Australian Government
Department of Health and Aged Care

Home Care Packages (HCP) Program

Operational Manual

A guide for home care providers

Version 1.5

November 2024

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Table of Contents

1. Introduction

This section covers:

- About the manual
- How the manual is updated
- Contact information
- Disclaimer

1.1 About the manual

This manual provides guidance on the policy context and operational requirements for the Home Care Packages (HCP) Program for approved home care providers.

The HCP Program Care Recipient Manual is available on My Aged Care.

If you are looking for a high-level summary of the program, you can find information on:

- Department of Health and Aged Care website
- My Aged Care website.

1.2 How the manual is updated

The HCP Program and the broader aged care system continue to operate in an environment of change. The Department of Health and Aged Care ('the department') will update the manual, as required, to ensure its currency and accuracy.

Please refer to the online version of the Home Care Packages Program Operational Manual to ensure that you have the most recent version. The footer on the front page includes the issue date of the manual.

The table below outlines the revisions made since its release.

Date	Summary of changes
March 2020	Manual (v1.0) first issued.
February 2021	Manual revised (v1.1). Includes content about Improved Payment Arrangements, the My Aged Care Service and Support Portal, addressing people as care recipients, updated web links and minor updates to wording.
September 2021	Manual revised (v1.2). Includes content about Improved Payment Arrangements.
January 2023	Manual revised (v1.3). Updates to Chapter 9: Inclusions and Exclusions including a decision tree and template providers can use to document agreed care and services with the care recipient; replaces all references to 'Department of Health' with the 'Department of Health and Aged Care'. Updates to Chapter 7 - Care Planning. Updates to Chapter 15: How does the HCP Program interact with other programs and schemes?

Date	Summary of changes
	Content updated to include information on price caps, pricing guidance, Serious Incident Response Scheme and unspent funds. All content has been revised and updated for currency.
August 2023	Manual revised (v1.4). Updated weblinks and contact details.
November 2024	Manual revised (v1.5). Updated grammar, and formatting, links, program clarifications and interface program information throughout. For more information on updates please see the summary of changes.

1.3 HCP Manual appendices

Visit the HCP Program Manual and appendices page on the department's website to download the appendices that accompany this manual.

Appendix A	HCP Program pre-1 July 2014 fee arrangements
Appendix B	HCP Program pricing schedule (introduced 1 July 2019)
Appendix C	HCP Inclusions/Exclusions Framework – decision tool and template
Appendix D	HCP Program compensation payments
Appendix E	Responsibilities of approved home care providers

1.4 Questions about the program

If you have questions about the HCP Program, contact the My Aged Care Contact Centre, which is open Monday to Friday 8am-8pm and Saturday 10am-2pm AEST.

You can call the My Aged Care Provider and Assessor Helpline on **1800 836 799**.

The My Aged Care Contact Centre is closed on Sundays and public holidays.

1.5 Additional assistance

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

WA	WAPlaces@health.gov.au
NSW/ACT	NSWPlaces@health.gov.au
VIC	vic.office@health.gov.au
QLD	engagement.QLD@health.gov.au
SA	SAPlaces@health.gov.au
TAS	TAS.Office@health.gov.au
NT	NTPlaces@health.gov.au

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

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

1.6 Disclaimer

The HCP Program is governed by the applicable legislation. Home care providers are responsible for understanding and complying with all legislation that is relevant to delivering home care. If in doubt, home care providers should consider the need to obtain their own appropriate legal advice relevant to their circumstances, especially in relation to the formulation of Home Care Agreements.

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

Any guidance released by the department is based on the policy intent of the program and a practical interpretation of the legislation.

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

- Department of Health and Aged Care
- My Aged Care
- Aged Care Quality and Safety Commission
- Services Australia
- Australian Competition and Consumer Commission
- Australian Tax Office

Key points to remember

- If you are reading a printed copy of this manual, please make sure it is the most up to date version. You can find the most current version of this manual on the department's website.
- Home care providers are responsible for understanding and complying with all legislation that is relevant to delivering home care.
- In this manual, older people in Australia who receive funding for care and services through the HCP Program are called 'care recipients' in line with the legislation. Information about the Aged Care Quality and Safety Commission (the Commission) will refer to older people as 'consumers' in line with governing legislation.

2. About the HCP Program

This section covers:

- Consumer-directed care approach
- Intent and scope of the HCP Program
- Establishing care recipient's related care needs and goals
- Governance of the HCP Program

2.1 What is the consumer-directed care philosophy underpinning the HCP Program?

Australians are living longer and healthier lives. Older people have told us that they wish to remain living independently in their own homes for as long as possible. It is important that, as people age, they have choice about their care.

Reviews into aged care have found that older people do not want to be passive recipients of services. Rather they want to play an active role in where they live, which provider they choose to deliver their care and how they provide services.

In response, the Government has implemented reforms to aged care to deliver a consumer directed care (CDC) approach to aged care services.

The following 3 CDC principles underpin all Government-funded aged care programs, including the HCP Program:

1. Older people should have access to care and services that support them to live in their own homes for as long as they can and choose to.

2. Older people can and should make decisions on the care and services they receive under Government-funded aged care programs.

3. The best care outcomes happen when older people and their home care providers work in partnership.

In consideration of the CDC principles, approved providers are expected to work with their care recipients to agree on the care recipient's level of involvement in their own care.

2.2 What is the intent of the HCP Program?

The HCP Program supports older people aged 65 or over (or First Nations people aged 50 or over) with complex ageing related care needs to live independently in their own homes, using a CDC approach to maintain the care recipient's capabilities as they age.

Home Care Packages ('packages' or HCPs) deliver coordinated care and services to meet people's assessed ageing related care needs within the limits of their individual home care budget and the scope of the program. How care and services

are identified and delivered should reflect and respect the individual, their ageing related care needs, personal situation and preferences.

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

The Aged Care Quality Standards (the Quality Standards) require providers to deliver safe and effective services and supports for daily living that optimise the person's independence, health, wellbeing and quality of life.

Services and supports for daily living include, but are not limited to domestic assistance, home maintenance, transport and recreational and social activities.

These may include services and supports to keep care recipients:

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

While the HCP Program is primarily intended to support complex ageing related needs, the program may also support the disability-related needs of older people, if they are not eligible for the National Disability Insurance Scheme (NDIS).

It is important to note that a HCP is not a source of income that care recipients can use completely at their own discretion. Providers need to work with care recipients to ensure that funding is used appropriately and transparently. Care recipients should be actively involved in deciding how their package funds are spent. This includes due consideration of the legislated exclusions from a package.

Care recipients will accrue unspent funds if their package funds are not fully expended each month.

Different care recipients, and their support networks, will want to have different levels of involvement in planning and managing their package, including self-management.

At every level, providers will need to work with care recipients to balance their duty of care with an individual's right to make choices that take reasonable risks. This right is known as 'dignity of risk' and is discussed further at Section 7.8 and Section 9.1. An approved provider is responsible for the compliance and quality of **all** care and services provided under a package.

The Improved Payment Arrangements (introduced 1 September 2021) allowed for greater transparency of unspent funds in the program. These changes:

- moved the responsibility for holding the Commonwealth portion of unspent funds for care recipients from the provider to the Australian Government.
- reduced the prudential risk in home care over time as the program grows
- improved protections for care recipients' home care funds
- reinforced the focus on delivering services to meet care recipients' needs and choices.

See resources on the Improved Payment Arrangements.

We also introduced changes to management and administration charges from 1 January 2023 to reduce excessive prices and improve price transparency for care recipients and their families. These changes included:

- capping how much providers can charge for care and package management (20% and 15% of the package level, respectively)
- eliminating exit amounts and charging separately for costs associated with third-party services.

These changes ensure more funds are available to meet the assessed needs of care recipients. Find more information on price caps.

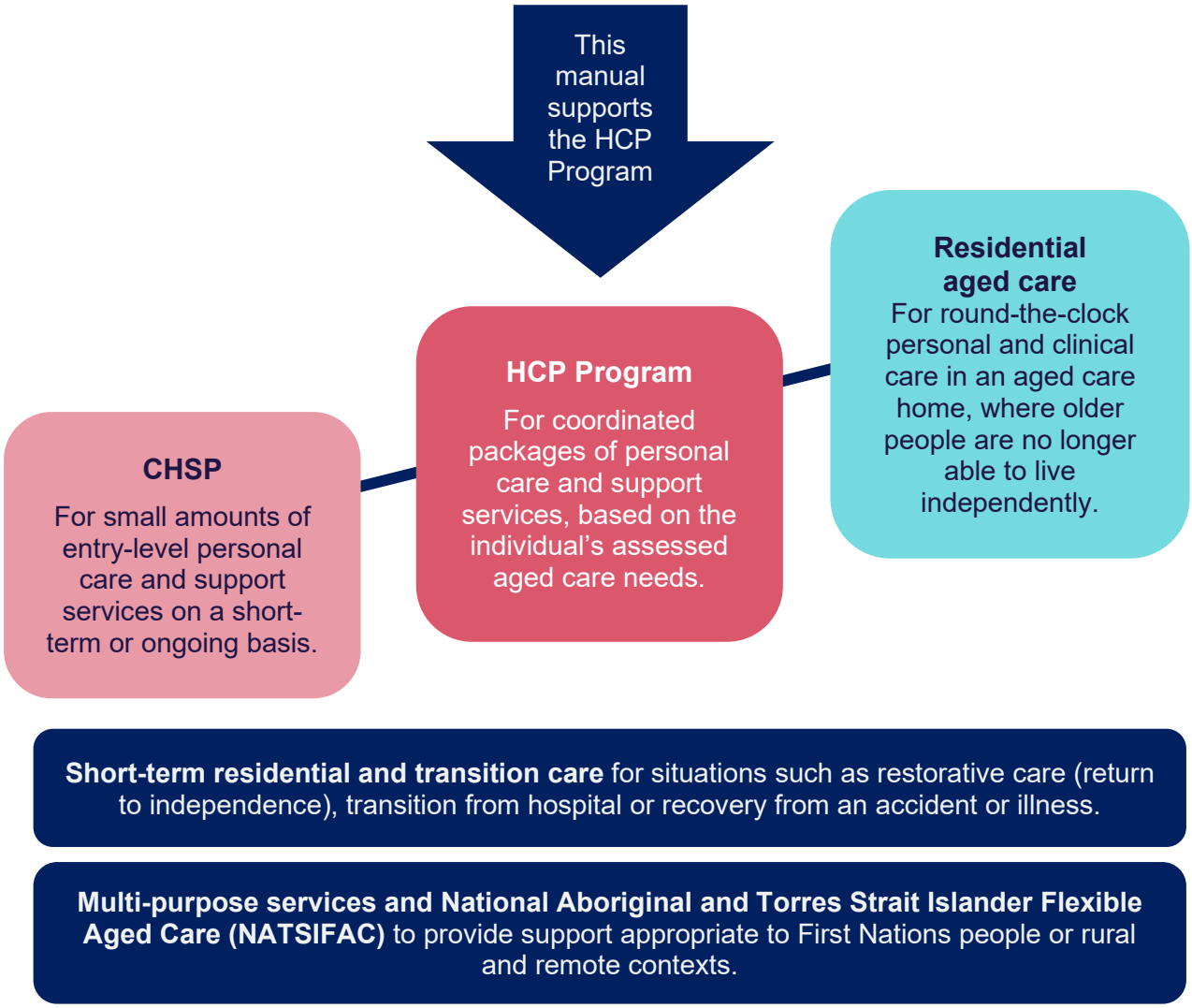
2.3 What is the scope of the HCP Program?

The HCP Program is part of the Australian Government's continuum of care for older people.

The HCP Program addresses the level of need between:

- the Commonwealth Home Support Programme (CHSP) that offers a relatively small amount of care and support services
- residential aged care that offers a high level of care in an aged care home.

The following diagram outlines where the HCP Program sits within the continuum:



Access to in-home aged care programs is determined by an independent assessment by an aged care assessor. My Aged Care will refer older people for an assessment as needed (see Section 2.4). Some older people receive services through flexible care or the CHSP and then get assessed for the HCP Program and other people will be assessed for the first time into the HCP Program. There is no requirement that anyone participates in programs earlier in the continuum of care to be eligible for the HCP Program. Further information on the interaction of these and other aged care programs is included at Section 16.

The HCP Program provides a basic subsidy (based on package level) and supplements (where an individual is eligible) towards a coordinated package of care, services and care management to meet each person's assessed ageing related care needs, care goals and preferences. There are 4 levels of packages to reflect the different levels of assessed ageing related care needs to support people to safely remain living at home as long as it is appropriate.

The HCP Program funds types of care and services that keep care recipients well and independent and maintain the capabilities of older people as they age and keep them connected to their community.

Primary categories of in-scope supports are set out in the table below:

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

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

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

Further guidance on how to decide what can be included under a package is detailed at Section 9.2 of this manual.

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

When a care recipient enters the HCP Program, their provider should ensure they understand that care recipient's assessed ageing related care needs and help them to establish goals for their care. The documentation from their aged care assessment will record assessed care needs at the time of assessment, and providers will need to discuss these with them.

In the time between the assessment and assignment of a package, assessed care needs may have changed. Providers are required to identify and assess, as per their obligations under the Quality Standards, how these needs have changed and can be met within the framework of the HCP Program. This can be done when discussing which care and services to provide under a package.

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

Each care recipient's package should equally be directed by their personal goals. A wellness approach should be taken to delivering all care and services in a way that is culturally appropriate, person-centred and trauma informed. Where possible and clinically appropriate, care and service should also align with reablement.

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

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

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

- training in a new skill or re-learning a lost skill
- minor modification to a person's home environment
- having access to equipment or assistive technology.

More information about wellness and reablement is at Section 7.4 of this manual.

2.5 What laws govern the HCP Program?

There are 3 tiers of laws that govern the HCP Program. These are:

- **Principal legislation:** this is the overarching law enacted by Parliament.
- **Legislative instruments:** these are subordinate legislation made with powers provided by the principal legislation. These instruments provide more details on how the HCP Program operates.

- **Determinations:** these are instruments that the legislation enables, if needed, to set out or clarify specific facts and details about the HCP Program.

For care recipients who entered the HCP Program after 1 July 2014, the *Aged Care Act 1997* (the Act) governs the HCP Program.

The Act is supported by a number of legislative instruments, titled 'Principles'. The Principles that are relevant to the HCP Program have been cited throughout this manual and listed below for reference:

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

In addition to the above law, transitional provisions were established for care recipients who entered the HCP Program before 1 July 2014 under the following legislation, instrument and determination:

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

Find information regarding these pre-1 July 2014 provisions in Appendix A.

Provider compliance and the quality of aged care is governed by the following legislation and instrument:

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

The Federal Register of Legislation is frequently updated. Therefore, this manual does not include links to the legislation. You can find the most recent version by searching for the instrument on the Federal Register of Legislation website[1].

The department funds the Business and Workforce Advisory Service to provide accounting and business advisory services to approved providers to maximise business performance and service viability. Services will review and assess the organisation, then providing advice and business management and financial strategies. Find more information about Business and Workforce Advisory Service.

Key points to remember

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

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

3. Rights and responsibilities

This section covers:

- Key legislation
- Charter of Aged Care Rights
- Responsibilities of providers in relation to the Charter of Aged Care Rights
- Responsibilities of aged care consumers in relation to the Charter of Aged Care Rights
- Responsibilities of approved providers
- Compliance with the Aged Care Quality Standards
- Serious Incident Response Scheme
- Privacy reporting obligations

3.1 Overview

This section outlines rights and responsibilities that should underpin delivery of the HCP Program.

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

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

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

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

See Section 4 and Section 15 for further detail on specific provider responsibilities.

3.2 Charter of Aged Care Rights

The User Rights Principles 2014 (made under the Act) contains the Charter of Aged Care Rights (the Charter). The Charter came into effect from 1 July 2019 and applies to all care recipients of the HCP Program.

The Charter consists of 14 individual consumer rights and is extracted below:

I have the right to:

1. safe and high quality care and services
2. be treated with dignity and respect
3. have my identity, culture and diversity valued and supported
4. live without abuse and neglect
5. be informed about my care and services in a way I understand
6. access all information about myself, including information about my rights, care and services
7. have control over and make choices about my care, and personal and social life, including where the choices involve personal risk

8. have control over, and make decisions about, the personal aspects of my daily life, financial affairs and possessions
9. my independence
10. be listened to and understood
11. have a person of my choice, including an aged care advocate, support me or speak on my behalf
12. complain free from reprisal, and to have my complaints dealt with fairly and promptly
13. personal privacy and to have my personal information protected
14. exercise my rights without it adversely affecting the way I am treated.

Find more information about the Charter.

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

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

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

Providers must offer all care recipients the choice to sign the Charter. They are not required to sign and can receive care and services if they choose not to sign.

By asking the care recipient to sign, it provides them with an opportunity to acknowledge that:

- their provider has given them a copy of the Charter

- their provider has assisted them to understand it
- they understand their rights.

Providers must meet all the consumer rights in the Charter – whether the care recipient signs their copy or not.

Find resources about providers' responsibilities under the Charter.

3.4 What responsibilities do care recipients have in relation to the Charter of Aged Care Rights?

All people involved in aged care (i.e. care recipients, their families, carers, visitors and the aged care workforce) must respect and be considerate of each other.

Quality aged care outcomes are more likely to be achieved in an environment of mutual respect.

Care recipients are expected to:

- give providers the information they need to properly deliver care and services
- comply with the conditions of their Home Care Agreement and pay fees outlined in the agreement on time
- respect the rights of aged care workers to work in a safe environment – any kind of violence, harassment or abuse towards staff or others is not acceptable.

Home Care Agreements have terms and conditions that set out the rights and responsibilities of the parties who have entered into the agreement. Home Care Agreements are discussed in detail at Section 6.6.

3.5 What responsibilities do I have as an approved provider?

Approved providers must understand and comply with a range of provider responsibilities specified in the Act and associated legislation.

These responsibilities relate to:

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

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

3.5.1 Security of tenure

As part of responsibilities outlined in Appendix E, providers are bound by security of tenure. Security of tenure means providers must deliver the agreed care and services for as long as the care recipient needs those services.

Providers may only stop delivering home care where they have met all requirements under Section 17 of the User Rights Principles 2014, which provides:

Exceptions to security of tenure

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

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

- (a) the care recipient cannot be cared for in the community with the resources available to the approved provider; or
- (b) the care recipient notifies the approved provider, in writing, that they wish to move to a location where home care is not provided by the provider; or
- (c) the care recipient notifies the approved provider, in writing, that they no longer wish to receive the home care; or
- (d) the care recipient's condition changes to the extent that:
  - (i) the care recipient no longer needs home care; or
  - (ii) the care recipient's needs, as assessed by an aged care assessor, can be more appropriately met by other types of services or care; or
- (e) the care recipient:
  - (i) has not paid to the approved provider, for a reason within the care recipient's control, any home care fee specified in the Home Care Agreement between the care recipient and the approved provider; and
  - (ii) has not negotiated an alternative arrangement with the approved provider for payment of the home care fee; or
- (f) the care recipient has:
  - (i) intentionally caused serious injury to a staff member (as defined in section 63-1AA of the Act) of the approved provider; or
  - (ii) intentionally infringed the right of a staff member (as defined in section 63-1AA of the Act) of the approved provider to work in a safe environment.

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

A provider should not use security of tenure provisions to cancel a Home Care Agreement where a care recipient does not consent to a change.

Cancelling a Home Care Agreement on the basis of security of tenure should only ever be used as a last resort. If you use this provision, you will have to demonstrate sufficient grounds for terminating provision of care.

Where service provision is no longer viable, you are expected to assist your care recipients to find a new provider, local to the region or support them to be referred to another system such as psychogeriatric care. For more information on negotiating changes to a Home Care Agreement see Section 6.8.

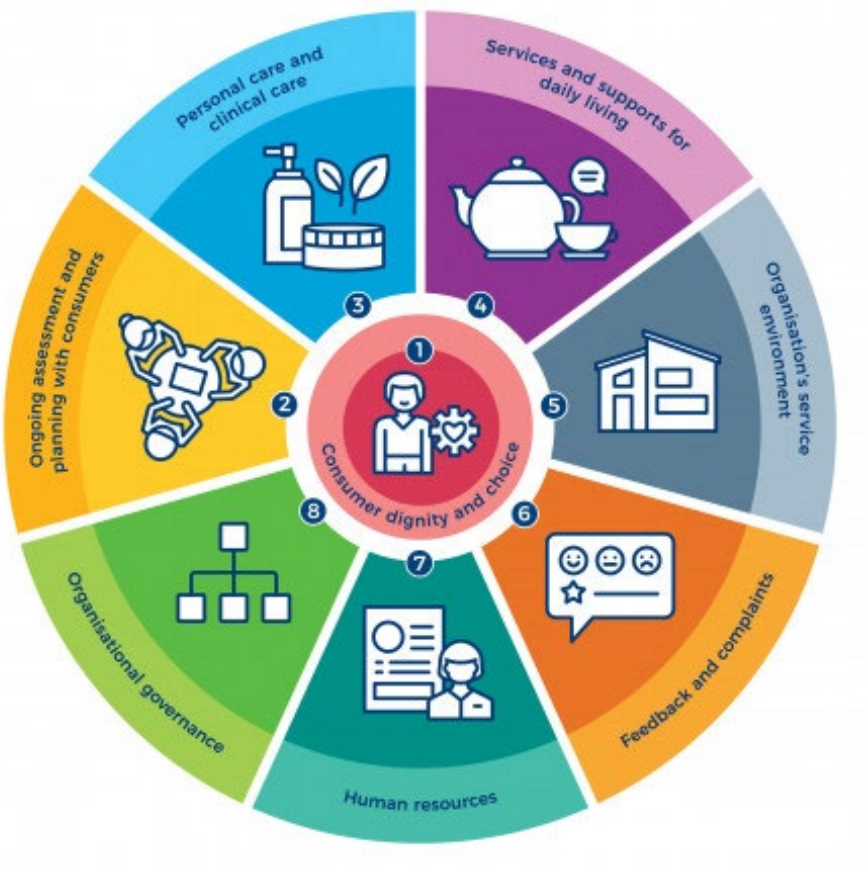
Where care recipients exhibit challenging behaviours that pose a risk to the worker, a provider should consider any underlying health conditions that may be the cause of this behaviour and work with the care recipient and their representative to put protocols in place to ensure the safety of the worker(s),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

- scheduling 2 workers at a time – the provider may need to call My Aged Care to request a Support Plan Review by an aged care assessment organisation if the package budget does not support such an arrangement)
- case conferencing with the care recipient's General Practitioner (GP) and other health professionals on a behaviour management plan (Medicare items may be payable for GPs and other health professionals to participate if behaviours relate to a chronic disease – a provider would fund their involvement through care management charges)
- contacting services such as Dementia Behaviour Management Advisory Service (DBMAS).

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

3.5.2 Aged Care Quality Standards

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



Source: Aged Care Quality and Safety Commission

The Quality Standards, displayed in the above diagram, focus on outcomes for consumers and reflect the level of care and services the community can expect from organisations that provide Government-funded aged care services.

The Quality Standards are made up of 8 individual standards.

The Commission has developed the Guidance and Resources for providers to support the Aged Care Quality Standards. It describes the Commission's expectations and provides supporting information, suggested practices, examples and evidence required to ensure compliance. It also indicates any matters that quality assessors will consider in evaluating compliance.

Find more information about the Quality Standards.

3.6 How is compliance against the Quality Standards assessed?

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

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

- interviewing consumers or representatives
- interviewing staff and management
- sampling consumer records
- reviewing documents such as policies, procedures, agreements and registers
- observing the environment, activities in progress and any interaction with consumers or representatives.

These assessment and monitoring processes are undertaken in accordance with the Aged Care Quality and Safety Commission Rules 2018, established under the *Aged Care Quality and Safety Commission Act 2018*.

Through engagement and education work the Commission aims to build confidence and trust in aged care, empower consumers, support providers to comply with Quality Standards, and promote best practice service provision.

Find more information about the Commission's functions and the Commission's assessment and monitoring process.

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

3.7 What is the Serious Incident Response Scheme and what are my incident management obligations?

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

The SIRS aims to reduce abuse and neglect of older people receiving Government-funded aged care services.

The SIRS establishes responsibilities for all approved providers, including home and community care providers, to:

- prevent and manage incidents (focusing on the safety and wellbeing of older people)
- use incident data to drive quality improvement
- to report serious incidents.

