



Australian Government

Department of Health

HOME CARE PACKAGES PROGRAMME

Operational Manual

A guide for home care providers

Updated December 2015

Operational Manual

Home Care Packages Programme: A guide for approved home care providers

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1. Foreword

This Operational Manual (the Manual) provides guidance to support the delivery and management of the Home Care Packages Programme on a Consumer Directed Care (CDC) basis.

The Manual is primarily for use by home care providers (providers), although it has also been written with a broader audience in mind. The Manual replaces the Home Care Packages Programme Guidelines 2014 (the Guidelines). Key changes from the Guidelines include:

- Updated information on fees and charges;
- Expanded information for providers on the care planning process; and
- Detailed information for providers when establishing individualised budgets and monthly statements with their consumers.
 - whilst the Manual outlines what information these documents should contain, the Australian Government (the Government) does not regulate how the individualised budget is presented. This approach provides flexibility for providers to determine how they will satisfy the new requirements.

Although the Manual refers to elements of the legislative framework; **it is not intended to be a source of legal advice**. The Manual provides reference points to source documents that providers should refer to for further information. As the Government continues to embed CDC into the Home Care Packages Programme, the Operational Manual will be updated as required.

A range of complementary resources for consumers and providers can be found through the [My Aged Care](http://www.MyAgedCare.gov.au) website at www.MyAgedCare.gov.au and the Home Care Packages Programme pages on the Department's website at www.dss.gov.au/homecarepackages

1.1 My Aged Care

My Aged Care is a website and contact centre set up by the Government to help providers and consumers navigate the aged care system.

The My Aged Care provider and assessor helpline, answers enquiries relating to the My Aged Care system and provides technical support.

Providers can contact the helpline on 1800 836 799, Monday to Friday, 8am to 8pm (closed on national public holidays) and on Saturdays, 10am to 2pm, local time across Australia.

Consumers can call the My Aged Care contact centre on 1800 200 422, Monday to Friday, 8am to 8pm (closed on national public holidays) and on Saturdays, 10am to 2pm, local time across Australia.

If you are deaf or have a hearing or speech impairment, we can help through the National Relay Service (NRS). Call 1800 555 677 and ask for 1800 836 799 (providers) or 1800 200 422 (consumers). Alternatively, you can visit the NRS website at www.relayservice.gov.au and choose your preferred access point.

Information is current from 1 July 2015 until January 2017.

2. Home Care Packages Programme

The Home Care Packages Programme is part of the Government's continuum of care for older Australians.

The Home Care Packages Programme is for people who have complex needs that can only be met by a coordinated package of care.

The objectives of the Programme are:

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

2.1 Package levels

There are four levels of home care packages:

Home Care Level 1: Supports people with basic care needs.

Home Care Level 2: Supports people with low level care needs.

Home Care Level 3: Supports people with intermediate care needs.

Home Care Level 4: Supports people with high care needs.

2.2 Home care subsidy

The Government home care subsidy is paid to a provider in respect of a home care place occupied by a consumer. It is not paid directly to the consumer.

Details of subsidy and supplement amounts are published on the Department's [Aged Care Funding webpage](#).

2.3 Supplements

In addition to the base level of subsidy for a home care package, consumers across all levels of home care packages may be eligible for one or more of the following supplements:

- Dementia and Cognition Supplement and Veteran's Supplement;
- Oxygen Supplement;
- Enteral Feeding Supplement;
- Viability Supplement;
- Top-up Supplement (EACHD consumers); and
- Hardship Supplement.

Supplements are paid to a home care provider, in respect to a consumer, in recognition of the additional costs associated with the consumer's particular care and service requirements.

For more information on supplements, refer to Section 4.4.3 'What is the Amount of the Home Care Subsidy?' of the [Guide to Aged Care Law](#) or the [Aged Care Subsidies and Supplements](#) page on the Department's website.

More detail on the Top-up Supplement can also be found in [4.2 Existing consumers at 30 June 2014](#) of the Manual.

2.4 Legal framework

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

- the [Aged Care Act 1997](#)
- Principles made under the Acts, including:
 - [Accountability Principles 2014](#)
 - [Allocation Principles 2014](#)
 - [Fees and Payments Principles 2014 \(No. 2\)](#)
 - [Quality of Care Principles 2014](#)
 - [User Rights Principles 2014](#)
 - [Approval of Care Recipients Principles 2014](#)
 - [Complaints Principles 2014](#)
 - [Records Principles 2014](#)
 - [Sanctions Principles 2014](#)
 - [Subsidy Principles 2014](#)
- Determinations made under the Acts (for example, setting relevant subsidy and supplement levels).

For more information on the treatment of fees for consumers who entered into a home care package on or before 30 June 2014, see:

- [Aged Care \(Transitional Provisions\) Act 1997](#); and
- [Aged Care \(Transitional Provisions\) Principles 2014](#).

For more information on the legal framework that underpins the Home Care Packages Programme, refer to the [Guide to Aged Care Law](#) or go to www.comlaw.gov.au

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

2.5 Target population

Although there is no minimum age requirement for a home care package, the Home Care Packages Programme has been developed to assist frailer older Australians to remain in their homes.

In some cases, younger people with disabilities, dementia or special care needs may be able to access a home care package. This should only occur where there are no other care facilities or care services more appropriate to meet their needs. The [National Guiding Principles for the Referral and Assessment of Younger People with Disability](#) provides further information on this.

There are no citizenship or residency restrictions on accessing a home care package. However, the packages are not intended for visitors to Australia or people requiring temporary or short-term care.

Special needs groups

All providers are expected to have policies and practices in place to ensure services are accessible by people with special needs.

Under the [Aged Care Act 1997](#), people with special needs include those 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.

Providers should have regard for consumer diversity, taking into account a consumer's individual interests, customs, beliefs and backgrounds. Providers should also work collaboratively with advocacy services, particularly the National Aged Care Advocacy Programme (NACAP) services, and specialist service providers for people from special needs' groups, where appropriate.

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

In December 2012, the Government released national strategies for two of these 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](#).

3. Pathway for the consumer

The consumer pathway involves a series of steps, from being assessed and finding information about home care packages through to being offered a package, service delivery and finally exiting the Programme.

The Manual has been written in conjunction with the Five steps to accessing a Home Care Package booklet (<https://www.dss.gov.au/ageing-and-aged-care/programs-services/home-care/five-steps-to-accessing-home-care-packages>) for consumers. It describes what is involved at each step and what providers are expected to do to support the consumer.

Step 1: Accessing a home care package

A person seeking Commonwealth funded aged care services will contact My Aged Care. If their care needs indicate they may need a home care package, they will be referred for an assessment to determine if they are eligible.

An Aged Care Assessment Team (ACAT), or Aged Care Assessment Service (ACAS) in Victoria, then assesses the person.

Please refer to [5. Accessing a Home Care Package](#) of the Manual.

Step 2: Offering a home care package

The consumer meets with a provider and discusses whether a suitable package is available. This determines whether a consumer can be offered a package by the provider.

Please refer to [6. Offering a home care package to a consumer](#) of the Manual.

Step 3: Determining a consumer's fees and charges

The Government pays for the bulk of aged care in Australia, but as with all aged care services, consumers may be asked to contribute towards the cost of their care if they can afford to do so.

Please refer to [7. Determining a consumer's fees and charges](#) of the Manual.

Step 4: Home Care Agreement and care planning

The provider and the consumer enter into a *Home Care Agreement*. The provider will also work in partnership to develop a care plan, which describes the care and services to be provided, and an individualised budget, which shows what funds are available and planned expenditure.

As part of the care planning process, the consumer outlines their goals and the level of control they wish to exercise over their package.

Please refer to [8. Home Care Agreement and care planning](#) of the Manual.

Step 5: Service delivery, monitoring and re-assessment

Services are delivered according to the agreed care plan, with flexibility to make changes to meet the consumer's needs. The provider will provide ongoing monitoring of the package.

Once services commence, the home care provider sends monthly statements to the consumer to show how their package budget is being spent.

Please refer to [9. Commencement of services](#) of the Manual.

Moving or exiting

This may occur if the consumer's needs have changed significantly over time. Where this is the case, a new ACAT assessment may be required to assess eligibility for a package within a higher band (e.g. Level 3 or 4) or residential care.

Please refer to [9.4 When consumers leave a Home Care Package](#) of the Manual.

4. Summary of changes to home care packages

When	Change	Impact
1 August 2013	Commenced the transition to Home Care Packages Programme	Where consumers were receiving an EACHD package, they were moved to a Level 4 home care package, with 'Top-Up' and 'Dementia and Cognition' supplements.
1 July 2014	Commencement of the <i>Aged Care (Transitional Provisions) Act 1997</i> and the <i>Aged Care (Transitional Provisions) Principles 2014</i>	Where consumers were receiving a home care package before 1 July 2014, they continue to be asked to pay the basic daily fee and any fees calculated on income they receive above the basic pension.
1 July 2014	Commencement of the <i>Fees and Payments Principles 2014</i> (Part 3A. 1 of <i>Aged Care Act 1997</i>)	For all consumers entering into a home care package from 1 July 2014, they will be asked to pay the basic daily fee, and an income-tested care fee only if their income is over the maximum income for a full pensioner.
1 July 2015	Commencement of the <i>Transitional provisions relating to the User Rights Amendment (Consumer Directed Care) Principles 2015</i>	<i>Home Care Agreements</i> entered into before 1 July 2015 do not need to be amended to comply with the requirements relating to the new CDC-related matters. Existing individualised budgets provided to consumers before 1 July 2015 are taken to have complied with subsections 21A(1), (2) and (3) in relation to the consumer. However, if there is a change to the care and services to be provided, or if the costs of providing care change, or if the consumer requests a revision to the budget, obligations to review and revise the budget and provide a copy of the revised budget to the consumer apply even if the original budget was provided before 1 July 2015.
1 July 2015	Commencement of the <i>User Rights Amendment (Consumer Directed Care) Principles 2015</i>	All home care packages must be delivered on a CDC basis. The key elements of CDC have been embedded in the principles and any CDC conditions of allocation have been revoked and replaced by these principles. All consumers entering into a home care package from 1 July 2015 must receive a <i>Home Care Agreement</i> that reflects CDC: <ul style="list-style-type: none"> ○ choice and flexibility; ○ care and services; and ○ an individualised budget and monthly statement.

