabilityCare Australia

From 1 July 2013, DisabilityCare Australia (the national disability insurance scheme) will commence initially in South Australia, Tasmania, the Hunter region in New South Wales, and the Barwon region in Victoria. The Australian Capital Territory and the Barkly region of the Northern Territory will join DisabilityCare Australia on 1 July 2014. Additionally, Queensland will begin to roll-out the scheme from July 2016.

DisabilityCare Australia is expected to be fully operational as a national program by 2019-20.

Further information about DisabilityCare Australia is available at the [DisabilityCare Australia website](#).

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

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

Each of these requirements is specified in Part 1 of the *National Disability Insurance Scheme Act 2013*.

9.3 Interface with the Home Care Packages Program

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

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

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

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

The final decision to offer a Home Care Package to a young person is made by the home care provider. The provider will need to consider the appropriateness of their service, including what can be offered under a Home Care Package at the level available, to meet the care needs of the younger person.

10. Continence Aids Payment Scheme (CAPS)

10.1 Overview of program

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

Further information about the Scheme, including who is eligible to apply for a payment, is available on the [Department of Health and Ageing bladderbowel website](#).

10.2 Interface with the Home Care Packages Program

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

11. Palliative care

11.1 Overview of palliative care

The Australian Government has undertaken significant reform to the health system to bolster primary care and preventative care services to keep people out of hospital, help people stay well in their community and importantly to ensure the health and well-being of Australians as they age.

While the Australian Government does not directly fund specialist palliative care services, it provides financial support to state and territory governments to operate palliative care services.

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

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

11.2 Interface with the Home Care Packages Program

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

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

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

12. Hospital in the Home

12.1 Overview of program

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

12.2 Interface with the Home Care Packages Program

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

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

13. Department of Veterans' Affairs Programs

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

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

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

13.1 Veterans' Home Care program

13.1.1 Overview of program

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

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

13.1.2 Interface with the Home Care Packages Program

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

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

The veteran or war widow/widower should not be accessing the same service tasks simultaneously from VHC and the Home Care Package, eg showering. In some instances, however, the veteran or war widow/widower may supplement the care provided under a Home Care Package with some VHC services, such as additional respite care, if the Home Care Package is not sufficient to meet the veteran's or war widow/widower's needs.

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

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

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

13.2 Coordinated Veterans' Care Program

13.2.1 Overview of program

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

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

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

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

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

13.2.2 Interface with the Home Care Packages Program

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

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

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

13.3 Department of Veterans' Affairs Community Nursing Program

13.3.1 Overview of program

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

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

- general practitioner;
- treating doctor in a hospital;
- hospital discharge planner; or
- Veterans' Home Care (VHC) Assessment Agency.

DVA has comprehensive guidelines for access to community nursing services, available on the [Department of Veterans' Affairs website](#).

13.3.2 Interface with the Home Care Packages Program

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

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

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

13.4 Department of Veterans' Affairs Rehabilitation Appliances Program

13.4.1 Overview of program

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

The program provides aids and appliances:

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

The equipment should be:

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

13.4.2 Interface with the Home Care Packages Program

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

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

13.5 Veterans' Transport for Treatment

13.5.1 Overview of program

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

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

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

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

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

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

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

- are aged 80 years or older;
- public, community or private transport are not available
- have any of the following **medical conditions**:

- legal blindness;
- dementia;
- psychosis;
- hemiplegia;
- ataxia;
- respiratory insufficiency severely limiting independent activity;
- cardiac failure severely limiting independence;
- recent coronary occlusion severely limiting independence;
- peripheral vascular disease severely limiting independence;
- amputation severely limiting independence;
- arthritis severely limiting independence;
- recent surgery severely affecting your capacity to use public transport;
- conditions that would cause you to be gravely embarrassed or that are unacceptable to other passengers on public transport e.g. incontinence of bladder or bowel, severe, deformity or disfigurement;
- significant trauma; or
- frailty that severely limits your independence.

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

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

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

- former Repatriation General Hospitals;
- public and approved private hospitals;
- providers of prosthetics, surgical footwear and orthotics;
- Office of Hearing Services accredited providers;
- medical specialist rooms; or
- radiology, imaging and pathology services.

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

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

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

13.5.2 Interface with the Home Care Packages Program

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

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

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

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

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

Where a former POW or VC recipient is already paying consumer fees for a Home Care Package, DVA can reimburse the consumer for fees paid on and after 21 August 2009. Consumers in these circumstances should contact DVA on **133 254**.

PART K – APPENDICES

Appendix A – Glossary of terms

Term	Meaning
ACAR	Aged Care Approvals Round
ACAT	Aged Care Assessment Team. ACATs are known as Aged Care Assessment Services (ACAS) in Victoria
ACFA	Aged Care Financing Authority
Act	<i>Aged Care Act 1997</i>
CACP	Community Aged Care Package
care fee (or home care fee)	Refers to the contribution that a consumer may be asked to pay by a home care provider under a Home Care Package (separate to the government subsidy). Also known as a care recipient contribution, care recipient fee or consumer fee
consumer (or home care consumer)	A person who is a receiving care and services under a Home Care Package funded by the Australian Government. In the <i>Aged Care Act 1997</i> , this person is described as a “care recipient”
claim form	The Department of Human Services form used by home care providers to claim home care subsidy payments
Commonwealth HACC Program	This program provides home and community care services for frail older people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over. The Commonwealth HACC program does not currently apply in Victoria and Western Australia
CDC	Consumer Directed Care
Department	Department of Health and Ageing
DVA	Department of Veterans’ Affairs
EACH	Extended Aged Care at Home package
EACHD	Extended Aged Care at Home Dementia package
home care	A type of aged care for which a home care subsidy is payable under Part 3.2 of the Act

home care consumer (or consumer)	A person who is a receiving care and services under a Home Care Package funded by the Australian Government. In the <i>Aged Care Act 1997</i> , this person is referred to as a “care recipient”
home care provider (or approved provider)	A corporation approved by the Department of Health and Ageing under Part 2.1 of the Act as suitable to provide home care. In the <i>Aged Care Act 1997</i> , this person or body is referred to as an “approved provider”
Home Care Agreement	An agreement entered into by a consumer and a home care provider outlining rights and responsibilities and what services will be provided to the consumer under the Home Care Package
Home Care Standards	The Home Care Standards means the <i>Home Care Common Standards</i> , as set out in Schedule 5 to the <i>Quality of Care Principles 1997</i>
Home Care Packages Program	The Australian Government program that provides funding for Home Care Packages aimed at supporting people to remain living at home for as long as possible
home care subsidy	The subsidy payable to a home care provider by the Australian Government under Part 3.2 of the Act
NACAP	The National Aged Care Advocacy Program is a program funded by the Australian Government that promotes the rights of people who are seeking or are receiving Australian Government funded aged care services
NRCP	National Respite for Carers Program
Principles	Aged Care Principles made under section 96-1 of the <i>Aged Care Act 1997</i>
re-ablement	The use of timely assessment and targeted interventions to assist people to maximise their independence, choice and quality of life and minimise support required – to enable people to actively participate and remain engaged in their communities
VHC	Veterans’ Home Care