Approved providers must also use the Service and Support Portal to notify the Commission if a reportable incident occurs.

Approved providers must comply with the incident management and reporting requirements under the Act (Part 4.1, Division 54) and the Quality of Care Principles 2014 (Part 4B).

Approved providers should refer to the legislation for information on detailed requirements and read through SIRS provider resources and guidelines.

If you have questions about SIRS, you can contact the Commission by emailing sirs@agedcarequality.gov.au or calling on 1800 081 549.

Find more information about the SIRS.

Key points to remember

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

4. Becoming an approved provider

This section covers:

- Key legislation
- Considerations
- Application process
- Approved provider notification

4.1 Overview

To deliver care under the HCP Program, an organisation must become an approved provider.

An approved provider of aged care is an organisation that has been approved to provide residential aged care, home and/or flexible care under the *Aged Care Quality and Safety Commission Act 2018*.

Approved providers must comply with their responsibilities under the Act.

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

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

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

- the Act
- *Aged Care Quality and Safety Commission Act 2018*
- Quality of Care Principles 2014
- Accountability Principles 2014
- User Rights Principles 2014
- Records Principles 2014
- *Aged Care Legislation Amendment (New Commissioner Functions) Act 2019*.

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

See Section 3 and Section 15 for further details on specific provider responsibilities.

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

To be approved as a provider of aged care under the *Aged Care Quality and Safety Commission Act 2018*, providers must satisfy the matters established in Part 7A.

Find more information about becoming an approved aged care provider.

To be approved, applicants must satisfy the following considerations:

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

4.2.1 Application process

To become an approved provider, an applicant needs to apply in writing. A fee is payable to apply.

Corporations must apply using whichever of the forms is most applicable to their circumstances. You can access all application forms for becoming an approved aged care provider.

The table below outlines the forms that can be used to apply, and the circumstances in which an applicant should use each form.

1. New applicant	2. Existing service provider	3. Government organisation
This form is for organisations that are not currently approved to provide any type of care under the *Aged Care Quality and Safety Commission Act 2018*.	This form is for an existing approved provider that wants to provide another care type. Because existing approved providers have already had their suitability to provide aged care	States/territories, authorities of a state or territory and local government authorities are taken to be approved in respect of all types of aged care. A simplified form has been developed

Note: if the applicant is an approved provider of CHSP only, and wants to provide home care, they must apply as a new applicant.	approved through a previous assessment process, the application form seeks specific detail to assess suitability to provide home care.	for these government organisations to enable the creation of a departmental record and payment of subsidies to the organisation.

For more guidance, please refer to the Aged care approved provider applicant guide.

4.2.2 Incorporated organisations

Only organisations that are incorporated are eligible to become an approved provider of HCP, residential aged care or flexible care. This means that if the applicant is a sole trader, partnership or other unincorporated entity, they cannot be approved as an aged care provider under the *Aged Care Quality and Safety Commission Act 2018* and the application cannot be accepted.

Find definitions of each of these organisation structures.

Note: States, territories and local governments are automatically approved to provide aged care.

4.2.3 Suitability to provide aged care

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

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

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

4.2.4 Key personnel

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

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

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

Under the *Aged Care Legislation Amendment (New Commissioner Functions) Act 2019*, all approved providers, including those providing home care, have ongoing responsibilities to continue to ensure key personnel meet the requirements about who can/cannot be key personnel as outlined in the *Aged Care Quality and Safety Commission Act 2018*. They also have reporting obligations if changes to key personnel materially affect their suitability to provide care, including if they become disqualified, or if changes to key personnel affects the organisation's contact details. This is discussed at Section 15 of this manual.

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

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

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

applies. Once an application is deemed complete, the applicant will receive written confirmation and advice that the application has progressed to assessment.

If the applicant is approved to provide aged care, they will receive a letter from the Commission to provide notice of the approval. You can find more information at Section 5 of this manual.

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

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

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

If the applicant wishes to appeal the outcome of the reconsideration, they can make an application to the Administrative Review Tribunal. Find more information on making an application to the Administrative Review Tribunal.

Key points to remember

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

5. Preparing to deliver services as an approved provider

This section covers:

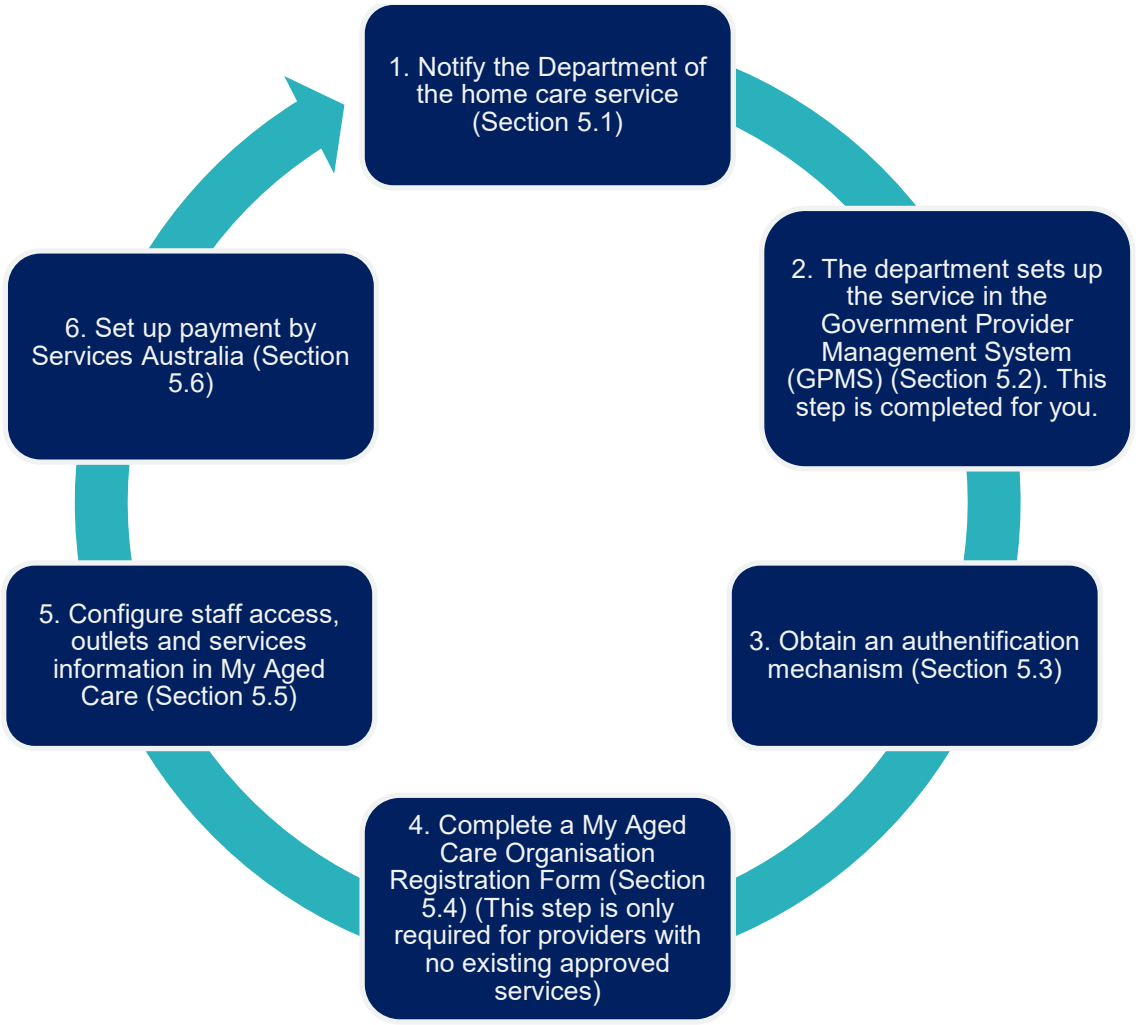
- Notifying the department of home care service
- GPMS registration
- Authentication mechanism
- My Aged Care administrator form
- Configuring information in the Service and Support Portal
- Payment setup with Services Australia

5.1 Overview

This section provides information on each of the activities providers need to complete before they can deliver services as an approved provider. It includes processes, requirements and systems.

These 6 steps may be completed in a different order to suit provider needs.

The diagram below outlines an order that may be helpful for providers.



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

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

- Sections 9-1A and 63-1 of the Act.

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

See Section 3, Section 4, Section 15 and Appendix E for further details on specific provider responsibilities.

5.2 How do I register for GPMS?

All approved providers will need to register for the Government Provider Management System (GPMS), which is a portal to access and report certain information to Government.

Providers who have been approved will receive a confirmation approval letter from the Commission advising of their approved provider status, GPMS ID and next steps. The GPMS ID is also known as the Provider GPMS ID.

Home care providers must use GPMS to submit:

- the Home Care Service Notification Form (see Section 5.3 below)
- the Provider Operations Collection Form (see Section 15.5).

Find more information on the GPMS.

5.3 How do I notify the department of my home care service?

Once the provider has been approved and can access GPMS, they need to notify the department of the home care services that they will provide. This can be done by completing the Home Care Service Notification Form.

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

The department will directly submit the Home Care Service Notification Form to the most relevant state or territory office for processing.

The state-based team will enter the details into the GPMS system. The provider will be notified by email once the information has been processed (new services or changes to existing services) and will receive a Service ID for any new services. The Service ID is different from the overarching Provider GPMS ID.

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

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

It is important to note that it can take up to 48 hours for a new service to appear in My Aged Care.

There are specific processes for moving home care services to another approved provider, merging home care services and combining home care services. Information on these is in Section 13.6.

Find more information on notification of change requirements.

5.4 How do I obtain an authentication mechanism?

New providers will need an authentication mechanism to securely access and use the My Aged Care system (see Section 5.5 below).

Since late March 2020, My Aged Care supports the following login methods:

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

5.4.1 VANguard FAS

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

VANguard FAS provides:

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

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

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

5.4.2 myGovID and RAM

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

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

Together, myGovID and RAM offer a secure login experience:

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

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

5.5 How do I set up provider access to My Aged Care?

If providers do not have existing My Aged Care Service and Support Portal administrators will need to request 'Organisation Administrator' access by contacting the My Aged Care Service Provider and Assessor Helpline on **1800 836 799** with relevant details. For more information on setting up access to My Aged Care.

The department will then email approved providers with instructions on setting up Organisation Administrator accounts at the appropriate time. This will allow the department to set up the initial administrator for a home care provider to access to the Service and Support Portal. Once registration is processed, the department will contact the nominated Organisation Administrator via email regarding next steps.

The nominated Organisation Administrator will be the first person from a provider organisation to log into the Service and Support Portal. They will be responsible for setting up staff access and managing the organisation's information and portal structure.

For more information, refer to:

- My Aged Care – Service and Support Portal resources
- Service and Support Portal User Guide: Part 1 Administrator Functions
- My Aged Care – Service and Support Portal user guide – Part 2: Team leader and staff member.

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

5.6 How do I configure my information in the Service and Support Portal?

The Service and Support Portal is an online platform that allows providers to self-manage information about the services they provide.

This information is displayed on the public Find a Provider tool on the My Aged Care website. This tool is used by care recipients and their carers to search and compare potential home care providers that can best meet their assessed ageing related care needs in their preferred location.

Find a provider is also used by My Aged Care Contact Centre staff and assessors to refer people to service(s). It also allows providers to accept and reject referrals.

It is essential that providers ensure all of their information on this platform is current, correct and complete. It should be written for care recipients in a way they can understand and with enough detail to support their decision-making. For more information, refer to the Service and Support Portal user guide – Creating service delivery outlets and adding service information.

As an approved provider, details of services are automatically listed within the Find a Provider tool. However, providers will need to ensure that these details are complete and updated as required.

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

For transparency, home care providers must include their pricing schedule on My Aged Care. Find more information about publishing prices for Home Care Packages.

Providers should always discuss pricing changes with their care recipients.

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

- cultural specialisations
- religious specialisations
- languages other than English that carers speak
- specialised services
- ability to provide services to individuals with diverse needs.

For more information, see guidance on completing the 'specialisations' section of the Service and Support Portal.

Providers can apply to have their specialised services independently verified against the My Aged Care Provider Specialisation Verifications Framework. Independent verification is required before claims to provide specialised care to diverse groups are published on My Aged Care. The criteria that the specialisation claims were verified against under the framework are also displayed on the provider's My Aged Care profile. Find out how to apply for Specialisation Verification for aged care services.

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

The department expects providers' service information to meet their requirements for managing service information in the Find a Provider tool on My Aged Care. The department can choose to remove organisations who do not comply. The requirements include:

- The same service, with the same GPMS Service ID, must only be listed once per location (i.e. the service must only appear once in the search results for that location).
- Outlet and service item names must not include phone numbers or marketing slogans.
- Service delivery areas must reflect only those locations where the provider can deliver services.
- Service availability should be regularly reviewed and updated (i.e. at a fortnightly basis as a minimum) to ensure that it is current. It is important to ensure staff members are authenticated users so that they can access the portal to make these updates.

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

Services Australia administers payments for aged care subsidies and supplements (where relevant) on behalf of the department.

Providers will need to set up their access to the Aged Care Provider Portal with Services Australia to make claims for services and receive payments. They will need to complete and return the following forms to Services Australia:

- Register, amend or remove users for Aged Care Provider Portal form (AC004)
- Application to add or change approved care service's bank details form (AC015).

Find more general information for home care providers, including how to claim the Home Care Package subsidy.

Key points to remember

- If an organisation is approved as an approved provider, there are 6 administrative tasks that need to be completed before they can provide services to care recipients:
    1. Notify the department of the home care service.
    2. The department sets up the service in GPMS.
    3. Obtain an authentication mechanism.
    4. Complete a My Aged Care Organisation Administrator Form.
    5. Configure staff access, outlets and services information in My Aged Care using the Service and Support Portal.
    6. Set up payment with Services Australia.
- Providers can complete these steps in a different order if they would like. If providers follow the above order, this process may run more smoothly.

6. Eligibility for care recipients to receive a Home Care Package

This section covers:

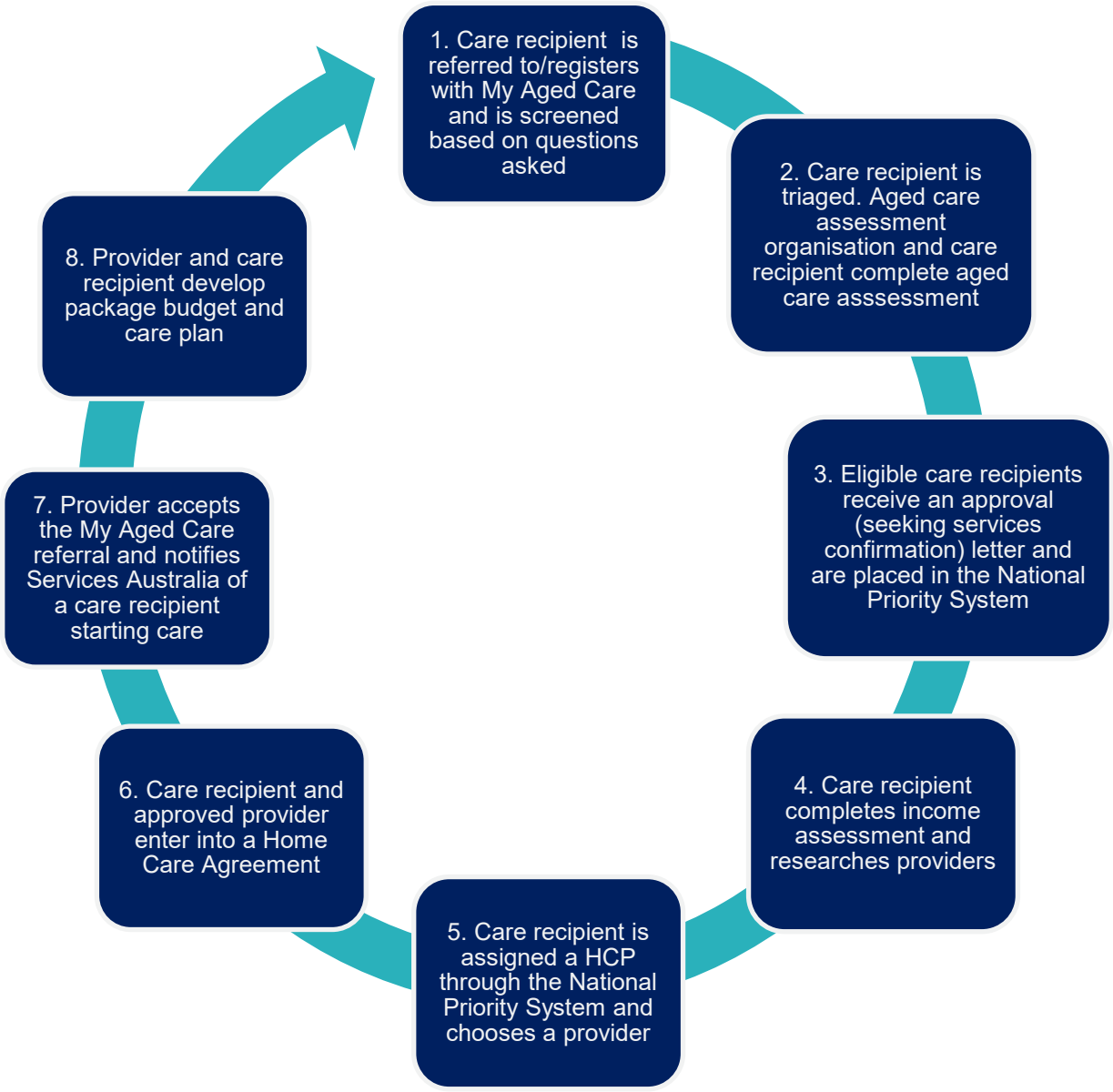
- Process to get a package
- Aged care assessment
- National Priority System
- Being assigned a package
- Home Care Agreement
- Considerations for entering into a Home Care Agreement
- Signing a Home Care Agreement
- Interpreting services
- Notifying Services Australia

6.1 Overview

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

Note: care plans need to be reviewed regularly during the course of delivering a Home Care Package. This review process is discussed at Section 10.7.

Preparing for a HCP diagram:



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

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

- Sections 56-2 and 63-1 of the Act
- Accountability Principles 2014
- User Rights Principles 2014.

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

See Appendix E for further detail on specific provider responsibilities.

6.2 How do care recipients access aged care services?

Care recipients and/or their representative are registered with My Aged Care and answer a series of short questions about their situation and needs (screening) to determine their pathway to aged care services. They can do this by calling the My Aged Care Contact Centre on 1800 200 422, visiting the My Aged Care website or through a referral from their GP, health professional or hospital.

If the referral indicates an aged care assessment is required, the My Aged Care Contact Centre or Aged Care Specialist Officer (ACSO) will refer them to an aged care assessment organisation to conduct the aged care assessment.

An ACSO can provide face-to-face appointments in selected Services Australia service centres to assist with accessing and navigating My Aged Care.

Find more information about ACSOs.

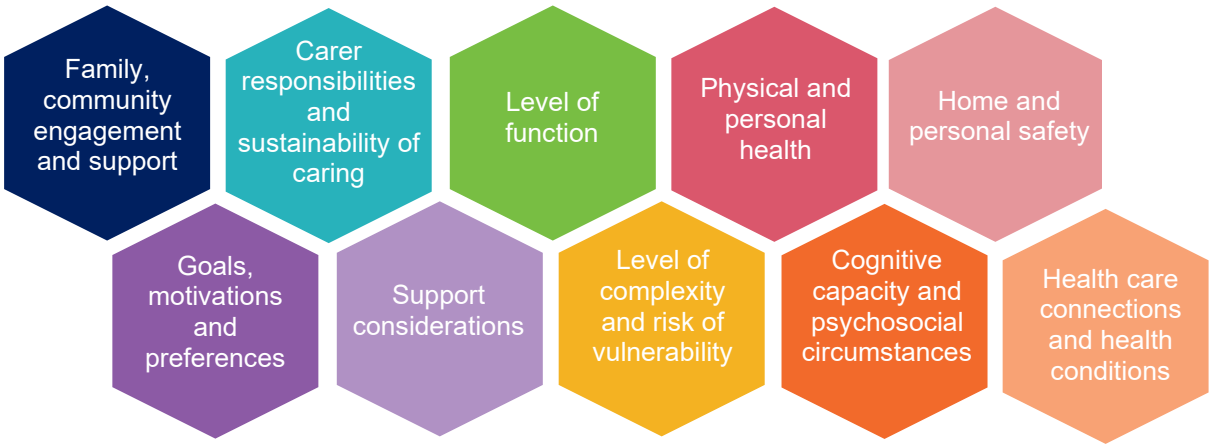
The care finder program can help vulnerable older people who need support to interact with My Aged Care, access aged care services and other relevant supports in the community. Vulnerable older people may be those who don't have family, friends, a carer or a representative they are comfortable receiving help from.

Find more information about the care finder program.

6.3 What is an aged care assessment and how does it work?

Eligibility for the HCP Program is assessed by an aged care assessor using the Integrated Assessment Tool (IAT).

The aged care assessment will consider elements such as those contained in the following image. Note the image below is not an exhaustive list.



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

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

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

6.3.1 Younger people and other care recipients with disability related care needs

While most care recipients enter the HCP Program due to ageing, it is acknowledged that other program entrants require supports for their care needs due to disability and/or chronic disease.

Aged care should only be used as a last resort for younger people. When an aged care assessor has identified that these needs **cannot** be met through any other Government-funded programs, younger entrants (under the aged of 65 or under aged 50 for First Nations people) may then apply to the HCP Program.

Providers must meet the care needs and goals of these program entrants based on the outcome of their aged care assessment by an aged care assessor.

Aged care services are designed to support the needs of older people and are generally not suitable for younger people. Ensuring that the needs of younger people are met by the most appropriate support system as early as possible is critical to ensuring they have appropriate and timely accommodation and care.

For more information, see the Principles and guidelines for a younger person's access to Government-funded aged care services.

To be eligible for aged care services, younger people must meet the eligibility requirements of the Act, including the Approval of Care Recipients Principles 2014. The Approval of Care Recipient Principles 2014 require that all options for age-appropriate accommodation and supports have been actively explored and there is documented evidence to support this.

Find more information on eligibility requirements.

6.4 What is the National Priority System?

The National Priority System is the system that assigns packages. Once an older person is assessed as eligible, they will be placed in the National Priority System, where they will wait for the assignment of a package. They will not be able to access Government-funded services under the HCP Program until assigned a package.

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

- priority for home care services as determined by the aged care assessor during the aged care assessment
- the date of approval for home care at that level.

Older people who were actively seeking care at the time of their approval will be automatically placed in the National Priority System and set as 'seeking services'.

They will receive a package as soon as one is available based only on the above 2 factors.

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

An older person can request to be set as ‘seeking services’ or ‘not seeking services’ at any point. This can be done by calling the My Aged Care Contact Centre, or by using the My Aged Care Online Account.

The department releases packages regularly, generally weekly, as indicated by the National Priority System. The number of packages released at each level takes into account the number of new packages that are available, as well as the number of packages that other people have left or not accepted in previous weeks.

Estimated average wait times for all package levels are available in time-bands on My Aged Care.

6.5 How does an eligible care recipient start receiving services?

When a package becomes available, eligible care recipients will receive a letter notifying them that they have been assigned a package.

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

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

If a person is assigned their approved level of package and it is withdrawn, they will be removed from the National Priority System. If they later decide they want to receive services through a package, they need to re-join the National Priority System by calling My Aged Care. People who re-join the National Priority System will have their date of entry recorded as the date they were originally approved for home care at that specific package level.

Providers may receive a referral in the Service and Support Portal through:

1. A system generated referral – created either by the My Aged Care Contact Centre or by an aged care assessor.
2. A direct referral – directly receiving a person's referral code (e.g., an eligible person has presented their package assignment letter and requested that the provider deliver their services).

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

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

Committing a package while another entry is in place may result in a dispute, so keep records of all conversations with My Aged Care, care recipient and current/previous provider. Failure to engage with the current provider to confirm cessation date may result in an overpayment of subsidy and debt collection activities by Services Australia, if 2 services claim for the one care recipient for the same period. Ensure you are aware of all program interfaces, outlined in Section 16.

Find more about managing referral care recipients' records on My Aged Care.