4.1 Existing Extended Aged Care at Home - Dementia (EACHD) consumers at 31 July 2013

From 1 August 2013, the EACHD package converted to a Home Care Level 4 package with a Dementia and Cognition Supplement (or the Veterans' Supplement, if eligible) and a 'Top-up' Supplement to ensure that existing EACHD consumers (i.e. those receiving an EACHD package on 31 July 2013) continued to receive the same level of funding, plus indexation.

Note: If the consumer terminates their *Home Care Agreement* for more than 28 days, they will no longer receive the Top-up Supplement and the new fee arrangements that commenced on 1 July 2014 will apply if they commence a new package.

If a consumer moves to a new provider, the Top-up Supplement can continue to be paid to the new provider as long as the period between ceasing the former package and commencing the new package is not more than 28 days.

4.2 Existing consumers at 30 June 2014

The changes to the income-tested care fee that started on 1 July 2014 will not apply to consumers who were receiving a home care package on or before 30 June 2014.

These consumers can continue to be asked to pay a basic daily fee. Providers can also charge these consumers an income-tested fee under the arrangements that existed for income-tested fees pre-1 July 2014 but the post-1 July 2014 income-tested care fees do not apply to these consumers. They will continue to receive the same package of care after 1 July 2014 and will not be affected by the new fee arrangements if they move between package levels.

Note: If the consumer leaves their current care arrangements and enters into a home care agreement with a new home care service within 28 days, they have the option of choosing to have their fees calculated under the new arrangements that commenced on 1 July 2014. Where the consumer chooses to be covered by the new arrangements, they cannot revert back to their previous fee and payment arrangements.

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

The maximum home care fee that these consumers can be asked to pay is determined by the [Aged Care \(Transitional Provisions\) Act 1997](#) and the [Aged Care \(Transitional Provisions\) Principles 2014](#), Chapter 4, Part 4 - Home care fees.

For more information on the calculation of fees for these consumers, see [7.1 Existing consumers at 30 June 2014](#) of the Manual.

4.3 New consumers entering from 1 July 2014

Where consumers take up a home care package after 1 July 2014, they may be asked to pay:

- a basic daily fee; and
- an income-tested care fee, **only** if their income is over the maximum income for a full pensioner.

Note: A full pensioner can only be asked to pay the basic daily fee.

The maximum fee that a consumer can be asked to pay in a basic daily fee is determined by Part 3A.1, Division 52D – Home Care fees of the [Aged Care Act 1997](#) and Part 3 – Home care fees of the [Fee and Payments Principles 2014](#) for information on treatment of fees for consumers who entered into a home care agreement from 1 July 2014.

For further information on the calculation of fees for these for these consumers, see [7. Determining a consumer's fees and charges](#) of the Manual.

4.4 Existing consumers at 30 June 2015

Transitional provisions relating to the *User Rights Amendment (Consumer Directed Care) Principles 2015* apply to existing consumers at 30 June 2015.

Individualised budgets

New subsections 25(1) and (2) provide that if a provider has given a consumer an individualised budget before 1 July 2015, they are taken to have complied with subsections 21A(1), (2) and (3) in relation to the consumer. This means the provider is not required to give the consumer another individualised budget after 1 July 2015.

However, subsection 25(3) clarifies that if there is a change to the care and services to be provided, or if the costs of providing care change, or if the consumer requests a revision to the budget, then obligations to review and revise the budget and provide a copy of the revised budget to the consumer apply even if the original budget was provided before 1 July 2015.

Subsections 25(4) and (5) apply where an approved provider has provided care to a consumer before 1 July 2015 and continues to provide care to the consumer after 1 July 2015, but has not given the consumer an individualised budget before 1 July 2015. In these circumstances, the provider must give the consumer an individualised budget, as soon as practical after 1 July 2015 after obtaining the necessary information to complete the budget.

Home Care Agreements

Section 26 provides that amendments to subsection 23(2) (made by items 2, 3 and 4 of the Amending Principles) only apply to *Home Care Agreements* entered into on or after 1 July 2015. This means existing *Home Care Agreements* entered into before 1 July 2015 do not need to be amended to comply with the requirements relating to the new CDC-related matters. However, providers must comply with the requirements of CDC.

4.5 All home care packages from 1 July 2015

From 2013, the Government progressively introduced CDC into the Home Care Packages Programme. From 1 July 2015, it applied to all home care packages.

The *User Rights Amendment (Consumer Directed Care) Principles 2015* (the Amending Principle) amends the User Rights Principles to require all providers to deliver home care packages on a CDC basis.

CDC was first piloted as a model of service delivery within the former Commonwealth funded Community Packaged Care Programme in 2010-11. Following the success of the pilot, the decision to implement CDC in home care packages was announced on 20 April 2012 as part of the *Living Longer, Living Better* reforms to aged care. From 1 August 2013, all newly released home care packages were required to be delivered on a CDC basis.

CDC is both a philosophy and an orientation to service delivery. It is a way of delivering aged care services that gives consumers greater flexibility by allowing them to make choices about the types of care and services they access and how those services are delivered.

The Manual has been written with the CDC model of service delivery built into it.

Key elements of consumer directed care

Since 1 July 2015, the *User Rights Principles 2014* and the *Charter of care recipients' rights and responsibilities-homecare* (the Charter), which recognise the rights and responsibilities of consumers and providers, explicitly acknowledge the key elements of CDC, emphasising the right of consumers to exercise choices in relation to the care provided to them.

Choice and flexibility

The Charter specifies consumers' right to:

- be supported by the provider to set goals, determine the level of ongoing involvement that they wish to have, and make decisions relating to their own care and to maintain their independence as far as possible;
- choose the care and services that best meet their goals, preferences and assessed needs, within the limits of the resources available;
- have choice and flexibility in the way the care and services are provided at home;
- participate in making decisions that affect them; and
- have their representative participate in decisions relating to their care.

Care and services

Consumers have the right to:

- receive care and services which are appropriate to meeting their goals, preferences and assessed needs;
- be given a written plan of the care and services that they expect to receive;
- receive care and services that take into account their preferences; and
- ongoing review of the care and services they receive, as required.

Individualised budget and monthly statements

An individualised budget must be developed in partnership between the consumer and the provider. It must list the amount of subsidy the Government is paying (including any

supplements), the maximum amount of home care fees payable by the consumer and the cost of the agreed care and services.

Consumers are to receive an individualised budget as soon as practical after the provider has all the necessary information to complete the budget.

The consumer is to also receive a monthly statement of available funds and expenditure for the care and services delivered in a particular period.

Both of these documents must be in an agreed format that is easy to read and understandable by the consumer.

For further information on the changes to the Charter, go to the *User Rights Amendment (Consumer Directed Care) Principles 2015* or Section 4.5 (home care packages) of the [Guide to Aged Care Law](#).

5. Accessing a home care package

A person seeking information on Commonwealth funded aged care services can contact My Aged Care. If their care needs indicate that they may need a home care package, My Aged Care will refer them for an assessment to determine their eligibility.

An ACAT (or ACAS) is able to assess and approve a person's eligibility to receive Government subsidised care such as residential aged care, residential respite care, home care and transition care. Prior to the assessment, the person will be asked to sign an Application for Care under the *Aged Care Act 1997* form.

ACATs cover all of Australia and are based in hospitals or in the local community. People can find their local ACAT (or ACAS) through My Aged Care at www.myagedcare.gov.au/ or by calling 1800 200 422. People are able to contact an ACAT (or ACAS) directly until their state or territory fully transitions to the My Aged Care system (see Section 5.3).

5.1 Eligibility for a home care package

Eligibility requirements for home care packages are set out in the [Aged Care Act 1997](#) and the [Approval of Care Recipients Principles 2014](#). ACATs are required to assess people in accordance with these criteria and approve only those who are assessed as eligible for this type of care.

For information on age requirements and citizenship or residency restrictions, see [2.5 Target population](#) of the Manual.

5.2 Assessment by an ACAT

In order to access a home care package, a person needs to first be assessed and approved as eligible by an ACAT (or ACAS).

ACAT assessments are comprehensive and holistic, independent, multi-disciplinary and multi-dimensional and client-focused. As part of the process, a person's physical, medical, psychological, cultural, social and restorative care needs are assessed to determine the type of services and supports that would be most appropriate to meet the person's needs.

The ACAT also considers the client's usual and community support systems and any other relevant matters. The needs of the carer or advocate are also taken into account.