6.6 What should I include in a Home Care Agreement?

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

Where a Home Care Agreement is not in effect, and a provider claims subsidy from Services Australia, the provider is liable for a debt owed to the Australian Government for the period in which a Home Care Agreement was not in effect.

To ensure compliance, providers should follow guidance on Home Care Agreements.

Providers should ensure their Home Care Agreements do not contain unfair contract terms. Although businesses may use standard form contracts for efficiency, it is important that businesses consider a consumer's (care recipient) rights when preparing their contracts. The *Competition and Consumer Act 2010* protects care recipients from unfair terms in standard form consumer contracts. The law offers care recipients increased protection in circumstances where they have little or no opportunity to negotiate with the provider.

Providers **cannot** charge people for entry or exit to the service.

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

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

A Home Care Agreement for people who started receiving services after 1 July 2014 must be readily accessible and written in a way the care recipient can understand. It must not contain any provision that would cause the care recipient to be treated less favourably in relation to any matter than they would otherwise be treated under any law of the Australian Government. Finally, it must include the following:

6.6.1 Relationship with the care recipient

#	Requirement	Legislation citation
1	A statement specifying that home care will be delivered on a CDC basis. CDC was discussed at Section 2.1 of this manual.	Section 23(2)(b)(i) of the User Rights Principles 2014
2	A statement specifying the care recipient's rights in relation to decisions about the care and services that are to be provided. CDC was discussed at Section 2.1 of this manual. **Note**: any changes to the Home Care Agreement must be agreed through informed, mutual consent of the provider and the care recipient. Variation of the Home Care Agreement is discussed at Section 6.6.5.	Section 23(2)(b)(iv) of the User Rights Principles 2014
3	A statement outlining: • that a care recipient is entitled to make a complaint about the provision of their care and services without fear of reprisal • the complaints mechanism the provider has in place. For more information on designing a complaints mechanism see Section 10.	Section 61-1(1)(f) of the Act Section 23(4) of the User Rights Principles 2014

#	Requirement	Legislation citation
4	A statement outlining any responsibilities of the care recipient as a recipient of home care from the service.	Section 61-1(1)(g) of the Act

6.6.2 Care and services

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

#	Requirement	Legislation citation
	Fees payable during suspension (leave) are discussed at Section 11 of this manual.	

6.6.3 Pricing and budget

#	Requirement	Legislation citation
11	A statement of home care fees (Income tested fees, Basic daily fee & additional fees) that the provider will charge to the care recipient. **Note**: the discussion at Item 13 of this table, below.	Section 23(2)(c)(i) of the User Rights Principles 2014
12	A statement of the policies and practices that the provider will follow in setting the price that the care recipient will be liable to pay to the approved provider for the provision of the care and services. Fees are discussed at Section 8 of this manual. Further information on how providers set, publish and charge prices for care and services and pricing changes introduced on 1 January 2023.	Section 61-1(1)(c) of the Act
13	A copy of the provider's pricing schedule as published on My Aged Care at the time the Home Care Agreement is signed. This is discussed further in Appendix B. All agreements entered into after 1 July 2019 must comply with the new pricing requirements. All prior agreements must be updated to become compliant by 1 January 2023. The prices under the Home Care Agreement must be the same as those in the pricing schedule published on My Aged Care at the time the Home Care Agreement is signed unless the provider and care recipient discuss and agree to a variation in pricing. If the provider and care recipient reach agreement on a variation, this must be documented within the Home Care Agreement. If the care recipient is to be charged an amount of the basic daily fee (discussed in Section 8 of this manual) that is different from the amount of the fee in the schedule, the provider and care recipient must also reach	Sections 23(2)(ba)-(bc) of the User Rights Principles 2014 Section 23(2)(c)(ii) of the User Rights Principles 2014

#	Requirement	Legislation citation
	agreement on a variation, and this must be documented within the Home Care Agreement.	
14	A statement specifying that the provider will give the care recipient a statement of the available funds and expenditure in respect of each month for the care and services provided to the care recipient during the month (a monthly statement). Monthly statements have been discussed further at Section 10.	Section 23(2)(cb) of the User Rights Principles 2014
15	A statement specifying that any care recipient portion or transfer portion of the care recipient's unspent home care amount will be paid in accordance with Part 3 Division 3A of the User Rights Principles 2014. For more information on how to action this please see Section 13 and Section 14.	Section 23(2)(cc) of the User Rights Principles 2014
16	Provision for financial information to be given to the care recipient about the home care that the care recipient will receive, including a statement that the approved provider must, within 7 days after a request by the care recipient, give the care recipient: • A clear and simple presentation of the financial position of the home care service, including the costs of home care that explains any ongoing fees payable by the care recipient. • A copy of the most recent statement of the audited accounts of the home care service or, if the home care service is operated as part of a broader organisation, the most recent statement of the audited accounts of the organisation's aged care component (that includes the home care service).	Section 23(2)(d) of the User Rights Principles 2014

6.6.4 Administration

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

6.6.5 Variation or termination

#	Requirement	Legislation citation
21	A statement that the Home Care Agreement may be varied by the approved provider if the variation is necessary to implement the *A New Tax System (Goods and Services Tax) Act 1999,* but that the Home Care Agreement must not be varied pursuant to the above unless the provider has given reasonable notice of the variation, in writing, to the care recipient.	Sections 23(3)(a)(i) and 23(3)(b() of the User Rights Principles 2014
22	A statement that, in any case other than that discussed at Item 21 above, can only be varied by mutual consent, following adequate consultation of the care recipient with the provider. Mutual consent requires active	Section 23(3)(b) of the User Rights Principles 2014

#	Requirement	Legislation citation
	acknowledgement by the care recipient. Mutual consent **is not** characterised by sending a letter to a care recipient to inform them of a change, offering an opt out and taking their silence as approval.	
23	A statement that the Home Care Agreement must not be varied in a way that is inconsistent with *A New Tax System (Goods and Services Tax) Act 1999*, the Act or the Extra Service Principles 2014. **Note**: in their current form, the Extra Services Principles 2014 contemplate residential aged care services only. They have not been considered further.	Section 23(3)(c) of the User Rights Principles 2014
24	The conditions under which either party may terminate the provision of home care, noting that providers may only terminate the provision of home care where security of tenure allows it. Security of tenure was discussed at Section 3.5.1 of this manual.	Section 23(2)(g) of the User Rights Principles 2014

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

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

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

The Australian Competition & Consumer Commission (ACCC) has developed guidelines for consumers and providers that outline consumer and business rights and obligations under the *Competition and Consumer Act 2010* (as they relate to the HCP Program).

For more information, see the ACCC's guide on home care services.

Approved providers should confirm with the care recipient or their family who has been authorised to enter into the Home Care Agreement. In some circumstances,

other arrangements may be in place for an authorised representative to act on their behalf.

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

The Commission has developed guidance for providers delivering care and services through the HCP Program and the CHSP. This guidance focuses on what is expected of providers in setting prices for home services and making changes to home service arrangements including Home Care Agreements. For more information, see Provider Guidance – Home Services Pricing and Agreements.

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

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

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

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

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

6.8.1 When a care recipient does not agree to changes to an existing Home Care Agreement

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

- negotiate to reach agreement with the care recipient and provide a detailed rationale in a format that the care recipient will understand

- encourage the care recipient to seek independent advice from consumer advocates, family members, or legal advisers
- advise the care recipient they are able to change providers (My Aged Care provides a range of tools to support choice).

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

6.9.1 Translating and Interpreting Service

For care recipients who speak a language other than English as their first language, the Department of Home Affairs provides free interpreting services through the Translating and Interpreting Service (TIS National).

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

TIS National is available 24 hours a day, 7 days a week and provides both telephone and onsite services. Bookings can be made:

- online via the TIS National.
- by calling **131 450** for immediate telephone interpreting
- by calling **1300 655 082** for on-site bookings.

Providers must register online for a TIS National Code. When accessing TIS National, providers will need to quote their service's unique code. If a provider is unsure of their care recipient's client code, they can contact TIS National.

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

Find more information about the TIS National.

6.9.2 Third-party interpreter costs

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

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

For more information on engaging a third-party see Section 7.6.

The agreed position and the responsibilities of the provider, care recipient and interpreter should be documented and included in the Home Care Agreement.

6.9.3 First Nations language translation services

TIS National does not provide Aboriginal language translation services. Instead, your state or territory may have a translation program. These include:

- Northern Territory (NT) Aboriginal Interpreter Service (**1800 334 944**)
- Aboriginal Interpreting Western Australia (**1800 330 331**)
- Interpreter Connect (via My Aged Care Contact Centre)

The My Aged Care Contact Centre uses the NT Aboriginal Interpreter Service and Interpreter Connect – both at no extra cost to the caller. To access, call My Aged Care and ask for an interpreter.

Government-funded First Nations interpreting services are not currently available for communication between a First Nations person and a provider. However, First Nations people can use the Elder Care Support program. Elder Care Support workers can assist in explaining and advocating for the needs of older First Nations people in Home Care Agreements. Find more information about Elder Care Support.

6.9.4 National Sign Language Program

The National Sign Language Program (NSLP) provides older people who are Deaf, Deafblind, or hard of hearing who are seeking to access or receive Government-funded aged care services free sign language interpreting and captioning services.

The NSLP supports older people to better engage and fully participate in their aged care journey. Sign language services can be provided face-to-face or by remote video, and live captioning services are available to support clients to engage with:

- activities of daily living
- health and medical appointments
- My Aged Care
- aged care assessors
- in-home aged care providers
- residential aged care providers
- other organisations involved in the provision of Government-funded aged care services.

The following sign language services are available:

- Auslan
- American Sign Language
- International Sign Language
- signed English for Deaf or people who are hard of hearing
- tactile signing and hand over hand for deafblind consumers.

Find more information on how to access interpreting services with the NSLP.

Providers can book a sign language interpreter by visiting the Deaf Connect website, calling Deaf Connect on 1300 773 803, or emailing interpreting@deafconnect.org.au.

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

Providers need to declare care recipient entry information to Services Australia within 28 calendar days of when they commenced their home care services.

Providers will first need to accept the referral in the Service and Support Portal, and then complete the paperwork to notify Services Australia. This paperwork can be completed through the Aged Care Provider Portal or through the submission of an Aged Care Entry Record (ACER) form (AC021).

Entry information must be provided to Services Australia as early as possible and before the care recipient's package take up deadline to ensure their package is not withdrawn. If providers do not advise Services Australia of entry information, or if they do not have a Home Care Agreement in place, they will not be paid any applicable subsidy or supplements. At this time, providers should also inform the department if a care recipient has commenced a package and also receives a compensation entitlement. For more information, see Appendix D.

Key points to remember

- Before older people can receive home care services, they need to:
  - register with My Aged Care,
  - be assessed by an aged care assessment organisation
  - be assigned a package through the National Priority System.
- Once they have been assigned a package, they need to enter into a Home Care Agreement with a provider within 56 days (or 84 days with an extension).
- If providers are entering into a Home Care Agreement with a care recipient, they are bound by the obligations of consumer law.
- If providers do not advise Services Australia of entry information, they will not be paid any applicable subsidy or supplements.
- Free interpreting services are available to help providers negotiate the Home Care Agreement, develop the care plan with the care recipient and advise on the monthly budget.

7. Care planning

This section covers:

- Care Plans
- Developing a care recipient's care plan
- Working with care recipients to develop their care plan
- Care plans for people living together
- Providing services
- Models of care delivery
- Sub-contracting services
- Care plan documentation

7.1 Overview

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

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

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

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

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

See Section 3, Section 4 and Section 15 for further detail on specific provider responsibilities.

7.2 What is a care plan?

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

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

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

During the care planning process, providers will need to take into account any supports the care recipient already has in place, such as carers, family members,

local community and other services. For each care recipient, providers need to be able to demonstrate assessment and planning that:

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

The care planning document should provide a detailed outline of services to be delivered, including how, when and where. This information should be specific (e.g., 2-3pm Tuesdays, rather than 'Tuesday'). Once the care plan and package budget (as discussed at Section 8) have been agreed, providers must give a copy to the care recipient for their records.

Information on approaches to care planning is set out at Section 7.4. Information on what services can (or cannot) be included in a care plan is set out at Section 9.

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

Because the HCP Program uses a CDC model and is governed by the Quality Standards (as discussed at Section 3.5.2), providers will need to work with a care recipient to develop their care plan with reference to the aged care assessment. This is an opportunity to support the care recipient to understand the policy intent of the HCP Program and work out a care plan that assists them to manage their ageing related care needs and goals. To do this, providers will need to consider their obligations under the Quality Standards relating to care planning and understand what the potential inclusions and exclusions are for each individual home care package. See Section 9 and Appendix C for guidance on how to do this, including a decision-making framework.

The department does not prescribe which validated tools, if any, should be used to inform care planning. However, if providers are looking for examples of what tools may be useful when conducting a care plan, a list is provided below.

Note: currently aged care assessors may make use of the following tools when using the Integrated Assessment Tool (IAT) during their assessment:

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

Some of these tools may have licensing restrictions. If in doubt, providers are encouraged to contact the copyright holder of the tool, if they wish to use these tools for care planning/management purposes.

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

If the care recipient consents, there may be merit in case conferencing with their GP and other health professionals to support the development of their care plan. GPs and other health professionals may be able to access Medicare items to fund their involvement in any case conferencing if the care recipient has a chronic disease. The home care provider's involvement would be funded under care management charges to the package.

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

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

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

When working with a care recipient to develop goals, providers may consider whether reablement or wellness approaches to providing care might help them meet their goals. Giving consideration to these 2 contemporary approaches supports providers to ensure that the care and services they deliver align with the core principles of the HCP Program. These concepts underpin a number of aged care services, and are outlined, at a high level, below.

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

Throughout the care planning process, providers should consider cultural safety and appropriate approaches for:

- First Nations people
- people from culturally and linguistically diverse (CALD) communities
- people of diverse sexual orientation and gender identity, including LGBQTIA+.

Providers should also consider healing and trauma informed approaches when developing care plans for all care recipients. These approaches may be appropriate for older First Nations people, care leavers and parents who have been separated from their children through forced adoption.

See Section 12.2 for further information on diverse needs.

7.4.1 Wellness approach

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

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

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

The following case study outlines how a wellness approach can make a difference.

Case study: Jing

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

Source: Silverchain

7.4.2 Reablement approach

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

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

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

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

- equipment and technology to help them live more independently at home
- skills for independent living provided through intensive, short-term support
- outreach – help with transport and getting out and about.

7.5 If 2 people live together, can they have one care plan that contains information for both of them?

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

However, they may elect to pool their resources to fund joint care or services across both of their package budgets. For example, if both have been assessed as requiring cleaning services once a week, they may pool resources to share the cost of the cleaner between the 2 packages.

Providers are required to include information about their respective home care fees payable in the Home Care Agreement, and the calculated home care fee amount being recorded in their respective package budgets.

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

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

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

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

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

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

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

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

It is expected most, if not all, additional costs to an approved provider associated with delivering third-party services will be recouped through care management and package management charges, which are capped at 20% and 15% of the package level, respectively.

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

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

Approved providers also need to remember that they, not the sub-contracted service provider, remain responsible for meeting all regulatory responsibilities. These regulatory responsibilities include ensuring that all police checks, and key personnel suitability requirements are met, as well as all obligations under the legislation. Appendix E outlines provider responsibilities under the Act and other legislation.

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

Find more information on third-party services, including how to incorporate costs into care and package management and direct charges when using a third-party.

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

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

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

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

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

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

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

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

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

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

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

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

Key points to remember

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

8. A care recipient's package budget

This section covers:

- Make up of a care recipient's package budget
- Government contribution to a care recipient's budget
- Care recipient's home care fees amount
- Care recipient facing financial hardship
- Review of care recipient's home care fees

8.1 Overview

As discussed at Section 7, providers need to work with each new care recipient to develop a care plan within 14 calendar days of the day the Home Care Agreement is completed.

The individualised package budget needs to be done as soon as providers have all the information needed and the care plan is place. This section explains what makes up a package budget and how to calculate each component. All the financial aspects of the HCP Program are defined by the legislation. Providers should refer to the legislation for more information.

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

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

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

- Sections 47, 48, 52D-1, 56-2 and 96 of the Act
- User Rights Principles 2014
- Fees and Payments Principles 2014 (No. 2).

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

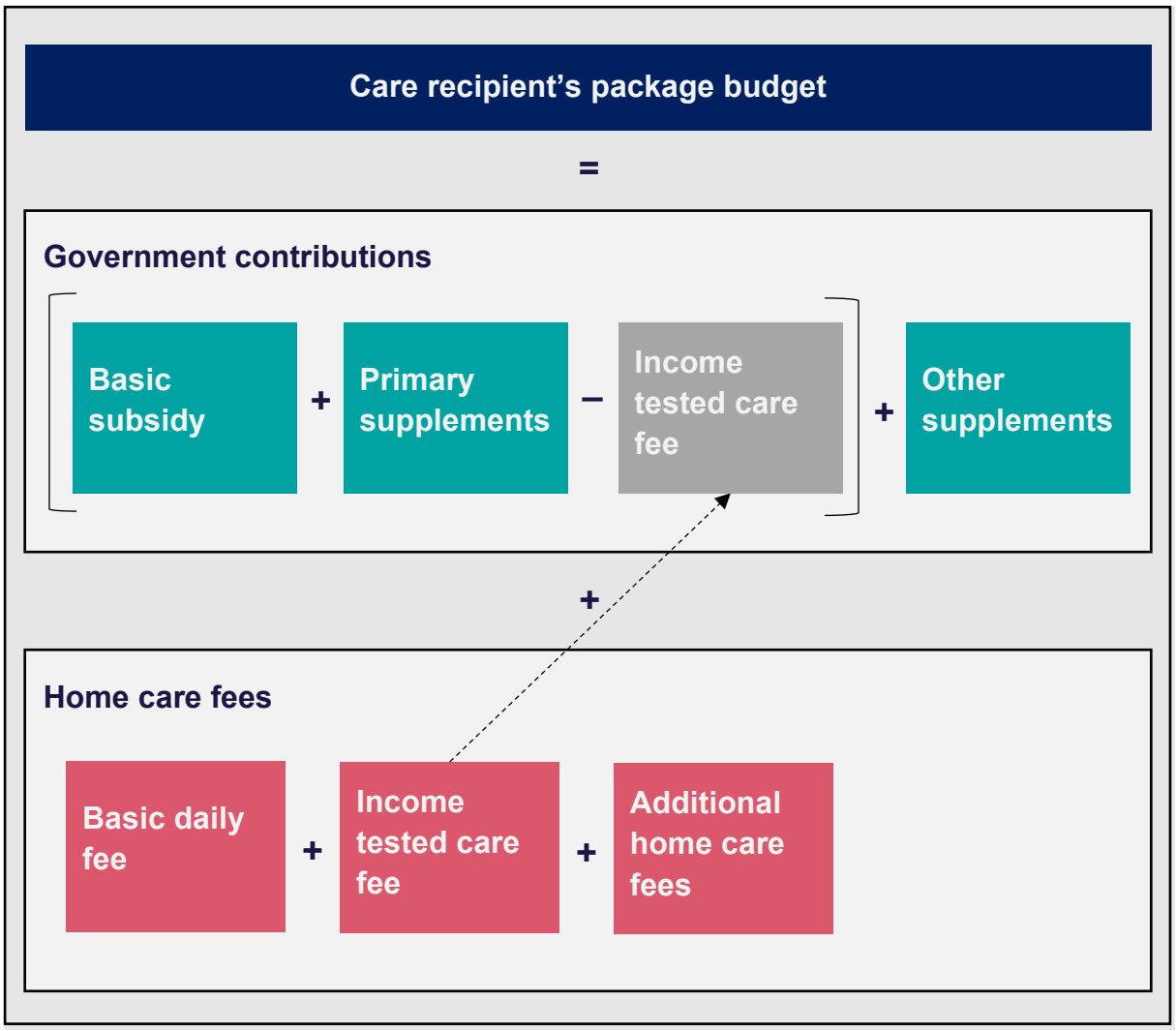
See Section 3, Section 4, Section 15 and Appendix E for further detail on specific provider responsibilities.

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

Each care recipient's package budget is made up of contributions from:

- the Australian Government (includes basic subsidy and eligible supplements)
- the home care fees payable by the care recipient (where applicable).

The components of a post-1 July 2014 package budget may include:



Note: A care recipient's package budget will be affected if they have received a compensable payment amount. See Appendix D.

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

The Government contribution (Home Care Package subsidy) is calculated as follows:

1. the basic subsidy amount
2. plus any primary supplements (i.e. oxygen supplement, enteral feeding supplement, dementia and cognition supplement, veterans' supplement)
3. subtract any reductions in subsidy and primary supplements (i.e. income tested care fee or compensation entitlement)
4. plus any other supplement (i.e. hardship supplement, viability supplement).

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

8.3.1 Basic subsidy

The basic subsidy is paid in accordance with the level of package the care recipient has been assigned.

There are 4 package levels, outlined in the table below:

Package	Needs
Level 1	Basic care
Level 2	Low level care
Level 3	Intermediate care
Level 4	High level care

For the current basic subsidy amount paid by the Government, refer to the Schedule of Subsidies and Supplements for Aged Care.

8.3.2 Supplements

If care recipients are eligible, providers can also claim for supplements that will be included in the Home Care Package subsidy. Supplements are an acknowledgement of additional needs, and the supplement funds can be used in the same ways as any other component of a package budget.

An authorised signatory of the approved provider must sign the dementia, oxygen and enteral feeding claim forms. Once a form is completed, the form and supporting evidence should be uploaded to Services Australia's Aged Care Provider Portal. Providers should keep copies of all supplement forms and supporting evidence in the care recipient's records. If providers require assistance with this process, please contact Services Australia directly on **1800 195 206**.

Any supplements providers claim for a care recipient must be added to their total package budget. Although they will be eligible for supplements if they require particular types of supports, the supplement funds do not have to be used to provide that specific support.

Providers can claim supplements for eligible care recipients on any package level.

The tables below identify and describe each of the supplements and outline the administration requirements.

8.3.2.1 Primary supplements

Supplement	Description	Application process and payment	What happens if the care recipient changes providers?
Dementia and Cognition Supplement in Home Care	The dementia and cognition supplement provides additional funding in recognition of the extra costs of caring for people with cognitive impairment associated with dementia and other conditions.	Assessment using one of the prescribed tools by an approved assessor. The approved provider is responsible for lodging an application with Services Australia.	The supplement will automatically continue to be paid into the care recipient's home care account. The new provider must obtain a copy of the record of assessment undertaken by the care recipient.
Veterans' Supplement in Home Care	The veterans' supplement in home care provides additional funding for veterans with a mental health condition accepted by the Department of Veterans' Affairs (DVA) as related to their service.	DVA determines eligibility and advises Services Australia. No action required by provider.	The supplement will automatically continue to be paid into the care recipient's home care account.
Oxygen Supplement	The oxygen supplement is for care recipients with a specified medical need for the continual administration of oxygen.	Paid into the home care account of eligible care recipients to help pay for specialised products and equipment. The approved provider is responsible for completing the application form available on the	Supplement does not automatically transfer with the care recipient. The new provider needs to submit a new application form (AC011) to Services Australia,

Supplement	Description	Application process and payment	What happens if the care recipient changes providers?
		Services Australia website. Once the form is completed, the form and supporting evidence can be returned to Services Australia.	including medical evidence.
Enteral Feeding Supplement	The enteral feeding supplement is for care recipients with a specified medical need for enteral feeding.	Paid into the home care account of eligible care recipients to help pay for specialised products and equipment. The approved provider is responsible for completing the application form available on the Services Australia website. Once the form is completed, the form and supporting evidence can be returned to Services Australia.	Supplement does not automatically transfer with the care recipient. The new provider needs to submit a new form (AC011) to Services Australia, including medical evidence.