The assessment should take into account any relevant information available from the person's medical practitioner and other specialist reports. The ACAT will conduct a face-to-face comprehensive assessment, if possible, to determine whether the person can be approved as eligible to receive a home care package.

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

Note: ACAT approvals for home care are 'broad-banded' to two categories – home care level 1 or 2 (low-level care) and home care level 3 or 4 (high-level care).

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

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

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

Information about the ACAT decision

The consumer will be advised in writing of the outcome of the ACAT assessment and receive 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 does not lapse, unless given on a time limited basis, and takes effect from the day the approval is given.

Referral from an ACAT to a provider or other services

Once a person is approved as eligible for a home care package, they will need to find a provider in their local area. Their ACAT representative can help them do this.

If a person wants to find their own provider, they can contact My Aged Care on 1800 200 422 or use the Service Finder on the My Aged Care website, which provides an overview of providers in the local area and their website details so the person can get a better understanding about what they offer. The consumer can also get their provider's contact details so that they can arrange a time to visit.

If a person is not found to be eligible for a home care package, an ACAT representative may refer a consumer to other care services that do not require an ACAT approval, such as the CHSP or the Veterans' Home Care Programme. In some instances, if the ACAT determines that an ACAT assessment is not appropriate for that person, they may refer the person to the My Aged Care Regional Assessment Service for a home support assessment.

5.3 Changes to My Aged Care in 2015

On 1 July 2015, My Aged Care was expanded. The changes included:

- a central client record to facilitate the collection and sharing of client information between the client and their representatives, assessors and service providers;
- the introduction of the My Aged Care Regional Assessment Service (RAS) to conduct face-to-face assessments of people seeking entry level support at home, provided under the CHSP;
- My Aged Care contact centre staff and assessors using the National Screening and Assessment Form (NSAF) to ensure a nationally consistent and holistic screening and assessment process;
- an electronic matching and referral capability;
- web-based My Aged Care portals for clients, assessors and service providers;
- clients using the client portal to view their client record;
- assessors using the assessor portal to manage referrals, use the NSAF and update the client record with assessment information; and
- service providers using the provider portal to maintain information about the services they deliver, manage referrals and update the client record.

From September to December 2015, ACATs will transition to full use of the My Aged Care system to undertake assessments, with the NSAF to approve care types under the Act and to match and refer clients to services. From full transition, people will be required to access an ACAT through the My Aged Care contact centre on 1800 200 222.

More information on My Aged Care can be found on <https://www.dss.gov.au/my-aged-care>

6. Offering a home care package to a consumer

Once a person is approved as eligible for a home care package by an ACAT, they will approach a provider to deliver care and services to them.

Note: The responsibility is on the provider to check that a person has a valid assessment approval. A home care subsidy will not be paid without this approval.

A provider can offer a person a package at either level within the relevant band they have been approved for by the ACAT (e.g. Level 1 or 2 package, or Level 3 or 4 package). The person is then able to choose whether or not to accept the package.

Note: A provider can only offer a level of home care package that it has an allocation for and has readily available.

Providers should always review the prospective consumer's ACAT Aged Care Client Record (ACCR). This provides important information about their characteristics, needs and circumstances. It should be considered together with other information provided by the consumer, including any relevant information from their medical practitioner, in determining whether a package can be offered and, if so, at what level (within the ACAT approved band).

A consumer can commence a home care package even when the income assessment is not complete. For consumers in receipt of a means-tested income support payment, they will not need to complete the income assessment as the Department of Human Services (DHS) will have sufficient information to determine the consumer's income-tested care fee.

For consumers who are not in receipt of a means-tested income support payment, the Government will fully meet the consumer's costs of care during the time that their information is being sought and the consumer will need to pay the basic daily fee.

The provider may choose to charge an interim fee while the consumer's fees are being determined by DHS. However, the Government does not set an amount of interim fee. Once DHS has advised of the fees payable by the consumer, any overpayments would need to be refunded. Similarly, regarding underpayments, the provider will need to seek any amounts owing from the consumer.

An indication of the consumer's fees payable can be obtained from the [Home Care Fee Estimator](#) on the My Aged Care website.

For more information on the income-tested fee, see [7.3 Paying fees](#) of the Manual.

6.1 Waiting lists

There may be waiting lists for packages in some areas. Providers manage their own waiting lists, giving access and priority according to each individual's need and the provider's capacity to meet that need.

People on a waiting list do not necessarily access care purely on a 'first come, first served' basis. 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.

People can be added to as many waiting lists as they want and providers cannot charge them a fee to be added to their waiting list.

6.2 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 broad-banded levels approved by the ACAT**. This means that a provider can offer a higher level package when a consumer's needs require a higher level of care – from Level 1 to 2, or from Level 3 to 4 – without the need for another ACAT assessment.

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

7. Determining a consumer's fees and charges

The Government pays for the bulk of aged care in Australia by paying subsidies and supplements for care to providers. However, consumers may be asked to contribute towards the cost of their care if they can afford to do so.

Providers must discuss and agree upon any fees with the consumer before any services begin. The maximum fees payable must be recorded in the *Home Care Agreement* see [8. Home Care Agreement and care planning](#) of the Manual.

A consumer's access to a home care package must not be affected by their ability to pay fees; however, a consumer's responsibilities include paying the fees specified in the *Home Care Agreement*. If a consumer does not pay the fees, or negotiate an alternative with their provider, providers are able to withdraw the service for non-payment of fees and re-allocate the package, as detailed in the [User Rights Principles 2014](#).

Note: People who entered into a *Home Care Agreement* on or before 30 June 2014 will have their fees determined differently to those who commenced a home care package from 1 July 2014.

7.1 Existing consumers at 30 June 2014

These consumers can continue to be asked to pay a basic daily fee. Providers can also charge these consumers an income-tested fee under the arrangements that existed for income-tested fees pre-1 July 2014 but the post-1 July 2014 income-tested care fees do not apply to these consumers. The consumer will continue to receive the same package of care after 1 July 2014 and will not be affected by the new fee arrangements if they move between package levels.

For these consumers, fees are calculated as follows:

If the consumer's income is...	then...
up to the basic rate of the single Age Pension	the maximum fee is 17.5 per cent of the basic rate of the single Age Pension.
more than the basic rate of the single Age Pension	the maximum fee is 17.5 per cent of the basic rate of the single Age Pension plus up to 50 per cent of income above the basic rate of the single Age Pension.

7.2 Pooling of Resources

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.

Providers are required to include information about fees payable in the *Home Care Agreement*. However, the calculated fee amount will be recorded in the consumer's individualised budget.

7.3 What constitutes a consumer's income?

Income is defined as income after income tax and the Medicare levy. When calculating income for the purpose of determining ongoing fees, the following are excluded:

- any Pharmaceutical Allowance, Rent Assistance or Telephone Allowance;
- the Pension Supplement;
- the Clean Energy Supplement; and
- in the case of a 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.

Please see Division 60 of the [Aged Care \(Transitional Provisions\) Act 1997](#) or section 130 of the [Aged Care \(Transitional Provisions\) Principles 2014](#) for more information.

7.4 Consumers entering from 1 July 2014

New consumers from 1 July 2014 may be asked to contribute towards the cost of their care, based on their income.

Providers can ask these consumers to pay:

- a basic daily fee (full pensioners can be asked to pay only this fee); and
- an income-tested care fee, **only** if their income is over the maximum income for a full pensioner.

Please see Part 3A.1 – Resident and Home Care fees of the [Aged Care Act 1997](#) for more information.

Basic daily fee

Providers can ask everyone taking up a home care package to pay the basic daily fee, irrespective of the consumer's income and whether or not they are a member of a couple (the basic daily fee has not changed with the introduction of CDC).

The basic daily fee is 17.5 per cent of the single basic Age Pension. The rate is readjusted on 20 March and 20 September each year in line with changes to the Age Pension.

Income-tested care fee

DHS calculates an income-tested care fee based on an assessment of the consumer's financial information. This assessment does not include the value of their home or any other assets.

Consumers can only be asked to pay an income-tested care fee if their yearly income is above the set thresholds, which takes into account personal characteristics.

If the consumer is a member of a couple, half of their combined income is considered in determining their income-tested care fee, regardless of which partner earns the income.

Following the assessment, DHS will advise the provider and the consumer on the maximum fees payable. These are the maximum fees and the provider can determine a lower amount but the full value of the package must still be provided as though these fees were paid in full.

Note: The amount of subsidy and primary supplements that the Government would normally pay to a provider on behalf of the consumer is reduced by the maximum amount of income-tested care fee that the consumer can be charged. The care subsidy reduction will be administered by DHS.

There are annual and lifetime caps that apply to the income-tested care fee. Once these caps are reached, the consumer cannot be asked to pay any more income-tested care fees for the relevant period. DHS will keep track of the caps, and notify the provider and consumer shortly after the cap has been reached. The Government will pay the remaining income-tested care fees for the consumer by way of increased subsidy to the provider after these caps have been reached. The annual and lifetime caps can be found on the [Schedule of Fees and Charges for Residential and Home Care](#).

Note: Full pensioners do not pay an income-tested care fee.

How a consumer's income-tested care fee is assessed

If the consumer receives a means-tested income support payment

If they receive a payment, such as the Age Pension (full or part), Disability Support Pension or Service Pension, they can call DHS on 1800 227 475 or the Department of Veterans' Affairs (DVA) on 1800 555 254 and request a fee advice for home care.

DHS (or DVA) will have enough information to calculate the maximum fees payable. These consumers do not have to complete an assessment form, unless they want to receive fee advice before they start a home care package.

Once the provider has notified DHS that the consumer has entered their service through the [Aged Care Entry Record](#), DHS will notify the provider and the consumer of the maximum fees payable based on the information it already holds.

If the consumer is a self-funded retiree or not in receipt of a means tested income support payment

These consumers will need to seek an income assessment from DHS.

To seek an income assessment, the consumer will need to fill out an [Aged Care Fees Income Assessment form \(SA456\)](#), which is available on the DHS website or by calling 1800 227 475.

Receiving a response from Department of Human Services

The results of the income assessment will be sent to the provider and the consumer via letter.

If a consumer has not received the results of their income assessment, the consumer should contact DHS on 1800 227 475.

If a provider has a home care package available for a consumer, and has not received a letter from DHS, they can charge an interim fee. The Home Care Fee Estimator can be used for this purpose. The amount the consumer pays can be adjusted if necessary when advice is received from DHS.

What if the consumer is unhappy with the results of their income assessment?

If a person does not think the assessment of their income is correct, they can ask DHS (or DVA if relevant) to review its decision.

The contact details to seek this review will be included in the fee advice letter they receive from DHS.

Determining fees before entering a home care package

Consumers can ask for fee advice from DHS before they enter a home care package.

The fee advice they receive before they start their package will be valid for 120 days, unless there is a significant change in their circumstances. If there is a change, the consumer will need to notify DHS, who will reissue their fee advice letter.

If a consumer seeks an assessment before commencing their package, only the consumer will receive the letter. The provider will receive a letter once they advise the DHS that the consumer has commenced a package with them.

My Aged Care Home Care Fee Estimator

In addition to providing information about fees, My Aged Care can give consumers an estimate of their likely fees. The fee estimator is available on the Home Care Fee Estimator page of the My Aged Care website or by calling the My Aged Care contact centre on **1800 200 422**.

Note: DHS is responsible for formally working out the maximum fees payable based on an assessment of the consumer's financial information and will notify both the provider and the consumer.

7.5 Paying fees

Providers cannot ask consumers to pay any fees before their home care package begins.

The fees and the contribution made by the Government go towards the overall value of the package and contribute to the provision of services the consumer receives.

Once the *Home Care Agreement* has been agreed, providers can ask the consumer to pay fees up to one month in advance. Any fees paid in advance must be refunded to the consumer if they leave the home care package, or move to another provider.

The fees that DHS advises are payable, and calculated daily, even on days a consumer does not receive a service. The Government subsidy and supplements are payable, or calculated, in the same way.

It is the responsibility of consumers to pay their agreed fees under the Charter of care recipients' rights and responsibilities – Home Care.

Review of fees

Existing consumers at 30 June 2014

A review of fees must be conducted periodically (or whenever the consumer requests a review). The consumer should be encouraged to seek a review if their financial circumstances change.

The maximum fees may need to be varied when new rates for the Age Pension are announced each March and September. Providers may need to discuss the impact of these changes on fees with the consumer and update their individual budget accordingly.

Consumers receiving a home care package on or after 1 July 2014

A quarterly review of income-tested care fees (or whenever the consumer requests a review) is conducted by DHS. The consumer should be encouraged to contact DHS or DVA to seek a review if their financial circumstances change.

The basic daily fee increases in March and September each year in line with Age Pension increases.

What if the consumer cannot afford the fees?

If the consumer thinks they will face financial hardship when paying the required fees, they can ask to be considered for financial hardship assistance. Each case is considered on an individual basis.

Note: Consumers who commenced a home care package before 1 July 2014 are not eligible for financial hardship assistance.

Depending on their situation, they may apply for financial assistance with:

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

If a care recipient is granted financial hardship assistance, an amount will be paid to the provider on their behalf by the Government by way of a Hardship Supplement. It may cover some, or all, of the consumer's basic and/or income tested fees. The consumer will be responsible for paying any portion of their fees that are not covered by the Hardship Supplement.

For a financial hardship application to be considered, a person must:

- have assets less than 1.5 times the annual Age Pension (plus supplements) as calculated under paragraph 60(2)(b) of the *Subsidy Principles 2014*;
- not have gifted more than \$10,000 in the previous 12 months or \$30,000 in the previous five years; and
- have had their income assessed in accordance with the [Aged Care Act 1997](#).

To apply for financial hardship assistance, the consumer needs to fill out an application form and submit the completed form to DHS. The form is available on the [Financial Hardship Assistance – Home Care and Respite Care form page on the DHS website](#) or by calling 1800 227 475.

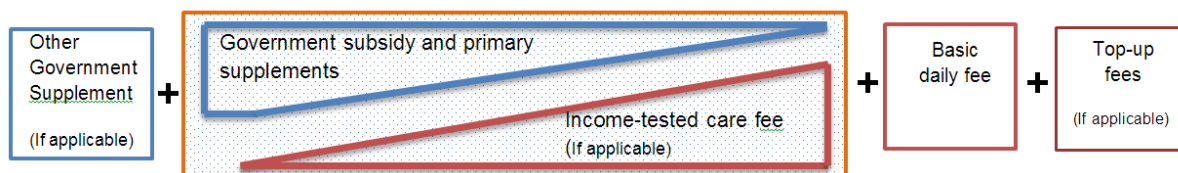
Level of services to be provided under a home care package when the full fees are not charged

For a consumer who started receiving a home care package on or after 1 July 2014, the subsidy and primary supplements payable by the Government are reduced by the maximum income-tested care fee payable by the consumer. The overall value of the package remains the same; what varies is the source of the funds.

Note: The Government subsidy is reduced whether or not the income-tested care fee is charged.

Part 2 of Schedule 3 to the [Quality of Care Principles 2014](#) lists the items which must not be included in the package of care and services. Payment of home care fees is listed as an excluded item.

The interaction between the Government subsidy/supplements paid and the income-tested care fee can be seen in the following diagram.



The subsidy and primary supplements will be reduced by the maximum income-tested care fee payable by the consumer so the overall value of the package remains the same. What varies is the source of the funds.

Example 1 – Adam

The Government subsidy and primary supplements of Adam’s home care package is valued at \$30,000 (in addition to the basic daily fee) and Adam has been assessed by DHS as being able to contribute \$10,000 towards his income-tested care fee. The Government subsidy payable for Adam’s care to his provider is the value of the home care package less Adam’s income-tested care fee (that is, \$30,000 - \$10,000 = \$20,000).

Adam’s provider asks Adam to pay the income-tested care fee as advised by DHS. Adam’s provider must provide him with services reflecting the full package valued at \$30,000.

If Adam’s home care provider does not collect the full income-tested care fee (regardless of the reason) the home care provider is still required to provide Adam with services as if the fee had been paid in full. That is, the home care provider and Adam cannot select a lower level of care and services to match the reduced value of the Australian Government subsidy paid.

The amount of basic daily fee charged has no impact on the amount of Government subsidy and primary supplements that are paid.

If Adam fails to meet his responsibilities, including the payment of fees, as described in Schedule 2 - Charter of care recipients’ rights and responsibilities – home care of the *User Rights Principles 2014*, his home care provider may cease to provide home care to him under the security of tenure provisions in subsection 17–2(e) of the *User Rights Principles 2014*. Adam’s Home Care Agreement must contain information such as the maximum fees payable by him and the conditions under which either party may terminate the provision of home care.

Example 2 – Emily

The Government subsidy and primary supplements of Emily's home care package is valued at \$20,000 (in addition to the basic daily fee) and Emily has been assessed by DHS as being able to contribute \$5,000 towards her income-tested care fee. The amount of Government subsidy payable for Emily's care to her provider is the value of the home care package less Emily's income-tested care fee (that is, $\$20,000 - \$5,000 = \$15,000$).

If Emily does not pay the income-tested care fee or Emily's provider does not collect an income-tested care fee, Emily's provider must still provide her with services reflecting the full package valued at \$20,000 and not services reflecting the amount of Government subsidy paid (\$15,000).

8. Home Care Agreement and care planning

The Home Care Agreement is an agreement between the provider and the consumer that sets out a number of key elements about how the package will be delivered. It specifies the requirements set out in sections 22 and 23 of the [User Rights Principles 2014](#).

For all home care packages, it is a legal requirement that a *Home Care Agreement* must be offered to the consumer before the package commences. 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.

For information on *Home Care Agreements*, refer to Division 61 – What are the requirements for *Home Care Agreements*? of the *Aged Care Act 1997* and Division 4 – *Home Care Agreements* of the [User Rights Principles 2014](#).

Once the *Home Care Agreement* is entered into, care and services can formally commence under the package and the provider is able to commence claiming the Government subsidy for the package.

A *Home Care Agreement* recognises the consumer's rights and may spell out the consumer's responsibilities and cannot exclude any rights the consumer has under Commonwealth or State/Territory law.

The *Home Care Agreement* must also specify how either party may terminate the *Home Care Agreement*. For more information, refer to [10.2 Rights and responsibilities of a consumer](#) of the Manual.

The *Home Care Agreement* should be written in plain language, be easily understood and, at a minimum, contain the consumer's care plan and individualised budget, which are often attachments or schedules to the Agreement.

Given the importance of the *Home Care Agreement*, the 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 [Advocacy](#) section of the Manual.

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.