8.3.2.2 Other supplements

Supplement	Description	Application process and payment	What happens if the care recipient changes providers?
Viability Supplement in Home Care	The viability supplement is paid into the home care accounts of care recipients in rural and remote areas (MMM4-MMM7) in recognition of the higher costs of delivering care and services in these areas. Providers should use this supplement by claiming additional costs associated with individual services, rather than a flat fee.	Provide location details (suburb and postcode) to Services Australia through entry event and location event screen in the Aged Care Provider Portal.	If a care recipient remains at the same location, the new provider does not have to apply for the viability supplement on behalf of the care recipient. The new provider must enter the same postcode and suburb on the Aged Care Provider Portal and the supplement will continue to be paid into the care recipient's home care account. A care recipient who relocates will automatically be reassessed for viability supplement based on their new location.
Hardship Supplement	The hardship supplement is available to recipients	Paid into the eligible care recipient's home care account as a	If a valid approval exists, the new provider does not

Supplement	Description	Application process and payment	What happens if the care recipient changes providers?
	of home care in genuine financial hardship who do not have the income to pay for their costs of aged care due to circumstances beyond their control. Care recipients who have commenced receiving a package on or after 1 July 2014 need to apply to Services Australia for financial hardship assistance.	hardship supplement in lieu of the basic daily fee and/or income tested care fee. Care recipients (or their representative) applies and submits the form to Services Australia.	have to apply for the hardship supplement on behalf of the care recipient. The supplement will continue to be paid into the care recipient's home care account. As this supplement is time-limited, the new provider should confirm if the care recipient is receiving a hardship supplement and the validity period.

The Schedule of Subsidies and Supplements for aged care contains the current daily rate for HCP Program subsidies and supplements.

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

There are 3 types of legislated fees a provider may ask a care recipient to pay:

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

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

Together these fees and the Home Care Package subsidy and supplements form the individualised package budget.

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

8.4.1 Collecting home care fees

The collection of the home care fees is a business decision for the home care provider and can be collected weekly, fortnightly or monthly.

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

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

It is the responsibility of the provider to put in place the business processes to collect and manage home care fees.

Where a care recipient chooses not to pay their home care fees and does not have financial hardship provisions in place, providers must set up a time to meet preferably face to face with the care recipient to clearly inform care recipients of:

- their responsibilities
- the reasons for the collection of the income tested care fee
- the consequences of refusal.

If the care recipient continues to refuse to pay the fees, then the provider may wish to use the security of tenure provisions outlined in paragraph 17(1)(e) of the User Rights Principles 2014.

These provisions enable providers to cease providing home care to the person when they have not paid their home care fees for reasons within their control and have not negotiated an alternative arrangement with the provider for the payment of their home care fees.

See Section 3.5.1 for information on security of tenure.

8.4.2 Basic daily fee

Providers can ask everyone to pay the basic daily fee. The maximum fee is set by the Australian Government at a percentage (%) of the single person rate of the Age Pension:

- Level 1 - 15.68%
- Level 2 - 16.58 %
- Level 3 - 17.05%

- Level 4 - 17.50%.

Rates for the basic daily fee are indexed in March and September each year in line with changes to the Age Pension. The current rates are available in the Schedule of Fees and Charges for Residential and Home Care.

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

When providers choose to collect the basic daily fee, they must publish it on the Find a Provider tool on the My Aged Care website.

8.4.3 Income tested care fee

The income tested care fee is paid by care recipients who have been assessed by Services Australia as able to contribute towards their cost of care. Full pensioners do not pay this fee. The income tested care fee is paid in addition to the basic daily fee.

If a care recipient has been assessed as needing to pay the income tested care fee, the provider must not waive the income tested care fee or adjust the price submitted to Services Australia as part of their claim process to avoid collecting it.

Furthermore, the provider must collect the income tested care fee in full. If not collected in full, the provider must fund the difference themselves. This is because Services Australia automatically deducts the income tested care fee amount from the Home Care Package subsidy for that care recipient.

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

Under the Improved Payment Arrangements that commenced 1 September 2021, if a care recipient's assessed income tested care fee is equal to or less than the price reported to Services Australia, the Government will not pay any Home Care Package subsidy entitlement to the provider. Any unspent Home Care Package subsidy will accrue in the care recipient's home care account for future care and services.

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

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

If an income tested care fee is refunded to a provider due to a review undertaken by Services Australia, the refunded fees must be returned to the care recipient in full, where the care recipient has paid all previous amounts to their provider as advised by Services Australia. If the care recipient has already left care and their balance has

been settled, then the income tested care fee must be refunded to the care recipient or their estate.

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

8.4.4 Income assessment

To find out if they need to pay an income tested care fee, care recipients need their income assessed by Services Australia or the Department of Veterans' Affairs (DVA). They will need to complete an income assessment form if Services Australia or DVA does not already have their current financial details. To do this they can use the Home Care Package Calculation of your costs of care form (SA456).

For more information about the income assessment, and how to complete a form, you can direct care recipients to Income and means assessments on the My Aged Care website.

Completing an income assessment is not mandatory, but care recipients who choose not to complete one can be asked to pay the maximum income tested care fee.

For an estimate of home care fees for the person, My Aged Care has a home care fee estimator.

Providers must support care recipients to understand fees and their income assessment. This may include providing information about how to request a review of the assessment decision by Services Australia, or how to apply for financial hardship assistance through Services Australia.

8.4.4.1 Delayed income assessment

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

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

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

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

To manage risk for new care recipients, providers can apply the maximum income tested care fee (the second daily cap in the Schedule of Fees and Charges) for any care recipients where they have not received their initial income assessment advice. This should not impact pensioners as their financial information reported for the age pension is automatically matched by Services Australia through government data and used in the home care income assessment.

Providers should manage their cash-flow to cover any future liabilities arising from late submissions of income assessments.

8.4.4.2 Income assessment adjustments

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

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

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

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

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

If a care recipient does not agree with the outcome of their income assessment, they can request Services Australia to review this decision.

If a care recipient is unable to pay their fees due to financial hardship, they can apply for financial hardship assistance with Services Australia.

8.4.5 Annual and lifetime caps

There are annual and lifetime caps that apply to the income tested care fee. The current caps are in the Schedule of Fees and Charges for Residential and Home Care". Once the annual cap is reached, the care recipient cannot be asked to pay any more income tested care fees until the next anniversary of when they first started receiving aged care. Providers can still ask for payment of the basic daily fee.

Where a care recipient meets the lifetime cap, they will pay no further income tested care fees while they continue to receive home care.

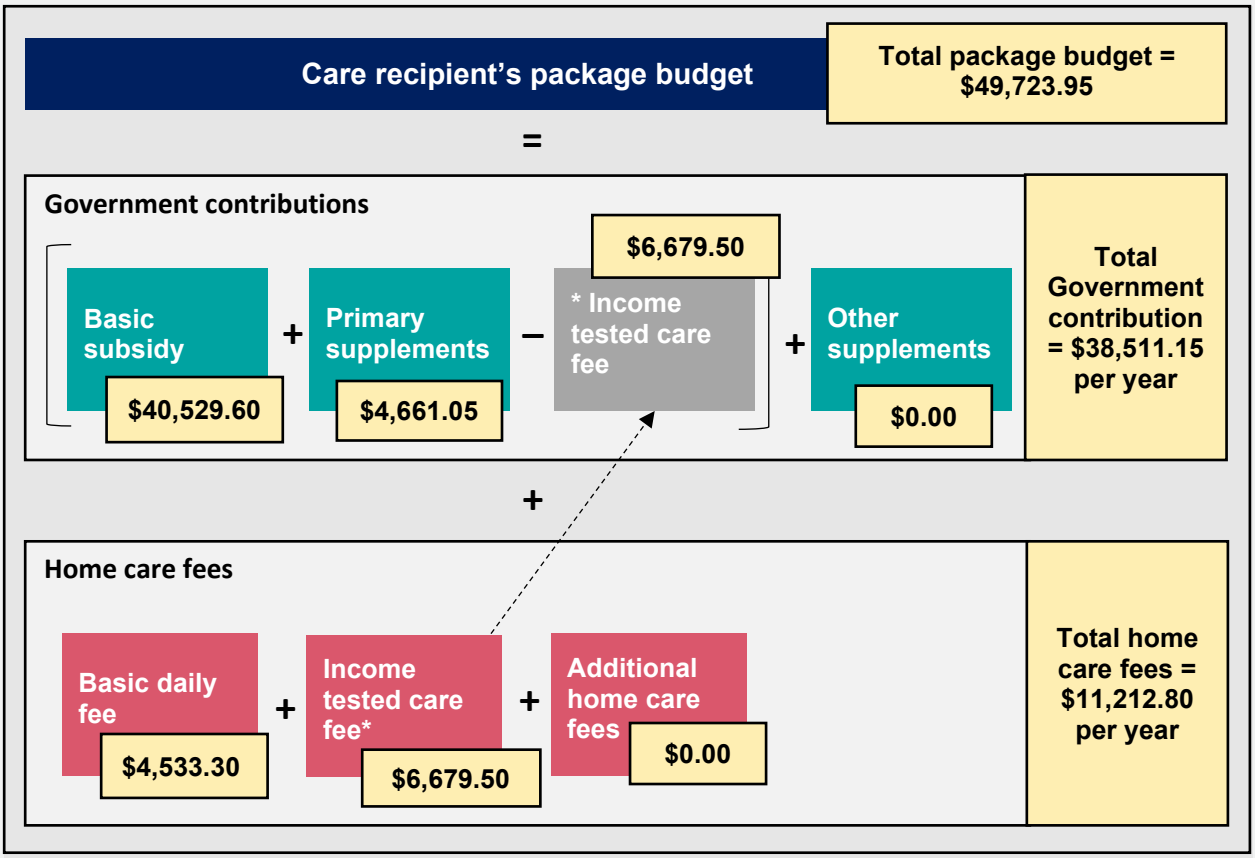
Services Australia will notify the provider and the care recipient once a cap has been reached. The Government will pay the remaining income tested care fees by way of increased Home Care Package subsidy to the provider.

Any income tested care fees a care recipient pays for a HCP will also contribute to the annual and lifetime caps on their income tested care fees if they move into residential aged care.

Worked example

How do we calculate Adam's package budget?
Adam lives at home with his partner David. Adam has been assigned a level 3 package. His daily package subsidy is $111.04 per day (as at 1 July 2024). This equates to $40,529.60 per year. Adam is also eligible for the dementia and cognition supplement. The value of the supplement at his package level is $12.77 per day. This equates to $4,661.05 per year. Adam is not eligible for any other supplements. The basic daily fee for Adam's package level is $12.42 per day. This equates to $4,533.30 per year. Adam has completed his income assessment and has been assessed by Services Australia as being able to pay $18.30 per day or $6,679.50 per year in income tested care fees. Adam did not agree to pay any additional fees in his Home Care Agreement. The diagram below outlines how Adam's home care budget is calculated.

How do we calculate Adam's package budget?



Adam's total package budget is valued at $49,723.95 per year. This is made up of $38,511.15 in basic subsidy and supplements and $11,212.80 in home care fees.

Adam has been assessed by Services Australia as being able to contribute $6,679.50 per year in income tested care fees. The basic subsidy and primary supplement payable for Adam's care to his provider is reduced by Adam's income tested care fee. That is, $40,529.60 + $4,661.05 - $6,679.50 = $38,511.15.

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

If Adam fails to meet his responsibilities, including the payment of fees, as described in section 17 of the User Rights Principles 2014, his home care provider may cease to provide home care to him under the security of tenure provisions.

Adam's Home Care Agreement must contain a statement setting out which home care fees are payable by him and the conditions under which either party may terminate the provision of home care.

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

If someone thinks they will face financial hardship when paying their aged care fees, they can apply to Services Australia for financial hardship assistance.

Each case is considered on an individual basis. Depending on their situation, they may apply for financial assistance with the:

- basic daily fee
- income tested care fee.

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

For more information on eligibility criteria and assessments for financial hardship.

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

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

Services Australia also regularly reviews income tested care fees and will send providers and care recipients a fee advice letter if there is a change. If a care recipient's financial circumstances change the care recipient can request a review with Services Australia or DVA.

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

Key points to remember

- A package budget is made up of Government subsidy and supplements, and home care fees.
- A care recipient's home care fees will depend on their circumstances. All care recipients may be asked to pay a basic daily fee. Some may also be asked to pay an income tested care fee.

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

9. Inclusions and exclusions

This section covers:

- Services in a care recipient's care plan
- Specified inclusions and exclusions
- Meal services and specialised foods
- Declining a request
- Inclusions / Exclusions Framework – Decision Tool and Template
- Allied health and equipment
- Large purchases
- Home modifications
- Permission for modifications on rentals or common property

9.1 Overview

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

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

To meet these obligations, providers may need to have challenging conversations with care recipients and their carers about whether a type of care, service or item can be included. A framework of considerations is included in Section 9.7 and Appendix C to support these discussions.

Additionally, the HCP Program Manual for Care Recipients can be provided to care recipients to further clarify the goods and services that can be delivered through the HCP Program. It is also important that providers document and retain records of the reasons why a service or item is included or excluded.

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

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

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

The Quality Standards are relevant throughout this manual. Providers should familiarise themselves with the obligations required of them. See Section 3, Section 4, Section 15 and Appendix E for further detail on specific provider responsibilities.

Providers will need to act in compliance with all relevant state, territory, and Australian Government laws. See a list of Australian Government legislation relevant

to aged care. Please consult your state or territory register of legislation for information on relevant state or territory laws.

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

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

Care planning involves:

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

When working with each person to clarify their assessed care needs and care goals, providers should encourage them to think about what supports will optimise their health and wellbeing. Their priorities and preferences are a key part of the discussion to co-produce their care plan. Care and services included in the care plan that will be purchased using the package budget should be drawn, for the most part, from the legislated inclusions, and must not include any legislated exclusions (see Section 9.3 and Section 9.4).

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

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

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

The Inclusions/Exclusions Framework (Appendix C) supports providers to take a flexible and responsive approach to working with care recipients on whether to provide proposed care and services that are not identified in the legislated inclusions. It allows providers to take a person-centred approach to care planning that supports a balance between assessed care needs, care goals and individual preferences, and

considers individual circumstances such as financial and social position, cultural diversity and location.

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

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

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

For each care and service type, several questions will need to be considered.

Where a service or item is not listed as a specified inclusion or exclusion in the Quality of Care Principles 2014, providers should use the HCP Inclusions and Exclusions Framework (see Appendix C) in determining whether to include the service or item in the package. To draw a conclusion, it is important that all the questions are considered in balance with each other.

Document all discussions about the inclusion or exclusion.

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

9.3 Specified Inclusions

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

This guidance is outlined in the Quality of Care Principles 2014. Further information is also available in the HCP Program Inclusions and Exclusions FAQs factsheet.

The inclusions have been extracted below.

9.3.1 Care services

Service inclusions	Content
Personal services	Personal assistance, including individual attention, supervision and physical assistance, with: • bathing, showering, including providing shower chairs if necessary, personal hygiene and grooming, dressing and undressing, and using dressing aids • toileting (including commode chairs) • mobility • transfer (including in and out of bed).
Activities of daily living	Personal assistance: • including individual attention, individual supervision and physical assistance • with communication including assistance to address difficulties arising from impaired hearing, sight or speech, or translation and interpreting needs • with the fitting of sensory communication aids, checking hearing aid batteries, cleaning spectacles and assistance using the telephone.
Nutrition, hydration, meal preparation and diet	• Assistance with preparing meals. • Assistance with special diet for health, religious, cultural or other reasons. • Assistance with using eating utensils and eating aids and assistance with actual feeding, if necessary. • Providing enteral feeding formula and equipment.
Management of skin integrity	Providing bandages, dressings, and skin emollients.

Service inclusions	Content
Continence management	• Assessment for and, if required, providing disposable pads and absorbent aids, commode chairs, bedpans and urinals, catheter and urinary drainage appliances and enemas. • Assistance in using continence aids and appliances and managing continence (including specialist cleaning of soft furnishings). • Continence aids in general if not already accessed through the Continence Aids Payment Scheme (CAPS). • Washing machine and dryers for severe and permanent incontinence only, as per the definition used by the CAPS.
Mobility and dexterity	• Providing crutches, quadruped walkers, walking frames, walking sticks, mobility scooters, medical grade footwear and wheelchairs. • Providing mechanical devices for lifting (in/out of bed), bed rails, slide sheets, sheepskins, tri-pillows, hospital grade linen and pressure relieving mattresses . • Some support for trained assistance animals (not otherwise funded by other programs). Note the animal must meet the definition of an assistance animal used by Health Direct. • Assistance in using the above aids.

9.3.2 Support services

Service inclusions	Content
Support services	• Cleaning. • Personal laundry services, including laundering of care recipient's clothing and bedding that can be machine-washed, and ironing. • Arranging for dry-cleaning of care recipient's clothing and bedding that cannot be machine-washed. • Light gardening. • Medication management such as Dose Administration Aids (sometimes to referred to as Webster-paks) not already funded by the Government through the Dose Administration

Service inclusions	Content
	Aids (DAA) Program. If the pharmacist is already a participant of the DAA Program then it is an exclusion. • Rehabilitative support, or helping to access rehabilitative support, to meet a professionally determined therapeutic need. • Emotional support including ongoing support in adjusting to a lifestyle involving increased dependency and assistance for the care recipient and carer, if appropriate. • Support for care recipients with cognitive impairment, including individual therapy, activities and access to specific programs designed to prevent or manage a particular condition or behaviour, enhance quality of life and provide ongoing support. • Providing 24-hour on-call access to emergency assistance including access to an emergency call system if the care recipient is assessed as requiring it (e.g., personal monitoring technology such as personal alarms and sensor mats). • Transport and personal assistance to help the care recipient shop, visit health practitioners or attend social activities (that cannot be funded through general income). • Respite care. • Home maintenance, reasonably required to maintain the home and garden in a condition of functional safety and provide an adequate level of security, such as cleaning gutters. • Home maintenance services provided to clients must focus on repairs or maintenance of the home and garden to improve safety, accessibility and independence within the home environment for the client, by minimising environmental health and safety hazards. This includes home and yard maintenance and repairs that mitigate or remove identified risks to a client's health and safety and/or services targeted at maintaining a home environment which supports a client's wellness and reablement goals. Activities funded can include a range of maintenance or repair tasks such as:

Service inclusions	Content
	○ accessible, low maintenance garden redesign to support wellness and reablement goals ○ minor plumbing, electrical & carpentry repairs where client safety is an issue ○ repair of internal flooring and external access pathways to address slip and trip hazards ○ secure access issues for clients' personal safety ○ working-at-height related repairs or cleaning for client health and safety (i.e. gutters, roofs, windows, ceilings, smoke alarms – changing batteries but not installation or other maintenance). • Modifications to the home, such as easy access taps, shower hose or bath rails. • Assisting the care recipient, and the homeowner if the homeowner is not the care recipient, to access technical advice on major home modifications • Advising the care recipient on areas of concern in their home that pose safety risks and ways to mitigate the risks. • Arranging social activities and providing or co-ordinating transport to social functions, entertainment activities and other out of home services (i.e. that cannot be funded from general income). • Assistance to access support services to maintain personal affairs.
Leisure, interests and activities	Provide encouragement to take part in social and community activities that promote and protect the care recipient's lifestyle, interests and wellbeing.

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

9.3.3 Clinical services

Service inclusions	Content
Clinical care	• Nursing, allied health and therapy services such as speech therapy, podiatry, occupational or physiotherapy services. • Other clinical services such as hearing and vision services not otherwise funded through other programs.
Access to other health and related services	Providing referral to health practitioners or other related service providers.

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

9.4 Specified Exclusions

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

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

Exclusions	Examples
Services, goods or supports that people are expected to cover out of their general income throughout their life regardless of age	• General home services that were never, or are generally not completed independently prior to ageing related functional decline, including home repairs/maintenance/specialist cleaning performed by a tradesperson or other licensed professional. • Food (**except** as part of enteral feeding requirements or items listed under food for special medical purposes as per the Australia New Zealand Food Standards Code – Standard 2.9.5 and Standard 2.9.3 for ageing related concerns). Further information on food is below under Meal services (Section 9.5). • Vitamins and nutrition supplements not included under the PBS and non-PBS medications. • Insurances (e.g., home and contents insurance, health insurance, car insurance, life insurance etc.). • Rates. • Water, sewage, gas and electricity costs. • Private transport related costs including vehicle registration, vehicle repairs, vehicle insurance and petrol. Local transit costs of public bus, ferry or train fares (except taxi vouchers/provider transport for transport and personal assistance to help the care recipient shop, visit health practitioners or attend social activities). • Pet care (including companion dogs) and associated costs such as pet food, registration, taxidermy, cremation and dog walking. • Electronic devices (computers, laptops, iPads/tablets, phones and similar devices), smart

Exclusions	Examples
	watches and Internet/telephone costs – these are general income expenses where the care recipient has the means to pay). **Exceptions include**: ○ Care recipients who are homeless or at risk of homelessness (as identified in a care recipient's aged care assessment) can use HCP funds for the ongoing monthly charges to ensure connection with service providers. ○ Care recipients who require the internet or landline to support delivery of medication management, remote monitoring service or delivery of an included service on the phone can use HCP funds to set-up telecommunications connections if they do not have the means to pay (e.g., to get internet connected but not ongoing costs). ○ Goods, equipment and assistive technology (GEAT) prescribed communication aid phones. ○ GEAT prescribed personal alarm or low vision/hearing watches. ○ Social inclusion under exceptional circumstances (e.g., prolonged pandemic lockdowns). • Beauty therapy (e.g., manicures) and hairdressing (except nail cutting and hair washing). • Cost of entertainment activities, such as club memberships and tickets to sporting events and apps/subscriptions. • Travel and accommodation for holidays. • Supplies to participate in any activity or hobby (e.g. gardening or crafts). • Using HCP funds to pay for solicitors or accountants for maintaining care recipients' personal affairs. • Funeral costs and funeral plans. • Gym or pool memberships/access costs when not prescribed for ageing related functional decline and monitored by health professional operating within their scope of practice.

Exclusions	Examples

Household, garden and accommodation costs	• Assistance with home purchase.
	• Mortgage payments.
	• Rent.
	• Permanent residential aged care (subsidised or private) and residential respite (subsidised).
	• Heating and cooling costs (purchase of appliances, installation and repairs).
	• Whitegoods and electrical appliances (except items designed specifically for frailty such as a tipping kettle).
	• Household furniture and furnishings:
	  ○ lounge suites and recliners which do not support a care recipient's mobility, dexterity and functional care needs and goals
	  ○ other general household furniture such as coffee tables, wardrobes, and bookshelves.
	  ○ massage chairs
	  ○ general mattress and frame for bed (exceptions for pressure relieving mattress or mattress/frame for an electrical adjustable bed or hospital bed).
	• Replacement/maintenance/servicing/cleaning of:
	  ○ water tanks
	  ○ solar panels
	  ○ fencing
	  ○ roofs
	  ○ heating and cooling or hot water systems, including wood cutting or purchase of wood
	  ○ swimming pools
	  ○ end of lease cleaning
	• Home modifications or capital items that are not related to the care recipient's ageing related care needs and are considered general homeowner expenses, for example:
	  ○ windows, roofs, pergolas, sunrooms, decking
	  ○ home modifications that don't support ageing safely (e.g., non-accessible bathroom and

Exclusions	Examples
	kitchen modifications, non-standard fittings in accessible bathroom modifications, such as mosaic tiles) ○ home modifications requiring development applications ○ aesthetic modifications of any kind ○ repainting the home ○ major plumbing ○ emptying of septic tank, remedying sewage surcharge (matter for water company/insurer) ○ major electrical work (e.g., rewiring house) ○ replacement of entire floor and floor coverings throughout the home unless safe passage for mobility equipment required or slip hazard reduction required, as recommended by a health professional for care recipients at risk of falls ○ replacement of foundation (e.g., concrete/cement slab) ○ significant changes to the floorplan of the home (e.g., adding a new bathroom or extension) • Extensive gardening services such as: ○ planting and maintaining crops, natives and ornamental plants ○ the installation and/or maintenance of raised garden beds ○ compost heaps ○ watering systems ○ water features and rock gardens ○ landscaping ○ tree removal ○ removal of garden beds ○ removal of shrubbery (unless preventing safe access and egress).
Payment of home care fees	• Defined at section 52D of the Act. • Includes income tested care fees, basic daily fees and additional fees.