There should be enough time for the consumer to look at the Agreement, and to seek independent legal advice, if they wish, before they sign it.

The signed *Home Care Agreement* must be provided to the consumer for their records.

What if the consumer is unable to sign the Home Care Agreement?

If the consumer is unable to sign a *Home Care Agreement* because of any physical incapacity or mental impairment, another person representing them may sign the Agreement on the consumer's behalf. See the [Advocacy](#) section of the Manual.

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

Providers must always offer and be prepared to enter into a *Home Care Agreement*, however, the consumer may choose not to sign a *Home Care Agreement*.

In such cases, providers are still required by legislation to observe their responsibilities to negotiate and deliver the level and type of care and services the consumer needs.

It is important that the provider documents the reasons the consumer has decided to not sign the *Home Care Agreement* and the basis on which agreed care will be delivered.

The provider should have an 'in-principle' *Agreement* in place and ensure it is readily available. This documentation may include a copy of the *Home Care 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*.

8.1 Home Care Agreement – Transitional arrangements

Home Care Agreements, entered into on or after 1 July 2015, must include that the home care will be delivered on a CDC basis and specify that the provider will give an individualised budget and a monthly statement to the consumer.

From 1 July 2015, *Home Care Agreements* must also include a statement that the consumer is not entitled to a refund of unspent home care fees if they cease to receive care from their provider. The only amounts of home care fees that are refundable are fees that have been overpaid by the consumer and any fees paid in advance of the date from which the services cease.

Existing *Home Care Agreements* before 1 July 2015 do not need to be amended to reflect the new requirements relating to CDC; however, providers and consumers must comply with the new arrangements.

Providers will be able to achieve this through the co-design of the consumer's new care plan and individualised budget. The provider will also need to provide their consumers with a monthly statement so that they can see how their budget is being spent.

8.2 Developing a care plan

The home care provider will already have some information about the consumer available to them from the consumer's ACCR, which holds up-to-date information on the person's needs, the results of any assessments, and any services they receive, and their ACAT/ACAS assessment. This will help the provider work in partnership with the consumer to develop their care plan and individualised budget.

The consumer should drive the development of the care plan, in consultation with the provider.

The care plan should include:

- the consumer's goals – what it is they would like to achieve through their package;
- identified care needs;

- the level of involvement and control the consumer will have in managing and coordinating their home care package;
- the exact care and services to be provided to support the consumer's assessed care needs and any identified goals;
- who will provide those services;
- when the services are to be delivered, including the frequency of services and days/times when regular services are expected to be provided;
- case management arrangements, including how ongoing monitoring and informal reviews will be managed;
- the frequency of formal reassessments; and
- the individualised budget.

See [8.5 What home care packages provide](#) of the Manual for information on the possible care and services that can be delivered within the Home Care Packages Programme.

During the care planning process, the provider should take into account any supports the consumer already has in place, such as carers, family members, local community and other services. A home care package is intended to meet needs that are not already being met by these other supports.

The care plan must be supported by the consumer's individualised (package) budget.

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

Goal setting and identifying care needs

Identifying goals and care needs will help consumers choose the care and services that best support them.

Before determining what services are to be provided, it is important to talk to the consumer about what they would like to achieve through their home care package – their goals.

A goal could be something like maintaining a healthy lifestyle or achieving independence in mobility.

Their goals will be shaped by their circumstances, including their health and wellbeing, cultural and personal values, and the amount of support available from family, friends and carers.

It is also important to identify a consumer's care needs, which are the areas of a consumer's life where they have been assessed as needing extra care and support. Care needs may be identified when the consumer is assessed by the ACAT and/or through their discussions with their provider during the care planning process.

Consumer involvement and control over the management of their package

Providers need to talk to their consumers about how involved they would like to be in managing and coordinating their home care package.

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

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

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.

Determining who has authority to make decisions

It is important to determine who has the authority to make decisions (e.g. the individual consumer, a family member or carer, a guardian, or (in some states) a person with power of attorney). Providers need to determine who has the legal authority to make decisions.

There should be shared decision-making between the provider, the consumer (to the extent that they are able to participate) and their appointed representative (if they have one).

This will be particularly important in situations where the consumer has some degree of cognitive impairment.

8.3 Individualised budget

Section 21A of the [User Rights Principles 2014](#) requires that all providers give a written individualised budget to each consumer.

The provider should develop the budget in partnership with the consumer (or their representative), based on the agreed care plan.

An individualised budget must be prepared having regard to:

- the consumer's goals, assessed needs and preferences;
- the resources available to the provider to provide the home care services (that is, the value of the home care package). The value of the package consists of the subsidies and supplements paid by the Government, any fees the consumer is charged, and, for consumers who enter from 1 July 2014, the maximum income-tested care fee calculated by the Government; and
- the services selected by the consumer and set out in the care plan.

The individualised budget should be amended whenever the care plan or costs change.

The individualised budget should clearly identify the total funds available to the consumer, which is made up of:

- the Government subsidy (and eligible supplements);
- the basic daily fee, which all consumers receiving a home care package can be asked to pay;
- the income-tested care fee, payable depending on the consumer's assessable income; and
- any other amount the consumer has agreed to with their provider.

The Government does not regulate how the individualised budget must look. This provides flexibility for providers to determine how they will satisfy the requirements

Providers can continue to utilise systems or processes they may have already established to comply with the previous requirements (that were set out in conditions of allocation and the Home Care Packages Programme Guidelines). Alternatively, they can use different approaches, such as including administration costs in their unit pricing. This is a matter for the provider to determine taking into account what will be most meaningful and useful for their consumers and their business model.

Planned expenditure

This includes all costs associated with the delivery of the home care package, including the provider's costs and the cost of care and services.

Regulation of administration costs

Providers are able to charge administrative costs to cover a range of overhead or operational costs, such as insurance, workers compensation, care co-ordination and travel costs.

The Department does not set a limit on administrative costs, but expects costs to be kept to a minimum so that consumers can receive the support they need.

Review of individualised budget

Providers must review and, if necessary, revise the individualised budget for the consumer if:

- a change to the care and services to be provided to the consumer through the home care package is proposed;
- the costs of providing the care and services change; and
- the consumer requests them to do so.

8.4 Monthly statement

Once care and services commence, providers must provide the consumer with a monthly statement that clearly shows their available funds, how those funds have been spent and the balance of any unspent funds. This must be delivered to the consumer as soon as practical, after the provider has all the necessary information to complete it.

A monthly statement must specify the following:

- the amount of home care subsidy paid or payable to the provider (including eligible supplements);
- the total amount of home care fees paid or payable by the consumer;
- the total amount paid or payable by the provider in respect of the home care provided;
- an itemised list of the care and services provided to the consumer and the total amount for each kind of care or service;
- the total of any unspent funds received from any previous month; and
- that any amount of home care fees paid by the consumer to the provider that has not been spent, and that is not refundable will not be refunded to the consumer if the provider ceases to provide home care to the consumer.

The Government does not regulate how the statement must look. The provider and the consumer need to agree on the level of detail in, and the format of, the statement.

The means by which the statement is provided to the consumer, e.g. hardcopy, email or web-based, can be negotiated between the provider and the consumer.

For more information on the monthly statement, please refer to Division 3 – Responsibilities of approved providers of home care – provision of information of the [User Rights Principles 2014](#).

Topping up services or additional services under a package

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

Any additional monetary contribution from the consumer to the provider for top-up services must be separately identified, either within the individualised budget or in a separate account.

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

In some cases, the 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 provider.

8.5 What home care packages provide

Once a consumer’s goals and level of involvement in the management of the package have been identified, the provider will work in partnership with them to determine what care and services are needed to support their goals and meet their care needs.

This will include who the care and services are delivered by, the timing and frequency of services, and the costs.

When a consumer is deciding what care and services they are after, they should not be limited to a list – they have a right to make choices about the types of care and services they access and how those services are delivered.

For example, a consumer may have a particular service, care worker or home care provider they would like to use. Any additional costs that may arise through setting up new arrangements must be made clear to the consumer and included in the individualised budget and monthly statement.

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

Care and services

For a list of care, support and services that may be provided under a home care package. Please see Schedule 3 – Care and services for home care services, Part 1 – Care and services of the [Quality of Care Principles 2014](#).

This list of care and services is not an exhaustive list, and other care and services can be provided to consumers if they meet the consumer's identified care needs and goals, as identified in the care plan.

However, Schedule 3, Part 2 of the [Quality of Care Principles 2014](#) specifies items that must not be included as part of a consumer's care plan. Refer to [Excluded items](#) in this section of the Manual.

In the delivery of care and services, all providers must meet the requirements set out in Schedule 3 – Care and services for home care services, Part 3 – Home Care Services, Division 1 – Responsibilities of approved providers, section 13 of the [Quality of Care Principles 2014](#).

When a provider agrees to use the home care package to fund items that do not clearly fall in either the inclusions or exclusions lists as identified in Schedule 3 of the *Quality of Care Principles 2014*, 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.

Innovative and digital technology, aids and equipment

Where safe, effective and clinically appropriate, providers are encouraged to offer innovative and digital delivery options to provide services to consumers. Home care packages may also be used to support the use of:

- **telehealth, video conferencing and digital technology** (including remote monitoring) 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.

Aids and equipment

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

An example of this is a motorised wheelchair (or motorised scooter). Given the high cost of these items, these items would be hired or leased, rather than purchased for the consumer.

The *Home Care Agreement* needs to specify whether it is leased or who owns the item and who is responsible for ongoing maintenance and repair costs, as well as what will happen to the item once the consumer leaves the package. The agreed position and the responsibilities of each party should be documented.

Excluded items

Schedule 3 – Care and services for home care services, Part 2 – Excluded items of the [Quality of Care Principles 2014](#) specifies the items that must not be included in a home care package. These items include:

- items that would normally be purchased out of general income;
- 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 Government;
- home modifications or capital items that are not related to a consumer's care needs
- travel and accommodation for holidays;
- cost of entertainment activities, such as club memberships and tickets to sporting events;
- gambling activities; and
- payment for services and items covered by the Medicare Benefits Schedule or the Pharmaceutical Benefits Scheme.

Declining a consumer's request

The following list provides a guide to 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 Schedule 3 of the [Quality of Care Principles 2014](#);
- The 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 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 provider;
- There have been previous difficulties or negative experiences with the consumer's suggested service provider; or
- The cost of the service/item is beyond the scope of the available funds for the package.

Where a provider is unable to give effect to the consumer's preferences or request for services, the reasons must be clearly explained to the consumer and documented.

8.6 Community Visitors Scheme (CVS)

The CVS is a national scheme that provides friendship and companionship to consumers who are socially isolated or at risk of social isolation. The CVS assists in supporting consumers to maintain their wellbeing and quality of life through social interaction.

The CVS works with providers to match volunteers with consumers. The volunteers provide friendship and companionship through one-on-one contact by visiting the consumer in their home on a regular basis.

Note: Volunteer visits accessed through the CVS are not charged to a consumer's home care package budget. Therefore, offering this scheme is an innovative way to provide the social support a consumer may need in addition to the care and services they receive as part of their care plan.

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

8.7 What if a consumer needs an interpreter?

To ensure that everyone can participate fully in the development of their care plan, home care providers are able to access free interpreting services through the Government's National Translating and Interpreting Service (TIS National) to support them in the delivery of aged care services to people from non-English speaking backgrounds.

Under this arrangement, TIS National provides on-site and phone interpreting services to the Government's subsidised home care, home support and residential aged care providers. This subsidised arrangement is a provider entitlement that is not directly linked to individual consumers.

Providers are able to access TIS National as part of their operational requirements under the Home Care Packages Programme. They can, free of charge, use TIS National to negotiate the *Home Care Agreement*, co-design the care plan and individualised budget, as well as to discuss the consumer's monthly statement.

Note: TIS National first becomes available to providers when they are working with their consumers on the *Home Care Agreement*.

Providers access services through a non-transferable TIS National code issued to the individual provider. The Department is subsequently billed for those services by TIS National.

Existing providers will already have been allocated a code and advised of this in writing. If a provider is unsure of their code, they should contact TIS National directly. New providers can register for their unique code via the TIS National website.

Interpreters outside the operational requirements of the programme

For providers who require an interpreter for their consumer outside of the operational requirements of the programme (for example, when consumers are receiving personal care and services as part of their care plan) all costs incurred should be paid for by the consumer's available funds.

These additional costs should be made clear to the consumer prior to the *Home Care Agreement* being entered into. Whatever is agreed must be affordable within the total budget available for the consumer's package.

9. Commencement of services

Once a consumer has signed their *Home Care Agreement*, their care and services can begin. Their package starts on the day the *Home Care Agreement* is signed, not from the day that care is first delivered.

Care and services will be delivered according to the care plan, as co-produced by the provider and the consumer.

9.1 How long does a consumer stay in a home care package?

A consumer can stay in the home care package for as long as they need to, as long as the provider is delivering services as agreed and the consumer is meeting their obligations, such as paying their fees. This is called 'security of tenure'.

The *Home Care Agreement* must specify how either party may terminate the *Home Care Agreement* and must not contradict the security of tenure provisions set out in the [User Rights Principles 2014](#).

9.2 Monitoring, review and re-assessment

Providers are responsible for ensuring that the needs of their consumers are being met on an ongoing basis. This requires 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 provider and the consumer. This review is informed by observations and feedback from staff and service providers who are in contact with the consumer.

Note: Although a consumer may choose to have an active role in the management of their package, they should not take on the functions of a case manager. Ongoing monitoring, reviews and re-assessment must be undertaken by the 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).

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.

If a consumer's care needs change, and they require different care and services to meet them, the provider may need to review the consumer's care plan and individualised budget. This needs to be done in partnership with the consumer.

Reasons for a 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; and
- a change in the costs of providing the care and services.

When reviewing the consumer's care plan, the provider must consider the consumer's needs, goals and preferences.

Note: A provider cannot change a consumer's care plan without their agreement.

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.

Support for consumer following re-assessment by home care provider

A re-assessment of a consumer's care needs could lead to significant changes in the types of support they receive. The provider should support the consumer, as much as possible, in any changes resulting from the review of their care plan.

What happens if a consumer's care needs have increased?

A consumer's care needs may increase significantly so that the person potentially requires home care in a higher band (e.g. Level 3 or 4, rather than Level 1 or 2), or entry to residential care. In these circumstances, the consumer will need another assessment by an ACAT. Providers can assist in arranging the ACAT assessment, with the permission of the consumer.

If the consumer is already in receipt of a Level 4 package, they may need to consider other options including:

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

The consumer will still have security of tenure of their package, and must continue to receive care and services as agreed, until they notify the provider in writing that they wish to terminate their *Home Care Agreement*, if they wish to do so.

9.3 Leave provisions

Under section 46.2 of the [Aged Care Act 1997](#), a consumer may take temporary leave from their home care package for any reason, such as for a hospital stay that may be followed by transition care, to receive respite care, or social leave.

For this to occur, the consumer must request the provider to suspend their home care package and specify the commencement date.

Note: A consumer's security of tenure is not affected while they are on leave.

Leave arrangements are the same across all four home care package levels.

Impact of suspension on the home care subsidy

The following table provides information about how the subsidy is paid to providers in relation to suspending the *Home Care Agreement*:

Type of suspension	Impact on payment of subsidy to provider
Hospital	<ul style="list-style-type: none"> Home care subsidy is payable (at the full basic subsidy rate) for up to 28 consecutive days in a financial year, for each episode of hospitalisation or transition care at a particular package level. After 28 consecutive days, the subsidy is payable at 25 per cent of the basic subsidy rate.
Transition care	
Residential respite care	<ul style="list-style-type: none"> Home care subsidy is payable (at the full basic subsidy rate) for up to 28 cumulative days in a financial year at a particular package level. After 28 cumulative days, the subsidy is payable at 25 per cent of the basic subsidy rate.
Social leave (all other suspension types)	

Impact of suspension on consumer fees (care fees)

A consumer may be required to pay an ongoing care fee to the 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 provider.

For information on the impact of suspension on consumer fees, please refer to:

- Division 46, section 46-2 of the [Aged Care Act 1997](#) and [Aged Care \(Transitional Provisions\) Act 1997](#);
- Division 2, section 72 of the [Subsidy Principles 2014](#);
- Section 108 of [the Aged Care \(Subsidy, Fees and Payments\) Determination 2014](#);
- Division 5, Part 4, subsection 130(5) of the [Aged Care \(Transitional Provisions\) Principles 2014](#).

Existing consumers at 30 June 2014

Consumers who were receiving a home care package on or before 30 June 2014 cannot be asked to pay home care fees while the consumer's package has been suspended and the consumer is receiving transition care or residential respite care.

Consumers on a home care package on or after 1 July 2014

These consumers can continue to be asked to pay the income-tested care fee (if any) while their package is suspended.

The full fee must be paid for up to 28 days (see above table), after which the consumer will pay whichever is the lesser of:

- their income-tested care fee, as previously advised; and

- the amount of the reduced home care subsidy, plus the primary supplements payable.

Note: Providers cannot charge consumers who entered into a *Home Care Agreement* on or after 1 July 2014 the basic daily fee when the consumer takes leave for **residential respite or transition care**.

Impact of suspension on monthly statements

Any subsidy, relevant supplements or care fees paid to the provider while the consumer is on leave must be included in the consumer's monthly statement.

9.4 When consumers leave a home care package

If a consumer decides to leave a home care package, they will need to advise their provider in writing.

When a consumer moves to a location outside their provider's area

As home care packages are allocated to providers, the consumer's package does not transfer with them in these circumstances.

Consumers who move to a new location that is not within a service provider's area (as outlined in their conditions of allocation) will need to find a new provider with an available suitable home care package in the new location.

The consumer may ask the provider to assist with their transition to a new provider. The provider should ensure continuity of service delivery during the transfer and assist, where possible, to arrange services in the new location.

Once the consumer finds a new provider, they will need to enter into a new *Home Care Agreement* and develop a new care plan with them. They will not need to be reassessed by an ACAT/ACAS unless their care needs have changed significantly.

Unspent funds when a consumer leaves a package

When a consumer leaves a package, there may be unspent funds in the budget. It depends on the circumstances as to how these unspent funds are used.

If a consumer moves to a higher level package with the same provider, any unspent funds must be available for them to use in their higher level package.

A consumer is not entitled to a refund of unspent home care fees if they cease to receive care from their provider. The only amounts of home care fees that are refundable are fees that have been overpaid by the consumer and any fees paid in advance of the date from which the services cease.

10. Rights and responsibilities

10.1 Rights and responsibilities of an approved provider

Approved providers have a number of responsibilities under the *Aged Care Act 1997*.