Exclusions	Examples

Payment of fees or charges for care or services funded or jointly funded by the Australian Government	• Co-payments for state/territory government-funded programs, such as subsidised taxi vouchers and/or aids and equipment schemes.
	• Dose Administration Aids (DAAs) funded by the Dose Administration Aids Program, where pharmacies receive a subsidy.
	• Dentures, dentistry and dental surgery. Public dental services are available through a Federation Funding Agreement on Public Dental Services for Adults. Find more information on Government dental care.
	• Prescription glasses/spectacles or contact lenses.
	• Prostheses (e.g., artificial limb).
	• Hearing aids available under the Hearing Services Program. Contact the Hearing Services Program (HSP) for guidance on hearing aid fittings and replacements and delegate approval for non-standard hearing aids.
	  ○ **Exception** if care recipient is not HSP eligible as HCP may cover like for like of typical hearing aid covered by HSP in this case only.
	• Continence aids if a participant in the Continence Aids Payment Scheme.
	• Diagnostic imaging.
	• Diabetes supports (these are funded under National Diabetes Services Scheme).
	• Natural therapies, including:
	  ○ Alexander technique
	  ○ aromatherapy
	  ○ Bowen therapy
	  ○ buteyko
	  ○ feldenkrais
	  ○ homeopathy
	  ○ iridology
	  ○ kinesiology
	  ○ naturopathy

Exclusions	Examples
	○ pilates (except sessions supervised by an exercise physiologist or physiotherapist) ○ reflexology ○ rolfing ○ shiatsu ○ tai chi (except sessions supervised by a Chinese Medicine Practitioner, exercise physiologist or physiotherapist) ○ western herbalism ○ yoga (except sessions supervised by an exercise physiologist or physiotherapist) ○ cannabis oil. • Payment for informal care – a Carer's Payments is available to fund the support of family and friends Section 16 specifies more information about which ageing related programs can and cannot be accessed while receiving a HCP.
Payment for services and items covered by Medicare, Pharmaceutical Benefits Scheme (PBS), or items that should be considered for funding through these schemes	• Co-payments or gap fees, including for services covered by private health insurance. ○ Medications, vitamins and supplements (as well as items not covered by the PBS such as off-indication prescriptions, medicines not endorsed for listing by the Pharmaceutical Benefits Advisory Committee (PBAC) or medicines where the manufacturer has chosen not to list the product on the PBS. ○ Consultation/tests/surgery with medical practitioner (GPs and specialists). The only **exception** to this is a private appointment (i.e. not covered by Medicare) with a GP to meet evidence requirements for the dementia and cognition supplement and oxygen and enteral feeding supplements: • hospital costs • ambulance cover • private health insurance premiums.
Provision of cash debit cards or like payments to	• Debit cards (unless the provider has rigorous systems in place to vet every payment and keep on

Exclusions	Examples
care recipients for any purpose	file all receipts in accordance with the Records Principles 2014. Debit cards may pose issues for GST credits. Consult with the Australian Taxation Office for more information). • Cash payments or gift vouchers/cards, including online vouchers and coupons. • Transfer of subsidy into care recipient or their family's personal/business bank account without rigorous acquittal by provider of funds against receipts matched to the Home Care Agreement, care plan and individualised budget in accordance with the Records Principles 2014.

9.5 Meal services and specialised foods

Food, general grocery, takeaway and restaurant meals are general income expenses that individuals must pay throughout their lives regardless of age and therefore these costs are program exclusions.

Meal services may be an inclusion of the HCP Program at the private cost of the raw food component and if there is an assessed need for meal services. Further, the provision of suitable quality, quantity and variety of meals is a requirement under the Quality Standards.

When deciding on the provision of meal services as part of a care plan, providers need to consider:

- Have meal services been prescribed or assessed in the aged care assessment?
- Have meal services been recommended by health professionals working within their scope of practice (e.g., GPs, dieticians or nutritionists)?
- Are the care recipient's dietary needs not being met by their current situation?
- Is the care recipient unable to prepare meals for themselves safely?
- Due to physical limitations, does the care recipient need assistance in the preparation of meals?
- Would the care recipient benefit from a reablement approach? For example, learning a new skill could require providing short-term support in preparing simple meals for themselves rather than accessing meal services.
- Has the care recipient been receiving meal services prior to entry into the program (e.g., through CHSP or directly from a meal service supplier)?

The provision of suitable quality, quantity and variety of meals is a requirement under the Quality Standards. Meals must meet this standard when the preparation and/or delivery is included in a HCP. Older people require balanced diets comprised of high-quality components.

The National Meal Guidelines is an appropriate guidance document for meal service suppliers and providers when meal planning for older people. The National Meals Guidelines were developed in consultation with practising dietitians as well as academics working in dietetics and nutrition at the University of Wollongong.

When choosing a meal service supplier, providers should refer to a health professional working within their scope of practice to determine if the meals from that supplier will meet the care recipient's diet and nutritional needs.

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

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

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

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

9.5.1 Specialised foods

Specialised foods, listed under Food Standards 2.9.5 - *food for special medical purposes* or formulations listed under 2.9.3 – *formulated supplementary foods*, that are prescribed by a treating health professional, are inclusions of the program.

Find more information in Food Standards Code Chapter 2.

These products are designed to address situations where the intake of energy and nutrients may not be adequate to meet an individual's requirements and are intended for the dietary management of a disease, disorder or medical condition that cannot be achieved without the use of the item.

Any nutritional and dietary supplements not listed under Standard 2.9.5 would be typically excluded from being provided through a HCP, with the exception of those administered via an enteral feeding tube and some products listed under Standard 2.9.3, specific to ageing related conditions.

Examples of specialised food include:

- Resource Plus

- Ensure Plus
- Nepro LP
- Nutren Diabetes
- Glucerna Triplecare Can
- Resource ThickenUp
- Sustagen Hospital.

By law these products must be prescribed by a health professional operating within their scope of practice and must only be consumed under medical supervision.

For the HCP Program, it is expected that these specialised foods would be used to support ageing related conditions (e.g., dysphagia or cognitive impairment).

The department does not endorse certain brands over others, and all brands listed above are referenced for demonstrative purposes only.

9.6 How can I respectfully decline a request?

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

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

The following case study explains the process for **when an item might be clinically necessary, but is an exclusion**:

Case study: Yashwant
Yashwant is in his 80s and on a level 3 package. He has accrued approximately $5,000 in unspent funds. Yashwant needs a new set of hearing aids. He can get these devices fully subsidised under the Hearing Services Program. He has decided, however, that he would like to use his unspent funds to get different

hearing aids that are partially subsidised or not available through the Hearing Services Program.

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

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

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

9.7 Inclusions/Exclusions Framework – Decision Tool and Template

The inclusions/exclusions framework decision tool and template are guidance resources for providers when making decisions on what is included and excluded in the HCP Program. These resources should also be used when working with care recipients to develop their care plan and individualised budget.

See the Inclusions/Exclusions Framework – decision tool and template (Appendix C).

The following case study explains the process for how to use the framework when deciding whether an item is an inclusion or exclusion:

Case study: Mary

Mary is 75 years of age and is receiving a level 3 package. She has been in the program for 4 years and has accrued $8,345.00 of unspent funds in her home care account during this time.

Recently, Mary's mobility has declined and she has been assessed by a physiotherapist as needing a 4-wheel walker. Mary's home has 3 steps up to the front veranda and there is no safe way for Mary to get in and out of the home with her new walker. Mary speaks with her provider about installing a ramp onto her front veranda.

Mary's provider first organises for an occupational therapist to assess Mary's need for the ramp, including considering alternative solutions to enter her home. The occupational therapist recommends the installation of a ramp, providing a detailed report of the assessment and recommendation outcome. Mary and her provider

then work through the Inclusions and Exclusions Framework and Decision Tool (Appendix C) together.

They conclude that the ramp may be included through Mary's package in this case, because this item:

- is not a specified exclusion
- aligns with the intent of the program and addresses a safety need
- is specifically for Mary and poses no benefit for others in the home
- aligns with the allied health professional's recommendation
- supports Mary's goals of independence
- is cost-effective to install and maintain, and fits within Mary's individualised budget with up-front costs covered by her unspent funds
- meets a need that cannot be met any other way.

9.8 Guidance on allied health and equipment

This guidance is intended to assist home care providers and care recipients to understand the allied health services that can and cannot be funded through a HCP.

Find more information on allied health care.

9.8.1 Allied health

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

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

9.8.2 Ageing related functional decline

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

Based on a care recipient's ageing related functional decline, assessors and providers are expected to determine the care recipient's ageing related care needs, which are the supports the care recipient will require to address the decline (e.g., personal care, home maintenance and nursing).

9.8.3 Goods Equipment and Assistive Technology (GEAT)

Recommendations for aids and equipment, care and services may be funded under the HCP Program, provided they meet the other requirements of the inclusions and exclusions framework at Section 9.7.

GEAT are available as part of a HCP where there is an assessed need. Health professionals operating within their scope of practice may assess for GEAT.

For further guidance on suitability of a health professional to assess for an item:

- Consult the DVA Rehabilitation Appliances Program (RAP) schedule (for reference purposes only – noting not all equipment covered by DVA is available under the HCP Program).
- Consult the CHSP provider geat2GO's Assessor and Prescriber webpage. All aids and equipment provided through geat2GO for CHSP would be considered inclusions of the HCP Program.

9.8.3.1 Ownership, maintenance, insurance and disposal of GEAT

If a care recipient purchases equipment through their HCP, then the care recipient owns the equipment. Providers would have temporarily obtained the equipment on a care recipient's behalf, using the home care subsidy.

If a care recipient has entered a leasing arrangement with either the provider or a third-party organisation, the item remains the property of the organisation holding the lease.

When purchasing an item, the maintenance, insurance and disposal of items should be considered and agreed with the care recipient and recorded in their Home Care Agreement/care plan, including:

- ensuring that there are sufficient funds available in the package for upkeep
- that any purchase will not impact on the ability to meet the continued assessed care needs of the care recipient.

If the item is no longer required, the item may be disposed of or donated.

If the Home Care Agreement does not specify disposal options, and/or the equipment is paid for outright, the provider is not responsible for waste management, and this will become a matter for the care recipient or their estate.

Items that have been paid for outright can be taken with the care recipient into residential aged care.

The care recipient may also sell the item if it is no longer required. In most cases the selling of an item may be appropriate disposal especially if an infrequent occurrence

or where the item was custom-made for the care recipient and therefore cannot be re-purposed.

If a provider is concerned that the item has been sold prematurely and without consultation, they should discuss the matter with the care recipient in the first instance and advise them that the HCP Program may not be able to fund a replacement item. Depending on the situation, the provider may wish to escalate the matter through:

- Elder Abuse Helpline (**1800 353 374**)
- the department's fraud line (**1800 829 403**).

For GEAT that is either leased or on lease-to-buy arrangements, the item remains the property of the organisation holding the lease.

While maintenance and disposal are generally the responsibility of the leasing organisation, the arrangements should be agreed with the care recipient and documented in the care plan.

This includes arrangements and agreement for payment of outstanding amounts by the care recipient should the care recipient exit the program before paying off the equipment. Such arrangements can only be entered into after gaining the informed consent of the care recipient. Find more information on key responsibilities for providers in engaging with care recipients in vulnerable circumstances in the ACCC's Consumer vulnerability: A business guide.

In the absence of clear agreement, and where the care recipient has departed the program, the responsibility for outstanding amounts is a matter for consideration under state/territory government fair trading law.

9.8.4 Accreditation and criminal history checks

Allied health providers must meet their respective accreditation and registration requirements and operate within the scope of practice of their regulated or self-regulated body.

Depending on the respective accreditation and registration requirements, this may permit activities being undertaken by allied health assistants. For example:

- Speech pathologists funded under the HCP Program must hold the Speech Pathology Australia Certified Practising Speech Pathologist credential.
- HCP funds can be used to pay for treatment from a registered podiatrist, but not for a reflexologist which is not an accredited or registered profession.

Not all allied health professions are registered with Australian Health Practitioner Regulation Agency (Ahpra). Some are self-regulated by a national professional association. The Ahpra regulated professions must adhere to the Criminal History Registration Standard, which requires the applicant to declare their criminal history on initial registration, and to disclose any changes to their criminal history upon

annual renewal. The self-regulated professions vary in whether they require professionals to declare criminal history on registration and/or renewal.

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

It is standard practice for allied health professionals to provide this on engagement with state and territory employers (such as in the form of a police check) and is then often maintained on a regular basis through credentialling requirements.

Most allied health professionals are expected to maintain a Working with Vulnerable People Check for any employment in a public setting, so this rule is not likely to be an impost to accessing allied health.

Providers should consider seeking one of the following documentation from the allied health professional:

- police check
- in some jurisdictions, a Working with Vulnerable People Card **may satisfy the requirements of the Accountability Principles 2014
- NDIS worker screening clearance.

**However, providers should check with their relevant jurisdiction if the Working with Vulnerable People Card is based on a police check no older than 3 years, and screens out persons who were convicted and imprisoned for murder, sexual assault or for any other form of assault.

9.8.5 Other Government-funded programs

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

- not specific to the care recipient's assessed ageing related care needs
- rebated by Medicare or their private health insurance – even if only partially
- treating a lifelong disability – except where trajectory is impacted by ageing (e.g., post-polio syndrome) and/or other Government-funded programs are not accessible to support the person
- treating a short-term illness or chronic health condition where ageing is not a confounding factor to the severity of the condition and/or other Government-funded programs are not accessible to support the person.

Care recipients with a chronic (or terminal) medical condition, which is being managed by their GP, may be able to access Chronic Disease Management through Medicare. Find more information on managing chronic conditions under Medicare.

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

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

9.8.6 Psychology

Psychology services may be covered under Medicare's GP Mental Health Treatment Plans if the GP considers the care recipient has a diagnosable mental health condition and should be used in the first instance.

Where these supports are exhausted and access to a psychologist is required for ageing related functional decline, this may be funded under the HCP Program. Psychiatry is a strict exclusion.

Find more information on GP Mental Health Treatment Plans.

9.8.7 Acupuncture

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

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

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

9.8.8 Remedial massage

Remedial massage may only be funded through a HCP, where it is an assessed care need and can be provided by an appropriately qualified and trained professional.

To be eligible to provide remedial massage under the HCP Program, a therapist must have a minimum of a diploma of remedial massage from a registered training organisation.

In addition, some Australian Health Practitioner Regulation Agency (Ahpra) regulated health professions may also provide remedial massage services including physiotherapists and osteopaths. Noting this, the provider should assist the care recipient to access remedial massage through an appropriately qualified and regulated practitioner.

9.8.9 Gap payments

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

While health insurers are not precluded from paying a benefit when the treatment is eligible for other benefits (e.g., HCP funds), many do not pay benefits for services funded by other programs. Private health insurers can pay benefits for various goods and services under general treatment.

General treatment cover provides benefits for allied health service providers. There are various limits that may apply, for example:

- a maximum amount
- percentage limit per service per year
- lifetime limits.

Health insurers usually find it necessary to limit these benefits to keep the cost of policies affordable.

9.9 How can package funds be used to make large purchases?

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

- be agreed within the care recipient's care plan
- be within the available budget for the package level, with any charges or additional service fees mutually agreed with the care recipient through the Home Care Agreement before purchase
- be related to the care recipient's ageing related care needs, which may require an assessment from a health professional** operating within their scope of practice (e.g., an occupational therapist, physiotherapist or registered nurse) to ensure the aid/equipment/home modification is fit for purpose.

****Assessment from a health professional**

- The cost of the assessment by the health professional may be covered by the existing charges for care management or direct service charge.
- In considering suitability of what type of health professionals should make the assessment, providers are to make use of their clinical judgement or alternatively can consult the following resources from other Government-funded programs for guidance on comparable health professional assessors for aids and equipment:

- DVA RAP schedule (for reference purposes only – noting not all equipment covered by DVA is available under the HCP Program).
- providers may also wish to review the product list for the geat2GO for the CHSP at which characterises products under 'General, Under Advice, Physiotherapist and Prescribed'.

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

Where a care recipient has transferred providers, their home care account (including any returned provider held Commonwealth unspent funds) will be under quarantine for a 70-day period – the new provider must wait until day 71 (release of unspent funds) to make the purchase. Find more information about this process at Section 13.

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

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

Example 1: Mauve

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

Example 2: Petro

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

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

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

There are certain circumstances where a care recipient can access CHSP services over and above the services provided through the HCP budget.

This may be subject to the available capacity of CHSP providers and their available funding, given CHSP clients will be the priority. Care recipient contributions, additional to the income tested care fee and basic daily fee, may apply.

See the CHSP Manual for more information.

9.10 Considerations for home modifications

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

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

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

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

Additional costs need to be mutually agreed with the care recipient and paid for privately through additional service fees.

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

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

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

If a care recipient's residence is under strata, or they otherwise are not the owner, providers should assist the care recipient to obtain permissions from the owner or body corporate before the commencement of any works.

However, any changes to common property in a strata complex to assist a care recipient's egress and access needs must be considered carefully. It is a poor outcome if the care recipient pays for the whole modification when others will benefit and is risked being devoid of funds for personal care and/or other services. Negotiation should take place to understand what portion the strata will pay, and whether there is option for the strata to pay for the whole project if it benefits multiple residents also requiring safe egress and access from the building. It is also advisable to seek advice from the state/territory government body responsible for strata to understand the body corporate's responsibilities under the *Disability Discrimination Act 1992*, noting the operation of this Act may vary across jurisdictions.

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

Key points to remember

- The HCP Program is not an income support program and must only be used to fund ageing related care and services.
- Care and services must not be approved through the HCP Program if already concurrently funded by another Government-funded program.
- The legislation provides some specified inclusions and exclusions.
- The department has developed the Inclusions/Exclusions Framework – decision tool and template to guide providers when making decisions on the approval of care and services that are not specified inclusions or exclusions.

10. Delivering care under a package

This section covers:

- Commencing services
- Claiming Home Care Package subsidy
- Managing package services
- Self-management
- Delivery of care by family and friends
- Reviewing care plans
- Monthly statements
- Usage of unspent funds
- Management of unspent funds
- Increase in care recipient's needs
- Not meeting care recipient's needs
- Elder abuse
- Complaints management
- Contingency funds

10.1 Overview

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

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

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

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

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

See Section 3, Section 4, Section 15 and Appendix E for further detail on specific provider responsibilities.

10.2 Commencing services

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

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

Providers must document all conversations and should not lodge the ACER until a Home Care Agreement is in place.

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

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

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

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

Importantly, the Improved Payment Arrangements mean that you cannot make large purchases until funds have been accrued in the person's home care account because the home care account cannot go into deficit. Care recipients will retain their full Home Care Package subsidy under these changes.

Find more information about the Improved payment arrangements.

10.2.1 Client summary tab

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

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

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

Find more information about the My Aged Care - Client summary tab .

10.3 How do I claim the Home Care Package subsidy for services I provide?

Providers can only claim the Home Care Package subsidy for people who have been assigned a package from the National Priority System and have a Home Care Agreement in place. This means that providers can only claim the Home Care Package subsidy from the date they entered into the Home Care Agreement, not the

date they start negotiating with the care recipient or completing pre-service delivery care planning.

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

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

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

10.3.1 Improved Payment Arrangements

The Improved Payment Arrangements changed the way providers were paid and unspent funds were managed, which was implemented in 2 phases:

Phase 1 (legislation passed December 2020, implemented on 1 February 2021)

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

Phase 2 (legislation passed February 2021, implemented on 1 September 2021)

- Providers paid in arrears, based on actual care and services delivered.
- Services Australia holds the Commonwealth portion of unspent funds, in each care recipient's home care account, until needed by the care recipient.

This measure reduced the financial and prudential risks of providers holding substantial amounts of unspent funds, by the Government holding them instead.

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

Find more information on the Improved Payment Arrangements for home care.

10.3.2 Claiming payments through Services Australia

Providers started submitting claims through Services Australia under the new model from the September 2021 claim period (from 1 October 2021). Providers claim through the Services Australia Aged Care Provider Portal or business-to-government (B2G) software purchased through an independent software developer.

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

Package management and care management are considered services and can be included as part of the price. GST is not included in the claim. Care and package management are distinct services that should be charged separately.

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

Providers should be accurate in their claiming and claim the costs associated with the services delivered in the month even if they have exceeded the subsidy.

Providers cannot split the cost over multiple claim months. Instead, providers will be paid the lesser of the shortfall amount or the maximum contribution amount. Any outstanding amounts for the claim period must be covered by the provider or by unspent funds held by the provider for the care recipient – or additional service fees payable by the care recipient.

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

Services Australia will automatically apply supplements if the care recipient is eligible. It will be included as part of the calculation completed by Services Australia of the Home Care Package subsidy available to the care recipient.

If the Home Care Package subsidy is more than the total cost of services delivered in the claim month, the difference will accrue in the home care account for future use. A care recipient's home care account balance will be available to their current provider through the Aged Care Provider Portal and the payment statement Services Australia issues to providers.

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

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

A care recipient should be allocated a care manager by a provider.

The care manager is responsible for enabling the steps discussed at Section 6.2, Section 6.6 and Section 7 (initial assessment, establishing the Home Care Agreement and care planning), as well as:

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

Care management service must comply with the Quality Standards, including:

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

Find more information on care management.

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

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

It is important that both the provider and the care recipient understand that the approved provider is ultimately responsible for compliance with the legislation (see Section 3, Section 4 and Section 15), Aged Care Quality Standards (see Section 3.5.2), and scope and intent of the HCP Program (see Section 2). Providers will still need to have oversight over which services self-managing care recipients receive and how they spend their package budget. Providers will also continue to undertake some required activities such as reviewing the care plan.

A provider must still provide care management to ensure delivery of safe and quality care and services based on their needs, goals and preferences. This may incur some costs and staff effort, so providers can charge a care management price proportionate to the work incurred to oversee the care recipient's self-management.

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

Payment to families and friends for care services is typically a program exclusion.

A family member carer may be able to get one or more payments from Services Australia depending on the circumstances of the care and the needs of the person needing the care.

- **Carer Payment** is a payment to provide constant care to someone with a disability or medical condition or who is frail or aged. Constant care means that the care is provided for a large amount of time daily. Find more information about the Carer Payment.
- **Carer Allowance** is a supplementary payment to care for someone who needs daily support. Find more information about the Carer Allowance.

Using HCP funds to pay for family carers raises serious probity issues under the *Public Governance, Performance and Accountability Act 2013* under which the aged care special appropriation sits.

There are **5 high level criteria** that approved home care providers need to consider when determining if the employment of family members is appropriate:

1. the individual does not already receive any funding as a carer
2. the potential carer does not live with the care recipient
3. the care recipient is located in a rural and remote region – as defined by the Modified Monash Model region (rural and remote 4-7)
4. the care recipient identifies with a CALD or First Nations community
5. the potential carer is appropriately qualified for the role.

If the employment of the family member meets **all** of these criteria, then the approved provider can make a determination as to whether they can employ the family member for the role.

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

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

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

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

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

When thinking about how often to review the care plan, providers should be aware of compliance with Quality Standards 2 and 3. For more information on the Quality Standards, see Section 3.5.2 of this manual.

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

- A review of current ageing related care needs, care goals and preferences.
- An evaluation of the quality and success of the services and supports that have been provided.

- A renegotiation and update of the care plan and individualised package. budget
- Support for the care recipient to continue to make informed choices about their care and services, and the life they choose to live, including whether they wish to change their level of involvement and decision-making in the management of the package.

Wellness and reablement are discussed further at Section 7.4.

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

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

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

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

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

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

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

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

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

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

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

- The amount of Home Care Package subsidy for the care recipient for the month.
- The amount of home care fees (if any) paid or payable by the care recipient for the month, and any unpaid home care fees relating to previous months.
- An itemised list of:
    - the care and services provided to the care recipient during the month (including travel, subcontracting arrangements and package management) for which the care recipient was charged
    - the price that the provider charged the care recipient for the month
    - the total of those prices.
- The care recipient's unspent home care amount (provider-held unspent funds) in respect of the previous and current months.
- If, during the month, the provider received the care recipient portion of unspent funds from another provider – the amount that was received.

Since the September 2021 payment period, you must split out the care recipient's unspent funds into the:

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

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

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

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

Statements do not need to break down the unspent funds balance into the provider-held care recipient portion, Commonwealth portions, or the home care account balance until providers are ready to include this information.

See the Monthly Statement resources, which includes a non-mandatory monthly statement template and guidance that providers should strive to align with.

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

10.9 What are unspent funds?

Unspent funds are the total amount of Home Care Package subsidy, supplements (if applicable) and home care fees that have not been spent or committed on a person's care. Since 31 December 2021, under the Improved Payment Arrangements, providers must report the Commonwealth portion of unspent funds they hold for each care recipient to Services Australia.

Unspent funds may be made up of the following:

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

More information on the Improved Payment Arrangements.

10.10 How can I work with my care recipients to manage unspent funds?

Providers should work with care recipients to ensure they are able to benefit from the full use of their package and budget.

However, there are several reasons why unspent funds may accumulate in a package budget – key examples are listed in the table below.