These responsibilities relate to:

- [Quality of Care Principles 2014](#) – Part 4.1 of the Act; which relate to the care and services that a provider of home care is to provide and the Home Care Standards that a home care provider is expected to meet as a part of quality review;
- [User Rights Principles 2014](#) – Part 4.2 of the Act, which covers the rights of the consumer; and,
- [Accountability Principles 2014](#) – Part 4.3 of the Act, which covers accountability for the care that is provided, including the suitability of their key personnel.

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

For more information on the rights and responsibilities of approved providers, refer to Section 2.2 Responsibilities & Obligations of the [Guide to Aged Care Law](#).

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 to provide quality care to consumers and to ensure the provider meets its responsibilities.

Providers 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.

The Home Care Standards apply to the delivery of home care packages. They are contained in Part 3, Division 2 of the [Quality of Care Principles 2014](#).

Sub-contracted or brokered services

Providers should, wherever possible, facilitate services being delivered by the person chosen by the consumer. Where this is not possible, providers should explain this to consumers in a manner they understand.

Services may be provided directly by the 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 provider remains responsible for service quality and meeting all regulatory responsibilities.

The provider should always inform the consumer of any risks or additional costs of purchasing services from another source. These costs should not be unreasonable.

Providers are encouraged to develop a list of 'preferred service providers' to support consumers' needs and choices and to build relationships with other organisations that specialise in providing services to people from special needs groups.

When consumers request that services 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 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.

Contracting to informal carers, family members or friends

Contracting service provision to informal carers, family members or friends is not encouraged under the Home Care Packages Programme. However, it is recognised there may be no workable alternative in some areas (for example, remote parts of Australia).

Providers should consider the following factors when considering whether to contract service provision to informal carers, family members or friends of the consumer:

- elder abuse safeguards;
- their 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 Government through programmes such as the Carer Allowance or Carer Payment. These programmes are administered by DHS and are not part of the Home Care Packages Programme.

Further information is available at the DHS' [Carers webpage](#).

Duty of care and dignity of risk

The following information has been developed through the [Home Care Today](#) Legal Issues project and may assist you with working through your duty of care while providing your consumer with dignity of risk.

Duty of care is the obligation of a person to exercise reasonable care in the conduct of an activity. Breach of that duty which causes damage or loss to another may give rise to a claim for damages. Workers have a responsibility to their clients to **reduce** or **limit** the amount of harm or injury they may experience. This responsibility is known as 'duty of care' and it can sometimes seem overwhelming. For example, our responsibility to one party (for example, our employer) might conflict deeply with our responsibility to our clients. It helps to remember that duty of care is a balancing act.

There are several aspects to duty of care:

- **Legal** - What does the law suggest we do?
- **Professional/ethical** - What do other workers expect us to do?
- **Organisational** - What does our organisation, and its funding body, say we should do?
- **Community** - What do the family members of our clients and other community members expect us to do?
- **Personal** - What do our own beliefs and values suggest we do?

The following steps provide a guide for a process that can be used to work through issues that have legal or ethical implications.

- 1. Discover:** Discover the person's identity and preferences, and reasons for seeking assistance. Identify their support networks and if they wish to nominate a representative to act on their behalf.
- 2. Discern and Dream:** Explore the person's goals and creative options to support health, wellbeing, maintaining roles and independence.
- 3. Duty of Care:** Act with due care and skill, providing relevant information to enable the person to make informed choices.
- 4. Dignity of Risk:** Respect the person's autonomy and self-determination to make choices for themselves and take calculated risks.
- 5. Discuss:** Work through the options and choices, outlining the consequences and any potential limits to the choices available. Work together to discern the best response to the person's needs within the resources available, balancing duty of care and dignity of risk.
- 6. Do:** Work with the person's choices and think about how their requests can be fulfilled safely.
- 7. Decline:** You can decline a request if the service is outside of the scope of home care packages or you have good reason to believe that the person's choices may cause harm or pose a threat to the safety of the person or staff, volunteers or contractors.
- 8. Document:** Document your discussions, the information you have provided and the choices that the person has made to demonstrate that you have met your duty of care.
- 9. Disclaimer:** Where a person has chosen a course of action that may involve a risk, the provider may ask the person or their representative to sign an indemnity form.
- 10. Disagreement:** Working through this process should lead to agreement but if this is not possible then the person should be made aware of the complaints process, their right to access the National Aged Care Advocacy Line and the Aged Care Complaints Service.

For more information, please refer to the 'Practice Guidance on the legal issues in consumer directed care' document which has been developed through the [Home Care Today](#) Legal Issues project.

Quality Reporting Programme

All providers are required to undertake a quality review by the Australian Aged Care Quality Agency (AACQA) during each three-year cycle.

These reviews encourage 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 Home Care Standards set the standards for the quality of care and services for the provision of home care to older Australians. The standards require:

- service providers to demonstrate effective management processes based on a continuous improvement approach to service management, planning and delivery
- the standards also require each consumer (current and prospective):
 - has access to services and consumers receive appropriate services that are planned, delivered and evaluated in partnership with themselves and/or their representative
 - is provided with information to assist them to make service choices and has the right (and responsibility) to be consulted and respected.
 - have access to complaints and advocacy information and processes and their privacy and confidentiality and right to independence is respected.
- each provider to demonstrate it has effective management processes based on a continuous improvement approach and ensure all consumers (current and prospective).

The Home Care Standards apply to the delivery of home care packages. They are contained in Part 3, Division 2 of the [Quality of Care Principles 2014](#).

Further information about the Home Care Standards and Quality Reporting arrangements is available on the [Department's website](#).

For more information on the AACQA, go to their [website](#).

Police checks and certificate requirements

Providers are required under Part 6, Section 47 of the [Accountability Principles 2014](#) 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 consumers
- volunteers who have, or are likely to have, unsupervised access to consumers.

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

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

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

Volunteers provided by the CVS have a police certificate and have been assessed as meeting the requirement.

Staff member

A staff member is defined in Part 1, Section 4 of the [Accountability Principles 2014](#) as a person who:

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

Volunteer

Under Part 1, Section 4 of the [Accountability Principles 2014](#), a volunteer is defined as a person who:

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

Key Personnel

Additional conditions apply to key personnel. Part 2 of the [Sanctions Principles 2014](#) outlines the reasonable steps to be taken by an approved provider to ensure none of its key personnel is a disqualified individual.

The provider must:

- obtain (with the person's written consent) a police certificate for the person;
- 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 or make arrangements for the person to be examined by a registered medical practitioner; and
- ensure a disqualified individual ceases to be one of the provider's key personnel.

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

Contractors

Where a provider has a contract with an agency that provides staff who work under the control of the provider, the contracted individuals may be considered staff members under Section 4 of the [Accountability Principles 2014](#). Sub-contractors who work under the control of the provider may also be considered as staff members under the Act.

The contract between the agency and the provider should state that staff must have a current police certificate, which does not preclude them from working in aged care.

Independent contractors

Police check requirements are not intended to extend to people engaged on an ad hoc basis. For example, trades people engaged as independent contractors generally do not require police checks. The policy intention is to allow for reasonable judgments to be made.

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

Services that are also provided to the public at large, such as a gym, would generally be regarded as services provided by independent contractors. If a home care consumer is attending a gym as part of his/her package, the 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 provider also do not require police checks.

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.

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 provider;
- the provider does not determine the working hours and wages of the contractor;
- the provider does not make superannuation payments on behalf of the contractor;
- and
- the 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](https://www.business.gov.au) website.

Further information about police checks is available:

- online: at the Police Certificate Guidelines for Aged Care Providers webpage
- by phone: 1800 200 422
- in writing to:
 - the Department's inbox agedcare.police.checks@dss.gov.au

- Aged Care Police Checks
Aged Care Quality and Compliance Group
Department of Social Services
PO Box 7576
CANBERRA BUSINESS CENTRE ACT 2610.

10.2 Rights and responsibilities of a consumer

The rights and responsibilities of consumers are set out in the *Charter of care recipients' rights and responsibilities – Home Care* (the Charter). The Charter is contained in Schedule 2 to the [User Rights Principles 2014](#).

Providers should clearly explain a consumer's rights and responsibilities to them and provide a copy of the Charter to them with their *Home Care Agreement*.

For more information on the rights and responsibilities of consumers, refer to the Charter on the [Department's website](#).

Advocacy

Consumers can request that another person of their choice assist and/or represent them in managing their care, such as:

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

Providers must accept the consumer's choice to be supported by an advocate and 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.

National Aged Care Advocacy Programme (NACAP)

Should the consumer require advocacy support, they can access advocacy services through the Government funded NACAP.

Under the [Aged Care Act 1997](#), NACAP services look after people who are, or are going to, receive a home care package or residential aged care services.

NACAP organisations provide free, confidential and independent advocacy support and information to consumers (or potential consumers) and their families and carers about their rights and responsibilities when accessing aged care services.

NACAP services:

- support consumers to be involved in decisions that affect their life and care needs;
- provide consumers with information and advice about their rights and responsibilities;
- assist consumers to resolve problems or complaints in relation to aged care services, through the provision of advocacy; and
- promote the rights of consumers to aged care service providers.

Consumers can contact a NACAP provider in their area on 1800 700 600 or visit the Department's website for further information.

Complaints

If consumers are concerned about any aspect of service delivery, they are encouraged to approach the provider, in the first instance. In most cases, they will be best placed to resolve any complaints and alleviate the consumer's concerns.

The provider needs to accept a complaint regardless of whether it is made orally, in writing or anonymously. The provider must also have appropriate processes in place to receive, record and resolve complaints. The provider should inform their consumers about how they can access these processes and they should be identified in the *Home Care Agreement*.

These processes should take into consideration people with special needs, such as people with vision or hearing impairments and people from culturally and linguistically diverse backgrounds.

Note: Providers must not discontinue care or services, refuse access or otherwise take action against any person because they have made a complaint. Providers must also handle and address any complaints fairly, promptly and confidentially.

It is important that home care providers record, monitor, collate and analyse trends in complaints so that this information can be used to improve services.

Providers should also actively encourage consumers to provide feedback about the services they receive.

Aged Care Complaints Scheme

The 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 Government subsidised aged care services.

Providers must make information available about the Complaints Scheme, including contact information.

The Complaints Scheme can be contacted on 1800 550 552. Complaints can also be made in writing via the [Complaints Scheme webpage](#).

When a complaint is made, a staff member from the Complaints Scheme will explain the process to the complainant, including options for resolution and what can be achieved through those options.

Options for resolution open to the Complaints Scheme include:

- asking the 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; or
- investigating the concerns.

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

- the 'Charter of care recipients' rights and responsibilities – home care'
- 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 [Complaints Scheme webpage](#).

The processes of the Complaints Scheme, including options for resolution, are governed by the [Complaints Principles 2014](#) under the Act.

For more information on the [Complaints Principles 2014](#), go to the [Guide to Aged Care Law](#).

11. Reporting and administrative responsibilities

11.1 Conditions of allocation to replace agreements

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

Conditions of allocation

The conditions of allocation for home care places form part of the Notice of Allocation issued to the provider under section 14-8 of the [Aged Care Act 1997](#).

11.2 Commencement of places

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

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

If the place has been allocated on a provisional basis, the provider must advise the Department in writing when they are able to commence providing services. A 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 is available on the [Management of Places Forms for Approved Providers page of the Department's website](#).

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

11.3 Variations, transfers and surrender or relinquishment of places

Variations of places

A 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.

The application form 'Application to vary conditions of allocation' is available on the [Management of Places Forms for Approved Providers page of the Department's website](#).

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

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

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

Transfer of places

The provider may apply in writing to the Secretary of the Department to transfer operational places under sections 16-1 and 16-2 of the [Aged Care Act 1997](#).

The 'Application form to transfer aged care places to another provider' is available on the [Management of Places Forms for Approved Providers page of the Department's website](#).

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

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

Surrender or relinquishment of places

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

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

11.4 Home care subsidy payments

Home care subsidies are calculated on a daily basis where there is a consumer receiving care through a package.

They are paid monthly in advance, based on the number of home care places occupied in the second last preceding payment period. For example, a payment to a 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.

Subsidy payments are made through the DHS aged care payment system, on behalf of the Department.

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.

Initial payments

A provider's initial payment claim form covers the payment period from the date when the home care places become operational.

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

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

For more information about the home care subsidy, refer to the [Aged Care Act 1997](#), the [Subsidy Principles 2014](#), or the [Guide to Aged Care Law](#).

11.5 Financial reporting to the Department

Division 4 – Responsibilities of approved providers for home care services of the [Accountability Principles 2014](#), sets out a provider's financial reporting responsibilities to the Department.

Taxation matters

Goods and Services Tax (GST)

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*.

The introduction of monthly statements has highlighted the treatment of GST and whether or not the GST should be passed onto the consumer. Although the Department advises that providers need to seek their own financial and taxation advice when applying commonwealth tax law, home care providers may like to refer to the next section of the manual 'A new tax system (Goods and Services Tax) Act 1999 – Sect 38.30'

A new tax system (Goods and Services Tax) Act 1999 – Sect 38.30

(1) A supply of * home care is GST-free if home care subsidy is payable under Part 3.2 of the *Aged Care Act 1997* or Part 3.2 of the *Aged Care (Transitional Provisions) Act 1997* to the supplier for the care.

(2) A supply of care is GST-free if the supplier receives funding under the Home and Community Care Act 1985 in connection with the supply.

(3) A supply of * home care is GST-free if the supply is of services:

(a) that are provided to one or more aged or disabled people

(b) that are of a kind covered by item 2.1 (daily living activities assistance) of Part 2 of Schedule 1 to the * Quality of Care Principles.

(4) A supply of care is GST-free if:

(a) the supplier receives funding from the Commonwealth, a State or a Territory in connection with the supply

(b) the supply of the care is of a kind determined in writing by the * Aged Care Minister to be similar to a supply that is GST-free because of subsection (2).

Other taxation matters

A provider must be able to quote its ABN in any GST dealings with the ATO or other government departments and agencies, including the Department and DHS.

If a provider does not have an ABN, it cannot be registered for GST, cannot charge GST and does not have any entitlement to input tax credits.

Providers should give their ABN to the Department and DHS so they can process and report payments correctly. Providers who do not supply their ABN may be subject to withholding tax.

New home care providers

To enable initial payments, or to change bank details to enable ongoing payments, providers must supply their aged care service's bank details to DHS via a form. The form is available on the DHS aged care forms webpage. The form is titled 'Add or Change Approved Aged Care Service's Bank Details'.

Aged Care Approved Provider Statement

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 required every three years. It ensures all aged care forms, claims and other relevant documentation to claim payments of subsidy under the [Aged Care Act 1997](#) are appropriately authorised. The provider statement only needs to be completed if the provider with services is not registered for Aged Care Online Claiming.

The current provider statement is valid for the period 1 July 2014 to 30 June 2017. The next statement is due 30 June 2017 and will be sent to providers with services not registered for Aged Care Online Claiming from DHS in April 2017.

For more information about claiming the home care subsidy, refer to the DHS claiming page.

12. Interface with other programmes and schemes

The Home Care Packages Programme does not have policies that restrict access to other programmes and schemes. Therefore, it may be possible for a consumer to receive care and services through a range of other programmes and schemes that they cannot receive as part of a home care package.

These programmes and schemes include:

- Transition Care Programme;
- Community Visitors Scheme;
- Disability Programmes;
- Continence Aids Payment Scheme;
- Palliative Care; and
- Department of Veteran's Affairs Programmes

More detailed information about the individual programmes is available on the [My Aged Care website](#) or the national contact centre on 1800 200 422.

For information about how other programmes or schemes interact with the Home Care Packages Programme, please refer to information on the programme or scheme you are interested in.

Commonwealth Home Support Programme (CHSP)

In certain circumstances, consumers are able to receive care and services through the CHSP on a time limited basis when they are in a home care package (that is, the additional CHSP services will not be charged to the consumer's individualised budget).

These circumstances include:

- Where a Level 1 or 2 home care package consumer's budget is already fully allocated, they can access additional, short-term or episodic Allied Health and Therapy services or Nursing services from CHSP
- Where the consumer's budget is already fully allocated, and a carer requires it, a consumer can access additional planned respite services under CHSP
- In an emergency (such as when a carer is not able to maintain their caring role), where a consumer's budget is already fully allocated, additional services under the broader CHSP can be obtained on an emergency or short term basis.

These instances should be time limited, monitored and reviewed.

Please see the [CHSP Programme Manual](#) for more information.

13. 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>
basic daily 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
CDC	Consumer directed care
claim form	The DHS form used by home care providers to claim home care subsidy payments
Consumer	A person who is receiving care and services under a home care package funded by the Australian Government. In the <i>Aged Care Act 1997</i> , this person is described as a “care recipient” In these Guidelines, references to the consumer include other people who are authorised to act on behalf of the consumer
Commonwealth Home Support Programme	This programme provides home and community care services for frail older people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over. The Commonwealth Home Support Programme does not currently apply in Victoria and Western Australia
Department	Department of Health
DHS	Department of Human Services
DVA	Department of Veterans’ Affairs
EACHD	Extended Aged Care at Home Dementia package
home care	A type of aged care for which a home care subsidy is payable under Part 3.2 of the <i>Aged Care Act 1997</i> and <i>Aged Care (Transitional Provisions) Act 1997</i>
home care consumer (or consumer)	A person who is receiving care and services under a home care package funded by the Australian Government. In the <i>Aged Care Act 1997</i> , this person is referred to as a “care recipient”
home care provider (or approved provider)	An organisation approved by the Department of Health 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”

Term	Meaning
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 Packages Programme	The Australian Government programme that provides funding for home care packages aimed at supporting people to remain living at home
Home Care Standards	The Home Care Standards means the 'Home Care Common Standards', as set out in Schedule 4 to the <i>Quality of Care Principles 2014</i>
home care subsidy	The subsidy payable to a home care provider by the Australian Government under Part 3.2 of the <i>Aged Care Act 1997</i> and <i>Aged Care (Transitional Provisions) Act 1997</i>
Income-tested care fee	Refers to the fee a consumer may be asked to pay for their home care, based on an income assessment
NACAP	The National Aged Care Advocacy Programme is funded by the Australian Government and provides advocacy support and promotes the rights of people who are seeking or are receiving Australian Government funded aged care services
Principles	Aged Care Principles made under section 96-1 of the <i>Aged Care Act 1997</i> and <i>Aged Care (Transitional Provisions) Act 1997</i>
suspension	Term used when a consumer takes a period of leave from their home care package, and some or all services are suspended