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

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

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

If a care recipient leaves a provider and does not establish a new Home Care Agreement within 56 days, the care recipient is considered to have exited from the program and on day 70, the Commonwealth portion of unspent funds must be returned to the Government.

Providers have a legal obligation to transfer any unspent funds if someone changes provider or return unspent funds if they leave the HCP Program. This is discussed further at Section 13 and Section 14. The department uses information about the returned Commonwealth portion of unspent funds as an input to determine the number of packages to be released to people on the National Priority System.

Find more information on the treatment of unspent funds under Improved Payment Arrangements.

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

Strategy	Information
Revise the care plan and package budget	Providers should work together with their care recipients to develop a plan that meets their assessed care needs. This includes talking about the funds available and how to spend those funds, through the package budget. This may include an agreement, based on the care recipient's choice, to set aside a small part of their package budget for future care needs. It is

	important to be able to save for future events, such as a carer going on holiday or needing respite. Providers should also ensure record keeping regarding care recipients' days in care is accurate and up to date (see Section 11 for further information on temporary leave).
Actively manage packages	Providers also play an important role in managing their care recipient's package. Providers will receive a notification if their care recipient's package is upgraded. The provider should talk to their care recipient about their assessed care needs and make updates to the care plan, Home Care Agreement and package budget as soon as possible, so that more essential services can be arranged. Doing this quickly will prevent unspent funds accumulating from the date of the automatic package upgrade.

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

A care recipient's care needs may increase significantly so that they potentially require home care at a higher level or entry to residential aged care. In these circumstances, they may need another assessment by an aged care assessment organisation. With the care recipient's prior consent, providers can assist in arranging the aged care assessment.

Providers can do this by submitting a Support Plan Review (SPR) request via the Service and Support Portal. Understand When to Request a Support Plan Review from an Assessor.

When requesting an SPR, the provider is required to attach supporting documentation about the care recipient's current care arrangements, such as the individualised package budget or care plan. The My Aged Care Contact Centre will also request this information when submitting SPR requests on behalf of providers.

If someone is already receiving a level 4 package, they may need to consider other options including:

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

10.12 Respite

The primary purpose of respite is to support and maintain the care relationship between carers and care recipients by providing good quality respite care for the care recipient so their carer may take a break from their usual care arrangements.

The types of respite are:

- residential respite (subsidised and private)
- in-home respite
- cottage respite
- respite through the CHSP.

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

The Carer Gateway provides practical information and support for carers.

10.12.1 Residential respite

Residential respite provides temporary care in an aged care home. Government-funded residential respite may be used on a planned or emergency basis.

An aged care assessment approval is required to access residential respite care. Eligible care recipients are entitled to 63 days of residential respite in a financial year. This can be extended by up to another 21 days if approved by an aged care assessment.

The Home Care Package subsidy cannot be used for co-payments. This is because residential respite delivered by a residential aged care provider is already funded or jointly funded by the Australian Government. As such, subsidised residential respite falls within the specified exclusions of a HCP as per the Quality of Care Principles 2014.

Before a care recipient enters residential respite, please review Section 16.5.2 on the interface between HCP and residential aged care, and set clear boundaries with the residential aged care facility to ensure they and the care recipient alert the home care provider before the entry is made permanent.

10.12.1.1 Accessing private respite

However, where subsidised residential respite is not available at a residential aged care facility and the care recipient wishes to take up a private respite bed, this may be funded by the HCP in some circumstances.

When using HCP funds to pay for private respite, the provider must consider the amount the Government pays for respite based on the person's aged care assessment which includes a Respite Class.

It would be unreasonable to pay above what the Government pays if the residential aged care facility is eligible for Australian National Aged Care Classification (AN-ACC) funding and has sufficient places available. For more information on what the Government pays for residential respite, see the Schedule of Subsidies and Supplements for Aged Care.

If private respite is to be funded through the HCP Program, providers should discuss with the care recipient to determine the impact on their package budget and ensure there is no change to their capacity to deliver other care and services.

10.12.1.2 Residential respite leave

A HCP must be suspended when a care recipient is receiving subsidised residential respite. For information on taking 'temporary leave', see Section 11.

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

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

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

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

10.12.2 In-home respite

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

In-home respite is funded through the HCP Program, provided it meets assessed care needs per the care plan and can be provided within the available package budget.

10.12.3 Cottage respite

Providers would also need to consider 'cost effectiveness' and 'value for money' in purchasing cottage respite, turning to the most cost-effective and economical respite that meets the care recipient's needs.

10.12.4 CHSP respite

If a care recipient does not have sufficient funding to access respite through their HCP and/or residential respite, they may be able to access respite services through the CHSP. Find more information in the CHSP Manual.

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

Once providers enter into a Home Care Agreement, they are required to continue to deliver the agreed care and services for as long as the care recipient needs those services. As discussed at Section 3.5.1, this is called security of tenure.

There are exceptions to security of tenure, such as when the care recipient can no longer be cared for safely in their home. These exceptions are extracted in full at Section 3.5.1.

If providers do not think they can meet the care recipient's needs, but none of the exceptions to security of tenure apply, they should consider sub-contracted arrangements to help fulfil obligations under security of tenure. Sub-contracting is discussed at Section 7.6.

If the reason the provider cannot meet the care recipient's needs is due to the provider being unable to make contact with the care recipient and/or their authorised representative for multiple months, the provider must place the care recipient on social leave until such time that contact is made.

Should communication continue to be unanswered the provider may send notice to terminate the Home Care Agreement to the care recipient advising:

- they have a reasonable period of time to respond to the request (e.g., 4 weeks) before date of cessation
- that upon termination of the Home Care Agreement, the care recipient has 56 days to enter into a new Home Care Agreement or will otherwise be deemed to have exited the program and will lose their unspent funds after 70 days.

However, the provider should also consider the vulnerability of the care recipient. For example, if the care recipient is homeless, it may be a better outcome to leave them on perpetual social leave until such time that the care recipient is able to re-engage with the aged care system.

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

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

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

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

State/territory	Organisation or resource	Contact
Australian Capital Territory	Older Persons Abuse Prevention Referral and Information Line (APRIL)	**02 6205 3535**
New South Wales	NSW Elder Abuse Helpline	**1800 628 221**
Northern Territory	Elder Abuse Information Line	**1800 037 072**
Queensland	Elder Abuse Prevention Unit	**1300 651 192**
South Australia	Elder Abuse Phoneline	**1800 372 310**
Tasmania	Tasmanian Elder Abuse Helpline	**1800 441 169**

Victoria	Seniors Rights Victoria	**1300 368 821**
Western Australia	Elder Abuse Helpline	**1300 724 679**

Find a case study that provides an example of financial elder abuse.

10.15 What do I need to do to manage complaints?

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

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

The complaints function must be outlined in every Home Care Agreement. If it is appropriate, providers may want to refer a care recipient to the Commission website for information on making a complaint.

If a complaint arises, the provider must:

- use their complaints resolution mechanism to address the complaint and
- advise the complainant of any other mechanisms that are available to address complaints, such as the Commission.

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

Find information on how to design a complaints function in the Commission's 'Better Practice Guide to Complaint Handling in Aged Care Services'.

The Commission also has case studies that outline some strategies providers might use to resolve complaints.

10.16 Contingency funds

Providers are required to discuss future planning, including any large purchases, with their care recipients and take these into account when planning package budgets. This must then be documented in a care recipient's Home Care Agreement and their care plan. Providers must ensure care recipients understand and agree to their care plan before services are put in place.

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

Charging and claiming for "contingency" is not consistent with the policy intent of the HCP Program. Contingency fees cannot be charged and accrued for future needs.

Under Improved Payment Arrangements (since 1 September 2021), any additional fees should only be used for current identified needs and delivered care and service.

Please note:

- Payment by Services Australia is only paid in arrears for services already delivered and providers should no longer be accruing unspent funds.
- The department does not support unnecessary fees which may have adverse impacts on the financial wellbeing of care recipients and do not serve to benefit the care recipient, in line with *Aged Care (Transition Provisions) Act 1997*, Part 4.2 which sets out the responsibilities relating to home care fees.
- Any additional fees a care recipient contributes are drawn down first by deduction from the price reported to Services Australia as part of a monthly claim.
- Where the claim is less than the Home Care Package subsidy, any unspent funds accruing would be the Commonwealth portion in the home care account and these funds would therefore not be available for reimbursement to the care recipient upon departure.
- In line with the Act, Part 3A.1, 52D-1(d): if the care recipient dies or provision of home care ceases – any fees paid in advance in respect of a period occurring after the care recipient's death, or the cessation of home care, must be refunded in accordance with the Fees and Payments Principles 2014.

Key points to remember

- Providers are required to review each care recipient's care plan regularly, at least once per year, and if their care needs change or they request it.
- Changes to a care recipient's care plan will result in changes to their package budget.

- Providers are required to give care recipients monthly statements. This is a financial document and shows them what makes up their package budget and how it is being spent.
- Approved providers and all of their employees need to be aware of elder abuse, including obligations in regards to reporting and response to elder abuse, which vary by state or territory.
- Providers need to have a complaints management function in place, and they must use it to manage complaints they receive.
- Under the Improved Payment Arrangements, providers receive funding based on the actual services delivered to care recipients in the previous month. This aligns the HCP Program with other Government-funded programs (e.g., NDIS) as well as modern business practices. These changes will not affect care recipients' subsidy entitlements.

11. Temporary leave

This section covers:

- When a care recipient takes leave
- Impact of leave on home care subsidy and supplements
- Impact of leave on home care fees
- Impact of leave on monthly statements
- Leave balances

11.1 Overview

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

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

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

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

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

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

11.2 When can a care recipient take leave?

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

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

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

Providers must include information in each Home Care Agreement, explaining how the care recipient can notify them if they are planning to take leave. If they choose to take leave, the provider should work with them to update their care plan accordingly.

See Section 10.12 for circumstances where a provider may place a care recipient on social leave without their consent (e.g., the care recipient and any representatives are non-contactable for multiple months).

11.3 What is the impact of leave on the basic subsidy and supplements?

The amount of Home Care Package subsidy paid to the provider is dependent on the type of leave the care recipient takes from their package, as set out in the following table.

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

* Primary supplements are oxygen, enteral feeding, dementia and cognition, and veterans. Other eligible supplements (i.e. viability and hardship supplements) continue to be paid during periods of leave. Supplements are discussed at Section 8.3.2.

** Package suspension for any other reason.

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

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

charged while a care recipient is on leave from their package is set in the table below:

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

11.5 What is the impact of leave on monthly statements?

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

Monthly statements are discussed at Section 10.8.

11.6 How do leave balances work?

A care recipient's leave balance resets on 1 July each year or if their package level changes at any time. Leave balances are specific to each care recipient and will transfer with them (e.g., if they change providers).

11.6.1 Worked examples:

Example 1: A care recipient has been in hospital for more than 28 consecutive days, and because they advised their provider to suspend their package, the basic subsidy has stepped down to 25% after the 28th day. The care recipient then moves into transition care for a period. How is the rate of subsidy calculated and how should the home care fees be calculated?

Hospital leave and transition care leave are 2 different types of leave. Each time a care recipient accesses either hospital leave or transition care leave, their provider receives the full basic subsidy rate for up to 28 consecutive days, after which the subsidy reduces to 25% of the basic subsidy rate. The leave will also impact on their basic daily fee and income tested care fee (if applicable).

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

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

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

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

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

Example 2: A care recipient is on leave in hospital but needs minor modifications to the home before they can be released from the hospital to go home. Do I need to do these minor modifications for the care recipient while they are on leave?

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

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

Example 3: A care recipient is going on a 3 month holiday. Their home needs household maintenance services (such as mowing) in order to make the home safe while they are away ready for their return home. Can I charge to the package budget while they are on leave?

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

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

Key points to remember

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

12. Responding to diverse needs and changing cognition in Home Care Package delivery

This section covers:

- Diverse needs
- Changing cognition
- Managing issues related to changing cognition
- Care recipient additional support in exercising choice

12.1 Overview

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

Approved providers need to be ready and able to respectfully and safely provide aged care services to people with diverse needs and changing cognition. This includes culturally appropriate, person-centred, trauma informed care. Individuals have a right to have their diverse needs and/or changing cognition respected. All services must treat each care recipient with dignity and respect, enable them to maintain their identity, and account for and cater to any diverse needs and/or changing cognition if they would like them to, or if it is necessary for them to remain living safely in their home.

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

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

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

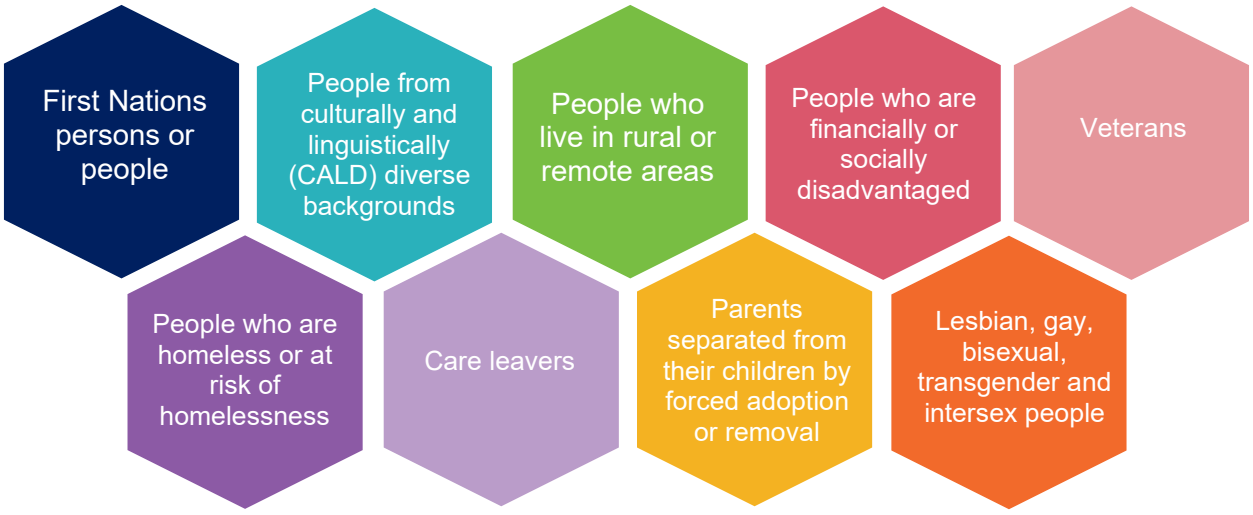
- Section 56-2 of the Act
- User Rights Principles 2014.

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

See Section 3, Section 4, Section 15 and Appendix E for further detail on specific provider responsibilities.

12.2 What are diverse needs?

The Act defines 9 types of special needs, referred to in this manual as 'diverse needs', as outlined in the figure below:



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

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

When working with people with diverse needs, it is worth remembering that they may have had negative experiences of discrimination, or other adverse actions, in the past. The best way to approach this is to work in partnership with them and have open and respectful conversations about their care needs and goals. All services delivered to care recipients with diverse needs should be culturally safe, culturally appropriate, trauma aware and healing informed.

The Aged Care Diversity Framework and action plans also helps providers consider how their services may be appropriately tailored to care recipients with diverse characteristics and life experiences. Care and support mental health training and resources are also available for providing trauma-informed care.

The Commission provides several examples on meeting the care needs of aged care recipients with diverse needs.

12.3 What is changing cognition?

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

12.3.1 Early warning signs of dementia

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

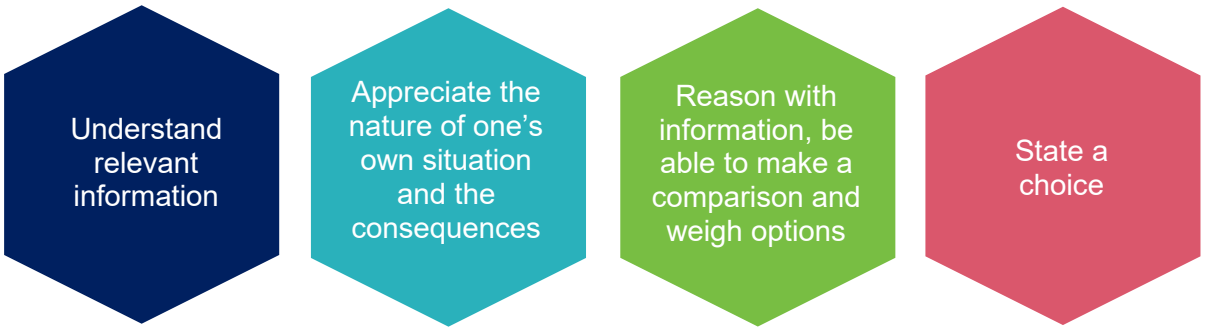
Dementia Australia provides guidance on early warning signs of dementia, which may be helpful to the provider and their team members in identifying whether one of their care recipients may be living with dementia. For more information, refer to Dementia Australia's guidance on early warning signs.

12.3.2 Determining capacity

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

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

Capacity means being able to:



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

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

Case study: Olga

Olga has been receiving home care services for several years. She has dementia and her needs have gradually increased, but she is capable of living semi-independently for now. Her 2 children live nearby and at least one of them visits daily. Olga gets on well with the care staff and makes it clear to them that she wants to keep doing as much of her own housework and personal care as she can.

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

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

12.3.3 Dementia Training Program

The Dementia Training Program, delivered by Dementia Training Australia, is a program available to providers, offering a national approach to accredited education, up-skilling, and professional development in dementia care. Services include:

- free accredited vocational level dementia care training
- targeted and tailored onsite training to aged care providers that is developed through a dementia trained needs assessment
- online training to complement face to face training delivery through facilitated and self-paced training and resources.

Find more information about the Dementia Training Program.

12.3.4 Dementia Behaviour Management Advisory Services

The Dementia Behaviour Management Advisory Services (DBMAS), delivered by Dementia Support Australia, provides support and advice when behavioural and psychological symptoms of dementia impact a person's care or quality of life.

Trained consultants work in community, residential aged care, acute and primary care settings to support service providers and individuals caring for people living with dementia. They also help providers and carers to understand the causes and/or triggers of behaviours and assist with the development of strategies that optimise function, reduce pain, support other unmet needs, and improve engagement.

Providers can access DBMAS through the 24-hour helpline, on **1800 699 799**, or the Dementia Support Australia website.

12.4 How do I manage issues related to changing cognition?

The CDC model encourages people receiving a package to continue to make choices and direct the support that they need.

However, some individuals may have more difficulty engaging with CDC and making choices about their care goals and services.

If they would like or need it, there are different ways in which they can be supported in their decision-making and in expressing their views about their service arrangements (see table below).

Strategy	Description
Representative	A care recipient may appoint a representative to assist with their decision making or be authorised to make decisions on their behalf. This may take various forms, such as an informal arrangement with a friend, family member or ally, someone with a formal power of attorney or a legal guardian. Regardless of who the care recipient would like as their representative, to make any decisions or to receive information through My Aged Care, the person must be noted as an authorised representative in the care recipient's My Aged Care record. To do this, the care recipient and the proposed representative should call My Aged Care on 1800 200 422 for assistance. Find more information about appointing a representative.
Supported decision-making	Supported decision-making is a model that has mainly been used for supporting people with disabilities, often cognitive disabilities, to make significant decisions and exercise their legal capacity. Specific decisions are addressed, weighed and concluded by the person with the disability, while drawing on the support of a network of people or an individual. Potential supporters may be friends, family, volunteers, community members or any other trusted person. These unpaid supporters may help the person with disability to gather, understand and consider relevant information about the decision in question, assist them to weigh pros and cons, predict likely outcomes and consequences or evaluate the available options. With this support, the person then makes the decision themselves. This process can be formally facilitated, for instance by creating written supported decision-making agreements. It often occurs informally within the community, both to support people with impaired decision-making capacity and to support anyone in making a challenging decision. This model of support aims to build and extend the decision-making skills of those using it, developing the ability of people to make and communicate decisions with more independence and confidence. Source: Disability Advocacy Network Australia
Power of Attorney	Powers of attorney are legal documents that let a person choose someone they trust to make decisions for them. An enduring financial or medical power of attorney, or enduring guardianship,

Strategy	Description
	are a way a competent person can appoint others to make decisions and manage their affairs in the event they are unable to make decisions for themselves. Arrangements may differ in each state or territory. Contact your Office of the Public Advocate in your state or territory for further information.
Guardianship	Guardianship is the appointment of a person (a 'guardian') to make decisions for an adult with a disability (the 'represented care recipient) when they are unable to do so. All adults over the age of 18 years, regardless of disability, are entitled to make their own decisions when they are able to do so. Australian guardianship law is the key regulatory mechanism for protecting the health of young persons, adults with disabilities and the elderly. Rules vary depending on state or territory. For more information, visit the Australian Guardianship and Administration Council website.
Care planning	All care recipient care plans should include a contingency plan, which is reviewed each year and provides clear guidance around what to do in the event that the care recipient's capacity to make decisions regarding their care changes.
Advance care planning	Advance care planning provides an opportunity for people to think, discuss and plan for the medical treatment they would prefer if they became too ill in the future to express their wishes. An Advance Care Directive is a legal document that records the medical treatment wishes of a person, which can then be used if they are unable to speak for themselves due to illness or injury. The document may also appoint a substitute decision maker and include non-medical wishes for end of life, such as spiritual care. You can find information about advance care planning on the department's website. Information, guidance, and resources are available from the End of Life Directions for Aged Care website. Advance Care Planning Australia has information about creating a plan, as well as contacts in each state and territory.

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

Case study: Ricardo and Alicia

Ricardo and Alicia had been living in their own unit for 3 years when Ricardo, aged 70, was diagnosed with a form of dementia that is progressing rapidly. They contacted their provider to discuss extra services they expected to need as the illness progressed. Recognising how important it was for Ricardo's final months to be comfortable and dignified and to reflect his wishes, even when he could no longer express them, the provider encouraged them to make a formal advance care plan.

A staff member trained in developing advance care plans helped Ricardo identify his values and treatment preferences. What mattered to Ricardo most was staying in his home with his wife and dog, taking daily walks and looking after the unit's small garden. He did not want treatment that might extend his life while its quality deteriorated. Following the provider's protocol for end of life planning, the staff member worked with Ricardo and Alicia to document a detailed advance care plan. Ricardo was pleased everyone knew his clinical, cultural and spiritual preferences.

Find more information on supported decision making in aged care in this resource by the University of Sydney.

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

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

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

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

An advocate may be made available through the National Aged Care Advocacy Program (NACAP) by the Older Persons Advocacy Network (OPAN). They provide free, confidential and independent advocacy support to older people receiving or looking to access Government-funded aged care services.

An advocate's support can help with the following:

For more information on OPAN's advocacy services.

Key points to remember

- Providers need to be ready and able to provide care and services to people with special needs and/or changing cognition. Care and services must be considerate of and appropriate to special needs and/or changing cognition.
- The Aged Care Diversity Framework and action plans can help providers consider how services may be appropriately tailored to people with diverse characteristics and life experiences.
- Capacity can be difficult to navigate with an older person and their family. This section outlines legal and advocacy strategies that providers can use to help with this.
- OPAN provides free, independent advocacy services. If care recipients need support making decisions, but can still make decisions for themselves, providers can connect them to this service.

13. Changing home care providers

This section covers:

- When a care recipient changes home care providers
- Effect on claims for care recipient's Home Care Package subsidy
- Obligations on providers
- Exit amounts
- Transfer of care recipients following a merger or acquisition

13.1 Overview

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

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

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

- Section 56-2 of the Act
- User Rights Principles 2014
- Accountability Principles 2014.

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

See Section 3, Section 4, Section 15 and Appendix E for further detail on specific provider responsibilities.

13.2 When can a care recipient change home care providers?

Once receiving a package, a care recipient can change providers if they are looking for a better fit, or for any other reason (e.g. a move interstate). If they decide to make a change, their unspent funds will move with them to their new provider.

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

Providers should help by informing care recipients of the steps involved in changing providers including the 70 day rule for retaining unspent funds and the 56 day rule for retaining the package.

If a care recipient is unable to enter a new Home Care Agreement within 70 days and no longer requires care and services, their existing provider can put them on social leave until they exit. This can be at the provider suggestion or care recipient request.

Whilst on social leave, the provider cannot charge care or package management. The home care account will continue to accrue.

13.2.1 Agreeing to a cessation date

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

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

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

13.3 How does this affect the claims for that care recipient's Home Care Package subsidy?

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

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

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

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

Recipient	26 June	27 June	28 June	29 June	30 June
		Subsidy paid			
New provider			Start date, Subsidy paid	Subsidy paid	Subsidy paid

Before providing home care services, the new approved provider should confirm the cessation date with both the care recipient and the existing provider to ensure there are no overlapping claims for Home Care Package subsidy.

- Where 2 or more approved providers claim subsidy for the same care recipient on the same date, payment will be made to the provider that first entered into a Home Care Agreement with them.
- When the start date and the cessation date are the same date, this does not represent an overlapping claim as Home Care Package subsidy is not paid for the cessation date.

13.3.1 Notifying the cessation date and start date

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

If a care recipient requires more time to enter a new Home Care Agreement, they can request an extension of 28 days, allowing a total of 84 calendar days to enter into a new Home Care Agreement with a new provider.

If a care recipient does not enter a new Home Care Agreement within 70 calendar days, the Commonwealth portion of unspent funds will be returned to the Government.

Note: per the legislation, the 56 day rule to retain the HCP is separate and distinct from the 70 day rule to retain unspent funds when changing providers.

The existing provider must notify Services Australia that they have ceased providing services to a care recipient within 31 calendar days of their cessation date. This must be done by submitting the care recipient's name and their cessation date through the Aged Care Provider Portal.

Note: For continuing care recipients who entered the HCP Program before 1 July 2014, to retain pre-1 July 2014 fee arrangements, they must enter a Home Care Agreement with the new provider within 28 days.

To opt into the post-1 July 2014 fee arrangements, they must complete the Continuing Care Recipient opting into the New Aged Care Arrangements from 1 July 2014 (AC022) form. The care recipient must submit this form to their new provider.

The new provider must give them a copy of the New Arrangements for Aged Care from 1 July 2014 – Home Care publication before they transfer to the new service.

See Appendix A for further information on the pre-1 July 2014 fee arrangements.

13.4 What are the obligations on providers?

13.4.1 Obligations for the existing approved provider

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

1. Provide cessation information to Services Australia	2. Notify care recipient of unspent home care amount/arrange payment	3. Retain records
Once a cessation date is agreed with the care recipient, the existing provider must notify Services Australia within 31 calendar days of care ceasing. It is important to remember that a Home Care Package subsidy is not paid for the cessation date.	Must take these steps: 1. Calculate the unspent home care amount. 2. Provide written notice of the unspent home care amount. 3. Make payment of the unspent home care amount.	The existing provider must retain: • written notice of the care recipient's unspent home care amount • records relating to the payment of the unspent home care amount to the new provider.

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

13.4.1.1 Calculate the unspent home care amount

The steps and requirements for calculating a care recipient's unspent home care amount are detailed in the User Rights Principles 2014.

Before completing the final reconciliation, the provider must make sure:

- claims for the care recipient are up-to-date
- that home care fees have been received

- all expenses have been identified, including any outstanding invoices from sub-contracted or brokered services.

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

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

13.4.1.2 Provide written notice of the unspent home care amount

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

- Cessation date for care and services.
- Unspent home care amount, which is the balance of any unspent funds in the package budget, broken down into the following portions:
    - the care recipient portion, which is the unspent amount of home care fees paid to the provider by the care recipient, less any unpaid home care fees owed by the care recipient
    - the Commonwealth portion held by the provider (if any), which is the unspent amount of basic subsidy and supplements for a care recipient
    - any unpaid home care fees which have been deducted (if applicable).

Under Improved Payment Arrangements, the existing provider will need to either:

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

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

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

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

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

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

Refer to Section 13.5 for more information on exit amounts.

13.4.1.3 Make payment of unspent home care amount

The care recipient must notify their existing provider within 56 calendar days after the cessation date of the new provider who they have entered into a Home Care Agreement with. This is to allow their existing provider to arrange payment of the care recipient portion of the unspent home care amount to the new provider. If the existing provider is not notified within this period, the existing provider must treat any unspent home care amount as if the care recipient has left home care. This is discussed at Section 14.

The existing provider is required to make payment to the new provider as soon as possible, but within 70 calendar days, after the cessation date. The existing provider must also provide a copy of the written notice of the unspent home care amount to the new provider at the time the payment is made. This allows the new provider to identify the transferred amount for the care recipient.

13.4.2 Obligations for the new approved provider

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

1. Accept the care recipient referral in My Aged Care	2. Develop a Home Care Agreement with the care recipient.	3. Provide care recipient entry information to Services Australia.
Providers must accept the care recipient's referral in the Service and Support Portal before submitting entry information to Services Australia.	The new provider should work in partnership with their new care recipient to develop a Home Care Agreement, care plan and package budget based on their assessed care needs.	The new provider must notify Services Australia within 28 calendar days of the care recipient starting care by submitting an ACER.

Once the new provider receives the unspent funds amount they must separately identify the transfer portion of the unspent home care amount in the care recipient's monthly statement. Under Improved Payment Arrangements (from 1 September

2021 onwards) the transfer portion will only consist of the care recipient portion of unspent funds. The Commonwealth portion will be held in the care recipient's home care account.

Care recipients who joined the HCP Program after 1 September 2021 will never have any Commonwealth portion held by the provider. Any unspent funds held by the provider will be entirely made up of the care recipient portion.

Find more information on the Improved Payment Arrangements.

13.5 Can I charge an exit amount?

Providers cannot charge a care recipient an exit amount in any circumstance.

Activities related to care recipient's exiting or moving to a new provider, such as transferring documents, may be covered under package management or care management, where reasonable and appropriate.

13.6 My organisation has undergone a merger or acquisition. How do I transfer my care recipients?

When a provider has undergone a merger or acquisition, their care recipients will need to be exited from their service and transferred to the new provider.

Providers are required to contact the department to advise of transfers, mergers or closures, including effective dates. The department will advise Services Australia of this information.

It is also the responsibility of providers to transfer all care recipients from the closing service to the continuing service.

Find more information about transferring home care services, including guidance on obligations for providers subject to a merger or acquisition.

Note that if a provider is looking to move care recipients from one of their home care services to another within their control, they can do this via a self-service process in the Service and Support Portal. Providers can find support with technology and guidance on how to use the Service and Support Portal.

Key points to remember

More information on administrative responsibilities is at Section 15 of this manual.

- Care recipients can change home care providers at any time.
- If a care recipient chooses to change providers, it is important that they and their existing provider agree on a cessation date. This affects the way the providers claim the care recipient's Home Care Package subsidy and when the existing provider will need to transfer the care recipient's unspent funds.
- The existing provider must transfer the care recipient's unspent funds to their new provider as soon as possible, but within 70 calendar days, of the cessation date.
- If a provider has a transferring care recipient who entered care before 1 July 2014 and they want to opt into the post-1 July 2014 fee arrangements:
    - they must complete the Continuing Care Recipient opting into the New Aged Care Arrangements from 1 July 2014 form (AC022)
    - the care recipient must submit this form to their new provider
    - the new provider must give them a copy of the New Arrangements for Aged Care from 1 July 2014 – Home Care publication before they transfer to the new service.

14. Leaving the HCP Program

This section covers:

- Administrative tasks
- Transferring unspent funds

14.1 Overview

This section tells providers the steps they need to take if a care recipient leaves the HCP Program.

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

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

- Sections 52D-1 and 56-2 of the Act
- Fees and Payments Principles 2014 (No.2)
- User Rights Principles 2014
- Accountability Principles 2014.

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

See Section 3, Section 4, Section 15 and Appendix E for further detail on specific provider responsibilities.

14.2 What administrative tasks do I need to complete?

14.2.1 Notify Services Australia of a care recipient ceasing care

Within 31 calendar days of a care recipient ceasing services, the provider must notify Services Australia through the Aged Care Provider Portal of their name, cessation date, and the reason for their departure (e.g., moving to residential aged care or passing away).

14.2.1.1 Care recipient moves to residential aged care

If a care recipient moves into permanent residential aged care, their start date with their residential aged care provider will be the date their home care provider ceases receiving payment of subsidies. It is important that the home care provider agrees with the individual and their residential aged care provider the cessation date for their package and the start date for residential aged care, to ensure the home care provider is eligible to receive all subsidies they are expecting to receive.

14.2.1.2 Care recipient dies

If a care recipient dies, the provider must take the following steps:

1. Ensure the departure is coded on the Service and Support Portal to stop subsidy accumulating.
2. Providers should call My Aged Care so they can update the client record to deceased. This is important, as it will ensure future communications with family members are mindful of this fact, and do not cause further distress.

Alternatively, providers can advise the care recipient's representative to call My Aged Care but should confirm both Step 1 and Step 2 have been actioned.

14.2.2 Complete hand over (if relevant)

It is important that aged care recipients have continuity of care. As a part of care management, providers should do a hand over with relevant parties when needed, to ensure each care recipient's care needs are understood. Providers should seek the care recipient's permission to share their information and documentation about their care. This will ensure any new providers of aged care will have as much information as possible to inform the care they provide.

This should occur before the care recipient's cessation date. If it occurs after the cessation date, the provider will not be able to charge the care management to them.

This will not be required if the care recipient has died.

14.2.3 Make payment of unspent home care amount

If a care recipient leaves home care or passes away, their provider must undertake the following with respect to unspent funds:

- Transfer the care recipient portion to the person or their estate. If they are leaving the HCP Program, this must be completed within 70 days after the cessation date. If they have passed away, this must be completed within 14 days of being shown the probate of the Will or letters of administration.
- If the provider has not opted-in under Improved Payment Arrangements to draw down on the Commonwealth portion of unspent funds (or if they have opted-in but not yet drawn down these funds to $0) the provider will need to notify Services Australia of the Commonwealth portion (including nil amounts) within 70 calendar days through the Aged Care Provider Portal.

Care recipients who join the HCP Program after 1 September 2021 will never have any Commonwealth portion held by the provider. Any unspent funds held by the provider will be entirely made up of the care recipient portion.

More information on the Improved Payment Arrangements.

Key points to remember

- Providers should support care recipients through the process of exiting the HCP Program, including when accessing other Government-funded aged care programs and services.
- Providers must notify Services Australia when a care recipient leaves the HCP Program.

15. Providers' reporting and administrative responsibilities

This section covers:

- Change in organisational circumstances
- Change in key personnel
- Financial disclosure obligations
- Provider Operations Collection Form
- Non-compliance with obligations or responsibilities
- Reporting issues

15.1 Overview

Once providers are set up to provide services under the HCP Program they need to continue to comply with their disclosure and reporting obligations.

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

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

- the Act
- Accountability Principles 2014
- Records Principles 2014
- *Aged Care Legislation Amendment (New Commissioner Functions) Act 2019*.

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

See Section 3, Section 4, Section 15 and Appendix E for further detail on specific provider responsibilities.

15.2 My organisation's circumstances have changed. What do I need to do?

There are 2 types of changes that providers need to notify either the department or the Commission about. These are covered in the sections below.

15.2.1 Changes to the home care service

Changes to the home care service includes things like changes of name, address or contact details.

In short, if the change affects who or how the department can contact the approved provider, they must notify the department. This can be done by completing the Notification of changes for Home Care Packages form.

15.2.2 Material changes to suitability

Approved providers have an ongoing responsibility to ensure they are ready and able to provide legislatively compliant, high quality and safe home care services at all times. For more information, see Section 2, Section 3 and Section 4 of this manual.

Provider suitability is assessed against the following 5 considerations:

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

If anything changes that materially affects these criteria, providers are required to disclose this information to the Commission. This information must be disclosed using the Notification of Material Change Form (s9-1, s9-2a) which can be found on GPMS. Find more information on how to submit this form.

All notifications must be made within 14 days of the change occurring. Penalties may be applied if a provider does not notify the Commission within this timeframe.

The Notification of Material Change Form can also be used by an approved provider to update information about its organisation, which may include changes to key personnel responsible for the overall governance of the organisation or the authorised contacts or address information.

15.3 My key personnel have changed. What do I need to do?

Providers are responsible for knowing who in their organisation meets the definition of key personnel as outlined in Section 8B of the *Aged Care Quality and Safety Commission Act 2018* and ensuring their key personnel are not a disqualified individual. Providers will be liable for any sanctions if it is determined that key personnel are disqualified individuals.

As discussed at Section 4.2.4, a disqualified individual is someone who has been convicted of an indictable offence, is insolvent or under administration, or is certified by a medical practitioner that they have a mental incapacity to perform their duties as key personnel. Each state and territory law identifies different types of offences as being indictable. These typically include serious offences such as murder, manslaughter, the intentional or unlawful administration of drugs or poisons, or committing fraudulent or dishonest activities.

Providers must take reasonable steps to ensure none of their key personnel are a disqualified individual. The following steps are taken by the legislation to constitute 'reasonable steps'.

For each of a provider's existing key personnel:

- Ensure that the person understands the obligations of key personnel and of approved providers under the Act in relation to disqualified individuals.
- If the provider reasonably believes that the person may be mentally incapable of performing his or her duties as one of their key personnel, make arrangements for the person to be examined by a registered medical practitioner.
- If the provider reasonably believes that the person may be a disqualified individual, take the steps outlined below.
- If the provider has ascertained that the person is a disqualified individual, ensure that the person ceases to be one of their key personnel.

For any person who proposes to become, or becomes, one of a provider's key personnel:

- obtain a police certification for the person (this requires their written consent)
- conduct a search of bankruptcy records
- conduct previous employment and referee checks.

If a provider fails to take reasonable steps to ensure their key personnel are not disqualified individuals, they may be liable to pay a fine, face revocation of their approved provider status or, in certain circumstances, face a prison sentence.

Providers need to keep documentation, such as police checks, confirming the suitability of their key personnel. These obligations arise under the Records Principles 2014 and outlined in Appendix E of this manual.

If there are any changes of circumstance relating to suitability of key personnel, providers are obliged to notify the Commission of these changes. Providers should also include the occurrence of events surrounding these changes. It is an offence not to comply with the responsibility to consider suitability matters relating to key personnel. Find more information on considering the suitability of key personnel.

15.4 What are my financial disclosure obligations?

Approved providers must complete an Aged Care Financial Report (ACFR) annually, 4 months after the end of their financial year.

All financial reporting requirements for residential aged care, HCP Program and STRC are reflected in the ACFR template so providers can report on all the aged care services they provide in one report to the department.

Find more information about the ACFR.

15.4.1 Home care financial reporting

To support all aged care providers to meet their legal obligation to complete the ACFR annually, the department sends each provider an ACFR User Guide. This guide is sent out during August, and a customised cover letter explains which sections of the ACFR are relevant to the recipient's organisation. The ACFR User Guide is also uploaded to the department's website annually.

Home care providers will be prompted to complete the Home Care Financial Report (HCFR) section of the ACFR. The HCFR is to be completed at a Planning Region level, with a home care service defined as an approved provider's home care operation within an aged care planning region.

While some providers will have their Home Care Service IDs at the planning region level, others will have their Service IDs at the package level (i.e. level 2 packages). Where Service IDs are at the package level, providers may be required to aggregate their financial information in order to complete the ACFR.

Home care providers that are not a state, territory or local government authority are also required to complete the:

- Approved Provider Income & Expenditure Statement
- Approved Provider Balance Sheet
- Approved Provider Cash Flow Statement.

Information on these can be found in the ACFR User Guide. These forms all collect financial data on the total operations of the approved provider, not just the HCP Program. There have also been recent changes to who can sign the declaration which is required to be submitted with the ACFR.

If the approved provider is not a state, a territory, an authority of a state or territory or a local government authority, the ACFR must be signed by:

- if the provider is a body corporate that is incorporated, or taken to be incorporated, under the *Corporations Act 2001*— a director of the body corporate for the purposes of that legislation
- otherwise—a member of the provider's governing body.

If the approved provider is a state, a territory, an authority of a state or territory or a local government authority, the ACFR must be signed by one of the approved provider's key personnel who is authorised by the provider to sign the report.

15.4.2 Lodgement

Providers must lodge all required sections of the ACFR with the department, via the online ACFR portal. The ACFR portal can only be accessed through VANguard or myGovID login. Providers must complete and lodge their ACFR by 31 October for the previous financial year ending 30 June.

There are no provisions within the legislation to grant extensions. Providers must lodge their ACFRs early to provide adequate time to address any issues and finalise all components of the ACFR as it relates to their organisation. The department may take compliance action if providers fail to comply with these requirements. A range of sanctions can be imposed on an approved provider including revoking or suspending approval as a provider of aged care services and restricting approval to provide aged care services. The type of sanctions imposed on an approved provider will depend on the nature of the non-compliance.

ACFRs cannot be lodged until all the required sections are completed and correct, and all necessary documents have been uploaded at the ACFR portal. The customised cover letter sent directly to all providers with each financial year's ACFR User Guide will outline all sections relevant to providers delivering the HCP Program.

15.4.3 Pricing review

Providers must also review their full price list and do one of the following:

- Report to the department that they have done so by entering 'Confirm review of pricing information' in the Service and Support Portal.
- Update their price list. This will cause the 'last updated date' to update in the department's systems and will be sufficient evidence that the provider has reviewed their price list.

Find more information on obligations related to pricing in Appendix B.

15.5 Provider Operations Collection Form

Providers must report information on their operations annually. This information is collected and published on My Aged Care through the Find a Provider tool.

The operation reporting period is from 1 July to 30 June each year. Information can be submitted starting in July and is due by 31 October each year.

Providers must submit information through the Provider Operations Collection Form on GPMS.

Providers must report the following operations:

- Executive position details, such as the Chief Executive Officer.
- Governing body membership, including:

    - the number of independent non-executive members and clinical care representation
    - whether the provider has exemption from this responsibility.
- A statement signed by the governing body stating whether the provider did or did not comply with its duties under the aged care legislation and:
    - each duty the provider failed to comply with
    - whether the non-compliance affected one or more services
    - the reasons why the provider failed to comply
    - actions taken to rectify the non-compliance
    - resolution of the non-compliance.
- Diversity information, including:
    - representation of First Nations, disability, gender diverse and culturally and linguistically diverse communities (or any other diversity demographic) within the provider's governing body
    - initiatives to support a diverse and inclusive environment for care recipients, residents and staff.
- Common kinds of feedback and complaints received by each service.
- Key improvements made to service quality.

15.6 What happens if I am not compliant with my obligations or responsibilities?

The consequences of identified non-compliance by aged care providers depends on the risks posed by the non-compliance and the provider's response to the Commission's concerns. The Commission's primary concern is the risks to the health, welfare or interests of current and/or future recipients of aged care services.

Reflecting this, compliance can include things like education, repayments, issuing a non-compliance notice or sanctions. If there is a recurring non-compliance, continued unwillingness or inability by the provider to address the non-compliance, the Commission may revoke their approval to provide aged care. Non-compliance could also result in criminal charges for the most serious breaches.

Note, other penalties or sanctions may also arise under other legislation, such as the consumer law.

Find more information about non-compliance on the Commission's website.

15.7 Reporting issues

Aged care providers are expected to spend package funds appropriately. Anyone can report suspected non-compliance to the relevant authorities for investigation.

15.7.1 Reporting suspected non-compliance with provider requirements

The Commission has processes for people to raise a concern or make a complaint about the quality of care or services provided to people receiving Government-funded aged care. Find more information about making a complaint to the Commission.

The consequences of identified non-compliance by aged care providers depends on the risks posed. When resolving complaints in relation to care and services, if the Commission finds a provider used package funds inappropriately then it can initiate compliance action, including at a minimum, repayment of any amounts that have been incorrectly charged.

15.7.2 Reporting suspected fraud

The department does not tolerate fraudulent use of HCP funding. If funding is used for purposes stipulated in the 'Specified Exclusions' table at Section 9.4 or for other items deemed not part of services or care to be funded by a HCP, the department may initiate a fraud investigation and take action accordingly.

The department has the power to investigate allegations of fraud against health funding and programs and is actively engaged in intelligence gathering with external agencies.

If you see something, say something because fraud is a criminal offence. If you suspect someone is engaging in fraud, please contact the department with the details of your concerns via email at ReportFraudorCorruption@health.gov.au. Alternatively, you can call the Health Fraud Hotline on **1800 829 403**, open 9am to 5pm AEST, Monday to Friday. You can report suspected fraud anonymously.

If an approved provider wants to self-report a concern, they should contact the department. Find more information on how to report suspected fraud.

Key points to remember

- Providers must notify the department of changes to their circumstances.
- Providers have an obligation to report financial information to the department annually by 31 October, relating to the previous financial year ending 30 June. They can complete reporting for all their aged care services in one form.
- Providers must notify the Commission of material changes to suitability.
- Providers are responsible for ensuring that key personnel are not disqualified individuals.
- Providers also have an obligation to review their price list annually.

16. Interface with other programs and schemes

This section covers:

- Interaction with the CHSP
- Interaction with other programs and schemes

16.1 Overview

This section provides information on what programs can be accessed at the same time as the HCP Program. It focuses on the CHSP, because it is related to the HCP Program within the Australian Government continuum of care for older people, but also discusses a broad range of other programs.

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

No specific obligations arise. However, the Act governs how the HCP Program interacts with other programs. As providers of services under the program, providers are expected to comply with those laws.

16.2 How does the HCP Program interface with other programs?

As outlined at Section 2, the HCP Program is a part of the Australian Government's continuum of care for older people.

It may be possible for a care recipient to receive care and services through a range of other programs and schemes that they cannot receive as part of their HCP.

Key programs and schemes are outlined below. Providers should work with their care recipients to identify additional services that they may need, and to explore the best available combination of health and aged care services.

Find more information about the individual programs on the My Aged Care website. Care recipients can also call the My Aged Care Contact Centre on **1800 200 422**.

The table below outlines what other services can or cannot be received at the same time as the HCP Program:

Services that may be received while receiving HCP Program services	Services that cannot be received while receiving HCP Program services
Commonwealth Home Support Programme (CHSP)^ Aged Care Volunteer Visitors Scheme (ACVVS)	Permanent residential aged care Short Term Restorative Care (STRC) Programme Transition Care Programme (TCP)

Continence Aids Payment Scheme (CAPS) Department of Veteran's Affairs (DVA) programs Residential Respite Care* Dementia Behaviour Management Advisory Services (DBMAS) Palliative care programs National Dementia Support Program	Multi-Purpose Services (MPS) Program National Aboriginal and Torres Strait Islander Flexible Aged Care (NATSIFAC) Program Disability Support for Older Australians (DSOA) Program National Disability Insurance Scheme (NDIS)

^Under limited circumstances

* Provided the care recipient has taken leave from their package.

16.3 Commonwealth Home Support Programme (CHSP)

The CHSP provides funding for a broad range of entry-level support services to assist frail older people aged 65 years and over (50 years and over for First Nations people) and who have functional limitations (including cognitive), to remain living independently at home and in their community[2].

Assessment for eligibility to access the CHSP is completed by an aged care assessment organisation. As with the HCP Program, older people can organise an assessment by calling the My Aged Care Contact Centre.

CHSP services are delivered on a short-term, episodic or ongoing basis. The CHSP has a strong focus on activities that support independence and social connectedness and taking into account each person's individual goals, preferences and choices. As with the HCP Program, people receiving services through the CHSP may need to contribute funds towards their services[3].

As an 'entry-level' program, the CHSP is designed to provide relatively low intensity (small amounts) of a single service or a few services to a large number of older people. These services are designed for older people who need only a small amount

[2] **Note**: the eligible ages for the Assistance with Care and Housing sub-program differ from those for the core CHSP. Find more information in the CHSP Manual.

[3] This occurs through the 'National CHSP Client Contribution Framework'. Find more information in Appendix F of the CHSP Manual (at the link above).

of assistance or support to enable them to maintain their independence, continue living safely in their homes and participate in their communities.

The CHSP is not designed for older people with more intensive, multiple or complex aged care needs, and does not replace or fund support services already provided through other programs or schemes, including the health care system. People with higher needs are supported through other aged care programs.

16.3.1 How does the HCP Program interact with CHSP?

The HCP Program is designed to support older people living in the community whose care needs exceed the level of support that can be provided through the CHSP.

While waiting the assignment of a HCP, older people may choose to access CHSP services in the interim.

However, once receiving a HCP, CHSP providers should only supply additional CHSP services to a care recipient where they have the capacity to do so. People who need CHSP subsidised services, but do not have access to other relevant support services, should be prioritised over people who are already receiving a HCP.

There are 6 defined circumstances in which care recipients are able to receive specific CHSP services on a time-limited basis when they are in a package. This means the additional CHSP services will not be charged to their package budget. These 6 circumstances are limited, to ensure the CHSP focuses on delivering entry-level services to their clients. They include:

1. **For care recipients on a level 1 or 2 package:** where the care recipient's package budget is already fully allocated, they can access additional, short-term or episodic Allied Health and Therapy services or Nursing services from the CHSP, where these specific services may assist the care recipient to regain functionality after a setback (such as a fall).
2. **For care recipients on a level 1 to 4 package:** where the care recipient's package budget is already fully allocated and a carer requires it, they can access additional planned respite services under the CHSP (on a short-term basis).
3. **For care recipients on a level 1 to 4 package:** in an emergency (such as when a carer is not able to maintain their caring role), where the care recipient's package budget is already fully allocated, additional services under the broader CHSP can be obtained on an emergency or short-term basis. These instances must be time limited, monitored and reviewed.
4. **For care recipients who are waiting for an upgrade to a level 3 or 4 package:** where the care recipient's package budget is already fully allocated, they can access additional minor home modifications from the CHSP.

5. **For care recipients on a level 1 to 4 package:** care recipients who have transitioned from the CHSP may continue to access their existing CHSP social support group on an ongoing basis to allow the continuity of social relationships. This only applies to care recipients attending a pre-existing CHSP social support group service.
6. **For care recipients on level 1 to 4 package or awaiting their package:** where there is urgent need, and the care recipient has insufficient funds in their package budget for GEAT, they may access GEAT in the short term. These instances should be time limited, monitored and reviewed.

During these times, the care recipient's package is not suspended and they will receive services from both the HCP Program and the CHSP concurrently.

Find more information in the CHSP Manual.

16.4 National Aboriginal and Torres Strait Islander Flexible Aged Care Program

The National Aboriginal and Torres Strait Islander Flexible Aged Care (NATSIFAC) Program is a separate aged care program specifically for older First Nations people.

Older First Nations people can access either the HCP Program or NATSIFAC Program, but they **cannot** access both.

Where older First Nations people access the HCP Program, home care providers may deliver culturally safe aged care services similar to those delivered by NATSIFAC providers. However, services must remain within the scope of the HCP Program.

Find more information on the NATSIFAC Program.

16.5 Residential aged care

Under the Act, an entry into permanent residential aged care will result in the immediate withdrawal of an active HCP.

Where a care recipient foresees that they will need to permanently move to a residential aged care facility, their home care provider is responsible for discussing this move with them and mutually agreeing a cessation date.

Sometimes entry to permanent residential aged care is unforeseen. Therefore, home care providers should plan with care recipients when negotiating the Home Care Agreement on how they will be alerted to an entry into permanent residential aged care so that they can cease service provision with immediacy.

Home care providers are also encouraged to create linkages with hospitals and residential aged care providers in their region to support continuity of care for the care recipient.

16.5.1 Transitioning to residential aged care

Check all prospective care recipients' My Aged Care client records for any active permanent residential aged care services before committing a package

In cases where aged care residents are on long-term leave from residential aged care for COVID-19 emergency leave or other emergency leave (e.g., for 6 months or longer), they may enter the National Priority System and be assigned a HCP. This is allowed by the system to ensure older people have choice and control to exit residential aged care.

Home care providers should check prospective care recipient's My Aged Care client record carefully before committing a package on their behalf and reject any older people who are still entered into permanent residential aged care until such time that they have:

- formally exited permanent residential aged care
- the home care provider has contacted the residential aged care service and confirmed cessation date
- a start date for home care is agreed to by both the care recipient and residential aged care service.

Do not lodge the ACER until the cessation date from permanent residential aged care is known. Once known, and if a Home Care Agreement is in place, make the entry date for home care for the day after departure from residential aged care.

If there is a lag in agreeing a cessation date from residential aged care and the package assignment letter from My Aged Care is withdrawn in the interim, either:

- The care recipient can call My Aged Care and ask to be placed back on the National Priority System – a new package will be assigned within a short period of time and entry can then be lodged from date of package assignment.
- Where the care recipient requires the package assignment referral code to be urgently reassigned for continuity of care, call My Aged Care and ask them to make an escalation to the department for delegate approval of package reassignment.

16.5.2 Care recipient believes they are in residential respite but are entered for permanent residential aged care

Where a care recipient believes they are in residential respite and a residential aged care provider submits an incorrect entry through the Aged Care Provider Portal, the home care provider should request the residential aged care provider to change the entry.

This may happen in cases where the residential aged care provider:

- submits an entry into the Aged Care Provider Portal for permanent residential aged care
- backdates a permanent care entry to override the period the care recipient was in residential respite.

Where the matter remains unresolved, providers should encourage the care recipient to make a complaint to the Commission for:

- exposing them to loss of unspent funds
- making them liable to pay the home care provider private fees if care and services continued for the period while the care recipient was thought to be in residential respite.

This applies if the package was not suspended due to the need to support the care recipient to return to the community (e.g., home modifications, light gardening, podiatry, speech pathology).

16.5.3 Care recipient knowingly enters permanent residential aged care while receiving a HCP

Where a care recipient knowingly enters permanent residential aged care, but does not alert their home care provider, depending on the terms of the Home Care Agreement, they may be liable to pay privately for any HCP care and services provided while they are in permanent residential aged care.

Providers must warn care recipients that entry to permanent residential aged care will result in:

- the immediate termination of their package
- potentially result in the loss of their Commonwealth unspent funds and, where relevant, a refund of their care recipient portion of unspent funds, **if** they do not return to the package within 56 days.

Where a care recipient has been in residential aged care for more than 56 days, and they intend to return to the community, care recipients must notify My Aged Care several weeks in advance of their return to facilitate re-assignment of their package.

Once a care recipient has withdrawn from the program, any care and services provided to the care recipient or their home cannot be funded through the HCP.

16.5.4 Resolution options for overlapping home care and residential aged care service claims

For retrospective overlapping claims, Services Australia will contact both the residential aged care service and home care providers and may ask for copies of Home Care Agreements and resident agreements to consider which claim to pay. Services Australia may offer you alternative options to seek recompense. It is suggested you follow this advice.

If a home care provider is unhappy with the outcome, contact your state/territory office to discuss other options for resolution. When contacting the state office, providers will need to provide copies of Home Care Agreements, care plans, individualised budgets, monthly statements, record of communication with the care recipient and/or their representative, and record of communication with the residential aged care service (if any) when making their case.

In extenuating circumstances where a care recipient has been in permanent residential aged care for less than 70 days and they exit residential aged care and return to the community, and where the residential aged care service is unable to retrospectively change the entry and an open complaint exists with the Commission, the delegate to the Secretary of the department may agree to reinstate the HCP and the home care account balance of the affected care recipient.

To do so, there should be evidence, substantiated by the Commission, that either:

- The residential aged care services did not provide the care recipient with choice and control because they did not have the respite allocation to admit them for residential respite.
- An acute health event led to an emergency admission and the care recipient and their family were not in a position to exercise choice and control.

16.6 Transition Care Programme

The Transition Care Programme (TCP) provides time-limited, goal-oriented and therapy-focused packages of services to older people after a hospital stay. The TCP aims to optimise the functioning and independence of older people after their hospital episode, and where possible, delay a person's entry into residential aged care.

Care recipients are able to access a transition care episode after a hospital stay if they are assessed and approved as eligible by an aged care assessor and take appropriate leave from their package. Information on temporary leave is at Section 11 of this manual.

It is the responsibility of the care recipient to notify their home care provider of their intention to take leave and enter transition care. It is expected, however, that the care recipient's home care provider and relevant transition care provider discuss and coordinate care provision to ensure that the care recipient's care needs are met.

The TCP is jointly funded by the Australian Government and state or territory governments, therefore older people receiving TCP cannot commence receiving HCP Program services until after they have completed their transition care episode. Home care providers must check for active transition care episodes and discuss this criterion with potential care recipients to ensure that they are aware that their transition care episode will cease if they enter into a Home Care Agreement.

It is expected that any transition from transition care to HCP will be discussed between the TCP and home care providers before commencement of the HCP to ensure the care recipients' continuing care needs are met.

Find more information on the TCP.

16.7 Short-Term Restorative Care

The Short-Term Restorative Care (STRC) Programme provides a time-limited, goal-oriented, multi-disciplinary and co-ordinated package of services. STRC aims to reverse and/or slow 'functional decline' in older people and improve their wellbeing.

A care recipient cannot receive STRC if they are also receiving a HCP. Home care providers must check for active STRC episodes and discuss this criterion with older people to ensure that they are aware their STRC episode will immediately cease if they enter into a Home Care Agreement.

It is expected that any transition from STRC to the HCP Program will be discussed between the STRC and home care providers before commencement of a HCP to ensure the care recipients' continuing care needs are met.

Older people may choose to end their STRC episode even if they have not yet met their physical and cognitive goals in order to enter the HCP Program. In this circumstance, the home care provider should ensure their care plan incorporates strategies to assist the care recipient to achieve these physical and cognitive goals.

Find more information on the STRC Programme.

16.8 Aged Care Volunteer Visitors Scheme

The Aged Care Volunteer Visitors Scheme (ACVVS), formerly known as the Community Visitors Scheme, supports volunteers to make regular visits to older people who are socially isolated or are at risk of social isolation or loneliness.

The ACVVS provides friendship and companionship by matching individuals with volunteer visitors. Providers should refer care recipient to ACVVS whose quality of life could be improved by the companionship of a regular volunteer visitor.

As part of the Lesbian Gay Bisexual Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy, the ACVVS was expanded to include services that specifically cater for the needs of LGBTI older people.

Care recipients may access ACVVS without any impact on services received through their package.

Find more information about the ACVVS, including frequently asked questions.

16.9 Continence Aids Payment Scheme

The Continence Aids Payment Scheme (CAPS) is an Australian Government scheme that provides a payment to eligible people with moderate to severe incontinence to assist with some of the costs of their continence products.

Under a HCP, the amount of care will vary from person to person, depending on factors such as the type of care and services being offered to the person, how and when those services are delivered, and whether some of the available budget is being used for specific items such as aids and equipment.

The care and services provided must be identified in the care plan and must fit within the available budget for the package level. Continence management is listed as an included item at Section 9.3.

Home care recipients can receive funding support under the CAPS so long as their package **does not already include** continence aids as part of their care plan. This is consistent with the eligibility requirements noted in the CAPS application form and guidelines.

Find more information on CAPS.

16.9.1 National Continence Helpline

A major resource of help for carers is the National Continence Helpline, run by the Continence Foundation of Australia.

The National Continence Helpline is staffed by professional continence nurse advisors who provide prompt and confidential advice and referral for people with incontinence, their families and carers, as well as health professionals and organisations with an interest in continence management.

The National Continence Helpline can arrange for resources and publications and provide advice regarding continence products and suppliers.The National Continence Helpline operates from 8am to 8pm, Monday to Friday on **1800 33 00 66**.

16.10 Department of Veterans' Affairs (DVA) programs

Older veterans or war widows/widowers may be able to access aged care services through the DVA and the HCP Program at the same time, as long as the same services are not accessed for both.

For example, a care recipient may access low-level domestic assistance and personal care through the Veterans' Home Care Program and receive social assistance and respite through the HCP Program.

Find more information on DVA home care programs.

16.11 Residential Respite Care

Care recipients are able to access residential respite if they are assessed and approved as eligible by an aged care assessor. Respite is standard practice to give carers a break and needs to be accounted for in care planning with care recipients. This is discussed further at Section 10.12 of this manual.

Care recipients can receive respite at the same time as a package, provided that they are not receiving the same services from both. For example, they may have a period of residential respite care but choose not to take leave from their package if they need gardening or other services about the home to keep it safe and secure. Leave is discussed at Section 11.

16.12 Palliative care

16.12.1 Palliative care and the HCP Program

Across the aged care and palliative care sectors, there is an expectation for home care workers to use a palliative approach to care.

16.12.2 The palliative approach

The palliative approach to care reflects a positive and open attitude towards dying and death, although it is important to note that 'palliative care' is not confined to the end stages of illness.

The use of a palliative approach to care by home care providers is reinforced in Quality Standards 2 and 4 of the Quality Standards, as discussed at Section 3.5.2.

Quality Standard 2 details the need for service providers to undertake assessment and planning to address current needs. The use of the palliative approach by aged care workers enables assessment and planning of the palliative care needs of care

recipients with life limiting illness (e.g., dementia, heart disease, cancer etc.) as well as end-of-life planning. The assessment and planning done by the home care provider will identify and address the care recipient's current needs, goals and preferences, including advance care planning and end of life planning.

Quality Standard 4 relates to the services and supports included in the HCP Program as listed in Section 9.3.

16.12.3 Specialist palliative care (SPC) services

Many care recipients will be well managed by aged care workers and primary care providers such as GPs and allied health providers and will not require specialist palliative care services. When a care recipient has complex or complicated symptoms, which cannot be managed by aged care workers using a palliative approach, a referral to a specialist palliative care (SPC) service is appropriate.

The skill mix and scope of practice of SPC team members is highly specialised and outside of the skill mix of the palliative approach provided by home care providers. Overall, SPC services offer a consultancy service where the SPC team member will review/assess the care recipient, liaise with primary care providers and home care providers and develop a palliative care plan for care recipients. The responsibility for everyday care such as personal care, ongoing generalist nursing, support services, care management and clinical care remains with the home care provider.

There is no duplication of services across nursing with the involvement of SPC services as the services they provide are outside of the expectations of the palliative approach to care of home care providers.

While the Australian Government provides a national leadership, education and policy role in palliative care, it provides funding to state and territory governments for the delivery of SPC services in their jurisdictions. This arrangement enables each state and territory government to make decisions about the provision of SPC services in their health systems, to meet the needs of their community. This forms part of their responsibilities through hospital and community service provision.

Find more information on SPC service providers.

16.12.4 Palliative care resources for aged care workers

The Australian Government funds education, experiential learning and resources in the Palliative Approach to Care.

16.12.4.1 Program of Experience in the Palliative Approach (PEPA)

The Program of Experience in the Palliative Approach (PEPA) is available to all levels of aged care workers (e.g., personal care workers, enrolled nurses, endorsed enrolled nurses and registered nurses).

Aged care workers are expected to utilise a palliative approach to care when caring for older people across the 3 tiers of support for aged care. In 2020, PEPA released learning guides for care workers as a learning resource on adopting a palliative approach to care. An aged care worker who has a working knowledge of the palliative approach to care will be able to assess and plan for the palliative care and end-of-life needs of care recipients.

Find more information on the PEPA, including access to learning guides.

16.12.4.2 End of Life Directions for Aged Care (ELDAC) Project

The End of Life Directions for Aged Care (ELDAC) Project aims to improve the palliative care skills and advance care planning expertise of aged care providers and GPs providing health care for older people receiving Government-funded aged care.

ELDAC provides a range of resources to support aged care workers to deliver quality palliative care including toolkits, services to improve connections between aged, primary and specialist palliative care services and palliative care navigation services.

Find more information on ELDAC.

16.12.4.3 PalliAGED

PalliAGED is a resource available to the aged care sector, which provides palliative care evidence and practice information for those providing care and also for older people, their families and friends. PalliAGED is managed through the Flinders University CareSearch project.

More information on palliAGED.

16.12.4.4 Other resources

Find a comprehensive list of palliative care funded programs and initiatives.

See guidelines for spiritual care in aged care.

16.13 National Dementia Support Program

The National Dementia Support Program (NDSP) funds Dementia Australia to provide education, resources, counselling and support to people living with dementia, their families and carers to improve awareness and understanding about the disease.

Under the NDSP, Dementia Australia have a website, National Dementia Helpline as well as professional counselling or group and individual support sessions. These resources can help care recipients, their families and carers with support strategies to cope with dementia, and provide advice on what to expect once they receive a dementia diagnosis. The NDSP also provides education and training to family members and carers of people living with dementia to help care recipients remain in

their own homes for longer (where appropriate) and help ensure family and carers are aware of the requirements of people living with dementia.

Providers should consider providing information about the NDSP directly to care recipients and their family members, particularly when the care recipient is eligible for the dementia and cognition supplement.

People living with dementia, their families and carers and health professionals can contact the National Dementia Helpline on **1800 100 500** (free call) to discuss any concerns or access information about memory loss or dementia.

Find more information on Dementia Australia and the NDSP.

16.14 National Disability Insurance Scheme

The NDIS funds reasonable and necessary supports that are not provided from other formal and informal sources. NDIS participants must be under 65 years of age when entering the scheme and meet other eligibility criteria.

Care recipients cannot receive NDIS and HCP funding at the same time.

For more information, refer to the NDIS provider toolkit.

Some people younger than 65 years of age need care but are ineligible for support through the NDIS. Find more information on supporting younger people in aged care.

16.15 Disability Support for Older Australians Program

The Disability Support for Older Australians (DSOA) Program commenced on 1 July 2021, replacing the Continuity of Support (CoS) Programme.

The DSOA Program is a closed program, available only to those who were receiving state administered disability supports prior to the rollout of the NDIS. It was designed to provide ongoing supports for older disabled people who, at the time of the NDIS being rolled out, were not eligible for the NDIS due to their age.

Once a DSOA client commences on a HCP, they are deemed to have exited the DSOA Program, and are not able to access funding from both programs.

Per Section 6.3 of the DSOA Program Manual that covers aged care assessments:

- A DSOA client can initiate an aged care assessment to access supports not available under the DSOA Program (i.e. CHSP services, such as social support, transport, home maintenance etc.).

- A DSOA client who feels their needs can be met through either a HCP or residential aged care would need to accept that accessing these services will mean exiting the DSOA Program.
- The DSOA service coordinator needs to make clear to aged care assessors if:
    - the client is being referred to access supports not available under the DSOA Program
    - the referral is because the client is expressing an interest in accessing aged care supports instead of the DSOA Program.

Find more information about the DSOA Program.

Key points to remember

- Generally, care recipients cannot receive service from both the CHSP and HCP Program at the same time. In limited circumstances they may be able to access small amounts of top up CHSP at the same time as the HCP Program.
- Care recipients can receive support from some other programs where needed.
- The HCP Program cannot be received at the same time as STRC, TCP, permanent residential aged care, NDIS and DSOA.

17. Glossary

This section covers:

- Terms and meanings

Term	Meaning
ACER	Aged Care Entry Record form (AC021) is used to notify Services Australia of new care recipients entering care, or changes to existing care recipients' circumstances.
Australian Government	The Federal Government of Australia.
The Commission	The Aged Care Quality and Safety Commission. The Commission is a statutory body, responsible for overseeing the Aged Care Quality Standards across the aged care sector.
The department	The Australian Government Department of Health and Aged Care.
Quality Standards	The Aged Care Quality Standards. The Quality Standards are established under the *Aged Care Act 1997*, and all approved providers of aged care are expected to be compliant.
Approved provider (or provider)	An approved provider of aged care is an organisation that has been approved to provide residential aged care, home and/or flexible care under the *Aged Care Act 1997*.
Basic daily fee	Refers to a home care fee that a care recipient may be asked to pay by a home care provider based on their package level (separate to the Home Care Package subsidy).
Care plan	A care plan is a document that defines the care, services and/or purchases that a care recipient is going to use their package budget to fund.
Care recipient (or 'home care recipient')	A person who is receiving care and services through a Home Care Package funded by the Australian Government, under the *Aged Care Act 1997*.
CDC	Consumer directed care.
Consumer	Consumer means a person to whom an approved provider provides, or is to provide, care through an aged

Term	Meaning
	care service. Includes other people who are authorised to act on behalf of the care recipient.
CHSP	The Commonwealth Home Support Programme that provides entry level 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.
Dignity of risk	An individual's right to make choices to take reasonable risks.
DVA	Department of Veterans' Affairs
Exclusions	Care, services or purchases that cannot be funded from a package budget.
FAS	VANguard Federated Authentication Service
GPMS	Government Provider Management System
Home care	Refers the Home Care Packages Program. A type of aged care for which a home care subsidy is payable under Part 3.2 of the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997*.
Home care provider (or approved provider)	An organisation approved by the Department of Health and Aged Care under Part 2.1 of the Act as suitable to provide home care. In the *Aged Care Act 1997*, this person or body is referred to as an "approved provider".
Home Care Agreement	An agreement entered into by a care recipient and a home care provider outlining rights and responsibilities and what services will be provided to the care recipient under the package.
Home Care Packages Program	The Australian Government program that provides funding for packages aimed at supporting people to remain living at home.
HCP	Home Care Package

Term	Meaning
Home care account	Since 1 September 2021, each care recipient has a home care account managed by Services Australia and into which their Home Care Package subsidy is paid.
Home Care Package subsidy	The total subsidy payable to a home care provider by the Australian Government under Part 3.2 of the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997*. The Home Care Package subsidy include the basic subsidy and eligible supplements.
IAT	Integrated Assessment Tool – replacement of National Screening and Assessment Form (NSAF).
Inclusions	Care, services or purchases that can be funded from a package budget.
Income tested care fee	A home care fee a care recipient may be asked to pay based on an income assessment.
Instrument	Primary legislation, delegated legislation, or a determination under legislation.
Improved Payment Arrangements	Changes in September 2021 to how the Australian Government pays home care providers.
Key personnel	Key personnel are: • People responsible for the executive decisions of the applicant (this includes directors and board members), whether or not the person is employed by the applicant. • People having authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the applicant, whether or not the person is employed by the applicant. • Any person responsible for nursing services provided, or to be provided, by the applicant, whether or not the person is employed by the applicant. • Any person who is, or is likely to be, responsible for the day-to-day operation of an aged care service conducted, or proposed to be conducted,

Term	Meaning
	by the applicant, whether or not the person is employed by the applicant.
Leave	A care recipient suspending care, services and purchases under their package for a specified period of time.
Maximum contribution amount	The full Home Care Package subsidy and anything available in the care recipient's home care account.
Monthly statement	A document provided to care recipients every month that shows the package budget funds available to that care recipient and what has been spent from the budget.
My Aged Care	My Aged Care is the starting point to access Australian Government-funded aged care services. The phone line and website can help older people, their families and carers to get the help and support they need.
NAPS	National Approved Provider System (system replaced by GPMS).
National Priority System	The National Priority System is a standardised process for prioritising assignment of packages.
NSAF	National Screening and Assessment Form .
Package budget	The funds available to be spent under a care recipient's package. A care recipient's package budget is made up of contributions from the Australian Government and, where applicable, home care fees paid by the care recipient themselves.
Pre-1 July 2014 care recipients	Care recipients who entered the HCP Program before 1 July 2014. Packages for pre-1 July 2014 care recipients have different home care fee arrangements.
Price	The amount that providers report to Services Australia in their claim. Providers report the price per care recipient, each month. Services Australia refers to the price as the invoice amount.

Term	Meaning
Principles	Delegated legislation made under the *Aged Care Act 1997*.
Reablement	Reablement is an approach to aged care, involving time-limited interventions that are targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities.
Residential aged care	This program provides high-levels of care to people in a residential aged care home.
Security of tenure	Security of tenure means providers are required to continue to deliver the agreed care and services for as long as the care recipient needs those services.
Services Australia	Formerly known as Department of Human Services and Centrelink.
Shortfall amount	The price (minus the Commonwealth portion of any unspent funds which are being returned, for providers that opt-in), minus any income tested care fee the care recipient is assessed to pay.
Subsidy	An Australian Government contribution to all care recipient's package budgets, determined on the basis of the level of the package the care recipient has been allocated.
Supplement	An Australian Government contribution to a care recipient's package budget, where the care recipient satisfies the specific eligibility criteria for that contribution.
The Act	*Aged Care Act 1997.*
The Principles	• Accountability Principles 2014 • Approval of Care Recipients Principles 2014 • Committee Principles 2014 • Fees and Payments Principles 2014 (No.2) • Information Principles 2014

Term	Meaning
	• Quality of Care Principles 2014 • Records Principles 2014 • Prioritised Home Care Recipients Principles 2016 • *Aged Care Legislation Amendment (New Commissioner Functions) Act 2019* • User Rights Principles 2014.
Unspent funds	Any component of a care recipient's package budget that has not been spent, including: • the balance of the provider-held care recipient contributed unspent funds • the provider-held Commonwealth portion of unspent fund • the Services Australia home care account balance (Government held unspent funds).
Wellness	Wellness is an approach to aged care involving assessment, planning and delivery of supports that build on the strengths, capacity and goals of individuals, and encourage actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home.